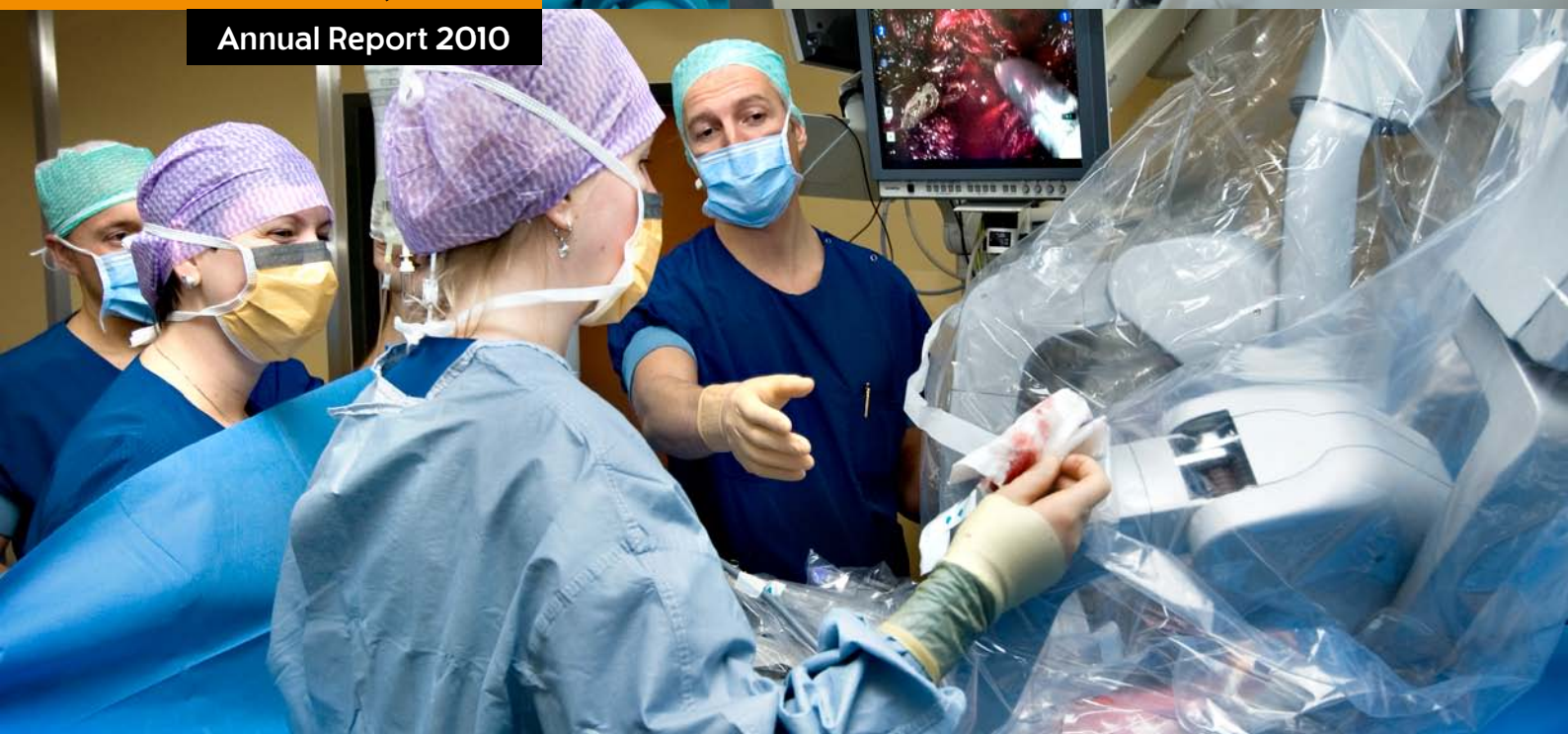
MAASSTAD ZIEKENHUIS

Everyone's hospital

Annual Report 2010



MAASSTAD ZIEKENHUIS

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Everyone's hospital

Content

MAASSTAD ZIEKENHUIS

Foreword by the Supervisory Board

Helping more patients with better quality care at lower costs is and will remain a continual challenge for hospitals. In the past five years Maasstad Hospital has shown that this is possible. Five years ago such a thing would have been hard to imagine.

At the time the gap between the actual position of the former MCRZ and the ambition expressed at the New Year meeting of 2005 to 'be among the top 10 in 2010' seemed unbridgeable. In 2010 we continued the positive trend of growth and development already noted in 2009 and a leading position in the Hospitals Top 100 of AD and Elsevier confirmed that our hospital is working on the right things.

Nevertheless, there are still enough challenges, for more production (about 15%) should still be possible through further synchronisation of the existing capacity. That does call for more flexibility in the steering of organisational units, in order to create a still better mix of result orientation and people orientation. That is and will remain an enormous challenge for the management of the hospital.

From 2011 we will start to close the economic and health gap in South Rotterdam, together with the partners on the Care Boulevard. We can also develop further regional cooperation in a number of priority areas. After all, strengthening and expanding the network with regional hospitals is an interesting option for further improvement and modernisation of hospital care in the south-western Netherlands.

2011 will be an exciting year, firstly, because at last, ten years after the merger of the Zuiderziekenhuis and the St. Clara hospitals, the main objectives of the merger have been facilitated with the move to the new building and the attainment of (affiliate) membership of the Association of Tertiary Medical Teaching Hospitals (STZ). Secondly, we will have had to find a mode to continue growth and development, while external pressure will increase demands for cost reductions and improvements in efficiency and effectiveness. A condition for this is a permanent association between the medical staff and the organisation. After all, without specialists there will be no patients and without patients there will be no hospital. The partnership between medical specialists and the organisation must increasingly become a key focus for the management of Maasstad Hospital.

The ultimate aim is to make the health value of our treatments increasingly transparent for patients, referring physicians and care insurers. The envisaged image of Maasstad Hospital is that of a provider of high-quality health care within the government financing structure. This value concept will be for health care what shareholder value is for the private sector.

MAASSTAD ZIEKENHUIS

The Supervisory Board thanks the staff and specialists of the hospital for their efforts.

On behalf of the Supervisory Board

A.J. Scheepbouwer
Supervisory Board Chairman
March 2011

Foreword by the Executive Board

Maasstad Hospital is growing, thanks to all of us.

On 24 September 2010 we received the keys to our new hospital at Maasstadweg 21, directly opposite Lombardijen railway station in Rotterdam. In this wonderful new building the staff are working all out in order to be able to open the hospital on 17 May 2011.

Our staff, numbering more than 3,000, are impatient to start work in a fresh, spacious and ultramodern new building. But they have also worked hard in the old buildings in the past year to improve our hospital.

Thanks to those efforts, more and more patients and their referring physicians are opting for our hospital. We achieved reasonable growth in 2010: about 4.2 % more initial outpatient visits and 5.4% more treatments.

The increased appreciation of our hospital was also shown by the AD Hospitals Top 100 in September. Our ranking in this list increased from 35th to 5th place. This excellent result is not a goal in itself for us, but does provide welcome confirmation that we are on the right track.

Better patient care was our primary objective this year. The Theory of Constraints (TOC) is an essential instrument for achieving that goal. In short, this theory means that we assess care processes and eliminate the bottlenecks that arise in these. Waiting times were reduced and patient flow through the care processes accelerated. The deployment of Critical Chain Project Management (CCPM) and the improvement of the reliability of supply in internal services contributed to the improvement of patient care.

We are also working on innovation in medical terms. In some areas we are even leading the field. In our Vascular Centre intervention radiologists and vascular surgeons teamed up in order to be able to help patients with vascular problems faster and more effectively. The development of our Robot Expertise centre also continued unabated. Our urologists and gynaecologists were already using robots for surgery for prostate cancer, kidney tumours and disorders of the womb. In the past year our surgeons also started to deploy robots for operations on intestinal tumours.

One example of the shared desire to improve patient care is the initiative of the intensivists, anaesthesiologists, gynaecologists and paediatricians to sleep on the premises in turns, in order to be able to assists patients quickly when they require emergency care or are in pain. Women in labour can, where necessary, be assisted quickly in this way and can be anaesthetised (epidurals). The differentiated shifts of the surgeons also contribute to the improvement of patient care.

In the spring of 2010 one of our cardiologists made the world's first implant of a new, advanced type of pacemaker. In January 2010 two intensivist cardiologists published a scientific study into stents in the internationally renowned medical journal The Lancet. I am proud of both these achievements.

Important agreements were reached in the field of worker and patient consultation in 2010. On a trial basis from mid-2011 the Nursing Advisory Council (VAR), the Patient Council and the Works Council (OR) will provide the management with replies and advice as a single block, while retaining their own regulations.

We have largely achieved the goals of the strategic long-term plan for 2006 - 2012. However, the bar was set high for our financial objectives in the past year. Partly, because some of our disciplines were struggling with vacancies, we did not entirely achieve the envisaged financial growth. Instead of the ambition of a budget surplus of €6 million we retained nearly €5 million.

In view of the change of government in our country and the long delay, before a new Minister of Public Health, Welfare and Sport took office, 2010 was a tense year for us. The plans of Minister Klink were entirely clear. In line with his guidelines we had therefore already conducted talks with the Netherlands Care Authority and the Ministry of Public Health, Welfare and Sport on a new remuneration system for our physicians, which had reached an advanced stage. Now that Minister Klink's successor, Minister Schippers, appears to wish to continue these ideas, we intend to pursue this issue vigorously in the coming year.

We are also ready for the Cabinet plans that will allow profit distributions in the care sector. In order to raise our complex care services to a level among the best in the Netherlands, whether or not in collaboration with an international partner, we aim to make the hospital a more attractive prospect for external investors. Although the Ministry wishes to temper competition in the care sector temporarily, we will continue to focus on our competitive position.

As already mentioned, we received the keys to our new hospital in September. That brings me to the main risk that our business has run in the past year. Although a modest budget overrun on the investment in the new building was inevitable, the extra investments remained within the limits of the long-term budget.

Our hospital will soon form part of the Rotterdam Care Boulevard, a unique concept in the Netherlands. The Care Boulevard association is an alliance of our Maasstad Hospital, Aafje Care Hotel, the Maternity Care Service for the Rotterdam area, the Delta Psychiatric Centre and the Rijnmond Central GPs Surgery. The initiators work closely together to improve the care and welfare of the residents of Rotterdam South. The health of local residents is relatively poorer than that of the average Rotterdam resident and still poorer than that of the average Dutch citizen. With closely interconnected care processes the initiators will attempt to improve that in the coming years.

In our new hospital, too, we will be working for our patients 24 hours a day, seven days a week. Naturally, we do this by providing the best possible medical care, but also by continuously providing a patient-oriented service every day. After all, patients attach great value to correct and personal treatment. Patients form opinions on the basis of questions such as 'Is the receptionist taking any notice of me? Does the nurse explain why she is giving me certain treatments? Does she comfort me, if

things become too difficult for me? Does she see me as a person? By designing the organisation to focus on this kind of matters, we will be able to treat our patients as 'guests', so that they will have confidence in their treatment.

I hope you will enjoy reading our 2010 Annual Report.

Paul Smits
General Manager, Maasstad Hospital
March 2011

Foreword by Medical Staff

The year 2010 was one in which we focused on safety and quality. Major steps forward were made in the digitisation of our medical records and accounts. An electronic prescription system was introduced, for example, which can reduce the number of medication errors to an absolute minimum. Thanks to the Electronic Patient File (EPD) our physicians can view the files of each other's patients, so that allergies, for example, can no longer be overlooked.

In the Intensive Care department the Safety Management System (SMS) was further implemented in the past year. Treatment of sceptic shock was standardised and we now control catheter sepsis, caused by infection from central venous catheters, more effectively.

We also took steps to improve the continuity and quality of care. Intensivists, anaesthetists, gynaecologists and paediatricians currently sleep at the hospital in turns, so that they can be available in emergencies quickly. Since mid-2010 an internist has always been on duty in the Emergency Care department.

I am also proud of our efforts in the multidisciplinary teams that have been formed in the past year. Vascular surgeons and intervention radiologists have joined forces, as have the cardiologists and radiologists who now jointly assess the magnetic resonance imaging (MRI) and computed tomography (CT) scans of their patients.

Finally, I am enthusiastic about the cooperation with GPs in our region, with whom we exchange knowledge and experience during our upgrading courses. We also started a partnership with the specialists of the neighbouring Ruwaard van Putten Hospital. While the Intensive Care staff were already working closely together in 2009, in 2010, the internists and surgeons of the two hospitals also started to work in partnership.

The medical staff of Maasstad Hospital regard all these alliances as vital to achieving our ambition to become a top referral hospital. Our patients' disorders are becoming increasingly complex. Through the development of knowledge and expertise we will be able to help them more effectively.

Albert Grootendorst
Medical Staff Chairman of Maasstad Hospital
March 2011

Reporting principles

This 2010 Social Responsibility Report (SRR) of the Foundation of Maasstad Hospital Rotterdam incorporates the affiliates MCRZ Holding B.V., MaAssist B.V., Poliklinische Apotheek B.V., Diagnostisch Centrum Rotterdam B.V. (DCR) and Diagnostisch Centrum Skoop B.V. (DC Skoop) in the consolidated statements. This report is part of the 2010 Annual Report, comprising the SRR, the financial statements and the quantitative data. For the financial statements, please see www.jaarverslagenzorg.nl, where these are disclosed. The quantitative data can also be viewed via this site, on the DigiMV web application.

In the SRR we present our performance in the year 2010 as transparently as possible. We do this partly by answering the accounting questions drawn up in compliance with the Admission of Health Care Institutions Act (WTZi) and the 2010 guidelines for annual reporting by health care institutions of the Ministry of Public Health, Welfare and Sport. Combined with the photographs, we hope to present a fine overall picture. In this way, we account to the stakeholders, both internal and external. We also wish to provide the public with an integral view of our organisation and to promote transparency in the health care sector.

The topics covered in this SRR are based on the Global Reporting Initiative, a framework used world-wide within and beyond health care, which is prescribed by the Ministry. In Chapter 2, 'Profile of the Organisation', we describe Maasstad Hospital, discussing the structure, key data and alliances. We then take you to Chapter 3, 'Governance, Supervision, Operations and Employee Representation', in which we present the allocation of tasks and responsibilities within Maasstad Hospital. We also discuss the principles of the Health Care Governance Code and how we dealt with employee representation in 2010. In Chapter 4, 'Policy, Input and Performance', we explain our long-term policy, quality policy and financial policy. With due pride we here describe our efforts and performance for parts of these policy fields. Finally, the last chapter describes our activities in the field of information and communication technology (ICT) and corporate social responsibility (CSR).

NB: The Annex contains a list of abbreviations.

MAASSTAD ZIEKENHUIS


MAASSTAD
ZIEKENHUIS

2 Organisation profile

In this chapter we describe the profile of our organisation. This includes general identification details and the legal and organisational structure of the organisation. We also describe the internal supervision, affiliated parties and finally, our key data.

2.1 General identification details

Contact details	
Maasstad Hospital Foundation	
Address	PO Box 9100
Postal code	3007 AC
Town	Rotterdam, The Netherlands
Telephone number	+31 10 291 19 11
Chamber of Commerce registration number	24299846
E-mail address	info@maasstadziekenhuis.nl
Website	www.maasstadziekenhuis.nl

Locations			
Location	**Street name - number**	**Postal code - town**	**Particulars**
Zuider (acute care)	Groene Hilledijk 315	3075 EA Rotterdam	The sale process has commenced. After the move the location will be shut down as soon as possible.
Clara (elective patient care)	Olympiaweg 350	3078 HT Rotterdam	The sale process has not yet commenced. After the move the location will remain partially operational in early 2011.
New location	Maasstadweg 21	3079 DZ Rotterdam	Location will open on Tuesday, 17 May 2011.
Maasstadhuis	Haastrechtstraat 7	3079 DC Rotterdam	The location is already partially in use. Other departments will move into the building in early 2011.

Affiliates				
Name	**Street name - number**	**Postal code - town**	**Interest**	**Chamber of Commerce registration number**
MCRZ Holding B.V.	Groene Hilledijk 315	3075 EA Rotterdam	100%	24394849
MaAssist B.V.	Groene Hilledijk 315	3075 EA Rotterdam	51%	24456370
Poliklinische Apotheek B.V.	Olympiaweg 350	3078 HT Rotterdam	90%	24428155
Diagnostisch Centrum Rotterdam B.V.	Vasteland 10	3011 BL Rotterdam	30%	24422431
Diagnostisch Centrum Skoop B.V.	Laan van Bol'Es 3	3122 AE Schiedam	65%	24450390
Care Boulevard B.V.	Paul Krugerstraat 181	3072 GJ Rotterdam	33%	24433781

2.2 Structure

2.2.1 Legal structure

The Maasstad Hospital Foundation is formally managed by a one-man Executive Board (General Manager Paul M.L. Smits MBA, medical doctor), under the supervision of a Supervisory Board. Mr Smits is the Chairman of a management team with which he manages the hospital.

Certification of the hospital

Maasstad Hospital is certified as a general hospital.

Figuur 1 Organigram Maasstad Ziekenhuis 2010

2.2.2 Organisational structure

See figure 1.

2.2.3 Internal supervision

Internal supervision is performed by the one-man Executive Board and General Manager Paul Smits. Together with the Director of Health Care Alex Dirks, Director of Operations Frank Arnoldy and (from 1 February 2010) Director of Health Care Saskia Baas, he forms the management team (see 3.2 for further details). The management directs the health care and other units and also has a number of hospital-wide portfolios.

Supervisory Board

The performance of the Supervisory Board and the day-to-day management is laid down in regulations. These regulations develop the provisions of the Articles of Association in more detail in agreements between the Supervisory Board and the Executive Board/ management. The core of the agreements in the regulations is:

- Provision for management that performs well (through appointment, assessment and dismissals of managing directors);
- Provision for effective internal supervision (through appointment, assessment and dismissals of (members of the) Supervisory Board);
- Acting as an advisor and sparring partner for the management;
- Performing overall supervision of the policy of the management and the general progress of operations in the institution;
- Approval of strategic management decisions;
- Issuing or cancelling instructions to the external auditors.

Executive Board

Supervision takes place on a structural basis, among other things through a fortnightly Executive Board meeting and a Board Review every four weeks. Decisions are taken in the Executive Board meeting, while during the Board Review, the entire management team spends an entire day checking compliance with agreements reached and whether we are on track or whether intervention is needed. We also check the status of the larger hospital-wide projects. These are the agreements for the 'going concern' and the current projects. After six months we check compliance with agreements reached once again. This control, too, takes place during the Board Review.

Management

The Chairman of the Medical Staff, a member of the Staff Executive, the Medical Affairs Manager and the Marketing, Communication & Sales Manager act as management advisors for decision-making by the Executive Board. The New Construction Manager also consults the Executive Board immediately after the Executive Board Meeting and during the Board Review.

Our hospital has a dual management at the tactical level. This means that the health care units in the organisation fall under the joint responsibility of a health care manager and a medical manager (specialist). The operational departments are under the responsibility of a manager. The managing director responsible has structured monthly meetings with his or her managers and medical managers. The outcome of these meetings serves as input for the Board Review.

2.2.4 Employee representation structure

Maasstad Hospital has four consultation/advisory bodies that represent different interest groups.
These bodies advise the Executive Board on policy and proposed decisions in the hospital, on request or at their own initiative. Their membership and the advisory reports issued are discussed in more detail in paragraphs 3.5 to 3.9.

From 2011, as a trial, the Patient Council, the VAR and the OR will advise the Executive Board as a single party, naturally while retaining their own regulations.

2.2.5 Affiliated parties

Until 31 December 2009 the Maasstad Hospital Foundation was part of the group that was consolidated under the head of the group, Steunstichting MCRZ. Until the end of that year the Maasstad Hospital Foundation published company financial statements, published at www.jaarverslagenzorg.nl.
The structure until that date is shown in the 2009 Annual Report as shown in figure 2.

Consultation/advisory body	Representation of
Patient Council	Patients
OR	Employees
Board of Medical Staff Association	Medical staff
VAR	Nurses and care staff

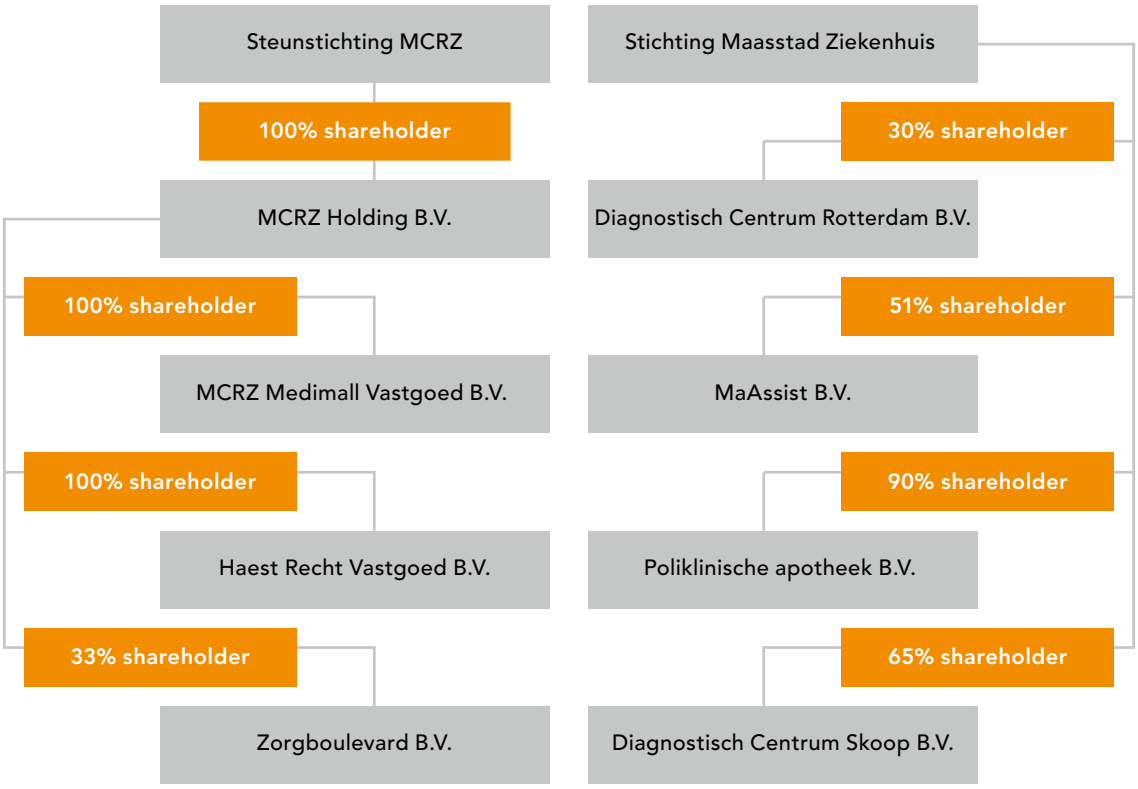


Figure 2 Structure of affiliated parties of Maasstad Hospital Foundation as at 31 December 2009

This structure relating to Steunstichting MCRZ was set up in 2006 to enable the development of the Medimall. In 2007, Maasstad Hospital decided to manage only the construction of the new hospital in-house. The outdoor location and the parking facilities were sold to an external party in 2008. In order to further optimise, complete, operate and manage the Care Boulevard, Zorgboulevard Rotterdam B.V. was formed. MCRZ Medimall Vastgoed B.V. (a wholly-owned subsidiary of MCRZ Holding B.V.) owns one third of this private limited liability development company, while the Vestia Group Foundation and Vitaal Zorgvast B.V. also each own one third.

Following this development the need for a structure around Steunstichting and its private limited liability companies largely disappeared. Consequently, a start was made in 2010 with the liquidation of Haest Recht B.V. and MCRZ Medimall Vastgoed B.V. The liquidation will be completed in the first half of 2011.

Since the sale of the outdoor areas MCRZ Medimall Vastgoed B.V. has no longer represented any value. Haest Recht Vastgoed B.V. owned one building on the Haastrechtstraat in Rotterdam, which was transferred to the Maasstad Hospital Foundation in 2009. The Steunstichting MCRZ was then dissolved and amalgamated with the Maasstad Hospital Foundation. After the dissolution and amalgamation the group has a new head, the Maasstad Hospital Foundation. The current structure is presented in figure 3.

In concrete terms this means that from 2010 the financial statements published for the Maasstad Hospital Foundation at www.jaarverslagenzorg.nl are no longer company financial statements, but the consolidated financial statements. Naturally, the company financial statements are still drawn up. The comparative figures published in this for 2009 are totals of the 2009 company figures for Steunstichting MCRZ and the Maasstad Hospital Foundation. This is a point for attention when the two financial statements are compared.

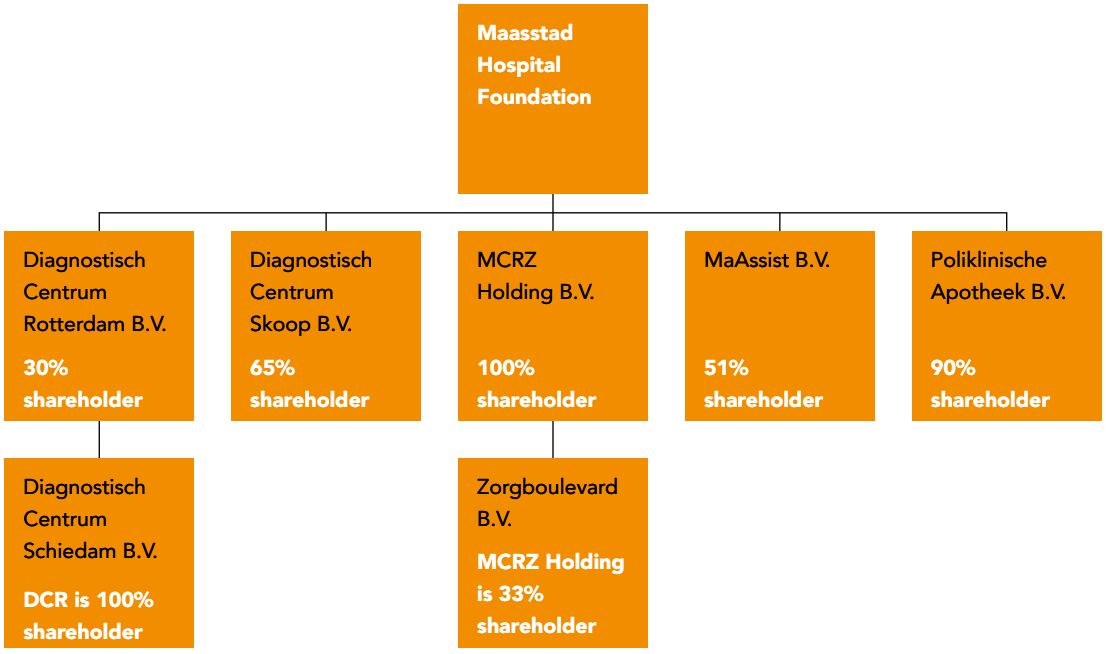


Figure 3 Structure of affiliated parties of Maasstad Hospital Foundation as at 31 December 2010

Not all affiliates of Maasstad Hospital are included in the consolidated statements. A condition for inclusion in the consolidation is that Maasstad Hospital has control over the policy pursued. This applies only for MCRZ Holding, MaAssist B.V. and Poliklinische Apotheek B.V. On the basis of the share capital, consolidation of the Diagnostisch Centrum Skoop B.V. would be expected. In view of the limited size of this private limited liability company and Maasstad Hospital's intention to dispose of 35% of the shares in the near future, this company is not included in the consolidated statements.

The following companies are included in the consolidated statements:

1 **MCRZ Holding B.V.**
MCRZ Holding B.V. was formed on 1 May 2006 with the aim of acting as the holding company for potential affiliates. MCRZ Holding B.V. holds 33 % of the shares of Care Boulevard B.V. The objective of this development company is the further realisation of the Care Boulevard. The Vestia Group Foundation is the ultimate owner and operator of the property.

2 **MaAssist B.V.**
This private limited liability company was formed at the end of March 2009. Maasstad Hospital owns 51% of the shares. The other 49% are owned by Assist Zorgondersteuning B.V. The objective of MaAssist is to provide care support to hospitals, in the first instance to Maasstad Hospital.

3 **Poliklinische Apotheek B.V.**
Poliklinische Apotheek was formed in early 2008. Maasstad Hospital owns 90% of the shares and Medsync the remaining 10%. Poliklinische Apotheek provides extra-mural medicines to patients who are not admitted to or have been discharged from the hospital. Intramural medicines (for patients who are admitted to the hospital) are provided by the hospital pharmacy.

The following companies are not included in the consolidated statements, but are shown in the financial fixed assets:

1 **Diagnostisch Centrum Rotterdam B.V.**
This private limited liability company was formed in May 2008 as part of Diagnostisch Centrum B.V., which has establishments throughout the Netherlands. Apart from Maasstad Hospital's 30% interest, Health Care Ventures (headed by Loek Winter) holds 35% of the shares and Stichting Administratiekantoor DC/Rotterdam (an alliance of the specialists working in the Rotterdam Diagnostic Centre) holds the remaining 35%. The objective of this organisation is to offer a complete package of high-quality diagnostic examinations for first-line care, which can be performed within 24 hours of being requested.
In early 2010 Diagnostisch Centrum Schiedam was formed as a subsidiary of DCR. The objective of this private limited liability company is the same as that of DCR. The company is registered in Schiedam.

2 **Diagnostisch Centrum Skoop B.V.**
Diagnostisch Centrum Skoop B.V. was formed in March 2009. Maasstad Hospital owns 65% of the shares. As with DCR, Health Care Ventures owns the remaining 35%. DC Skoop specialises in endoscopic diagnosis and forms part of the same diagnostic centre as DCR and DC Schiedam. DC Skoop is still a relatively small private limited liability company and the intention is to sell 35% of the shares in the near future.

Active foundations with no financial influence:

1 **Friends of Maasstad Hospital Foundation**
This foundation was formed in 2007. It currently focuses primarily on raising funds for the benefit of the new hospital building.

2 **Maasstad Hospital – Laquintinie Hospital Partnership Foundation**
This foundation was formed in December 2010 to achieve some of the desired improvement in the quality of care for patients in Africa. The choice was made for a partnership with Laquintinie Hospital in Douala, Cameroon. The foundation has reached agreements with this hospital on matters including staff exchange projects and the provision of equipment.

2.3 Key data

Maasstad Hospital is a large general hospital that was formed on 1 January 2000 through the merger of Zuider Hospital and St. Clara Hospital. Acute care is concentrated at the Zuider location and elective care at the Clara location. This is the care that can be planned and provided during regular opening hours, such as cataract operations or replacing a hip or knee. Our Zuider location has a Casualty department and the Clara location an outpatient clinic for first aid referrals. The catchment area of Maasstad Hospital covers the Rijnmond region. In 2010 the polyclinic catchment area held a population of 232,544 and the clinical catchment area a population of 260,773. Maasstad Hospital has a larger catchment area for a number of specific specialised clinical functions.

2.3.1 Core activities and further classifications

As a general hospital Maasstad Hospital provides specialised medical care (diagnostics, treatment and after-care) and the related nursing and care.

Association of Tertiary Medical Teaching Hospitals

In 2011, Maasstad Hospital hopes to qualify for membership of the STZ. We received a visit from the plenary Visitation Committee of the STZ for this purpose on 1 December 2010. In order to be accepted for membership, a hospital must offer at least nine advanced education courses, including at least six in a primary referral specialism. The Visitation Committee will decide in April 2011 whether we will be admitted as an associate member. Associate membership is granted for a maximum term of five years. Within that period a new visit must be requested, at which our hospital must comply with the criteria for full membership. See table 2.

Specialised clinical care and specialised referrals

In addition to the regular basic functions, we offer specialised clinical care in a number of fields. These are shown in Annex 1. The surgery discipline is also one of the first disciplines in the country to be working on a fully differentiated basis, by priority area.

Table 1 Key-data

Capacity	**Number**			
	2010		2009	
Available beds/places for clinical capacity and day/part-time treatment	601		601	
Capacity by location	**Zuider**		**St. Clara**	
	2010	**2009**	**2010**	**2009**
Total number of available beds	352	352	249	249
Beds for cardiac monitoring	13	13	0	0
Beds for intensive care with artificial respiration available	16	16	4	4
Beds for intensive care with no artificial respiration available	0	0	0	0

>

Production	Number	
	2010	2009
Number of opened diagnosis/treatment combinations (DBCs) (drawn from ZIS, not DIS)	251,401	245,144
Specialised medical care cases, analysed by:		
Number in A segment Netherlands Care Authority (NZa) rates)	*195,576*	*190,876*
Number in B segment (market rates)	*55,825*	*54,268*
Number of DBCs contracted (drawn from ZIS, not DIS)	244,077	238,860
Specialised medical care cases, analysed by:		
Number in A segment NZa rates)	*188,300*	*193,970*
Number in B segment (market rates)	*55,777*	*44,890*
Number of other and support products charged to insurer – O(V)P's –, including treatments at the request of first line services	205,751	150,495
Number of clinical admissions excluding internal transfers during the year under review	34,619	31,549
Number of patients discharged	34,667	31,966
Number of initial outpatient visits	168,944	162,537
Number of other outpatient visits	300,676	289,746
Number of day nursing days (regular and intensive) or half-day treatments	35,334	34,806
Number of clinical nursing days (including wrong bed)	151,484	150,396
Number of wrong bed days	*245*	*5,256*
Staff	**Number (at end of year under review)**	
	2010	**2009**
Number of staff members in permanent employment, excluding medical specialists	2,731	2,657
Number of FTEs in permanent employment, excluding medical specialists	2,216	2,151.9
Number of medical specialists (permanent employment + hired + self-employed)*	194	184
Number of medical specialist FTEs (permanent employment + hired + self-employed)*	164,5	159
Operating revenues	**Amounts in euros**	
	2010	**2009**
Total operating revenues	284,965,000	244,303,000
Of which statutory budget for acceptable costs	*196,105,000*	*166,674,000*
Of which B-segment	*63,669,000*	*56,443,000*
Of which other operating revenues and non-budgeted operations	*25,191,000*	*21,186,000*

* *The figures for 2009 were adjusted (in relation to the 2009 Annual Report) in accordance with the calculations for 2010, so that the two years are comparable.*

Table 2 Medical specialisms available at Maasstad Hospital

List of specialisms	
Allergology	Paediatrics
Anaesthesiology and pain control	Clinical chemistry
Pharmacy	Clinical physics
Cardiology	Clinical pathology
Surgery	Pulmonary medicine
Oncology	Gastro-intestinal and liver diseases
Vascular surgery	Medical microbiology
Thoracic surgery	Neuro-surgery
Dermatology	Neurology
Gynaecology/obstetrics	Radiotherapy
Internal medicine	Eye specialist
Haematology	Orthopaedics
Nephrology	Plastic surgery
Oncology	Radiodiagnostics
Intensive Care	Rheumatology
Oral surgery	Revalidation
Ear, nose and throat specialist	Urology

Annex 3 shows the specialisms for which Maasstad Hospital is a teaching hospital. There are specialised follow-up courses for nurses and basic training at intermediate and higher education level for school-leavers. In short courses and meetings we provide upgrading programmes and theme meetings for GPs, home care providers and doctors' assistants, among others.

Maasstad Hospital offers eleven advanced medical courses, including six advanced medical courses in primary referral specialisms. The Neurology department also takes part in the psychiatry course (Delta Hospital).

Table 3 shows which advanced courses are available and the number of doctors in training as specialists (AIOSs) attached to these courses. Maasstad Hospital has an affiliation agreement with the South-West Netherlands Education and Training Region

Table 3 Advanced courses at Maasstad Hospital and the number of AIOS students per advanced course
(P) = Primary referral specialism

Advanced courses	Number of AIOS students
Anaesthesiology (P)	3
Gynaecology (P)	3
Surgery (P)	11
Internal medicine (P)	8
Paediatrics (P)	3
Clinical Chemistry	1
Clinical Pharmacy	2
Clinical Physics	1
Medical Microbiology	3
Radiology	10
Rehabilitation (P)	3
Total	**48**

(OOR). This means that AIOS students come from the Erasmus MC University. AIOS students from Ghent in Belgium are regularly accepted for the Gynaecology course. Occasional exchanges with other regions take place for various preliminary courses and there are AIOS who come from Leiden University Medical Centre.

Laboratories
Maasstad Hospital is working on two projects to strengthen the competitive position of the laboratories. The first project concerns the integration of the Clinical Chemistry Laboratory (KCL) and the Medical Microbiology Laboratory (LMM) departments. The outcome of this new structure is that we will ultimately work with five different units in this laboratory. Clients will then be able to present everything to one single department. Through the integration of the LMM and KCL we will deal more efficiently with e.g. equipment and support. The second project concerns the integration of the Deltalab of Delta Psychiatric Hospital with the laboratory of Maasstad Hospital.

Development of expertise centres
In order to address the increasingly complex care needs of patients Maasstad Hospital once again worked hard in 2010 on the development of its medical expertise. In the Robot Expertise Centre our surgeons began robot-assisted operations on intestinal tumours. Gynaecologists and urologists improved their skills with robot-assisted operations for uteral and cervical descensus, hysterectomies and treatment of kidney and prostate cancer.

Almost 300 patients were operated in the bariatric surgery expertise centre as a first step towards a healthier weight. In the

Table 4 Patients, capacity, production, personnel and revenues of Maasstad Hospital as at 31.12.2010

Production	2010	2009
Number of DBCs opened	251,401	245,144
Percentage of wrong bed patients (average)	1.9%	3.5%
Number of admissions (excluding transfers and day nursing)	34,619	31,549
Number of initial outpatient visits	168,944	162,537
Number of other outpatient visits	300,676	289,746
Number of day nursing admissions (normal and intensive) and part-time treatments	35,334	34,806
Number of clinical nursing days	151,484	150,396
Average duration of nursing	4.4	4.8

Table 5 Bed capacity at Maasstad Hospital as at 31.12.2010

Capacity	Number on 31.12.2010	Number on 31.12.2009
Available beds (clinical + day treatment beds)	601	601

vascular centre intervention radiologists and vascular surgeons joined forces to offer patients better treatment for their vascular disorders.

Defence tasks
Maasstad Hospital also performs Defence tasks. Our staff can be deployed for UN peace missions. The purpose of this is to provide military personnel who are posted on peace missions with adequate hospital care in the areas in which the missions take place. The Ministry of Defence pays for an extra surgical team at the hospital, which is available for four and a half of every 18 months for posting to peace missions. Maasstad Hospital provides two surgical teams from its own staff for this, which are available for call-up for six weeks of every 18 months. Four employees of our hospital were deployed for this in 2010.

2.3.2 Patients, capacity, production, personnel and revenues

See tables 4 en 5.

Figure 4 on page 24 shows that the number of initial outpatient visits (EPBs) and (day) admissions have risen enormously in the past five years. The number of EPBs increased by 20.7% in the last five years and the number of admissions (clinical and day nursing) by 67%. The average duration of nursing decreased from 6.9 days in 2005 to 4.4 days in 2010, a reduction of 36.4%.

Lists of production per specialism are presented in Annexes 2 and 3.

2.3.3 Catchment area
Maasstad Hospital is established in Rotterdam South. The hospital has a regional role with respect to basic care. The catchment area of the hospital covers the municipalities of Rotterdam, Ridderkerk, Barendrecht, Korendijk, Albrandswaard, Oud-Beijerland, Cromstrijen, Binnenmaas, Oostflakkee, Brielle, Spijkenisse, Westvoorne, Hellevoetsluis and Capelle aan den IJssel. The catchment area includes the Rijnmond region. For 2009 the outpatient potential amounted 232.544 and the clinical potential 260.773 residents. See figure 5 and table 6 on page 25.

For specialised referrals and specialised clinical care Maasstad Hospital has a supra-regional role and the catchment area is much larger. This also included Alblasserdam, Bernisse, Dirksland, Dordrecht, Goedereede, Hendrik Ido Ambacht, Krimpen aan den IJssel, Maassluis, Middelharnis, Rozenburg, Schiedam, Strijen, Vlaardingen and Zwijndrecht.

Maasstad Hospital has 27 disciplines and 34 different specialisms. The hospital also has a number of care processes involving combinations of disciplines: oncology, the vascular centre, bariatric and hand and wrist specialists and a number are in development/at various stages of formation.

The Ark
Since the end of the 1950s polio patients have been offered care and rehabilitation at the Zuider location. Because the new Maasstad Hospital does not offer any living environment, the last residents of the Ark were moved to their own apartment in a new care building operated by Laurens on the Sportsingel in Rotterdam in the spring of 2010.

Holiday dialysis centre
Maasstad Hospital has provided dialysis facilities at the Cape Helius holiday dialysis centre in Hellevoetsluis since 2006. The holiday dialysis centre is an initiative of Maasstad Hospital and Roompot Vakanties. Six dialysis stations enable dialysis patients from the Netherlands and elsewhere to undergo dialysis in a home setting during a holiday in the Rijnmond region. In 2010 39 patients were treated at Cape Helius, including 27 holiday guests and 12 Maasstad Hospital patients.

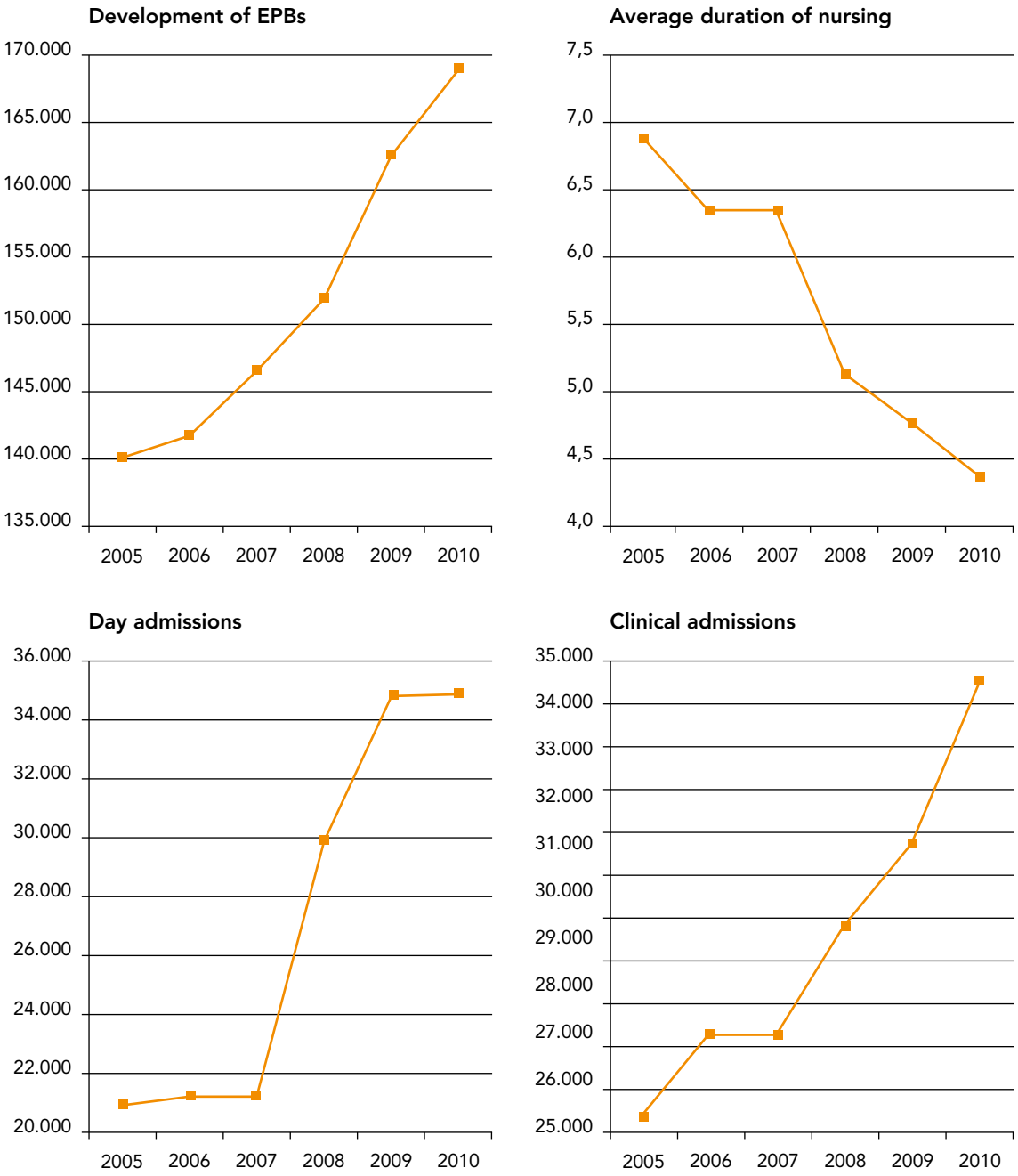


Figure 4 Development of EPBs, day admissions, clinical admissions and average duration of nursing

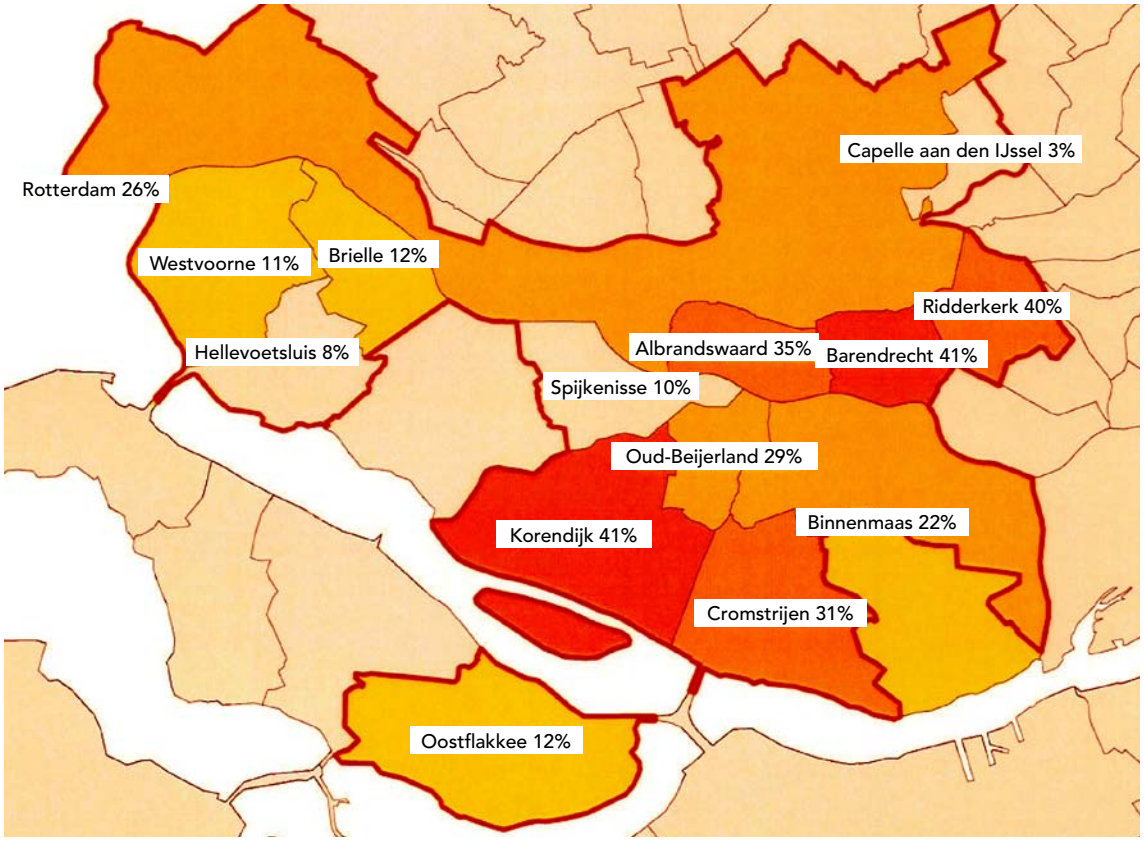


Figure 5 Market shares in the catchment area based on the number of admissions in 2009 (Source: LAZR, Prismant Management Facetten 2009, data on 2010 will be available in 2011)

Table 6 Catchment area of Maasstad Hospital with a list of market shares per municipality based on admissions and consultations in 2009 (Source: LAZR, Prismant Management Facetten 2009)

Location	Market share based on number of admissions in 2009	Market share based on number of consultations in 2009
Albrandswaard	35%	33%
Barendrecht	41%	39%
Binnenmaas	22%	21%
Brielle	12%	8%
Capelle aan den IJssel	3%	3%
Cromstrijen	31%	31%
Hellevoetsluis	8%	6%
Korendijk	41%	39%
Oostflakkee	12%	8%
Oud-Beijerland	29%	31%
Ridderkerk	40%	37%
Rotterdam	26%	23%
Spijkenisse	10%	7%
Westvoorne	11%	7%

2.4 Stakeholders

Maasstad Hospital has alliances with a large number of parties.

Partners and sub-contractors

- Rotterdam-Rijnmond Ambulance Service[1];
- Burns Foundation;
- Ambulance Post Switchboard;
- GP Posts Rijnmond Switchboard;
- Daniel den Hoed Clinic (Radiotherapy);
- Delta Psychiatric Centre[2];
- Dirksland Hospital (pharmacy provided by MZ);
- De Stromen Opmaat group[3];
- Erasmus Medical Centre;
- Hôpital Laquintinie, Cameroon[4];
- Integrated Cancer Centre West (IKW)[5];
- Kempenhaeghe;
- Rotterdam Maternity Care;
- Rotterdam Palliative Care Network;
- Rotterdam Rijnmond Regional Emergency Service;
- RiAGG (memory outpatient clinic);
- Rijndam Rehabilitation Centre;
- Roompot (holiday dialysis centre);
- Rotterdam Stroke Services;
- Ruwaard van Putten Hospital;
- Sophia Rehabilitation centre;
- Allied Rijnmond Hospitals Foundation[6];
- Van Weel Bethesda (pharmacy and IC);
- Midwifery alliance (alliances enabling midwives to work in our hospital);
- Care Hotel.

Maasstad Hospital maintains close cooperative relationships with Humanitas, De Stromen Opmaat group, Laurens, Rotterdam Home Care and Careyn in order to assure responsible quality of patient discharges.

Patient and client organisations

- Rijnmond Kidney Patient Association;
- Diabetes Association;
- Rheumatism Fund;
- Asthma Fund;
- Child and Hospital Association.

Government and supervisory authorities

- Labour Inspectorate;
- Calibris;
- Central Committee for Human Research (CCMO: supervisory authority for medical research);
- Data Protection Board;
- Reorganisation of Health Care Institutions Board;
- Rotterdam Municipal Authority;
- Accident and Emergency Medical Service (GHOR)[7];
- Health Care Inspectorate (IGZ);
- Medirisk ;

1 *Together with the Rotterdam-Rijnmond Ambulance Service Maasstad Hospital organises transportation for severely ill intensive-care patients in the Rijnmond region (MICU). Maasstad Hospital collects patients from other hospitals who will be treated in its own IC and also transports patients between the ICs of other hospitals.*

2 *Maasstad Hospital and Delta Psychiatric Centre opened a medical psychiatric unit in 2008. This is a special treatment unit with 12 beds for patients with a combination of physical and psychiatric disorders. By working together, both institutions are preparing for 2010, the year in which Delta Psychiatric Centre will open a new establishment on the Care Boulevard. The launch of a 12-bed unit enables the hospital to gain the necessary knowledge and experience of working with such patients on a small scale.*

3 *De Stromen has a Care Hotel in Maasstad Hospital at the Clara location.*

4 *Maasstad Hospital aims to go beyond offering optimal care for its own patients and to work internationally, in Cameroon, Africa, as part of corporate social responsibility. The partnership contracted in 2009 has many components. The aim is to improve the quality of patient care at Hôpital Laquintinie by sharing medical, nursing, technical and management know-how. Maasstad Hospital will transfer medical equipment and the knowledge to operate that equipment. Through exchange projects, our employees can work in Cameroon and vice versa, in order to learn from each other.*

5 *The IKW is part of the Integrated Cancer Centres Association, the national alliance of the nine integrated cancer centres in the Netherlands.*

6 *Maasstad Hospital is one of the 11 hospitals in the Rijnmond region that are affiliated to the Allied Rijnmond Hospitals Foundation umbrella organisation. Through various projects and consultation, the Foundation works to strengthen diverse alliances between hospitals and chain partners.*

7 *Agreements are reached with the GHOR on aid for patients in the event of disasters and other emergencies in the Rijnmond region.*

- Health Care Sector Environmental Platform (MPZ);
- Ministry of Defence;
- Ministry of Public Health, Welfare and Sport;
- Dutch Healthcare Authority;
- Netherlands Transplant Foundation;
- Regional Educational Centre (ROC) Albeda College[8];

Health Insurers[9]
- Achmea;
- Agis;
- UVIT10;
- CZ;
- Multizorg;
- Menzis.

Capital providers
- ING, BNG and Fortis[11];
- Guarantee Fund for the Health Care Sector (WFZ)[12].

Diverse
- Medirisk

8 *Most of the (follow-up) training courses for nurses are provided in cooperation with the ROC Albeda College.*

9 *Talks are conducted with health insurers on a structural basis. The topics discussed are production agreements, quality policy, health care innovation, accreditation of medical specialists and developments in the region.*

10 *Univé-VGZ-IZA-Trias*

11 *ING acts as the home banker. The banks receive the financial reports (quarterly reports and financial statements) and regular talks are conducted.*

12 *The WFZ stands surety for a number of loans and on those grounds also receives the financial reports.*

Het directieteam: van links naar rechts Frank Arnoldy (directeur beheer), Saskia Baas (directeur zorg), Alex Dirks (directeur zorg) en Paul Smits (algemeen directeur)

3 Governance, supervision, management and employee representation

In this chapter, Maasstad Hospital aims to provide the fullest possible picture of its governance. Following a discussion of the application of the Health Care Sector Governance Code in 2010 a transparent description is provided of the composition, duties, working methods, performance and remuneration of the Executive Board and the Supervisory Board. Paragraph 3.4 explains the operations and the risk management policies applied in the year under review. The chapter ends with a brief description of the hospitals committees and councils.

3.1 Standards for good governance

With the 2010 Health Care Sector Governance Code the Health Care Sectoral Organisations (BoZ) took a step towards further professionalization of governance and supervision. The BoZ describes the code as a compilation of modern and now widely supported general views in the health care sector regarding good governance, supervision and accounting.

3.1.1 Application of the Health Care Sector Governance Code

Maasstad Hospital applies all the principles of the Health Care Sector Governance Code. The new Governance Code took effect on 1 January 2010. The new code implements a number of important changes in relation to the Health Care Sector Governance Code of 2005. The changes shown in table 7 are relevant for Maasstad Hospital.

Investigative rights

Pursuant to Article 6.2 of the WTZi Implementation Decree an article was added to the Charter in 2007 with respect to the right of inquiry. This article provides that an organisation representing the interests of Maasstad Hospital patients is authorised to submit requests to conduct investigations into the policy and procedures Maasstad Hospital to the Enterprise Division of the Amsterdam Court of Appeal. The Enterprise Division will rule in response to a specific request whether the applicant is sufficiently representative for a 'body that represents the patients of the institution'. The Supervisory Board has decided that the investigative rights are also open to the Patient Council. This change in the Charter will be implemented in early 2011.

Table 7 Changes in the Health Care Sector Governance Code

Important changes in the new 2010 Governance Code	**Application of the Code: Yes/No. If the Code is not applied, we explain why (situation at year-end 2010)**
Making responsibility for quality and safety explicit	Applied
Description of the approval powers of the Supervisory Board	Maasstad Hospital will adjust the Supervisory Board regulations in this respect in 2011.
Inclusion of a whistle-blower scheme	Maasstad Hospital considered a whistle-blower scheme at the end of 2009. No new scheme was introduced in 2010, but this is to be established in early 2011. No reports were made via the whistle-blower scheme in 2010.
Sharpening up the article on conflicts of interest	Applied
Revision of the provisions of the Code concerning the dialogue with stakeholders	Maasstad Hospital will adjust its Charter to this provision of the Code in 2011.
Expansion of the scope to include affiliated businesses and legal persons	Applied
Limitation of the number of supervisory directorships of a Supervisory Board member	If we apply the Dutch Corporate Governance Code[1] to Maasstad Hospital in this respect, three of the five supervisory directors hold too many ancillary positions. However, the Maasstad Hospital Supervisory Board takes the view that the current situation fulfils the tasks well and that the availability, time and flexibility of the Supervisory Board members is assured.
The rule that at least one supervisory director must have knowledge and experience in health care relevant to the health care institution	Applied
More attention to the training of supervisory directors	The Supervisory Board Regulations will be amended in 2011 with an article on (the content of) an introductory or training programme for new supervisory directors.
Accounting by the Supervisory Board in the Annual Report	Applied
The final responsibility of the Executive Board for quality and safety in relation to the position of the private specialists and their representative body, the Medical Staff Association.	The Executive Board will play an active part on monitoring developments in this field at the Ministry of Public Health, Welfare and Sport[2], the NVZ and the Order of Medical Specialists[3].

1 This states that a supervisory director of a Dutch listed company may not hold more than five supervisory directorships, with a position as an Executive Board or Supervisory Board Chairman counting double.
2 Concerning an adjustment of the admission contract
3 Concerning a new model for a contractual relationship between the hospital and private medical specialists

3.2 Executive Board / Management

3.2.1 Executive Board

Maasstad Hospital has a one-man Executive Board consisting of Mr P.M.L. Smits. On Mr Smit's appointment in September 2004, a one-man Executive Board was chosen in order to get the hospital on track quickly and effectively. It was agreed that the Supervisory Board would regularly assess this choice. The hospital is now on track, with a strong management team. Partly for this reason, the Supervisory Board and the General Manager opened talks in 2010 on whether an expansion of the Executive Board according to the Charter would be more appropriate to the new situation. These talks will be concluded in the first quarter of 2011. The responsibilities and powers of the Executive Board are described in more detail in the Maasstad Hospital Charter.

3.2.2 Management team

The CEO is part of the management team, which consists of four members, see table 8.

Together they formed the management of the hospital in 2010, with final responsibility resting with the General Manager. The management team members all have responsibilities for a number of departments that report to them, as well as for a number of hospital-wide portfolios. They also support the General Manager in talks with the various advisory and representative bodies, to ensure that the continuity and input from the various portfolios is adequately assured. Maasstad Hospital has regulations defining the tasks and responsibilities of the management.

Table 8 Membership of the management team and ancillary positions

Management team	Position	Portfolio (see Organisational Chart for the allocation of the departments)	Ancillary positions
P.M.L. Smits, physician, MBA	General Manager and CEO		- Managing Director of MCRZ Holding B.V., Chairman of the Netherlands Association of Burns Units, - Manager of the Rotterdam Research and Treatment Centre Foundation, Board member of the MICU Rotterdam Rijnmond Foundation, Executive Board member of the Rijnmond Hospitals Foundation (SRZ), - Member of the Rotterdam Economic Development Board (EDBR) and Executive Board member of Capacity Body
A.R. Dirks	Health Care Director	Quality and safety	- Managing Director of MaAssist B.V. - Managing Director of Poliklinische apotheek B.V. - Supervisory director of Health Care Teaching Station
S. Baas	Health Care Director (from 01.02.2010)	Customer perceptions, patient satisfaction	- Member of Utrecht Library Council
F. Arnoldy	Operations Director	Relocation to New Building Project, Investment Committee	- Board member of Friends of Maasstad Hospital Foundation

Core of the agreements in the regulations:
- Provision for an effective Executive Board (through appointment, assessment and dismissal of managing directors);
- Provision for effective internal supervision (through appointment, assessment and dismissal of supervisory directors);
- Acting as an advisor and sparring partner for the Executive Board;
- Maintaining overall supervision of the policy of the Executive Board and the general progress of the institution;
- Approval of strategic decisions by the Executive Board;
- Issue and cancellation of instructions to the external auditors;

The management meets every two weeks in the presence of the Chairman of the medical staff, a member of the Executive Board of the Medical Staff Association (VMS), the Medical Affairs Manager and the Marketing, Communication & Sales Manager. This guarantees coordination with the medical staff. The agenda for these management meetings is also discussed in the Executive Board of the VMS and is known to key officials. (Proposed) decisions taken in the management meetings are announced to the entire organisation within 48 hours. Following any recommendations or consent, the decisions are endorsed in the management meetings. The decisions are widely circulated throughout the hospital. The departmental and health care managers have direct access to the documents on the basis of which the decisions are taken. The management decisions and accompanying documents are also communicated on the intranet.

3.2.3 Conflicts of interest

The Governance Code contains four points concerning the issue of 'conflicts of interest'.

1. The main principle for these four points is that the Executive Board must show integrity and enables assessment of its own performance. Every form and appearance of personal conflicts of interest between any member of the Executive Board and the health care institution must be avoided. Decisions to conduct transactions involving conflicts of interest of managing directors of material significance to the health care organisation and/or the relevant managing directors require the approval of the Supervisory Board.

2. Executive Board members are not members of the Supervisory Board of the health care organisation or of another health care organisation within the Maasstad Hospital catchment area. Executive Board members may be supervisory directors of a number of health care organisations that are closely affiliated to the health care organisation through a shareholding.

3. Executive Board members do not hold new ancillary positions, for payment or otherwise and shall not accept such positions without the consent of the Supervisory Board. An important factor in any consent for an ancillary position, in relation to other paid or unpaid ancillary positions or otherwise, is that these do not generate more than a minimum workload and do not conflict with the interests of the health care organisation in other ways.

4. The Executive Board provides the Supervisory Board with insight into ancillary positions at the earliest request of the Supervisory Board. The Supervisory Board has concluded that there is not conflict of interest with respect to the existing ancillary positions of the Executive Board.

3.2.4 Assessment and remuneration of the Executive Board

Mr Smits has had a permanent contract since 2008. Both the fixed and the variable amount of his salary are determined on the basis of level Q1[1] of a report by the Hay Group research consultancy (maximum of 40%). Mr Smit's severance pay is fixed at a maximum of one year's salary, regardless of years of service. Mr Smits does not have a company car, but a fixed gross travel expenses allowance. With this scheme Mr Smits does not comply with the regulations of the Netherlands Association of Hospital Directors. The reason for this is that these regulations are not in line with market rates, taking account of the ambition, complexity, size and location of Maasstad Hospital and the comparison with businesses outside the health care sector. In 2010, the fixed income was not adjusted, apart from an annual increase in accordance with the collective labour agreement (CAO). The maximum share of the variable salary is 40%. The maximum amount is awarded, if the following criteria are met:

- An increase in the 'net promoter score' of patients (see paragraph 4.2.2 for details);
- An increase in the ranking in the AD Hospitals Top 100;
- Retention or increase in the market share;
- Meeting or exceeding the envisaged financial result;
- Realising the new building within scope and budget.

The various aspects are determined in quantitative terms in advance. This means that no discussion concerning the determination of the bonus is possible (no scope for 'Yes, but …'). On the basis of the criteria, the maximum bonus possible is 35%. The Supervisory Board may reduce or increase the bonus by a maximum of 5% at its own discretion (the maximum total bonus is therefore 40%).

In 2010 the maximum bonus was paid, with an increase of 5%, for the attainment of the results in 2009 in comparison with 2008, in view of the overall results achieved. The same criteria will apply for 2010. It is already clear that the financial result was below budget. No bonus will therefore be paid for this. The other points cannot be assessed as yet, as the results for these are not yet known.

3.3 Supervisory Board

The task of the Supervisory Board is to maintain overall supervision of both the preparation and the implementation of the Executive Board's policy and the qualitative performance of its tasks. The Supervisory Board also acts as an advisor and consultant for the Executive Board.

3.3.1 Composition of the Supervisory Board

See table 9.

The Supervisory Board has both broad experience in the private sector and relevant experience in health care. The main positions and ancillary positions of the members are described in Annex 2. Each member performs his role as a supervisor with his own knowledge, insights and expertise. Annex 1 lists the specific priority areas for each supervisory director. In addition to these specific priority areas the individual members have proved able to find the correct balance between the interests of the patients, employees, the environment (insurers, GPs and other care providers) and finances. Annex 1 also shows that the Supervisory Board members play an independent role. The independence of the members is assessed in the evaluation investigations.

Two supervisory directors were reappointed in 2010. Supervisory directors are appointed for

1 *Level Q1 means that 25% of people with a similar number of Hay points earn less and 75% of those with the same number of Hay points earn more.*

Table 9 Composition and ancillary positions of the Supervisory Board

Name	Main position	Priority areas	Ancillary positions
A.J. Scheepbouwer	CEO of KPN	Clients (patients, GPs, etc.), financial and economic affairs	- Supervisory Board Chairman of Havenbedrijf Rotterdam N.V. - Supervisory director and investor in RFS Holland Holding B.V., Zwolle. - Member of the Advisory Council of ECP.NL. - Supervisory director of Oyens & Van Eeghen.
J.C.G. Stam	Director of Netherlands Heart Foundation	Health care, government /public health, politics	- Supervisory director of the De Stromen-Opmaat Group (DSOG), an umbrella group of nursing and care institutions and a home care organisation - Member of Advisory Council of Advies HD Projectrealisatie Rotterdam. - Director of Dutch Clinical Trial Foundation - President of European Heart Network. - Vice President Elect of World Heart Federation - Supervisory director of Durrer Institution for Cardiogenetic Research - Director of Association of Fund-Raising Institutions (VFI) - Director of Central Fund-Raising Bureau (CBF) - Director of Cyclists Association - Director of Cardio-Vascular Education Institute (CVOI) - Director of Public Health Lottery Campaigns (SLV) - Member of Advisory Council of Care Within Reach Foundation
W.C. Weeda	Managing Director of Vektis BV and Vektis C.V. (01.03.2010: early retirement) Management Consultant, Verdonk Klooster & Associaties (VKA) Zoetermeer (01.10.2010)	Health care, government/public health, business operations and legal affairs	- Supervisory Board Chairman of Utrecht Graphical Lyceum - Supervisory Board Chairman of Curriculum Development Foundation
R.S. Kahn	Professor of Psychiatry at Utrecht University Medical Centre	Health care, government/public health	- Member of Health Council - Member of Royal Netherlands Academy of Arts and Sciences (KNAW), Medicine section - Member of Medical Research Council of the National Mental Health Board, UK - Supervisory director of Hubrecht Laboratory, UMC Utrecht - Treasurer of Schizophrenia International Research Society
A. van Tooren	Retired	Financial and social and business management affairs	- Supervisory director of Hunter Douglas N.V. - Supervisory director of Imtech N.V.





a term of four years. The Supervisory Board has adopted the following rotation schedule.

Supervisory Board rotation schedule
See table 10.

3.3.2 Tasks and working methods

The tasks and responsibilities of the Supervisory Board are laid down in the Maasstad Hospital Charter. The working methods are further developed in the Supervisory Board Regulations. The Regulations describe the supervisory role of the Board and how it accounts for its actions.

The Supervisory Board met in the presence of the Executive Board on six occasions in 2010. One further meeting was conducted by telephone.

Attendance list of Supervisory Board meetings in 2010
See table 11.

The meetings are prepared by the Chairman of the Supervisory Board and the CEO. Before the meeting, an 'annotated' agenda is drawn up, in which the Supervisory Board receives detailed information regarding the various topics and the Executive Board's questions to the Supervisory Board. Any underlying documents are attached to the agenda. If necessary, a brief presentation is also given at the meeting.

Supervision of the strategy and performance

The Supervisory Board supervises the performance of the organisation on the basis of the quarterly reports. The Supervisory Board also discusses performance at an annual meeting with the external auditors and if necessary, also at an interim meeting. The auditors' findings are discussed in the meetings with the Supervisory Board. In 2010 the auditors performed an interim audit based on the figures for the second and third quarters. The auditors' findings were discussed with the Supervisory Board.

Table 10 Supervisory Board rotation schedule

Name	Date of appointment	Date of 1st reappointment	Available for reappointment	Year of resignation (at end of current term of office)
A.J. Scheepbouwer	1 September 2005	1 September 2009	No	1 September 2013
J.C.G. Stam	1 May 2005	1 May 2009	No	1 May 2013
W.C. Weeda	1 May 2005	1 May 2009	No	1 May 2013
R.S. Kahn	1 October 2006	1 October 2010	No	1 October 2014
A. van Tooren	1 June 2006	1 June 2010	No	1 June 2014

Table 11 Attendance list of Supervisory Board meetings

Name	24 Mar	28 May	13 Jul*	25 Aug	6 Oct	10 Nov	6 Dec
A.J Scheepbouwer	x	x	x	x	x	x	x
J.C.G. Stam	x	–	x	x	x	x	x
W.C. Weeda	x	x	x	–	x	x	x
R.S. Kahn	x	–	–	x	–	x	–
A van Tooren	x	x	x	x	x	x	x

* *Meeting conducted by telephone*

In addition to the financial data, the performance indicators are reported in the quarterly reports, to the extent that these are available per quarter. Special attention is devoted to the outcomes and changes in the investigative method for the quarterly Patient Satisfaction Monitor (see table 30 and the six-monthly outcomes of the Employee Satisfaction Survey (see table 50).

Information sources
The Executive Board ensures that the Supervisory Board receives detailed information before and during each meeting. The Executive Board provides the Supervisory Board with information on important developments between meetings. The principle here is that the Supervisory Board should be informed of progress sooner than not.

In 2010 the Supervisory Board was provided with detailed information on risk management. Where risks were identified, the Supervisory Board monitored these at its meetings. In 2010 risk management will be incorporated in a system, so that risks can be considered still more closely in correlation.

However, Maasstad Hospital does not yet have an information protocol. In view of the more detailed requirements of the IGZ, also concerning the organisation of governance, it has been agreed that an information protocol will be drawn up in 2011.
The core of this regulation is the agreement that the Executive Board will keep the Supervisory Board informed of:

- Developments relating to the positioning and strategy of the Foundation;
- Developments concerning matters on which decisions require the approval of the Supervisory Board;
- Realisation of targets for quality and patient safety;
- Problems and conflicts of any significance within the organisation;
- Problems and conflicts of any significance in relationships with third parties, such as the government, health insurers and partners;
- Emergencies reported to the IGZ or the Justice department;
- Court proceedings;
- Publications and issues that can be expected to attract publicity.
- The realisation of the social function, the strategy, including the associated risks and the mechanisms for their control, the quality of care and the treatment of ethical issues;
- Its assessment of the internal control systems, including the provision of management information, in relation to the objectives of the Foundation;
- The financial position of the Foundation (on a quarterly basis).

In 2010 the Supervisory Board asked the Executive Board to draw up a programme for 2011 to enable it to examine future developments in health care in more depth. The proposal is to invite a number of external experts for this in 2011.

3.3.3 Committees
In view of its limited size, the Supervisory Board has no formal separate committees such as an Audit Committee or a Financial Committee. Where necessary, one of the supervisory directors is involved in complex financial matters. This is discussed at the Supervisory Board meetings.

3.3.4 Evaluation of own performance
In the autumn of 2010, the Supervisory Board instructed an external agency to evaluate the performance of the Supervisory Board and the Executive Board. The guiding theme for the evaluation is the Health Care Sector Governance Code. The agency considered for each subject whether the Boards comply with the code and whether there are points for improvement. The Supervisory Board and

Executive Board are satisfied with each other's performance. A number of minor points for improvement were revealed in the analysis of their performance. For example, the criteria of the Health Care Sector Governance Code must receive more explicit attention in decision-making and the regulations of both the Supervisory Board and the management team should be posted on the Internet. Both recommendations were adopted.

3.3.5 Remuneration of the Supervisory Board

The remuneration of the Supervisory Board is presented in table 12.

3.4 Management

The Finance & Control (F&C) department is responsible for implementing the planning and control (P&C) function and for the provision of management information. This department previously consisted of two separate departments, the Business Administration Department and the Business Economic Bureau. In the interests of further professionalisation and to promote better coordination of these departments they were amalgamated in 2010 to form a single department headed by one responsible manager.

3.4.1 Planning and control cycle

The F&C department monitors the performance of the work relating to the P&C cycle on the basis of an annual calendar fixed by the management team at the start of the year. The P&C cycle consists of the following primary parts:

- The long-term budget;
- Annual plans and budgets;
- Quarterly reports;
- Monthly reports.

The annual calendar shows the dates on which P&C products (e.g. the annual, quarterly and monthly reports) for the Executive Board and the management will be delivered.

Long-term budget for 2010 – 2013

An update of the long-term budget for 2009-2012, which was developed in this form for the first time in 2009, was produced in the first half of 2010. In the long-term budget, we forecast our revenue/production and expenditure for the 2010-2013 period early in the year, on the basis of a large number of assumptions. This information was then translated in terms of assessment frameworks for the 2011 annual budget. The (progressive) long-term budget is a tool for obtaining a better grasp of changes and risks in our environment. With the model the effects for the operating results and performance indicators can be calculated for various scenarios (best case, worst case and most likely). (See also the

Table 12 Remuneration of the Supervisory Board

	2010		2009	
Name	**Remuneration**	**Taxable income**	**Remuneration**	**Taxable income**
A.J Scheepbouwer	19,635	19,635	19,635	19,635
J.C.G. Stam	11,000	11,000	10,000	10,000
W.C. Weeda	11,000	11,000	10,000	10,000
R.S. Kahn	11,000	11,000	10,000	10,000
A. van Tooren	11,000	11,000	10,000	10,000

paragraph headed 'Early Warning System' on page 104).

Annual plans and budgets
On the basis of the long-term budget and an annual planning letter from the Executive Board, managers draw up annual plans for their departments, which are translated in financial terms into a budget for the coming year. The Executive Board approves this budget, which forms the financial steering framework during the years. The other key performance indicators (KPIs) that are determining factors for the annual plan are also described.

Quarterly reports
The quarterly steering process was improved further in 2010. Each quarter the management accounts to the Supervisory Board and financiers for its policy (in particular the financial policy) and an income statement and balance sheet are presented. The figures for the second and third quarter are also examined by the external auditors. In 2010 more focus lay on the quality of the forecasts and greater attention was devoted to determining the adjusted results in the quarterly reports.

Monthly reports
Each month, the management accounts for the results achieved in terms of production growth/growth in market share, finances, quality/safety and customer satisfaction. The management also devotes attention to any measures required to steer adjustments and the correlation of developments between the different result areas. Through further structuring and standardisation of the agenda and reporting on the monthly meetings, the Executive Board and the management also gained a better grasp of the (agreed) improvements in the operating results in 2010.

3.4.2 Management information supplies

Most of the information needed to achieve and adjust the hospital's objectives at the strategic, tactical and operational levels comes from source records kept and managed by the different departments. The data are primarily read into the hospital's data warehouse on a regular basis via automated systems (such as the Electronic Care Information System (EZIS) and the financial accounts in Exact). From this source, the F&C department provides for regular reports for the Supervisory Board, the Executive Board, the management and external stakeholders (such as banks and health insurers). Standardised reports and dashboards tailored to the departments can be viewed continuously from every computer via a network connection, with the aid of the reporting tool Webfocus. The hospital's performance is measured and made transparent by means of performance indicators that become available on a regular basis (weekly, monthly and quarterly). A tool for the analysis of the performance achieved is a balanced scorecard with some 80 indicators, which are updated each month (see also page 75). With this broad set of performance indicators the hospital responds to changes in its environment, increasing risks, greater competition and the switch to output financing, which imposes new requirements on business operations.

The indicators are divided over the four pillars of our strategy:
- Health care information (on quality and safety);
- Production growth (in both the regulated and the liberalised segments of hospital care);
- Financial performance;
- Patient satisfaction.

For each indicator performance is measured in terms of a standard.

Changes in operations
In 2010, we worked to improve the reliability of the steering information and business intelligence processes through the 'Steering

for Results' programme, in order to make the hospital still more manageable and achieve 'in control' status. All performance indicators were evaluated to ensure that they correspond still more closely with the hospital's strategy. In early 2011, this will lead to further adjustments in conjunction with the Performance Management programme (see page 90). The Supervisory Board was kept informed of this in the quarterly reports. The quarterly reports to the Supervisory Board discuss all sections, including the quality indicators and the indicators for the employees.

In response to the DBCs 'Towards Transparency' Improvement Plan (DOT) the 'DOT Opportunity' programme was set up in early 2010. The programme originally consisted of seven projects aimed at the implementation of DOT. Following the fall of the government, we took account of different scenarios: with or without continuation of DOT or performance funding/withdrawal of function-oriented budgeting (FB) and any expansion of the B segment. For 2010 we therefore opted to start two projects which focused mainly on the national application 'the Grouper' and source registration under the DBC system.

Risks, opportunities and uncertainties
Maasstad Hospital steers for the risks that affect the achievement of the hospital's objectives by making these risks transparent and keeping them manageable.

Changes in risk management
Because the health care sector and, therefore, Maasstad Hospital are in the middle of a change of funding system and are furthermore affected by the current economic crisis, the importance of risk management has increased substantially. Increasing competition and the switch to output financing also place new demands on business operations. As a result, the management decided to reinstate the position of Group Controller as of 1 November 2010. This official can obtain a more extensive overview of all current risks and develop a faster warning function. The Group Controller focuses on matters such as risk management, management of fiscal risks, support for the Executive Board in strategic decisions and advising the Executive Board on the further design of hospital management. In addition to the Group Controller, an Internal Control team has been appointed. This team operates under the responsibility of the Finance and Control Manager. The Executive Board, the manager in question and the Group Controller use the results of audits for further risk management and improvement of business processes.

In 2010, the Internal Control team addressed the following business processes in the risk analysis and control plan and discussed the results with the management:
- Commissioning of new hospital and development of the Care Boulevard;
- DBC registration and invoicing;
- Changes in costs and financing;
- Creditor and stock accounts;
- Personnel administration.

Special attention was devoted to the following in 2010:

3.4.3 Commissioning of the new hospital and development of the Care Boulevard

In view of the scale and thus the growing complexity of the commissioning of the new hospital the management closely monitors the risks on the basis of a risk monitor. This risk monitor sets out the risks for the entire 'commissioning of the new hospital' project in detail. Finance and Control keeps the data up to date. The management receives a separate new hospital report each month. Together with the managers responsible, the management discusses the analyses each month and takes appropriate measures where necessary. This matter will certainly remain a subject of special attention until after the relocation in May 2011.

3.4.4 DBC registration and invoicing

On the basis of the assessment of the accounting document drawn up and the assessment of the outcomes of random samples, our external auditors determined that Maasstad Hospital complies with the requirements of the Administrative Organisation/Internal Control (AO/IC) Regulations for DBC Registration and Invoicing (CU/NR-100.060). The DBC management statement was issued on 14 February 2011. In total, an error fraction of 1.48 was found, while the permissible error fraction is 3.0. The registration level in 2010 was therefore more than adequate. The errors found related to incorrect and erroneous source registration, such as the registration of the commencement and closing date of a DBC. The errors found were fed back to the relevant specialism and the source records were adjusted. In 2011, we shall focus on timely and correct implementation of the charges for the B segment, expansion of our financial monitoring service to other fields and updating of the working agreements and authorisations relating to the new DOT registration system (for further information on DOT, see paragraph 4.3.1, page 75). The consequences of DOT are expected to be felt financially. In the follow-up process, we will therefore (continue to) focus on accurate, prompt and full recording and reliable dispatch information, so that we can continue to aim for optimisation of efficient and patient-friendly care processes in this way. In 2010, preparations were made for the performance of the financial DOT impact analysis by an external agency affiliated to the Netherlands Hospitals Association (NVZ).

3.5 Patient Council

The Patient Council was installed in the autumn of 2005 to represent the joint interests of the clients of Maasstad Hospital. In 2010, the membership of the Patient Council was as follows:

Table 13 Membership of Patient Council

Name	Management position
F. Tromp	Chairman
J.R. Bausch	Vice Chairman
J. P.M. Nabbe	Secretary
R.J.M. Copier	Member
D.J. van der Heiden	Member

Tasks and working method

Regulations were established for the work of the Patient Council. The Patient Council works on the basis of an annual plan, for which a budget is approved. The Council draws up a separate annual report. Both are posted on the hospital's website.

The Patient Council met on five occasions in 2010. Discussions were also conducted with the Executive Board during these meetings. With the OR, the VAR and the Medical Staff the Patient Council reviewed how these advisory bodies can coordinate their performance more effectively.

The Patient Council received information on various current matters, naturally always considered from the patient's point of view. For example, a health insurer provided a presentation in 2010 and a meeting was held with the Director of the Care Boulevard. The Council also considered the current position internally, through regular visits to the new hospital location and visits to the Gynaecology and Paediatrics departments. Through membership of the Health Care Client Councils Network, the Patient Council participates in a network that generates ideas for improvements in health care. The Patient Council considers whether the ideas from all these sources can be applied at Maasstad Hospital.

Advisory reports and input

- The Patient Council discussed the 2009 Annual Report and the results up to the

third quarter of 2010. At the time of writing the 2011 budget was not yet available for advice. The Patient Council did conduct talks with the Group Controller to prepare the advisory report to be issued.
- The Patient Council nominated a candidate for membership of the Complaints Committee.
- The Patient Council issued an advisory report on the contents of the new complaints procedure.
- The Patient Council contributed ideas on the implementation of the SMS.
- The Patient Council posed critical questions concerning cooperation between the founding members of the Care Boulevard. The Patient Council accepted the replies given.
- With a number of reservations, the Patient Council accepted the amalgamation of the various laboratories.
- The Patient Council issued an advisory report on the declaration of intent concerning surveys of partnerships with third parties in relation to laboratory diagnostics, a partnership with the Maternity Care organisation and the merger of Maasstad Hospital with a support foundation.
- The Patient Council advised on various matters concerning the new hospital location, such as the direction signs and the catering facilities.

3.6 Works Council

In addition to the Patient Council, Maasstad Hospital has an OR. Membership of the OR as shown in table 14.

The Executive Board adopted all OR recommendations in 2010.

The OR recommended in favour of:
- The partnership between IC and the Burns Unit (BWC) and looks forward with interest to the final declaration of intent for the partnership between IC and BWC;
- The adoption of the Oncology policy plan;
- The split of the Neurology/Neurosurgery/Clinical Neurophysiology care unit as of 1 September 2010;
- The introduction of a nine-hour working day in oral surgery. The OR did call for attention to the staff comments on the increasing pressure of work. This must not be allowed to have a negative effect on continuity.

The OR explicitly reported that it will recommend in favour of the following requests if the employees receive appropriate assistance in finding other jobs. The positive recommendations concerned:
- Declaring a number of employees in the Building and Technology department redundant;
- The organisational changes in the Logistics department;
- The closure of the short-stay department on 1 March 2011;
- Declaring the kitchen staff redundant;
- Declaring the employees of the linen/clothing unit redundant on the basis of the staffing plan.

The OR accepted:
- The decision concerning the work of the Medical and X-Ray Archives. The OR is counting on the staff receiving assistance with finding new jobs, either within or outside the organisation;
- A nine-hour working day for day-treatment employees to enable more efficient use of treatment rooms in C8;
- The car scheme, including the user agreement, with the comment that preference goes to a small, environmentally-friendly car (hybrid);
- The implementation proposal for 'shortage jobs' that are classified at a lower level in relation to health care job valuation. The OR recommended to the management

Table 14 Membership of the OR (31 December 2010)

Name	Position	Management position
Marijke Gommans-Dane	Coordinator of infection prevention	Chairwoman
Bea Nobel	Dialysis nurse	Vice Chairwoman
Henny Rozeboom-Nesse	Dermatology outpatient assistant	Secretary
Bert den Breker	Head of events	Member
Dick de Bruijn	Maasstad laboratory quality assistant	Member
Ger de Hoogh	Nutrition & catering assistant	Member
Nel Sleeuwenhoek	Surgery outpatient nurse	Member
Kees Stigter	Physiotherapist	Member
Roelof Mevius	ICT assistant	Member
Bas Quist	EZIS application controller	Member
Coby Termijn	Maasstad laboratory clerk	Member
Iris Weerman	Head of night nursing	Member
Monica Deugd	Cardiology outpatient assistant	Member
Nel Evers-Schollaart	Secretary	Official secretary

that jobs in short supply be offered for a period of one year, with an evaluation of whether the position remains a job in short supply after nine months;
- Structural adjustment of the working hours of the pharmacy distribution unit;
- A merger with the support foundation;
- Establishment of a protocol for sickness absences.

3.7 Medical Staff Association

The medical specialists are organised and represented in the VMS. On 31 December 2010 the VMS had 191 members. The Board consists of seven members (see the table below for the membership). The VMS has its own budget and financial statements.

The tasks and responsibilities of the Board of the VMS are recorded in Regulations. The management meets the VMS members once a month in the key staff meeting, in which each discipline is represented by a key staff member, see table 15. Decisions are made in this meeting on requests for advice from the organisation, policy proposals and substantive health care matters. A general meeting of the members is held twice a year, at which the Board elections take place and the financial statements are adopted. The Board of the VMS and the Executive Board of Maasstad Hospital met once a month in 2010. In addition, a VMS Board delegation (the chairman and the secretary) attended management meetings.

The year 2010 was marked by:
- The challenge of making the right choices in an environment that poses contradictory requirements (more care, but not more money);
- An uncertain future for medical specialists;
- The need for Maasstad Hospital to expand its production;
- Improving quality and making it still more transparent;
- The ambition to strengthen our position as a top referral hospital;
- Realising the switch to a paperless hospital.

Table 15 Membership of VMS Board (31 December 2010)

Name	Position	Board position
A.F. Grootendorst	Internist	Chairman
H. Spijker	Hospital pharmacist	Secretary
D.C.D. the Lange	Urologist	Treasurer
P.P.L.O. Coene	Surgeon	Member
W.B. Becking	Radiologist	Member
J. Rapon	Anaesthesiologist	Member
P.E. van der Moer	Gynaecologist	Member

We are proud to be able to report that none of these factors disrupted the harmony among the staff or between staff and management.

Performance

- We took many steps in 2010 to improve cooperation with our neighbouring hospitals. This led to a sharp increase in the number of patients referred to our hospital from Van Weel Bethesda Hospital and Ruwaard van Putten Hospital. This flow of referred patients helped us to continue and improve the treatments than can only be performed, if a minimum number is attained. In order to play a top referral role, adherence to 400,000 patients is necessary. We can only achieve this number through regional cooperation.
- Quality also imposes requirements for the continuity of the care provided. For this reason surgeons switched to realising differentiated services per sub-field and intensivists and anaesthesiologists are available in-house around the clock.
- We completed the first round of Individual Performance of Medical Specialists (IFMS) in 2010. The IFMS is a method for evaluating and improving the performance of individual specialists.
- We spent a great deal of time on implementing a registration system and improving records relating to mortalities. Electronic prescription of medicines has been completed and will help us to avoid complications due to incorrect medication in the future.
- Finally, the role of the Maasstad Academy was strengthened and associate membership of the STZ was applied for.

We are proud that financial threats for specialists did not prevent expansion of the staff: as many as 10 new medical staff were appointed in 2010, whereas six specialists left the hospital, despite the realistic threat that the expansion of production would not be achieved. However, it remains challenging for the staff to be required and willing to work on production growth and at the same time to run the risk that they will have to fund this growth themselves.

In order to promote coherence in such a large staff we held 11 core staff meetings and two general meetings of members. We made a start on the organisation of monthly staff receptions and there were traditional staff days. Maintaining coherence is and will remain a major challenge. Overall, we may conclude that we have a staff to be proud of: they responded proactively to the demands made by our environment and are willing to make further advancements in quality, increase the number of training courses and make efforts to increase production.

Table 16 Membership of the VAR (31 December 2010)

Name	Position	Department	Board position
Peter van der Weegen	Care manager	Gyn/Obst/Paediatrics General	Chairman
Peter van Hilten	Paediatric nurse	BWC	Vice Chairman
Henk Kok	Nurse	Intervention Cardiology	Secretary
Machteld Hiensch	Specialised nurse	Cardio Care Unit (CCU)/MCC	Member
Jolanda Malefason	Nurse	Intensive Care	Member
Louise van Schelven	Specialised nurse	Casualty (SEH)	Member
Rob Oosterhof	Coordinator	Night coordination	Member
Rob van Komen	Specialised nurse	BWC	Member
Marielle van Driel	Nursing practitioner	SEH	Member
Puck van der Toorn	Nursing consultant	Outpatient Neurology	Member
Janneke Verburg	Specialised nurse	Dialysis Centre	Member
Nel Evers	Official secretary	OR	Secretary

3.8 Nursing Advisory Council

The VAR is an advisory body for the nursing and care occupational group. The main aim of the VAR is to improve and secure the quality of nursing care in the hospital, leading to optimal patient care. See table 16.

Tasks and working methods

The VAR advises the management on policy concerning nursing care by nursing and care staff. The VAR advises the management only on subjects in which both the management and the VAR have an interest. The VAR also contributes to promotion of expertise in the nursing and care occupational group (training requirement).

- The VAR identifies and advises on bottlenecks in nursing care.
- The VAR identifies and advises on nursing developments.
- The VAR advises on quality requirements for the nursing profession.

Following a training course in spring the VAR decided, by agreement with the management, to start work on an annual plan. The VAR wishes to investigate, whether this is possible via the CCPM with which projects in the hospital are monitored. The VAR agreed with the management that it will try to issue clear instructions and will monitor, whether the management adopts its recommendations more effectively.

Advisory reports

In 2010, the VAR presented the following advisory reports to the management:

- The VAR issued a positive recommendation to the management on the Oncology policy plan. The VAR recommended that the oncology course be offered as an option to these nurses.
- The VAR advised the management to issue a clear policy on vaccination safety in Maasstad Hospital. The management should include procurement as a consideration for contracting new agreements for injection needles.
- The VAR advised the management to include polo shirts in the new clothing line.
- The VAR advised the management to prevent EPD nurses from being able to prescribe medicines.

Table 17 Membership of the TWOR (31 December 2010)

Name	Position	Management position
T.I. Yo		Chairman
W.A.A.M. van den Bergh	Deputy lawyer	Secretary
T. Bosch	Clinical pharmacologist	Member
M.A.J.M. Buijsen	Ethics specialist	Member
H. Ferguson	GP	Member
M. Groeneweg,	Physician	Member
P.N. van Es		Added member
K. Helbers		Trial persons member
W.C.J. Hop	Methodologist/statistician	Member
E.H. Hulst	Lawyer	Member
F.E. de Jongh	Physician	Member
G.C.H. Metz		Added member
C.D. Schutrups-Duyvendak		Trial persons member
H. Spijker	Hospital pharmacist	Member
D.J. Theunissen	Hospital pharmacist	Member

3.9 Association of Surgeons in Training

The Association of Surgeons in Training (AAV) is an association for all surgeons in training (AIOS and doctors not in training as specialists (ANIOS)) and assistants of the medical support specialisms (hospital pharmacists, clinical chemists and clinical physicists). The objective of the AAV is to represent the interests of doctors' assistants. It also aims to promote communication and social cohesion among assistants in different specialisms.

Objectives for 2010

In 2009, the AAV of Maasstad Hospital was reactivated after last being active in 1992. 2010 was marked by further design of the management structure, setting up a member file and widely increasing the name recognition of the AAV.

Objectives achieved in 2010

A management structure was created in 2010, in which the Board had regular meetings with the Central Training Committee (COC), the Executive Board and the Maasstad Academy. The membership consists of the 70 physician assistants from all the different disciplines. Attention was also widely drawn to the AAV by means including flyers and newsletters to other potential members.

The AAV was closely involved in the STZ visit. The following activities were organised:

- Symposium on financial aspects of medical specialisation.
- Visit to the Bodies Exposition evening exhibition.
- Workshop on domestic violence
- Informal get-togethers.

3.10 Other committees and advisory bodies

3.10.1 Medical Ethics Assessment Committee

Medical research is needed for the development of new treatment methods, medicines and medical aids. Maasstad Hospital takes part in this research. Medical research on humans may only be conducted with a positive assessment of a Medical Ethics Assessment Committee (METC) and the approval of the management. Together with the Ikazia Hospital Maasstad Hospital has formed the Rotterdam Regional Research Assessment Committee (TWOR). This allows both hospitals to develop the ambition to play a role in the regional assessment of research. The TWOR is an institutional committee recognised by the CCMO, which provides for the primary assessment of the research protocols of both hospitals on the basis of the Human Research Act (WMO, 1999). See table 17.

Hospital pharmacist H. Spijker chaired the TWOR since its formation. At the end of 2010 he was succeeded by T.I. Yo, surgeon. The TWOR met monthly during 2010.

Agreements were reached with neighbouring hospitals on the assessment of their primary protocols. The TWOR complies with the requirements of the WMO and is entitled to assess clinical research into medicines.

3.10.2 Local Feasibility Committee and Research Bureau

In order to stimulate and support research at Maasstad Hospital the Local Feasibility Committee (LUC) and the Research Bureau (WB) operate alongside the TWOR. See table 18.

The LUC advises the management on the local feasibility of proposed research approved by a recognised METC. The LUC assesses whether:

- The researchers concerned are sufficiently expert
- The necessary infrastructure is sufficiently available at the hospital
- All parties involved are well-informed
- The patient information is tailored to Maasstad Hospital
- The research is adequately insured.

The LUC also advises the management on research that is not governed by the WMO. This concerns research involving questionnaires, research in which only patient data is recorded or research involving further use of bodily substances. In the case of this research the Committee primarily considers how the privacy of those involved is protected.

As a rule the LUC meets twice a month.

The WB assists researchers in submitting research protocols to the TWOR and LUC and provides support for both committees. As part of Maasstad Academy the WB also provides support for research content, such as advice on drawing up research plans, assistance in setting up a database, statistical analyses and the presentation of research results. See table 19.

3.10.3 Complaints Committee

In compliance with the Complaint Rights of Health Care Sector Clients Act, Maasstad Hospital has a Complaints Committee consisting of five internal members (representing the medical and nursing staff of the hospital), three external members (representing organisations of GPs and patients in the region) and an independent chairman, see table 20. A list of the complaints submitted is presented in paragraph 4.4.2.

3.10.4 Employee Complaints Committee

The management and OR consider it important that Maasstad Hospital is able to critically reflect on issues arising in the organisation that concern employees. The

Table 18 Membership of the LUC (31 December 2010)

Name	Position	Position in LUC
H. Spijker	Hospital pharmacist	Member (chairman)
W.A.A.M. v.d. Bergh	Deputy lawyer	Member (secretary)
J. Nijman	Science officer	Member
M.C. Abels	Secretary	Secretary

Table 19 Membership of the Research Bureau (31 December 2010)

Name	Position	Position in WB
J. Nijman	Science officer	Science officer
M.C. Abels	Secretary	Secretary

Table 20 Membership of the Complaints Committee (31 December 2010)

Name	Position	Management position
A.F. de Kok	Secretary-lawyer, Regional Medical Disciplinary Board	Chairman, external member
C. Sallaerts	Member of Patient Council	Vice Chairman, external member
V. Moraal	Member of Patient Council	External member
R. Hoegen	GP	External member
M. Westerink	Neurologist	Internal member
R. Kingma	Orthopaedic specialist	Internal member
M.L.F. Voll	Anaesthetist	Internal member
N. Wansink	Rehabilitation Care Manager, Neurology	Internal member
A. Maliepaard	Team Leader, Patient Registration & After-Care Bureau	Internal member

Table 21 Membership of Employee Complaints Committee (31 December 2010)

Name	Management position
B.I. Nobel (dialysis nurse)	Representing the OR
M.M.T. Deugd (cardio-physiology laboratory researcher)	Representing the OR
K. Stigter (physiotherapist)	Representing the OR
P.E. de Goeij (official secretary of Patient Complaints Committee)	Representing the employer
D.B.M. van der Hijden (chaplain)	Representing the employer
I.M. Mathura (team leader)	Representing the employer
M.H. Toele (application manager)	Representing the employer
N. Evers	Official secretary
J.G.M. van Rossum	External chairman

Table 22 Membership of VIM Committee (31 December 2010)

Name	Management position
Vacancy	Chariman
W.A.A.M. van den Bergh (lawyer)	Secretary
T.J.M.A. Frijns (hospital pharmacist)	Member
M.T.C. Over de Vest (team leader)	Member
R. ten Kate (anaesthesiologist)	Member
O. Boonstra (surgeon)	Member
I. Pons (KCL operations manager)	Member
E. Baan-Huberts (team leader, outpatient surgery)	Member
N. Beks (junior surgeon)	Member
A.E.M. van der Pool (junior surgeon)	Member
M.C.C. Langenberg (junior surgeon, internal medicine)	Member
B. van Kruining (quality officer)	Member
R. Kortenhorst (IC nurse)	Member
H. Iddekinge (IC nurse)	Member
G.C.M. Baan-Barayazarra	Secretary

Employee Complaints Committee offers individual employees an opportunity to submit complaints to an independent internal employee complaints committee. See table 21.

Complaints are handled concerning forms of harassment, assistance in the event of traumatic experiences, entries in the annual hours recording system, the Social Plan and job ranking objections. The Committee can be contacted by all employees with an employment contract with Maasstad Hospital. This group includes students, trainees, co-assistants, volunteers, temporary employees and medical specialists affiliated to Maasstad Hospital pursuant to an admission contract. The Committee makes use of regulations.

3.10.5 Safe Incident Reporting Committee

As part of the overall quality policy, the Safe Incident Reporting (VIM) Committee focuses on the assessment of reported incidents (errors, accidents, near incidents and unsafe situations) and advises the management and the VMS Executive on that basis. The issue here is not who is to blame for an incident, but how such incidents can be avoided in the future. The Committee's aim is therefore to obtain an insight into the aspects of care provision that require improvement. See table 22.

Only if incidents are reported systematically is it possible to identify causes and to start up improvement actions. In this way the VIM Committee aims to contribute to the quality of care provision. See paragraph 4.4.4 for a review of the number and nature of the reports.

3.10.6 Casualty Committee

Casualty Committee is a consultative body for the development and determination of policy on the casualty service at Maasstad Hospital. The aim of the Committee is to evaluate and steer the (medical and nursing) organisation of the Casualty department. It also issues

Table 23 Membership of the Casualty Committee (31 December 2010)

Name	Management position
G.R. Roukema (surgeon and Casualty medical manager)	Chairman
M.W. van Bokkum (team leader, Observatory and Plastering Section)	Member
Demirkiran, (trainee surgeon)	Member
M. van der Heijden (anaesthesiologist)	Member
J. Ligthart (internist)	Member
C. van Noord (trainee internal medicine specialist)	Member
M.R. Remijn (manager, Casualty/Patient Logistics care unit)	Member
A.C. Sikkenk (radiologist)	Member
F. Smit (paediatrician)	Member
M. van der Stel (Casualty team leader)	Member
M. Westerink (clinical chemist)	Member
R.W. Wulkan (clinical chemist)	Member
B.M. van Bregt (secretary to M. Remijn)	Secretary

Table 24 Membership of Organ and Tissue Donation Committee (31 December 2010)

Name	Management position
J.M.M. Boots (internist-nephrologist)	Chairman
F. Huisman (donations officer)	Secretary
J.C. van Leeuwen (donations officer)	Secretary
B. Cleffken (surgeon-intensivist)	Member
J.P.A. Samijn (neurologist)	Member
De Lind–Van Wijngaarden (junior surgeon)	Member
G. Chong (internal medicine AIOS)	Member
R.F. Roodenburg (patient representative)	Member
N.R. Christianen (Observatory nurse)	Member
J.A.M. Hagenaars (transplantation coordinator)	Advisory member

advisory reports to the VMS and the management, on request or otherwise. See table 23.

The quality policy for Casualty departments is codetermined nationally by the influence of the IGZ and Medirisk. The Casualty Committee determines the quality policy for the Casualty service of Maasstad Hospital on the basis of the set guidelines.

3.10.7 Organ and Tissue Donation Committee

With the introduction of the Organ Donation Act Maasstad Hospital acquired obligations in the field of organ and tissue donation. In order to implement the donation policy at Maasstad Hospital effectively, an Organ and Tissue Donation Committee was formed. See table 24.

Table 25 Membership of Reanimation Committee (31 December 2010)

Name	Management position
K. Gigengack (anaesthesiologist)	Chairman
E. Monteban (temporary IC care manager)	Member
J. Assink (internist-intensivist)	Member
H. Stas (paediatrician-neonatologist)	Member
H. Spijker (pharmacist)	Member
H. Toppen (Neonatology/Paediatric Department team leader)	Member
C. Kuijs (reanimation coordinator)	Member
W. Mes (IC nurse)	Member
P. Muilwijk (IC nurse)	Member

The donations officers are the point of contact for all questions concerning donations. These officers provide for the procedures concerning organ and tissue donation, in compliance with the Act, and their implementation. They also provide for the circulation, development and compliance with the (model) organ and tissue donation protocol. Other important tasks are the education, information and in-service training of employees on all aspects of organ and tissue donation.

3.10.8 Reanimation Committee

The Reanimation Committee is a consultative body for the development, establishment and evaluation of policy concerning reanimation and training in Maasstad Hospital. The Reanimation Committee organises Basic Life Support (BLS) reanimation courses for nurses and everyone involved in patient care. These courses should be followed each year. See table 25.

Since February 2008 courses in BLS for children have been provided. In the first instance these courses are intended for employees who come into contact with paediatric patients. For nursing staff (Casualty, IC, CCU, BWC, anaesthesia and intervention cardiology), evening-night coordinators and surgeons in training) an external agency provides Advanced Life Support courses.

3.10.9 Emergency team

The Emergency Team consists of five employees, who focus on the coordination of preparations for and handling of emergencies. The Emergency Team has drawn up a unique plan based on an integrated approach to both internal and external emergencies and safety procedures. This is a general plan for all incidents, combining a number of safety plans required by law. The team holds primary responsibility for the implementation and assurance of the emergency plan. Part of the emergency plan concerns emergency management. Various crisis teams are described, which will form the most important links in the organisational field during an emergency. The staffing and hierarchy of these crisis teams is described in the Emergency Plan.

MAASSTAD ZIEKENHUIS

4 Policy, input and performance

This Chapter first describes our long-term policy, general policy and quality policy. We then discuss the quality policy regarding patients, followed by a specific discussion of that of our employees. Maasstad Hospital also undertakes activities in the field of CSR. We present a picture of our goals, policy, input and performance in that field during 2010. The Chapter concludes with the most transparent picture possible of our financial policy.

4.1 Long-term policy

4.1.1 Mission and vision

Maasstad Hospital operates in a rapidly changing and competitive environment. This has led the hospital to a strong focus on customer-orientation in its vision and mission, in order to distinguish the hospital still more clearly from other care institutions.

This has led to the following vision:

> ***'The hospital is for us all'***
> *Maasstad Hospital is the hospital that patients, family members, visitors, employees, GPs and health insurers perceive as MY hospital.*
> *('I am proud of my hospital')*

In order to realise this vision we have formulated the following mission statement:

> ***'Leading, professional and customer-oriented'***
> *We ensure that we empathise with our patients, family members, visitors, GPs and health insurers in such a way that they will recommend us to everyone and promote our hospital.*
> *('I have faith in Maasstad Hospital')*

MAASSTAD ZIEKENHUIS

Table 26 Strategic long-term plan

Core value	Priority area	Target for 2012 (SMJBP)
Safe with good quality outcomes	Quality and safety	- SMS implemented - Recognised accreditation
'Guest-oriented' thinking and actions by inspired personnel	Patient satisfaction	- Average Net Promoter Score (NPS): 25% - Average score between 8 and 8.5
Financially successful	1. Outpatient market share 2. Result on ordinary activities 3. Capital ratio[1] 4. Ratio of 'revenue[2] & growth' costs 5. Debt-Service Coverage Ratio (DSCR)	1. Market share is 25% 2. Result is EUR 4.4 million 3. Capital ratio is 15% 4. Ratio is 1.25 5. DSCR is at least 1.4

1 Equity/total revenue, including extraordinary expenses
2 Revenue is equal to the total operating revenue

4.1.2 Ambitions

In order to be able to implement the mission it is important to know what we want to be. We refer to this as the core values of our structure, which must be seen not as individual units, but as a consistent whole.

Maasstad Hospital wants:
1. To be safe with good quality outcomes;
2. To continually improve;
3. To provide 'guest-oriented' thinking and action by inspired staff;
4. To be financially successful.

4.1.3 Strategic Long-Term Policy Plan

The core values described above have been translated in the Strategic Long-Term Policy Plan (SMJBP). This policy plan was initially drawn up for the years 2006 – 2010, but in view of the progress with the results, was revised for the years 2006 – 2012.

The objectives

The SMJBP formulates the objectives on the basis of the four core values. The objectives are based partly on a thorough analysis of the market, the available capacity and specialisms of the hospital, the deployment of resources and the size and possibilities of the new hospital, which will be commissioned in mid-May 2011. See table 26.

Fourth core value: continuous improvement

It is self-evident for us and our patients that we want to continually improve in what we do each day. As a core value for our hospital, 'continuous improvement' has also been the driver for starting the programme based on the TOC). In short, this theory means that care processes are examined and problems arising in these are eliminated. With the aid of the TOC, we have learned how to manage projects more successfully and how to design

	Target for 2010 (towards 2012)	Realisation in 2010	Realisation in 2009
	- 7 of the 10 national themes of the SMS programme implemented - Recognised accreditation	- Start on implementation in accordance with three national themes of the SMS programme - Accreditation to be redirected	- First four national SMS themes implemented - Compliance with NTA standard 8009:2007
	- Average NPS: 25% - Average score between 8 and 8.5	- Average NPS: 13.8% - Average score of 8.1 (based on the 1st quarter)	- Average NPS: 17.0% - Average score of 7.9
	1. Market share of 21.5%, including 168,944 initial outpatient visits 2. Budget 6.6 million. 3. Capital adequacy is 15% 4. Ratio is 0.80 5. DSCR at least 1.0	1. 168.944 initial outpatient visits, for which the market share will be announced in the summer of 2011 2. Result is EUR 4.8 million 3. Capital adequacy is 16.2% 4. Ratio is 0.98 5. DSCR 3.49	1. 158,289 initial outpatient visits, representing a market share of 21%. 2,3,4 and 5: no targets yet in 2009

care processes ('care paths'), so that patients are more satisfied with how agreements are made with them and met (Source: Care magazine No. 10, October 2010). In 2010 we doubled the number of projects completed successfully with the same number of staff in half the time, with the aid of Critical Chain Project Management. In 2011 we shall continue to aim for:

- Reliability of delivery of ≥ 90%;
- 30% reduction in throughput time;
- 30% increase in productivity;
- Calm and focus in project teams and management.

By applying TOC we are able to help more patients with the same capacity, leading to growth. The core value of 'continuous improvement' is not yet included in the long-term plan. The objectives have been formulated for different departments, however. These are shown in paragraph 4.2.5. See also figure 6.

Chain care: an opportunity

Finally, the hospital wishes to distinguish itself through the way in which we cooperate with other providers. The alliance that Maasstad Hospital has contracted with the other health care providers for the Care Boulevard at the new location is an example of how we aim

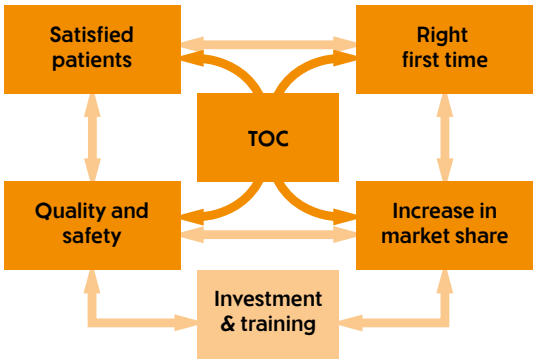


Figure 6 Theory of Contraints

Table 27 Policy quality and safety

Core values	Priority area	Target for 2012 (SMJBP)
Safe with a good quality outcome	Quality and safety	- SMS implemented - Recognised accreditation

to be an innovative hospital operating at the heart of its society and moving with the times. Together with the Delta Psychiatric Centre, Aafje Zorghotel, Rotterdam Maternity Care and the Rijnmond Switchboard for GP Posts, Maasstad Hospital formed the Rotterdam Care Boulevard Association in April 2008.

With the aid of the Association the five care partners aim to coordinate the care services of the various tenants, so that a logical chain is created, tailored to patient and client demand. Examples of cooperation include the midwifery partnership with Maasstad birth hotel, the partnership with Delta Psychiatric Centre for psychiatric patients with somatic complaints and the Emergency Square, where our Casualty department works together intensively with the Rijnmond Switchboard for GP Posts. These initiatives are designed to improve patient satisfaction and increase the market share to 25%.

4.1.4 Evaluation and adjustment of the strategic long-term policy plan

The SMJBP has been adjusted on a number of points. For example, the hospital decided to discontinue steering for 'cost-to-serve'. Steering for this element was withdrawn in 2010. This steering measure dates from several years ago, when Maasstad Hospital was climbing out of a financial trough. Modern times call for steering for different indicators.

The 'financially successful' pillar was made measurable in 2010 and was monitored for the following three indicators:

1. Result: result on ordinary activities;
2. Capital adequacy: equity/total revenue including extraordinary expenses;
3. Ratio of revenue growth to cost growth: revenue is equal to total operating revenues.

Preparation of new long-term plan

Preparations for a new long-term plan for the hospital, with the working title 'STIP 2015', began at the end of 2010. In other words: where do we want to be in 2015? This plan will be developed further, with concrete targets, in the spring of 2011. An important factor here is the direction announced by the Minister of Public Health for the future of the hospitals. Maasstad Hospital aims to make full use of the scope that will be created.

4.2 General policy

This paragraph describes policy for sections of the long-term policy, on the basis of our core values. We discuss the policy, efforts and performance achieved in 2010 here.

4.2.1 Core value: safety with a good quality outcome

Our patients are entitled to assume that Maasstad Hospital is safe. The safety of our patients must be guaranteed. For a patient, 99% safety is not reliable enough. Patients must also be able to rely on the proposed medical treatment leading to the most successful recovery from the illness. In other words, on 'a good quality outcome'.

	Target for 2010 (towards 2012)	Realisation in 2010	Realisation in 2009
	- 7 of the 10 national themes of the SMS programme implemented	- Start of implementation of the next three national themes of the SMS programme	- First four national SMS themes implemented
	- Recognised accreditation	- Accreditation redirected	- Compliance with NTA standard 8009:2007

No quality without safety and no safety without quality.

Safety management system (SMS)
We have set ourselves the goal of full implementation of the SMS in the year 2012. The SMS contains a safety management system and 10 largely evidence-based substantive medical themes. With the SMS we can continually identify risks, implement improvements and base policy on this. See table 28.

Maasstad Hospital implemented the first four national themes in 2009, after which the hospital worked on the next three themes according to the national SMS standard from January 2010. This is scheduled for completion in early 2011. Our plans are still aimed at implementing the entire SMS programme by the end of 2012. With the efforts in 2011 there is a realistic prospect of achieving this goal. See table 27.

On the basis of the Safety Risk Identification & Evaluation (VRIE) and the analysis of the VIM, we also addressed three of the six internal themes:
- Theme: Safety of medication;
- Theme: Compliance with and use of protocols;
- Theme: Access to and employability of Personnel (Not) in Permanent Employment (P(N)IL).

Safety controls
In the year under review, the hospital developed indicators that were included in the Management Information System, so that the management can steer for safety and the position in the safety field becomes transparent. Team leaders, managers and the Executive Board closely monitor and discuss

Table 28 SMS themes

Theme	Started	Year	Completed
Theme 5: Preventing unintended avoidable injury among older patients	Yes	2010	No
Theme 6: Preventing mortality due to cardiac arrest	No	2011	No
Theme 7: Preventing unnecessary pain for patients	No	2011	No
Theme 8: Preventing incidents in the preparation and administration of high-risk medication	Yes	2010	No
Theme 9: Preventing exchanges of and among patients	No	2011	No
Theme 10: Prevention of kidney insufficiency in the use of contrast agents and medication	Yes	2010	No

progress with these indicators. This allows appropriate measures to the taken immediately, throughout the year, if necessary.

For our employees we organise theme days on the SMS to improve their knowledge and/or conduct interesting discussions. 'Siren actions' are also organised throughout the organisation each month in order to check whether a particular department has the safest possible situation. Hygiene and medical equipment are among the issues assessed. We also make safety rounds of the hospitals, in which we conduct talks with employees on safety, together with a representative of the management.

Accreditation

Following talks with the Netherlands Institute for Accreditation in Health Care (NIAZ) Maasstad Hospital decided in 2010 not to continue with preparations for accreditation according to the NIAZ standards. The working method required for NIAZ accreditation is insufficiently matched to the design of steering for the hospital. Accreditation would impose too many other requirements, which the hospital believes would have a counterproductive effect on the development of quality and safety. At the same time, NIAZ accreditation does not cover the performance of the medical staff sufficiently. Although this would be possible under the hospital's own responsibility, the hospital decided to investigate whether a different accreditation was possible. The possibility was found in accreditation by the Joint Commission International (JCI) from the US. In the spring of 2011, the hospital will make a final decision on whether to opt for the JCI and the term within which this accreditation is possible.

Fraud control

If employees are found to be committing fraud, they will at least be issued with an official warning and dismissal and reporting to the police may follow. Disciplinary measures will be taken in proportion to the severity of the offence.
The Certificate of Good Conduct, which is mandatory on contracting of an employment contract/partnership agreement with Maasstad Hospital, is one of the preventive measures taken to control fraud.
In the hospital, the rule is that active action is taken if fraud by patients or staff is detected. In 2010, reports of fraud by patients were made on two occasions. These both concerned a patient who obtained care with another person's health insurance card. In both cases, the relevant care insurer was contacted, which then solved the problem with the patient. The hospital takes responsibility for recording the citizen service number, which is used to prove the identity of the patient.

4.2.2 Core value: Guest-oriented thinking and action by inspired personnel

The core value of 'guest-oriented thinking and action by inspired personnel' forms the main pillar of our ambition. With this concept we aim to distinguish ourselves from other health care institutions. This means that we treat our

Table 29 Policyplan Patient Satisfaction

Core value	Priority area	Target for 2012
Guest-oriented thinking and action by inspired personnel	Patient satisfaction	- Average NPS: 25% - Average score between 8 and 8.5

NPS =% definite promoters: patients who assign a score of 9 or 10, less percentage of patients who are unlikely to recommend Maasstad Hospital (scores of 6 or less)

patients more like guests than like patients. As a good host, we aim to provide our guests with all conveniences and make their stay as pleasant as possible. Perhaps even more important is that our guests can be themselves and feel at ease. The question of which behaviour patients always want to see in order to become true promoters of our hospital is answered by:

1. Attentive listening;
2. Do what you say and say what you are doing;
3. Do you understand the problem I am dealing with?!

If I feel good, I move through my world with confidence, but if I am ill, I feel uncertain about my illness and its influence on my life.

For Maasstad Hospital guest-oriented thinking and action means that all hospital employees do their utmost together for our patients: genuinely giving patients attention together. As a good host, our ambition is to provide our guests with every convenience and make their stay as pleasant as possible. Our ambition is therefore that all employees empathise with patients, their family members, visitors, GPs and care providers, so that they are so satisfied that they recommend us to everyone and act as promoters of our hospital.

As a translation of the long-term policy plan the accompanying targets and performance are presented below. We measure progress at the group level with:

1. The NPS;
2. Average score of the Patient Satisfaction Monitor.

See also table 29.

1 The Net Promoter Score

The NPS is based on one question: Would you recommend us? The method is based on the fact that there is a strong correlation between the growth rate of a company and the percentage of 'promoter' clients. Maasstad Hospital scored an NPS of 16% in 2008, rising to 17% in 2009. However, in 2010 the hospital scored an NPS of 13.8%. The graph shows the quarterly results from 2008 onwards.
This break in the trend may be explained by the change in our survey method. Since April 2010 surveys of patient satisfaction have no longer been conducted by telephone, but via a digital questionnaire. The figures in the telephone survey proved to be more positive than in the online survey. The diminution appears to be an effect of the time at which the switch was made from the telephone to the online survey method. The main reason for this difference is that respondents in online surveys can give their replies more anonymously. The respondents are not dealing with an interviewer asking the questions and consequently dare to be more critical in online surveys. Telephone surveys therefore lead to more socially desirable replies. We also changed the formulation and the number of questions of those in earlier years, as a result of which we must take a critical look at whether these results are properly comparable

	Target for 2010	Realisation in 2010	Realisation in 2009
	- Average NPS: 25% - Average score between 8 and 8.5	- Average NPS of 13.8% - Average score of 8.1 (based on the 1st quarter)	- Average NPS of 17.0% - Average score of 7.9

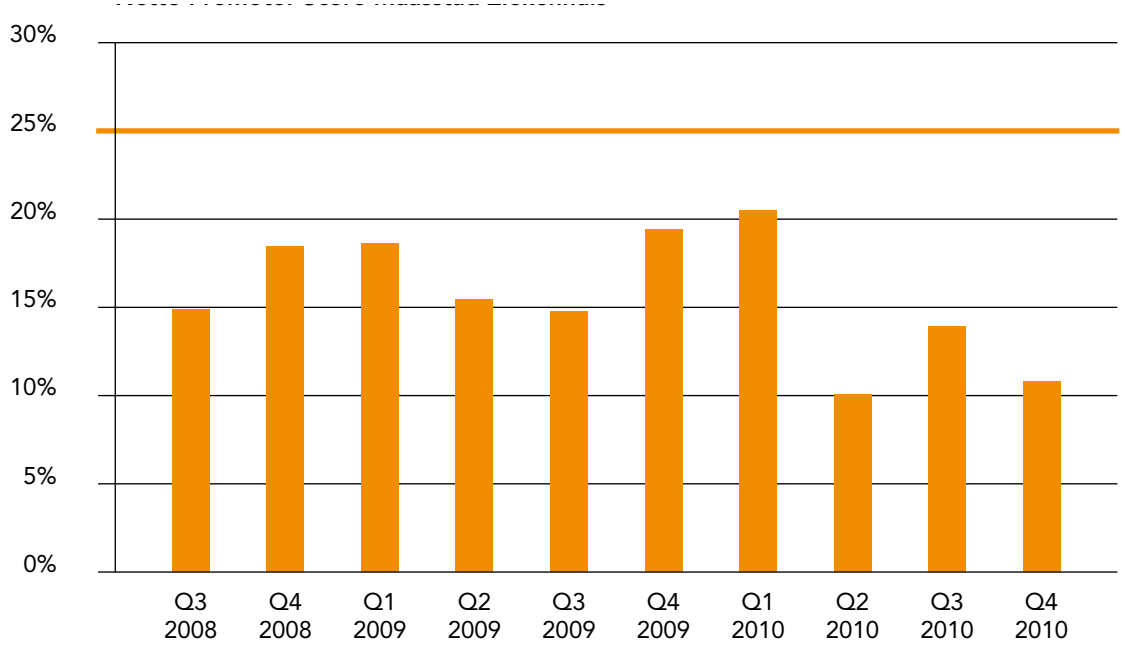


Figure 7 Nett Promotor Score

with earlier years. Naturally, we will continue to assess developments in patient satisfaction and to take measures to increase patient satisfaction. See also figure 7.

2 Patient Satisfaction Monitor

With the Patient Satisfaction Monitor (PTM) the hospital investigates whether patients are satisfied with the care, attention and service provided. The survey is conducted by an independent research agency, Blauw Research. This agency contacted patients selected randomly to take part in this online survey, after which Maasstad Hospital received the anonymous results. The average score in 2008 was 8.0. The hospital scored 7.9 in 2009. In the first quarter of 2010 patients assigned a score for general satisfaction for these factors. The average score in that quarter at the hospital level was 8.1.

In the second quarter we began measuring general satisfaction with the aid of a five-point scale (very satisfied to very dissatisfied). The results of this for the remaining three quarters of 2010 were as follows:

Table 30 Results of Patient Satisfaction Monitor (per quarter)

	Q2	Q3	Q4
Very satisfied	25.4%	29.3%	25.5%
Satisfied	65.6%	61.8%	66.5%
Not satisfied, not dissatisfied	5.7%	5.8%	5.8%
Dissatisfied	1.8%	1.9%	1.3%
Very dissatisfied	1.2%	0.9%	0.7%
Don't know	0.3%	0.3%	0.2%

Main general conclusions:

- Once again in 2010 the vast majority were satisfied with the care provided by Maasstad Hospital and a third or more of the patients of almost all health care departments were promoters.
- The dialysis (33), pulmonary medicine (27), anaesthesiology (27) and plastic surgery (27) departments achieved very good scores for intended recommendation.
- Continued focus on departmental waiting times is required, primarily at SEH.

- In addition to the provision of information, human behaviour such as listening and empathy with the patient's situation became priorities in 2010.

Efforts in our drive for greater patient satisfaction

In order to achieve this goal the hospital has developed a great number of activities in the 'Patient as Promoter' programme since 2008.

What has been done with the survey results?

The results of the survey provided an insight into how we should increase capacity for empathy with our patients. It also gives us a picture of what we should focus attention on as individuals, as departments and as an organisation. Activities are developed at each level. In 2010, for example, the hospital:

- Appointed a hostess to receive patients and if necessary, help them undress;
- Mirrorconversations with patients;
- Conducted intervision meetings at which nurses learn to support patients with serious illnesses in different ways;
- Held a treat day for oncology patients;
- Initiated continual work by departments with recommendations from the Employee Satisfaction Survey (MWO) (see paragraph 4.5.14) and the internal service monitor (paragraph 4.3.16).

The following improvements were also implemented:

- Telephone access was further improved (see figure 8). Telephone access is measured and monitored in the outpatient departments of Maasstad Hospital each month. The graph below shows improvements in access in 2010 in comparison with 2009;
- Waiting times were shortened and made more pleasant (see table 33);
- Patient after-care was considerably improved by follow-up calls to patients. Any questions can then be answered immediately and if required, appropriate action can be taken.

Guest-orientation as a core competency of our staff

In 2010 guest-orientation was established as a core competency for all Maasstad Hospital employees, in addition to willingness to

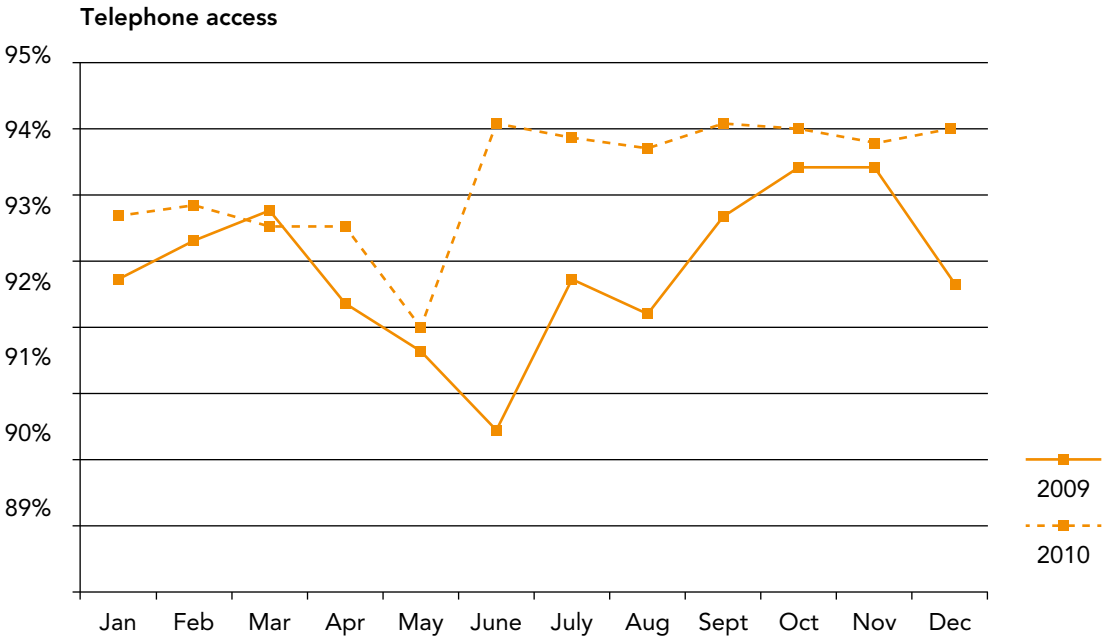


Figure 8 Telephone access

cooperate and result-orientation. The rules of conduct were also adjusted. Intensive talks on what this would mean in concrete terms were conducted in almost every department of the hospital. A separate module was also designed for new employees, to familiarise them with our vision, emphasising their own role in this. In order to keep the theme of guest-orientation alive, (humorous) actions are held every quarter on different themes:

- I make the difference;
- I empathise;
- We achieve our goal together;
- I solve the problem.

See also figure 9.

Power of commitment

Guest-orientation will remain an important goal in 2011. Under the motto of 'The Power of Commitment' we aim to:

- Continue to investigate working processes (at the new hospital) from the patient's point of view;
- Invest in a series of training courses in the field of guest-orientation for all employees;
- Continue to organise actions on different themes.

If support departments work professionally, they can provide good support for the health care departments, among other things. This enables the health care units to provide patients with good care and service. We assume here that responding to patient perceptions leads to greater patient satisfaction, as a result of which the number of (new) patients will grow.

Since 2007, we have conducted research into:

- Patients' perceptions of the hospital, through the PTM;
- Employees' perceptions of the hospital, through the MWO (see also paragraph 4.5.14);

Figure 9 Parts of Guest-orientation

- Employees' perceptions of internal services, through an Internal Service Monitor (ISM) (see also paragraph 4.5.16).

The objectives for the market surveys in 2011 are:
- To create links between the three surveys (PTM, MWO and ISM);
- To digitise the survey results for faster feedback to the staff;
- To develop the survey results in terms of more workable recommendations for improvement for each department;
- To set up a market research department in order to meet the growing demand for follow-up surveys.

4.2.3 Core value: Financially successful

The 'financially successful' core value is extremely important for our hospital. We aim to be financially successful to enable us to continue making investments in the future and to continue innovating. Maasstad Hospital has formulated four priority areas for the 'financially successful' core value:
1. Increasing the outpatient market share;
2. Result on ordinary activities;
3. Capital adequacy;
4. Relationship between growth of revenue and growth of costs.

Table 31 Policy Financially successful

Core value	Priority area	Target for 2012	Target for 2010	Realisation in 2010
Financially successful	1. Outpatient market share 2. Result on ordinary activities 3. Capital adequacy: equity/total revenues, including extraordinary expenses 4. Ratio of growth in revenue to growth in costs: revenue equals total operating revenues	1. Market share is 25% 2. Result is 4.4 million 3. Capital adequacy is 15% 4. Ratio is 1.25 5. DSCR is at least 1.4	1. Market share of 21.5% including 168,944 initial outpatient visits 2. Budget 6.6 million 3. Capital adequacy is 15.0% 4. Ratio is 0.80 5. DSCR is at least 1.0	1. 168,944 initial outpatient visits, the market share for which will be announced in the summer of 2011 2. Result is 4.8 million 3. Capital adequacy is 16.2% 4. Ratio is 0.98 5. DSCR 3.49

Table 32 Development of outpatient market share (target versus realisation)

	Realisation in 2010	Target 2010	Realisation in 2009	Realisation in 2008
Number of 1st outpatient visits	168,944	169,917	162,537	151,964
% growth in 1st outpatient visits in comparison with a year earlier	3.9%	4.5%	7%	3.7%
Market share	Known in the summer of 2011	21.5%*	21.0%	20.4%

** Forecast based on growth of the market in the past five years*

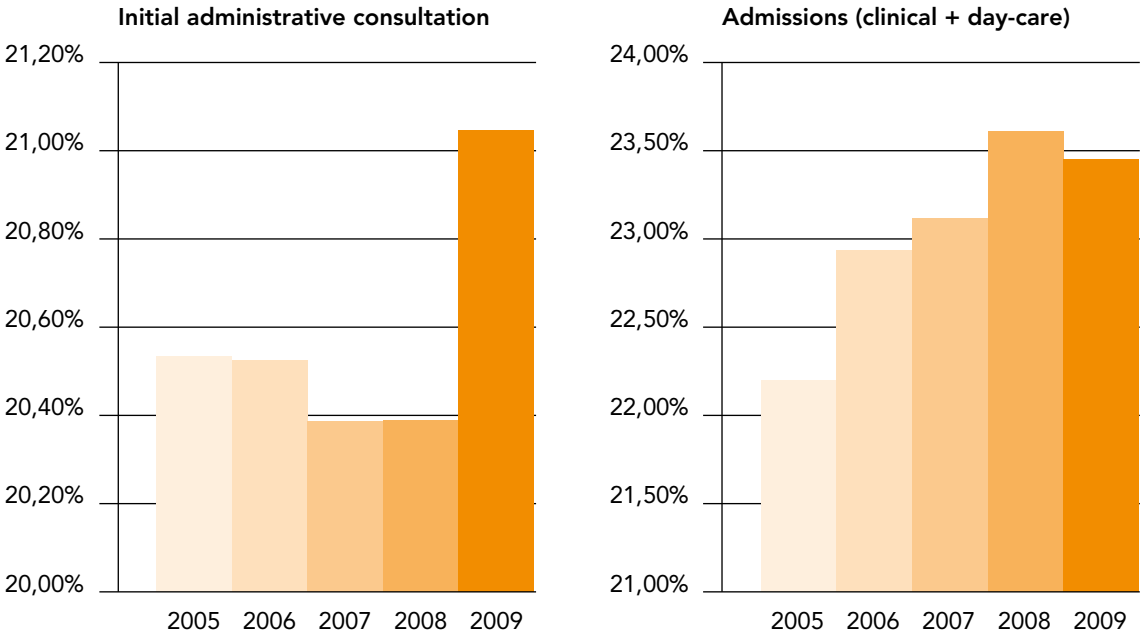


Figure 10 Movements in market share (outpatient and clinical + day-care)

Maasstad Hospital is responsible for its own housekeeping. We must watch our income and expenditure ourselves.

The targets and realisation are presented in the tables 31 and 32.

1 Outpatient market share

In 2009 our outpatient market share in the Rijnmond catchment area proved to have grown considerably in comparison with 2008, from 20.4% to 21%. This was because Maasstad Hospital was growing faster than the market. In 2010 there were 168,944 initial outpatient visits, compared with a target set at 169,917. Unfortunately, this target was not met in full. The market share that Maasstad Hospital achieved in 2010 will be announced in the summer of 2011, as there will then be an insight into the growth of the overall market. See table 32 and figure 10.

Efforts in our drive for a larger market share

In 2010 Maasstad Hospital gained a more competitive position in the region. In order to increase the outpatient market share:

- Maasstad Hospital listened closely to patient requirements in order to then match the hospital's care processes and services to those requirements. Among other things, we achieved shorter entrance and waiting times in the outpatients' departments, as well as new combined surgery hours.
- Do what we say and say what we are doing. We want to distinguish ourselves by continually making what we do transparent for the patients, which will increase patient satisfaction.
- We invested in a better relationship with referring physicians such as GPs, for example through a broad package of accredited upgrading courses (see 4.3.9).
- We increased our name recognition among (potential) patients through our corporate campaigns.

2 Result on ordinary activities

In the long-term budget for 2010-2013 Maasstad Hospital recorded that it aims for continued profit growth in 2012, from a sound basis in 2010, following a modest profit in 2011. We take account here of substantial once-only costs for the preparation of the new hospital. Realisation in 2010 did not entirely meet expectations. Costs are growing faster than forecast in relation to the revenues. The hospital has implemented a large number of efficiency measures. A large number of further efficiency measures are also in preparation, in order to achieve a better result. The Executive Board and the management (medical and organisational) are closely involved in this process. The developments are described in more detail in paragraph 4.7.

3 Capital adequacy

In recent years the hospital achieved good capital adequacy for the health care sector. The explicit aim is to continue growth in this field. Driven by the growing risks in the sector and the desire to maintain a strong position in relation to financiers, the hospital is aiming for a capital adequacy ratio of 15% in 2012.

Due to the result, which trailed expectations, realisation was not entirely in line with the budget in 2010. With supplementary measures to improve the result the hospital wishes to maintain the target.

4 Ratio of growth in revenue to growth in costs

Maasstad Hospital aims for a revenue mix in which revenue growth contributes to growth of the result. This can be achieved partly by providing patient care (more) efficiently and partly by reaching agreements with insurers in the B segment on covering prices with a result margin. As part of more efficient operations, opportunities for outsourcing, partnerships or profit improvements are continually considered as alternatives for the present operations.

In the course of 2010 revenue growth proved to be continuing, in a more balanced way than in recent years, in both the A and the B segment. However, we did not succeed in

reaching the target formulated, with assumes a growth in results parallel to the revenue growth. The growth of production is largely realised in relatively high-cost patient care. Although growth in patient care is one of the hospital's priorities, it was not accompanied by sufficient revenue growth. Such patient care includes robot surgery, vascular surgery and the implantation of automatic implantable cardioverter defibrillators (AICDs). The hospital did reach agreements with insurers on higher rates for robot surgery. However, in 2011 these rates will again be under pressure. For vascular surgery and AICDs, which fall in the A segment, the rates do not cover the costs. Despite budget compensation of 80%, the sharply increasing expenditure for high-cost medicines also places direct pressure on the results in respect of the remaining 20%.

Efforts in our drive for a healthy ratio

For some years now the hospital has made efforts to reduce expenditure for temporary staff (PNIL), with little result so far, in particular with respect to the specialised nurses. The labour market for that sector is under severe pressure. For 2011 we have plans to finally actually reduce the deployment of temporary staff.

After the move in 2011 we will be able to work more efficiently in the new hospital through the amalgamation of departments, as a result of which the net result for patient care should also grow in financial terms.

4.2.4 Core value: continual improvement

'Guest-oriented thinking and action' and 'continual improvement', as two of the four core values in the Maasstad Hospital mission and vision, were the drivers for starting with an innovative steering philosophy in 2007, aimed at continual improvement. This philosophy, based on the TOC, comprises:

- Establishing targets in the field of throughput of (patient) logistics;
- Recording and prioritising the constraints to realisation of these targets;
- Bottom-up, multi-disciplinary and methodological solution of these prioritised constraints by medical and nursing

Table 33 Implementation of TOC in Casualty (target versus realisation)

	Realisation in 2010	Target 2010	Realisation in 2009
Casualty throughput time	95% within three hours	98% within three hours	98% within four hours
Observatory throughput time	77% within 12 hours	75% within 12 hours	75% within 12 hours

Table 34 Movements in average duration of admissions (target versus realisation)

	Realisation in 2010	Realisation in 2009	Target 2009	Realisation in 2008	Benchmark (2nd half of 2006 and 1st half of 2007)
Average duration of admissions	4.4 days	4.8 days	4.9 days	5.1 days	6.3 days

professionals, management and employees, with support from executive staff;
- A short, efficient throughput time for these improvement cycles through a structured escalation procedure, as a result of which proposals for improvement are presented to the Executive Board within two months;
- Continual monitoring of the realisation of the targets, resulting in a monthly review by the management in the 'Board Review'.

Continual improvement with continually more satisfied patients.

ToC applications to patient logistics in each health care domain are developed in more detail below. Maasstad Hospital also uses the TOC for project management and care development.

TOC in Casualty

With 45,000 visitors per year Maasstad Hospital has the busiest Casualty department in the Rotterdam area. The target for 2010 was to release or admit 98% of patients within three hours. Ultimately, this was achieved for 95% of all patients in 2010. Although the target was not met, Casualty patients are demonstrably helped fastest at Maasstad Hospital[1].

TOC in the Observatory

The Observatory is an extension of the Casualty department towards the nursing departments. Patients are admitted to this department with ten beds, from all specialisms, if a longer observation period is needed or pending the results of tests to determine whether admission is needed. The target for 2010 was that 75% of patients would be discharged from the Observatory or admitted to a nursing department within 12 hours. This target was achieved. See table 33.

TOC in nursing departments

We also make use of the TOC in the hospital's nursing departments. This takes place by agreeing a provisional discharge date for every patient. During the patient's stay, the implementation of the tasks is monitored, so that the discharge date is actually achieved. The result of this working method is that the average time spent by patients in hospital was reduced from 4.8 to 4.4 days. In addition to a reduction in the admission period, the supply of information to patients was also improved.

1 *In comparison with other hospitals in the Netherlands*

Patients and their families are informed on admission how long the expected stay will be and what the plans are. See table 34.

The TOC principle has been applied to various (health care) departments. A reference to the various with the accompanying result in 2010 is presented below.

TOC in Obstetrics

The Triage department at Maasstad Hospital is an emergency department for pregnant women. In May 2010 a similar TOC application to that in Casualty was implemented in this department. Day-care patients can be divided into three flows, with accompanying targets:

Table 35 Implementation of TOC in Triage (target versus realisation)

	Realisation in 2010	Target 2010
Patients assisted within 30 minutes	60% within 30 minutes	90% within 30 minutes
Patients assisted within 60 minutes	60% within 60 minutes	90% within 60 minutes
Patients assisted within 90 minutes	60% within 90 minutes	90% within 90 minutes

Although this did not meet the targets, we are not dissatisfied with the realisation, as in practice, the improvements in obstetrics proved to be more complex than e.g. in Casualty.

A number of actions were taken to further improve the results in Obstetrics. A junior doctor was deployed with experience in emergency care and more attention was devoted to familiarisation and support. Investments were also made in the partnership between the Laboratory and Obstetrics, so that blood test results are provided faster. Finally, we are investigating a quality improvement in registration (the speed with which patients are assisted), the process relating to the deployment of triage nurses and the available capacity.

TOC in the operating theatre

In early 2010 Maasstad Hospital began to apply the TOC to the elective patient flows. The physician plans a date for surgery, together with the patient, in the outpatient unit, after which the support departments perform a number of tasks in sequence to ensure that this surgery date is achieved. The Urology discipline began the switch to this working method in 2010, followed by the Ear, Nose and Throat specialists, Gynaecology and Neuro-surgery. A start was made with the other specialisms.

The objective of this form of TOC is to give every patient a surgery date from the outpatients' units. The aim is also to operate on all patients within the medical and Tree standards. We were able to monitor this in 2010 via TOC Elective. Unfortunately, the results cannot yet be measured effectively, because we started half-way through a year, but it did become clear that the entire process accelerated and waiting lists were reduced (20%). See table 36.

More departments began working with TOC Elective from 1 January 2011. We expect to be able to measure the results for 2011 more effectively.

TOC in Day-Care

The TOC method was introduced in the Day Care department in February 2010. The purpose of the TOC for day care is to determine whether sufficient capacity is available and to design this more efficiently (in order to help more patients with the existing capacity). Day care patients can be divided into three flows, with the accompanying targets. See table 37.

The result achieved to date is due to the intervention to call up patients more shortly before the operation. Patients welcome this, as their waiting times are shorter now. Agreements

Table 36 TOC Elective

	Realisation in 2010	Target for 2010
Patients are given a surgery date from the outpatient unit	Not yet measurable, process acceleration and reduction in waiting lists achieved	100%
Patients are operated on within the Tree standard	Not yet measurable, process acceleration and reduction in waiting lists achieved	100%
Patients are operated on within medical and commercial standards	Not yet measurable, process acceleration and reduction in waiting lists achieved	100%

Table 37 Implementation of TOC in Day-Care (target versus realisation)

	Realisation in 2010	Target 2010
Patients in attendance all day	85% assisted within 8 hours	98% assisted within 8 hours
Patients in attendance for an average of five hours	50% assisted within 5 hours	98% assisted within 5 hours
Patients in attendance for an average of three hours	95% assisted within 3 hours	98% assisted within 3 hours

have also been reached in relation to the prescription policy, which has led to better quality patient care.

Major gains can still be achieved, particularly in the category in which patients are in attendance for an average of five hours. The key to this lies in changes in organisational working methods, such as clear agreements on the availability of physicians to be able to discharge patients and/or to reach agreements with disciplines on discharge criteria, to improve the throughput of patients. The implementation of this is scheduled for the first quarter of 2011. Further implementation of best practices in the medical field, such as in the field of pain control and anaesthesia, will be investigated in more detail and discussed with the parties concerned.

TOC in outpatients' departments

We are also keen to apply the TOC method in outpatients' departments, with the aim of reducing the admission and waiting times. The implementation requires a link with the EZIS. The development of this will take a fair amount of time. This was not feasible for 2010, but a pilot will start following the relocation to the new hospital in April 2011.

More reliable and faster admission times, shorter waiting times and improved care paths

In 2009 Maasstad Hospital developed a new working method with 'Rapid Reliable Response' (RRR). The objectives of the working method are to

- Achieve more reliable and faster access times;
- Reduce waiting times;
- Improve care paths.

We apply this working method with a view to guest-orientation and in order to be able to help more patients.

The care paths were analysed in 2010. Improvement processes were implemented on the basis of these analyses. The hospital uses a TOC-based application for the analysis, development, introduction and monitoring of these processes.

As a result of the projects performed, access times and throughput at the hospital were substantially improved. This means that after referral by a GP, a patient can complete an

initial hospital visit faster and once in the hospital, can also undergo follow-up tests and/or treatments and interventions faster. This takes place e.g. through combined appointments in which a patient undergoes all the necessary tests in half a day and, if necessary, sees different specialists during that half day.

Obviously, the quality of the care paths improved as a result of a better organisation. New medical equipment was procured, a more practical layout of the areas in the outpatient departments was realised and more efficient timetabling was introduced for medics and paramedics. The working method with RRR projects has proved successful and will be continued in 2011.

Access and waiting times

Access times for the hospital's outpatient departments and waiting times for a number of treatments are presented in the tables 38 and 39.

Advisory Board Company

Maasstad Hospital became a member of the Advisory Board Company in 2009. This network of 2,700 international health care institutions exchanges knowledge and experience and performs benchmarking studies at the management, operational and nursing levels. Membership was contracted for both the Executive Board and the Operational Board in order to make use of shared knowledge and experience and for the purpose of inspiration for development and innovation of business processes in Maasstad Hospital itself.

In 2010 a management delegation attended meetings in Brussels and Washington. On the basis of this experience the management decided to renew the membership for two years, until 2012. The analyses of the Advisory Board Company form an important source for the determination of the hospital's strategy for the 2011 – 2015 period.

Table 38 Maasstad Hospital access times (in weeks)

Specialism	Clara location	Zuider location
Allergology	3	-
- Hay fever	1	-
Cardiology	2	2
General surgery	1	1
Dermatology	2	2
Gastro-enterology	6	-
General gynaecology	1	1
General internal medicine	2	1
Oral surgery	4	-
Ear, nose and throat specialism	2	3
- Palatine and nasopharyngeal tonsils (children)	4	3
General paediatrics	2	2
Pulmonary diseases	1	2
Neuro-surgery	3	-
Neurology	7	7
Ophthalmology	2	-
Orthopaedics	1	-
Pain control / Anaesthesiology	1	-
Plastic surgery	-	4
Rheumatology	10*	-
Rehabilitation therapy	-	2
Urology	2	-

* *Due to large patient flows from the region in connection with the retirement of a specialist from another hospital*

Table 39 Waiting times (in weeks) for a number of treatments at Maasstad Hospital

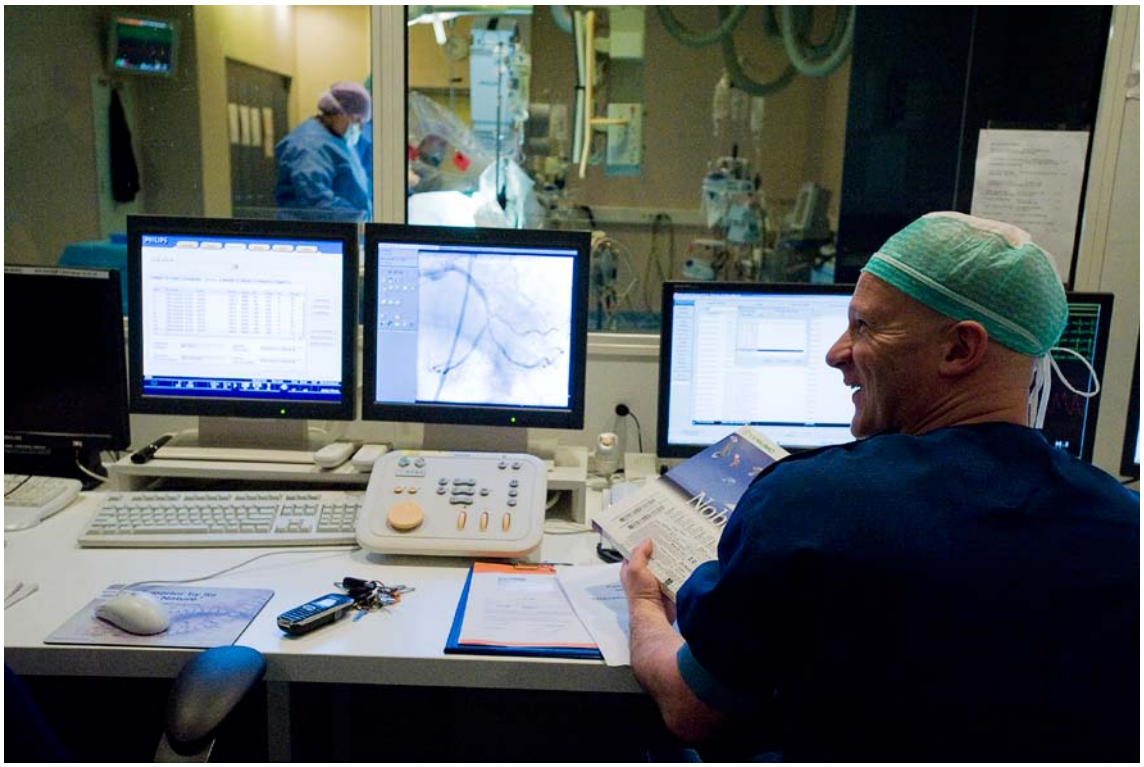
Specialism	Clara location	Zuider location
Cardiology		
- Percutaneous coronary intervention	-	2
Surgery		
- Hernia	4	5
- Varicose veins	5	4
- Carpal tunnel syndrome	2	4
- Gall bladder	5	5
- Circumcision	4	6
- Male sterilisation	2	2
Plastic surgery		
- Breast reduction	-	12
- Breast enlargement	-	12
- Abdominoplasty	-	12
- Dupuytren's contracture	-	4
- Carpal tunnel syndrome	-	4
Pain control		
- Invasive neuromodulation	5	-
Gynaecology		
- Laparoscopy	5	3
- Female sterilisation	4	5
- Hysterectomy	4	5
- Female incontinence	4	6
- Curettage	1	1
Ear, nose and throat specialism		
- Palatine and nasopharyngeal tonsils	4	-
- Grommets	3	-
- Septoplasty	10	-
Neuro-surgery		
- Hernia	5	-
- Carpal Tunnel Syndrome	3	-
Ophthalmology		
- Cataracts	8	-
Orthopaedics		
- Full hip operation	7	-
- Keyhole surgery for knee	4	-
- Full knee operation	9	-
Urology		
- Male sterilisation	2	-
- Prostate operation / prostate cancer	5	-
- Circumcision	5	-

4.2.5 The new hospital

Maasstad Hospital is on the eve of a move to its new hospital building. The St. Clara Hospital and Zuiderhospital locations will be combined in a new building. We performed a great deal of work for this in 2010, the year of delivery. The contractors, Ballast Nedam and ULC, completed the main construction work for the new hospital in 2010. The first construction stage was delivered on schedule in September and the second in December, after which the contractors officially transferred the building to Maasstad Hospital. The building permit for the Environmental Park was issued in mid-2010. This section was also delivered in December. The permit for the helideck is expected in early 2011, after which the construction can begin. This work was and is performed under the direction of the New Construction Project Office. The Project Office will perform finishing work until 17 May, after which it will be disbanded.

Commissioning of the New Building Programme 2010

A great deal must be organised in order to steer the move from two locations to one on the right track. For that purpose the Commissioning of the New Building Programme staff started work in 2009 on the preparations for the relocation. The programme focuses on all work that must be performed between the delivery of the building and its commissioning on 17 May 2011. To ensure that the programme runs smoothly, a project organisation was set up with nine projects. These projects concern the constructional, technical and logical side of the commissioning, as well as the human side of this change. By appointing one or more quartermasters in each department, who were involved at an early stage and assisted in the projects, we were able to create a link between the departments and the new construction organisation. The structural delivery of the building at the end of September was a milestone in the programme. From that time on the project organisation has been performing all



the work in accordance with the plans, which were prepared in minute detail.

Outlook for 2011

Until the commissioning on 17 May, the activities will shift from constructional adjustments and the installation of medical equipment to the complete fittings and furnishings. We opted to keep the removal process as short as possible. The outpatient departments will close on Friday, 13 May, after which removal activities will take place 24 hours per day for three days. The patients will transfer on Monday, 16 May, when the hospital will unpack and lay out the new departments. The new hospital will open its doors on Tuesday, 17 May.

4.2.6 Information & Communication Technology

The transfer to the new hospital is also an important milestone in the field of ICT. Our objective for 2010 was therefore to prepare for this as well as possible. Maasstad Hospital has worked towards the move by performing a large number of ICT projects. The target of full digitisation was achieved in 2010 for file creation, image digitisation and dismantling of the medical archives. The proposed digitisation has been achieved for the entire hospital.

In the field of security of information, the hospital continued on course to comply with the NEN7510 quality standard. An independent audit conducted on the basis of the NVZ assessment regulations showed that the hospital complies with the security of information requirements of the IGZ.

Electronic Patient Files

Almost all specialised medical files and related nursing files were implemented by the end of 2010. Together with the further optimised Joint Core File an integrated digital patient file has now become a reality for the entire hospital. With the implementation of the final files, the main condition for being a 'paperless hospital' has been met. The availability of the digital information on functional assessments makes the integrated patient file complete. Our aim is to be a paperless hospital (fully digitised) in the new hospital. In order to facilitate this, we must also provide and settle orders and requests digitally. We made a start on this at the end of 2009 and optimised this further and integrated it in the EPDs in 2010.

ICT infrastructure

We have improved a great deal of the basic ICT infrastructure, as a foundation for the overall ICT service. This was revised and expanded further in 2010. In anticipation of the move we began replacing outdated infrastructure and adjusting it to modern operating requirements and ICT standards in stages. The possibilities of an external data centre, Rotterdam Internet Exchange (R-IX), were developed further here, in combination with the technical facilities of Maasstad Hospital. The adjustments ensure improved access and continuity and form the basis for further standardisation and professionalisation of our services.

The storage architecture of the hospital has been improved in key respects. New primary storage for the EZIS provides for data availability of virtually 100% and a sharply reduced management burden. The outdated technology for the Tier 2 and 3 storage of other applications has been replaced and expanded. The back-up and restore solution has also been modified, reducing restore times by an average of 75%. The digital archive has been reconfigured on the basis of Storage as a Service. Both Digital Imaging and Communications in Medicine (DICOM) data and other information are stored safely on the basis of a service taken at various locations in the Netherlands.

The virtualisation of both servers and workstations represents a major step forward in the reliability, scalability and standardisation of the architecture. More than 80% of all servers

and workstations are virtualised. Through the centralisation of virtual servers in far more manageable virtual server clusters, control of the overall service chain has increased. At the workstations work is performed on the basis of largely standardised work stations, the 'thin clients'. As a result, services for end-users have improved and are performed at lower costs.

We have replaced and standardised almost the entire local and inter-local network (LAN/WAN). The external links have also been adjusted and are now, without exception, set up redundantly. This has created an exceptionally reliable network tier that offers major opportunities for future developments. A 'technology refresh' is included in the contracts with suppliers, so that we have assured ourselves of the latest technology for a longer period.

Regional cooperation
Maasstad Hospital attaches considerable importance to regional cooperation. The hospital works intensively with two regional diagnostic centres, where the exchange of (image) information is an important factor. This was realised in 2010. We also work on the furthering the exchange of patient details in the region, together with the Erasmus MC, the Sint Franciscus Gasthuis and the National Health Care Information and Communication Technology Institute (expertise centre for the development of ICT for the health care sector). The care portal for health care providers was launched at the end of 2010. This enables us to share data outside the hospital walls. GPs can access certain data on their own patients from the EPD. This also shows immediately which of the GPs patients have been admitted to the hospital and the wards on which they are staying.

4.2.7 Sourcing

The transfer to a new location also involves a great deal for the Sourcing department. In 2010 we completed projects including the following:

Optimal Decentralisation
All decentral stores are designed on paper to fit into the new hospital situation. Some have already been physically converted in order to simulate the situation in the new building. As a result staff are becoming familiar with the system and the layout and fixed stock levels are tested in real life.

Support for the new building
Sourcing has played an important role in the run-up to the opening of the new hospital. A procurement plan was drawn up for investments of €45 million. Sourcing also supported various contracting processes at the operational level.

Medimall/Care Boulevard
Sourcing has taken responsibility for the build-in packages of the departments that will be accommodated in the Medimall on the Care Boulevard. These are Rehabilitation, Outpatient Plastic Surgery, the Call Rooms and the staff restaurant (La Place). These will open at the same time as the hospital.

DigiMaas
The DigiMaas project facilitates the Maasstad Hospital departments in the digitisation of the non-EPD-linked files to enable them to work and store files digitally in a way that makes them easy to access and view after the move.

Central Sterilisation Department in Barendrecht
In addition to the construction of the hospital the conversion of the Central Sterilisation Department also began in 2010. A suitable building has been found for this at the industrial site (Vaanpark 4) in Barendrecht. All instruments used in operations or interventions will be cleaned and sterilised in this building. The distribution centre will also be

located here, to enable optimal stocking for the hospital.

In addition to the special new construction projects, the following projects were realised:

Buffer management
In the Buffer Management project the TOC theory was applied to reporting management at the Maasstad Service Point. This project made performance transparent and raised the service provision to a higher level.

Prospitalia
Through the Group Purchasing Organisation, procurement benefits were achieved in the field of medical appliances and consumables.

Student pool
The student pool consists of a multidisciplinary group of students who are deployed as support for day-to-day work and projects. The students are given an opportunity to apply their studies in practice. This creates a win-win situation.

More Efficient Operations Programme
Maasstad Hospital anticipates a potential government cutback. By starting projects that enable us to increase our revenue or to operate more efficiently, we aim to anticipate the cuts. A number of managers are investigating the possibilities with the aid of the student pool.

Service-Oriented Patient Transportation
Through the use of a request system, responsibility for transportation of patients has largely been transferred from nursing to the logistics staff. As a result, patients arrive for appointments on time and the nursing staff are relieved of logistical work.

Patient Entertainment
The Patient Entertainment project provides for the need to provide patients with the home conveniences during a stay in hospital, such as radio, television and the Internet. Patient Entertainment also enables the hospital to improve information supplies for patients. Patients can also order meals themselves.

4.3 General quality policy

4.3.1 Quality management system

The Balanced Score Card has been used as an important tool in the management of Maasstad Hospital since 2010. The Balanced Score Card is divided into the following quadrants: Financial, Client, Quality and Innovation. A number of critical success factors (CSFs) are shown for each quadrant, with performance indicators and the accompanying standards laid down for each CSF. The Balanced Score Card is discussed each month in the Board Review at both the Executive Board and the management level, and the steering adjustments needed in response to the developments are determined. The Board Review for this lasts one working day.

In the Quality quadrant we focus on both the quality of care and the quality of the other processes in the organisation. In addition to the Balanced Score Care we widely apply the TOC management principles within the hospital. In 2010, close attention was devoted to further implementation of the Balanced Score Card and the underlying philosophy in the Steering for Results (SOR) programme. Partly on this basis, steering on the basis of the Balanced Score Card and more specifically, the Quality quadrant has become an integral part of the Maasstad Hospital management system.

Quality of information and registration
In recent years quality of registration has become increasingly important. A growing number of stakeholders require detailed information. Whether this concerns recording of figures, amalgamations or amounts, the recording of information forms the basis for answering the large number of queries from various stakeholders.

In 2010 preparation for the implementation of the improvement plan for the DBC system took place via the 'DOT Opportunity' programme. In these preparations we were able to implement improvements in source registration, generating revenues estimated at more than € 715,800. We set up a continual process of feedback and knowledge-sharing with the source and recorded this in working agreements. We also optimized various working processes, such as the registration of authorisations, incorrect bed days and patient records. In 2011 we implemented the different facets of the DOT improvement plan via the programme, which initially consisted of seven projects. The implementation of a new invoicing programme is also taking place. For the financial accounts the introduction of a new cost-location structure, tailored to the new hospital and a new creditor module are planned.

Obviously, the above activities and measures to promote the quality of registration also lead to improvements in the quality of the information. A number of management measures were taken to secure the quality of the information circulated e.g. via the Balanced Score Card and the quarterly financial reports. This concerns, for example, reconciliation controls between the 'supply' systems for the data warehouse, such as the EZIS and Exact. Reconciliation and association controls are also included in the source systems themselves. In addition to EZIS, controls developed by ValueCare are used for the production accounts, providing an extra assurance of the accuracy and completeness of the source records and the information to be generated from this. To prepare for the monthly reports figure analyses are performed that are designed to provide an insight into the quality of the information. We also analyse signals from users regarding the reliability of the information provided in more detail. Where necessary, these signals lead to structural adjustments.

Following the experience with and the substantial expansion of the work with the Balanced Score Cards and Dashboards in Webfocus in 2010, it is now time for the next step. The Balanced Score Card used by the management and the accompanying KPIs will be further geared to the long-term objectives formulated in our 'orange book':

1. Safe with a good quality outcome;
2. Continual improvement;
3. Guest-oriented thinking and action by inspired personnel;
4. Financially successful.

4.3.2 Data protection

Patient data are increasingly digitalized. As a result, security of information is becoming increasingly important and increasingly calls for our attention. Boundaries within and outside the hospital are fading through information links and data exchanges. Maasstad Hospital is aware of this and invested more than ever before in this form of patient safety during 2010. We worked together on updating the security of information policy and drew up an information security plan for the coming years. In the autumn of 2010 is an awareness campaign was launched, with the aim of assuring secure treatment of (patient) data in the conduct of all our staff. We also took technical measures in order to deal more securely with patient information. We continued to develop identity management, for example, which will enable us to sharpen controls in 2011 through log book consultation (in compliance with NEN7513).
A new workplace standard was developed for the new hospital, which facilitates such secure operations. This improves the availability and reliability of information and information systems and these will be better protected against unauthorised access. 'Follow me printing' ensures that print-outs are no longer left unsupervised on printers, so that patient data and other data on paper also becomes increasingly safe. Partly through this extra attention, improvements were found in almost

every point examined during the electronic data processing audit of the hospital and at the end of the year we complied with the external requirements of the NVZ assessment regulations for NEN7510 in all areas examined for the first time.

4.3.3 Quality of buildings

Building maintenance

The relocation to the new hospital is planned for May 2011. Consequently, only the absolutely essential maintenance was performed for the existing buildings in 2010. Logically, the necessary actions were performed in the interests of safety. There were 10,274 requests or malfunctions, installations and maintenance matters that were or could have been life-threatening, if no action had been taken. These included e.g. the maintenance of the fire alarm switchboard, the compressed air unit (in connection with artificial respiration) and the lifts. The Maasstad Hospital meets all requirments concerning fire safety.

Table 40 (Renewed) certificates and/or accreditation, by department

Department	Standard/Inspectorate	Certificate since
Dialysis	HKZ-ISO 9001:2000 Harmonisation of Health Care Sector Quality Assessments Foundation (HKZ)	2003
Dialysis	Cape Helius Holiday Centre	2010
Clinical physics (drip pumps and haemodialysis equipment)	International Organization for Standardization (ISO) – TNO QMT certificates	2006
Vascular centre	Vascular certificate (The Cardiovascular Group)	2007
Hospital pharmacy	Manufacturer's permit (Farmatec-BMC)	2007
Hospital pharmacy	GMP-Z6	2008
Paediatric department	Smiley (Child and Hospital Foundation)	2008
Day care	Smiley (Child and Hospital Foundation)	2008
Medical Technology	Quality for Medical Technology (TNO)	2002 update in 2008
Clinical Chemical Laboratory	CCKL/Accreditation Council	2009
Surgery	Pink Rosette (Netherlands Breast Cancer Association)	2010
Maasstad Academy	Nursing & Care Providers Quality Register (upgrading and retraining courses)	2010

Table 41 Visitations by discipline in 2009

Specialism	Quality or training visit	Result
Rehabilitation	Training	Accredited until 2015
Surgery	Training	Accredited until 2015
Internal Medicine	Training Quality	Accredited until 2015

Sale of buildings
The Zuiderhospital location was sold to the Groene Group of Rotterdam. However, the Groene Group notified Maasstad Hospital that it was not willing to take up the Zuiderhospital location. The hospital does not agree with this view and has provided for an investigation into the best next step to ensure that the Groene Group does take up the location. After the move to the new hospital this location will be shut down as quickly as possible. The Clara location will remain operational after the move for a number of functions that will not transfer to the new hospital until later or will transfer to the new Central Sterilisation Department. The sale process for the Clara location has not yet begun. The hospital is first examining the possibilities for use in the light of existing laws and regulations. Another important factor is whether Rotterdam municipal authority proceeds with the Park Stadium plan.

4.3.4 Certification and accreditations
Maasstad Hospital holds a number of certificates and accreditations. Recognition of the association, cohesion and/or partnership between all quality elements leads to accreditation. In 1010, the following Maasstad Hospital departments held (renewed) certificates or accreditation. See table 40.

In 2008 we began work for certification for security of information in compliance with the NEN 7510 standard. Our aim of certification in 2010 was achieved on the basis of the NVZ Assessment Framework.

4.3.5 Visitations
In relation to the core values of 'quality and safety' Maasstad Hospital was visitated by the Medical Specialist Registration Committee of the scientific associations in connection with training. Visitations were also made in connection with quality. A quality visitation is a form of inter-collegial assessment directed at the operation of a company or professional discipline. Each practice is visitated once every five

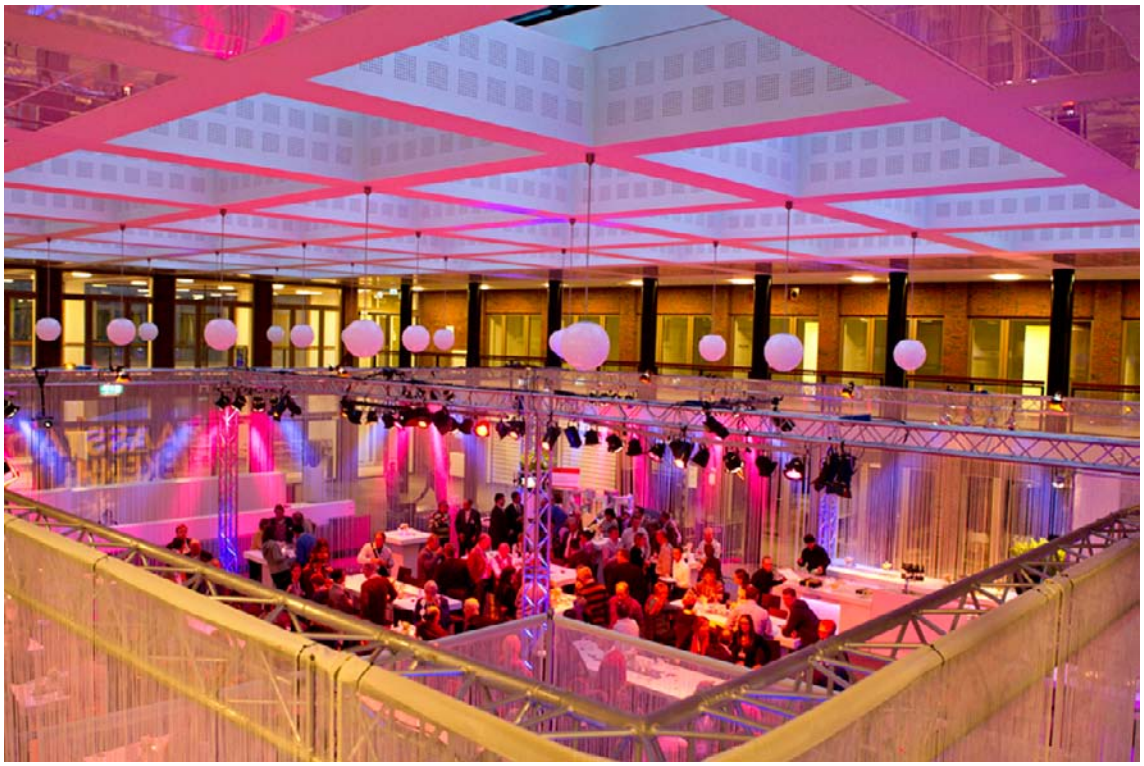
years. The preparatory actions for a quality visitation are discussed at the corporate level. This leads to conclusions and an improvement plan which the visitating committee receives.

Results
Three disciplines were visited by their professional associations in 2010. All received a positive assessment. The next visit for these disciplines is planned in five years' time. One discipline received a quality visit, resulting in a positive assessment. See table 41.

STZ visit
Maasstad Hospital has the ambition to join the STZ. The STZ consists of 27 large Dutch hospitals that provide highly specialised medical care. These teaching hospitals work together in the field of specialised medical training and other courses in health care, scientific research and supra-regional top-level clinical care.

In addition to the above visits of individual disciplines Maasstad Hospital received a visit from the STZ visiting committee on 1 December 2010. The management of the STZ will recommend in favour of Maasstad Hospital's membership to the representatives of the STZ hospitals at the general meeting in April 2011. The official and final 'Yes' to our associate membership will follow in that month. Maasstad Hospital regards associate membership the first step towards full membership, which is our ambition.

4.3.6 Relationship with GPs
As part of the 'financially successful' core value, Maasstad Hospital aims for an outpatient market share of 25%. The development and maintenance of good relations with referring physicians is extremely important for our hospital. The referrers are important for us to coordinate first and second-line care as effectively as possible. We do this by listening to the experience of the GPs and considering what we can do to improve the alliance. We also inform GPs of (new) developments and services at our hospital and provide refresher courses. Our account managers play a bridging role here between the hospital and the GPs.



Various activities and efforts were provided in 2010, such as:

- Reaching agreements with the GP association in relation to prescription of generic medication
- Regular meetings between a number of specialisms and GP practices, through which partnership agreements arose (e.g. on the COPD, dermatology, pain control and ophthalmology);
- The Maasstad Hospital GPs Meeting was held on three occasions (to promote mutual cooperation);
- The monthly upgrading formula courses were held for GPs (Lombardijen fora);
- An upgrading course was held for midwives and physicians of the Centre for Youth and Family (CJG);
- A symposium was held on robot surgery;
- Attendance of the GP fair in Ahoy, with a stand at which GPs and practice support staff could follow a course in automatic external defibrillators (AEDs). They could also practice with laparoscopes and taking cervical smears;
- The BetterEvent, at which GPs and specialists met to share experiences, was held. A visit was also paid to the new hospital location.

Once again, Maasstad Hospital worked in accordance with the ZorgDomein referral application in 2010. The main results of this were:

- GPs and patients are better informed;
- Communication between professionals in the care chain runs more smoothly;
- Patients are referred to the right surgeries more easily;
- Unnecessary visits are avoided.

Apart from Maasstad Hospital the Ikazia Hospital in Rotterdam and the Albert Schweitzer Hospital in Dordrecht/Zwijndrecht were connected to ZorgDomein in 2010, as a result of which the model has won broad support in the Rijnmond-South region.

4.3.7 Relationship with health insurers

In addition to the relationship with our referring physicians, the relationship with health insurers is extremely important for Maasstad Hospital. We consider it important that our patients have access to insured care at our hospital, regardless of their insurance policies. Negotiations with health insurance in 2010 were dominated by the lack of clarity concerning developments at the national level. Reductions in the remuneration of specialists, lack of clarity regarding the improvement plan called "DBCs on the Way to Transparency (DOT)" in 2012 and the threat of extra cut-backs made progress with these talks more difficult. Nevertheless, we once again contracted agreements with all health insurers in 2010 for the provision of care in the B segment. Negotiations for the A segment were conducted during the year with Achmea and CZ. Agreements were reached with the various insurers on the price, volume and quality of care. Achmea once again opted to work with preferred suppliers in 2010, for a small number of treatments. The preferred suppliers were chosen on the basis of quality data and services. Maasstad Hospital was chosen as a preferred supplier for as many as three treatments in 2010: i.e. for knee and hip replacements and for hernias.

4.4 Quality of care

4.4.1 Performance indicators

The performance of all hospitals is measured and made transparent with the aid of performance indicators and quality indicators. The objective of this is to improve the quality and efficiency of hospitals and increase patient freedom of choice, as this shows which hospitals perform well or less well.

Maasstad Hospital has provided the IGZ with performance indicators since as long ago as 2003. In recent years we also provided performance indicators developed by the

Transparent Hospital Care Foundation, an alliance of stakeholder organisations in the health care sector (including health insurers, the Order of Medical Specialists and the Netherlands Hospitals Association), which provide for uniform requests for information among care providers and increased transparency of the health care offered for patients, health insurers and other stakeholders.

The performance indicators for the IGZ are posted on the website at www.hospitalstransparant.nl and on the Maasstad Hospital website (www.maasstadhospital.nl). Many data can also be viewed at www.jaarverslagenzorg.nl/documentatie. A number of the indicators are shown at www.kiesbeter.nl, a website used to compare hospitals.

In the AD Hospital Top 100, in which some of the performance indicators are used to compare hospitals in the Netherlands, Maasstad Hospital rose to 5th place 2010 (35th place in 2009, 56th place in 2008 and 84th place in 2007).

A large number of the performance indicators are included in our dashboard, a tool used to report to the management each month on areas including production, finance and quality. These indicators are structurally monitored in the Board Review once a month. The management can steer for adjustments where necessary.

4.4.2 Complaints

For the core value of 'continual improvement', Maasstad Hospital opted to include registration of complaints in the SMS. The software in which both VIM reports (temporarily) and incidents of aggression are recorded as complaints was acquired in 2009. The module for decentralised settlement of complaints was procured and set up and was rolled out to the entire organisation in February 2010.

In our complaints procedure we distinguish between mediation of complaints and settlement of complaints.

Mediation of complaints

In mediation of complaints, both our complaints officers play a key role in the intake and registration of complaints and in monitoring their settlement. These complaints are settled decentrally as far as possible. The aim is to be transparent for all parties concerned, to improve (structural) shortcomings, promote closer involvement in the settlement of complaints and to take a proactive attitude in the long term with respect to prevention of complaints.

As a standard practice complaints are sent digitally to the (health care) manager and the managing director whose portfolio includes the relevant business unit. After the management has discussed the compliant, the health care manager sends the complaint via the system to the person who will settle it. The person who settles the complaint records how this happened and the complainant's perception of this. The complaints officer then inquires of the complainant whether the complaint was settled satisfactorily and then closes the complaint file. If the complaint is not settled decentrally, it is settled centrally via the complaints officer.

In 2010, 413 complainants submitted 510 complaints to the two complaints officers.

Table 42 Number of complaints reported to officers

Subject	Number of complaints submitted
Medical/nursing	221
Relationship	159
Organisational	112
Financial	18
Total	510

Settlement of complaints
Maasstad Hospital has a Complaints Committee to which clients can (arrange to) submit complaints on the conduct of hospital employees. We notify our patients of this via the admission booklet, leaflets in the outpatients' department and information online. Employees also notify clients of the existence of the Complaints Committee.

The hospital's Complaints Committee consists of an independent external chairman, three other external members and four members from the health care and medical departments. This composition ensures that the Complaints Committee can assess the complaints presented to it independently. The Committee's working method is laid down in regulations. If a complaint is found to be admissible, the Complaints Committee opens an investigation and requests the necessary information. The Committee gives the person against whom the complaint is made an opportunity to give an explanation in writing and then notifies both parties of each other's views. The complainants and the subject of the complaint are invited for an oral hearing of the case. During the procedure, both parties can engage representation.
To ensure that the complaint is settled within a reasonable period, the regulation provides that the Complaints Committee must reach a decision as quickly as possible and no later than five months after the receipt of the complaint. In exceptional circumstances, this term can be extended. The parties concerned are notified of any such extension in writing, stating the reason and fixing a new term. In addition to findings on the grounds for the complaint, stating the reasons, the decision sometimes includes a recommendation to the management of Maasstad Hospital. The Committee's decision is binding. The recommendations have the force of significant advice.

In 2010 the Complaints Committee issued decisions on 12 complaints, four of which were found to be justified. These four files led to two recommendations by the Complaints Committee. The management adopted all recommendations made by the Committee. The most common subject in the recommendations was communication, divided into parts such as instructions, consultation, notification, formation of files and supply of information. In one case the Complaints Committee did not issue a decision, in connection with a lack of verifiable facts. See table 43.

4.4.3 Reporting of Patient Care Incidents

Hospitals are required by law to report (near) incidents to an internal committee that deals specifically with such reports. This is the VIM Committee. The objective of the Committee is to obtain a better insight into the parts of the health care service that require improvement. Only if incidents are systematically reported is it possible to determine the causes and start up improvement actions.

Employees can even make reports from home on a digital reporting form. They can use this to state what they regard as the risk of a repetition of the incident. The risk analysis is used to determine whether the incident should be handled centrally or decentrally.
Many incidents are settled decentrally. Decentral VIM committees have been formed in various departments, often consisting of a health care manager, a team leader, possibly a quality employee and a physician. If an incident has a high risk of repetition, it is sent to the central VIM Committee. Serious incidents are reported to the management and are settled by the central committee. The central committee consists of members of the various units of the organisation. Both the central and the decentral committees work according to regulations.

Since 1 January 2010 employees in all departments must report incidents decentrally. In the course of the year it became clear that the

Table 43 Number of complaints submitted in 2010 and decisions issued on complaints

Subject	Number of complaints submitted	Number of decisions*	%	Founded	%	Unfounded	%
Medical/nursing	39	8	21%	2	5%	5	13%
Relationship	9	4	44%	2	22%	2	22%
Organisational	3		-		-		-
Financial			-		-		-
Total	**51**	**12**	**24%**	**4**	**8%**	**4**	**8%**

** Including current cases from 2009*

Table 44 Number of reported incidents

Nature of the report	2010	2009	% increase/ decrease
Treatment and care	373	173	+115
Blood products		10	
Medication and infusion	362	297	-+22
Falling incidents	158	178	-12
Other reports	741	556	+33
Laboratory reports separated from April 2010	219		
Total number of reports	**1853**	**1304**	

Table 45 Number of reported incidents (2010)

	Treatment & Care	Laboratory report	Medical & Infusion	Other reports	Falling incidents	
Jan	31	0	38	61	18	
Feb	30	1	38	57	13	
Mar	39	0	29	84	12	
Apr	35	2	35	69	9	
May	17	2	27	75	8	
June	37	15	31	97	14	
July	26	20	25	53	14	
Aug	31	35	23	44	11	
Sept	22	27	29	51	9	
Oct	34	27	25	41	21	
Nov	37	31	32	65	14	
Dec	34	59	30	44	15	
Total	**373**	**219**	**362**	**741**	**158**	**1853**

start-up problems led to a reporting situation that was less than optimal. It is clear that the reporting propensity of our employees has increased enormously through the new working method. The number of reports at the end of December was 1,853. See table 44 and 45.

4.4.4 Care innovation and efficient projects

In relation to the core value of 'continual improvement' Maasstad Hospital worked hard once again to develop its medical expertise in order to address the increasingly complex care requirements of patients.

Our hospital has a Robot Expertise Centre, at which our surgeons operate on intestinal tumours using robots. Gynaecologists and urologists increase their skills with robot-assisted operations on womb and cervical decensus, hysterectomies and treatment of kidney and prostate cancer. In the Bariatric Expertise Centre almost 500 patients were operated as a first step towards a healthier weight. In the Vascular Centre intervention radiologists and vascular surgeons teamed up to offer patients better treatment for vascular disorders.

Maasstad Hospital regards the financial support of health insurers as an ideal opportunity for further innovation in patient care and to improve the quality and safety of care still further. Health insurers have allocated €1,600,000 for care innovation projects at the hospital. In 2010 eight care innovation projects were performed in areas ranging from highly specialised medical care for specific target groups to process improvements within the organisation. In 2009 23 care innovation projects were carried out.

Examples of care innovation projects launched in 2010 included:

- Domestic violence;
- Multi-disciplinary treatment of children with urine incontinence.

Oncology Centre
However, a large part of these cash funds (€ 685,000) was released for the development of a (virtual) Oncology Centre headed by the Oncology Council (formerly the Oncology Committee). We set this up to create a tumour-oriented chain organisation, covering everything from referral to follow-up or rehabilitation. In addition to internal agreements partnership agreements were also made with external partners such as home care organisations and palliative and psycho-social care institutions. In this way patients experience continuity of care throughout the chain.

Multi-disciplinary care chains have now been set up for the following six types of tumours:
- Prostate;
- Mammary;
- Pulmonary;
- Ovarian;
- Colonic-rectal;
- Brain tumours / metastasised tumours.

The design of the chain is determined by a multi-disciplinary tumour working group led by a director (medical specialist). The tumour working group received information from the psycho-social care, nursing care, ICT, complementary care and training working groups. A case manager (nursing specialist or specialised nurses) is responsible for the day-to-day chain planning and supervision of the patient.

A palliative care chain has also been set up, which is not tumour-specific. A mobile palliative team will soon coordinate hospital-wide palliative care.

4.4.5 Emergency team
The Maasstad Hospital Emergency team consists of three crisis coordinators who are supported in emergencies by two secretaries. In cases arising, the strategic crisis team is supplemented by a managing director and an employee from the Marketing, Communication and Sales department.

Table 46 Emergencies and near-emergencies in 2010

Date	Internal/external	Description
4 January	Internal	Malfunction in oxygen supply for Neonatology department
27 January	Internal	Network malfunction
18 March	Internal	Network malfunction
4 May	Internal	Telephone outage
17 May	External	Power outage at BP resulting in complaints of noxious odours at Maasstad Hospital
20 July	Internal /External	Accident with local volunteer bus for Clara location
25 July	Internal	Suicide at Clara location
21 October	External	Building collapse in Rotterdam
1 November	External	Outage of network facilities

Table 47 Rough mortality figures

Year	Total day admissions	Total clinical admissions	Mortality in day admissions	Mortality in clinical admissions	% Day care	% Clinical
2009	34,806	31,549	0	586	0.00	1.86
2010	35,028	34,585	0	579	0.00	1.67

An incident becomes an emergency, if there is a threat of a serious disruption of the business process. That may be an external incident, such as a major accident with many injured arriving in Casualty or an internal 'accident', such as a major power outage. The departmental manager, Casualty or a head of night duty alerts the crisis coordinator. We are also actively connected to the regional network of government services, such as the police, the fire service and the GHOR. For large-scale incidents, the crisis coordinator on duty can call for assistance with a pager.

The strategic crisis team met on several occasions in 2010 in connection with actual or near-emergencies. These were evaluated after the event, orally and/or in writing. A list of the emergencies and near-emergencies in 2010 is presented in table 46.

There were nine emergencies or near-emergencies in 2009.

4.4.6 Regional IC alliance

Maasstad Hospital also aims to (continue) to provide quality in the field of intensive care, not only for its own patients, but for all patients from the Rijnmond-South region.

The IC departments of Maasstad Hospital, the Ruwaard van Putten Hospital in Spijkenisse and the Van Weel Bethesda Hospital in Dirksland have worked closely together to facilitate this since March 2009. Thanks to this alliance the IC departments of the smaller hospitals in Spijkenisse and Dirksland can remain open, so that patients from these regions also have fast access to IC care. The intensivists at Maasstad Hospital are responsible for the (Level 1) IC care in these hospitals. The medical head of the IC at Maasstad Hospital is also the head of the IC in both the two other hospitals. A number of our intensivists make day visits to the other hospitals and are on call, in rotation, around the clock.

In emergencies an intensivist will be in attendance within two hours. If necessary (for example when a patient needs to undergo a major operation), patients are transferred to Maasstad Hospital, which has a Level III IC, with the mobile IC unit.

The junior doctors and nurses in the affiliated hospital have now all undergone thorough retraining in intensive care, so that they can provide the necessary first aid in emergencies. They also work on training placements at Maasstad Hospital, in turns. Since the alliance was formed, all three IC departments follow the same protocols for e.g. the administration of medication and use the same artificial respiration machines.

All hospitals also use the same patient status and hold meetings on patients using videoconferencing. All IC patient data are stored in the Maasstad Hospital Patient Data Management System.

4.4.7 Hospital Standardised Mortality Rate

The Hospital Standardised Mortality Rate (HSMR) is calculated by comparing actual mortality with the mortality to be expected on the basis of a number of patient features (during hospital admission). This makes it an indicator of potential avoidable mortality in hospitals.

The IGZ requires all hospitals in the Netherlands to provide transparency regarding mortality figures. Our objective for 2010 was to comply with this requirement. We met the requirement by publishing the raw mortality figures for 2009 in July 2010.

In 2009 there were 66,355 admissions for both day-care and clinical treatment. A total of 586 patients died in our hospital. No day-care patients died. Overall, our mortality percentage for 2009 in the clinical departments amounts to 1.86% (compared with the highest score of 2.73% on a national level).

In 2010 there were 69,613 admissions, again for both day-care and clinical treatment. A total of 579 of these patients died in our hospital. The mortality percentage in the clinical departments for 2010 amounts to 1.67%. The highest score at the national level was not known at the time of writing, as these figures had not yet been released. See table 47.

The data that Maasstad Hospital has recorded in the National Medical Register (LMR) are used to calculate the HSMR. The model is based on the 50 main diagnoses[2] that account for 80% of mortality in Dutch hospitals. The mortality rates are corrected for factors including age, gender, diagnosis on admission, severity of the main diagnosis, acute admission and secondary diagnoses. This concerns mortality for both day-care and clinical admissions.

In the past Maasstad Hospital opted to encode only the main diagnosis in the LMR for each admission (and not any secondary diagnoses). As a result, no reliable HSMR can be calculated. From January 2010 these secondary diagnoses were recorded again. The analysis also shows that in a number of cases the source registration was not available on time and in full, which makes correct coding more difficult. Improvement proposals were formulated for this, such as control of storage documents via our monitoring software ValueCare and the recording of (secondary) diagnoses in the EPD). These improvement proposals will be implemented in 2011.

In order to monitor the results of the improvement proposals in relation to the mortality

2 *According to the CCS codes*

figures, the management acquired the Real Time Monitoring[3] application. With the aid of this tool the medical encoders critically reexamined the codes of deceased patients in 2009 and adjusted these where necessary. The codes for each (LMR) month will also be critically reexamined in 2011. These codes are then presented to the medical managers for approval, as the specialist is responsible for making the final (correct) diagnosis. These improvement proposals will lead to the calculation of a reliable HSMR figure for 2011.

4.5 Quality regarding employees

4.5.1 Personnel policy

The objectives relating to personnel policy in 2010 were dominated by the professionalisation of HRM and the consequences of the new hospital. Key parts of this included the strategic personnel planning, recruitment and selection, employee benefits and sickness absences and performance management. The new building will also involve a digitisation switch for the Personnel department. At the end of 2010 all 4,000 staff files and 1,000 employee benefit files were fully examined and digitised.

The digital personnel file, including the existing files, will be introduced in early 2011. The necessary preparations were made for the digitised sickness absence process and the personnel-related administrative processes. It is our intention that these systems will operate from April 2011.

In addition to these important issues relating to the new hospital further professionalisation of the Personnel department, to form an HRM department, began at the end of 2010. We introduced the concepts of HR Business Partner, HR Service Centre and HR Expertise

Centre. These will be implemented further in 2011. The purpose of the reorganisation is to create a match with our strategic objectives.

In 2010 work was also carried out on the development of a new job centre, an MWO, Dynamic Personnel Planning (DPA) and a new social plan.

4.5.2 Strategic personnel planning

The staffing requirement, the composition of the current staffing and ways to achieve the staffing requirement were considered on an organisation-wide basis. Where staffing was not sufficient, the Recruitment & Selection department recruited the right employees.

4.5.3 Recruitment and selection

Job applicants can report their interest in a vacancy via an online application form in the recruitment and selection system, known as ROOS. In 2010 attention was devoted to generating information from this system. The possibility of making online assessments of suitable candidates was also considered.

3 *From the Praktijk-Index consultancy*

Table 48 Movements in absences

Year	2010	2009	2008	2007	2006
Absence rate*	3.45	3.5%	2.6%	3.3%	3.5%
Reporting frequency*	1.45	1.47	1.41	1.65	1.77
Average duration of illness*	12.61	11.83	10.5	9.8	9.7

** Excluding pregnancy*

Table 49 Incidents of aggression and violence

Year	2010**	2009	2008	2007	2006	2005
Number reported	48	68	77	94	63	69
Sanctions:						
- Official warning	7	14	9	6	4	0
- Formal ban	3	1	0	2	1	0

Personnel advisors were trained to interpret the results of such assessments and to translate these into points for development.

In 2010 a start was made on the review of the recruitment and selection strategy for the 2010 – 2015 period. We began by deploying social media and a CV search. In the coming years the Recruitment and Selection departments hopes to realise a further expansion of the ROOS package, the design of management and a management dashboard, the formation of the internal and external talent pool, setting up adequate relationship management and more effective deployment of financial resources.

4.5.4 Working conditions and absences

In the summer a software application was implemented to support managers and the Working Conditions and Absence department in the reintegration of absent employees. This application will also lead to an improvement in file formation. The first half of 2010 brought changes in company doctors and working conditions services. Stability returned in July with the contracting of a new working condition service and a new company doctor. See table 48.

4.5.5 Safety Risk Identification and Evaluation

The VRIE, a detailed inventory and evaluation of risks in the departments, was completed in 2010. In total sound Action Plans were drawn up in 64 departments (care and care support). In the coming period the managers of the relevant departments will implement this plan.

4.5.6 Incidents of aggression and violence

Unfortunately, we had to note that incidents of aggression and violence also occur in Maasstad Hospital. The close cooperation with security and with the company lawyer on sanctions continued. Reports of incidences of aggression are recorded in a digital reporting system. From there we monitor after care of victims following an incident. The number of written sanctions –the official warning ('yellow card') and formal barring from the hospital ('red card') varies from one year to another. Most of the incidents (23 in 2009 and 12 in 2010) took place in Casualty. In 2010, 10 incidents occurred in the Internal Medicine department. See table 49.

4.5.7 Piercing and cutting accidents

The protocol for reporting piercing and cutting accidents was changed at the end of September. Reports are now included in a questionnaire that the physician treating the case in Casualty must complete in the EPD. The report then matches the treatment. This has substantially increased the response rate. Around 58 piercing accidents were reported in 2010.

4.5.8 Furniture for the new hospital

A final choice of office furniture was made for the new hospital in early 2010. The working conditions consultant was involved in the selection and choice.

4.5.9 MRSA Bacteria

Screening for MRSA bacteria for new employees continued in 2010 and the working procedures were streamlined. Checks are also performed for adequate protection against hepatitis B for new employees. If this is not the case, a vaccination process begins. Four contact surveys were conducted in 2010 after employees came into contact with a patient infected with TBC. The annual repeat surveys of the prevalence of TBC among employees were also conducted in selected departments.

4.5.10 Vitality management

In times of a difficult labour market retaining good staff is a must. The hospital is therefore aware of the need for a good policy, in which employees remain permanently employable. A start was made on the development of vitality management. In 2011 this is an integrated part of processes and activities designed to keep Maasstad Hospital employees vital and employable in the long term, in a safe and healthy manner.

4.5.11 Performance Management

Work will start on performance management in 2011. This will help our hospital to realise the corporate goals and creates commitment to these goals among the employees. With performance management we shall introduce a new assessment cycle, in which both results and competences are assessed.
A competence catalogue has been developed for the assessment of competences, in which the core competences of guest-orientation, cooperation and result-orientation are described, as well as job-related competences. A link to the new employee job profiles is created in the competences. Performance management and competence management will be introduced in stages. A start will be made with the most senior management tiers in 2011, after which this experience will be used for the implementation in the entire organisation.

4.5.12 Health care job assessment

A new job classification survey was created in 2008 following the consistency survey. All jobs were redefined in it and they were assessed in accordance with the current collective labour agreement (CAO). The consistency survey enables the existing 600 different classifications to be reduced to a maximum of 150. The project consists of four stages:

- The preparatory stage;
- Description of job types;
- Classification of job types;
- The after-care stage.

These stages were followed for each individual employee. The project was completed at the end of 2010, with the exception of a number of objection procedures. Naturally, the job classifications retain our attention, as they are subject to change.

4.5.13 Social plan

In the run-up to the relocation a number of departments and jobs will be withdrawn. The social plan, based on assistance in moving from job to job, was applied here. Nevertheless, regular talks are conducted with the trade unions to assess whether the social plan is still appropriate and where personalised arrangements can be provided.

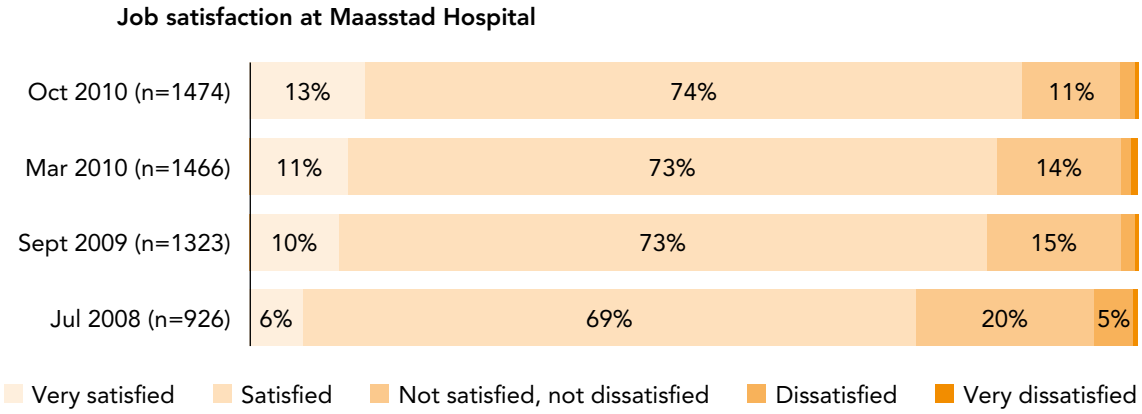


Figure 11 Outcome of Employee Evaluation Survey

4.5.14 Employee Evaluation Survey

A new survey of our staff was conducted in 2010. The results provide an insight into changes in the evaluation of the staff by the hospital and the extent to which they are proud of the hospital. The results were compared with those for 2008 and 2009.

Table 50 Response rate, Employee Evaluation Survey

October 2009	42%
October 2010	48%

In general terms, we may conclude that the staff are more positive about Maasstad Hospital in all respects than during the surveys of 2008 and 2009. Job satisfaction at the hospital has increased in comparison with earlier surveys. Most of the employees are (very) satisfied with their jobs at Maasstad Hospital. In October 2010 87% of employees were satisfied. This represents an increase of 5% in comparison with 2009 (83%) and 12% in comparison with July 2008 (75%). The share of very satisfied employees also increased from 6% in July 2008 to 13% in October 2010. See figure 11.

In addition, more employees (92%) were proud to work at Maasstad Hospital in 2010 than in 2008 (89%) and 2009 (91%). Maasstad Hospital is well-regarded as an employer, but employees are still cautious about recommending Maasstad Hospital as a hospital (21%). Nevertheless, a clear rising trend can be seen in this recommendation. In 2008 the percentage was 7% and in 2009 14%. The Employee Evaluation Survey will be repeated in 2011.

4.5.15 Introduction of new employees

An introductory programme was developed in 2009 and was further developed in 2010 into a general introductory meeting for new employees and introductory meetings for specific target groups, in order to achieve uniformity in working methods and conduct.

During these meetings the new employees familiarise themselves with the hospital, partly via an animated film. They are also given presentations on the past, present and future of the hospital and the vision and mission statement are explained. Special attention is devoted to client perceptions, a subject that has high priority at the hospital. In 2010 a 'return lunch' with one of the managing directors was launched for new employees who had been working at the hospital for one month. These lunches are well-attended and have led to valuable feedback. They will therefore be followed up in the coming years.

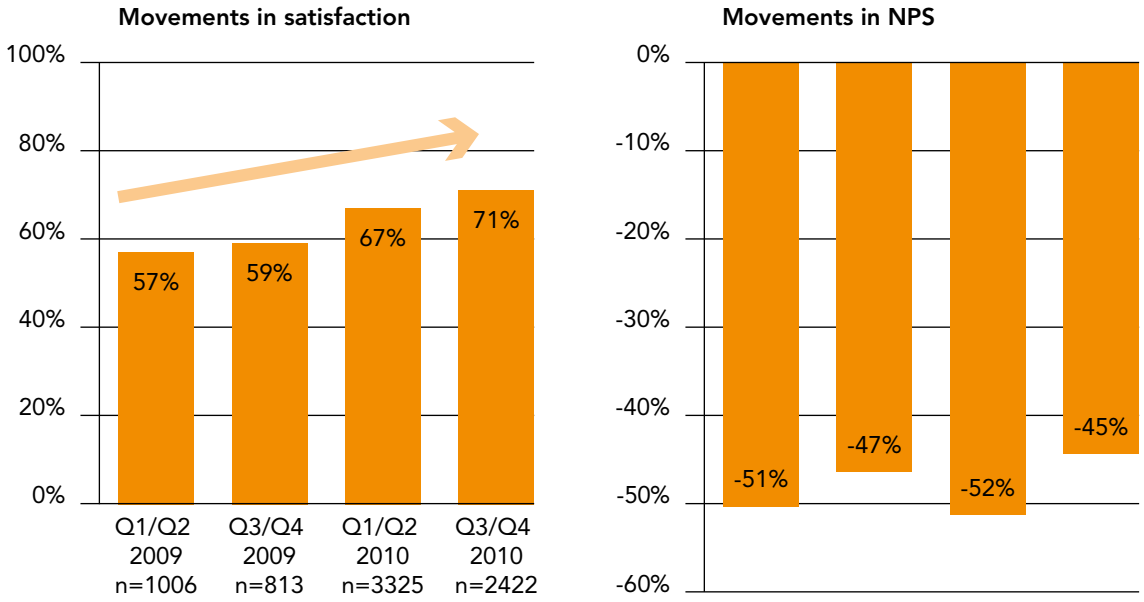


Figure 12 Movements in NPS for the ISM

4.3.16 Internal Service Monitor

The Internal Service Monitor (ISM) measures the extent to which the employees are satisfied with the services of the (medical) support departments of the hospital. The ISM has been performed quarterly, on a structural basis, since the final quarter of 2008 and every six months since 2010. The target group consists of internal clients: junior doctors, specialists, medical managers, team leaders

and (health care) managers. From 2010 all employees have received the questionnaire. A total of 11 support departments and eight medical support departments are included in the survey. It has been decided in outline that movements in satisfaction and the NPS must show a positive trend. Movements in satisfaction for the management departments also reflect a positive trend, rising from 67% in Q1/Q2 2009 to 71% in Q3/Q4 of 2010. The NPS in the second half-year also improved in comparison with the first half, from -52% to -45%. The 2009 figures cannot be compared with the results for 2010, as a decision was made in 2010 to include all employees in the survey, rather than a selected target group only. Furthermore, satisfaction with the different elements is investigated in a different way from 2009. In 2009 this took place via a points system and in 2010 via a satisfaction scale (from very satisfied to very dissatisfied). As a result, a break I the trend occurred. This comparison can be made in 2011.

Movements in satisfaction for the medical support departments remained stable, although these departments invested in their services. The NPS showed a very positive development in 2010, from -38% to -26%. See figure 12.

The main conclusions for 2010 are:
- The medical support departments score higher for general satisfaction than the support departments.
- The employees are most satisfied with the Radiology (89%), Pathology (87%) and Pharmacy (82%) medical support departments. These departments also have the highest score for intended recommendation (NPS). Pathology is the most highly recommended by its internal clients.
- The Central Sterilisation Department has the lowest score of the medical support departments for many criteria. The priorities of this department are compliance with agreements, quality and meeting requirements.
- The employees are most satisfied with the advisers of the Advice & Development Team (79%), the Maasstad Academy (77%) and Buildings & Technology (76%). These departments face the challenge of maintaining the level attained. The Maasstad Academy is most frequently recommended by its internal clients.
- Sourcing has the lowest score of the support departments for many criteria. It has been asked to give priority to the criteria of expertise, clear agreements and meeting requirements.

4.5.17 Dynamic Personnel Planning

The DPA project was performed in 2009 and 2010. The project is aimed at reducing the costs of PNIL by creating a flexible working 'shell' in the departments.

We achieved this as follows:
- Increasing the flexible pool of employees;
- Making production transparent in relation to input, with the input of permanent employees and PNIL.

This creates a steering tool for managers and team leaders, with the aim of reducing personnel costs. A project named DPA Stage II was started at the end of 2010 to further install the principles of DPA I in the organisation.

4.5.18 Patient service employee

Together with Assist Zorgondersteuning Maasstad Hospital has formed a company named Maasstad Ziekenhuis Patiëntenservice (MaAssist BV) with the aim of patient-friendly organisation and implementation of the care support processes in the nursing departments of Maasstad Hospital. MaAssist B.V. provides for the planning and implementation of housekeeping and light care tasks in health care institutions. Hospitable and customer-oriented operations are key concepts in this service. One person, the Patient Service employee, is responsible for all care support

tasks around the bed or on the ward. Furthermore, Patient Service employees take over work from the nurses. They provide care for patients and their surroundings, making the patient's stay more pleasant. As a result, the service gains a single face which creates ties with the patient. MaAssist B.V. achieved a positive financial result in 2010, reflected in a reduction in the hourly rate. This helps to win support for the concept and may lead to an expansion of the number of hours.

4.5.19 Evaluation interviews for medical specialists

The medical specialists of Maasstad Hospital are invited to reflect on their individual performance via the Individual Performance of Medical Specialists (IFMS) process. The process was launched in 2008 in cooperation with Nosce Orbis, the employment agency for doctors. The system used is unchanged. It involves completing a 360° feedback questionnaire based on competences (as used for

Table 51 IFMS subjects

Subjects/questions	Score on scale of 1-5 (range)	
	2010	2009
Participation in 360° feedback survey is not perceived as threatening	4.4 (3-5)	4.4 (3-5)
Would advise a colleague to take part in a 360° feedback survey	4.0 (1-5)	4.2 (2-5)
Participation in follow-up interviews is not perceived as threatening	4.2 (3-5)	4.5 (3-5)
Would advise a colleague to take part	4.1 (1-5)	4.4 (3-5)
Presence of a buddy is valuable	4.1 (2-5)	4.3 (4-5)
Valuable to repeat 360° feedback survey	3.5 (1-5)	3.7 (2-5)
Valuable to repeat follow-up meetings with buddy	3.8 (1-5)	4.0 (2-5)

specialists in training), i.e. communication, medical action, professionalism, organisation, cooperation, knowledge and research and social conduct. This is followed by two interviews with a psychologist, the second of which is conducted in the presence of a fellow-specialist. The results of this evaluation are confidential and will not, therefore, be published in this annual report.
The evaluation of the 95 medical specialists who completed this process in full are summarised in the table below. The values are included in the evaluation in the first period of the 360° feedback system. The evaluation will be performed in early 2011, considering whether to maintain this system or whether another system might be more appropriate. See table 51.

In mid-2010 15 of the 20 companies/disciplines started the process. Three disciplines discontinued their participation, stating that the design of the IFMS was not the reason in any of these cases.

4.5.20 Training courses

As an explicit condition for continual improvement we continually invest in knowledge, skills and experience of the management and staff in the training courses that we offer. Leadership courses were once again given for (new) employees and medical specialists in 2010. At Maasstad Hospital employees can direct their own careers. All training courses are combined centrally and transparently at the Maasstad Academy, which is making progress in the field of educational innovation. Ambitious professionals can in this way continually improve, broaden and deepen their knowledge and skills.
Maasstad Hospital is one of the biggest teaching hospitals in the Rotterdam-Rijnmond area. We aim to improve health care by conducting research and by expanding and sharing our knowledge, partly through the provision of training courses. We aim to be an organisation in which employees are inspired to get the best out of themselves. 'I learn and develop in my hospital' is therefore part of our mission statement.

We are a serious player in the training market and aim to attract and retain well-trained and expert paramedical, medical and health care support and support staff. Doctors are trained as medical specialists at Maasstad Hospital, while there are specialised follow-up courses for nurses and foundation courses at the secondary and higher professional training levels for school-leavers. We invest heavily in retraining and refresher courses. In short courses and meetings, the hospital also provides upgrading programmes and theme meetings for GPs, home care workers, doctors' assistants and others.

We again invested a great deal in training courses in 2010. This is shown by the application for associate membership of the STZ. We received a visit for this in December 2010. In addition to regular training, the hospital also provides training in applied medical research, evidence-based medicine, clinical epidemiology and statistics.

Maasstad Academy

During 2010 the Maasstad Academy grew to become the contact point for everything to do with education and training, training courses, symposia, congresses and scientific research. The Maasstad Academy organises and facilitates training courses on request. It also provides advice in various fields, relating to education and training, opportunities, didactics, materials and resources.

In 2010 the e-learning and information programme acquired in 2009 was introduced in the organisation, facilitated by the Training Management System. The skills lab was also expanded further. In the occupational training course, competence-oriented training was introduced. A start was also made in 2010 on cooperation with the other partners in the Care Boulevard in the field of training and development. In the autumn skills training in actions reserved under the Act on Occupations in Individual Health Care (BIG).

These courses involve blended learning, a combination of online learning and contact education. The target groups are nurses and doctors' assistants. A carrousel model was set up at the end of 2010 relating to these skills courses (venous puncture, installing a drip, bronchial toilet, bladder catheterisation and inserting a stomach probe).

In the new skills laboratory at the new hospital we can offer advance simulation training for the ANIOS and AIOS, coassistants and specialised nurses. The laboratory is also used for Casualty training courses in accordance with the IGZ Casualty Maintenance Plan (IGZ-2010-219211/EA). Preparations for this are in full swing at present. ANIOS and AIOS surgeons practice skills for laparoscopic surgery in five laparoscopic practice cabins. Operating staff also use this to improve their professional knowledge.

Occupational training and occupational follow-up courses

Maasstad Hospital profiles itself as a hospital with regional and social responsibility. In 2010 the hospital offered training places for occupational training and occupational follow-up courses. The hospital also offers training courses for audiology assistants, HLO analysts, central sterilisation assistants, endoscopy assistants, MC PACU, dental hygienists, orthoptists and technical ophthalmology assistants.

We supervised many trainees on training placements in 2010. These trainees came from:

- Higher vocational training – Courses for nurses (Level 5);
- Regional Education and Training Centres (ROCs) – Course for nurses (Occupational Training, Level 4);
- GP assistants course (Level 4)
- Military Medical Services Training Centre – Training as General Military Nurse (Level 4);
- Nursing institutions in and around Rotterdam – Courses for nurses (Levels 3 and 4);

- Universities – Courses for physicians and Health Care Policy Management (health care training placement).

A table showing the number of occupational and corporate training courses as at year-end 2010 is included in Annex 3.

Medical training courses

AIOS

Maasstad Hospital provides 11 medical follow-up courses, including six in primary specialisms. The Neurology department also participates in the psychiatry training course (Delta Hospital). The table below shows the follow-up courses available and the number of AIOS taking these courses.

Table 52 Number of follow-up courses and AIOS places

Follow-up course	Number AIOS
Internal medicine (P)*	8
Paediatrics (P)*	3
Rehabilitation (P)*	3
Gynaecology (P)*	3
Surgery (P)*	11
Anaesthesiology (P)*	3
Clinical Chemistry	1
Clinical Pharmacy	2
Medical Microbiology	3
Radiology	10
Clinical Physics	1
Total	**48**

(P)= referral specialism*

Coassistants

Maasstad Hospital has an affiliation contract with the EMC. Eight medial disciplines at the hospital contributed to the training of coassistants, of which an average of 35 are always present. The Maasstad Academy organises a monthly lunch for coassistants, with the aim of maintaining mutual commitment. The lunches show that the coassistants highly appreciate the training climate at the hospital. The lunches form an important tool for the quality of the education and training climate. Twice a year an evaluation takes place with the Coassistant Council. The results of the evaluations are fed back to the trainers of the coassistants and are discussed in the Education Committee.

4.6 Society

4.6.1 Preparation for disasters and crises in the region

Maasstad Hospital takes its responsibility for preparation for disasters and crises in the region very seriously. Various training courses were provided in 2010 aimed at external disasters and crisis management:

- Nurses from Casualty, the Observatory, the OK and staff of the Security department followed the Hospital Major Incident Management System course for Emergency Response Officers.
- Nurses from Casualty, security officers and a member of the strategic crisis team follows the 'Dealing with Contaminated Victims' course.
- Various combinations of the crisis team membership have been intensively trained in the field of crisis management and communication.
- The crisis coordinators took part in the monthly regional crisis coordinators meeting organised by the GHOR.

The hospital also once again took part in the Exodus exercise, in which an accident on the Rotterdam underground is simulated. This revealed that we are well-equipped to treat large numbers of victims.

4.6.2 Environment

Maasstad Hospital is aware of its responsibilities for patients, employees, visitors and its surroundings in relation to the environment.

Our policy is to prevent or limit the negative impact of our own operations on the environment. Naturally, we comply with the environmental legislation. Controls by the Rijnmond Environmental Service (DCMR), among others, shows that we comply with the Environmental Management Act and the requirements of the environmental permit. We also conduct regular talks with this environmental service on current affairs and (new) developments.

The hospital's energy consumption stood at the same level as in earlier years. Due to the relocation, no further investments were made in energy-conservation measures in 2010. Energy conservation technologies have been applied in the new building. In mid-2012 the hospital will investigate whether further energy conservation is possible. The main factors creating a burden on the environment in 2010 were the production of waste, energy consumption (gas, water and electricity) and emissions into the soil and air. By devoting attention to these contaminant factors, for example through responsible separation and processing of waste, the hospital makes its contribution towards a better environment.

Table 53 Movements in energy consumption

Year	Gas (m^3)	Electricity (kWh)	Water (m^3)
2010	3,921,269	12,362,288	126,202
2009	3,507,051	12,660,660	124,592
2008	3,476,295	12,173,332	121,144
2007	3,328,555	12,225,954	120,689

Table 54 Movements in gas consumption

Year	Gas (m^3)	Grade day	Corrected consumption
2010	3,921,269	2704	3,826,973
2009	3,507,051	2790	3,536,202
2008	3,476,295	2767	3,120,751
2007	3,328,555	2484	3,500,075

Waste generation has increased accross the board at the hospital. The increase in specific hospital waste is explained by the fact that from mid-2009 dialysis wastes could not longer be removed as corporate waste, but were classified as specific hospital wastes. Compared with the volume of specific hospital wastes in the final six months of 2009, no significant increase is seen in 2010. The volume of corporate waste does show a notable increase. This is due to the upcoming relocation, as a result of which the hospital is disposing of many superfluous products.

Table 55 Movements in waste flows

Year	Total wastes (kg/GPE)	Specific hospital wastes (kg/GPE)
2010	1.19	0.110
2009	1.19	0.108
2008	1.21	0.086
2007	1.20	0.075

4.6.3 Transport policy

For 2011 the hospital will develop a transport policy in order to reduce use of cars to travel between home and work in favour of bicycles or public transport. The elements of this policy are:

- Discouraging parking at the new hospital through high charges for the car park;
- Introduction of paid parking in the area around the hospital;
- Changing allowances for travel between home and work, to encourage use of bicycles and public transport;
- Free bicycle insurance.

4.6.4 Waste processing

The hospital also aims to arrange for CO2-neutral processing of the waste generated in 2011, with annual waste scans to see where savings are possible.

4.6.5 Pact at South, Care Boulevard Opportunity Card and Care Boulevard Administrative Order

The Pact at South is a programme of Rotterdam municipal authority, municipal districts and housing corporations in Rotterdam South, designed to reduce selective migration (the departure of middle and higher-income residents) to zero in the years to 2015 and increase resident satisfaction. The Care Boulevard is one of the Pact at South opportunity cards that offers opportunities for the economic, physical and social growth of Rotterdam South. In order to develop this opportunity card the municipal authority issued an administrative order.

This mentions the following four assignments for four tempo teams:

- Optimising access and a better layout of public spaces, optimising parking and improving public transport connections;
- Strengthening the health care profile;
- Giving shape to the economic spin-off of the Care Boulevard;
- Spin-off for residents of South in the form of training courses, jobs and training placements.

The implementation of the administrative order is a joint process for five parties: Rotterdam municipal authority, IJsselmonde District Council, Pact at South, Care Boulevard Rotterdam BV and the Care Boulevard Rotterdam Association. The implementing organisation consists of an administrative tier and a core team supervising four tempo teams.

The four tempo teams are working on the order. Concrete results in 2010 included:

- Improved access to the Care Boulevard;
- Agreements on parking at and parking policy around the Care Boulevard;
- Improved and safe access for pedestrians from the road and to the station;
- Development of care arrangements for teenage mothers;
- A concept for giving local people opportunities to start their own businesses on the Care Boulevard;
- An initiative to develop a care academy and an apprenticeship centre on the Care Boulevard, together with employers and schools.

These represent important steps towards concrete development of the synergies within the Care Boulevard and between the Care Boulevard and its social environment. This development will continue in 2011.

4.6.6 Friends of Maasstad Hospital Foundation

After a somewhat financially meagre 2009 the Friends of Maasstad Hospital Foundation continued with optimism in 2010. The foundation set itself the target of raising € 3.5 million. Fortunately, the economic climate was clearly recovering in a number of sectors. A total of € 1.8 million was raised in 2010, compared with € 75,000 in 2009. While this did not achieve the target, it did represent a substantial increase in comparison with the year 2009.
Deltalinqs made efforts to collect funds for the OK of the BWC. This achieved a long-cherished wish for the BWC to have its own OK in the new hospital, too.
The donation fund DELTAPORT made a sum available for the design and realisation of play containers. The games in the form of a container, especially designed for Maasstad Hospital are located in waiting rooms visited by many children. Thanks to a contribution from the Dada Foundation and Smith Holland, far more play containers can be found in the hospital than was initially envisaged.
The foundation received a subsidy from Rotterdam municipal authority for the construction of seven planted roofs on the new hospital. The planted roofs, with a surface area of 3,300 square metres, were laid on the

lower sections of the new hospital. The roofs are covered with various types of succulents, herbs and mosses. Planted roofs provide for better insulation, better collection of rain-water and a longer useful life for the roof.

Thanks to a generous contribution from the Neyenburg Foundation, the foundation was also able to co-finance the planted patios. These planted patios enable patients and visitors to retreat for a while into enclosed gardens, surrounded by large trees.

Companies occasionally contact us spontaneously. Holland Casino Rotterdam, for example, contacted the hospital on its own initiative. Each year the organisation donates the value of found chips to a good cause. We found a fine use for the amount in the garden furniture in the Maternity department.

Art must have a prominent place in the new hospital: accessible art that sometimes refers to the old Zuider and Clara locations. This will be possible thanks to the efforts of the foundation. The G. Ph. Verhagen Foundation made a sum of money available which enabled us to give a photography commission to Jannes Linders.

2010 was also the year in which we called on employees to think of actions to raise money and offered them the possibility of donating the value of their Christmas hampers to the foundation. Fifty employees took up this option. It is heart-warming to see that they feel committed and are keen to contribute towards a more attractive hospital.

The foundation also has many other donors. Some have loyally donated a monthly sum for more than two years. Others respond to the calls and register as new Friends. As a result the foundation gained 62 new Friends in 2010. At year-end 2010 it had a total of 440 donors.

4.6.7 Partnership with Hôpital Laquintinie

Project group
The partnership with the Laquintinie hospital in Douala, Cameroon, developed further in 2010. A project group is implementing the partnership in practice.

Foundation
At the end of 2010 the Maasstad Hospital – Hôpital Laquintinie Partnership Foundation was formed in order to improve the quality of care for patients in the Cameroon hospital. The foundation works to achieve through:
- (Provision for) the organisation of exchange projects between staff of Hôpital Laquintinie and Maasstad Hospital;
- Providing medical equipment, other and financial resources, staff, knowledge and expertise;
- Fund-raising.

Sterilisation container
In cooperation with the Ministry of Defence a sterilisation container has been built in Douala. Three Linden sterilisers have been built into a marine container and a power supply has been connected. The container has been positioned next to and connected to the OR complex. In this way sterilisation can take place in a sound and controlled manner. Furthermore, the unit is low-tech and maintenance-friendly. In July the container was fitted with other equipment and ancillaries and was officially handed over in August.

Inventory of Maasstad Hospital equipment
At the same time as the inventory of the equipment for the new Maasstad Hospital, the project group listed the equipment that was still suitable for (re-)use in Cameroon, taking account of the requirements in Cameroon, the economic residual value and the possibilities for maintaining the equipment there.

Visit
A delegation from Maasstad Hospital visited the Laquintinie hospital in August. The visit served three purposes:
- Confirmation of the partnership;
- The transfer of ancillary equipment;
- Familiarisation with the local situation for follow-up projects, such as the IC unit.

Outlook
In the first half year of 2011 the emphasis will lie on collecting and shipping the equipment remaining from our two old locations after the transfer to the new hospital. The follow-up process for the IC will take shape and a start will be made on implementing other projects. According to the plans the focus in the

second half of 2011 will lie on the OK complex at Hôpital Laquintinie.

4.7 Financial policy

4.7.1 General financial developments

The budget for 2010 was fixed with a positive result of 6.8 million. After the third quarter the forecast for 2010 was adjusted to a positive result of € 4.6 million. The final result (for the company) was a net profit of € 4.8 million. Although the result was still positive, we regard this development as a cause for concern which must be addressed vigorously in 2011.

The Maasstad Hospital budget for 2011 is primarily based on the growth targets set in the long-term budget for 2011-2013 and on controlling the growth of costs. Naturally, we kept account of this with the developments which occurred during 2010 after the long-term budget was adopted[4] and the progressive insights relating to developments in 2011.

In addition to the effects of the relocation to the new building the additional hospital cutbacks announced by the Ministry, due to the € 549 million overrun of the Health Care Budget Framework, played a particularly important role. The additional cutbacks have since been adjusted to € 314 million. To date the Netherlands Hospitals Association (NVZ) has not received a reply to its request for adequate support for this amount fixed by the Ministry.

We primarily paid attention to the additional costs, to some extent incidental, for the delivery and commissioning of the new building in 2011. Strong cost-orientation is also needed, partly because in the new building we shall work with fewer beds on a structural basis. 2011 is the year in which, through accelerated throughput and further reductions in the duration of hospital stays, we must achieve growing production within the walls of the new hospital building. A study was conducted in early 2010 into further details of our revenues and costs for each discipline. The results must provide leads for the structure of the (long-term) budgets for 2011 and subsequent years. The outcomes of the study have been or will be discussed with the professional groups in order to be able to realise developments, strategies and choices together with these groups, partly with the aim of more efficient and effective work of a high quality standard, without relinquishing our growth targets.

With respect to the personnel policy we shall focus more on reducing the costs of temporary employees in 2011 by strengthening the position of the internal flexible working hours office. Flexible deployment of staff within our own organisation must be increased.

The increase in equipment costs in the budget is only limited in comparison with 2010. The measures announced in relation to the 2011 budget are aimed at reducing the growth in variable patient-related costs in order to restore profits. The growth of the capital costs is primarily due to the increased interest charges in 2011. These will be covered by the growth in the external budget for 2011.

The 2011 budget shows a limited profit of € 0.9 million. This takes account of the following exceptional developments:

- Incidental charges for the relocation to the new building, such as duplicate costs, until the new building is finally transferred, totalling € 6.8 million;
- The additional Government cutbacks, over and above the cutbacks fixed earlier, now calculated on the basis of an additional € 314 million in the hospitals sector.

Switch to performance-based funding

Although further liberalisation of prices in the health care sector entails risks, we regard these developments as an opportunity. A

4 *The long-term budget for 2012-2014 will be drawn up after the 2010 financial statements have been adopted.*

system in which performance and good quality care are rewarded is consistent with the strategy of the hospital. The Government will not take the next steps in this process until 2012. We must therefore prepare for this in 2011.

2010 capital costs scheme

In view of the situation of new construction, with a relocation in May 2011 and the related increase in our capital costs, we are devoting extra attention to developments in this area. Final decisions on this matter must create certainty regarding the effects for Maasstad Hospital. This concerns both the total depreciation for the old building and the acceptance of depreciation for the stages of the new construction work. The transfer scheme fixed for Maasstad Hospital in the course of 2010 provides sufficient scope to cover the capital costs for the A-segment for both processes. Scope must be created in the price negotiations to cover the capital costs for the B-segment, too. In order to utilise the opportunities and hedge the risks of this as effectively as possible the new hospital was capitalised in 2010. For the A segment depreciation also began in that year. Depreciation for the B segment will start in 2011.

4.7.2 Movements in the balance sheet and income statement

The individual items are explained in detail in the financial statements. We also wish to mention some of these here. For example, the amount recognised for non-current liabilities in the balance sheet is more than six times as high as in 2009. However, the current liabilities are almost € 100 million lower. The reason for this can be found in the conversion of short-term loans into a long-term loan.
In the income statement the increase in personnel costs is particularly striking. This is due to a number of developments in the CAO (Collective Labour Agreement). In 2010, for example, a provision was made for the personal life-stage budget for the first time as a result of this. The increase in PNIL costs is also notable. This is explained partly by the large number of people working on preparations for the relocation and the introduction of DOT in 2012.

4.7.3 Ratios

The ratios for 2010, determined in terms of the full company result for the financial year, are as follows:

Table 56 Result

Result ratios	2010	2009
Result ratio	1,7%	5,8%
Cash	**2010**	**2009**
Cash (current assets/ current liabilities excluding financing surplus)	97,2%	27,5%
Capital adequacy	**2010**	**2009**
Capital adequacy (total equity/ balance sheet total)	13,4%	15,5%
Capital adequacy (total equity / total revenue	16,2%	16,5%

Fluctuations in these ratios are caused by two factors. Firstly, the extraordinary income had a positive impact of € 8.9 million on the result for 2009. This substantially increased the result ratio for 2009, in particular. The second cause was the conversion of many of the short-term loans into a single long-term loan. This led to a reduction in short-term borrowings and thus a strong positive effect on the cash position.
A comparison between 2009 and 2010 without the extraordinary income is somewhat more realistic. The result ratio is then as follow:

Table 57

	2010	2009
Result ratio	1,7%	2,4%

4.7.4 Current financing

An arrangement has been contracted with a bank consortium consisting of ING, Fortis, Van Lanschot and BNG to finance the new building, the medical and other equipment and the working capital. The overall financing facility for the new hospital was increased to € 330 million in the course of 2009.
The financing facility consists of loans of:

- € 75 million for the working capital;
- € 205 million for the new building;
- € 50 million for other fixed assets.

In view of the credit crisis the banks tightened the conditions for the loan, both financially and in qualitative terms. The measures taken by the Government to still enable financing of health care investments were very necessary in order to reach agreements with the financiers.

In 2010 Maasstad Hospital contracted agreements for a total of € 240 million with parties in the SWAP/Interest Rate Swap consortium to hedge interest risks.

4.7.5 Early Warning System

In response to financial incidents at various health care institutions demand arose at the Ministry of Public Health, Welfare and Sport for an early warning system. The use of a warning instrument is intended to make the threat of financial problems visible at an early stage. That visibility will make for prompt adjustments and can thus prevent escalation. ZinData has set up an extensive early warning system on a national scale. ZinData assessed all hospitals in the Netherlands in terms of a number of 'risk points': i.e. results, revenue, resilience, debts, production, productivity, efficiency and market position. Depending on their importance, existing risks are assigned a maximum number of points. Up to 24 points can be assigned: the higher the number of points, the poorer the score. According to ZinData, the average score in 2010 was 4.0 points. Maasstad Hospital was well below that average, with 3 points.
Maasstad Hospital's early warning system is based on the planning and control cycle (see section 3.4).
The long-term budget forms the main framework. This consists of verifiable assumptions and scenarios and calculates the outcomes through to the various performance indicators. The Finance and Control (F&C) department reports progress with the KPIs every quarter. The actual results are assessed in terms of the expectations on that basis. Variations are analysed and explained to the Supervisory Board, the Executive Board and external

stakeholders such as banks. These reports are also discussed with the Supervisory Board. In 2010 KPIs such as the number of initial outpatient visits, the sickness absences rate, budget discipline and the average length of hospital admissions was regularly discussed with the Executive Board and the Supervisory Board and, if necessary, appropriate adjustments were made. The long-term budget is adjusted annually in terms of the latest information on external developments, supplemented with information from annual plans and budgets. The long-term budget is drawn up by F&C in cooperation with the Marketing, Communication and Sales department, after talks with professional groups and managers. Monthly reports are also drawn up, on the basis of which managers can explain their results to the Executive Board. The reports include a list of scores for KPIs such as:

- Number of new patients;
- Access time to the hospital, in terms of weeks;
- Cost-to-Serve;
- Quality and safety;
- Patient satisfaction;
- Sickness absence rate.

This is used throughout the year to steer tightly for the prevention of differences between the plans and the actual outcomes.

Annex 1 Top clinical/top referential care

Specialism	Top clinical/top referential care
Anaesthesiology / Pain control:	Third line referrals for neurostimulation, i.e. spinal cord stimulation, intrathecal drug delivery and intrathecal Baclofen therapy
Cardiology	Intervention cardiology with regional function for acute cardiology in cooperation with the Erasmus MC
	Implantation of implantable cardioverter defibrillators and biventricular pacemakers (Electronic Resynchronisation Therapy for heart failure)
	Advanced cardial imaging in cooperation with Radiology with regional function (Cardiac CT, cardiac MRI, nuclear cardiology)
	Specialised outpatient care for patients with heart failure, dyspnoepoli in cooperation with the Pulmonary Diseases department, 'one-stop-visit' outpatient treatment for chest pain, post-arrest outpatients.
Surgery	Treatment of burns
	Vascular Centre, unique partnership between Surgery and Radiology centrum (Vascular Centre in formation)
	Centre of Excellence for bariatric surgery and obesity care (nurse practitioner, FT, dietician, endocrinologist; including complex and repeat surgery)
	Plastic surgery, reconstruction after breast amputation
	Intestinal failure and the complex IC requirement for abdominal surgery (multi-disciplinary)
	Fecal incontinence (endorectal echography, nurse practitioner)
	Peri-anal tumour
	Colon care
	Pancreatic surgery
	Oesophagal surgery
	(Certified) pulmonary surgery
	Referral centre for malunions of the distal radius and ulna
	Endoscopic surgery: gastro-intestinal, herniae, lungs, arthroscopy
Diabetes care	Transition outpatient care for juvenile diabetic patients (see paediatrics)
	Outpatient care for pregnancy in diabetics
Endocrinology	Thyroid outpatient care with thyroid ultrasound scans and punctures by endocrinologists

Specialism	Top clinical/top referential care
Gastro-enterology MDL centre	ERCP for the region
	Video capsule endoscopy
	Double balloon enteroscopy
	Endo-echography
	Multi-disciplinary treatment of pancreatitis oesophagal and pancreatic tumours
Gynaecology	Stages 1 and 2 in-vitro fertilisation
	Treatment of uteral prolapse with robot-assisted laparoscopic surgery
IC	IC Level III Intensive Care
	IC Mobile Intensive Care Unit
	IC Regional IC function
Internal medicine	Haemodialysis and peritoneal dialysis
	Night dialysis
	HIV treatment centre
	Hepatitis treatment centre
	MRSA outpatient treatment
	Knowledge centre for thyroid disorders
	Oncology centre; cotreatment with bone marrow transplants (together with EMC)
Ear, Nose and Throat	Septum navigation surgery
	Internal and external nasal corrections
	Stapes surgery
	BAHA surgery
	Celon surgery for snoring
Paediatrics	Post IC/HC neonatologiy
	Third line centre for defecation problems
	C status paediatric oncology
	Paediatric endoscopy
	Multi-disciplinary team for children with eating disorders
	Multi-disciplinary team for children with developmental problems
	Combined asthma-allergy-eczema outpatient unit also specialising in paediatric respiratory nursing support
	ADHD outpatient unit with specialised nurse and cooperation with child psychology
	Paediatric burns unit
	Paediatric diabetes team for entire Rotterdam South region (secondary referrals from Ikazia ZH) : 2 paediatricians with specialised knowledge of this, two specialised paediatric diabetes nurses, one diatician, one child pyschologist, one medical social worker

Specialism	Top clinical/top referential care
	Registered centre for children with Familial Hypercholesteroaemia (via STOEH foundation)
	Child abuse officer
Pulmonary medicine	EBUS and EUS
Neurology	Epilepsy
	Multiple Sclerosis
	Treatment with botulin toxin for dystonia
Casualty	Regional function
Urology	Third-line centre for robot-assisted surgery for prostate cancer
	Robot assisted laparoscopic nephro-ureterectomy
	Robot assisted laparoscopic pyelum surgery
	Robot assisted laparoscopic partial nephrectomy
Medical Microbiology	Third-line laboratory with all microbiological sub-specialisms, i.e. virology, molecular diagnostics and mycology and pharmacogenetics
	Laboratory for Public Health Care in accordance with a covenant with the GG&GD for the Rotterdam area
	Continually develops products for microbiological and molecular diagnostic services
Clinical pharmacy	Hospital pharmacy with regional function

Annex 2 Production per specialism

Specialism	Admissions			Nursing days		
	A-segment	B-segment	Total	A-segment	B-segment	Total
Allergology	2	-	2	2	-	2
Anaesthesiology	161	128	289	988	390	1,378
Cardiology	4,055	2,677	6,732	10,951	9,572	20,523
Surgery	5,743	1,073	6,816	27,703	5,444	33,147
Dermatology	12	5	17	132	64	196
Gastro-Enterology	895	89	984	6,040	640	6,680
Internal Medicine	5,458	559	6,017	26,611	2,877	29,488
Oral surgery	86	-	86	226	4	230
Ear, nose and throat	136	153	289	315	332	647
Paediatrics	2,637	52	2,689	12,442	308	12,750
Pulmonary diseases	1,896	144	2,040	13,283	451	13,734
Neuro-surgery	178	991	1,169	477	3,380	3,857
Neurology	651	690	1,341	3,859	4,123	7,982
Ophthalmics	4	13	17	7	31	38
Orthopedics	292	649	941	1,414	3,680	5,094
Plastic surgery	273	62	335	889	161	1,050
Rheumatology	59	52	111	450	435	885
Rehabilitation	-	-	-	-	-	-
Urology	317	716	1,033	1,162	2,721	3,883
Obstetrics/Gynaecology	1,085	2,626	3,711	1,725	8,195	9,920
Total	**23,940**	**10,679**	**34,619**	**108,676**	**42,808**	**151,484**

Specialism	Day care			EPBs		
	A-segment	B-segment	Total	A-segment	B-segment	Total
Allergology	534	-	534	1,376	-	1,376
Anaesthesiology	1,749	1,317	3,066	834	945	1,779
Cardiology	113	533	646	6,141	7,013	13,154
Surgery	2,088	1,033	3,121	26,231	2,159	28,390
Dermatology	54	388	442	7,442	2,888	10,330
Gastro-Enterology	1,847	705	2,552	3,402	938	4,340
Internal Medicine	5,263	1,793	7,056	14,617	2,571	17,188
Oral surgery	417	-	417	9,655	32	9,687
Ear, nose and throat	855	2,130	2,985	6,589	2,571	9,160
Paediatrics	1,525	6	1,531	6,862	127	6,989
Pulmonary disease	1,231	31	1,262	4,373	294	4,667
Neuro-surgery	32	331	363	1,307	758	2,065
Neurology	916	246	1,162	5,276	3,531	8,807
Ophthalmics	245	1,259	1,504	5,703	3,261	8,964
Orthopedics	690	839	1,529	9,187	1,209	10,396
Plastic surgery	1,471	213	1,684	4,669	425	5,094
Rheumatology	234	868	1,102	3,957	2,110	6,067
Rehabilitation	21	-	21	3,337	1	3,338
Urology	987	927	1,914	4,746	1,095	5,841
Obstetrics/Gynaecology	1306	1,137	2,443	8,075	3,237	11,312
Total	**21,578**	**13,756**	**35,334**	**133,779**	**35,165**	**168,944**

Annex 2a Average duration of nursing per specialism

Specialism	Average duration of nursing	Repeat visits	Total number of outpatient visits
Allergology	1.0	3,358	4,734
Anaesthesiology	6.1	3,064	4,843
Cardiology	2.7	20,849	34,003
Surgery	4.8	45,873	74,263
Dermatology	11.0	26,047	36,377
Gastro-Enterology	6.8	5,698	10,038
Internal Medicine	4.9	34,786	51,974
Oral surgery	2.6	6,813	16,500
Ear, nose and throat	2.3	11,767	20,927
Paediatrics	4.7	8,762	15,751
Pulmonary disease	7.0	9,955	14,622
Neuro-surgery	2.7	2,640	4,705
Neurology	5.9	9,906	18,713
Ophthalmics	1.8	9,356	18,320
Orthopedics	4.8	18,317	28,713
Plastic surgery	3.3	11,262	16,356
Rheumatology	7.6	17,128	23,195
Rehabilitation	-	6,439	9,777
Urology	3.7	11,994	17,835
Obstetrics/Gynaecology	1.6	36,662	47,974
Total	**4.5**	**300,676**	**469,620**

Annex 2b Movements in production

	2010	2009	2008	2007	2006	2005	2005-2010	2005-2010
							Absolute	Percentage
EPBs	168,944	162,537	151,964	146,494	141,768	140,020	28,924	20.7
Day admissions	35,334	34,806	29,854	27,198	21,179	20,899	14,435	69.1
Clinical admissions	34,619	31,549	29,679	27,964	27,202	25,324	9,295	36.7
Ratio of D (D+K)	50	52	50	49	44	45	5	-
Nursing days	151,484	150,396	152,471	165,639	172,704	174,186	-22,702	-13
Average duration of nursing	4.4	4.8	5.1	5.9	6.3	6.9	-2.5	-36.4

Annex 3 Number of occupational and corporate training courses as at 31.12.2010

Occupational training course	Accreditation	Number on 31.12.10	Training institute
BBL nursing, regular, Level 4	Calibris	68	Albeda College
BBL nursing, sandwich course, Level 4	Calibris	30	Albeda College
BBL higher vocational training (HBO) nursing, Level 5	Calibris	7	Hogeschool Rotterdam
Nursing training placement		Average for 2010: 60	Miscellaneous
Training placements for doctor's assistants	Calibris	Average for 2010: 6	Miscellaneous
Specialised nursing follow-up courses			
Oncology		5	EMC
Haematology		4	EMC
IC nursing	CZO	12	Albeda College
HC		3	Albeda College
HC burns nursing		3	Albeda College
Paediatric nurses	CZO	9	Albeda college
Paediatric oncology		2	EMC
Obstetrics	CZO	3	EMC
Neonatology		2	EMC
Medium Care		1	Albeda College
Intervention Cardiology		1	EMC
Nurse Practitioners		4	HRO of In Holland
Physician Assistants		3	HRO
Course for burns nurse		7	BWC
Dialysis nurses	CZO	12	Albeda College
Casualty	CZO	4	Albeda College
Plastercasting master	CZO	2	EMC
Anaesthesia assistants	CZO	11	UMC

Surgical assistents	CZO	16	UMC
MC pacu		7	Albeda College
Radiodiagnostic laboratory worker	CZO	12	Albeda College Fontys Hogeschool Haarlem EMC
Upgrading and refresher courses		**Number on 31.12.2010**	**Training institute**
MS Office courses		40	Twice IT
Medical Terminology		33	Kiwa Prismant
File compilation		61	Maasstad Hospital
Ergocoach		13	Maasstad Hospital
Selection interviews		51	Maasstad Hospital
Communication on Donation		21	Maasstad Hospital
Work supervision course		216	Maasstad Hospital
Reserved actions		12	Maasstad Hospital

Annex 4 Abbreviations

AICD	Automatic implantable cardioverter-defibrillator
AIOS	Doctor in training as specialist
ANIOS	Doctor not in training as specialist
AO/IC	Administrative Organisation and Internal Control
BLS	Basic Life Support
BOZ	Health Care Sectoral Organisations
BWC	Burns Unit
CCMO	Central Committee for Human Research
CCPM	Critical Chain Project Management
CCU	Cardio Care Unit
CSF	Critical Success Factor
DBC	Diagnosis/treatment combination
DCMR	Rijnmond Environmental Service
DCR	Diagnostisch Centrum Rotterdam B.V.
DOT	DBCs 'Towards Transparency' Improvement Plan
DPA	Dynamic Personnel Planning
DSCR	Debt-Service Coverage Ratio
EPB	Initial Outpatient Visit
EPD	Electronic Patient File
EZIS	Electronic Care Information System
F&C	Finance and Control
GHOR	Accident and Emergency Medical Service
HSMR	Hospital Standardised Mortality Rate
IFMS	Individual Performance of Medical Specialists
IGZ	Health Care Inspectorate
ISM	Internal Service Monitor
JCI	Joint Commission International
KCL	Clinical Chemistry Laboratory
KPI	Key Performance Indicator
LMR	National Medical Register
LMM	Medical Microbiology Laboratory
LUC	Local Feasibility Committee
METC	Medical Ethics Assessment Committee
MWO	Employee Satisfaction Survey
NIAZ	Netherlands Institute for Accreditation in Health Care
NPS	Net Promoter Score
NVZ	Netherlands Hospitals Association
OR	Works Council
P&C	Planning and Control
PTM	Patient Satisfaction Monitor
RRR	Rapid Reliable Response
SEH	Casualty
SMJBP	Strategic Long-Term Policy Plan
TOC	Theory of Constraints
SMS	Safety Management System
STZ	Association of Tertiary Medical Teaching Hospitals
TWOR	Rotterdam Regional Research Assessment Committee
VAR	Nursing Advisory Council
VIM	Safe Incident Reporting
VMS	Medical Staff Association
VRIE	Safety Risk Identification and Evaluation
WB	Research Bureau
WFZ	Guarantee Fund for the Health Sector
WMO	Human Research Act
WTZI	Admission of Health Care Institutions Act

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