Hospital

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Plus

- Ensuring Quality in Outsourcing
- Operating Room Efficiency
- Clinical Laboratory Business Analysis
- Focus: Poland

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SOLIDARITY – NOW, MORE THAN EVER...

Willy Heuschen

As I write these lines, many are worried about the cohesion of Europe. Several European summits were necessary to arrange for the long-term support of a few Member States. However, even if these measures taken by the Ministers of the European Council were to be efficiently implemented, Member States should nevertheless prepare for more turbulence ahead. Drastic cost-cutting packages are announced in most countries, and hospitals are already getting their first distinct taste of just how difficult and risky their implementation is.

"Leading Change in Challenging Times" – this was the banner headline chosen by the Health Management Institute (HMI), our Irish sister association, for its first annual meeting. We will be publishing some of the most interesting contributions in upcoming editions of *(E)Hospital*. How to cut costs without compromising the quality of the health services offered was the fundamental question at the heart of all contributions. Remarkably, our Irish colleagues also turned to expertise from the European mainland in their search for answers. Speaking amongst other colleagues from the United Kingdom, Heinz Kölking, President of the EAHM, stressed the fact that even in countries not so badly affected by the current crisis, cost-cutting is still very much on the daily agenda. Regarding German hospitals, he illustrated the balancing act between cutting costs and ensuring quality, made possible by an adaptable corporate culture. Regarding this particular form of management we would like to refer our readers to this issue's leadership cover story with articles from Prof. Malik and Sue Hodgetts.

Apart from their valuable content, these contributions also symbolise the idea of solidarity. Solidarity is a fundamental requirement in the process of growing closer together, not only in times of crisis. This is true on a global scale, for Europe, for European institutions, for our own countries – and it is also true for hospital managers. Learning about the difficulties a neighbour might face, helping them to find a solution, employing their knowledge and experience without lapsing into presumptuousness... in short, benchmarking aimed at values is an adequate tool, but it is also an expression of solidarity.

It is my firm belief that hospitals should remain places of solidarity par excellence. The funding systems of public health and therefore of hospitals are currently already based on the principle of solidarity. All insured persons have with equal financial contributions, a right to treatment and care that adequately treats their medical condition. We know that solidarity is often questioned. For instance, several statutory health insurances are considering passing costly treatment onto private insurances; likewise, some hospitals are contemplating cutting loss-making treatments from their list of offered services. If patients really and truly are at the centre of all acts within our hospitals, such practices should be seen as highly questionable.

In managing our institutions we experience this solidarity on a daily basis; within a team of workers, within and between different professions. And solidarity is the precondition to find common ground for our goals.

Solidarity must be a value to be lived by, and this is also true for the EAHM. Against the background of the financial crisis of their country, our Greek colleagues are doing their utmost to organise the 24th EAHM Congress in Athens 2012. At the moment the risks are not fully calculable, and we have to carefully examine the prerequisites needed to guarantee the smooth running of the congress. The Board of the EAHM has decided to support our Greek colleagues with this task. We will present the results to the Executive Committee in Dusseldorf, who will then make a final decision. We are making all efforts to not only realistically assess the risks but to also include solidarity as a basic principle into this difficult decision-making process. We explain our decision and the process behind it more closely in the "Letter from the President", which all members will receive in December and which will also be available on our website. It is more than just an educated guess that solidarity, greater than ever before, will be required from each and everyone of us, in order to ensure a promising future.

Willy Heuschen
EAHM Secretary General and Editor-in-Chief

The editorials in *(E)Hospital* are written by leading members of the EAHM. However, the contributions published here only reflect the opinion of the author and do not, in any way, represent the official position of the European Association of Hospital Managers.

Leadership

This issue's cover story focuses on leadership. Sue Hodgetts believes that effective leadership is key to the smooth running of a hospital and shares with us the three fundamental axioms of leadership. Prof. Malik, an expert in the field, introduces us to uncluttered management thinking. He believes there are six principles all managers should stick to. Our dossier on leadership concludes with an article on the time-old debate: Do physician leaders improve hospital performance?

Operating Room Efficiency

The OR is one of the most cost-intensive areas of a hospital and has been found to account for up to 40 percent of total hospital costs. It makes perfect sense that, in an era of reduced government budgets or reimbursements, hospital management need to make cost savings in this department. Maximising the capacity of the OR is therefore a key factor in minimising cost.

Focus: POLAND

In this issue's country focus we look to Poland, current holders of the Presidency of the Council of the European Union. Articles include an overview of the healthcare system; an introduction to the Polish Association of Hospital Managers and their recent activities; and a look into Polish patient associations and their collaboration on the European level. We also learn more about the objectives of the Polish Presidency in terms of European healthcare.

Capital Equipment Investment

Capital Equipment Strategic Planning is a proactive approach to cost-effectively prioritising the annual replacement of aging equipment. Such plans provide an unbiased framework for evaluating and prioritising a hospital's capital equipment needs. Hospital executives can now make better-informed decisions because the provided data was validated and weighted, most often by an unbiased third party consultant.

WP-IT MANAGERS KICKS OFF **WITH CEO SEMINARS IN VIENNA AND VILNIUS**

The Working Party IT-Managers (WP-ITM) has set the first steps in bringing CEOs and IT as well as CIOs and management closer together. The approach taken by the WP-ITM is a direct result of the reflection process held last year within the EAHM. The first regional seminars for CEOs in Vienna, Austria and in Vilnius, Lithuania have taken place with great success. During these seminars, CEOs were invited to look into the translation of the hospital strategic plan into an IT masterplan.

Before delving into the masterplan background on the topic was given to the participants from different angles. First, the problem of IT-governance in hospitals was discussed and linked with a typology of IT decision makers in hospitals. Secondly, different challenges in health informatics were presented together with different international initiatives to help the hospitals. Given this context, the seminars continued with the topic of IT-Strategy based on the mission and hospital strategy, which was further divided into system, organisational and resource strategy.

Once an IT-strategy is defined, the IT-masterplan can be started. Attention was given to the content and how to setup an IT-masterplan as well as its approval and implementation. In the last core session, attention was given to the follow-up of the implementation of the IT-masterplan for which some guidelines have been formulated. Part of the seminar was devoted to workshops in which participants worked together in formulating an IT-strategy and setting up an IT-masterplan.

The seminar in Vilnius was complemented with several cases which made the theme more alive, including topics such as the development of hospital IT and improving efficiency of healthcare institutions by implementing eSolutions. An exhibition in Vilnius gave the possibility for the participants to meet the partners and to discuss the possibilities of presented solutions.

Through these seminars the WP-IT has reached around 100 CEOs. The discussions made clear that hospital managers are aware of the growing role of IT in running a hospital and that the development of IT-infrastructure must be profitable and sustainable for the hospital so the hospital can fulfill its mission and objectives. It was also clear that interconnections are growing, in the hospital itself but also with other institutions and organisations. The situation may differ from country to country but national, local and also European authorities have a significant role in assuring that holistic and standardised information can be exchanged in an efficient way with the many actors healthcare in the best interest of the patient.

The WP-ITM is now looking into organising seminars for other regions in Europe.

Note: the presentations of the seminars are available on our website: **www.eahm.eu.org**

These seminars were made possible by the support of following speakers:
B. Carr *(Adelaide Meath Hospital, Ireland)*
Dr. Carl Dujat
(promedtheus AG)
Gerhard Härdter
(Klinikum Stuttgart, Gemany)
Gunther Kostka
(Az Sint Lucas & Volkskliniek, Belgium)
Dr. Pierre-Michael Meier
(Entscheiderfabrik, Germany)
Jos Vanlanduyt *(EAHM)*

and by the following partners:
KMS, Id Information Und Dokumentation Im Gesundheitswesen, Intersystems, Meierhofer, Ser and Vamed *(Seminar in Vienna)*

For more information, please contact:
Jos.vanlanduyt@eahm.eu.org

Agenda 41st Normal General Assembly

The meeting will be held on 18 November 2011 from 17.30 – 18.30, at Messe Düsseldorf, CCD-Ost, room M Düsseldorf (Germany)

1. Approval of the agenda
2. Approval of the minutes of the 40th Ordinary General Assembly, held on 9 September 2010 in Zurich, Switzerland
3. President activity report 2010-2011
4. Tendering of accounts for 2010
   - **4.1.** Presentation by the Secretary General
   - **4.2.** Auditors' report
   - **4.3.** Approval of accounts for 2010 and discharge of the Board and the Secretary General
5. Economic plan for 2012
   - **5.1.** Approval of the proposed membership subscription fees of full members and associate members (2.4.c of statutes)
   - **5.2.** Approval of the economic plan for 2012
6. Election of auditors for the year 2011
7. Admission and exclusion of members
8. Next Ordinary General Assembly 2012

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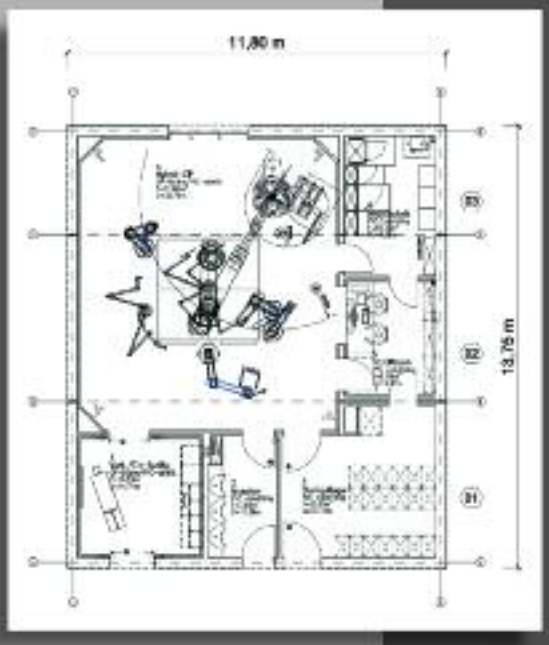

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LEADING CHANGE IN CHALLENGING TIMES

The Role of the Health Manager

The Health Management Institute of Ireland (HMI) held their inaugural annual conference in Dublin on 3 October 2011.

Held in the historic location of Farmleigh House (former residence of the Guinness family) in Phoenix Park, the one-day conference was opened by Minister for Health, Dr. James Reilly. The Minister stressed that regardless of the economic situation the patient should come first. He believes they are often second to processes, "You grapple daily with the challenges of delivering complex services safely and efficiently within diminishing resources. But diminishing resources don't change the central imperative of any health service. The first instruction to a doctor has historically been: 'First, do no harm.'" Dr. Reilly praised the work of the HMI in helping managers to develop high levels skills and providing continuous professional development. He stressed that "every part of the health service should be managed at a professional level by people equipped with the knowledge, understanding and skills to carry out this demanding task."

Speakers were a mix of Irish and international health managers and experts. The morning session was entitled 'New Policies, New Practices'. During this session, Mr. Cathal Magee, Chief Executive Officer of the Health and Safety Executive (HSE) addressed the challenge of health service reform, a huge issue in Ireland at the present moment and indeed many other European countries. Mr. Heinz Kolking, President of the EAHM spoke of European healthcare funding strategies another important topic in the current economic climate.

After lunch and a quick guided tour of the historic surroundings, the afternoon session 'The Challenge for Managers' began. This session examined the challenge facing managers in bringing about the changes required. What leadership competencies are required? What breakthrough strategies will deliver results? What strategic investments should now be planned to enable delivery of the change require?

David Fillingham, Chief Executive of AQUA (Advancing Quality Alliance), focused on the time-old question: Can we get better quality healthcare at a lower cost? Also in this session, Sue Hodgetts, Chief Executive of the Institute of Healthcare Management introduced attendees to new leadership competencies. There was time for a panel discussion at the end of each session during which there several lively debates offering health managers the opportunity to share their experiences.

Photo 1
Left to right: Gerry O'Dwyer, Heinz Kolking, Sue Hodgetts, James Reilly, Richard Dooley, Willy Heuschen

(E)Hospital spoke to Mr. Richard Dooley, President of the HMI during the event. He explained the motivation behind this first annual conference, "There is recognition in the health service that we need a voice, a professional voice for managers and we need a mechanism to put this voice together. We have had the HMI in place for about 8 years. It has a threefold mission: To educate, to inform and to involve." With help from strategic partner SHRC Consulting the HMI fulfil education requirements through innovative training products and e-learning. Members are kept informed through the e-magazine Health Manager and the conference is the third step, "today's conference is about involvement, bringing managers together."

Mr. Dooley recognises that the current model of service delivery is not fit for service and reform is a necessity. He believes that management is key to successful reform, "reform has commenced but it has been haphazard in its commencement. In order to progress reform you need management and leadership calibre of the highest order to achieve that. We believe this can be done by investing in health service managers, investing in their professional development so that we can put the right management and leadership competencies in place with managers at the right level that will allow them to see through this reform."

For more information on the conference or the association, please visit: **www.hmi.ie**

ECDC DIRECTOR SPEAKS ON REINFORCING TRUST, KEY ROLE OF DOCTORS, HEALTHCARE WORKERS TO REACH EU VACCINATION GOALS

"The role of doctors and healthcare workers in direct contact with parents and children is paramount," said ECDC Director Dr. Marc Sprenger at the World Health Summit in Berlin, Germany. Speaking at a panel on 'Bridging Health Gaps with Vaccines', Dr. Sprenger emphasised that "effective communication (to parents) is important to reinforce trust. Here the support of paediatricians, family practitioners and nurses is essential."

He presented the situation of measles in Europe. "Measles is re-emerging in Europe – and in a dramatic way. In 2010 alone, more than 30,000 cases of measles were reported in the EU." He added that some people think that it is a 'fairly harmless disease.' But statistics from the ECDC European monthly measles monitoring report states that there are eight measles-related deaths and 24 acute measles encephalitis in EU countries from this year alone. In addition, around 25 percent of those affected with measles need hospitalisation, due to complications such as pneumonia and high fever in young children.

ECDC is committed to support doctors and healthcare workers with effective communication tools, to provide expert advice and methods regarding how to monitor and assess immunisation programmes. To this end, the ECDC will organise workshops for Member States to share experiences and best practices and provide data for action.

The World Health Summit was held from 23-26 October 2011 in Berlin.

For more information, please visit:
www.worldhealthsummit.org

HEALTH INFORMATION SEEKING BEHAVIOUR ON THE WEB

Eight out of every ten physicians report experience of patients presenting printed internet-sourced health information at visits, which suggests a new dynamic in the traditional doctor–patient relationship. This is one of the findings of the literature review on health information-seeking behaviour on the web that ECDC published recently.

The purpose of the review is to provide an overview of online health information-seeking behaviour by adults from the perspective of both the health consumer and the health professional. Research shows that, although they have difficulty of identifying and filtering the most useful, accurate and credible sources, the health professionals' use of the internet to obtain health and medical information has increased.

As for the online health consumer, they tend to be more educated, earn more, and have high-speed internet access at home and at work. The literature review also shows that women are more likely than men to search for health information.

The report concludes by outlining the implications for health communication research in Europe and the identification of gaps and the focus for further research.

The literature review, one in a series of 'Insights into health communication' on the prevention and control of communicable disease in the European context, focuses on research published from 2006 to 2010 in English language.

For more information, please visit:
http://ecdc.europa.eu/en/publications/Publications/Forms/ECDC_DispForm.aspx?ID=753

Healthcare's Moment of Truth.

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THE EU'S WAR ON DRUGS

By Rory Watson

European authorities are gaining new weapons in their fight against counterfeit medicines and new synthetic drugs. At the end of October, the world's first international treaty to make dealing in counterfeit medicines and devices a criminal offence was opened for signature. A few days earlier, the European Commission announced it would be overhauling European Union rules on illicit drugs in order to take stronger action against new psychoactive substances in particular.

The Council of Europe's Medicrime Convention breaks new ground in efforts to clamp down on counterfeit medicines. Three years in the making, the convention was immediately signed by a dozen countries as soon as it became possible to do so on 28 October at a conference in Moscow examining ways to tackle the growing phenomenon.

The new convention is not designed to add further protection to the intellectual property rights of bona fide drug manufacturers since these are extensively covered by existing legislation. Nor does it impinge on EU and national responsibility for ensuring the safety and efficacy of medicines. Instead, it addresses the harm which counterfeit medicines can cause to the health of individuals.

As Kristian Bartholin, a Council of Europe official involved in drafting the convention, explains: "We want to do something different and shift the focus on to the protection of public health. Counterfeiters have no qualms at all in putting poison in medicine." As an example, he cited pills which had been coated in yellow paint used for road markings to give them the necessary distinctive colour and had caused liver failure.

The convention makes it a criminal offence to manufacture, supply, offer to supply or traffic in counterfeit medical products; to falsify documents; to manufacture and supply medical products without authorisation; and to market medicines without complying with industry standards.

Countries signing up to the convention will be required to have the necessary criminal law in place to investigate and punish any crimes detected. It will be up to national authorities to determine the level of penalties to be applied, but these will include prison sentences and confiscation of assets. One of the convention's strengths is that it positively encourages cooperation between the competent health and law enforcement authorities in different countries and makes it possible to extradite suspects from one jurisdiction to another.

Since the counterfeiting of medical products and devices is a global phenomenon, the Council of Europe has taken the rare step of inviting countries other than its 47 members to sign up to the convention. It has regularly informed the World Health Organisation of progress in drafting the convention and will explain to other countries in the months ahead the benefits it can bring.

According to the WHO, counterfeit medical products account for less than 1% of market value in developed countries where efficient regulatory control mechanisms exist. But this can rise to over 50% in developing countries. In some parts of Europe, such as the Balkans and Russia, they represent between 6% and 20% of the market.

While the Council of Europe has opened a new front in the fight against counterfeit medicines, the EU is looking to strengthen its defences against illegal drugs. It aims to do so by putting forward a package of measures in the months ahead. This will include legislation on new psychoactive substances which could include temporary bans and a clamp down on internet sales; improving definitions of offences and sanctions to target cross-border drug trafficking; new laws on drug precursors; measures to deprive drug traffickers of their illegal financial gains; and an emphasis on closer international cooperation.

According to a recent pan-European Eurobarometer survey, 5% of young people have used new synthetic drugs. Use is highest in Ireland (16%), Poland and Latvia (9%) and the UK (8%). At the same time, the survey revealed that throughout the EU, a large majority of 15 to 24-year olds favour banning the substances.

In another development, the European Parliament is drawing attention to the need to step up the fight against resistance to antimicrobial agents in human medicines. It has called on the European Commission to "propose without delay a legislative framework for action against antimicrobial resistance" by promoting responsible use initiatives.

In particular, it is emphasising the need for prudent use of antimicrobial agents both for humans and animals by ensuring these are only used when effectively needed for the actual treatment of disease, while respecting the correct level, frequency and duration of the dosages. MEPs are also calling for more monitoring and research into antimicrobial resistance.

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EFFECTIVE LEADERSHIP

The Key to Successful Hospital Management

By Sue Hodgetts

The Top Hospital Award (www.chks.co.uk) bases its criteria on five categories: Quality and change; safety; leadership; organisational culture; and external Influence. And although leadership is a separate category and specifies strong stable continuity of the CEO; distributed leadership model; empowered clinical leaders and patients; investments in development; and the totality approach, I can't help but think that the other categories would be impossible to achieve without effective leadership.

Leadership is an overused word, but the capacity for leadership is often woefully lacking. If we start with the desire for leadership from organisations, a desire for someone to lead them through to greatness, to make the organisation famous for its good works so everyone working there will feel a sense of pride, we start with a dream. I'm not saying that these organisations don't exist (see " Top Hospital award" winners), or that there aren't leaders capable of the above, but more often than not, the organisations that desire leaders can be structured in ways that kill (metaphorically) leaders. Of course an effective leader can overcome this, take bold moves to change the culture and the structure and turn an organisation around. But organisations can become machines that destroy leaders; conformists or role-players are encouraged, with an impoverished sense of who they are and what they stand for. Ineffective leaders give rise to disenchanted followers and organisation malaise.

To continue in this vein (not much longer I promise), I believe our understanding of leadership is blinkered, despite all of the literature and the great films that depict the ideal leader, it is surprising how little we know about leadership. This is not a criticism of our academic colleagues, but an observation about the methodology used and the fundamental assumptions upon which much research has rested.

The main body of research is about the characteristics of leadership and has a strong psychological basis. The research implies that leadership qualities are inherent and leadership is something we do to others, rather than being reliant on forming appropriate relationships and working with others. I realise that of course there is a dichotomy of views here and I am aiming my criticism at one end of that spectrum.

My view, based on a lifetime of observation in both public and private sector work, is that there are no universal leadership characteristics; it can't be cloned. What works for one, may not work for another. Authenticity underpins the success of a leader and individuals who aspire to be leaders need to discover what it is about them that they can mobilise in a leadership context. Individuals need to identify and deploy their own leadership assets.

Ineffective leaders give rise to disenchanted followers and organisation malaise

Effective leaders have an overarching sense of purpose together with sufficient self knowledge of their potential leadership assets, they don't know it all, but they know enough, and they are willing to listen and learn.

Three Axioms of Leadership

Individual leaders are driven to become more effective as a leader, but also to develop other leaders. Thus, I believe there are three fundamental axioms of leadership:

- Situational;
- Non Hierarchical; and
- Relational.

Common sense tells us that that leadership is situational; the kind of leadership required will be influenced by the situation. Many leaders have had their time and their place. For example, Winston Churchill: An inspirational war-time leader, but his bulldog style was ill suited to the reconstruction agenda in post war Britain. Nelson Mandela, by contrast has the ability to offer leadership across widely different contexts: A prison cell contrasting with the graceful lawns of Union House in Pretoria.

I'm sure we all have examples closer to home. An effective hard edged turn around leader manager, who lacks the qualities to offer leadership when it is time to build organisations. More adaptable colleagues are able to take their teams with them.

Situation sensing is the key to effective leadership; picking up important situational signals; understanding what is going on under the surface; having both micro and macro skills; walking the corridors as well as managing stressful and challenging board meetings. The situation/context is the starting point, once understood actions can then shape that context to deliver efficiently. Leaders can reframe the situation, not reframe themselves, support others to reframe the context and develop those all-important relationships.

Productive leadership is non - hierarchical. Interestingly, a job title may confer hierarchical authority, but that doesn't make you a leader. Qualities that take you to the

top of an organisation may have nothing to do with leadership, but may arise due to political acumen, personal ambition, time serving, nepotism and the like. Great organisations have great leaders at all levels. Successful organisations seek to build leadership capacity widely and give people the opportunity to develop it.

> There are no universal leadership characteristics; it can't be cloned. What works for one, may not work for another

Relational leadership is essential to success as a leader. You can't be a leader without followers. Leadership is a social construct that is recreated by the relationship between leaders and those who they aspire to lead. Leaders are actively engaged in a complex series of relationships that require cultivation and nurturing. The web of relationships is often fragile, requiring constant re- creation. Relationships aren't necessarily harmonious, they are often "edgy" and provide challenge in a healthy organisation; challenge to improve, innovate and take risks.

Underpinning all of the above is authenticity; consistency between words and deeds, coherence in role performance, and an underlying thread of focus and fairness. As a leader you need to be yourself, know and show yourself, challenge yourself and others and take risks. Take time to learn about the context, remain authentic, but be able to conform- enough, manage fragile networks, communicate with care and develop an authentic "followship." Without the above, you will be found out!

Effective leadership is hard. Never underestimate the amount of effort and energy required, never underestimate the skills and knowledge required. True leadership is evident through the behaviour of an individual. What you see and experience is what you get.

Accredited Managers

Good leaders measure themselves, and a robust way of doing this would be to look at the eleven behaviours that make up the IHM Accredited Manager Award. This award is not just for executive and senior managers, but is also available for middle and frontline managers. It provides a career framework for managers that requires re-accreditation every three years. This is about continuous professional development, ensuring currency and competence for all managers. The eleven behaviours are as follows:

- Contextual leadership;
- Managing the political and stakeholder environment;
- Delivery outputs;
- Putting safety first;
- Managing resources effectively and efficiently;
- Building winning teams;
- Communication and relationship management;
- Improvement and innovation;
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- Reflection; and
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Thus I leave you with two quotes:

"There is only one thing more painful than learning from experience, and that is not learning from experience"
Archibald Macleish

"Working is about daily bread…
We have the right to ask of work that it include meaning, recognition, astonishment and life"
Studs Terkel

True leaders never stop learning and champion the rights of others.

Author:
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UNCLUTTERED MANAGEMENT THINKING

Management Principles as a Way to Results

By Fredmund Malik and Johannes Flecker

Imagine an operating room with surgeons and scrub nurses operating on a patient. Imagine they all had a different understanding of the word 'surgery'. Imagine they were unsure about their tasks, competencies, and responsibilities. Imagine they would evaluate their performance by the duration of the operation rather than by the outcome. Imagine they would handle the medical instruments by instinct rather than by mandatory education and years of experience. Unimaginable.

Thinking is uncluttered in the operating room. The medical language is clear and concise, as misunderstandings and failures lead to immediate adverse effects on patients' well-being.

Uncluttered Thinking is Necessary for Management

It's essential to think, speak and act in a right and uncluttered way in management too. Failures result in negative effects on quality, productivity, creation of value, use of resources and competitiveness of companies, organisations and whole countries. The satisfaction not only of employees, but of society as a whole depends in a large part on the quality of management decisions. Therefore, management is the most important profession in modern society. Anybody wishing to manage an organisation effectively should pay special attention to uncluttered management thinking.

Today, there are more people than ever before making managerial decisions. Whether they label themselves 'managers' or not does not matter: A chief physician in the hospital, a cancer scientist as group leader, a head nurse; they all have to manage themselves, the people around and their area of responsibility.

Whereas medicine has highest quality standards for education and licensure, no such thing exists in management. Generations of managers had to learn management mostly based on trial-and-error, intuition, and of course through their experience. University education in business mostly focuses on business administration, but not on management itself. Acknowledging the great responsibility of managers in all aspects of daily life, this is an unbearable situation.

Everybody Can Learn to Manage, Everybody Must Learn to Manage

Management lacks a common understanding. Instead, there exists a clutter of management methods, styles and often contradicting and doubtful management approaches. Too often, questions like 'Who is an ideal manager?' are discussed in the media, leading to unrealistic lists of criteria that no individual can possibly fulfill. Instead, the right question is 'What should managers do?'. This shifts the perspective from management as an elite profession for special, chosen individuals to management as a mass profession that can be taught and learned by everyone.

The first and foremost responsibility of hospital managers is to transform resources to results and value for patients. This is the raison d´être for any hospital and the reason why managers are paid. People create value for patients. Therefore, managers have to manage and enable their employees to be able to dedicate themselves to doing that all day long. A central question must be: How do we organise ourselves so that the employees really do what they are paid to do?

Management Principles as Basis for Effective Management

To ensure clear and concise management knowledge, a common understanding of the elements of this profession is fundamental. Uncluttered management thinking means to sieve out the necessary and sufficient elements that all managers must control in any location, in any situation, in any organisation, and at all times. Management prin-

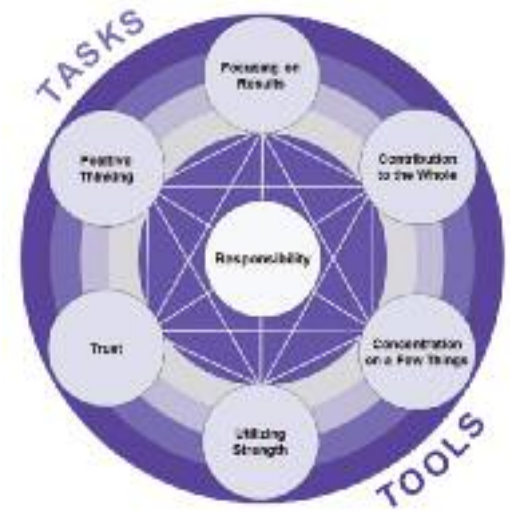

Figure 1
Principles of effective management

NO-FUSS

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ciples are one of the elements of management as a profession.

Effective managers follow six principles that govern the quality of their daily work, the efficiency of the tasks they fulfill and the tools they use. Principles ensure that an organisation is based on a common understanding of management. No talent is required to understand and to follow management principles, the only things that are needed are insight and discipline. Whereas principles are no guarantee that an organisation will succeed, a lack of principles will result in failure.

First Principle: Result Orientation

Thinking in results changes the perspective from work input and questions like 'How long do I work every day' to the result-oriented question 'What have I achieved?'. The responsibility for any manager is to achieve results, to make sure that employees are able to produce results and that they can devote their working time to that. Result orientation coerces managers to think about the things that really matter for the organisation. As a consequence, it reveals many zeitgeist management tenets as harmful, e.g. the claim 'work should be pleasurable'. Professions like critical care paramedics, ward physicians or the cleaning staff in operating rooms are not fun, yet society strongly relies on their accurate work. Hence, the focus must not be on input-driven factors like the degree of fun, but on the quality of the output and the achieved benefit for the patients. Cured patients as well as perfectly sterile operating rooms will provide pleasure, meaning and satisfaction to the responsible job holder.

Second Principle: Contribution to the Whole

This principle is the fastest way to achieve 'holistic thinking' in organisations in a down-to-earth manner. Effective managers think about their contribution to the whole by asking themselves: 'Why am I on the payroll of this organisation?' and: 'What am I responsible for in this organisation?'. They demand that their subordinates be able to answer those questions too. Any evaluation on whether or not employees are spending their time doing the right things can only be carried out when the employees know what their contribution to the organisation is. This is especially true for knowledge-based organisations like hospitals where only highly trained specialists are able to create value for patients. Having said that, employing 'specialists-only' is dangerous for any organisation. What is needed, are specialists who integrate themselves into the whole.

Third Principle: Concentrate on a Few Things

Let's have a look at the operating room again. Imagine the surgeon answering a phone call during a heart surgery. Unimaginable again, as he focuses on the surgery, his really important task in that situation. Contrarily, in management there exists an outworn cliché of effective managers coping with many things simultaneously, which in fact has an adverse effect. As it is difficult today to focus on a few things, this principle has become even more important. There are some keys to concentration, e.g. management by objectives, an efficient personal working method or systematic abandonment of habits that distract from creating value for clients and patients.

Fourth Principle: Using Existing Strengths

The fourth principle is one of the keys for top results. Effective managers identify their own strengths and the strengths of their employees. The best method to recognise strengths are tasks where a person has already achieved good results. Matching individual strengths with a person's job assignment is a direct, fast and economical way to achieve peak results. However, many organisations focus on attenuating weaknesses of their employees with time- and cost-intensive measures. The outcome is mediocrity and lack of motivation. These issues will not occur when the focus lies on strengths, as it makes weaknesses irrelevant and people concentrate on tasks they are good at.

Fifth Principle: Trust

What matters in the end is mutual trust. Mutual trust inside an organisation makes management situations more stable and robust enough to deal with management failures. To create trust, it's necessary to follow a few simple rules: The subordinate's mistakes are the boss's mistakes, at least to the outside world and to the senior management. Caring about participative or authoritarian management style is not as important as creating trust, as there is no evidence that one or the other style per se leads to better results or to a more stable organisation. What matters is being genuine.

Sixth Principle: Positive Thinking

Positive thinking turns the manager's attention from problem solving to opportunities, to make the best of a given situation with the available resources. As the things are as they are, the only difference managers can make is how they decide to perceive and react to them. This doesn't mean that problems can be ignored, but it is an invitation to seek and find possibilities even in bigger problems and asking the question: 'Is there an opportunity in this problem?'. Positive thinking is the step from dependency to self-determination. People who are able to motivate themselves, want primarily to change things, they want to act, and not simply recognise and passively adapt. This provides a significant competitive edge.

Principles as a Guideline for Uncluttered Management Thinking and Acting

These six management principles affect all kinds of management activities. They influence the development of organisational mission and strategy in terms of transforming existing strengths into future results. Principles influence the design of organisational structure, which should empower the employees to concentrate on their tasks without redundant coordination issues. Principles define organisational culture, which arises as an emergent criterion. This organisational culture in turn is mainly based on the personal role model of superiors in the organisation. Principles can be used as a foundation for the appropriate use of management tools and tasks, as they determine their alignment in an organisation.

Principles of management support the development of uncluttered management thinking. They provide an excellent framework to become more effective and efficient in creating value for clients and patients.

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World premiere: Cadolto presents the operating room of the future as a cost-effective, rational prefabricated solution

Fully equipped hybrid operating room on display at Medica 2011

Hybrid operating room with Siemens Healthcare Artis zeego angiography system. Operating table, lights, OVEs and Maquet digital OR integration.

The hybrid operating room is the standard of the future, on that medical opinion is largely unanimous. While the combination of conventional operating equipment and angiography has long posed enormous challenges for hospitals in terms of design and construction, only now is prefabrication being viewed as a solution: the prefabrication specialist Cadolto, based in Cadolzburg near Nuremberg, is exhibiting a full-equipped hybrid operating room core module at Medica 2011.

Room design challenge

The hybrid operating room is gaining ground everywhere. It is now no longer only cardiologists and heart surgeons who are enthusiastic at the prospect of performing minimally invasive, catheter-based and conventional operating procedures in one and the same operating room; this will sooner or later become the norm in the majority of surgical disciplines. When image-guided diagnostics make their way into the traditional operating theatre environment, it is not simply a case of installing new equipment. Rather, the hybrid operating room revolutionises the whole layout and equipment of the room. For example, the angiography units require a different arrangement of the operating room staff around the patient. This means that the paths taken by staff, for example in the event of complications, must be carefully thought through. The ceiling mounted screens affect the air flows in the room and also hygiene management. More space is required for ancillary rooms and storerooms, and much more besides.

Innovative modular solution: prefabricated hybrid operating room

The first prefabricated solution

In other words: hybrid technology is completely redesigning the operating room. The complex issues which arise have hitherto always been dealt with on a case by case basis by interdisciplinary teams in lengthy, complicated processes. In future, hospitals will no longer necessarily have to shoulder this extremely costly burden for each project. A new room module developed by Cadolto for the first time translates the knowledge of hybrid operating room experts into a rational prefabricated concept. In close collaboration with Siemens Healthcare, Maquet, Trumpf and Philips, the global market leader in high-tech modular buildings has developed a room unit, unique in terms of complexity and design features. Conventional operating room technology, high-end imaging and workflow-oriented room and space management are combined in a hybrid solution that meets the highest current standards in cardiology, heart and vascular surgery, neuroradiology and neurosurgery.

World premiere at Medica 2011. Hall 13, Stand A 10.

Cadolto will present its innovative development to the public for the first time at Medica 2011, to be held from 16 to 19 November in Düsseldorf. As in previous years, the company can be found at Stand A 10 in Hall 13, where it will have on display two hybrid operating room core modules with a floor area of around 100 m² and weighing over 50 tonnes. The key feature, however, is the "interior design benefit", as the room modules are fully equipped with all the medical facilities and fittings associated with a hybrid operating room – including a Siemens Healthcare Artis zeego angiography unit, Magnus OR table, OR lights, OVEs and Maquet digital OR integration. This will enable visitors to see for themselves the quality and possibilities afforded by a concept that provides a fully developed, cost-effective, compact solution for the operating room of the future.

Specialist in prefabrication in the factory

Cadolto has for many decades been operating on global scale as a leading specialist in the construction of complex, technically sophisticated, modular buildings. The company's key expertise lies in the high proportion of the building prefabricated in the factory. This enables the rapid completion of a turnkey construction project. The company's comprehensive design and consultancy service, factory prefabrication and rapid, cost-effective and high quality completion of construction projects give Cadolto customers the security of a professional partnership.

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PHYSICIAN LEADERS AND HOSPITAL PERFORMANCE

Is There an Association?

By Amanda Goodall

The question of whether hospitals are better run by doctors or non-medically trained managers has been hotly debated for a number of years. Amanda Goodall makes a start at trying to address this issue. She identifies the most highly-ranked hospitals in the US in three specialist fields, and asks who are the CEOs? Results show that hospital-quality scores are about 25 percent higher in physician-run hospitals than in the average hospital.

In the past, hospitals were routinely led by doctors. That has changed. In the UK and the US, most hospital chief executive officers (CEOs) are non-physician managers rather than physicians (Falcone and Satiani 2008). Of the 6,500 hospitals in the US, only 235 are led by physicians (Gunderman and Kanter 2009).

It has been suggested that placing physicians in leadership positions can result in improved hospital performance and patient care (Horton 2008, Falcone and Satiani 2008, Darzi 2009, Candace and Giordana 2009, Stoller 2009, Dwyer 2010). The UK has recently established five academic health science centres. Their mission is to bring the practice of medicine closer to research in the hope that innovative science can more quickly be translated into clinical procedures (Smith 2009). Physician leadership was also prioritised in the 2008 National Health Service (NHS) review (Darzi 2008, 2009). Some outstanding US medical facilities, for example the Cleveland and Mayo clinics, have explicitly introduced leadership training (e.g. Stoller et al. 2007), and management and leadership education is being incorporated into medical degrees.

Despite the growing body of research into hospital performance, there are currently no empirical studies that assess the physician-leadership hypothesis that hospitals perform better when they are led by doctors. To establish a clear relationship between leadership and organisational outcomes is challenging. Unlike in medical trials, random assignment – in this case of chief executive officers to hospitals – cannot be used. My research provides an empirical inquiry (Goodall 2011). It looks at the leaders currently being hired by hospitals and examines whether CEOs in the higher ranked hospitals are typically physicians or non-medical managers.

The wealthiest and most prestigious hospitals arguably have the widest choice of leadership candidates. If it can be shown that hospitals positioned higher in a widely-used media ranking are more likely to be led by medical experts rather than managers, this is one form of evidence that physician-leaders may make effective CEOs.

Studying CEOs of Top-Ranked US Hospitals

The paper identifies the CEOs in the top ranked hospitals in America, determining whether those hospitals situated higher in the league-table are more likely to be headed by physician-leaders or professional managers. To do this, one particular quality ranking is used, namely, the league tables produced by US News and World Report's "Best Hospitals" 2009. I construct a dataset on CEOs in the top-100 hospitals in the three specialties of cancer, digestive disorders, and heart and heart surgery.

The US News and World Report ranking is designed to inform consumers about where to seek treatments for serious or complex medical problems. Media-generated league tables cannot be viewed as entirely reliable measures of quality; nonetheless, using rating systems as heuristic devices to assess healthcare providers has become common in the US (Schneider and Epstein 1998) and it has been shown to influence consumers' behaviour (Pope 2009). I use this ranking because it is one of the most established.

The data in my study cover the top-100 hospitals in the three specialist fields of cancer, digestive disorders, and heart and heart surgery. Each hospital CEO is then identified and classified into one of two categories: Physician-leaders, who have been trained in medicine (MD); and leaders who are non-physician managers.

Physician-Led Hospitals are Higher-Quality Hospitals

To establish whether hospitals higher in the rankings are more likely to be led by physicians, I use t-tests and regression equations. I do this for the top-100 hospitals in each of the three medical fields of cancer, heart and heart surgery and digestive disorders.

In the field of cancer there are 51 physician-leaders among this set of 100 CEOs. Thirty-three are in the top-50 hospitals, and 18 lead hospitals in the lower 50 group. For the other two specialities, there are, respectively, 34 physician-leaders in the top-100 hospitals in digestive disorders, and 37 in heart and heart surgery. As can be seen in Figure 1, in each of the three cases, the average hospital quality score of hospitals where the CEO is a physician is greater than the score of the hospitals where the CEO is a professional manager.

In the statistical analyses, the regression equations reveal that the presence of a physician CEO is positively associated with an extra 8 to 9 hospital quality points (at the $p<0.001$ level) – in short, hospital quality scores are approximately 25 percent higher in physician-run hospitals than in the average hospital.

To control for the size of hospital, in the field of cancer I included a variable for the number of beds. However, this size variable was insignificant and, importantly, it did not affect the importance of physician-leaders. The US News and World Report ranking also includes an 'Honour Roll' category, which is

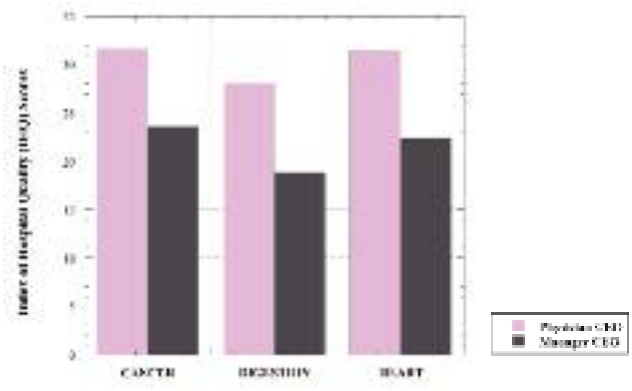

Figure 1. Mean Index of Hospital Quality (IHQ) Score of Hospitals Led by Physician CEOs and Manager CEOs in Three Specialty Fields

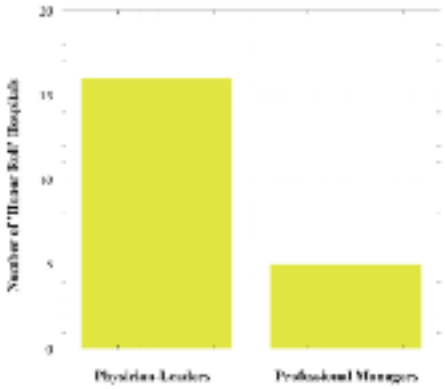

Figure 2. Hospitals Led by Physician-Leaders and Professional Managers in the Elite 'Honour Roll'* (*Mean performance score of hospitals led by physician-leaders is 18.38. Mean score of hospitals led by professional managers is 12.60.)

made up of the most outstanding hospitals; those that achieved high hospital quality scores in at least six specialty fields. Figure 2 shows that the CEOs in 'Honour Roll' hospitals are more likely to be medically trained physician-leaders. Using a simple check I have found that in each year since 2009, when the data in this study were collected, 'Honour Roll' hospitals have continued to be dominated by physician CEOs.

Why are Better Hospitals More Likely to be Led by Physicians?

This study's results are cross-sectional associations and use one particular hospital-quality ranking. This means they have important limitations. The findings do not prove that doctors make more effective leaders than professional managers. Potentially, they may even reveal a form of the reverse –assortative matching in that the top hospitals may be more likely to seek out MDs as leaders and vice versa. Arguably, however, the better hospitals will have a wider pool of CEO candidates from which to choose, because of the extra status and wealth that they attract. This makes the fact established in this study an interesting one. The results show that hospitals positioned highest in the ranking have made judgements that differ from those hospitals lower down. On average they have chosen to hire physician leaders as CEOs.

These findings are consistent with my earlier work on the role of "expert leaders" in other (non-medical) settings; for example, we have shown that research universities perform better when they are led by outstanding scholars (Goodall 2006, 2009a,b), and NBA basketball teams gain more wins when they have coaches who were previously outstanding players (Goodall et al. 2011).

Cross-sectional analyses can only be suggestive of causality. Nevertheless, it is interesting to consider possible explanations. Experts may have the advantage that they have acquired a deep intuitive knowledge about the core business of their organisations and this may help with decision-making and institutional strategy. Falcone and Satiani (2008) suggest that a physician leader who has spent years as a medical practitioner has acquired integrity that implies "walking the walk" (2008) which, they argue, enhances a leader's credibility.
Physician-leaders who have greater credibility may act as role models for medical staff and their presence may help hospitals to attract talented medical personnel. Hiring practices may be driven by homophily – like-for-like selection – thus, great surgeons and researchers may be more likely to hire other great surgeons and researchers. More importantly, it is probable that physician-leaders share the same values as other medically trained staff, and, therefore, they may create better working conditions for doctors, surgeons and nurses.

There has been much journalistic coverage in the UK over recent years about the increase of managers and management practices in UK hospitals. UK hospitals are overwhelmingly led by non-MD managers. Might these manager CEOs have been creating the right conditions for other managers? Such explanations are merely suggestive; the mechanisms are not properly understood.

Conclusion

There has been much discussion in the US, and increasingly in Europe, about the relative merits of having physicians and non-physician managers in leadership positions. Yet no evidence has been published one way or the other. This work does not establish that physicians make more effective leaders when compared with professional managers; but it starts the empirical process. It finds – in each of three disciplinary fields – that hospitals positioned higher in the US News and World Report's "Best Hospitals" ranking are led disproportionately by physicians. The next, and vital, step for researchers is to design longitudinal inquiries into the possibility that physician-leaders improve the performance of hospitals.

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www.iza.org/en/webcontent/personnel/photos/index_html?key=4508

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MORE THAN TIME AND MONEY

Defining Operating Room Efficiency

By Michael Greiling

Efficiency is typically defined within the restricted terms of time and money savings, even if time is often ultimately translated into its financial value. While it is certainly true that, in the current economic climate, health services are called upon to provide a more economically efficient service, I ask whether we need a broader definition of efficiency in the context of the operating room (OR), and a well-considered way of achieving it which has benefits for patients, healthcare professionals, the environment and health service budgets.

The OR is one of the most cost-intensive areas of a hospital and has been found to account for up to 40 percent of total hospital costs. It makes perfect sense that, in an era of reduced government budgets or reimbursements, hospital management need to make cost savings in this department. Whether a whole hospital runs economically or not can be determined to a large extent by the OR. The high financial outgoings are principally due to the cost of a set of critical requirements:

- Healthcare professionals involved in a procedure (one or two surgeons, operating room nurses, an anaesthetist and anaesthetic nurse plus other staff such as operating room technicians);
- Drugs;
- Sterilisation and use of instruments;
- Anaesthesia machinery;
- Room cleaning; and
- Drapes, gowns and surgical gloves.

Maximising the capacity of the OR is therefore a key factor in minimising cost: Ensuring each patient spends only the necessary amount of time in the OR and that time between procedures is minimised to enable its full use during the entire working day. Many studies have been devoted to improving the use of the OR by considering such options as administering anaesthesia in the induction room while the OR is being prepared or using certain planning methods for staff schedules to make best use of teams and rooms.

It goes without saying that clinical standards and patient safety must not be adversely affected by any efficiency measures. Our challenge is always to improve efficiency without compromising standards. For example, we may call a skin antiseptic efficient if it is effective against the widest possible range of bacteria and viruses, easy to administer and long lasting. A surgical gown is efficient if it prevents microbial contamination of the surgical wound and protects the healthcare professional from the patient's pathogens as well as being comfortable and easy to work in. And so a broader definition of OR efficiency begins to emerge.

Making the Right Choices in Terms of Efficiency

So what needs to be taken into consideration when choosing a piece of equipment or planning an OR staff schedule in order to make the right choice in terms of efficiency? In addition to patient safety and outcome, and financial rigour, there are still further elements that contribute to the efficiency of the OR.

A closer look at the studies in this field reveals other findings which play a role in OR efficiency. For example, a study recommending a parallel processing system which allows a surgical team to work on two patients simultaneously found that the system not only contributed to greater throughput of patients but also to a greater sense of team unity, and this led to a positive effect on stress management. This sense of increased team unity was brought about by the new parallel processing routine and the OR benefited in terms of significantly reduced turnover time. In this way, staff well-being and efficiency would appear to be contingent on one another.

Reduced stress among the OR staff, whether it is due to teamwork or less time spent on administration, must surely be implicated in improved outcomes for the patient, increased job satisfaction and lower staff turnover. Further efficiencies through the reduction of staff stress may be achieved by providing effective and easy to use equipment or simply through allocating tasks for which a staff member has been trained and can perform well. Time saved does often mean financial saving – fewer empty periods in the OR or overtime payments when surgery over-runs the scheduled list. However, it also means a patient may be seen in a timely manner and fewer OR cancellations – better for both patients and for the morale of the surgical team.

Reducing time wasted in inefficiencies can be used more profitably for patient education or further training. These all contribute to the financial efficiency of a hospital but also to optimal treatment outcomes and a positive experience for patients and staff.

Analyse Every Aspect of the OR

Such benefits for staff and patients alike can be brought about by looking carefully at each aspect of the OR and seeing where changes can be made. A change to a single-use custom procedure tray, for example, has shown benefits not only in the OR but also in improving the logistics of ordering and storing equipment. The tray can be customised to suit any given procedure, cutting down on the use of individual instruments, improving consistency of the items provided and allowing procurement to standardise procedures. At the same time, storage space is minimised, allowing less stock and faster access to stock when needed. A case study on custom procedure tray efficiency showed that time expenditure was reduced by 40 percent across the entire OR process, from ordering materials through to waste removal, and also showed that staff satisfaction increased. Overall, use of custom procedure trays led to greater theatre utilisation and provides a good illustration of how streamlining OR logistical processes both internally and externally can

be a potentially fruitful target for increasing efficiency as it has a positive impact on both time and on staff stress levels.

The value of initiatives designed to make the OR more efficient is being increasingly recognised by large organisations. Well-designed technologies are actively supported by organisations such as the Association for Perioperative Practice, which now supports the development of materials which lead to OR efficiency. The NHS in the UK supports innovation in technologies and accelerates its use through the NHS Technology Adoption Centre. Training for people working in the OR in new technologies and pieces of equipment supports efficient use of new technologies or equipment and is also offered by some manufacturers. The US-based Association of periOperative Registered Nurses publishes competencies, which set standards and inform training needs.

In addition small innovations can also make a big impact on the bottom line. Adapting surgical equipment so that it is perfectly suited to its purpose, for example, can save time, reduce risk of infection and enable the surgeon and their team to carry out the procedure in a stress-free manner. For example, a drape with the required number of openings for multi-surgical interventions or a dressing tailored to suit a wound in a particular location on the body may be small adaptations but may make a sizeable impact on OR efficiency.

Environmental Efficiencies

The activities of the OR and their efficiency also impact the environment and though the OR is necessarily resource intensive, there are ways in which environmental efficiencies can be achieved. Using technology wisely can reduce our carbon footprint rather than increase it. Using fit-for-purpose and well-designed instruments and equipment reduces wastage. One NHS Trust in Liverpool, UK, found that single-use procedure trays cut down waste by one bag per major operation and reduced total packaging waste weight by nearly 90 percent, contributing significantly to carbon savings for the hospital Trust. Another UK hospital found that by reviewing its procedure for sterilising OR equipment, not only were cancellations of operations reduced, but the more efficient running of the sterilisation department resulted in a 33 percent reduction in equipment power, water and consumables consumption as well as in department lighting and heating costs. Buying supplies that have been made with minimal environmental impact can make a significant contribution to OR efficiency. The industry continues to research further ways of promoting sustainability in the OR, such as seeking an alternative to inhaled anaesthetics that contribute to greenhouse gases or a commitment to recycling OR equipment where possible.

> Our challenge is always to improve efficiency without compromising standards

Conclusion

In summary, the definition of OR efficiency needs to be broad. In using high-quality goods and services which save time, allowing healthcare professionals to focus on their areas of competency while maintaining clinical standards, we may find the increase in the numbers of surgical procedures, shorter hospital stays, reduced environmental impact, and streamlined organisational structures that are required to deliver against restricted budgets. Furthermore, it is key to the values of any health service that the OR efficiency we strive for should also be able to embrace greater healthcare professional satisfaction and optimal patient outcome.

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ENSURING QUALITY **OF OUTSOURCED CLEANING AND SANITISATION**

The ANMDO–CERMET Standard

By Gianfranco Finzi and Daniela Gabellini

Considering the gradual outsourcing of technical-administrative services to support the "core" services of health facilities, ANMDO, the National Association of Hospital Department Physicians and CERMET, a certification institute with extensive experience in the health sector, have developed a standard for good environment and health facility cleaning and sanitisation practices, complete with an adequate and computer-backed control system.

The service presented by ANMDO and CERMET aims at assessing, on an objective basis, the hygienic and quality standard of the outsourced cleaning and sanitising service, promoting a better integration of the service with the routine management of activities performed in hospitals.

The refinement of the service has been made possible thanks to the experimental application of the standard in conjunction with the L'Operosa Cooperative involving the contract of Bologna's Azienda Ospedaliero-Universitaria (Hospital-University Corporation), S.Orsola-Malpighi General Hospital and Markas Service s.r.l., as well as that of Health Unit 15 Alta Padovana. To date other major companies in the sector have started qualification procedures and recognised the importance of the service above all in terms of the chance to set up a partnership with the contracting body so as to achieve ongoing improvement for the better satisfaction of end users.

The Role of the Third Body

The involvement of CERMET, as independent third body, in the outsourced service qualification system is keyed to ensuring principles at the bottom of service quality assessment sustainability over time, and more specifically:

- Impartiality in the technical-operational management of the qualification process and therefore the same treatment for all applicants;
- Independence as regards auditing for issuing qualification and therefore the absence of conflicting interests;
- Cultural, technical and professional expertise of the auditors who follow coded procedures to carry out the assessment activities and use tested and validated instruments.

To ensure compliance with such principles, which convey value and credibility to the qualification process, CERMET operates by referring to standards recognised at national and international level and effective within international certification systems.

The Standard

The ANMDO–CERMET Standard, pre-concerted within a specific work team, made up of representatives of health facilities, cleaning companies and other stakeholders, fully expresses the quality concept applied to the service sector comprising:

- System requisites, which outline the minimum quality system for ensuring company management governance;
- Process requisites, of a general nature, aimed at ensuring service governance;
- Element-specific result standards, aimed at ensuring the quality of the service provided.

In particular, system requisites comply with ISO 9001:2008 international standard and relate to basic aspects concerning staff training, control of cleaning service (quality controls, process controls, internal inspection audits) and the management of relations with clients (client satisfaction, complaints management). The process requisites refer to the need on the part of the company to define criteria able to ensure the quality of the provided service, in terms of the drawing up of protocols and cleaning methods and related equipments and products. The effectiveness of the cleaning process is checked in terms of actual "dirtiness/cleanliness" by means of direct on-site inspections with respect to defined result standards. The "dirty/clean" control system exploits, instead of normally used methods such as the Bacharach Scale or the floor dust meter, the bioluminescence phenomenon and use of the Bioluminometer.

The Control System

Consistently with the standard structure, the assessment system has been defined entrusted to the third body and which contemplates three types of audit:

a) System audits, carried out annually at the supplier's facility to determine the company organisation system.

b) Process/service audits of direct type, carried out quarterly at the facility of the contracting entity to determine:
- Compliance with service performance procedures;
- The appropriateness of the equipment given to the staff, with respect to established quality plans; and
- The quality of the provided service in terms of "dirtiness/cleanliness".

c) Process/service audits of indirect type, carried out continuously, which consist of continuous monitoring of the controls entrusted to the first party, second party and third party for the identification of the critical areas in which to implement suitable upgrading measures.

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Management Inspection System) able to manage: The personal details of those charged with controls (company, contracting entity, CERMET), personal details of the staff charged with carrying out the audits and details of the specifications/ - contract where all the information is configured needed to perform controls on elements according to the critical situation level, as well as information relating to the type of job to be done per area/environment/element and relevant cleaning protocol. The system makes available to those involved the required planning data, with the option of using the application offline. The results of the controls are communicated online to the CERMET data centre which issues reports personalised to the type of user and function for which access to the software was configured, as well as allowing the processing of the global quality index of the contracted service, an indicator expressing the "state of health" of the cleaning service provided obtained from the weighted sum of three different sub-indices, i.e., the results of the system audits, the process/service audits of direct type and the process/service audits of indirect type.

The sampling of the areas subject to assessment is established according to principles that correlate the risk of infection to control intensity.

Within a single area (e.g., hospital ward, operating theatre, intensive care...) at least one environment per type is controlled (hospital room, bathroom, locker room, closet, kitchen...) along with all the elements, critical and non-critical, inside it.

Third-party audits must be performed within one hour from cleaning, depending on the type of environment (e.g., the bathroom must be inspected immediately after cleaning).

The "dirty-clean" audit of the elements is mainly based on two procedures:

- Visual inspection of all the elements
- Instrumental inspection (BIOLUMINOMETER) of 10 percent of critical elements

The percentage of elements to undergo instrumental control has been defined with reference to the indication of the UNI ISO 2859-1:2007 standard "Sampling procedures in attribute inspection - Part 1: Sampling diagrams indexed according to acceptable quality limit (AQL) in lot by lot inspections" considering 10 percent represents a good compromise between control cost cutting and significance of obtained result.

The proposed control system is "zero tolerance" meaning the way it has been designed does not contemplate "non-conformities" and consequently the AQL is to be deemed always identical to 1. As specified above in fact, the "dirty/clean" control is made straight after the cleaning services has terminated, and consequently the "dirty/clean" inspection provides indications on the validity of the process in terms of: Staff training, effectiveness and correct implementation of the cleaning protocols and adequacy of the cleaning equipment used. In brief, the control does not aim merely at inspecting in terms of "dirty/clean" but at determining the effectiveness of the cleaning system furnished by the company.

Representation of Results

Audits are carried out with the aid of control sheets for recording the findings in the different environments undergoing assessment. The overall result is recorded in the audit report given to the supplier and a copy to the contracting body. The number of nonconforming elements with respect to the total of the critical and non-critical ones assessed is represented using histograms, for:

- Risk area;
- Hospital Unit / Ward;
- Type of premises; and
- Type of element.

This ensures easier interpretation of results in order to identify any causes of systematic nonconformities requiring remedial actions in a perspective of continuous upgrading.

The Benefits for Health Facilities

The ANMDO-CERMET services for companies provide concrete benefits for the health facilities where they are implemented, i.e.:

- Supplier/contracting company partnership for the benefit of the parties stimulated in a perspective of continuous upgrading thanks to the supervision of the reciprocal contractual undertakings entrusted to an independent third body;
- Efficiency meant as rationalisation of the control system for the monitoring of the outsourced service, thanks to the use of the software platform for planning and recording the results of first, second and third party controls visible to all the parties involved; and
- Effectiveness thanks to supervision by the third body of the successful implementation of the remedial actions undertaken by the company with respect to the conformities found during first, second and/or third party audit in a perspective of continuous upgrading for the satisfaction of the client, the end user and more in general, the parties involved.

Conclusions

The contract control system developed for the cleaning and sanitisation of health facilities has the following advantages:

- The joint commitment of ANMDO and CERMET to periodically revise the standard, to keep it updated to the state-of-the-art and ensure continuous upgrading;
- The general worthiness of the criteria adopted as reference for the definition of the control system, which allows its easy declension depending on the different types of supplied services; and
- The reproduction of the guarantee elements for safeguarding the parties involved (clients, supplier, users), which form the basis of the sustainability of the health facility service outsourcing process over time.

In the light of the substantial impact outsourced services have on the quality of the provided health service, ANMDO and CERMET will continue their cooperation, with the aim of contributing to the continuous upgrading of the health system.

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CLINICAL LABORATORY **BUSINESS ANALYSIS**

Improving Business Operations Without Compromising Quality

By Vikica Buljanovic, Hrvoje Patajac and Mladen Petrovecki

An increase in expenses has led to the introduction of rationalisation in healthcare. With this comes the emergence of business operation analytics of each entity with a view to improve the business operations with unaltered quality of work. A hospital-based clinical laboratory is part of the healthcare system, but it can also be viewed as an independent unit. The goal of the clinical laboratory as a unit is the accuracy and reliability of laboratory tests. Today, the benchmarks of financial business operations are becoming more important; productivity evaluation, i.e. efficient business operations.

Laboratory business operation analytics provide us with an insight into a successful business performance. The increase in productivity of clinical laboratories relates to the technical development of the laboratory diagnostics, which can at first be viewed as an expense, because it requires a financial investment. The introduction of an IT system into the laboratory leads to a better control of work procedures, improvement of work organisation, saving time and subsequently affects productivity. The laboratory business operation analytics, as well as the financial cost-effectiveness of the investment can be seen by developing an economic model, i.e. model of a laboratory as an economic entity. The creation of the model of a laboratory as an economic entity implies the identification of revenues and expenses and their comparison in a specific time period, typically one year.

> The introduction of an IT system into the laboratory leads to a better control of work procedures, improvement of work organisation, saving time and subsequently affects productivity.

A sum that shows whether the laboratory performs its business operations profitably or not is obtained by comparison of total revenues and all expenses of the clinical laboratory. It is the starting point from where the measures for business performance improvement shall be taken.

The goal of this study was the analysis of the clinical laboratory business operations as an economic entity over one year, as well as the analysis of business operations of the model, with a potential improvement and deterioration of business performance compared to the basic model. The models were made using SWOT analysis; the model of deterioration was based on weaknesses and threats, and the model of improvement on strengths and opportunities of the laboratory, as shown in one previous study.

Materials and Methods

Institution

The institution chosen for this research was Clinical Laboratory of the General County Hospital (GCH) Našice, Croatia. It is a typical provider of laboratory services for all hospital in-patients, hospital outpatients, and patients referred from primary healthcare providers in the region. GCH Našice is a non-profitable institution funded from the State Budget of the Republic of Croatia through the Croatian Institute for Health Insurance (CIHI).

Profit and loss account

The analysis of laboratory performance was carried out using the method of profit and loss account, which shows the profitability of the laboratory. The basic elements of the profit and loss account are revenues and expenses, and the difference between them represents profit or loss in business operations and proves profitability. The total revenues consist of the fees charged for the tests performed and the expenses are all expenses necessary for earning the revenues. The revenues and expenses are categorised.

Graded profit in the profit and loss account is shown using the contribution margin, gross profit, and operating profit. Contribution margin is total revenue less direct material expenses. Gross profit is the difference between total revenue and total production expenses. Operating profit with a positive number sign indicates profitable business operations, whereas negative number sign indicates unprofitable business operations.

Economic sensitivity analysis

Economic sensitivity analysis was used to show how business operations may be altered by changing one or more parameters in the profit and loss account. Three models with changed operating profit as compared to the basic model were shown, i.e. the economic sensi-

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tivity analysis was performed, for which the data had been obtained through the SWOT analysis.

Results and Discussion

The profit and loss account for 2008 showed profitable business operations of the laboratory and the positive operating profit in the amount of 470,423 euro. Using the economic sensitivity analysis, three models with modified operating profit were developed:

- Reduced tests;
- Technological improvement (automation with informatisation); and
- Technological improvement with three employees less and additional tests.

Weaknesses and opportunities represent internal characteristics of the laboratory, whereas the strengths and threats are derived from the clinical laboratory environment, in other words the geographical surroundings in radius of fifty kilometers with 100,000 inhabitants.

In the reduced tests model, the number of tests was reduced for all specialist tests in outpatient services and none were performed for primary healthcare. The operating profit would amount to only 21,542 euro.

The technological improvement model, due to the expenses for automation and informatisation, would reduce the operating profit to 431,464 euro.

In the increased operating profit model, conditioned by the technological improvement that would facilitate the work with three employees less with simultaneous addition of tests, it would amount to 535,804 euro.

This research shows that the clinical laboratory GCH Našice performed its business operations profitably in 2008. Profitable business operations were shown in the profit and loss account, where the operating profit was positive and amounted to 470,423 euro. The profit realised in the clinical laboratory GCH Našice in the amount of 470,423 euro represents operational earnings that would remain to the owner of a business entity on the market.

The SWOT analysis tested the threats for the laboratory arising from its surroundings. The threat to the analysed laboratory is loss of patients, i.e. reduced tests, which could become real by the establishment of a new clinical laboratory in the radius of 50 km with 100,000 inhabitants. The establishment of such a laboratory, which could take over patients from the primary healthcare providers and provide specialist tests for outpatients, would decrease the operating profit to only 21,542 euro. In order to prevent such threats from becoming real, it is necessary to continuously develop the laboratory and to perform market research.

> Regardless of the price, potential automation and informatisation significantly improve the quality of service

The technological improvement model that would introduce potential automation and informatisation showed the reduction in operating profit to 431,464 euro in comparison to the basic model. This reduction in the operating profit is actually the price for potential automation and informatisation, which is not high compared to its benefit, since the difference in the operating profit is only 38,959 euro. Regardless of the price, potential automation and informatisation significantly improve the quality of service. The inexistence of total automation and informatisation in the laboratory is a weakness that could become an opportunity, because it facilitates work with three employees less as well as performing additional tests. Those additional tests in the researched laboratory are the ones performed by other laboratories in the radius of approximately 50 km, such as medical examinations, physician's certificates or laboratory tests that are directly paid. If the potential to carry out additional tests, work with three employees less with automation and informatisation, as shown in the technological improvement with additional tests and three employees less model, were realised, the operating profit would increase to 535,804 euro.

Business performance could be improved either by augmenting the scope of work, connected with the expansion on new markets, which is a customary practice in the US and market-oriented states or by reducing the costs through monitoring the work procedures in detail. Constant development, monitoring of market demands and reduction in operating costs can certainly lead to the improvement in business performance of the laboratory, independent of its funding.

Conclusion

The risks of reduced tests amount to 448,881 euro, the potential to increase the profit 65,381 euro. Hence, the risk of the decrease in profit is seven times higher than the potential increase based on opportunities. In other words, the results showed a potential decrease in the operating profit by 95 percent, because it would be reduced from 470,723 to only 21,542 euro, whereas the potential increase in the operating profit could be only to 535,804 euro or 14 percent. In conclusion, reduced tests due to the establishment of a new clinical laboratory would have a significant negative impact on the profitability compared to the potential increase of profitability.

Such business analysis can result in positive financial breakthrough even in the institutions where primary health system function is not making profit. It clearly shows the need for basic education in economics and its implementation by managers in individual departments in the healthcare system. The profitability of any clinical laboratory can be increased using the analytics shown in this report and using the knowledge in economics.

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THE NEW CENTRAL STERILE SUPPLY DEPARTMENT OF UNIVERSITY HOSPITAL AUTHORITY ST. ORSOLA- MALPIGHI POLYCLINIC

By G. Finzi et al.

The new Central Sterile Supply Department (CSSD) of the University Hospital Authority St. Orsola-Malpighi Polyclinic was inaugurated in September 2010. The CSSD collects functions of diagnosis and treatment of high technological impact, such as emergency room, diagnostic imaging, operating blocks and intensive care. The intervention was executed by a service contract for the design, construction, management, operation and maintenance of the unique CSSD.

The creation of a unique CSSD to serve the entire polyclinic is a great benefit to the hospital, facilitating the adoption of uniform methods in the treatment of surgical instruments for all operating blocks. The complex activities performed within a CSSD, i.e. cleaning, disinfection (by hand, ultrasound, automatic washers), packaging (control and maintenance of the instruments, composition of the kits), loading of kits in autoclave, sterilisation and storage, require a careful functional design of the spaces for each stage of the process, from the arrival of surgical instruments at the CSSD until their return to the wards.

In the new CSSD, traceability systems for the surgical instruments have been installed ensuring the successful and proper execution of all phases of the sterilisation process. The CSSD spaces and technologies to be installed were dimensioned on the basis of the annual surgical activity provided by the entire polyclinic (about 30,000 surgical interventions/year), to which must be added activities of outpatient, Emergency Room and ward which require medical device sterilisation.

The CSSD has a gross surface of 1,100 square metres and provides distinct areas for contamination level as required by the Presidential Decree 14 January 1997, where it is stated that the sterilisation service must provide spaces divided into clearly separated areas, one area intended to the receiving, washing, packaging of materials, one to the sterilisation, one to the storage and distribution of the sterilised materials. The path must be progressive from the unclean to the clean area.

The minimum provision of environments for the sterilisation service must include areas for receiving, sorting, cleaning and preparing materials; a sterilisation area; an anteroom for the staff before they access the sterile area; a storage room for sterile materials; a storage room for soiled materials; staff toilets.

Material Flows

The material to be sterilised coming from the operating blocks of the surgery centre, the emergency room and other areas of the polyclinic arrives in the reception area via a dedicated elevator. The new CSSD has a layout that allows for a one-way flow for the instruments.

Unclean Area

Unclean reception area: This area, suitably dimensioned, allows the reception and temporary storage of the trolleys transporting the equipment to be sterilised which come from the operational areas of the surgery centre or from other pavilions of the polyclinic. The trolleys can reach this area by a dedicated elevator. Two computer stations provide access to the incoming goods information and verify the type of material to identify the specific treatment to be executed.

Unclean decontamination/pre-treatment area: After the acceptance phase the trolleys containing the goods are taken to the decontamination/pre-treatment area, where the first critical stage of the process in terms of "risk management" occurs.

In this area, pre-treatment for the removal of pollutants with automatic cycle is performed. It was designed to maintain this area at "negative pressure" compared with the surrounding environment to reduce the risk of contaminating the other areas of treatment. In fact, this is the area most at risk of contamination for the operators involved in the opening of containers and separation of the unclean material.

The position of this operational area is also strategic in terms of material flow due to the presence of two automatic pass-through washer-disinfectors where trolleys and containers, devoid of surgical instruments, can be directly treated. The exit from the washer-disinfectors is connected to both the packaging area through an anteroom and the distribution area. In fact, after the pre-treatment, the containers should be made available in the packaging area to be reused for the reconstruction of the surgical kits which should be sterilised in autoclaves, while the clean trolleys will be stored in the distribution area in order to be filled with already sterile containers.

Washing Area

The surgical instruments decontaminated in the pre-treatment area are transferred by dedicated trolleys to the washing area. This area was provided with natural light in accordance with requirements for occupational health and safety. Natural light is provided not only in the washing area but also in the other operational areas such as the packaging, the sterile and distribution areas of the CSSD.

The washing area has wide operational zones equipped with tables for manual processing of surgical instruments and benches with washbasins, blowguns and ultrasonic cleaning units. In addition, a battery of six pass-through automatic washers is installed with a capacity of 10 DIN, which allows for excellent flexibility in terms of setting the cycles of treatment if compared with the washer-disinfectors.

The number of washers ensures an efficient back-up in the event of machine downtime. A pass box for transferring material from the packaging area to the washing area was installed in the wall equipped with the washers.

Nine computer stations were provided for activities that take place in this operating area. Also included is a deposit for stocking material needed for instrument treatment and a washing/cleaning room containing material used to sanitise this operating area and which is directly and functionally connected with the area to be treated.

It should also be noted the central position with respect to the operational areas of the head nurse room, which has glass walls to facilitate direct visual inspection of operations in the washing area and an easy visual communication with the packaging area.

Packaging Area

The packaging area is the one with the most climate control, it is maintained at higher pressure than the washing area, thus preventing air contamination from the adjacent dirtier areas.

Twelve large benches equipped with a computer station for the management and tracking of surgical instruments were provided for the staff involved in the packaging and control activities.

A storage area for new surgical instruments was also created. These new instruments will serve as a backup of any devices that might arrive damaged at the CSSD and that should be replaced without stopping or slowing down the process of preparing the surgical kits.

The connection of this storage area, through an appropriate filter, to the unloading area of the washer-disinfectors allows the movement of the treated containers directly to the packaging area, where they are ready to be used for the preparation of the kits.

The process of sterilisation is performed by means of six pass-through autoclaves of various capacities (12 - 8 and 6 U.S.), which transfers the sterilised material directly to the sterile area. Two additional single port gas plasma sterilisers permit the reconditioning of heat-sensitive devices, which are then transferred to the Sterile Area via pass-boxes.

Sterile Area

Cooling and packaging area: The operations subsequent to the sterilisation process are carried out in this area. During the cooling of containers, biological testing and electronic weighing of the containers are carried out to detect any residual humidity. Bundling machines for the application of a plastic shrink film were also provided to protect the primary packaging.

Three computer stations for the traceability system are installed in this area. The containers are then transferred in the distribution area by means of pass-through cabinets for preparing for the withdrawal phase.

Other Operational Areas

Distribution Area: The trolleys to transport the treated material are located in this area. The staff working here set up the trolleys with various devices (packages, containers) to be distributed to the operating theatres and to the other departments.

Importantly, the trolleys for transporting material will be sanitised every transport thanks to the architectural design of the CSSD that provides the entry into the two washer-disinfectors directly in the decontamination/pre-treatment, packaging and distribution areas and the output connected both at the packaging and the distribution areas.

Withdrawal Area: This area is placed at the end of the path of the treated material. Here a computer station is provided for managing the delivery of materials and the transport documentation.

Areas of support: As well as the operational areas of the CSSD, additional rooms were planned for complementary functions to the production process. Particular attention has been paid to the comfort of staff, by dedicating relaxation areas for the workers both in the unclean and in the packaging and sterile areas. In particular, the relaxation zone for the staff working in the unclean area has glass walls to maintain a visual communication with the head nurse room and with the working areas if needed.

Staff Pathways

Staff pathways in the different operational areas are particularly important to ensure safety of the instruments treated in the CSSD. There are two different changing areas, one for the staff in the unclean area, another for the staff in the packaging and sterile areas.

Changing rooms for the Unclean Area: Two pass-through changing rooms/anterooms for men and women were designed. Both changing rooms are equipped with toilets and showers and are dimensioned for about 20 people. From the two changing rooms operators can access a common area where they equip themselves with PPE and then enter the working area. This common area also has two large basins (surgeon sinks), which allow easy disinfection of the operators coming from the unclean area before entering the changing room. From the anteroom, operators can also access the relaxation area dedicated to workers in the unclean area.

Changing rooms for packaging and sterile area: There are two large changing rooms for men and women, located in the area for withdrawing the treated material. These rooms, equipped with toilets and showers were designed so that staff that enter the distribution area from the withdrawal area have already changed their clothes. Before entering the sterile and packaging areas personnel must go through an additional anteroom to wear suitable clothing in order to protect the environment from exogenous contamination by operator.

Specific Materials Ensure Quality, Hygiene and Comfort

The choice of materials and finishes used to build the CSSD ensure high levels of quality, hygiene and comfort. The floors are easy to clean and can be treated with disinfectants, connected to vertical surfaces with coating leveled coving in order to ensure adequate and easy cleaning. Rubber floors were provided for the operational areas and support rooms.

In the changing rooms and anterooms the floors are made of granite-gres fine porcelain. The coatings were made with non-scratch, washable and treatable materials to ensure an adequate and easy cleaning.

Ventilation

The installation of the CSSD has an important role in relation to all aspects of air conditioning and ventilation systems that can have an effect on air bacterial contamination as well as on operator comfort; it must essentially be put at the service of production processes that play inside the CSSD. During the design and implementation, particular attention was paid to the integration of machinery and instruments necessary for sterilisation processes.

The ventilation system for the entire CSSD and related services such as changing rooms, relaxation areas and anterooms, is without air recirculation and integrates perfectly with the systems in the other areas of the surgery centre. The control of the airflow and temperature will be locally ensured by variable capacity single duct boxes and post-heating batteries that allow the temperature regulation room by room in full compliance with current standards on energy saving.

In order to achieve the correct pressure gradient in each operational area, a box was installed in the supply diffuser, which controls the inlet airflow and temperature, and a box in the exhaust grill, which regulates the airflow extracted from the environment.

All boxes are interfaced with the supervision system through which the parameters of the system can be displayed and recorded and the airflow and temperature set points can be controlled. Reading and controls are possible through a terminal located in a special room inside the CSSD.

By regulating airflows, pressure gradients among different areas can be created and maintained, subject to the minimum requirements. The monitoring of the relative pressures is provided by differential pressure sensors mounted on the partition walls between rooms. These sensors are constantly interfacing with the supervision system and will provide data for the assessment and feedback control of pressure by means of airflow modulation.

In addition to the systems traditionally used in Italy and exhibited so far, pressure stabilisers were introduced in some rooms. A pressure stabiliser behaves like a pressure relief damper installed on the wall that separates two environments with different pressures and, if the relative pressure between the two environments exceeds the set value, it allows air transit from the environment at higher pressure, cleaner, to the one at lower pressure, more dirt.

From the point of view of contamination control, the differential pressure is not important in itself but as an "engine" that drives the air and consequently the airborne contaminants from a higher pressure environment to an environment at lower pressure. Despite the fact that airflow into the room after an absolute filtration is free of bacteria, contaminants are introduced into the environment by operators or dirty equipment. In order to protect those areas intended for sterile processes it is essential to ensure airflow from those areas to less clean environments.

The conditions of overpressure that can be created by balancing supply and resumption of airflows can be disrupted very easily from simple and common events such as opening a door that suddenly collapses to zero the relative pressure between the two environments. The pressure stabiliser, an entirely mechanical device, which can be easily adjustable to the desired differential pressure, opens automatically when the preset pressure is reached and, when opened, allows the air transit towards the less clean environment.

The ventilation system thus provides a different balance than a traditional system and must resume from a more dirty environment the air blown into a cleaner one; however this brings clear advantages during the transient phases and in particular during the opening of doors. While opening a door, the relative pressure between the two environments will fall down, the stabiliser will shut down instantly and the air that normally flows through the stabiliser will go through the door.

In particular, for the different ventilated rooms, the system allows to:

1. Ensure that contaminants are not released outside the decontamination area in which the packages containing the dirty instruments are opened (the dirtiest area of the entire CSSD);
2. Easily and safely maintain the head nurse room at positive pressure compared to the washing area, thus preventing that the typical smells of washing zone get inside the room itself;
3. Easily and safely maintain the washing zone at negative pressure compared to the packaging zone, with the certainty of not unbalancing the system during the opening of doors.

Tracking

In addition to the architectural and engineering aspects, the adoption of appropriate management and tracking information system of surgical instruments is vital for the functioning of the CSSD.

The application software installed in the new CSSD has been specifically developed for the following activities:

- Management control of the CSSD processes;
- Programming needs;
- Reporting consumption;
- Clinical traceability of the production and of devices use; administrative and statistical effective reporting; and
- Organisation and tracking of logistics, transportation, etc.

Software allows the user to follow the life cycle of a set or a single instrument since its inclusion in the registry of the application, for all of the steps followed in the CSSD and at the end user, until disposal. Through the management system we are updated on the configuration of the surgical set by recording changes and replacement of worn or damaged instruments.

All phases of the materials process can be tracked and verified through two ways: Supervision through which we can follow the kit working phase inside the CSSD and see the record of maintenance; and tracking through which we can search a set of instruments through searching criteria (bar code, lot code, patient code, date of the surgical intervention, even partial description) and get a synthetic report of all data processing related to the wanted set.

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ARE YOU OPTIMISING **YOUR CAPITAL EQUIPMENT INVESTMENT?**

By Lorraine Dowell and John Evanoo

If you are a hospital executive or department manager, you know the "joys" of annual budgeting and capital planning. With the rapid advancement of healthcare technologies, people are seeing this yearly task morph into an even more complex maze of unknowns and endless requests for big-ticket items. That is why healthcare systems are adopting Capital Equipment Strategic Plans (CESP). Such plans provide an unbiased framework for evaluating and prioritising a hospital's capital equipment needs.

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Capital Equipment Strategic Planning is a proactive approach to cost-effectively prioritising the annual replacement of aging equipment.

Hospitals can no longer afford to let the "squeaky wheel" or departmental politics drive capital equipment decisions. Rather, with CESP, the perils of opinion-based investments are replaced with qualitative and comprehensive analyses. Hospital executives can now make better-informed decisions because the provided data was validated and weighted, most often by an unbiased third party consultant.

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To develop an optimal Capital Equipment Strategic Plan, a myriad of metrics are evaluated. The process begins by assessing your current equipment as well as your highest priority needs going forward. The outcome is a multi-year strategic plan that identifies your hospital's best approach to capital equipment investment.

The transparent process asks, for example, which strategy would provide the greatest benefit to patients? Which approach best drives operational efficiency? How do you capture the greatest return on investment? What is your risk exposure with phased acquisition? What investment strategy best supports your business objectives?

Bottom line, CESP looks at your options from a multitude of perspectives. The value you place on these different viewpoints ultimately determines the most efficient Capital Equipment Strategic Plan for your hospital.

Integrated Process

From a high-level perspective, developing a custom CESP involves three major phases:

1. Evaluate existing clinical equipment: This includes compiling vendor-provided equipment lifecycles, documenting active warranties, evaluating maintenance histories, understanding true lifecycle ownership cost, etc.
2. Identify hospital's equipment needs: This phase addresses the necessary capital equipment investment to support your business objectives. Which equipment is really needed? At what point do you risk overinvesting? What is the ideal acquisition timing to capture newest and most capable technologies?
3. Propose multi-year equipment replacement plan within your budget, which strikes the ideal balance between adding new equipment technologies to your inventory and the risk of keeping aging assets current. At this point, ways to further capture value are considered (e.g., phased and group purchasing).

Typically consultants are employed to help hospitals walk through the Capital Equipment Strategic Planning process. These specialists offer an objective perspective as well as a potentially broader grasp of vendor offerings, industry best practices, and new technologies expected to hit the market. Hospital personnel will then implement the approved multi-year plan, making needed modifications due to market shifts, etc.

Data-Driven Solutions

Healthcare executives like the data-driven solution CESP provides. Their business objectives play a direct role in determining how the evaluation criteria are weighted. Factors such as return on investment, equipment lifecycles, maintenance costs over time, exposure to risk, group purchasing opportunities, and more are assessed and incorporated. The result is a strategically weighted equipment acquisition and maintenance plan.

Phased Approach

Given the rising cost of healthcare delivery as well as other marketplace factors, some hospitals have delayed replacing or updating their clinical equipment. Whatever your scenario, CESP can help you accurately understand your present situation and evaluate your highest priority capital equipment needs.

In fact, given group purchasing options and strategic sourcing, CESP can potentially enable you to upgrade equipment sooner than expected.

Conclusion

Medical technologies are one of a hospital's largest capital expenditures. Developing a strategic approach to managing clinical equipment acquisition actually can lower your total capital costs and improve your results.

CESP is a data-driven solution supported by a multi-year acquisition programme based on efficiencies and your business objectives.

Otherwise, without a strategic equipment plan in place, often the "squeaky wheel gets the grease." This expenditure is too costly to leave to chance.

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OVERVIEW OF THE POLISH HEALTHCARE SYSTEM

Capital Stock and Investments

In 2009 there were 754 general hospitals in Poland. The vast majority (526 or 70%) were public, and the rest (228) were private, representing 90.2% and 9.8% of general hospital beds. In the same year, there were 52 psychiatric hospitals.

There are substantial differences in the proportion of public and private hospitals between regions. Voivodeships with the highest proportions of private hospitals (such as Kujawsko-pomorskie, Małopolskie and Pomorskie) are those that are economically well developed or are located close to national borders.

According to the CSIOZ's register of healthcare units (RZOZ) about 50% of all hospitals in Poland have less than 150 beds, with the proportion of small hospitals being higher for private institutions. On the other hand, most medium-sized hospitals (between 151 and 500 beds) are public.

The latest RZOZ data (2011) shows the average age of hospitals in Poland as 15.1 years. Most hospitals (58%) are between 10 and 20 years old. However, this assessment may be skewed due to the inclusion of very small or not functioning units in the registry. Most private hospitals have been established after 1999 and are therefore in relatively good conditions. On the other hand, some public were built in the 1970s and 1980s, and many are still housed in buildings constructed before World War II. As a result, their general condition is poor, and maintenance is very costly.

According to the 2008 Green Book II on Healthcare Financing in Poland (Ministry of Health, 2008), the average level of depreciation of fixed assets in the healthcare sector was approximately 62% at the end of 2006, whereas (according to construction industry standards) 40% is the level of depreciation that would qualify a building for an extensive overhaul (Ministry of Health, 2008). The situation is further aggravated by the widespread, long-standing practice of using amortization write-offs to cover financial losses. This practice stems from the financial limitations faced by the SPZOZs (independent public healthcare facility) and results in reduced spending on modernisation and renovation of facilities. According to the Green Book, over 60% of hospitals' fixed assets require major repairs or replacement and 40% of the buildings must be modernised.

The amount earmarked by the state for investment in healthcare is determined yearly in the budget. In the budget planned for 2011, over PLN 807 million was allocated to investment funding in healthcare, out of which PLN 265 million was allocated to healthcare programmes (some of these programmes also cover investments in equipment and clinics). The majority of budgetary funding (80-90%) was allocated to implementation of projects co-financed by the EU (see below). In theory, contracts with the NFZ (National Health Fund) should also provide hospitals with money for renovations, expansion and replacement of equipment. However, after paying for human resources, medicines and other expenses, the amount left for capital investments is negligible. Other sources, such as non-governmental organisations are used to finance smaller investments.

Infrastructure

In Poland, there was very little change in the number of beds until the late 1990s, but the restructuring that followed the 1999 reform resulted in a decrease of 11,547 beds between 1999 and 2002. Since then, the number of beds has been slowly declining. An increase in the number of general hospital beds between 2007 and 2008 visible in public statistics was mainly caused by the change in the methodology of counting beds (beds and incubators for the newborns were included in the number of general beds).

The average length of stay (ALOS) in hospital has been falling continuously in Europe in the past few decades. At 5.7 days in 2008, the ALOS in Poland compares relatively well with other European countries. The hospital occupancy rate in Poland has increased since the 1990s. In 2009, the highest occupancy rates were observed in haematology, psychiatric and addiction wards and the lowest in ophthalmic, neonatology, and paediatric wards.

The deficit of long-term care beds has long been on the health policy agenda. Plans to reduce the number of acute hospital beds in favour of long-term and psychiatric beds have been in place since the early 1990s. For example, conversion of acute care beds into long-term care beds was one of the components of the 2006 draft law on "hospital networks" but, as already mentioned, this law was eventually not implemented.

EU investments in healthcare infrastructure for 2007-2013 are channelled through the Operational Programme on Infrastructure and Environment, which provides European Community support under the convergence objective. The total budget of this programme is 37.56 billion euro (this is the biggest operational programme in Poland and in the EU), out of which nearly 412 million euro was allocated to Priority 12 (health, safety and improvement of health protection system), which provides support for developing an integrated emergency medical services system and healthcare infrastructure. At the end of 2010, the value of contracted funds amounted to 86% of the total funds available for Priority 12. Most contracts (231 out of a total of 283) were in

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***IT @ Networking Awards 2012*, is a global healthcare IT and medical technology competition, recognising and promoting outstanding healthcare IT and medical technology projects.**

COMPETING SCIENCE

Today, shrinking funds require us to deliver more for less. We experience this reality in all aspects of life, even in science. Hospital departments, healthcare institutions and regions have to create professional business cases to receive sufficient funding to realise their projects.

The *IT @ Networking Awards 2012 (IT @ 2012)*, recognises this new reality: excellent projects are competing against each other in order to win. The Expert Panel, attending peers and competitors can cast their vote supporting their favourite implementations.

HOW IT WORKS

IT @ 2012 is a fast-paced, interactive event with two presentation rounds:

Day 1 – MindByte Presentation - each presenter is given 5 minutes to highlight the key advantages of his project and persuade the audience to vote for them. This is followed by a 5 minute Q&A by with the audience who vote based on the presentation/voting criteria. Only the top 8 rated projects will succeed and move into the next presentation round.

Day 2 – WorkBench Presentation – each presenter is given 25 minutes to provide an

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in-depth insight into their project. The aim is that the audience will support the project. Corporate supported projects are allowed to highlight the industry angle in the Work-Bench session.

In a 15 minute Q&A session all questions can be answered, followed by the final vote to cast the winner.

THE PRESENTATION / VOTING CRITERIA

IT @ 2012 will highlight installations from all areas in healthcare to support cross-departmental understanding. All presenters are required to follow a strict structure allowing the audience to compare on common grounds:

1. THE IMPORTANCE OF TECHNOLOGY
   - What technology was used and how was it integrated into the workplace?

2. BENEFITS
   - Has the project helped those it was designed to help?
   - Has the project changed how tasks are performed?
   - What new advantages or opportunities does the project provide?

3. ORIGINALITY
   - What makes the solution special?
   - Are there any original features?
   - Is it the first, the only, the best or the most effective application of its kind?
   - Is it an improvement on existing implementations?

4. DIFFICULTY
   - What important obstacles had to be overcome?
   - Were there any technical or organisational problems?

5. SUCCESS
   - Has the project achieved or exceeded its goals?
   - How do you see the project's success affecting other applications, your facility or other organisations?
   - How quickly would the users accept the implications of this innovation?

6. IMPACT
   - What is your overall impression of the project?

THE VOTING SYSTEM

IT @ 2012 uses a highly sophisticated voting system with two separated groups of voters: the expert panel and the audience/presenters, each with 50 % impact.

Based on the Bayesian Model the expert panel is setting a trend. To avoid bias, every vote from the audience out of a credible margin will be automatically disqualified.

WHY IT IT @ 2012 SO DIFFERENT?

The main difference lies in the element of competition. Presenters from across the world must present their idea to the highest standard, master all questions and persuade the audience and judges that their solution deserves to win. By allowing presenters to cross-examine their competitors, the Q&A sessions take on a new dimension.

IT @ 2012 requires the open disclosure of difficulties during planning and implementation of the solutions and how these issues where solved. This allows the audience to learn from others' mistakes and bring new methods and solutions back to their own institutions.

WHY ATTEND?

IT and medical technology is of key importance to healthcare. Intelligent IT solutions increase cost-effectiveness, productivity and safety.

IT @ 2012 will expand your knowledge on different medical technology and IT solutions from all areas in healthcare and supports a cross-departmental understanding like no other event.

HOW TO REGISTER

To register, please visit:
https://www.conftool.net/itawards2012/

LOCATION

IT @ 2012 will take in Brussels, the capital of Europe.

Hotel reservations can be obtained through www.booking.com.

For more information please visit our website **www.itandnetworking.org** or contact us on +32/2/2868501 or send an email to **office@hitm.eu**

We look forward to seeing you in January!

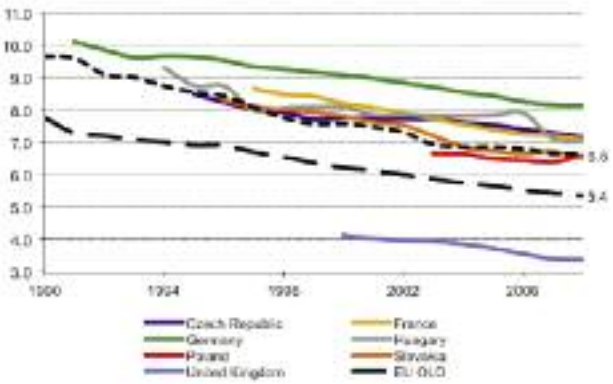

Figure 1. Hospital beds per 1,000 inhabitants 1990–2008
Source: WHO (2011)

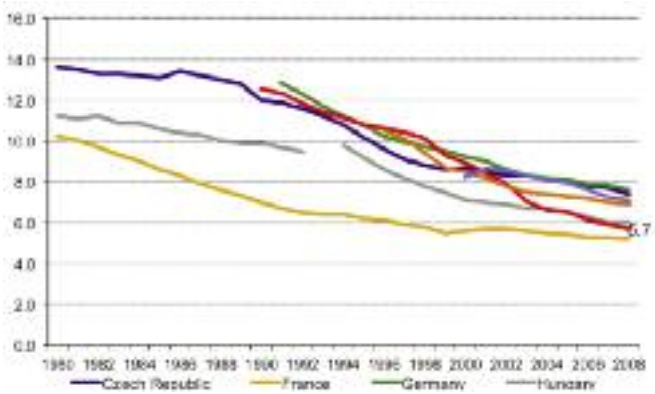

Figure 2. Average length of hospital stay in Poland and selected EU countries, 1990–2008. **Source:** OECD Health Statistics 2010.

Note: *Since 2004. in-patient average length of stay is calculated by dividing number of curative care bed days by in-patients in all general and specialised hospitals (public and non-public hospitals). Since 2008. calculation of the average length of stay includes neonatology wards in general hospitals.*

the area of the integrated emergency medical services system.

Highly specialised hospital equipment is funded by the Ministry of Health from the State budget. Funding may also be awarded under the Operational Programme Infrastructure and Environment. Medical equipment used by emergency rescue teams and hospital emergency wards may be financed by the Ministry of Health, other Ministries, voivodes and local self-governments.

Information Technology

In primary care computers are mainly used for patient registration and administrative purposes but not during medical consultations – neither the physician nor the patient have access to electronic data (such as patient records). Although computers are used in the majority of healthcare units in Poland, usage in single-physician medical practices and middle-sized ambulatories is low and medical documentation is still maintained in paper form. Several voivodeships have well developed IT systems in large clinics and specialist hospitals, in which the administration is connected to the flow of medical data from hospital wards, hospital pharmacies and surgery management systems.

However, the use of IT in secondary care still seems to be much less advanced than in Western Europe. The use of e-health in Poland is very low but some initiatives in this area have been piloted. For example, although virtually all prescriptions are dispensed in printed form, prototype e-prescriptions were implemented in sixteen pharmacies, two medical practices and two outpatient clinics in 2011 in Leszno. A prototype of Internet patient account (with information on medical history) was introduced in 2011 in several diabetic medical centres in Kraków. County-wide rollouts by 2014 are the ultimate goal in both cases.

Some university clinics and specialist hospitals use telemedicine in the areas such as cardiology and orthopedics. Electronic appointment booking is not widespread but there are encouraging examples of such practices (e.g. for online booking of specialist appointments in hospitals). Electronic patient registration is one of the tools foreseen in Project P1 of the Healthcare Computerization Programme, which was launched in 2009 and is in 85% co-financed by the EU under the Innovative Economy Programme 2007–2013. Large hospitals are more likely to use IT infrastructure, for both administrative purposes and for medical records keeping.

Currently, there is redundancy of collected data (the same or similar data can be found in different registers), inconsistency of data between registers (for example, a change of address in one register is not automatically updated in other registers) and no linkages between various databases. Medical ICT systems are usually developed separately by individual healthcare units and compatibility and coordination are low. There have been initiatives (co-funded by the EU) to unify ICT infrastructure and software, but they were small and only on regional level. However, a more comprehensive approach was introduced by the Healthcare Computerization Programme. This included the creation of an electronic platform for gathering, analysing and sharing of digital records with mostly patient-oriented functionalities (for which patients and healthcare employees will be the principal users) and a second platform providing entrepreneurs (healthcare providers) with online access to the services and resources of digital medical registers (Project P2). This initiative is particularly useful since medical records are currently maintained by individual health service providers and a central register is lacking. Implementation of the programme, which is managed by CSIOZ, is due to be finished in 2014.

There are also regional initiatives in the area of e-health. Future strategy in the area of e-health is outlined in a recent CSIOZ study introducing the "e-Health Poland" strategy. Its key goals include digitalization of medical registers and strengthening of their legal basis (some have outdated or no legal basis); achieving interoperability of information systems, improve accessibility to information systems for the public administration, physicians and patients; reducing the cost of data collection and processing; and implementing EU directive on patient rights in cross-border healthcare (Directive 2011/24/EU). The strategy was backed up by legislation proposed by the Ministry of Health and adopted in April 2011 (Act on the information system in healthcare). The Act sets out the organisation and operation of an information system in healthcare, with the goal of reducing information gaps in the sector. An improved healthcare information system should facilitate optimal policy decisions in the future and lead to improved performance of the Polish healthcare sector.

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THE POLISH ASSOCIATION OF HOSPITAL DIRECTORS

Past, Present and Future

By Mieczysław Pasowicz

A formal visit of the delegation of directors of Lesser Poland hospitals in frameworks for cooperation of the Krakow Province and city of Copenhagen and discussion with the Chairman of Danish Association of Hospital Managers, Mr. Asger Hansen were inspiration to establish the national association in 1992. Soon, in June 1993, the Polish Association of Hospital Directors (PAHD) became a legal entity, and an Honorary PAHD Membership was awarded to Mr. Asger Hansen.

The association is a non-governmental organisation gathering directors of hospitals and other institutions in healthcare. The organisation is funded through membership fees, extra-budgetary centres and donations. An exchange of experiences and information is one of main tasks of the association in order to provide modern and effective functioning and management of healthcare in Poland. The PAHD achieves its goals through the organisation of domestic and international conferences, consulting and initiating legal documents and the cooperation with related associations in other countries and with international organisations.

On the recommendation of their German friends, the Polish association was admitted into European Association of Hospital Managers (EAHM) during the 1994 EAHM congress. Mieczysław Pasowicz, the founder and president of PAHD was made a member of the Executive Committee.

Activities: Past and Present

From the beginning, PAHD has been involved in current healthcare issues. In 1995 an international conference in Czestochowa was organised. Its topic was " Autonomy and financing hospitals in Central Europe". National conferences of the association are regularly organised as part of the activities stipulated in the articles of association. First meetings had a local and regional character and concerned matters such as the status of the hospital administrator, innovations in Polish hospitals and IT.

The association organises numerous events, aimed at national and international audiences. The largest international meeting, the 19th EAHM congress held in 2002, was hosted by the city Krakow. The meeting was held under the honorary partronage of Aleksander Kwasniewski, the President of the Republic of Poland. The theme was "Patient focused care: from structural reforms to integrated care."

More recent activities include an international scientific conference organised by PADH in October 2011. The conference focused on "Medical dilemmas of the 21st century" and was held in Krakow. It was connected with the problem of our ageing society and potential of new medical technologies to overcome the challenges of the future. In moderated panel debates with representatives from politics, public health, medicine and social science attendees discussed health challenges of the future, the significance of public health and the use of new technologies to overcome problems connected with demographic, epidemiological, and socioeconomic transformations.

The association was also one of the consultants on social drafts of regulations of the Department of Health. PAHD consulted on issues such as the scope of activities of the doctor, nurse and the midwife in primary healthcare; the amendment to regulation on spa treatment; state aid and restructuring of public healthcare centres.

The Future of the Association

The PAHD was formed 18 years ago in a completely different political and economic situation. Back then the focus was on educating managers on the changing healthcare system and the preparation for necessary reforms. Today health policy in Poland still requires modification but the level of the professional awareness is higher and in general better at coping with the changing situation in healthcare. Failures of reforms are caused mainly by lack of funding and legal inconsistencies.

The restructuring of hospitals is the next important issue. During the transformation period the number hospital beds was reduced and as a consequence, so was the number of public hospitals in Poland. On the one hand, it is an advantageous tendency as only the strongest and best institutions will remain. On the other hand, such a situation is giving rise to problems of another kind; social issues such as the emigration of doctors and nurses and the general complaint of poor/reduced access to medical services.

On that account the association will propose new organisational and technical solutions in the area of hospital and medical services, considering factors such as the ageing of the population, need for the reduction of hospital debt, implementing additional sources of financing in healthcare, coordination of care, effectiveness of hospitals etc. PAHD will also focus on strengthening the national network of hospitals and public-private sector cooperation. A development programme for e-health services and all-Polish information system is another key activity.

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POLAND: THE PATIENTS' PERSPECTIVE

By Tomasz Szelagowski

Patient organisations are quite unique as they take strength and courage to build. There are almost 5000 of them registered in Poland (around 40,000 in Europe). Patient organisations should work as a collective, bringing together the various views and priorities of its members. It takes time to integrate all organisations and maintain the coordination, but when it works, the result is a powerful voice.

The Federation of Polish Patients (FPP) is an umbrella organisation that recognises integration of patient associations as one of its most important priorities. In many cases, taking care of the interests of their own members, patient organisations compete with each other. Building awareness of the partnership among them can be a very difficult task. The situation in Poland in this sense is very similar to those in other Central European countries.

Nevertheless there are plenty of active organisations to choose from to form solid alliances. FPP concentrates on its members' opinions and delivers them to decision makers. At the beginning of FPP's existence the most important topic was access to healthcare and this still remains very important but other subjects have grown in importance: Quality of medical services, innovative treatment, early prevention of chronic diseases and e-health issues.

This large spectrum of issues on national level can only be tackled by building a larger partnership with medical professionals, industry and regulators. Another partner on that trail is European Patients' Forum (EPF), an umbrella organisation of European and national patients' organisation. It provides a platform for knowledge exchange, education and consultations for its members. Support received throughout those channels enables FPP to take part in many projects and to organise large-scale events.

In this context, the aim of the EPF and FPP Warsaw conference on the rights and needs of older patients held in July 12-13, 2011 (the biggest patient-led event during Polish Presidency) was to exchange experience and insights with stakeholders at EU and national level on how to ensure high quality, patient centred equitable care for older patients, and ensure that the current challenges facing health and welfare systems are met whilst maintaining the respect, dignity and quality of life of older patients with chronic diseases and addressing their needs. It also aimed at exploring current initiatives and policy at EU level to debate how they can help address the needs of older patients.

A key principle of the European Innovation Partnership is that innovation should be centred on the user's needs. Participants identified barriers to the take-up of innovations from the perspective of patients and carers, such as communication issues. They also identified success factors such as equal partnership, and financial investment in the outcomes, as well as including a societal approach in health technology assessment

Another big topic (not only for Poland) is health literacy and information for older patients, including e-health literacy. Participants concluded that EPF/FPP's recommendations on health literacy are still valid but need to be reviewed in light of older patients. Participants stressed that good practices exist but that there is an evidence barrier, which prevents their transfer and implementation at national/local level. They also highlighted health literacy as a crucial topic which should be addressed as a priority by the partnership.

There was a consensus among participants that implementing these rights will be beneficial for patients, improving their health outcomes and quality of life and that it is a sound strategy for the sustainability of healthcare system.

Patients and E-Health

The "Chain of Trust" project is another patient-led activity. Prepared and coordinated by EPF, it is conducted in six European countries. The overall objective of this project is to advance the empowerment of patients, health professionals and national health authorities across the EU in their understanding and effective use of telehealth services in an effort to actively contribute to the vision of high quality, patient-centred, equitable healthcare. FPP (as EPF member) is organising a series of focused and well-defined actions so the project will also strengthen significantly the levels of awareness and trust for all key stakeholders.
Two specific objectives have been set out for this project:

1. Knowledge gathering.
2. Raising awareness and understanding.

The FPP is also a member of the Steering Committee of the Centre for Healthcare Information Systems in Poland, adding a patient voice. This way a unique and unprecedented assessment of the views, needs, benefits and barriers related to telehealth from the perspective of patients and health professionals will be produced.

With the wider deployment of electronic medical records there is an unprecedented opportunity to provide truly collaborative, more equitable patient-centred care to all patients in Poland and across the EU. Giving patients access to electronic health records can lead to huge benefits in terms of improved disease management and quality and safety in healthcare, particularly by reducing errors and improving coordination of care, better more efficient communication between healthcare providers and patients and, last but not least, enabling the patients to become active players in the healthcare delivery system.

Next year, the European Year of Active Ageing and Solidarity between the generations, will offer a valuable and concrete opportunity for change as the political focus will be on ageing.

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HEALTH PRIORITIES

Polish Presidency of the Council of the European Union

By Bolesław Samolinski

Non-Communicable chronic diseases are a hot topic at the minute. The WHO has developed international programmes and prepared and adopted a resolution during the 64 UN General Assembly. For this reason, chronic non-communicable diseases have become the main health theme of the Polish presidency of the Council of the European Union. The two priorities are:

- Alignment of differences in the health of EU Member States;
- Degenerative brain diseases, including Alzheimer's.

The first includes the two aspects of respiratory disease in children as a risk factor for impaired health in the later stages of life and communication disorders in children (hearing, speech and visual) as significantly toxic to children in working life, social, and responsible for delayed development and social exclusion.

Childhood disorders deserve special attention as they are poorly represented in existing EU programmes. Respiratory diseases, for example, especially allergy and asthma are among the most common chronic diseases of developmental age and affect 10 to 30 percent of the European population. This upward trend is observed in almost all EU countries. The final result of this epidemic is the increase in the incidence of COPD (chronic obstructive pulmonary disease). The cost of treating these conditions in Western Europe exceeded 40 billion euros in the mid-nineties (Allergy White Paper) and continues to grow. Disability resulting from asthma (12-16% of children, young people and up to 44 years of age in Poland by the ECAP) or allergies (over 40% of the population according to data ECAP) has the hallmarks of an epidemic. The result is both economic and social health burdens (e.g. 1 / 10 for the reimbursement of costs for prescription drugs is spent on drugs for asthma and respiratory allergies).

It is an important epidemiological chain: Allergic rhinitis (ANN) is the highest risk factor for asthma, and this in turn leads to the COPD, which is a condition likely to cause persistent respiratory distress, increasing respiratory insufficiency, circulatory, significant disability and death. It is estimated that in 20 years COPD will be the third cause of death in industrialised countries. By 2030, 44 million citizens in Europe will be affected.

These diseases are affected by public health issues such as smoking, pollution and alcohol abuse. It therefore seems reasonable to build a new vision of integration for health problems in Europe. Their high prevalence, their impact on quality of life - especially in ageing societies - and the significant economic consequences for the individual and society, make chronic non-communicable respiratory diseases a major clinical problem and also a challenge for public health.

Among the current task lists is to develop and implement a system enabling the collection, analysis and dissemination of data and information on trends in mortality, the population burden, risk factors, as well as plans and programmes related to the topic of non-communicable chronic diseases. The international dimension recognises the need for coordinated cooperation in order to monitor and evaluate progress in the prevention and control of chronic non-communicable diseases.

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THE HEALTHCARE FORUM, **KRYNICA, POLAND**

By Maciej Bogucki

The Healthcare Forum is a discussion on the current and future situation in healthcare. Politicians, experts, doctors and industry representatives have the opportunity to discuss current problems in healthcare and possible solutions for the benefit of patients.

"How much State in Healthcare?" was the motto of this year's Healthcare Forum. The role of the state and the market in the healthcare system was discussed in Krynica in many ways. One of the most important questions raised was the regulation of the healthcare system, including the role of the payers in the system. The discussion was also connected with the organisation, the ownership structure of service providers and healthcare financing. Speakers recognised the increasingly important role of healthcare insurance, public - private partnerships and corporate governance.

The next Healthcare Forum will take place during the Economic Forum in Krynica on 4-7 September 2012.
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Willy Heuschen

UNE SOLIDARITÉ PLUS QUE JAMAIS NÉCESSAIRE

Au moment où j'écris ces lignes, beaucoup expriment leurs craintes pour la cohésion de l'Europe. Plusieurs sommets européens ont été nécessaires pour soutenir dans le long terme certains États membres. Même si les mesures prises par le Conseil des ministres de l'Union européenne sont mises en œuvre de façon efficace, il n'est pas exclu que de nouveaux troubles inquiètent les États membres. Des mesures d'austérité drastiques sont annoncées dans presque tous les pays et les hôpitaux perçoivent très clairement la difficulté et le risque inhérent à leur mise en application.

« Où et comment économiser ? », c'est autour de cette question que le « HEALTH MANAGEMENT INSTITUTE » (HMI), la Fédération nationale irlandaise affiliée à l'AEDH, a organisé sa première réunion annuelle. Parmi ses plus intéressantes présentations, certaines seront publiées dans les prochains numéros de notre magazine. La question fondamentale qui a donné le ton était de savoir comment économiser sans compromettre ou négliger la qualité de l'offre des services de santé. Il est étonnant de constater que nos collègues irlandais étaient également à la recherche d'une réponse du côté des autres pays européens. À côté des conférenciers du Royaume-Uni, Heinz Kölking, président de l'AEDH, a précisé dans son discours que les pays qui n'étaient pas directement touchés par la crise faisaient également des économies budgétaires leur préoccupation permanente. En se référant à son expérience dans les hôpitaux allemands, il a expliqué comment l'équilibre entre la réduction des coûts et la qualité est plus facile à trouver si on nourrit une culture d'entreprise personnalisée. Nous vous conseillons de lire dans ce numéro l'entretien avec le professeur Malik ainsi que l'article de S. Hodgets.

Outre leur très intéressant contenu, ces articles nous dépeignent un certain exercice de la solidarité. La solidarité n'est pas seulement un préalable indispensable au développement de la croissance en temps de crise. Elle est une valeur fondamentale dans le monde entier comme en Europe, dans les institutions européennes, et dans nos propres pays, ainsi que pour nous, les gestionnaires des hôpitaux. Prendre connaissance des difficultés de ses voisins, les aider à trouver des solutions, apporter ses connaissances et son expérience sans tomber dans le « je sais tout » et l'arrogance... bref, si l'analyse comparative des valeurs est un outil adapté à ce genre d'exercice, elle est aussi une expression de la solidarité.

Les hôpitaux doivent rester, à mon avis, des lieux de solidarité par excellence.
Nos systèmes de financement des soins de santé, et donc des hôpitaux, sont encore basés sur le principe de la solidarité. Les assurés ont donc le droit, grâce à leurs cotisations, à un traitement adapté. Nous savons que cette solidarité est souvent remise en question. Ainsi, certaines caisses publiques d'assurance maladie voudraient que les traitements coûteux soient couverts par les compagnies d'assurances privées. Elles parlent également d'exclure de la liste des traitements pris en charge les prestations qui ne sont pas financièrement rentables pour les hôpitaux. Si les patients sont vraiment au centre des activités de nos hôpitaux, que devons-nous penser de telles pratiques ?

Notre responsabilité de directeur de nos institutions nous permet de faire chaque jour l'expérience de l'importance de la solidarité, que ce soit au sein des équipes, ou à l'intérieur et entre les différents groupes professionnels. Elle est un préalable pour travailler ensemble à des buts communs.

La solidarité est une valeur qui a sa place également au sein de l'AEDH. Dans le contexte de la crise financière qui sévit dans leur pays, nos collègues grecs font de nombreux efforts pour organiser le 24ème Congrès de l'AEDH en 2012 à Athènes. Actuellement, les risques ne sont pas encore entièrement prévisibles. Nous devons nous assurer que les conditions seront remplies pour assurer au Congrès un bon déroulement. Le Bureau de l'AEDH a décidé de soutenir ses collègues grecs et présentera prochainement ses conclusions à Düsseldorf à notre conseil d'administration, qui sera alors en mesure de prendre une décision définitive. Nous ne ménagerons pas nos efforts pour que, en sus d'une véritable évaluation des risques, la valeur fondamentale de la solidarité trouve à s'exprimer lors de ces décisions difficiles. Dans la « lettre du Président » qui sera envoyée à tous les membres de l'AEDH en décembre et qui pourra également être consultée sur notre site, nous expliquerons notre décision et sa justification. On peut dores et déjà annoncer que la solidarité de tous, comme jamais auparavant, est ici nécessaire.

Willy Heuschen,
Secrétaire général et rédacteur en chef de l'AEDH

Les éditoriaux d'*(E)Hospital* sont rédigés par des membres des instances dirigeantes de l'AEDH.
Les contributions publiées ici ne reflètent cependant que l'opinion de leur auteur et ne représentent en aucune façon la position officielle de l'AEDH.

LA « WP-IT MANAGERS » DÉBUTE À VIENNE ET À VILNIUS AVEC DES SÉMINAIRES DESTINÉS AUX DIRECTEURS

Le « Working Party IT-Managers » (WP-ITM) a permis le rapprochement des directeurs, des gestionnaires et des responsables informatiques. L'approche qu'elle a adoptée est l'aboutissement direct du processus de réflexion tenu l'année dernière au sein de l'AEDH. Ces premiers séminaires régionaux destinés aux directeurs et organisés à Vienne, en Autriche, et à Vilnius, en Lituanie, ont connu un franc succès. Au cours de ces séminaires, les directeurs ont été invités à se pencher sur la traduction du plan stratégique hospitalier en un plan « IT master ».

Avant de se plonger dans le plan « IT master », quelques informations ont été données aux participants. Le problème de la gouvernance informatique dans des hôpitaux a été tout d'abord, discuté et relié à une typologie des décideurs informatiques au sein des hôpitaux. Ensuite, nous avons assisté à la présentation de quelques challenges concernant l'informatique de santé ainsi que de différentes initiatives internationales pour aider les hôpitaux. Puis a été abordée la stratégie informatique basée sur la mission et la stratégie de l'hôpital, elle-même divisée par la suite en stratégie des ressources, du système, et organisationnelle.

Une fois qu'une stratégie informatique a été définie, le plan « IT master » peut commencer. L'attention a été accordée au contenu et à la façon d'effectuer sa configuration, son approbation et sa mise en œuvre. La dernière séance a porté sur le suivi de sa mise en application grâce à quelques lignes directrices. Une partie du séminaire a été consacrée à des ateliers où les participants ont travaillé ensemble à la formulation d'une stratégie informatique et à la mise en place d'un schéma directeur informatique.

Le séminaire de Vilnius s'est terminé d'une agréable façon grâce à la présentation de plusieurs cas abordant des sujets comme le développement de l'informatique hospitalière et l'amélioration de l'efficacité des établissements de santé par la mise en application de solutions internet. Vilnius a également donné la possibilité aux participants de rencontrer les différents partenaires et de discuter sur les possibilités des solutions qui étaient présentées.

Grâce à ces séminaires, la « WP-IT » a rassemblé près de cent directeurs. Les discussions ont montré que les directeurs d'hôpitaux sont conscients du rôle croissant de l'informatique dans la direction d'un hôpital et que le développement de l'infrastructure informatique doit être rentable et durable pour l'hôpital afin qu'il puisse remplir sa mission et ses objectifs.

Il était également clair que les interconnexions sont de plus en plus importantes à l'intérieur de l'hôpital mais aussi avec les autres institutions et organisations. La situation peut différer d'un pays à l'autre, mais les autorités nationales, locales et même européennes ont un rôle important à jouer en s'assurant que les informations peuvent être échangés de manière efficace entre les nombreux acteurs de la santé dans le meilleur intérêt du patient.

La « WP-ITM » prévoit d'organiser d'autres séminaires dans les autres régions d'Europe.

Remarque : les présentations des séminaires sont disponibles sur notre site : **www.eahm.eu.org**

NOTE

Ces séminaires ont été rendus possibles grâce au soutien des intervenants suivants : B. Carr (Adelaide Hospital Meath, Irlande), le Dr Carl Dujat (promedtheus AG), Gerhard Hardter (Klinikum Stuttgart, Gemany) Gunther Kostka (AZ Sint Lucas & Volkskliniek, Belgique), le Dr Pierre-Michael Meier (Entscheiderfabrik, Allemagne), Jos Vanlanduyt (AEDH), et par les partenaires suivants : KMS, Id information Und Dokumentation Im Gesundheitswesen, Intersystems, Meierhofer, Ser et VAMED (séminaire de Vienne).

Agenda de la 41e Assemblée générale ordinaire

La réunion se tiendra le 18 Novembre 2011 de 17 h 30 à 18 h 30 dans la salle M, CCD-Ost, Messe Düsseldorf, Allemagne

1. **Approbation de l'ordre du jour**
2. **Approbation du compte rendu de la 40e Assemblée générale ordinaire qui s'est tenue le 9 Septembre 2010 à Zurich, en Suisse**
3. **Rapport d'activité 2010-2011 du Président**
4. **Les comptes 2010**
   - **4.1.** Présentation par le Secrétaire général
   - **4.2.** Rapport des vérificateurs
   - **4.3.** Approbation des comptes de 2010 et décharge du Bureau et du Secrétaire général
5. **Plan économique pour 2012**
   - **5.1.** Approbation des propositions de cotisation pour les membres et les membres associés (2.4.c des statuts)
   - **5.2.** Approbation du plan économique pour 2012
6. **Election des vérificateurs pour l'exercice 2011**
7. **Admission et exclusion des membres**
8. **Prochaine Assemblée générale ordinaire en 2012**

Un leadership efficace est la clé d'une gestion hospitalière réussie
Par Sue Hodgetts

Les trois principes fondamentaux du leadership sont qu'il est contextuel, non hiérarchique et relationnel. D'un premier abord, on s'aperçoit que le leadership est situationnel, c'est à dire que les décisions seront prises en fonction de la situation. Au sein même des situations, c'est le discernement qui est le plus important : il faut savoir déceler les signaux conjoncturels importants, comprendre ce qui se passe sous la surface, posséder à la fois des micro et des macro compétences, savoir aussi bien circuler dans les couloirs que diriger des réunions stressantes et difficiles. Un leadership fécond sera non hiérarchique : les grandes organisations placent de grands dirigeants à tous les niveaux. Le leadership relationnel est primordial pour asseoir sa position en tant que chef. Les responsables sont activement engagés dans une série de relations complexes qui requièrent à la fois la culture et l'attention. À la base doivent rester l'authenticité, la cohérence entre les paroles et les actes et la cohésion avec la raison profonde de sa mission, unis en un fil conducteur fait de convergence et d'équité.

« Uncluttered management thinking » : les principes de la gestion fondée sur les résultats
Par Fredmund Malik, Johannes Flecker

L'« Uncluttered management thinking » permet de privilégier les éléments nécessaires et suffisants que tous les gestionnaires doivent contrôler à n'importe quel endroit, dans n'importe quelle situation, dans toute organisation, et en tout temps. Une gestion efficace se base sur le respect des six principes qui régissent la qualité du travail quotidien d'un gestionnaire, son efficacité au sein de sa fonction, et les outils qu'il utilise. Par ces principes, on s'assure qu'une entreprise s'appuie sur une conception générale de la gestion.

Les six principes de gestion sont l'orientation résultats, la contribution à l'ensemble, la concentration sur l'essentiel, l'utilisation des forces existantes, la confiance et la pensée positive.

Ces principes de gestion peuvent soutenir le développement de l' « Uncluttered management thinking ». Ils fournissent un excellent cadre qui permet de déployer plus d'efficacité et d'efficience lors de la création de valeurs pour les clients et les patients.

Existe-t-il une relation entre la performance d'un hôpital et le fait que ses dirigeants soient des médecins ?
Par Amanda Goodall

La question de savoir si les hôpitaux sont mieux gérés par les médecins ou par des cadres possédant une formation non médicale a été ardemment débattue pendant de nombreuses années. Amanda Goodall tente de répondre à cette question. Elle a choisi parmi les hôpitaux américains ceux qui étaient classés parmi les plus performants dans trois domaines spécialisés, et a recherché de quelle formation étaient issus leurs responsables. Les résultats montrent que les scores de qualité d'un hôpital sont d'environ 25 % plus élevés dans les hôpitaux gérés par des médecins que dans la moyenne des hôpitaux.

Ses résultats montrent que les hôpitaux qui se sont rangés plus haut dans le classement ont pris des décisions différentes : en général, ils ont choisi d'embaucher des médecins pour occuper les places de directeurs. Ces résultats corroborent les travaux antérieurs sur le rôle des « leaders experts » dans d'autres configurations (non médicales) : par exemple, nous avons découvert que les universités de recherche avaient de meilleurs résultats quand elles étaient dirigées par des chercheurs exceptionnels et que les équipes de basket-ball NBA gagnaient plus souvent quand leurs entraîneurs avaient été des joueurs exceptionnels. Ces experts pourraient présenter l'avantage d'avoir acquis une profonde connaissance intuitive sur l'activité principale de leurs organisations, ce qui peut les aider à une prise de décision adéquate et à une meilleure stratégie institutionnelle.

Assurer la qualité du nettoyage et de la désinfection externalisés
Par Gianfranco Finzi, Daniela Gabellini

On assiste à l'externalisation progressive des services techniques et administratifs pour soutenir les services « essentiels » des établissements de santé. Une norme a été développée pour encourager des pratiques de nettoyage et de désinfection des établissements de santé qui ne nuisent pas à l'environnement, ceci grâce à un système de contrôle informatique. Le service vise à évaluer, sur une base objective, la norme de qualité et d'hygiène du service de nettoyage et de désinfection externalisé, afin de promouvoir leur meilleure intégration dans la gestion quotidienne des activités effectuées dans les hôpitaux.

Plus que le temps et l'argent, définir l'efficacité en salle d'opération
Par Michael Greiling

La salle d'opération est l'une des plus coûteuses zone d'un hôpital et il a été établi qu'elle peut être à l'origine de 40 % des coûts hospitaliers totaux. Il est parfaitement logique, dans une ère où les budgets gouvernementaux et les remboursements sont réduits, d'essayer de faire des économies dans ce département. Maximiser la capacité en salle d'opération est donc un facteur clé dans la réduction des coûts : s'assurer que chaque patient n'y passe que le temps nécessaire et que le temps entre les procédures est minimisé afin de permettre la complète utilisation des salles sur une journée entière de travail.

En utilisant des biens et services de haute qualité qui permettent d'économiser du temps, en permettant aux professionnels de santé de se concentrer sur leurs domaines de compétence tout en maintenant les standards cliniques, nous devrions assister à une augmentation du nombre de procédures chirurgicales. Les séjours hospitaliers devraient être plus courts, l'impact environnemental réduit et les structures organisationnelles rationalisées, ce qui est plus que nécessaire en période de restrictions budgétaires.

« Clinical Laboratory Business Analysis »

Par Vikica Buljanovic, Hrvoje Patajac, Mladen Petrovecki

Le « Clinical Laboratory Business Analysis » peut fournir un aperçu de la performance d'une entreprise prospère. L'augmentation de la productivité des laboratoires cliniques provient du développement technique touchant les diagnostics effectués en laboratoire. Étant donné qu'ils requièrent un investissement financier important, ils peuvent à première vue être considérés comme non profitables. L'introduction d'un système informatique dans le laboratoire mène à un meilleur contrôle des procédures de travail, à l'amélioration de l'organisation du travail et à un gain de temps qui affecte la productivité. L'analyse du fonctionnement commercial du laboratoire, ainsi que de la rentabilité financière de l'investissement peuvent être perçues sous l'angle du développement d'un modèle économique, c'est à dire d'un laboratoire pensé comme une entité économique. La création du modèle d'un laboratoire pensé comme une entité économique implique l'identification des revenus et des charges et leur comparaison sur une période de temps spécifique, généralement un an. Une telle « Business Analysis » peut se traduire par des bénéfices financiers substantiels. Elle montre clairement la nécessité d'une formation de base en économie et sa mise en application par les gestionnaires dans les différents départements au sein du système des soins de santé.

Le nouveau service central de stérilisation de l'hôpital universitaire Authority St. Orsola – polyclinique Malpighi

Par G. Finzi et al.

Inauguré en Septembre 2010, le nouveau service central de stérilisation de l'hôpital universitaire rassemble des fonctions auparavant prises en charge dans les services de diagnostic et de traitement d'un niveau technologique élevé comme les soins d'urgence, l'imagerie diagnostique, les blocs opératoires et les soins intensifs. C'est par un contrat de service qu'ont été réalisées la conception, la construction, la gestion, l'exploitation et la maintenance de cette seule unité centrale.

La création d'un tel département au service de toute la polyclinique est un grand avantage pour l'hôpital : il permet l'adoption de méthodes identiques pour le traitement des instruments chirurgicaux pour tous les blocs opératoires. Les activités complexes qui y sont réalisées, le nettoyage, la désinfection (à la main, par ultrasons, ou avec des machines à laver automatiques), le conditionnement (le contrôle et l'entretien des instruments, la composition des kits), le chargement des kits en autoclave, la stérilisation et le stockage, nécessitent une conception attentive et fonctionnelle des espaces pour chaque étape du processus, depuis l'arrivée des instruments chirurgicaux au service central de stérilisation jusqu'à leur retour dans les salles.

La Pologne

Admise dans l'Association européenne des directeurs d'hôpital en 1994, l'Association polonaise des directeurs d'hôpitaux est une organisation non gouvernementale qui rassemble les directeurs des hôpitaux et des autres établissements de santé. L'échange d'expériences et d'informations est l'une des tâches principales de l'association avec l'objectif d'offrir un fonctionnement et une gestion modernes et efficaces aux soins de santé polonais. L'association réalise ses objectifs en organisant de conférences nationales et internationales, en accomplissant des actes juridiques et en coopérant avec des associations similaires étrangères et avec les organisations internationales.

Willy Heuschen

SOLIDARITÄT- NÖTIGER DENN JE ...

Während ich diese Zeilen schreibe, bangen viele um den Zusammenhalt Europas. Mehrere europäische Gipfeltreffen waren nötig, um einige Mitgliedsstaaten langfristig zu stützen. Selbst wenn die vom EU-Ministerrat getroffenen Maßnahmen auch effizient umgesetzt werden, bleiben den Mitgliedsstaaten weitere Turbulenzen möglicherweise nicht erspart. Drastische Sparpakete sind fast in allen Ländern angesagt und die Krankenhäuser spüren sehr deutlich, wie schwierig und riskant deren Umsetzung ist.

‚Wo und wie sparen', zu dieser Fragestellung organisierte das HEALTH MANAGEMENT INSTITUTE (HMI), der uns angeschlossene irische Nationalverband, erstmalig seine Jahrestagung. Einige der interessanten Beiträge veröffentlichen wir in den kommenden Ausgaben unserer Fachzeitschrift. Wie sparen ohne die Qualität der angebotenen Gesundheitsleistungen zu schmälern oder deren Qualität abdriften zu lassen. Diese Grundfrage war der Tenor in allen Beiträgen. Auffallend war, dass die irischen Kollegen in dieser Fragestellung auch auf das europäische Ausland blickten. Neben Sprechern des Vereinigten Königreichs verdeutlichte Heinz Kölking, Präsident der EVKD, in seinem Beitrag, dass auch in nicht- krisengeschüttelten Ländern dennoch Einsparungen zur ständigen Herausforderung gehören. Vor dem Hintergrund der deutschen Krankenhäuser erklärte er, wie mit einer angepassten Unternehmenskultur die Gratwanderung zwischen Kostensenkung und Qualität einfacher zu bestehen ist. Zur Führungsarbeit verweisen wir in dieser Ausgabe besonders auch auf das Interview mit Prof. Malik sowie auf den Artikel von S.Hodgets .

Neben dem wertvollen Inhalt symbolisieren diese Beiträge auch, wie Solidarität aussehen kann. Sie stellt ja nicht nur in Krisenzeiten eine unentbehrliche Grundvoraussetzung des Zusammenwachsens dar. Dies gilt Welt und Europa weit, bei den europäischen Institutionen, in unseren eigenen Ländern und auch für Krankenhaus Manager. Die Schwierigkeiten des Nachbarn kennen lernen, ihm bei der Lösungssuche helfen, seine Kenntnisse und Erfahrungen einbringen ohne in Besserwisserei oder in Überheblichkeit zu verfallen...kurzum ein auf Werte ausgerichtetes Benchmarking ist ein adäquates Hilfsmittel, aber auch Ausdruck der Solidarität.

Krankenhäuser sollten nach meinem Dafürhalten, Orte der Solidarität, par excellence, bleiben.

Schon die Finanzierungssysteme des Gesundheitswesens und somit der Kliniken basieren derzeit noch auf dem Solidaritätsprinzip. Versicherte haben demnach bei gleicher Beitragszahlung Anrecht auf eine ihrem Gesundheitszustand angepasste Behandlung und Versorgung. Wir wissen, dass diese Solidarität des Öfteren in Frage gestellt wird. So überlegen einige gesetzliche Krankenversicherungen die kostspieligen Behandlungen auf Privatversicherungen abzuschieben oder Kliniken Verlust bringende Behandlungen aus ihrem Leistungsangebot auszuklammern. Wenn Patienten wirklich im Mittelpunkt allen Tuns unserer Krankenhäuser stehen, dann sind solche Praktiken anzuzweifeln.

In der Führungsaufgabe unserer Einrichtungen machen wir tagtäglich die Erfahrung, dass Solidarität innerhalb der Mitarbeiterteams, in und zwischen den verschiedenen Berufssparten eine Voraussetzung ist, um überhaupt Ziele gemeinsam zu erarbeiten.

Und auch auf Ebene der EVKD muss Solidarität als Wert gelebt werden. Vor dem Hintergrund der Finanzkrise ihres Landes unternehmen unsere griechischen Kollegen viele Anstrengungen, um in 2012 den 24.EVKD in Athen auszurichten. Zurzeit sind die Risiken noch nicht voll kalkulierbar und es muss überprüft werden, welche Bedingungen zu erfüllen sind, um die Durchführung des Kongresses reibungslos sicherzustellen. Das Präsidium der EVKD hat beschlossen, die griechischen Kollegen dabei zu unterstützen. Das Ergebnis wird unserem Vorstand in Düsseldorf vorgelegt, der dann eine definitive Entscheidung fällt. Es ist uns aller Bemühen, neben einer realen Einschätzung der Risiken auch die Solidarität als Grundwert in dieser schwierigen Entscheidungfindung mit einzubeziehen. Im ‚Brief des Präsidenten', der allen Mitgliedern im Dezember zugestellt und auch auf unserer Website nachzulesen sein wird, erklären wir die Entscheidung und wie sie zustande kam. Es ist schon zu ahnen, dass auch dann Solidarität, wie nie zuvor, von Jedem nötig ist, um zukunftsträchtig zu bleiben.

Willy Heuschen
EVKD Generalsekretär u. Chefredakteur

Leitartikel in *(E)Hospital* werden von Führungspersönlichkeiten der EVKD verfasst. Die hier veröffentlichten Beiträge geben dennoch ausschließlich die Meinung der Autoren wieder und sind nicht als offizielle Stellungnahme der EVKD zu werten.

WP-IT MANAGER: KICK-OFF MIT CEO-SEMINAREN IN WIEN UND VILNIUS

Die ersten Schritte sind gemacht: Working Party IT-Manager (WP-ITM) bringen Geschäftsführung und IT sowie CIO und Management näher aneinander. Der von WP-ITM gewählte Ansatz ist direkt auf den im letzten Jahr innerhalb der EVKD durchgeführten Reflexionsprozess zurückzuführen. Die ersten regionalen Seminare für CEOs in Wien und im lithauischen Vilnius waren von großem Erfolg gekrönt. Im Rahmen dieser Seminare wurden CEOs eingeladen, sich die Umsetzung eines Strategieplans für ein Krankenhaus in einen IT-Masterplan genauer anzusehen.

Bevor man sich jedoch in den Masterplan vertiefte, bekamen die Teilnehmer die Hintergründe aus verschiedenen Blickwinkeln präsentiert. Zunächst wurde das Problem der IT-Leitung in Krankenhäusern diskutiert und mit einer Typologie von IT-Entscheidungsträgern in Krankenhäusern verknüpft. Als zweites wurden die verschiedenen Herausforderungen auf dem Gebiet der Gesundheits-Informatik vorgestellt, zusammen mit verschiedenen internationalen Initiativen zur Unterstützung von Krankenhäusern. In diesem Kontext befassten sich die Seminare dann mit dem Gebiet der IT-Strategie je nach Leitbild und Krankenhausstrategie, was weiter unterteilt wurde in System-, Organisations- und Ressourcen-Strategie.

Sobald eine IT-Strategie feststeht, kann der IT-Masterplan eingeleitet werden. Das Augenmerk lag hier auf dem Inhalt und wie man einen IT-Masterplan aufsetzt, sowie dessen Freigabe und Implementierung. In der letzten Sitzung lag der Fokus auf der Nachbeobachtung der Implementierung eines IT-Masterplans, für welchen einige Richtlinien formuliert wurden. Ein Teil des Seminars widmete sich Workshops, in denen Teilnehmer zusammen die Formulierung einer IT-Strategie und das Aufsetzen eines IT-Masterplans ausarbeiteten.

Das Seminar in Vilnius wurde ergänzt durch die Berichterstattung über einige reale Fälle, was das ganze Thema noch extra auffrischte. Dazu zählten etwa Themen wie die Entwicklung von Krankenhaus-IT und die Verbesserung der Effizienz von Gesundheitseinrichtungen durch die Implementierung von e-Solutions. Eine Ausstellung in Vilnius gab den Teilnehmern die Möglichkeit, die Partner kennenzulernen und die Möglichkeiten der vorgestellten Lösungen zu diskutieren.

Im Rahmen dieser Seminare erreichte die WP-IT etwa 100 CEOs. Die Diskussionen zeigten deutlich, dass sich Krankenhausmanager der wachsenden Rolle des IT bei der Leitung eines Krankenhauses voll bewusst sind. Auch wissen sie, dass die Entwicklung der IT-Infrastruktur für das Krankenhaus profitabel und nachhaltig sein muss, damit das Krankenhaus seine Mission und seine Ziele erfüllen kann. Es war außerdem klar, dass die Querverbindungen im Wachsen begriffen sind, im Krankenhaus selbst, aber auch mit anderen Einrichtungen und Organisationen. Die Situation mag sich von Land zu Land etwas unterscheiden, doch nationale, regionale und auch Europäische Behörden spielen eine wesentliche Rolle für die Sicherstellung dafür, dass holistische und standardisierte Information auf effiziente Weise und mit vielen Teilnehmern im Gesundheitsbereich ausgetauscht werden kann, im besten Interesse des Patienten.

Der WP-ITM hat nun vor, auch in anderen Regionen Europas Seminare zu organisieren.

Anmerkung: Die Präsentationen des Seminars sind abrufbar unter **http://www.eahm.eu.org**

ANMERKUNG

Diese Seminare wurden ermöglicht durch die großzügige Unterstützung der folgenden Referenten: B. Carr (Adelaide Meath Hospital, Irland), Dr. Carl Dujat (promedtheus AG) Gerhard Härdter (Klinikum Stuttgart, Deutschland) Gunther Kostka, (Az Sint Lucas & Volkskliniek, Belgien), Dr. Pierre-Michael Meier (Entscheiderfabrik, Deutschland), Jos Vanlanduyt (EVKD); und der folgenden Partner: KMS, Id Information Und Dokumentation Im Gesundheitswesen, Intersystems, Meierhofer, Ser und Vamed (Seminar in Wien);

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41. Ordentlichen Mitgliederversammlung

abzuhalten am Freitag, den 18. November 2011, von 17.30-19.00 Uhr im Congress Center, Eingang Ost (Ost), Raum M Stockumer Kirchstraße-D-40474 Düsseldorf

Tagesordnung:

1. **Genehmigung der Tagesordnung**
2. **Genehmigung des Sitzungsprotokolls der 40. Mitgliederversammlung vom 9. September 2010 in Zürich, Schweiz**
3. **Bericht des Präsidenten zur Tätigkeit der EVKD 2010-2011**
4. **Rechnungslegung des Jahres 2010**
   - **4.1.** Erläuterungen durch den Generalsekretär der EVKD
   - **4.2.** Prüfungsbericht der Rechnungsprüfer
   - **4.3.** Genehmigung der Rechnungslegung 2010 und Entlastung des Präsidiums und des Generalsekretärs
5. **Wirtschaftsplan für das Jahr 2012**
   - **5.1.** Genehmigung der Beitragsordnung der ordentlichen und assoziierten Mitglieder (Art. 2.4.c. der Statuten)
   - **5.2.** Genehmigung des Wirtschaftsplanes für das Jahr 2012
6. **Wahl der Wirtschaftsprüfer für das Jahr 2011**
7. **Aufnahme neuer Mitglieder**
8. **Nächste Ordentliche Mitgliederversammlung 2012**

Effiziente Führerschaft: der Schlüssel zum erfolgreichen Krankenhaus-Management
Von Sue Hodgetts

Es gibt drei Grundsätze der Führerschaft: Sie muss situationsbezogen, nicht-hierarchisch und relational sein. Der gesunde Menschenverstand sagt einem schon, dass Führerschaft situationsbezogen ist: Die jeweilige Situation beeinflusst die Art der Führerschaft. Das Begreifen der Situation ist der Schlüssel; ebenfalls bedeutsam ist das Erfassen wichtiger situationsbezogener Signale; ein Verständnis dafür, was sich unter der Oberfläche abspielt; Fähigkeiten im Mikro- und Makromanagement; die Kunst, auf Augenhöhe mit den Arbeitnehmern zu sprechen ebenso zu beherrschen wie das Leiten anstrengender und fordernder Vorstandssitzungen. Eine produktive Führerschaft ist immer non-hierarchisch – hervorragende Organisationen haben auf allen Ebenen hervorragende Führungskräfte. Auch die relationale Führerschaft ist essentiell für den Erfolg als Führungskraft. Führungskräfte engagieren sich aktiv in komplexen Beziehungen, die gefördert werden wollen. Grundfeste all dieser Faktoren ist die Authentizität; Übereinstimmung von Worten und Taten, ein konstantes Rollenverständnis und ein besonderer Blick auf Fokus und Fairness.

Aufgeräumtes Management-Denken: Prinzipien des Managements ebnen Weg zu Ergebnissen
Von Fredmund Malik, Johannes Flecker

Unter aufgeräumtem Mangement-Denken versteht man das Aussieben aller überflüssigen Elemente. Manager müssen in der Lage sein, dies an jedem Ort, in jeder Situation, in jeder Organisation und zu jeder Zeit durchführen zu können. Effiziente Manger folgen sechs Grundsätzen, welche nicht nur die Qualität ihrer täglichen Arbeit bestimmen, sondern auch die Effizienz der von ihnen ausgeführten Aufgaben und die von ihnen dazu ausgewählten Werkzeuge maßgeblich beeinflussen. Die Grundsätze gewährleisten, dass eine Organisation auf einem gemeinsamen Verständnis von Management beruht. Die sechs Grundsätze des Managements:

- Ergebnisorientiert;
- Beteiligung am Ganzen;
- Fokus auf wenige Dinge;
- Einsatz bereits vorhandener Stärken;
- Vertrauen und
- Positives Denken.

Die Grundsätze des Managements unterstützen die Entwicklung eines aufgeräumten Management-Denkens. Sie bieten einen ausgezeichneten Rahmen dafür, effizienter und effektiver daran zu arbeiten, um für Klienten und Patienten Wertschöpfung zu betreiben.

Ärztliche Leiter und Performance eines Krankenhauses: Gibt es einen Zusammenhang?
Von Amanda Goodall

Die Frage, ob Krankenhäuser besser von Ärzten oder von nicht-medizinischen Managern geführt werden, wird bereits seit Jahren hitzig diskutiert. Amanda Goodall versucht, sich diesem Problem zu nähern. Sie identifizierte die am besten gereihten Krankenhäuser in den USA auf drei Spezialgebieten, und fragte nach: Wer sind die Geschäftsführer? Ergebnisse zeigen, dass die von Ärzten geleiteten Krankenhäuser bezüglich der Krankenhausqualität-Scores um etwa 25 Prozent höher liegen, als ein durchschnittliches Krankenhaus. Auch zeigte sich, dass die Top-Häuser andere Entscheidungen getroffen haben, als die weniger gut bewerteten Krankenhäuser. Im Durchschnitt haben sich diese Top-Häuser dazu entschlossen, Ärzte als Geschäftsführer einzustellen. Diese Ergebnisse stimmen überein mit früheren Untersuchungen über „sachverständige Führungskräfte" in anderen (nicht-medizinischen) Umfeldern. Beispielsweise konnten wir zeigen, dass Forschungsuniversitäten bessere Leistungen erbringen, wenn sie von herausragenden Wissenschaftern geleitet werden, und dass NBA Basketball Teams häufiger gewinnen, wenn deren Trainer vormals exzellente Spieler waren. Experten könnten den Vorteil aufweisen, dass sie ein grundlegendes, intuitives Wissen über das Kerngeschäft ihrer Organisation haben. Dies könnte bei Entscheidungsprozessen und Aufstellung von Geschäftsstrategien hilfreich sein.

Sicherstellung der Qualität bei Auslagerung von Reinigung und Desinfektion
Von Gianfranco Finzi, Daniela Gabellini

Unter Berücksichtigung der allmählichen Auslagerung technisch-administrativer Leistungen, um die „Kern"-Dienstleistungen der Gesundheitseinrichtungen zu unterstützen, wurde ein Standard für gute, umweltverträgliche Reinigungs- und Desinfektionspraktiken der Gesundheitseinrichtungen entwickelt, einschließlich eines entsprechenden und computergestützten Kontrollsystems. Das Ziel ist die objektive Bewertung der Hygiene- und Qualitätsstandards der ausgelagerten Reinigungs- und Desinfektionsleistung, zur Förderung der Integration dieser Dienstleistung in das routinemäßige Management der Krankenhausaktivitäten.

Mehr als Zeit und Geld: Effizienz im Operationssaal
Von Michael Greiling

Operationssäle zählen zu den kostenintensivsten Bereichen eines Krankenhauses, nach Schätzungen machen sie etwa 40 Prozent der gesamten Krankenhauskosten aus. In Zeiten geschrumpfter Regierungsbudgets und Kosten-

rückerstattungen ist es für Krankenhausmanager sinnvoll, auf diesem Gebiet Kosten einzusparen. Die Maximierung der OP-Kapazitäten ist ein Schlüsselfaktor für die Kostenminimierung: Es ist sicherzustellen, dass jeder Patient nur die nötige Zeitdauer im OP verbringt und dass die Zeit zwischen den Prozeduren so kurz wie möglich gehalten wird, um im Verlauf eines Arbeitstages die volle Auslastung zu ermöglichen. Der Einsatz hochqualitativer Güter und Dienstleistungen spart Zeit und erlaubt es dem medizinischen Fachpersonal, sich auf ihre Kompetenzbereiche zu konzentrieren und dabei klinische Standards einzuhalten. Zudem könnte man mit diesem Ansatz auch bei eingeschränkten Budgets die folgenden Ziele erreichen:
- Erhöhung der Anzahl chirurgischer Verfahren
- Verkürzung der Krankenhausaufenthalte
- Verminderte Umweltbeeinträchtigung
- Rationalisierung organisatorischer Strukturen.

Betriebswirtschaftliche Analyse klinischer Laboratorien

Von Vikica Buljanovic, Hrvoje Patajac, Mladen Petrovecki

Betriebswirtschaftliche Analysen von Laboratorien bieten uns einen Einblick in eine erfolgreiche Geschäftsleistung. Die gesteigerte Produktivität klinischer Laboratorien hängt mit der technischen Entwicklung von Labordiagnosen zusammen; diese kann zunächst als Ausgabe eingestuft werden, da zunächst eine gewisse finanzielle Investition erforderlich ist. Die Einführung eines IT-Systems in ein Labor führt zu besserer Kontrolle der Arbeitsabläufe, Verbesserung der Arbeitsorganisation und Zeitgewinn und beeinflusst so letztendlich die Produktivität. Die wirtschaftliche Analyse der Laboratorien, ebenso wie die finanzielle Kosteneffizienz der Investition, kann als Entwicklung eines wirtschaftlichen Modells verstanden werden, d.h. das Modell eines Laboratoriums als wirtschaftliche Entität. Die Erstellung des Modells eines Labors als wirtschaftliche Entität bedeutet die Identifizierung von Einnahmen und Ausgaben und deren Vergleich in einem bestimmten Zeitfenster, üblicherweise ein Jahr. Solche wirtschaftlichen Analysen können zu einem positiven finanziellen Durchbruch führen. Der Bedarf für eine grundsätzliche wirtschaftliche Ausbildung und deren Implementierung durch Leiter einzelner Abteilungen im Gesundheitssystem ist klar erkennbar.

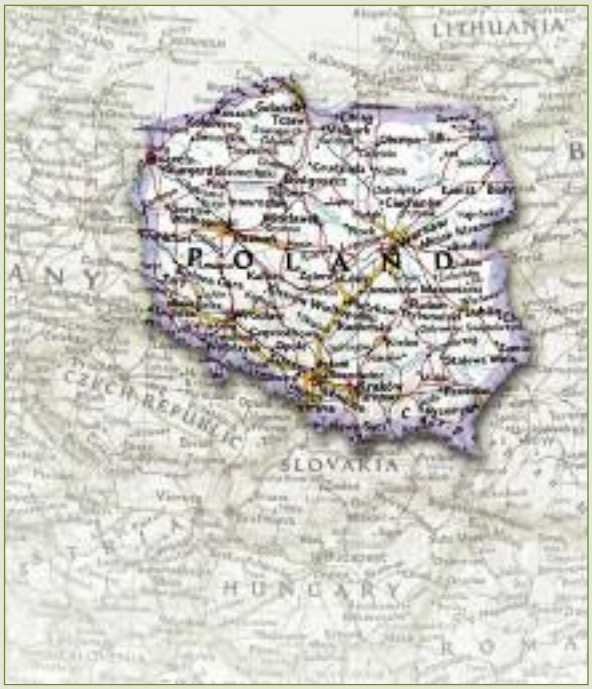
Das neue „Central Sterile Supply Department" (CSSD) der „University Hospital Authority St. Orsola-Malpighi Polyklinik"

Von G. Finzi et al.

Eingeweiht im September 2010 umfasst das CSSD diagnostische und therapeutische Funktionen von hohem technologischem Aufwand, wie etwa Notfallaufnahme, diagnostische Bildgebung, Operationssäle und Intensivstation. Ein Dienstleistungsvertrag übersieht Design, Konstruktion, Management, Durchführung und Wartung des einzigartigen CSSD.

Die Aufstellung des CSSD, das der gesamten Polyklinik zur Verfügung steht, hat für das Krankenhaus große Vorteile. Es erleichtert die Übernahme einheitlicher Methoden für den Umgang mit chirurgischen Instrumenten in allen Operationsräumen. Die innerhalb eines CSSD ausgeführten komplexen Verfahren, d.h. Säubern, Desinfektion (manuell, Ultraschall, automatische Waschanlagen), Verpackung (Kontrolle und Wartung der Instrument, Zusammenstellung der Instrumente-Sets), das Einladen der Sets in den Autoklav, Sterilisation und Aufbewahrung erfordern eine sorgfältige funktionelle Gestaltung des Raums für jedes Stadium des Vorgangs, von der Ankunft der chirurgischen Instrumente im CSSD bis zu deren Rücksendung an die Abteilungen.

Polen



1994 in die EAHM aufgenommen, ist der Polnische Verband der Krankenhausmanager eine Nichtregierungsorganisation, die Leiter von Krankenhäusern und anderer Gesundheitseinrichtungen umfasst. Der Austausch von Erfahrungen und Information ist eine der Hauptaufgaben des Verbandes, mit dem Ziel, die Gesundheitsleistungen in Polen moderner und effizienter zu gestalten. Der Verband erreicht seine Ziele durch die Organisation nationaler und internationaler Konferenzen, der Konsultation und dem Aufstellen von Schriftsätzen und der Zusammenarbeit mit entsprechenden Verbänden in anderen Ländern und mit internationalen Organisationen.

> AGENDA 2012

January

IT @ Networking Awards 2012 18-19
Brussels, Belgium
www.itandnetworking.org

February

HEALTHINF 2012 1-4
Algarve, Portugal
www.healthinf.biostec.org/
25th Annual Rural Health Care Leadership Conference 5-8
Phoenix, USA
www.healthforum.com
Electronic Document Management in Healthcare 9
London, UK
www.healthcareconferencesuk.co.uk

March

ECR 1-5
Vienna, Austria
www.myesr.org
European Association of Hospital Pharmacists Congress 21-23
Milan, Italy
www.eahp.eu
ECCMID 31/3- 3/4
London, UK
http://www.congrex.ch/eccmid2012.html

April

Hospital Build Europe 2012 24-26
Berlin, Germany
http://www.hospitalbuildeurope.com/

> EAHM EVENTS COMING SOON

January 18-19, 2012 / *Brussels, Belgium*
IT@Networking Awards 2012,

For more information, please visit:
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September 27-28, 2012 / *Athens, Greece*
24th EAHM-congress,
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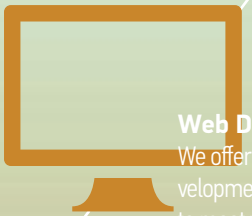

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- **The MyHCL Project (Lyons public hospitals, France)** by Cecile Dolla; Hospices Civils de Lyon and Microsoft, France
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- **Clinician Developed EMR for Rheumatology** by Shashi Gogia; Amla Mediquip and Indian Spinal Injuries Centre, India
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