

Hospital



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SAFETY

Plus

- > Interview: WHO Europe
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TIME TO CHANGE OUR PERSPECTIVE ON SAFETY



Nikolaus Koller

A journal with the mission of reporting on the most important themes and topics of the health-care system and its managing structures must also focus on both patient and staff safety. We must not forget to discuss and reflect upon these topics, especially in times of economic crisis and financial insecurity. Therefore we would like to introduce our readers to new innovative measurements and methods to take care of their clients and colleagues and also reduce errors and high costs.

The simple fact is that mistakes can happen in any situation and areas of human interaction. Another fact is that in most cases, smaller mistakes are often ignored or overlooked, or no greater significance is given to them before a disaster has happened. One of the most well-known reports in the health-care sector is the American Institute of Medicine To the Err is Human report in 1999: Building a Safer Health System. No report since has garnered more attention. A Harvard Medical Practice Study found that each year, 44,000 to 98,000 Americans die because of medical mistakes. The number of deaths was so high that they were able to compare it with a daily jumbo jet crash. Until this report, almost nothing had been done in the area of patient safety. After time, some measurements, strategies and later risk management was established. Also the WHO has defined its own risk factors, the High Five Recommendations. Based on my experiences in healthcare I would recommend each hospital to implement a risk management strategy. You should work with the international standards of the WHO in connection with national standards and individual measurements for each hospital.

In addition to patient safety, the safety of hospital staff must also be a priority. Workplace safety is better guaranteed with adopted, legitimated and defined rules and handlings. Nevertheless, accidents happen; needle stick injuries can result in infections

(HIV, hepatitis B/C) and a trip, fall or slip can result in a fracture. Defined rules and allowances are given to the employee but most of these accidents happen because of human carelessness or negligence.

Every hospital manager knows about the existing rules and protocols for patient and staff safety but maybe it is time to change our perception on it. For greater safety perhaps we should focus on unique interdisciplinary collaboration between doctors, nurses, pharmacologists and the administration. Also the traditional, rigid hierarchies must be abandoned, without forgetting the importance of good management. Nevertheless, an established and well-managed risk management should be in place in excellently managed hospitals. These are some important steps towards good managed safety for patients and staff.

For the future it is advisable to think about how we are able to cope with the changing patient population. As everybody knows the demographic development shows a huge rise in old people. So the health sector will be much more concerned or engaged with older and sicker people than today. In conjunction to the age-related diseases the diversity of cancer and autoimmune diseases are increasing. For these challenges we have to be prepared.

This issue of (E)Hospital also includes a Slovakian country focus. Slovakia has a contributory insurance system, all residents are compulsorily insured by one of the five public health insurances. Those are controlled by a governing body. Another interesting singularity is that patients are bound to their primary care physicians for six months (general practitioners, pediatricians, gynecologists and dentists).

Nikolaus Koller
President Editorial Board



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.



Safety

This issue's cover story focuses on the ever important issue of safety. Hospitals must ensure the safety of both their patients and their staff. EAHM Secretary General Willy Heuschen kicks off our dossier on safety by asking: "What is the Price of Quality in Healthcare?" The article goes on to discuss the European Council Directive on the prevention from sharps injuries in the hospital and healthcare sector. Johnny Lundgren introduces us to EAHM partner BD and their work on safety in hospitals and our Italian colleagues draw our attention to safety in the high risk arena of the operating room.

Oncology Special

This issue we have a special oncology supplement with two articles focusing on breast cancer. Vrijens and Stordeur assess the effect of hospital volume on processes of care and survival rates for breast cancer while Dietel and Klauschen introduce us to digital pathology software and how it can be used to improve breast cancer diagnosis and care. The other hot topic is interventional oncology and its growing role within multidisciplinary cancer care.

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Focus: SLOVAKIA



The Slovak healthcare system has been in a process of transformation since 1990. After elections in 2004 the system went through a turbulent process of change when a move towards the marketisation of healthcare was met with great opposition.

The Slovak Hospital Association (ANS) was established in 1991 with the objective of defending the common interests of hospital managers, providing mutual support and exchanging information and best practices.

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HOSPITAL MANAGEMENT IN TIMES OF CRISIS: CONSTRAINTS, CHALLENGES AND OPPORTUNITIES

EAHM is proud to announce that its 24th congress will take place on 28-30 November 2013 in Luxembourg.

Once again more than 600 hospital managers will gather from across Europe to share their experiences and best practices. This year the congress will focus on how to deal with economic constraints and transform them into opportunities. We will examine how

hospitals can continue to improve quality of care while faced with economic uncertainty and decreased budgets.

The congress will focus on practical experiences with presentations, roundtable discussions and poster sessions. The key topics are as follows:

- Strategic guidelines in crisis;
- Business process re-engineering; and

- New buildings, new logistics, new technologies.

A lively social programme has also been arranged including a reception hosted by the City of Luxembourg and a gala dinner on the final evening.

For more information on the congress, please visit:

www.eahm-luxembourg2013.lu

42nd ORDINARY GENERAL ASSEMBLY

The meeting will be held on Friday, November 16th, 2012 from 17.00 – 18.30, at the Messe Düsseldorf entrance East (Ost), Room M

Agenda:

For decision

1. Approval of the agenda
2. Approval of the minutes of the 41th Ordinary General Assembly, held on Friday, November 18th 2011 in Düsseldorf.

3. EAHM activity report 2011-2012 by the president

4. Tendering of accounts for 2011

1. Presentation by the Secretary General
2. Auditors' report

3. Approval of accounts for 2011 and discharge of the Board and the Secretary General

5. Economic plan for 2013

1. Approval of the proposed membership subscription fees of full members and

- associate members (4.3.e of statutes)

2. Approval of the economic plan for 2013

6. Election of auditors for the year 2012

7. Admission and exclusion of ordinary and associate members

8. Next Ordinary General Assembly: Luxembourg, November 28th 2013

For information

9. 24th EAHM Congress (2013), Luxembourg: Presentation of main theme
10. EAHM partnerships: Arcadis

SPECIALIST SUPPLEMENTS IN (E)HOSPITAL

This year we have been publishing specialist supplements with each issue of *(E)Hospital*. We hope these have been of interest to you and would like to take this opportunity to clarify their purpose.

(E)Hospital knows that hospital managers need to keep up to date with the latest innovations and news across all medical specialities to better understand the needs and challenges of each hospital department. We recognise that the healthcare sector is constantly changing, research studies are published on a daily basis and new technologies constantly released into the market. It is for this reason that we have been publishing

specialist supplements with each issue. Two copies are included: An insert for your own use and a pull out to pass on to a relevant colleague.

We hope that the information contained in the supplements will help you keep abreast of the latest developments in each hospital department and help you make the right decisions for

your hospital and its patients.

We welcome any feedback on the content and suggestions for future topics in 2013. Please contact Managing Editor Lee Campbell, lee@myhospital.eu.



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11:00 am Green hospital
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3:00 pm Renting and financing solutions

Thursday, 15.11.2012

11:00 am Modular laboratories
1:00 pm 20 years of experience with modular
construction from a user's viewpoint -
Dieter Bopp, Managing Director
Klinik Löwenstein / Hohenloher
Krankenhaus gGmbH
3:00 pm Renting and financing solutions

Friday, 16.11.2012

11:00 am Green hospital
1:00 pm 20 years of experience with modular
construction from a user's viewpoint -
Dieter Bopp, Managing Director
Klinik Löwenstein / Hohenloher
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3:00 pm Modular laboratories

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HMI HOSTS SECOND NATIONAL CONFERENCE IN DUBLIN



Health Management Institute of Ireland

To an audience of almost 300 delegates, conference speakers addressed issues of policy, assessed the experience of health service managers and challenged long held beliefs and mindsets about how health services in Ireland are delivered.

HMI President, Mr. Richard Dooley opened the event urging that health managers must “move away from the control paradigm that has evolved and that is in danger of making tech-

nocrats of people who joined the health services primarily to foster positive health strategies and deliver positive health outcomes to the communities that we serve”.

Dooley stressed the challenging and changing situation of the Irish healthcare system, “We are in our fourth year of successive and extensive budget cuts which had seen almost two billion euro removed from our funding base with a loss of almost 5,000 staff over the same period.” He explained the continued need for structure and strong management of the healthcare delivery system, with clearly defined relationships to ensure an efficient, inclusive and responsive system. Emphasis was placed on the relationship between the state and healthcare managers and the need for the for-

malisation and professionalisation of health service management. Health minister Dr. James Reilly, T.D was also present at the conference and addressed the crowd. His focus was on the training and support of health managers, “We have never sufficiently valued strong leadership in the health services. These skills must be nurtured, encouraged and, if necessary, taught to our managers. I know that good work is already under way in training and developing managers which is a very positive development.”



Louise McMahon, Director of Performance and Service Improvement at Health and Social Care Board, Northern Ireland

The Minister emphasised the key role of the health manager, believing that good organisation and good management saved lives in the health services and stressed that it should be health managers who should drive the culture of change in the health system in both the short and medium term.

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Health Minister, Dr. James Reilly, T.D

In recognition of the precarious situation of healthcare in Ireland, Dr. Reilly said that the health service has no choice but to do better with less and spoke of increased patient involvement in care. He concluded by saying, "We stand at the cusp of an enormous and unprecedented task and you as Managers are at the sharp end of it."

Other highlights in the packed programme included a significant address from Dr. Ambrose McLoughlin, Secretary General of the Department of Health. McLoughlin assured the HMI and health man-

agers of the full support of the Department for the professional development of managers.

"The competence of managers is as important as the competence of clinicians. The development and maintenance of managers' competence and the development of your capabilities is something about which, as Secretary General, I feel very strongly."

For more information on the conference and the HMI in general, please visit: www.hmi.ie

EHL BECOMES FHL, MARKING A CHANGE IN GOVERNANCE AND FOCUS



The Entente des Hopitaux Luxembourgeois has rebranded as the Federation des Hopitaux Luxembourgeois to mark its new governance and focus on mutualisation.

During their general assembly on the 22nd May 2012, the EHL confirmed a change in governance. For the past two years the EHL debated the issue and decided that the association must consider in a better way all the actors in the hospital, defending the interests of the hospital and also the hospital managers.

Including all actors in the hospital is not without its complications. Medical doctors, for example, are independent workers and so not part of the decision-making structure of the hospital. They are, however, key actors in the sector and need to be included in meetings and work with managers. There are many actors with specific interests and lobbies. For this reason the new structure was developed with three platforms:

1. Medical directors
2. Nurse directors
3. Administration and financial directors

The executive committee remains but there is a new board to work between the committee and the three platforms. The idea is to be more active: pro-active and reactive and to improve working stan-

dards by considering the activities and interests of the different actors in the hospital.

The current economic climate has shown that hospitals and associations must be more efficient and must work together. Projects of politicians, of stakeholders health insurance companies must be taken into consideration and everyone must work together by mutualisation. This will include discussion on the level of logistic activity but also for core business- medical services. One current project is the creation of a new association structures for IT in hospitals with structures for laboratory and purchasing to follow.

For more information, please visit: www.fhlux.lu (N.B. The new Website is under construction and will be accessible in December 2012)

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COMMISSIONER DALLI RESIGNS

On 16 October 2012, Commissioner John Dalli announced his resignation as a member of the Commission with immediate effect.

Mr. Dalli informed the President of the European Commission Jose Manuel Barroso of his decision following an investigation by OLAF, the EU's antifraud office, into a complaint made in May 2012 by the tobacco producer, Swedish Match. The company alleged that a Maltese entrepreneur had used his contacts with Mr. Dalli to try to gain financial advantages from the company in return for seeking to influence a possible future legislative proposal on tobacco products, in particular on the EU export ban on snus. As soon as the Commission received the complaint it immediately requested OLAF to investigate.



The OLAF final report was sent to the Commission on 15 October. It found that the Maltese entrepreneur had approached the company using his contacts with Mr. Dalli and sought to gain financial advantages in exchange for influence over a possible future legislative proposal on snus. No transaction was concluded between the company and the entrepreneur and no payment was made. The OLAF report did not find any conclusive evidence of the direct participation of Mr. Dalli but did consider that he was aware of these events.

The OLAF report showed clearly that the European Commission's decision-making process and the position of the services concerned has not been affected at all by the matters under investigation. The final OLAF report and its recommendations are being sent by OLAF to the Attorney General of Malta. It will now be for the Maltese judiciary to decide how to follow up.

After the President informed Mr. Dalli about the report received from OLAF, Mr. Dalli decided to resign in order to be able to defend his reputation and that of the Commission. Mr. Dalli categorically rejects these findings.

Mr. Barroso has decided that Vice President Maros Sefcovic will take over the portfolio of Mr. Dalli on an interim basis until a new Commissioner of Maltese nationality is appointed in accordance with article 246 (2) of the Treaty on the functioning of the European Union.



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WHAT IS THE PRICE OF QUALITY IN HEALTHCARE?

By Willy Heuschen

As Europe sees its countries struggling to keep their commitments towards greater (cost) efficiency and general improvement of living and working conditions in all areas, it is with even more concern that we see some deadlines coming closer and closer. European, national, as well as regional plans and campaigns put in place before the economic crisis are, nevertheless, maintained. We can consider them as a welcome sign of relentless striving for improvement, albeit with a slight worry for our already stretched

hospital Managers (EAHM), as it lies within one of its core missions to promote the competence and responsibility, along with the strengthened cooperation of hospital managers across Europe. In our close connection with European healthcare policies, we are calling for a positive standardisation of levels of care in all member States, which would be defined by the creation of a 'European Accreditation Model', for instance. This relates to our other core mission, which is to encourage greater cooperation and

fierce competition and general economic insecurity, healthcare organisations are now compelled to implement new safety measures and reporting systems, train their personnel, and invest in new safety-engineered devices and equipment, in order to be in line with the European legislation.

Training takes time, different safety policies, measures and practices are not adopted overnight, and equipment and renovations need to be funded. The dichotomy between good will and monetary concerns seems inevitable. As is often the case, money wins the battle and prevents healthcare managers from making a radical but much needed change to achieve optimal safety and quality of care. Instead, a number choose (or is it really a choice?) to limit the improvements to the acceptable minimum in order to preserve their scarce resources. Although no healthcare manager would deny the importance of sharps injuries or other risks faced by their staff, they are not often in a position to follow the sole ethical or humane motivation for a change of this scale.

However, the pressure is rising, and the cost of retribution might become the main impetus behind full compliance to the legislation. As some Hospital Managers have experienced, one single sharps injury leading to infection can be sufficient to cause emotional distress, costly treatment and potentially even more costly lawsuits and damage to their hospital's reputation. In recent years, insurance companies have started adding clauses to their contracts, granting themselves the right to refuse cover to a healthcare employer if an accident, affecting a healthcare worker or a patient, could be proven to have been avoidable through effective safety measures, compliant premises, or safety-engineered equipment. This is no doubt one of the increasing signs that safety will not be treated by any decision maker in the healthcare sector just as a noble goal, but as a crucial priority to put into practice by any means, as harsh as they may seem.

It is also important to note that investment in injury prevention can reap financial ben-

“Training takes time; different safety policies, measures and practices are not adopted overnight, and equipment and renovations need to be funded”

budgets and latent insecurity about our society's ability to recover financially.

One of the deadlines approaching fast for all healthcare organisations in Europe is the coming into effect of the European Council Directive 2010/32/EU¹ on the prevention from sharps injuries in the hospital and healthcare sector. Scheduled for 11 May 2013, the newly formulated law will require employers to take an active step towards safety and quality in their organisations and provide their employees with the best possible working conditions in order to avoid any risk posed to them and, consequently, to their patients. This will contribute to reduce the staggering number of one million sharps injuries estimated to occur in Europe each year², and enhance the global quality of care provided in our hospitals.

Quality management has long been a priority for the European Association of Hos-

practice sharing between different countries' healthcare systems to bring about a Social Europe.

As a consequence, our position is one of stirring and inspiring our Hospital Manager members to do better, while striving to represent their profession and defend their interests to the best of our capacities in the numerous institutions of the European Union.

This dual role, however, gives us an insight in the healthcare decision makers' often conflicted relationship with the human responsibility they would like to honour, and the base reality of their lack of means to achieve their goals. While we can only rejoice at the official recognition of sharps injuries as a major concern all over Europe, we cannot ignore the financial pressure most of our members are already under. In our present situation of tightening budgets,

efits through the avoidance of consequential costs that can be incurred whenever an injury takes place. In the case of medical sharps injuries, these costs can be significant, particularly where it cannot be ruled out that the medical device involved in the injury had been used on a patient with a high risk of carrying a dangerous blood-borne infection.

The European Union is making funds available through regional grants and aids, but there are other methods which hospitals, both in the private and the public sector, could utilise to be more cost-efficient, implementing safer working practices. Where training on new measures and reporting systems can be carried out by some suppliers,

building renovation contracts and investments in devices and equipment could be organised into grouped purchases. By combining orders, different hospital buyers could have better leverage on prices and on the inclusion of value-added services to aid the implementation of changes and to ensure sustainable benefits.

This example of a cost-efficiency method also brings us back to a greater aim: by sharing the investment in increased safety and better quality in products, healthcare organisations could effectively, collectively, harmonise and raise the level of quality of care they offer their patients. In exploring possibilities for international cooperation

and grouped purchases could help hospital managers become competitive actors on innovation, technology and cost-efficiency, and able to build a Social Europe.

Author:

Willy Heuschen

Secretary General

EAHM (European Association of Hospital Managers)

References:

¹ EU Council Directive 2010/32/EU

² EU Commission for Employment, Social Affairs and Inclusion, New legislation to reduce injuries for 3.5 million healthcare workers in Europe, 8th March 2010

INTERVIEW: JOHNNY LUNDGREN, REGIONAL VICE-PRESIDENT NORTH WEST AND SOUTHERN EUROPE, BD

Firstly, tell us a bit about BD. What does the company do? What are its objectives?

BD is a leading global medical technology company that develops, manufactures and sells medical devices, instrument systems and reagents. The company is dedicated to improving people's health throughout the

and healthcare issues.

BD is committed to: Enabling safer, simpler and more effective parental drug delivery; improving clinical outcomes through new accurate and faster diagnostics; providing tools and techniques to the research community that facilitate basic science, drug discovery and cell

healthcare institutions, life science researchers, clinical laboratories, the pharmaceutical industry and the general public.

You have recently signed a partnership agreement with EAHM. How did this partnership come about and what do you hope to achieve?

The partnership came about by being introduced to the Secretary General of the EAHM, Mr Willy Heuschen. We initiated discussions around how to develop the partnership in order to improve quality and reduce costs in the European market. Our aim is to achieve a foundation of partnership where patient outcome, high quality and cost efficiency are the corner stones.

As a company that works in close collaboration with hospitals across European countries, what do you think are the main issues facing European hospitals today? How can we overcome these challenges?

The main issues facing European hospitals today is pressure on budgets, which, in turn, affects quality of care. Hospitals are required to provide for the increasing demand for care and an ageing population with less resources. Therefore healthcare managers are having to make tough decisions and are keenly looking for ways of making budgets work harder.

“Our aim is to achieve a foundation of partnership where patient outcome, high quality and cost efficiency are the corner stones.”

world. BD is focused on improving drug delivery, enhancing the quality and speed of diagnosing infectious diseases and cancers, and advancing research, discovery and production of new drugs and vaccines. BD's capabilities are instrumental in combating many of the world's most pressing diseases

therapy; and enhancing disease management in diabetes, women's health and cancer, and infection control.

Founded in 1897 and headquartered in Franklin Lakes, New Jersey, BD employs approximately 29,000 associates in more than 50 countries throughout the world. The company serves

The added challenge of new legislation, such as the EU Directive on sharps injury prevention to healthcare workers, means hospitals will also be required to put into place new and robust procedures and invest in medical technology.

In most European countries, a major obstacle to the adoption of medical technology is silo budgets. Countries may be looking to cut their healthcare procurement costs at the moment, but their budgets are still in silos, which

The new EU Directive (2010/32/EU) on sharps injury prevention will legally oblige healthcare organisations to take measures to prevent sharps injuries to their staff, and has to be transposed into national legislation by all EU members by 11 May, 2013.

The legislation specifically refers to the focal role played by safety-engineered medical devices in reducing such injuries, making the use of safety-engineered needles,

both designed to help healthcare organisations improve healthcare worker safety, better understand this important legislation and plan compliance.

The safety website provides an overview of BD's newly launched healthcare worker safety programme, which takes a holistic approach to safety, providing tools and best practice advice on crucial elements such as health economics, risk assessment, conversion management and training. To help healthcare workers learn how to avoid sharps injuries, we, in conjunction with the RCN, also brought together a group of leading nursing professionals in and a series of educational workshops around the UK.

BD's extensive set of tools are designed to support institutions as they work to achieve a straightforward, seamless and cost-effective transition to safer working practices and comply with the new EU Directive.

Lastly, this is your chance to address hospital managers from across Europe. What advice do you have for them?

While the adoption of safety-engineered medical devices does have an additional investment implication, in the long term it provides a viable return on the investment. Sharps injury costs can be substantial when treatment, lost working time and staff turnover are taken into account. Not only can the use of safety-engineered devices help reduce these related costs, but they also help avoid damaging legal action, costly compensation claims, and adverse publicity, all of which divert attention away from core objectives of delivering high quality healthcare.

In Spain for example, five of the autonomous regions have now made the use of safety engineered devices a legal requirement. A study completed as early as 2002 by the General Council of Hospitals, identified some 30 million euro/year in savings from the conversion to safety-engineered devices.

Converting an entire hospital to safety-engineered devices can be daunting and challenging for healthcare managers, but we have been helping many healthcare organisations plan and implement their conversion strategies, drawing on the experience of early European adopters, the conversions in the US since the 2000 passage of safety legislation, and European regions that already have mandatory requirements in place.

“The issue of introducing technology into a health system is very much to do with pricing and the value of the technology.”

affects their ability to adopt and integrate technology effectively.

Overcoming these challenges and adopting best practices around new technologies will take some time. The issue of introducing technology into a health system is very much to do with pricing and the value of the technology.

Obviously, safety is a key concern for hospital managers. Tell us more about your Healthcare Worker Safety Programme. What is it and how does it help?

BD's Healthcare Worker Safety programme is the reflection of more than 25 years of experience developing and implementing safety programmes with different healthcare institutions across the world. The BD Safety Programme provides the necessary tools and advice to ensure that healthcare workers are well aware of the risks of handling sharps, legislation and local safety policies, good practices and safe systems of work regarding prevention of sharps injuries, the importance of recording injuries, and all available support programmes.

I see that you are helping hospitals to comply with the new EU Directive on the Prevention of Sharps Injuries in the Hospital and Healthcare Sector. What is the purpose of this Directive and what is BD doing to help with its implementation?

phlebotomy devices and intravenous catheters that incorporate shielding or retraction of the needle, a very important element of ensuring compliance.

Simply by carrying out risk assessment procedures, introducing safety-engineered medical devices, and improving training and working procedures, a significant reduction in the number of sharps injuries can be achieved. This, in turn creates an environment for staff and clinicians that provides proper protection against injuries and their potential for transmitting 30 potentially dangerous blood-borne pathogens, such as hepatitis or HIV.

Despite pressure on health budgets across Europe, many leading healthcare organisations have already begun the process of formulating a strategy for compliance to the new legislation, and have started to contact suppliers to research transition strategies and support. Their reasoning usually combines economic, risk and ethical factors.

BD has distilled its experience – gained from working with a wide variety of forward-thinking healthcare organisations both across Europe and throughout the world – and has introduced a number of tools and initiatives to help healthcare organisations plan and implement their conversion strategies. We have published a set of management guides and recently launched a new Europe-wide safety website (www.bd.com/europe/safety/en),

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ENSURING OPERATING ROOM SAFETY: THE ITALIAN APPROACH

By Dr. Salvatore Paolo Cantaro, Dr. Salvatore Scarlata

Policies for the management and control of risks associated with healthcare constitute one of the priorities of the modern health systems. Like most European countries, the Ministry of Health in Italy has recognised the importance of assessing quality and safety on all levels of the system, taking into account patient expectations and enhancing the role and responsibility of health professionals.

Through the establishment of a ministerial working group dedicated to patient safety, there have been many clinical governance initiatives, the most significant being the Information System for Monitoring of Sentinel Events (SIMES). SIMES allows the collection of information on the spread of sentinel events in healthcare facilities needed for the analysis of contributing factors and deter-

minants, and develops specific recommendations for the safety of patients. The major care priorities are identified and the systematic use of best practices for patient safety is promoted.

The many critical points of each surgical procedure have the potential to cause serious harm to the patient and that is why safety in the operating room is a challenge and a priority for health systems and the management.

minants, and develops specific recommendations for the safety of patients. The major care priorities are identified and the systematic use of best practices for patient safety is promoted.

Operating Room Safety

Particular attention has been placed on safety in the operating room in the light of guidance and awareness initiatives launched by the WHO in the World Alliance for Patient Safety and the Safe Surgery Saves Lives programme in particular. Surgical activity, the volume of surgical activity and the inherent

complexity of all procedures related to it, even the simplest, is one of the areas with the highest probability of error. The many critical points of each surgical procedure have the potential to cause serious harm to the patient and that is why safety in the operating room is a challenge and a priority for health systems and the management. Using risk assessment we can implement the

best solutions for organisational and logistical security so that they constitute an effective barrier system for errors.

In Italy, operating room safety is often the centre of attention due to the occurrence of particularly severe adverse events. In Sicily, for example, the emergence of a number of incidents in the operating room, in different contexts and over a relatively short period of time, led to the establishment of a regional commission of experts for a large scale verification of safety procedures. The survey was completed in a few months and resulted in the closure of several facilities operating without safety requirements. This

confirmed the role of the organisation and maintenance in causing adverse events and has led to increased risk control and dissemination of a safety culture. The next step is a special plan for modernisation and increase the safety of the medical devices.

The Italian Ministry of Health considered it essential to launch a major campaign to raise awareness among health professionals on the issue of safe surgery. This was done through the creation of a manual for safety in the operating theatre derived from the WHO Guidelines for Surgery and centred on 16 goals for the safety of the peri-operative process including 10 derived from the cited WHO document.

Within the scope of the manual for safety in the operating room, a ministerial working group has also developed an Italian adaptation of the WHO OR checklist including controls on the most important aspects of the surgical safety, such as the confirmation of the identity of the patient and type of surgery, the verification of systems for monitoring and maintenance of vital parameters and confirmation, within the team, of the knowledge of the procedure that they are going to perform. Compared to the 19 items of the original version, the Italian checklist presents an additional item to control the prophylaxis of venous thromboembolism, which is considered essential for the prevention of adverse events in the postoperative period.

The checklist should not only allow for the verification of the process and a reminder mnemonic for the proper performance of a particular task, but also facilitate communication within the team especially with regard to critical information about the patient and intervention, with better identification of roles within the team and a more optimal exchange of critical information regarding the clinical condition of the patient and the type of work that he is going to perform. The Ministry has

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also recommended that the health facilities in the National Health Service also take into account the recommendations of the WHO. The checklist will be adapted locally based on the characteristics of each healthcare organisation or particular procedures used. Altered versions could include the addition of further control or elimination of items of routine use and therefore unnecessary.

Promoting the Checklist

In order to raise awareness among health professionals and promote the use of the checklist, the Ministry of Health has developed some explanatory videos to explain the correct procedures for carrying out checks during the course of surgery.

A working group composed of influential figures in the Italian health system took the WHO video as a starting point along with other similar experiences in different countries and adapted the scenes and content to the Italian situation. Particular attention was paid to the choice of surgical procedures on which to apply the checklist, to ensure they are consistent with the local situation.

In order to create a tool that can positively influence the behaviour of the operating team it was also decided to include testimonials from prestigious figures in the national health system, including presidents and members of scientific societies and organisations for the protection of patients: Francesco Basile, Dean of the Faculty of Medicine, University of Catania; Louis Conte, Italian Hospital Surgeons Association (ACOI); Giorgio Della Rocca, the Italian Society of Anesthesia and Intensive Care (SIAARTI); Giuseppe Greek, chairman of the Standing Conference of regions Cittadinanzattiva Tribunal for Patients' Rights; Giuseppe Mancini, President of Operating Room Nurses (AICO); Barbara Mangiacavalli, Secretary of the Central Committee of the Federation of Colleges IPASVI; Walter Mazzucco, national president of the Italian Secretariat of Postgraduate Doctors; Gianluigi Melotti, President of the Italian Society of Surgery (SIC). Famous faces from the world of culture, Maestro Nicola Piovani and actress Mariella Lo Giudice created the soundtrack and narrated the video. In order to facilitate the sharing of the video within the international scientific community, scenes filmed in the Italian language were captioned in English.

The ministerial working group also considered strategies to highlight the key role of managers as facilitators of the use of the checklist. At the beginning and end of the video a short presentation was inserted to draw attention to the purpose and the importance of corporate policies of clinical risk management in preventing error. Stefano Cencetti, Director General of the Hospital Policlinico of Modena and Gianfranco Finzi, Medical Director of Presidio dell'Azienda University Hospital S. Orsola Hospital in Bologna and president of the National Association of Doctors Hospital Management (ANMDO) described the purpose of the initiative. These statements put in proper perspective the role that health managers play in the governance of healthcare organisations and emphasise the importance of the organisational aspects at all stages of surgery in which important decisions are made or activities that require high attention especially in terms of communication between the team mem-

to gather information on the adoption of the manual and checklist and local training initiatives. The first results of the national survey, although still incomplete, already show a high level of adherence by all health facilities across Italy thus confirming the important role that health policies play in the construction of an error proof system. It is significant that the ministerial handbook for safety in the operating room and related checklist has favoured the creation of a national network for safe surgery. Evidence of this success can be seen through the large number of reports on the theme presented during the last Risk Management Forum of Arezzo.

For a comprehensive approach to safety, which covers all aspects of structural, technological and organisational management, the contribution of the professionals involved is of paramount importance. Strategic synergy is needed to ensure seemingly minor aspects, which may be fundamental to the

The ministerial working group also considered strategies to highlight the key role of managers as facilitators of the use of the checklist

bers and the exact identification of the tasks assigned to the operators.

The video, made in 2009 was presented to health professionals as part of a dissemination campaign launched at the annual Risk Management Forum of Arezzo; one of the main Italian events in training and updating clinical risk. The key strategy was the involvement of scientific societies including ANMDO to stress the important role doctors as facilitators of the adoption of the checklist.

There is a risk that the use of a large-scale national checklist, although highlighting sensitivity to the issues of clinical risk, is likely to remain a bureaucratic formality with no added value for safety. Particular attention has therefore been paid to the verification of the use of the checklist on a regional level. This was implemented by the Ministry of Health through a questionnaire

prevention of the error, are not ignored. A logical system of safety and quality assurance is decisive for the prevention of error.

In this context, of particular importance is the role of the medical director and medical management. Acting as the pivot and facilitator of the process and as a reference for the establishment of a proactive vision for safety, management can ensure error analysis is used as a tool to learn how the same error can be avoided in the future.

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

Fully equipped hybrid operating room on display at Medica 2012



Hybrid operating room with Siemens Healthcare Artis zeego angiography system, Operating table, lights, DVEs 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, 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 2012.

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.

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, neuro-radiology and neurosurgery.

Hybrid operating room at Medica 2012. Hall 13, Stand A 10.

Cadolto will present its innovative development to the public at Medica 2012, to be held from 14 to 17 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, DVEs 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.

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SUSTAINABILITY FOR FINANCIAL AND ENVIRONMENTAL SUCCESS

Quality Healthcare Provision in Economic Uncertainty

Following on from last issue's interviews with representatives from Greece and Portugal, *(E)Hospital* spoke to Mr. Josep M. Piqué, CEO of Hospital Clínic at the University of Barcelona; and to Mr. Richard Dooley, President of the Health Management Institute of Ireland; to find out how Spanish and Irish hospitals are coping with the effects of the financial crisis.

Your country has been severely affected by the ongoing economic crisis. What have been the main effects on the Spanish healthcare system and hospitals in particular?

(Mr. Josep M. Piqué) During the frame period of 2011–2012 there has been a significant reduction in the budget of regional healthcare systems. In Catalonia the healthcare system budget was reduced by 10%, compared with the increases of 4–5% that had been taking place in recent years. Because of that, the budget of the hospitals has decreased in a range of 6–12%. This has implied reductions in all expenditure items including salaries and job positions in many institutions.

has halted all service development. The renewed focus on efficiency and service cuts can only go so far before you are rationing services.

Is your government making special provisions to protect the healthcare sector? If so, please tell us about them.

(Mr. Josep M. Piqué) Beyond cost cutting measures such as the reduction of salaries for civil servants, increments in drug co-payment have been introduced. In the coming months, some services will be excluded from the 100% public payment portfolio. Also, there is a plan to introduce structural reforms in our system but those measures have not yet been introduced or they

of national programmes in place. They are nationally driven, nationally led and bring new models of service delivery into the system. One welcome initiative in place over the last two years is the national clinical programme. It looks at how we deliver services across the main specialties and is certainly bringing about efficiencies and cost savings as the current high rate of expenditure per head of population is just not sustainable in this country.

On the hospital level, what are you doing to combat these financial constraints? How are you sustaining high quality healthcare?

(Mr. Josep M. Piqué) Because our contract with our public insurer was reduced to 8% of the total budget, we had to cut our costs in the same proportion. To achieve that goal we looked for measures to increase the efficiency of our processes and to cut expenses in those procedures that do not add a significant value to our healthcare product. This includes eliminating some redundant diagnostic tests, more cost-effective selection of drug prescription, policies to reduce electricity, gas, or communication technologies expenditure, etc. In addition to that, we closed some additional beds in summer, which resulted in a slight reduction in activity in non-critical procedures. Finally, some wage cuts were also applied.

“we looked for measures to increase the efficiency of our processes and to cut expenses in those procedures that do not add a significant value to our healthcare product.”

(Mr. Richard Dooley) Well the main effects would be that we are almost rationing service delivery and there is now an inability to plan. The whole planning environment has hugely changed, you can't plan forward with the same surety that you could before; it

are only partially or preliminary implemented. Some of these reforms include concentration of tertiary procedures in a few selected and well-experienced centres.

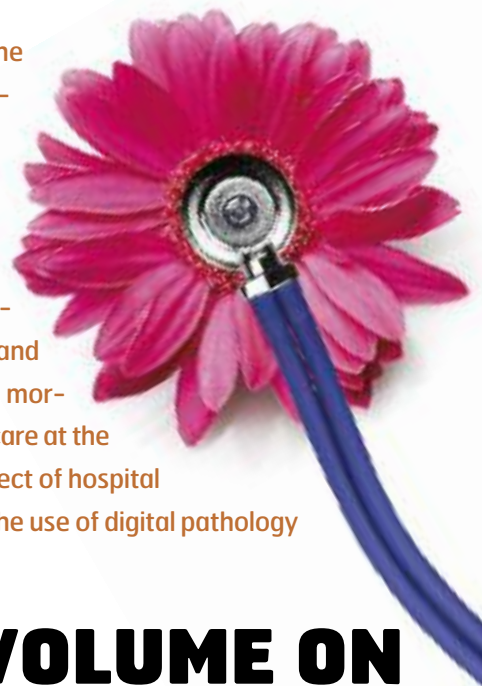
(Mr. Richard Dooley) There are a number

Regarding investments in new health technologies or products, a new policy was introduced. This was done in order to make a more accurate selection of which technologies should be incorporated based on rigorous cost-effectiveness or cost-opportunity analysis. Our Innovation Department was in charge of the analysis per-

» CONTINUES ON PAGE 31

(E)Hospital knows that hospital managers need to keep up to date with the latest innovations and news across all medical specialities to better understand the needs and challenges of each hospital department. For this reason we have been publishing specialist supplements with each issue. Two copies are included: An insert for your own use and a pull out to pass on to a relevant colleague.

This issue the focus is on oncology. According to the World Health Organisation there are more than three million new cases of cancer each year and 1.7 million deaths, making cancer the most important cause of death and morbidity in Europe after cardiovascular diseases. Facts like this put oncology care at the top of the healthcare agenda. Our supplement covers three areas: the effect of hospital volume on cancer care; the growing role of interventional oncology; and the use of digital pathology software for cancer diagnosis and care.



EFFECT OF HOSPITAL VOLUME ON PROCESSES OF CARE AND 5-YEAR SURVIVAL AFTER BREAST CANCER

By France Vrijens, Sabine Stordeur

The link between a higher survival rate after a diagnosis of breast cancer for high volume hospitals compared to low volume hospitals has been consistently demonstrated over the last ten years. Less frequent are studies on the differences in processes of care between high and low volume providers. In Belgium, a set of 11 process indicators to assess the quality of the treatment of breast cancer has been recently constructed, tested and validated. Building on this previous work, the present study aimed at comparing overall survival and 11 processes of care by hospital volume in Belgium.

The completeness of reporting pathological data (stage and grade) was much better in high volume hospitals (94%) than in very low volume hospitals (85%)

How Does It Work?

Three national databases were linked using a unique anonymous patient identifier:

1. The Belgian Cancer Registry database. It contains clinical information (date, staging) of all new primary invasive breast tumours. For this study, all women with a cancer incidence date between 1 January, 2004 and 31 December, 2006 were selected.
2. The Claims database hosted by a national consortium of all sickness funds. It contains detailed information on all reimbursed

pharmaceutical products, consultations, diagnostic and therapeutic procedures, both in hospital and ambulatory settings.

3. The Belgian population database.

It contains the vital status of all citizens living in Belgium.

Hospital volume was based on the annual number of patients treated by the centre and was computed as the average volume over 2004, 2005 and 2006. Hospitals were categorised as very-low-volume hospitals (<50 patients per year), low-volume hospitals (50-99 patients per year), medium-volume hospitals (100-149 patients per year) and high volume hospitals

(≥150 patients per year). The last cut-off corresponds to the minimal recommended size by the European Society for Breast Cancer Specialists (USOMA), by the European directive on breast cancer treatment and by the 2007 legislation in Belgium (after a transition period where volume of 100 was accepted or allowed).

Process and outcome indicators were retrieved by a systematic literature search, including international and Belgian clinical guidelines. The quality indicators were pilot tested using Belgian Cancer Registry data and claims data from 50,039 women with invasive breast cancer over a five-year period. A final set of 11

process indicators was measurable, showing results that largely correspond to other studies in the field.

Cox proportional hazard models were used to assess the influence of the annual patient volume on the five-year survival, adjusting for patient's age, cancer stage and grade. Logistic regression models were used to assess the influence of volume on the probability that a process indicator occurred, without any adjustment for differences of populations.

Results

A total of 25,178 women diagnosed between 1 January, 2004 and 31 December, 2006, and treated in 111 hospitals were included in the study. Half of the hospitals (N = 57) were labeled as "very-low-volume" and treated 20% of the cohort. Only 14 hospitals were labeled as "high-volume" and treated 38% of the patients.

The mean age of the cohort was 60.8 years. Patients treated in very-low-volume hospitals

were almost four years older on average than patients treated in high-volume hospitals. The completeness of reporting pathological data (stage and grade) was much better in high volume hospitals (94%) than in very low volume hospitals (85%). However, the distribution of reported stages and grades was largely similar across hospitals, whatever their annual volume.

The observed five-year survival was 80.2% for the entire cohort with variations according to the annual volume: 74.9%, 78.8%, 79.8% and 83.9% for patients treated in very-low-volume, low-volume, medium-volume and high-volume hospitals respectively. After case-mix adjustment for age, stage and differentiation grade, patients treated in very-low-volume hospitals had a hazard ratio (HR) for death of 1.26 (95% CI 1.12, 1.42) compared to patients treated in high-volume hospitals. Patients in low-volume hospitals also had an increased risk of death compared to patients in high-volume hospitals (HR 1.15; 95% CI 1.01, 1.30). Age, stage and differentiation grade were found to

be prognostic factors for five-year survival.

Among a set of 11 processes studied, six were more often performed in high-volume hospitals: More frequent multidisciplinary team meetings (MDT), more frequent use of appropriate diagnostic and staging techniques (cytological and/or histological assessment before surgery), more frequent use of breast-conserving surgery (BCS), and more frequent use of adjuvant therapies having an impact on overall survival (radiotherapy after BCS), and finally more adequate follow-up strategy (follow-up mammography within the first year post treatment). All details are presented in Table 1. The five remaining process indicators showed no differences between low volume and high volume centres.

Limitations

There are four limitations to our study. Firstly, it is based on rather old data (2004-2006), and some changes in the organisation of care in Belgium were

Table 1. Process indicators in breast cancer by hospital annual volume

Domain	Process QCI	Annual volume of hospitals (2004-2006)								All patients	
		Very low <50		Low 50-99		Medium 100-149		High ≥150		N	%
		N	%	N	%	N	%	N	%		
General QCI	Proportion of breast cancer women discussed at MDT meeting	5036	72.0	5555	81.0	5008	84.7	9579	82.1	25178	80.4
Diagnosis and staging	Proportion of newly diagnosed cStage I-III breast cancer women who underwent two view mammography or breast sanography within 3 months prior to surgery	1741	88.3	2103	89.1	2220	91.0	5480	80.5	11544	85.3
	Proportion of breast cancer women in whom an ER and PgR status assessment were performed before any systemic treatment	4462	97.9	4963	98.2	4364	97.9	8474	97.9	22263	98.0
	Proportion of breast cancer women with cytological and/or histological assessment before surgery	4599	62.0	5068	62.3	4525	75.2	8877	76.2	23069	70.1
Neoadjuvant treatment	Proportion of operable cT2-T3 breast cancer women who received neoadjuvant systemic therapy	758	7.3	1021	14.1	1015	13.2	2576	19.4	5370	15.5
Surgery	Proportion of cStage I and II women who undergo breast-conserving surgery	3274	65.2	3737	69.5	3488	68.8	7006	71.1	17505	69.2
	Proportion of breast cancer women receiving adjuvant chemotherapy after surgery	4599	37.6	5068	37.4	4525	34.9	8877	37.7	23069	37.1
Adjuvant treatment	Proportion of breast cancer women receiving adjuvant endocrine therapy after surgery	4599	43.9	5068	44.1	4525	44.1	8877	40.6	23069	42.7
	Proportion of breast cancer women who received radiotherapy after breast-conserving surgery	2666	83.9	3147	88.7	2802	90.2	5632	90.3	14247	88.7
	Proportion of metastatic breast cancer women who received systemic therapy as 1st and/or 2nd line treatment	210	89.5	248	87.9	223	90.6	426	85.4	1107	87.8
Follow up	Proportion of women with a mammography after history of breast cancer	3796	77.8	4320	81.6	3943	81.4	8059	82.3	20118	81.1

N eligible = Number of patients eligible for that process indicator

% Percentage of eligible patients with the process completed.

Source: Vrijens F., Stordeur S., Beirens K., Devriese S., Van Eycken E., Vlayen, J. (2011). "Effect of hospital volume on processes of care and five-year survival after breast cancer: A population-based study on 25 000 women." *Breast*. 2012 Jun;21(3):261-6.

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introduced since then, such as the formal recognition of breast clinics since 2007. Nonetheless, the results can serve as a baseline to follow up the quality of care in the future.

Secondly, our analysis does not account for the effect of surgeon volume, a variable which has been shown to be a prognostic factor for survival from breast cancer. However, as high-volume surgeons tend to operate in high-volume hospitals, part of the effect that was attributed to the hospital is probably due to the experience of the surgeon. Also, we did not investigate whether the observed effects could be explained by other characteristics of the hospitals, such as teaching status or geographical location (urban or country).

Thirdly, it cannot be excluded that the observed survival differences between low- and high-volume hospitals are due to patient characteristics other than those accounted for in our study, such as social status, co-morbidity, or other residual confounding variables. Although this is a possible explanation for the observed survival differences, it is not consistent with the differences observed in processes of care, which residual confounding cannot explain.

Finally, all process indicators were calculated based on claims data. In the unlikely but not unrealistic event that a process was performed but not billed, it could not be identified in our study.

Discussion

This study has shown that several processes of care are more often performed in high-volume centres compared to low-volume centres. Some hypotheses are formulated below.

- Differences in breast conserving surgery rates could be explained by the higher technical skills needed to perform BCS compared to mastectomy, expertise that is probably more frequently available in high-volume centres.
- Differences in use of neoadjuvant treatment could also be partly explained by the choice for BCS or mastectomy, as neoadjuvant treatment is intended to reduce tumour size and hence to increase the likelihood of BCS. These differences could also be attributed to a higher proportion of MDT meetings in high-volume centres, which has been shown to change the surgical management of patients, owing to the additional information in mammographic and pathologic interpretation as evaluation by medical and radiation oncologists and surgical breast specialists.
- A possible explanation of the differences in the use of adjuvant radiotherapy after BCS is that this recommendation is based on a

relatively recent systematic review of the Early Breast Cancer Trialists Collaborative Group, and that high volume hospitals may pick up new evidence more quickly than low-volume centres. Furthermore, most high-volume centres have their own radiotherapy centre, which is not the case for low-volume centres. The latter could be reluctant to transfer their patients for adjuvant radiotherapy in another hospital. An exploratory analysis of our data showed that high-volume centres also more frequently provide radiotherapy after mastectomy (50.9% in very-low-volume hospitals, 57% in low and medium-volume hospitals, and 65.7% in high volume hospitals; data not shown), confirming the latter hypothesis.

- The lower rate of diagnostic mammography or breast ultrasonography in high-volume hospitals (80% versus about 90% in other hospitals) is somewhat surprising and could be explained by the use of alternative imaging procedures such as Magnetic Resonance Imaging.
- Also, the lower rate of systemic treatment for patients with metastatic cancer in high-volume hospitals, which are also often academic hospitals, is perhaps explained by the increasing recruitment of these patients in clinical trials. In Belgium, costs of the experimental treatment are supported by the industry, are not reimbursed and hence not registered in the claims database. This hypothesis should be further validated.

Conclusion

The present study showed that women with invasive breast cancer treated in very low-volume hospitals (<50 patients per year) and in low-volume hospitals (50-99/year) had a higher risk of death within five years after diagnosis than women treated in high-volume hospitals (≥150/year). The increased mortality risk was higher for very low-volume hospitals (26%) than for low-volume hospitals (15%). In addition to the relationship between hospital volume and survival, our study showed large differences in the application of evidence-based processes between hospitals according to their volume. Among a set of 11 processes studied, six were more often performed in high-volume hospitals.

These results should not really surprise the informed reader, as differences in processes of care across volume categories have already been reported for other cancer types (such as bladder cancer or esophageal cancer) and in high-risk cancer surgery. Also in other domains of care, such as cardiology, the link between

process and volume has been extensively studied, and showed similar results.

In conclusion, survival benefits reported in high-volume hospitals suggest a better application of recommended processes of care, justifying the centralisation of the management of breast cancer patients in these hospitals.

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THE GROWING ROLE OF INTERVENTIONAL ONCOLOGY WITHIN MULTIDISCIPLINARY CANCER CARE

By Małgorzata Szczerbo-Trojanowska, Adam McLean

Interventional radiology (IR) is already well established within the field of oncology and the contribution it makes to cancer care continues to grow. Minimally invasive image-guided interventions started out having an ancillary role in oncology; treating the complications of cancer (e.g. clearing occluded ducts and vessels) or managing the side-effects of disease and of treatment (e.g. haemorrhage). However, over the past decade modalities to treat the tumours themselves have been developed and made available.

Interventional oncology, increasingly recognised as the fourth arm of cancer treatment, describes the range of procedures offered by IR in the field of oncology. This range includes many palliative and adjunctive therapies such as ablation, embolisation, chemoembolisation and radioembolisation. Innovation and development are characteristic of IR in general and this is no less true for interventional oncology; a specialty which is expanding, not only thanks to advances in imaging and interventional techniques, but also due to keen efforts supporting multidisciplinary collaboration.

Quality Imaging Vital

One of the defining features of IR is good quality and detailed imaging, which is absolutely crucial at every stage of image-guided interventions. Initially in each case, the most appropriate imaging modality for the particular patient must be selected; the lesion is then located and evaluated with high precision. This in turn allows an informed choice of the most suitable therapeutic procedure and a thorough planning of the treatment strategy, including selection of the most suitable devices and calculating the optimal trajectory to reach the lesion. Pre-procedural imaging is nowadays assisted by a range of technologies, not least 3D reconstruction.

During the procedure itself, imaging confers the ability to visualise the lesion, guide the instruments and devices, and assess the progress of the intervention.

Finally, post-procedural follow-up is of the utmost importance to accurately evaluate the success of a treatment, assess complications, and to detect any recurrence of the disease as early as possible. A general shift away from isolated technical service provision towards com-

prehensive clinical care has meant that IR is increasingly involved at each stage of therapy, including follow-up. The importance of imaging to the work of IR makes a close working partnership with diagnostic radiology a prerequisite.

Multidisciplinary Synergy

Cancer is a huge area of medicine and radiologists are necessarily involved, at the very least having contact with oncological patients many times each day: they are therefore part of the multidisciplinary team.

Modern medicine is not a one-man show and no single specialty can be the sole provider of care or the only driving force of innovation. It is especially true of oncology that all the new ideas and treatment modalities are coming about at the crossroads of many specialties. It is through biochemists, geneticists, oncologists, radiologists and many others working together that development and improvement is assured.

The increasing importance of synergy between the various medical specialties has already begun to influence and will continue to influence the way in which radiologists are trained. Modern imaging techniques now allow us to see more than just morphology; for example, the metabolism of tissues can be seen. Radiology residents and students therefore must be taught not only the relevant anatomy to read images but also much more clinical knowledge and the relevant basic sciences that underpin understanding and competence with the new technologies.

IR Conference Supports Teamwork

At the European Conference on Interventional Oncology, one clearly sees that the scope

of IR is widening at all clinical stages of cancer care. The conference acknowledges and fosters multidisciplinary collaboration through the recurring incentive programme whereby referring physician colleagues of IRs receive support to attend.

In this way, oncologists, surgeons, and physicians of other specialties can experience and contribute to the meeting. The mutual understanding and co-operation that arise out of such opportunities are crucial and ultimately lead to a better service provision for patients. IR can be present in a hospital and be ready to offer effective oncological interventions, but unless patients are referred nobody will benefit. All the specialties involved in oncology need to be familiar with what the others offer if they are to pool their expertise and achieve superior outcomes.

Co-Operation at the Medical University in Lublin

The awareness of other specialties does not stop when the conference ends, but rather the spirit of teamwork and drive for multidisciplinary co-operation continues back at the hospital.

At the Medical University in Lublin, Poland, interventional radiologists have successfully established close co-operation with many other groups. This began with neurologists, as well as with endocrinologists and diabetologists, due to IR having the facilities and expertise to provide carotid stenting and below-the-knee angioplasty respectively.

Likewise, there is close co-operation between the various hospital departments involved in cancer care, including IR. This is not a new phenomenon; even before the new minimally invasive treatment options became available -

what are now collectively termed interventional oncology - IR had been providing palliative tumour embolisation and catheter drainage for many years. Many patients with advanced malignant tumours were frequently referred to IR from the oncology department. This has meant that the oncologists at the hospital have long had an awareness of the skill base of IR and how this can translate into services for cancer patients.

For historical reasons there is a Department of Diagnostic Radiology and a separate Department of Interventional Radiology at Lublin, which is not the typical situation in Poland. The two separate units co-operate very closely, understanding each other's roles and sharing resources. The Department of Interventional Radiology has two MRI machines and two ultrasound machines and has free access to CT machines within the Department of Diagnostic Radiology, allowing diagnosis and the necessary pre-procedural investigations.

For interventions, the IR Department has three operating theatres equipped with up-to-date angiography equipment and a room for ultrasound procedures. There is also a bi-plain angiography suite which is dedicated completely to neurointerventions. This capacity allows the treatment of many patients from Lublin and beyond and due to having the necessary equipment and trained staff, the department has been the site of introduction for many of the newest procedures.

Interdepartmental Cancer Care

Every day, interdepartmental meetings are held to discuss clinical cases, so the most suitable therapeutic procedure can be chosen for each cancer patient, whether it is provided by IR, surgery, or another oncology department. The oncologist remains in charge of the patient clinically, and is still very much involved even when the patient is referred to IR, being alongside the patient in the Interventional Radiology Department when the procedure is carried out. This makes the situation much more comfortable for the patient, keeps two-way communication open between the oncologist and radiologist, and helps to streamline patient care.

There are no dedicated beds in the IR Department, but IR does have use of beds within the Vascular Surgery Department. The close co-operation with the various other departments enables patients undergoing IR neurointerventions, for example, to stay in the neurosurgery department, where there are beds

reserved for neurointervention patients. This arrangement is duplicated in the various departments, including vascular surgery, gynaecology, and oncology.

The best clinical care is guaranteed as the patient is based in the relevant department with the required specialist support staff and equipment on hand. The interventional radiologists, however, do still attend to post-procedural monitoring and are integral to the ongoing team effort.

Developments in Interventional Oncology

IR as a specialty has been a major contributor to the recent revolution in the treatment of cancer. Its main advantage is the elegant and precise way in which lesions are targeted, thus minimising harm to surrounding areas.

This particular strength of interventional oncology is continually being refined, the next step being automated guidance, a technology already present in some kinds of surgery. At the moment, device trajectory during a procedure is corrected manually by the radiologist but soon the navigation will be automatic, with the highest possible accuracy and precision assured by robotisation. One of the main technical challenges to overcome is that the organs IR often treats are not stationary, but continuous imaging with ultrasound or X-ray can be used to constantly adjust pre-procedural MR and CT images, thus making automated navigation possible.

Another area of development in terms of procedure guidance is virtual CT sonography and virtual MRI sonography. This fusion of two imaging modalities is very advantageous: if part of a lesion is not seen with one modality, but is seen with another, the images can be synchronised. Furthermore, being able to perform CT much earlier on, rather than during the procedure, reduces burden of radiation to the patient.

Similar to the growing tendency to merge imaging techniques, there is also a tendency to combine interventional procedures. When performing radiofrequency ablation of tumours, for example, systemic chemotherapy can be administered simultaneously. Particular cytostatic drugs are more effective at higher temperatures, so the heat generated by the ablation can boost the action of the chemotherapy.

Increasing sophistication in imaging allows us to not only localise the tumour, but also to see the structure in more detail than was previously possible. The use of ultrasound contrast media, for example, is already making a

significant clinical impact. Contrast-enhanced ultrasound (CEUS) provides images showing intra-tumoural vascularity and blood flow, comparable to the information obtained by computer tomography and dynamic magnetic resonance imaging. An advantage of CEUS is no exposure to radiation, and the absence of nephrotoxic contrast agents.

Tumour metabolism is indeed an area upon which research is now focusing, with the therapeutic goal to inhibit angiogenesis, tumour growth and proliferation. The future promises much more specific ways to treat tumours involving the exertion of influence over cell division processes and controlled initiation of apoptosis in targeted cells. The action of some of the drugs in this area could be induced by a controlled impulse, light being just one example. IR is set to play a central role in delivering these therapies, as it will in other biotechnological approaches such as gene therapy.

Benefits to the Hospital

The availability of interventional oncology services in a hospital represents many advantages. As many of the procedures can be performed on an outpatient basis, hospitalisation time and the associated costs can be reduced. The lower level of discomfort reported by patients, compared to other procedures, is also noteworthy. Interventional oncology procedures are often effectively employed in connection with other therapies, such as surgery, improving the success of the latter, and may also provide options in cases where other treatment modalities are not possible.

Due to the complex nature of cancer care, hospitals that attract patients with interventional oncology services will increase the case-loads of other departments generally, due to the likely necessity of a range of follow-up investigations and procedures, which will be delivered by the appropriate specialists; all members of the multidisciplinary cancer team.

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HOT TOPICS FROM ESMO 2012

The key message from this year's European Society for Medical Oncology (ESMO) was that equal access to cancer care is a medical and ethical imperative, including early diagnosis, treatment and supportive care.

Personalised medicine

President of the society, Prof Martine Piccart addressed the conference on the final day, "The goal we are working toward is personalised medicine, and there is a long road to travel before we get there... High quality cancer care can extend the lives of patients and significantly lessen their suffering, and thereby also the costs to society." Piccart concluded with a call to intensify interna-

tional collaborative research.

Managing the costs of emerging oncology therapies

The congress highlighted the growing need to address issues of health economics in the field of oncology. The Young Oncologist's breakfast session was a forum exploring the management of the costs of emerging therapies. Shocking figures from the conference include the fact that the annual EU cost of cancer care is a staggering 124 billion euro and research suggests that European countries are spending between 4.1% and 10.6% of healthcare resources on cancer care.

Integrated oncology and palliative care

The European Society for Medical Oncology also awarded ESMO Designated Center of Integrated Oncology and Palliative Care accreditation to 16 new oncology centres. First set up in 2003, this project aims to improve the infrastructure for the provision of palliative care globally. The initiative came partly in response to the World Health Organisation (WHO) report "Cancer pain relief and palliative care".

For more information, please visit:

www.esmo.org

ECIO HIGHLIGHTS POTENTIAL OF INTERVENTIONAL ONCOLOGY

As always, the European Conference on Interventional Oncology (ECIO) provided attendees with interesting insights into the latest developments in the growing discipline of interventional oncology. The congress opened with a look at cutting-edge research, in Image-guided tumour ablation: technological advances. New ablation methods such as focused ultrasound, microwave ablation and irreversible electroporation were discussed, and the session also examined whether in light of these new data, the "gold-standard" therapy, radiofrequency ablation, is still a viable and

effective treatment option.

The honorary lecture was given by Prof. Andreas Adam. He delved into both the clinical and political aspects of interventional oncology and argued that in order to deliver robust and effective treatment safely, interventional oncology (and interventional radiology generally) must remain anchored within the radiology department, as well as developing their natural partnership with radiation oncologists further.

Another key presentation came from Dr. Lizbeth Kenny, renowned radiation oncologist. Fittingly she focused on the impor-

ance of multidisciplinary collaboration for cancer care. A debate afterwards dealt with the question of creating a specific curriculum for interventional oncology.

The drug delivery in interventional oncology session gave a fascinating introduction to the most dynamic area of oncology – local delivery of targeted drugs. IR plays a central role in accurately deploying the gene-therapies, thermally activated liposomes and modified viruses that herald the future of cancer treatment.

For more information on the conference, please visit: www.esir.org

ELEKTA AND PHILIPS ESTABLISH RESEARCH CONSORTIUM FOR CANCER CARE

Elekta and Royal Philips Electronics will expand a joint programme to develop a breakthrough in cancer care with an imaging-treatment platform that merges radiation therapy and magnetic resonance imaging (MRI) technology in a single treatment system. The programme for development will include a research consortium of leading radiation oncology centres and cli-

nicians, which today includes the University Medical Centre Utrecht (the Netherlands).

The consortium's mission will be to merge precision radiation delivery with MRI in a single MRI-guided radiation therapy system. This will enable doctors to achieve exceptional soft tissue imaging during radiation therapy and to adapt treatment delivery in real-time

for extremely precise cancer treatments. Working with University Medical Center Utrecht, the medical device companies have built and tested a prototype system that integrates a linear accelerator and a 1.5 Tesla MRI system. The success of early tests has enabled the project to move to the next phase of development and testing by a select group of consortium partners.

DIGITAL PATHOLOGY SOFTWARE TO IMPROVE BREAST CANCER DIAGNOSIS AND THERAPY

By Manfred Dietel, Frederick Klauschen

Its reliance on biomarker evaluation for diagnosis and treatment decisions makes breast cancer care a good example of personalised medicine. In addition to breast cancer biomarkers such as the oestrogen/progesterone receptor and the Ki-67 proliferation marker, HER2 (Human Epidermal growth factor Receptor 2) has received particular attention in the recent years. 20 - 30 % of women with breast cancer test positive for the HER2 protein, associated with an especially aggressive breast cancer variant. HER2 positive patients usually respond poorly to conventional chemotherapy, but benefit from therapy with Herceptin®, a humanised HER2 antibody that costs on average approximately 100,000 dollars per patient. Because this approach does not help HER2 negative patients, doctors need to reliably detect and quantify the expression of this biomarker in breast cancer patients or else risk prescribing expensive and ineffective therapy.

Biomarker detection and analysis is the responsibility of a hospital's pathology department, which follows standardised protocols to score each sample as objectively as possible based on visual criteria. While the ability of pathologists to interpret histomorphological characteristics, such

Background

Breast cancer is among the most prevalent cancers in the world. World Health Organization (WHO) data indicates the disease strikes more than one million women every year, and kills more than 500,000 annually. Screening with novel imaging technologies can lead to earlier detection, and in turn improved prognoses and survival rates. However, there are numerous subtypes of breast cancer, and physicians must identify a patient's specific disease state to ensure proper treatment. Biopsies with (immuno-) histopathological and in-situ genetic biomarker analysis are the most common and effective ways to understand the molecular characteristics of a patient's cancer.

relevant because therapeutic decisions rely on the quantitative scoring result.

Therefore, pathologists and clinicians now cite a growing need for accurate biomarker quantification tools that can support treatment decisions.

cer. This project also has implications beyond pathology into radiology as both fields rely on visual analysis to understand patient disease states.

Seeking to arm its physicians with the best possible information about their patients' health, the Institute of Pathology at the Charité began working with Definiens, a provider of image and data analysis technology, to develop a software solution for automated scoring procedures for breast cancer patients. Based on previous healthcare projects, Definiens has shown the capability to provide robust quantitative image analysis solutions. Both organisations focus on developing a prototype that could be integrated into the pathology department and ensure oncology teams receive reliable information about patient disease states.

Charité Berlin

Charité University Hospital is organised in 17 centres comprising 103 medical departments with over 3,200 beds located in four locations in Berlin. More than 3,700 scientists and physicians work at the Charité, covering a broad range of subspecialties in biomedical research and clinical medicine. The Charité Institute of Pathology was founded by Rudolf Virchow and is one of the largest pathology university departments in Europe.



Employing software to automate image analysis of histological sections can enhance doctors' understanding of breast and other types of cancer

as whether a tissue is cancerous, is extremely reliable, human interpretation of quantitative image features appears more difficult. Measuring the number of cells positive for a specific biomarker and, even more so, visually quantifying the intensity of biomarker stains, may suffer from significant inter-observer variability. However, objective and accurate assessment, especially in case of the predictive biomarker HER2, is highly

Employing software to automate image analysis of histological sections can enhance doctors' understanding of breast and other types of cancer by providing insights into functional and molecular genetic characterisation of tumours. Charité Berlin is working on such a project, which is designed to provide pathologists with access to reliable, objective and standardised information that can inform treatment decisions around breast can-

Overcoming the Challenges of Conventional Image Analysis

As pointed out above, the analysis of stained sections can vary between pathologists, affecting the reliability of such scores. Automated scoring algorithms are subject to no such inconsistencies, but image analysis technology is constrained in other ways. Pixel-based approaches often cannot determine the morphological features impor-

tant in a tissue section, and are thus of limited value for most histopathological applications. Definiens' approach, however, unlike other technologies, is designed to analyse structures within the sample, and can understand the relationship of tissue structure, cellular components and sub-cellular features. These features are particularly important for histological biomarker analyses because they are the basis not only for accurate quantification but also for the reliable discrimination between tumour and healthy tissue.

The computer-assisted diagnostics systems the physicians and scientists from Charité pathology and Definiens conceived integrates different histopathological modalities (similar to different imaging sequences in MRI), analysing the tissue morphology with conventional H&E (Hematoxylin and Eosin) staining; quantifying the protein markers ER (estrogen receptor), PR (prog-

IHC markers and HercepTest for membrane — allows the pathologist to communicate with clear and well-documented recommendations for targeted therapy. With respect to HER2, cases with a low expression (scores of 0 and 1+) are not suitable for further investigation for inhibitory treatment, while a high HER2 expression (score 3+) is predictive of the efficacy of Herceptin therapy. Cases that score 2+ are followed up with a measurement of the amplification of the HER2 gene using SISH, and, in case of amplification, Herceptin therapy is recommended.

To develop and validate a software prototype that can present a simple numerical score to physicians, Charité Berlin provides Definiens with 150 samples. For each sample, seven sections are stained: one for H&E, one each immunohistochemically stained for biomarkers HER2, ER, PR and Ki67, and SISH analysis for HER2 and Chro-

management providers in pathology labs.

To develop the software as an intuitive component of a pathologist's workflow, Charité Berlin and Definiens are paying special attention to the graphical user interface (GUI), implemented in a web browser with Web 2.0 technologies such as XHTML, Javascript and Ajax. This allows the pathologist to perform different jobs and access data and analysis with a variety of hardware (whether from a desktop, a laptop or a tablet) and operating systems (Microsoft Windows, Apple OS, Linux). The GUI is often similar, if not nearly identical, to radiology applications. The web-based GUI will also allow pathologists to perform remote work (e.g. telepathology) or to consult with other experts using the internet. The system may also be used for education purposes to train students for manual scoring and tissue examination.

Broader Implications

Collaboration between research and clinical disciplines enables physicians to draw upon new findings in predictive molecular pathology, where pathologists not only diagnose a certain disease but also provide molecular characterisation and recommend a particular therapy. In this regard, image analysis promises to provide insights into functional and molecular genetic mechanisms of tumours, and helps translate this knowledge into clinical practice. Furthermore, the software prototype provides a new, image analysis-based evaluation algorithm that considers a range of immunohistochemical factors in recommending treatment decisions. Given the need for more reliable, objective scoring regimens in pathology, it represents what Charité Berlin expects will be among the first in a new generation of image analysis programmes.

Such an image analysis approach can work similarly for radiology as for pathology. Given the convergence of the two fields, one can expect the development, implementation and benefits of new programmes to track Charité Berlin's experience with the breast cancer-oriented software thus far. In this case, software may well provide quality improvements that could augment physicians' clinical effectiveness and help patients receive the best treatment possible.

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The goal is to offer pathologists a comprehensive and objective basis for therapy recommendation, improving breast cancer treatment by selecting the appropriate therapy for the individual patient.

esterone receptor), Ki-67 (cell proliferation), and HER2 with immunohistochemistry; and assessing the HER2 (Human Epidermal growth factor Receptor 2) gene amplification status with SISH (Silver In Situ Hybridisation).

Together, this allows the software to correlate the different tissue features within their spatial context and derive reliable, reproducible scores. While the current scope of the prototype is for research purposes only, the goal is to offer pathologists a comprehensive and objective basis for therapy recommendation, improving breast cancer treatment by selecting the appropriate therapy for the individual patient.

Scoring Mechanism

The software is designed to compute scores based on a wide range of clinically significant variables, particularly morphology and multiplex biomarker expression. In practice, scoring of the tissue section images according to the established algorithms - Elston-Ellis for H&E, Allred for nuclear

mosome 17 (Chr17). All these data are fed into a three-level hierarchical classifier. First, relevant features are extracted from the image data for each slide. The programme then determines a score for each modality examined. Finally, the individual scores are combined into a total score to be reviewed by the pathologist and presented to the attending physician. Pathologists manually score half the samples as reference points.

Interface Development

The new prototype works with many different platforms because a pathologist's working environment is marked by a heterogeneous hardware and software environment. On the hardware side of the equation, slide scanners from Aperio, Leica, 3DHitech and Hamamatsu are common. A recently developed system from Philips promises even higher throughput and automation. The data management is often independent but connected to the hardware; companies such as Roche, Aperio and Nexus are the most common such data

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formed using validated tools for health technology assessment.

(Mr. Richard Dooley) I suppose the continuous challenge is to maintain the high quality of service delivery that we have been achieving; it is maintaining that quality and sustaining it into the future. Areas that need to be improved take resources from another service area and some services have to make do without.

Has anything positive come out of this situation?

(Mr. Josep M. Piqué) This budget constriction was a good opportunity to fuel those initiatives oriented to enhance efficiency and more rational use of public resources. Also, these circumstances provided an appropriate professional climate and environment to introduce structural reforms otherwise difficult to perform in upward economic cycles.

(Mr. Richard Dooley) Yes, it calls for new skills and competencies from managers. A certain level of leadership is required to sustain the quality of healthcare delivery that we need. This is one element and a huge challenge. From my knowledge, it has brought to the fore both clinical and administrative leaders in a way that I haven't seen before.

From the management point of view it has entailed a far closer scrutiny of how we actually spend our resources and has highlighted that our finance systems aren't sufficiently detailed to the level that we want them. This has brought a renewed focus on the whole area of financial management and management accounting; making sure that every euro spent has a tangible outcome.

What is your outlook for the future?

(Mr. Josep M. Piqué) This is not a transient crisis. This is a combination of a deep economic crash and a profound crisis of our healthcare model. Taking into account this perspective, it is crucial to introduce deep changes to our approach of providing healthcare. It is particularly relevant how we will manage chronic diseases in elderly peo-

ple, how we will finance chronic treatments for until recently inexorably fatal diseases such as AIDS or advanced cancers, or how we will implement strategies for the prevention and prediction of prevalent diseases.

In this context, we need the improved commitment of health professionals to obtain long-term sustainable health outputs, better coordination of different care levels, a new approach and incentives remunerating healthcare providers and professionals, and a more intensive participation of the patients and citizens in healthcare decisions.

How has your national association of hospital managers addressed the financial crisis? What are they doing to help?

(Mr. Richard Dooley) Our regional forums and networking opportunities are hugely important. The national conference held recently received huge positive feedback. It allowed managers to get their voices out into the open on these issues and it has been achieved with a level of profile that has not been achieved before. All of the key players in Irish healthcare attended: the Minister for Health, Secretary General of Department of Health and the new CEO of the HSC.

One of the key things that came out of the conference was the need to professionalise and skill-up the whole area of management within the health service and the HMI is there, leading the discussion on behalf of managers.

Finally, what advice do you have for other countries in similar situations?

(Mr. Josep M. Piqué) I would advise others to anticipate as much as possible the reforms in their healthcare systems, to be prepared for the huge transformation needed to fulfil the demands of taking care of an ageing population, and to absorb those increasingly expensive new technologies with significant impact in life expectancy.

I would also advise cutting routine healthcare procedures, disinvesting on those technologies with no proven significant value and increasing the awareness that incor-

porating any technology, product or organisational innovation has to be done by means of rigorous analysis of health technology assessment.

This is an opportunity to go back and look at how we build management as a profession in health services

(Mr. Richard Dooley) My advice is to look at the formal and informal training that is in place for managers and clinician leaders. There is a great opportunity here for the profession of health service management. Health managers have the opportunity to influence the current debates about the system. These debates need to be led and contributed to by health service managers

At a lower level, we need to focus on how we train managers. When you look at it, you put a person in charge of a hospital that may have a budget of 150-200 million euro, that is a huge resource and too often we place managers that are not equipped or skilled or don't have the necessary competences or the training that is required to fulfil delivery at that level. We don't do it well enough. This is an opportunity to go back and look at how we build management as a profession in health services and it is the only way that we will go onto a sustainable platform into the future.

Interviewees

Josep M. Piqué

CEO
Hospital Clínic
University of Barcelona

Richard Dooley

President
Health Management Institute
Ireland

INTERVIEW: DR GERALD ROCKENSCHAUB, WHO EUROPE

Dr Gerald Rockenschaub, Programme Manager for Country Emergency Preparedness with the WHO took some time out of his busy schedule to talk to *(E)Hospital* about the importance of disaster preparedness and emergency response and the key role of the hospital manager.

What is the role of WHO Europe and what part do you play in it?

The WHO Europe is one of the six regional offices within the World Health Organisation (WHO). The WHO regional office for Europe is based in Copenhagen and supports the 53 member states of the European region; namely the 27 EU Member States and the former countries of the Soviet Union. Turkey and Israel are also part of our mandate.

We provide technical support to countries in terms of policy development and the development of strategies to reduce disease burden and to promote public health. I am programme manager for country emergency preparedness. We aim to prepare countries for any types of emergencies, be it communicable disease outbreaks, natural disasters or health problems associated with violent conflict. Activities include training, capacity building and working with countries to put

What are the most common disasters in hospitals and what should hospital managers be doing to ensure that their hospitals cope?

Well I think in general, well prepared and fully operational hospitals are essential in emergency situations, primarily in the context of mass casualty incidents; such incidents generate an extraordinary patient load for hospitals and in such situations hospitals need to quickly shift from the normal mode of operations to an extraordinary emergency mode. Triage suddenly becomes important and the challenge arises when you can't devote all the resources to take care of one particular patient but where you need to manage your resources to generate the best possible outcome for an extraordinary high number of critical patients. This is often not within the immediate mid set of a hospital environment and of health professionals working in that context.

So triage is an important issue in mass casualty incidents, but also the hospital site,

working with countries to ensure that hospitals are seen as critical infrastructure and that they remain operational when they are needed most. We try to promote and ensure that there are business continuity plans in place, that emergency preparedness plans are updated and tested and that health professionals in hospitals are trained accordingly to be able to manage those types of situations.

Our cover story this issue is on patient and staff safety in the hospital. Clearly this is of paramount importance to the WHO. What have been the most significant policies and new developments in safety in recent years?

Well we have the "Safer Hospitals Initiative", which particularly emphasises that our hospitals need to be disaster resilient and operational in emergency situations. This was the topic of the World Health Day 2009 so it was successfully promoted globally to raise awareness.

The WHO has also developed some tools to provide technical support in that respect. We have the hospital safety index, which is a basic tool to assess the structural and functional vulnerability of hospitals, which not only looks at the structural safety of buildings but also at the operational preparedness. In the European region we have developed the Hospital Emergency Response Checklist that gives hospital managers a quick and easy tool to assess where are the gaps and whether they have the key components of an incident management system in place in order to respond accordingly to all types of emergencies.

These tools are available online and translated into different languages including Russian. In fact we organize trainings and workshops in several countries. We have a well established collaboration with Polish hospitals, which evolved in the context of the Euro 2012 preparations as Poland was co-hosting the UEFA championship with the Ukraine. So we worked closely with Polish

In times of financial instability it becomes increasingly difficult to mobilise the necessary resources, to promote emergency preparedness, to have the necessary systems in place, and to make them sustainable.

emergency plans in place. We also work to improve cross-border collaboration in terms of crisis preparedness. Basically, our focus is on building capacities in countries to better prevent and address the health implications of disasters and emergencies.

the physical infrastructure and the critical supply lines a hospital needs to function in the aftermath of a disaster. What we often see is that hospitals become dysfunctional in disaster situations when they are actually needed most to save lives and provide emergency care. For this reason we are

hospitals and the health authorities to standardise the preparedness plans and worked on trainings and exercises to test the plans.

The EAHM is currently focused on the implementation of the European Directive on Cross-Border Healthcare and its effect on both hospitals and patients. Was WHO involved in the discussion process and what do you think will be the outcome of this new piece of legislation?

The EU Directive on cross-border healthcare is mainly focusing on patient rights and we are involved in the sense that our entry point is usually the Member States. If Member States have an issue in developing or being part of the discussion, developing this directive, they often do this through technical exchanges with the WHO and then there is some high level policy exchange between our regional director and the decision makers within the EU bodies.



World Health Organization

Do you think the directive will have a positive effect during a crisis or disaster?

I think that is definitely something that is helpful in that respect, with the high level of mobility these days and also some cross-border arrangements in providing emergency care or even coordination between neighbouring countries. This is definitely a helpful step forward in that direction.

From your experience, how greatly does healthcare provision and quality vary from one European country to another?

We definitely see different systems across Europe and if you look at the per capita spending of countries in our region there is of course great variation. But often that is not necessarily reflected in the quality of care. In countries that do not have the resources to invest heavily in hospital care and infrastructure, they still try their best to provide high-level quality care to their

patients within the limited resources. For us the critical issue is vulnerable groups. We lobby for vulnerable groups that are not financially that well off but still need and should have access to critical care, to hospital care and to high quality care.

How is the financial crisis affecting the WHO and its activities?

For us in the emergency field, it is critical to ensure that access to care is available, particularly in a disaster/crisis situation. We lobby to ensure that systems for critical and emergency care are in place and that this care is accessible to everyone. But I am not denying that financial constraints are a serious challenge. In times of financial instability it becomes increasingly difficult to mobilise the necessary resources, to promote emergency preparedness, to have the necessary systems in place, and to make them sustainable.

Currently, what are the main threats to health and hospitals in Europe?

An influenza pandemic is definitely a threat that we need to be prepared for. At any time a new influenza pandemic can evolve but we also have other hazards, there are substantial natural hazards that affect many of our countries, there are floods, earthquakes and forest fires. For this reason we work with countries to promote an all-hazards approach to emergency preparedness in hospitals. It basically means that irrespective of the hazard, it is essential that you have a generic preparedness system in place to be able to address all types of hazards and to initiate an effective response to cope.

Hospitals need an incident management system in place supported by a functioning coordination mechanism with other hospitals. You need to increase the hospital networking in order to have surge capacity in place. You need to have the appropri-

ate communication systems in place and the logistics around the information system and so forth. It doesn't matter whether you are confronted with an earthquake or mass casualty incident or a flood situation or an infectious disease outbreak, the key building blocks of an effective health response remain similar. Of course you need to have specific expertise on top of that but if you can ensure that those generic mechanisms are in place and functioning well, then you already have a good basis in order to launch an effective response.

This is your chance to address hospital managers from across Europe. Do you have any final recommendations or advice?

The message I'd like to leave is that we need to raise the awareness that all hospitals should be prepared to address major emergencies. We need to have this emergency management capacity in place and we need to have a critical mass of health professionals that are adequately trained in that area. Health professionals usually know how to deal with individual emergencies really well but it is a different type of skills that you need to address the management issues around a mass casualty emergency or a disaster situation. When you are confronted with a large number of patients overwhelming your hospital then you need to have the mechanisms in place to quickly move from a normal mode of managing your facility to an emergency mode to mobilise your resources and your surge capacity, to have triage mechanisms in place. I think this is the key and it is often not on the immediate radar in countries where emergencies are not happening on a frequent basis. In fact we see that hospitals respond much better in countries that are frequently confronted with such situations, or who frequently test their systems in exercises and drills. Hospitals often respond less effectively if those incidents happen on a rather infrequent basis.

To find out more on the safe hospitals index, the hospital emergency response checklist and general information on hospital resilience and vulnerability assessments please visit:

<http://www.euro.who.int/en/what-we-do/health-topics/emergencies/disaster-preparedness-and-response/activities/hospital-resilience-and-safety>

OUTSOURCING SERVICES IN HEALTHCARE: TECHNICAL STANDARDS, INNOVATION, HORIZON SCANNING AND BENCHMARKING

By Ugo Luigi Aparo, Gianfranco Finzi, Barbara Gozzi

“Outsourcing Services in Healthcare: Technical Standard, Innovation, Horizon Scanning and Benchmarking” is an on-going project, first started in 2011 by ANMDO (Italian National Association of Hospital Medical Directors). The main objectives of the project, focused on management issues in the outsourcing of non-core healthcare related services, are the definition of technical standards, best-practice certification and diffusion and the identification and testing of innovative solutions. To achieve these objectives, horizon scanning and benchmarking methodologies are used to assess both the quality of outsourced services and the economic results.

Definition

Outsourcing is the set of economic practices used by firms to use other companies to perform certain stages of the production process. Although specialised companies for providing manufacturing services to companies have existed in Italy since the early sixties, the term 'outsourcing' became quite popular in the managerial community only in the late eighties, early nineties.

The project activities are carried out with the involvement of a set of different healthcare sector representatives:

- Healthcare Associations: ANMDO; FARE (Italian association of healthcare products and services buyers); SIAIS (Italian Society of healthcare architecture and engineering);
- Industry: FISE, Legacoop services, Confcooperative, AFIDAMP Fab e Com;
- Technical and scientific associations: TEROTEC and Italian National School of Services;
- Company representatives.

Sanitation activities in Italy employ about 500,000 people, and over 100,000 are active in the healthcare sector, not taking into account those responsible in the healthcare facilities of managing non-core outsourced contracts.

In June 2011, an updated version of the “Capitolato Tecnico del Servizio di Sanifi-

cazione Ambientale in Sanità” – a technical guideline of specifications and tools to be used in defining and closing contracts dealing with environmental sanitation in healthcare – was presented in the framework of the 37th ANMDO National Congress in Bologna, and a new phase of activity began.

Lines of Activity

- Identification of relevant technical standards to define non-core healthcare services outsourcing specifications;
- Identification of technical proposals presenting innovative aspects;
- Progressive integration of newly defined technical standards;
- Identification of best management and operational practices facilitating efficient and effective outsourcing buyer-seller relationships;
- Comparison of experiences and diffusion of practical results;
- Control system evolution, both first hand or third party based, to ensure the optimal management of procurement contracts, processes and services results, customer satisfaction, both internal and external, and the overall system efficiency; and
- Monitoring of the impact of regulations and reduced economic resources.

Work Procedures

The main characteristics of the working procedures of this project are involvement, analysis of on-going processes and a 360-

degree vision with the active involvement of various players. A significant part of the project entails is the promotion of the registration of health professionals working on these issues to a dedicated web portal, in order to facilitate the comparison and the circulation of experiences. The analysis of the dynamics and the understanding of the practical effects is a key objective.

The entry into force in 2011 of the “Regolamento di Attuazione del Codice dei Contratti Pubblici” – the new set of Regulations for Implementation of the Public Contracts Code – and the evolution of the economic scenario, are the driving factors that privilege cost savings versus service quality standards. Therefore, it is necessary to significantly revise tender specifications, contract management and control tools and processes to avoid negative consequences for the parties involved: users and healthcare providers.

The system efficiency and effectiveness is based on the individual components, but also on the virtuous partnership between the different players. As a consequence, several aspects that modify and define expectations of non-core services have to be taken into account:

- Increasingly detailed and articulated quality expectations;
- Coordination with new organisational models related to health system evolution (i.e. hospital for intensive care); and
- Full integration with environmental sustainability and social responsibility issues.

The overarching objective of the project is to evaluate on-going and forecasted dynamics and changes in order to optimise the planning and implementation of work activities. The working group is an "open" group enriched by the continuous flow of ideas and experiences dealing with new topics and issues.

Short and Medium Term Objectives

The main short-medium term objectives of the project are to:

- Write a detailed description of technical standards for each service;
- Develop/integrate UNI control related regulation (UNI EN 13549:2003);
- Create an observatory and a technical reference point for innovation in outsourced services in healthcare;
- Benchmark analysis of competitive tenders for cleaning (the expected quality economic sustainability index);
- Benchmark analysis of various non-core outsourcing services: Report Card Service with the direct contribution of the users association "Cittadinanza Attiva";
- Develop specific environmentally sustainable solutions (i.e. forthcoming publication of CAM (Criteri Ambientali Minimi), which is a specific regulation for cleaning); and
- Promote ECM training programmes for health professionals.

The sharing and dissemination of the collected and validated information and knowledge is achieved through its publication on a dedicated website: www.standardsanificazione.it and in scientific magazines. The website offers interactive communication and dialogue channel between the project team and the wide variety of health operators and technical experts.

In the first phase, the main objective was to define a possible structure for technical standards and best practices in order to promote the evolution of technical communication and the ability to identify the appropriate choices.

Nowadays, the project is evolving towards the implementation of a factual benchmark analysis of the relationship inquiries/values provided by the competitive tender, and to all dimensions of quality and efficiency of the service ('Report Card Services' according to the model

shared with the Scuola Nazionale Servizi).

On the website one can find useful information about service companies, associations and stakeholders participating in the project.

the XII Hygiene and Health Committee of the Senate and of the Ethics Committee PAA (Public Affairs Awards) presented the award during the 4th National Conference of the Public Affairs Association.

the articulation and development of the activities...is based on the active involvement of various healthcare players and professionals in order to promote the comparison and the circulation of experiences

Results

The involvement of the different players and the use of web tools that allow direct relationships and dialogue between healthcare providers is essential for a strong dissemination of information in real time of knowledge, pilot experiences, and best practices. These elements greatly enhance the identification of macro or single features that become object of attention and can produce opportunities for improving the integrated management of non-core services in relation to the various processes of diagnosis and treatment in health facilities.

We would like to highlight that the project Outsourcing services in Healthcare: technical standard, innovation, horizon scanning and benchmark presented by ANMDO at the Italian Public Affairs Awards 2012 competition has been named 'Winner of the Public Affairs Awards 2012' for the category 'Societies and Scientific Associations'.

The project presented by ANMDO was chosen by a jury composed of representatives of Parliament, academia, business, end users, journalists and representatives of national and international organisations active in the field of institutional relations. Senator Antonio Tommassini, President of

Conclusions

Our project, Outsourcing Services in Healthcare: Technical standards, innovation, horizon scanning and benchmarking, promotes the use of common tools in the healthcare world such as risk analysis, evidence-based results assessment, results, identification and dissemination of best practices and horizon scanning. This is a prerequisite to meeting efficiency targets without jeopardising the quality of secondary services, and factors of great importance for the proper working of health facilities.

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HEALTHCARE IN SLOVAKIA



Until 1990, the Slovak healthcare worked as a centralised public system, organised as the National Healthcare System independent from the Czech Healthcare system in federal Czechoslovakia. It was financed from central resources (federal state budget), distributed in the three regions of Slovakia (western, central and eastern).

After 1990, the process of decentralisation, de-etatisation, privatisation and the change of health system financing from state financing to the health insurance system combined with public financing (investment) began. This process is still ongoing. Problems occur in connection with transformation of all public sectors.

Table 1. Basic facts on the Slovak healthcare system

Total expenses for healthcare (% GDP)	9
Healthcare expenses per capita /USD)	2095
Expenses on medicaments (% of total expenses)	26.4
Number of doctors per 1000 inhabitants	3.3
Number of nurses per 1000 inhabitants	6
Number of beds for acute care in hospitals	4.7
% of used beds, just in hospitals of acute care	67.5
Average time of care in days	8.4
Number of CT per million inhabitants	13.8
Number of MR per million inhabitants	6.8

Source: OECD – updated 2010

In Slovakia there are 147 in-patient health institutions (some combined with social care facilities) with 35,520 beds (31 December 2009). These numbers are changeable due to the continued transformation of the healthcare system (reduction of the number of hospital beds, transfer of acute beds into chronic beds, reduction of the hospital care and transformation into one day surgery or into ambulatory and homecare). Many hospitals cannot be defined as acute or chronic hospitals or beds because they are mixed together and also with social beds. Most hospitals owned by the state.

In 2002 new legislation related to transformation of hospitals into non-profit or

non-government organisations was introduced. Hospitals can become private, regional or district and municipal hospitals. A large number of hospitals were transferred from state ownership to regional ownership. For more than five years primary care has been completely privatised, except for some polyclinics and specialists that are partly employees of state or regional hospitals and partly with private practices.

Table 2. Basic Information about the Slovak Republic

Population	5,397,036
Area (square kilometres)	49,034
Official language	Slovak
Capital	Bratislava
GDP (billion of USD)	95.9941
Life expectancy - men	71.27
Life expectancy - women	78.74
Birth rate	11.3
Mortality rate	9.8
Natural increase per 1,000 inhabitants	1.53

Source: Institute for Informatics and Statistics (INFOSTAT) – updated 2009

Undergraduate medical education is provided at the Medical Faculty of the Comenius University in Bratislava (the capital), Martin (Central Slovakia) and Medical Faculty of the Šafarik University in Košice (Eastern Slovakia). There are five College Hospitals (three in Bratislava, one in Martin and two in Košice). Postgraduate education for the medical and nursing specialists is provided by the Postgraduate University in Bratislava. Undergraduate nursing education is provided at medical college, at other Universities and some at college hospitals.

Financing

Financing of the Slovak healthcare system is performed completely through the health insurance system, but the budget for investments (buildings, expensive equipment) for state hospitals is financed from the state budget. Health insurance in Slovakia is compulsory. There are three health insurance

companies, one public and two private. The Slovak Government is at the present time considering merging all health insurance companies into one state owned Health Insurance Company.

Services Provided

Healthcare can be divided into three main categories: Ambulatory (outpatient), inpatient and other.

Ambulatory care includes general first point of care outpatient departments, direct contact and specialised care outpatient departments.

Inpatient healthcare is predominantly provided by hospitals (local, regional, central and specialised hospitals). There are also specialised professional institutions, professional medical institutions and specialised sanatoriums, palliative care organisations and spas and health resorts that provide inpatient care.

Other healthcare services include the emergency medical services, the home nursing agency and dialysis centres.

Current Challenges

- The current considerations of changing the pluralistic healthcare insurance system into a single state owned insurance company;
- Recently implemented wage increases from 1 April 2012 and for Doctors from 1 January 2012 and 1 July 2012;
- Personnel stabilisation in the healthcare department. Wage levels for all healthcare employees is a complex issue;
- The economic stabilisation of the healthcare system by increasing payments for public policy holders for 2013;
- Equal position of healthcare institutions within the system; fair inter-sector division; and
- Current government policy on medicines.

Authors:

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THE SLOVAK HOSPITAL ASSOCIATION (ANS)



History

In March 1991 the directors of several Slovak hospitals initiated a meeting aimed at establishing a voluntary association of hospitals which would serve to defend common interests, provide mutual support, exchange information and collaborate with similar organisations abroad. Upon this initiative the Slovak Hospital (ANS) was established in the same year.

The idea of a collective organisation was gradually gaining more and more support and

the foundation for establishing the school of medical managers in 1992, which was transformed into an independent public corporation known as School of Medical Managers in 1994.

In 1991 ANS was granted the status of an observer in European Association of Hospital Managers, and in 1994 ANS became a permanent member of EAHM. ANS is at EAHM represented by Mr. Juraj Gémeš MD, MPH, who is at the same time member of the editorial board of Hospital magazine.

interest of ANS members;

- To maintain the pressure on the National Council of the Slovak Republic, the Government of the Slovak Republic and the President of the Slovak Republic while promoting requirements of ANS members in the state budget;
- Defending interests of ANS members in relation to central authorities and representatives of state administration and to other legal subjects;
- Exerting pressure on transparent distribution and efficient resource allocation in medical establishments;
- Promotion of return to intersectoral segmentation;
- Exerting pressure on implementation of major policies for financing the healthcare system in Slovakia as follows:
 1. Using 7-9% of GDP on financing the healthcare system;
 2. Defining the prices and tariffs of medical procedures;
 3. Adopting a law on negotiation of financing medical facilities;
- Amending the legislation of Slovak Republic;
- Assertion of interests of ANS members' in distribution of EU structural funds;
- Creating dignified conditions for employees;
- Collaboration with other employers and professional organisations in assertion of ANS requirements; and
- Intense communication with mass media.

The goal of the ANS is to gather and represent medical establishments in the Slovak Republic to promote concerted action in solving issues of economic, legislative, employer and professional concern

so the number of ANS members increased gradually, from original 35 members in 1991 to 105 members in 2002.

In 1993 ANS took a significant step forward when accepted to the Federation of Employers Associations of the Slovak Republic (FEA SR). This allowed ANS to gain direct contact with the community of employers and also address the Slovak Government and trade unions, thus creating the opportunity to promote the interests of hospitals in preparation of legislation. ANS became a partner to other Slovak non-government associations, health insurance companies and to the Ministry of Health of the Slovak Republic.

Throughout the 21 years of its activity, the ANS has managed to stabilise its position in accomplishing its main goal – to protect interests of in-patient medical facilities in order to maintain and increase the quality of healthcare.

As one of four partners, ANS co-founded

General Characteristics

ANS is a voluntary, employer-promoting, non political and independent common-interest association of legal entities, in-patient hospitals or other eventual medical establishments active within the territory of the Slovak Republic that provide medical care. The current president of the ANS is Mr. Marián Petko. The goal of the ANS is to gather and represent medical establishments in the Slovak Republic to promote concerted action in solving issues of economic, legislative, employer and professional concern. The position of the ANS members is based on the principles of equality and mutual solidarity.

The primary tasks of the ANS at present time are:

- To maintain the intense pressure on health insurance companies in promoting the

Recent Developments in the Slovak Healthcare System from ANS Prospective

In 2004, after the laws of the then new government were passed, development in the healthcare system was rather turbulent. Two opposite views were alternating constantly. One side promoted the implementation of market mechanisms into healthcare system, whereas the other, represented mainly by the views of political opposition, did the opposite. The system – “Brake – Accelerator - Brake – Accelerator” – has never been good for the healthcare system. From the ANS prospective, the development should be an evolution,

not a revolution. There are two possible reasons for the failure of the reform: either the idea that the market should be able to solve problems in healthcare system proved to be wrong, or it happened because the reform did not have enough time or space to be completed. From ANS prospective the former seems to be the more probable variant; we believe there are limitations to using market mechanisms to solve important issues in healthcare system.

The transformation process has also affected the ANS and its function. During the six-seven year period there was a considerable switch in the ownership of hospitals, which previously had been under the Ministry of Health. Hospitals were gradually transferred to self-governing regions or became private, non-profit organisations. This changed the whole structure of the association.

The position of the ANS also changed significantly, as there was a change in fixed prices for medical procedures and price regulations were cancelled. ANS started to negotiate with health insurance companies about prices for the medical care provided. ANS also started to communicate more intensely with mass media and to be more involved in legislation amendments. Another major change was the mutual position of ANS and trade unions. All hospitals had been previously public, and therefore salaries had been determined by the Ministry of Health and by the law. After the Act on Public Service was cancelled, the issue of salary increases started to unwind, mainly from negotiations with trade-union organisations.

The intensity of the work of the ANS before and after the transformation cannot be compared. When public ownership of hospitals was removed, the representation of hospitals was in a major part taken over by the association. The tasks of ANS became more complicated but its existence became even more justified. In the past, membership in the Association depended on the will of the state; if the government wanted to have hospitals associated in the ANS, they were so. Later all university college hospitals and teaching hospitals left the association, and a number of smaller hospitals were shut down.

Throughout this period there were significant changes within the association. Membership had quite notably depended on the position of the government. In the period of the changes in the Slovak healthcare system mentioned above, all university college

hospitals and teaching hospitals left the association (and subsequently founded the Association of College Hospitals), number of smaller hospitals ceased to exist which resulted in sudden and considerable decline in membership. After these changes had taken place, the trend gradually started to turn, medical establishments were integrated by active effort into ANS and their number reached today's level.

Fluctuation of membership was also connected with the fact that the ANS was also

of different hospital structures, both legally and internally, so it is not always possible to negotiate conditions favourable to everyone. However, it is our goal that deals we secure should cover the needs of the greatest possible number of hospitals. Negotiations can be complex procedures as apart from the court there is no arbitrary body defined by the government that would rule in case of controversies between hospitals and health insurance companies. The endeavour of ANS is to implement such insti-

From the ANS prospective, the development should be an evolution, not a revolution

trying to find its position in the whole healthcare system. Hospitals changed significantly with some turning into strictly commercial enterprises, or into subsidised organisations of the higher territorial self-governing units. Therefore it was the owners of hospitals, not the hospitals themselves, that changed their views on the ANS.

The goal of ANS, however, is to represent hospitals as a whole with no preference for a particular group. As we represent subsidised hospitals, as well as private enterprises and non-profit organisations, we are looking for our common interests. Where there is divergence of views and we cannot find mutual agreement, the hospital or group of hospitals solve their issues themselves, not within the ANS. We promote all that we have in common, not what divides us.

When dealing with insurance companies, ANS always seeks to win the best possible conditions for everyone. However, it is always a matter of compromise and pressure. The results of negotiations cannot be estimated unambiguously in favour of any of the parties. When our requirements are higher, insurance companies argue that they can only provide us with as much resources as available within the financing system. Positive results from dealings with medical insurance companies can be observed for example in comparison to other segments in the system. Negotiations are also complicated due to the different perspectives

tute that should, in our opinion, be performed by the healthcare surveillance authority. As a solution for cases of various discriminations occurring within the system, the ANS also recommends the implementation of a DRG system.

Outlook for the Future

In the near future ANS aims to continue to integrate hospitals that are not members of the Association of College Hospitals into the association. A wider member base will create better conditions for negotiations, and therefore advantages for the hospitals involved.

ANS will also focus on better communication with the Association of College Hospitals to join forces to solve common issues and interests. Other aims include the introduction of a DRG system within four years and continued active involvement in legislative matters as well as increased communication with the Slovak Trade Union of Healthcare and Social Services.

Finally, ANS has the continued ambition to work as a professional association, functioning on a professional and not political basis.

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IL EST GRAND TEMPS DE CHANGER NOTRE POINT DE VUE SUR LA SÉCURITÉ

Un journal qui s'est donné pour mission de couvrir les thèmes les plus importants intéressant les systèmes de soins de santé et leurs structures de gestion doit également savoir porter son attention sur la sécurité du patient et du personnel. Nous savons qu'il est de notre devoir de discuter et de réfléchir sur ces questions qui deviennent essentielles en période de crise économique et d'insécurité financière. Ainsi, nous souhaiterions présenter à nos lecteurs des mesures et méthodes innovantes capables de les aider à prendre soin de leurs patients et de leurs collègues, et susceptibles de contribuer également à réduire le nombre d'erreurs médicales et de limiter les coûts.

Nous sommes conscients que des erreurs peuvent se produire dans n'importe quelle situation ou zone d'activité où l'action humaine est en jeu. Un autre fait avéré est que les petites erreurs sont, dans la plupart des cas, souvent ignorées ou négligées – en tout cas qu'on ne leur accorde pas une très grande importance – jusqu'à l'arrivée d'une catastrophe. L'un des textes les plus connus dans le secteur de la santé est celui de l'Institut américain de médecine paru en 1999 sous le titre « to the Err is Human report in 1999: Building a Safer Health System », (l'erreur est humaine : bâtir un système de santé plus sûr). Aucun compte rendu n'a depuis lors davantage attiré l'attention.

Une étude effectuée à Harvard révélait que 44 000 à 98 000 Américains mouraient chaque année à la suite d'erreurs médicales. Le nombre de décès était si important qu'on pouvait le comparer à celui qu'occasionnerait un accident d'Airbus quotidien. Jusqu'à la publication de ce texte, pratiquement rien n'avait été fait pour la sécurité des patients. Après un certain temps, des mesures ont été prises, des stratégies étudiées et plus tard une procédure de gestion des risques créée. De plus, l'OMS a défini ses propres facteurs de risque, les recommandations « High Five ». Sur la base de mes expériences dans les soins de santé, je souhaite recommander à chaque hôpital de mettre en œuvre une stratégie de la gestion des risques. Il est parfaitement possible de travailler à partir des normes internationales établies par l'OMS tout en restant en accord avec les normes nationales et les mesures que chaque hôpital a pu auparavant mettre en place.

Si la sécurité des patients est essentielle, celle du personnel hospitalier doit également devenir une priorité. La sécurité au travail est bien mieux garantie si l'on suit des règles et adopte des conduites légitimées et bien définies. Néanmoins, des accidents peuvent se produire : les bles-

sures par piqûre d'aiguille peuvent entraîner des infections (HIV, hépatites B et C) et un faux pas, une chute ou une glissade provoquer une fracture. Des règles de conduite précises sont remises à chaque employé et des tolérances lui sont octroyées, mais la plupart du temps, ces accidents se produisent suite à une négligence humaine.

Chaque directeur d'hôpital connaît les règles et les protocoles existant pour la sécurité des patients et du personnel, mais peut-être faut-il maintenant changer notre conception de la sécurité. Peut-être devrions-nous nous concentrer sur la collaboration interdisciplinaire unique qui réunit les médecins, les infirmières, les pharmacologues et l'administration. À nous également d'abandonner les hiérarchies traditionnelles trop rigides, et de toujours nous rappeler l'importance d'une bonne gestion. Quoi qu'il en soit, un hôpital qui se veut bien administré devrait mettre en place une procédure de la gestion du risque solidement établie et bien gérée. Les quelques étapes importantes que nous venons de lister œuvrent pour une bonne gestion de la sécurité à destination à la fois des patients et du personnel.

Nous devrions dès maintenant réfléchir à la façon dont nous pourrions faire face, dans l'avenir, à l'évolution de la patientèle. Comme chacun le sait, l'évolution démographique promet une hausse considérable du nombre de personnes âgées. On peut dès lors penser que le secteur de la santé sera beaucoup plus sollicité par des gens plus âgés et plus malades qu'ils ne le sont aujourd'hui. En plus des maladies liées à l'âge, le nombre de cancers et de maladies auto-immunes est en augmentation. Si nous voulons être en mesure de relever ces défis, nous devons nous y préparer.

Ce numéro de *(E)Hospital* met également l'accent, dans son country focus, sur la Slovaquie. Le système d'assurance de la Slovaquie assure à tous les résidents la couverture automatique par l'une des cinq assurances de santé publique contrôlées par un organisme de réglementation. Il est intéressant de souligner que les patients sont liés à leurs médecins de soins primaires pendant six mois (médecins généralistes, pédiatres, gynécologues et dentistes).

Nikolaus Koller

Président du comité de rédaction



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 GESTION HOSPITALIÈRE EN TEMPS DE CRISE : CONTRAINTE, DÉFIS ET OPPORTUNITÉS

L'AEDH est fier d'annoncer que son 24^{ème} congrès aura lieu du 28 au 30 novembre 2013 dans la ville de Luxembourg.

Plus de 600 directeurs d'hôpitaux venus de l'Europe entière se réuniront cette année encore pour partager leurs expériences et leurs bonnes pratiques. Cette année, nous chercherons comment composer avec les contraintes économiques et les transformer en opportunités. Nous examinerons de quelle façon les

hôpitaux peuvent continuer à améliorer la qualité des soins tout en faisant face à l'incertitude économique et à la diminution des budgets.

Le congrès mettra en avant les expériences pratiques grâce à des conférences, des tables rondes et des présentations de posters. Les thèmes principaux seront :

- les orientations stratégiques en situation de crise ;
- la réingénierie des processus d'affaires (ou Business process

re-engineering) ;

- les nouveaux bâtiments, les nouvelles logistiques et les nouvelles technologies.

Un programme d'animation a également été préparé, dont une réception organisée par la Ville de Luxembourg et un dîner de gala le dernier soir.

Pour de plus amples informations sur le congrès, veuillez visitez notre site: www.eahm-luxembourg2013.lu

42^{ème} ASSEMBLÉE GÉNÉRALE ORDINAIRE

Elle se tiendra le vendredi 16 novembre 2012 de 17h00 à 18h30 en salle M, entrée Est (Ost) du Centre des congrès de Düsseldorf.

Ordre du jour:

Pour décision

1. Approbation de l'ordre du jour
2. Approbation du compte-rendu de la 41^{ème} Assemblée générale du 18 novembre 2011 à Düsseldorf, Allemagne
3. Rapport d'activités 2011-2012 par le

président

4. Approbation des comptes 2011 :
 - a. Présentation par le secrétaire général
 - b. Rapport des commissaires aux comptes
 - c. Approbation des comptes 2011 et décharge du Bureau et du secrétaire général
5. Budget 2013
 - a. Approbation des cotisations des membres ordinaires et associés (Art. 4.3.e. des statuts)
 - b. Approbation du budget de l'année

2013

6. Désignation des commissaires aux comptes pour l'année 2012
7. Admission et exclusion de membres ordinaires et associés
8. Prochaine Assemblée générale 2013 : Luxembourg, le jeudi 28 novembre 2013.

A titre d'information

9. 24^e Congrès AEDH (2013), Luxembourg; présentation du thème principal
10. Partenariat AEDH: Arcadis

LES SUPPLÉMENTS SPÉCIAUX PARUS CETTE ANNÉE DANS (E)HOSPITAL

Cette année, nous avons publié des suppléments dans chaque numéro de *(E)Hospital*. Nous espérons qu'ils ont su éveiller votre intérêt et nous souhaiterions profiter de cette occasion pour clarifier leur objet.

Toute l'équipe de *(E)Hospital* est consciente que les directeurs d'hôpitaux ne doivent pas se laisser distancer en regard des dernières innovations et de l'actualité de chaque spécialité médicale ; c'est la meilleure façon pour eux de comprendre les besoins et les enjeux

qui se présentent dans chaque service que compte leur établissement. Nous savons que le secteur de la santé est en constante évolution : chaque jour des études sont publiées et régulièrement de nouvelles technologies sont lancées sur le marché. C'est pour cette raison que nous avons publié, cette année, des suppléments spéciaux à raison de deux exemplaires par numéro : l'un est destiné à votre propre usage et l'autre peut être donné à la personne de votre entourage qui est le plus concernée.

Nous espérons que les informations contenues dans ces suppléments vous aideront à suivre les derniers développements qui touchent les services de votre établissement et à prendre les meilleures décisions pour votre hôpital et pour ses patients.

Nous accueillons toutes vos remarques concernant leur contenu et vos suggestions de sujets à traiter en 2013. Veuillez pour cela vous adresser à notre directrice de la rédaction, Lee Campbell, par email à lee@myhospital.eu.



Quel est le prix à payer pour la qualité des soins ?

Par Willy Heuschen

La gestion de la qualité a toujours été une priorité pour l'Association Européenne des Directeurs d'Hôpitaux (AEDH) ; la promotion de la compétence et de la responsabilité ainsi que le renforcement de la coopération entre les directeurs d'hôpitaux européens relèvent effectivement de nos missions essentielles. Grâce au lien étroit que nous entretenons avec les directives de santé européennes, nous appelons à une normalisation positive des niveaux de soins des États membres, qui pourrait être définie, par exemple, par la création d'un « modèle européen d'accréditation ». Car il s'agit bien là, autre mission qui nous est essentielle, d'encourager une plus grande coopération et un échange de bonnes pratiques entre les systèmes de santé des différents pays pour parvenir à une Europe plus sociale.

Tous les établissements de soins de santé européens sont concernés par cette échéance imminente : l'entrée en vigueur de la directive européenne 2010/32/UE du Conseil du 10 mai 2010 portant application de l'accord-cadre relatif à la prévention des blessures par objets tranchants dans le secteur hospitalier et sanitaire. Son application, prévue pour le 11 mai 2013, obligera les employeurs à prendre des mesures proactives en faveur de la sécurité et de la qualité dans leur établissement et à fournir à leurs employés de meilleures conditions de travail afin d'éviter tout risque auxquels ils pourraient être exposés, pour eux-mêmes et pour leur patients. Cela contribuera à réduire le nombre impressionnant de blessures par objets tranchants – il est estimé à un million chaque année en Europe – et à améliorer la qualité globale des soins dispensés dans nos hôpitaux. Si nous ne pouvons pas nous réjouir que la reconnaissance officielle des blessures par objets tranchants soit devenue une préoccupation majeure dans toute l'Europe, nous ne pouvons pas ignorer la pression financière qui s'exerce déjà sur la plupart de nos membres.



Assurer la sécurité dans les blocs opératoires : la méthode italienne

Par Salvatore Paolo Cantaro, Salvatore Scarlata

Comme la plupart des pays européens, le ministère de la Santé italien a reconnu l'importance d'une évaluation de la qualité et de la sécurité à tous les niveaux du système qui prendrait en compte les attentes des patients et renforcerait le rôle et la responsabilité des professionnels de santé. Un groupe de travail ministériel consacré à la sécurité des patients a ainsi été créé afin d'agir sur la sécurité au bloc opératoire en s'appuyant sur des initiatives d'orientation et de sensibilisation lancées par l'OMS (en particulier le programme « Safe Surgery Saves Lives »).

L'activité chirurgicale étant à l'origine d'un grand nombre d'erreurs, elle représente un défi qui est devenu une priorité pour les hôpitaux. Suite à la survenue en Italie de plusieurs événements indésirables graves dans les blocs opératoires, le ministère italien de la Santé a fait du lancement d'une campagne de grande ampleur visant à sensibiliser les professionnels de la santé sur la question de la sécurité chirurgicale l'une de ses priorités essentielles. C'est à cette fin qu'a été créé un manuel pour la sécurité au bloc opératoire s'inspirant

des directives éditées par l'OMS pour réduire les risques chirurgicaux. Basé sur seize points qui permettent d'assurer la sécurité des processus avant, pendant et après l'opération, dix d'entre eux proviennent des lignes directrices et de la liste de contrôle publiées par l'OMS. Cette version augmentée a été élaborée et mise en œuvre dans les hôpitaux du pays ; elle était accompagnée d'une vidéo proposant un complément d'information.



Le volume d'un hôpital a-t-il une influence sur les processus de soins et sur la survie à 5 ans après un cancer du sein ?

Par France Vrijens, Sabine Stordeur

Il a été régulièrement démontré au cours des dix dernières années que le taux de survie était plus élevé après un diagnostic de cancer du sein si la personne recevait des soins dans un hôpital à volume élevé d'activité plutôt que dans un hôpital à faible volume d'activité. En revanche, les études portant sur les dissemblances entre les processus de soins établis dans ces différents établissements sont moins fréquentes. En Belgique, un ensemble de onze indicateurs a été récemment élaboré, testé et approuvé pour évaluer la qualité du traitement du cancer du sein. S'appuyant sur les travaux antérieurs, l'étude actuelle menée en Belgique visait à comparer la survie globale et ces onze critères attachés aux processus de soins, en fonction du volume de l'hôpital.

Cette étude a démontré que les femmes atteintes d'un cancer du sein invasif traitées dans des structures à très faible volume d'activité (moins de 50 patients par an) et à faible volume d'activité (50 à 99 patients par an) avaient un risque plus élevé de décès dans les 5 ans après le diagnostic que les femmes traitées dans des hôpitaux à volume élevé d'activité (plus de 150 patients par an). Le risque de mortalité était plus élevé dans les structures à très faible volume d'activité (26 %) que dans celles à faible volume d'activité (15 %). En plus de la relation entre le volume de l'hôpital et la survie, cette étude a démontré que l'application des processus fondés sur des analyses statistiques et scientifiques varie considérablement en fonction du volume de l'hôpital. Sur les onze processus étudiés, six étaient préférentiellement et plus souvent réalisés dans les hôpitaux à volume élevé d'activité.



Le rôle croissant de l'oncologie interventionnelle dans le traitement multidisciplinaire du cancer

Par Małgorzata Szczerbo-Trojanowska, Adam McLean.

La radiologie interventionnelle a déjà une place bien établie en oncologie et sa contribution au traitement du cancer ne cesse de croître. Lorsque les interventions minimalement invasives guidées par l'image ont débuté, elles avaient un rôle accessoire en oncologie ; le traitement des complications du cancer (on peut citer l'embolisation des vaisseaux nourrissant la tumeur) ou la gestion des effets secondaires de la maladie et du traitement (l'hémorragie par exemple). Néanmoins, au cours des dix dernières années, les procédures pour traiter les tumeurs ont été développées et continueront encore de progresser.

L'oncologie interventionnelle, de plus en plus reconnue comme la quatrième option thérapeutique dévolue au traitement du cancer, décrit l'éventail des procédures offertes par la radiologie interventionnelle dans le domaine de l'oncologie : elle comprend de nombreux traitements palliatifs et d'appoint comme l'ablation, l'embolisation, la chimio-embolisation et la radio-embolisation. L'innovation et l'évolution sont caractéristiques de la radiologie interventionnelle en général, et ce n'est pas moins vrai pour la spécialité en pleine expansion qu'est l'oncologie interventionnelle : elle bénéficie non seulement des progrès des techniques d'imagerie et interventionnelles, mais aussi des efforts enthousiastes pour faciliter la collaboration multidisciplinaire.

► **Un logiciel de pathologie numérique pour améliorer le diagnostic et la thérapie du cancer du sein**
Par Manfred Dietel, Frederick Klauschen

Le traitement du cancer du sein étant dépendant, pour le diagnostic et la décision thérapeutique, de l'évaluation qui est faite par des biomarqueurs, les soins qui sont réalisés peuvent être considérés comme un bon exemple de médecine personnalisée. Anatomopathologistes et cliniciens se mettent d'accord pour dire qu'il existe actuellement un besoin croissant d'outils fiables de quantification par des biomarqueurs capables d'appuyer les décisions thérapeutiques. L'emploi d'un logiciel pour automatiser l'analyse d'images à partir de coupes histologiques, en fournissant un aperçu de la caractérisation génétique fonctionnelle et moléculaire des tumeurs, peut aider les médecins à appréhender le cancer du sein – et d'autres types de cancer. L'hôpital de la Charité, à Berlin, travaille sur un tel projet. Il se propose de fournir aux anatomopathologistes l'accès à une information fiable, objective et standardisée capable d'éclairer les décisions thérapeutiques dans le traitement du cancer du sein.

► **Les services de sous-traitance pour les soins de santé : normes techniques, innovation, Horizon Scanning et benchmark**
Par Ugo Luigi Aparo, Gianfranco Finzi, Barbara Gozzi

Voici une étape supplémentaire dans le processus entamé avec la parution de la « Capitolato Tecnico del Servizio di Sanificazione Ambientale in Sanità » – une liste de spécifications et d'outils à utiliser pour l'élaboration et la souscription de contrats portant sur le respect de l'environnement dans les établissements de soins de santé présentée lors du 37ème Congrès national A.N.M.D.O. qui s'est tenu à Bologne en 2011.

Parmi ses objectifs, elle souhaite la participation active des principaux sous-traitants exerçant dans les services de soins de santé, ce qui lui permettrait de définir les normes techniques, de diffuser les bonnes pratiques et d'identifier et de tester des solutions innovantes. Une attention particulière est consacrée à la place de ces services de sous-traitance au sein de l'effort qui nous est demandé pour le développement durable.

Les informations et les connaissances qui ont été collectées et confirmées sont partagées et diffusées sur un site Internet dédié,

www.standardsanificazione.it, et publiées dans les revues scientifiques. Le site offre une plate forme de communication et de dialogue interactif entre, d'une part, l'équipe du projet et d'autre part les différents personnels responsables de l'entretien des établissements de santé et les experts techniques.

► **Gros plan sur la Slovaquie**



Le système de santé slovaque subit depuis l'année 1990 un processus de transformation. Après les élections de 2004, alors qu'une « marchandisation » des soins de santé avait été annoncée et avait alors soulevé une grande opposition, il a connu des moments difficiles.

La Slovaquie possède 147 établissements hospitaliers de soins de santé (certains d'entre eux combinés avec des services d'aide sociale) et 35 520 lits. Ces chiffres sont très souvent sujets à variation à chaque transformation effectuée sur le système de santé : réduction du nombre de lits dans les hôpitaux, transformation des lits de soins intensifs en lits d'hospitalisation, ou réduction du nombre de soins effectués à l'hôpital, certains actes de chirurgie étant effectués en hospitalisation de jour, en soins ambulatoires ou à domicile. Le financement du système de soins de santé en Slovaquie est entièrement effectué par le système d'assurance maladie, mais le budget pour les investissements des hôpitaux publics (bâtiments, équipements coûteux) est à la charge de l'État.

L'Association des hôpitaux slovaques a été créée en 1991 avec pour objectif de défendre les intérêts communs des gestionnaires d'hôpitaux, de leur fournir un soutien mutuel, ainsi qu'une plate forme d'échange d'informations et de bonnes pratiques. L'Association des hôpitaux slovaques est une association réunissant des personnes morales et des établissements médicaux, hôpitaux ou autres, actifs sur le territoire slovaque. Elle assure le soutien de l'employeur, est apolitique et indépendante. En 1994, elle est devenue un membre permanent de l'AEDH.



Nikolaus Koller

ZEIT, UNSEREN GESICHTSPUNKT DER SICHERHEIT ZU ÄNDERN

Ein Magazin, das sich der Gesundheit und deren Managerstrukturen verschrieben hat, kommt nicht um jenes Thema der Patienten- und Arbeitsplatzsicherheit herum. In Zeiten der wirtschaftlichen Krisen und der Einsparungen werden diese Themen oft vergessen oder vernachlässigt. Dabei sollte man sich über die Sicherheit der Patienten und der Mitarbeiter immer Gedanken machen und nach innovativen und neuen Sicherheitsmaßnahmen Ausschau halten.

Fehler passieren immer wieder und zwar in allen Bereichen des menschlichen Miteinanders. Kleine Fehler werden meist übersehen oder es wird ihnen keine größere Bedeutung geschenkt. Erst wenn sich daraus eine Katastrophe ergibt, wird der Mensch handeln. Ende des Jahres 1999 veröffentlichte das amerikanische Institut of Medicine to Err is Human den Report: Building a Safer Health System. Kein weiterer Report hat für mehr Aufmerksamkeit gesorgt als dieser: Die veröffentlichte Studie der Harvard Medical Practice Study stellte fest, dass jährlich 44.000 – 98.000 Amerikaner aufgrund medizinischer Fehler versterben. Die Zahl der Todesfälle war so groß, als ob in den USA pro Tag ein Jumbojet abstürzen würde. Bis zur Veröffentlichung dieses Reports wurde im Bereich der Patient Safety kaum etwas unternommen. Erst nach und nach wurden Maßnahmen, Strategien entwickelt und ein Risikomanagement etabliert. Mittlerweile gibt es weltweit fest definierte Risikofaktoren, die High Five Recommendations of the WHO.

Neben der Patientensicherheit steht auch immer die Sicherheit des eigenen Personals im Vordergrund. Rechtlich festgelegte Vorschriften werden als Garantie für die Sicherheit am Arbeitsplatz festgelegt und zwingend umgesetzt. Dennoch passieren auch hier immer wieder Unfälle, angefangen von möglichen Nadelstichen und daraus entstehenden Infektionen, bis hin zu schweren Verletzungen durch menschliche Unachtsamkeit oder Fahrlässigkeit.

Für die Wahrung der Sicherheit gibt es Definitionen und Regeln, die wichtig sind. Dennoch gilt es hier auf mehrere Faktoren zu achten wie einer einzigartigen interdisziplinären Anstrengung mit neuartigen Interaktionen zwischen Ärzten, Krankenschwestern, Pharmakologen und der Verwaltung. Althergebrachte rigide Hierarchien sollen aufgegeben werden, ohne die Wichtigkeit guter Mitarbeiterführung zu vergessen. Ein etabliertes und gut geführtes Risikomanagement ist ein Muss in einem hervorragend geführten Unternehmen des Gesundheitswesens.

In dieser Ausgabe 4 konzentrieren wir uns aber nicht nur auf die Sicherheit von Patienten und Mitarbeitern im Gesundheitswesen, sondern legen unseren Fokus auch auf das immer wichtiger werdende Thema dem „Umgang mit der stetig wachsenden Patientenpopulation“. Durch die jetzige und zukünftige demographische Entwicklung ist ersichtlich, dass der Gesundheitssektor sich öfter mit älteren und somit auch kränkeren Menschen beschäftigen wird, als es heute und gestern noch war. Neben den altersbedingten Krankheitsbildern muss man hier aber auch immer stärker auf die verschiedensten ausgeprägten Krebserkrankungen oder Autoimmunerkrankungen denken. Wie wir uns auf diese Entwicklung einstellen und vielleicht sogar umstellen müssen, wird in dieser Ausgabe beschrieben. (So glauben wir!)

Des Weiteren wird in dieser Ausgabe der Länderfokus auf die Slowakei gelegt, welches über ein beitragsfinanziertes Pflichtversicherungssystem verfügt. So sind alle Einwohner bei einer der fünf gesetzlichen Krankenkassen pflichtversichert, welche durch Aufsichtsgremien kontrolliert werden. Interessant hierbei ist, dass Patienten sich für ein halbes Jahr an ihren Primärarzt (Allgemeinärzte, Kinderärzte, Gynäkologen und Zahnärzte) binden müssen.

Nikolaus Koller



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.

KRANKENHAUSMANAGEMENT IN KRISENZEITEN: EINSCHRÄNKUNGEN, HERAUSFORDERUNGEN UND CHANCEN

Die EVKD ist hocherfreut, den 24. EVKD-Kongress anzukündigen, der vom 28.-30. November 2013 in Luxemburg stattfinden wird.

Einmal mehr werden über 600 Krankenhausmanager aus ganz Europa zusammenkommen, um ihre Erfahrungen und Best Practices mit ihren Kollegen auszutauschen und weiterzugeben. Der Fokus des Kongresses 2013 liegt auf dem Umgang mit wirtschaftlichen Einschränkungen und wie man diese in Chancen verwandeln kann. Wir werden

analysieren, wie Krankenhäuser auch in Zeiten wirtschaftlicher Unsicherheit und Etatkürzungen weiterhin die Qualität der Betreuung verbessern können. Der Kongress setzt hierbei wie immer auf praktische Erfahrungsberichte mit Präsentationen, Diskussionen am Runden Tisch sowie Postersitzungen. Die wichtigsten Themenbereiche sind:

- Strategische Richtlinien in der Krise
- Die Umstrukturierung betrieblicher Abläufe und

- Neue Gebäude, neue Logistiklösungen, neue Technologien.

Wir haben zudem ein abwechslungsreiches gesellschaftliches Programm zusammengestellt, das einen von der Stadt Luxemburg ausgerichteten Empfang und ein Galadinner am letzten Abend umschließt.

Mehr Informationen zum Kongress finden Sie auf

www.eahm-luxembourg2013.lu

42. ORDENTLICHE MITGLIEDERVERSAMMLUNG

abzuhalten am Freitag, den 16. November 2012, von 17.00-18.30 Uhr im Congress Center, Eingang Ost (Ost), Raum M

Tagesordnung:

Zur Beschlussfassung

1. Genehmigung der Tagesordnung
2. Genehmigung des Sitzungsprotokolls der 41. Mitgliederversammlung vom 18. November 2011 in Düsseldorf, Deutschland
3. Bericht des Präsidenten zur Tätigkeit der EVKD 2011-2012

4. Rechnungslegung des Jahres 2011

- 4.1. Erläuterungen durch den Generalsekretär der EVKD
- 4.2. Prüfungsbericht der Rechnungsprüfer
- 4.3. Genehmigung der Rechnungslegung 2011 und Entlastung des Präsidiums und des Generalsekretärs
5. Wirtschaftsplan für das Jahr 2013
- 5.1. Genehmigung der Beitragsordnung der ordentlichen

und assoziierten Mitglieder (Art. 4.3.e der Statuten)

- 5.2. Genehmigung des Wirtschaftsplanes für das Jahr 2013
6. Wahl der Wirtschaftsprüfer für das Jahr 2012
7. Aufnahme neuer Mitglieder
8. Nächste Ordentliche Mitgliederversammlung 2013

Weitere Informationen

- 9.24. EVKD Congress (2013), Luxemburg: Präsentation des Hauptthemas
10. EVKD Partnerschaften: Arcadis

FACHWISSENSCHAFTLICHE BEILAGEN IN (E)HOSPITAL

In diesem Jahr haben wir jeder Ausgabe des *(E)Hospital* fachwissenschaftliche Beilagen beigelegt. Wir hoffen, dass diese auf Ihr Interesse gestoßen sind und möchten die Gelegenheit nutzen, ihren Zweck zu verdeutlichen.

Das Team von *(E)Hospital* weiß: Krankenhausmanager müssen hinsichtlich der aktuellsten Innovationen und Neuigkeiten im Bereich sämtlicher Fachrichtungen am neusten Stand sein, um die Bedürfnisse und Herausforderungen jeder Krankenhausabteilung besser ein-

schätzen zu können. Wir sind uns im Klaren darüber, dass der Gesundheitssektor konstanten Änderungen unterworfen ist, dass Forschungsstudien auf täglicher Basis veröffentlicht werden und neue Technologien fortwährend auf den Markt kommen. Dies ist der Grund dafür, dass wir mit jeder Ausgabe auch fachwissenschaftliche Beilagen veröffentlicht haben. Zwei Kopien sind inbegriffen: Eine Beilage für den Eigengebrauch, und eine Ausziehkopie für einen interessierten Kollegen.

Wir hoffen, dass die in den Beilagen

enthaltene Information dabei hilft, Sie bezüglich der aktuellsten Entwicklungen in jeder Krankenhausabteilung auf dem Laufenden zu halten, und Sie dabei unterstützt, für Ihr Krankenhaus und seine Patienten die richtigen Entscheidungen zu treffen.

Wir freuen uns über alle inhaltlichen Rückmeldungen sowie über Vorschläge für zukünftige Themenbereiche für 2013. Bitte wenden Sie sich diesbezüglich an Redaktionsleiterin Frau Lee Campbell unter lee@myhospital.eu.

▶ **Wie hoch der Preis der qualitativen Gesundheitsversorgung?**

Von Willy Heuschen

Qualitätsmanagement ist schon seit langem eine Priorität für die Europäische Vereinigung der Krankenhausmanager (EAHM), da dies innerhalb der Kernaufgabe der Vereinigung liegt, die Kompetenz und Verantwortlichkeit sowie die bessere Zusammenarbeit von Krankenhausmanagern in ganz Europa zu fördern.

Aufgrund unserer engen Verbindung zu gesundheitspolitischen Themen innerhalb der EU fordern wir eine positive Standardisierung der Versorgungsstufen in allen Mitgliedstaaten, die beispielsweise durch die Erstellung eines „Europäischen Akkreditierungsmodells“ definiert wäre. Dies bezieht sich auf unsere zweite Kernaufgabe: der Förderung einer besseren Kooperation und Austausch von Best Practices zwischen den Gesundheitssystemen der verschiedenen Länder, um ein Soziales Europa herbeizuführen.

Ein rasch näher rückender Stichtag für alle Gesundheitsorganisationen in Europa ist das Inkrafttreten der Richtlinie des Europäischen Rats 2010/ 32/EU über die Vermeidung von Verletzungen durch scharfe/spitze Instrumente im Krankenhaus und im übrigen Gesundheitssektor. Geplant für den 11. Mai 2013 wird das neue Gesetz Arbeitgeber dazu verpflichten, aktive Maßnahmen für die Sicherheit und Qualität in ihren Organisationen durchzuführen und ihren Angestellten die bestmöglichen Arbeitsbedingungen zu bieten, um jegliches Risiko für sie und somit ihre Patienten zu vermeiden. Dies wird dazu beitragen, die erschütternde Zahl von einer Million Verletzungen durch scharfe/spitze Instrumente zu vermindern, die nach Schätzungen jedes Jahr in Europa vorfallen, und generell die Qualität der Versorgung in unseren Krankenhäusern zu verbessern. Während wir uns über die offizielle Anerkennung der Verletzungen durch scharfe/spitze Instrumente freuen können, ist es dennoch unmöglich, gleichzeitig die finanziellen Belastungen zu ignorieren, der sich unsere Mitglieder ohnehin schon täglich gegenüber sehen.

▶ **Sicherheit im OP: der italienische Ansatz**

Von Salvatore Paolo Cantaro, Salvatore Scarlata

Wie die meisten Europäischen Länder hat auch das italienische Gesundheitsministerium die Wichtigkeit erkannt, die Qualität und Sicherheit auf allen Systemstufen zu evaluieren, unter Berücksichtigung der Erwartungen der Patienten und Förderung der Rolle und Verantwortung von im Gesundheitssystem Tätigen. Eine ministerielle Arbeitsgruppe ist für die Patientensicherheit zuständig und betont dabei vor allem die Sicherheit im OP. Hintergrund sind hier die von der WHO lancierten Richtlinien und Initiativen der Bewusstseinsbildung (hier insbesondere das Programm ‚Safe Surgery Saves Lives‘).

Die chirurgische Tätigkeit ist mit einer sehr hohen Fehlerwahrscheinlichkeit behaftet und stellt somit eine Herausforderung und eine Priorität für alle Krankenhäuser dar. Aufgrund mehrerer schwerer Ereignisse, die in italienischen OPs vorgefallen sind,

hielt es das italienische Gesundheitsministerium für unerlässlich, eine große Kampagne zu starten, um das Bewusstsein für Sicherheit im OP unter Ärzten und anderem medizinischen Personal zu stärken. Diesbezüglich wurde ein Handbuch für Sicherheit im OP erstellt, das sich von den WHO Richtlinien für Chirurgie ableitet und sich auf 16 Vorgänge für die Sicherheit des perioperativen Vorgangs konzentriert, einschließlich 10 Richtlinien, die aus dem zitierten WHO Dokument stammen. Eine erweiterte Version der WHO Checkliste wurde formuliert und landesweit in den Krankenhäusern implementiert. Um die neue Vorgangsweise weiter zu fördern wurde zudem ein Video mit zusätzlichen Erklärungen verteilt.

▶ **Wie wirkt sich die Krankenhausgröße auf Betreuungsvorgänge und das 5-Jahres-Überleben bei Brustkrebs aus?**

Von France Vrijens, Sabine Stordeur

In großen Krankenhäusern gibt es eine höhere Überlebensrate nach Brustkrebs-Diagnose als in kleineren Häusern – dieser Zusammenhang wurde in den letzten zehn Jahren regelmäßig unter Beweis gestellt. Weniger häufig werden Studien über die Unterschiede der Betreuungsvorgänge zwischen kleinen und großen Spitälern durchgeführt. In Belgien wurde kürzlich ein Satz von elf Prozess-Indikatoren aufgestellt, getestet und validiert, um die Qualität der Behandlung bei Brustkrebs zu bewerten. Aufbauend auf früheren Arbeiten zielt die vorliegende Studie darauf ab, das Gesamtüberleben und 11 Betreuungsvorgänge je nach Krankenhausgröße in Belgien zu vergleichen.

Die vorliegende Studie zeigte, dass Frauen mit invasivem Brustkrebs, die in sehr kleinen Krankenhäusern (<50 Patienten pro Jahr) bzw. kleinen Krankenhäusern (50-99/Jahr) behandelt wurden, ein höheres Sterberisiko innerhalb von fünf Jahren nach Diagnose hatten, als Frauen in großen Krankenhäusern (≥150/Jahr). Das erhöhte Mortalitätsrisiko war höher bei sehr kleinen Krankenhäusern (26%) als bei kleinen Krankenhäusern (15%). Zusätzlich zur Beziehung zwischen Krankenhausgröße und Überleben zeigte unsere Studie zudem große Unterschiede in der Anwendung Evidenz-basierter Vorgänge zwischen den Krankenhäusern, wiederum je nach Größe. Von den elf untersuchten Vorgängen wurde sechs häufiger in den großen Krankenhäusern durchgeführt.

▶ **Die wachsende Rolle der Interventionellen Onkologie in der interdisziplinären Krebsbetreuung**

Von Małgorzata Szczerbo-Trojanowska, Adam McLean

Die Interventionelle Radiologie (IR) ist innerhalb der Onkologie gut etabliert und ihr Beitrag in der Betreuung von Krebskranken nach wie vor im Ansteigen begriffen. Die minimal-invasiven bildgeführten Interventionen hatten zunächst eine Hilfsrolle in der Onkologie, so etwa die Behandlung von karzinogenen Komplikationen (z.B. Öffnen ver- schlossener Ducti und Gefäße) oder das Management von Neben-

wirkungen von Krankheit und Behandlung (z.B. Blutung). In den letzten zehn Jahren kam es jedoch auch zur Entwicklung von Modalitäten zur Behandlung der Tumore selbst.

Die Interventionelle Onkologie wird zunehmend als vierter Arm der Krebsbehandlung anerkannt, und beschreibt die Palette der Verfahren der IR im Bereich der Onkologie. Diese Palette umfasst viele palliative und adjunktive Therapien wie etwa Ablation, Embolisierung, Chemo-Embolisierung und Radio-Embolisierung. Innovation und Entwicklung sind generell Merkmale der IR und dies gilt ebenso für die Interventionelle Onkologie; ein Fachbereich in Expansion, nicht nur dank der Fortschritte bei Bildgebung und interventionellen Verfahren, sondern auch aufgrund der intensiven Anstrengungen in der Unterstützung der interdisziplinären Zusammenarbeit.

Digitale Pathologie-Software verbessert Brustkrebsdiagnose und -therapie

Von Manfred Dietel, Frederick Klauschen

Bei Brustkrebs hängen Diagnose und therapeutische Entscheidungen stark von der Evaluierung von Biomarkern ab – ein perfektes Beispiel für die personalisierte Medizin. Pathologen und Mediziner verweisen nun auf einen immer größeren Bedarf für genaue Werkzeuge der Biomarker-Quantifizierung, die diese Behandlungsentscheidungen unterstützen können. Die entsprechende Software zur Automatisierung der Bildanalyse bei histologischen Schnitten liefert Einblicke in die funktionellen und molekulargenetischen Merkmale des Tumors und kann somit dem Arzt ein besseres Verständnis für Mamma- und andere Karzinome liefern. Die Charité Berlin arbeitet an einem solchen Projekt, das Pathologen Zugang zu verlässlicher, objektiver und standardisierter Information liefern soll und somit therapeutische Entscheidungen bei Brustkrebs beeinflussen kann.

Auslagern von Dienstleistungen im Gesundheitswesen: technische Standards, Innovation, Früherkennung und Benchmarking

Von Ugo Luigi Aparo, Gianfranco Finzi, Barbara Gozzi

Die Aktivität stellt einen weiteren Schritt in einem Prozess dar, der mit der Aktualisierung des „Capitolato Tecnico del Servizio di Sanificazione Ambientale in Sanità“ begann – einer Liste von Spezifikationen und Werkzeugen, die für die Definition und Zeichnung von Verträgen in Verband mit Umwelthygiene im Gesundheitswesen eingesetzt werden soll und am 37. A.N.M.D.O Nationalkongress in Bologna 2011 vorgestellt wurde.

Zu den Zielen dieser Aktivität zählt die aktive Mitarbeit der wichtigsten Outsourcer in Gesundheitsdiensten, um technische Standards zu definieren, Best Practices zu verbreiten sowie innovative Lösungen zu identifizieren und zu überprüfen. Besondere Aufmerksamkeit erfährt dabei die Umweltassoziierte Nachhaltigkeit der ausgelagerten Dienstleistungen.

Das Teilen und Verbreiten der gesammelten und validierten Information und Wissen wird durch die Veröffentlichung auf der entsprechenden Website www.standardsanificazione.it sowie in

Wissenschaftsmagazinen erreicht. Die Website bietet interaktive Kommunikationsmöglichkeiten sowie den Dialog zwischen dem Projektteam und der weiten Bandbreite von Akteuren des Gesundheitssystems sowie technischen Experten.

Fokus: Slowakei



Das slowakische Gesundheitssystem befindet sich seit 1990 in einem Umbauprozess. Nach den Wahlen 2004 durchlief das System eine turbulente Veränderungsphase, da der Versuch der Einführung der Marktwirtschaft in der Gesundheitsversorgung auf starken Widerstand stieß. In der Slowakei gibt es 147 stationäre Gesundheitseinrichtungen (manche von ihnen kombiniert mit sozialen Betreuungseinrichtungen) mit insgesamt 35.520 Betten. Diese Zahlen sind aufgrund der Transformation des Gesundheitssystems konstanten Änderungen unterworfen (Reduktion der Anzahl der Krankenhausbetten, Umwandlung akuter Betten in chronische Betten, Verminderung der stationären Betreuung mit Umwandlung in Ein-Tages-Praxen oder in ambulante bzw. häusliche Betreuung). In der Slowakei erfolgt die Finanzierung des Gesundheitssystems ausschließlich über das Krankenversicherungswesen, das Budget für Investitionen (Gebäude, kostenintensive technische Ausrüstung) der staatlichen Krankenhäuser wird aus dem Staatsbudget gespeist.

Die Vereinigung der Slowakischen Krankenhäuser (ANS) wurde 1991 gegründet, mit dem Ziel, die gemeinsamen Interessen der Krankenhausmanager zu vertreten, sich gegenseitige Unterstützung zu bieten sowie Information und Best Practices auszutauschen. Die ANS ist eine freiwillige, Arbeitnehmer-gerichtete, apolitische und unabhängige Interessensvertretung für juristische Personen, stationäre Krankenhäuser oder andere medizinische Einrichtungen, die innerhalb des Territoriums der Slowakischen Republik aktiv sind und medizinische Versorgung anbieten. 1994 wurde die ANS ständiges Mitglied der EAHM.

December

ICI Meeting 2012 2-4
Tel-Aviv, Israel
www.icimeeting.com

The World Congress Leadership Summit on Physician Liaisons 4-5
Philadelphia, USA
www.worldcongress.com

The 3rd Annual World Health Care Congress Middle East 9-11
Abu Dhabi, United Arab Emirates
www.worldcongress.com

Amsterdam Endoscopy 2012 19-20
Amsterdam, The Netherlands
www.amsterdamendoscopy.com

January 2013

MIR Winter Course 10-12
Seefeld, Austria
mir-online.org

Critical Care Congress (SCCM) 19-23
San Juan, Puerto Rico
www.sccm.org

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- ▶ Putting the Cross Border Healthcare Directive in Hospital Practice:
How to Manage Quality ? (EAHM seminar 2012)
- ▶ Business Performance- Optimising Efficiency
- ▶ Integrating New Technologies
- ▶ Supplement: Information Technology
- ▶ Focus: Romania

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