

## **Health Promoting Hospitals in Practice: Developing Projects and Networks**

Proceedings of the 6th International Conference  
on Health Promoting Hospitals,  
Darmstadt, April 29th – May 2nd, 1998

## **The Health Promoting Hospital Series**

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WHO Collaborating Centre for Hospitals and Health Promotion

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Vol. 3

# **Health Promoting Hospitals in Practice: Developing Projects and Networks**

Proceedings of the 6th International Conference  
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Edited by  
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**Pathways to a Health Promoting Hospital**  
**HPH Series Vol. 3**

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Hartmut Berger, Karl Krajic, Rainer Paul;

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## *Preface*

# ***The Vision of the Health Promoting Hospital in Practice: Developing Projects and Networks on the Way to a Health Promoting Organization***

The 6<sup>th</sup> International Conference on Health Promoting Hospitals presents the underlying concept as a live process that can be described internally as an on-going process of differentiation with a wealth of new project ideas and externally as one of expanding national and international networks.

Seen from the perspective of the local organizers, the wide array of topics covered in 85 presentations and 30 poster presentations can be condensed into five focal areas:

1. ***European Dissemination of the Idea:*** The development since conclusion of the pilot stage of the International Network of Health Promoting Hospitals in 1998 in Vienna has been marked by the founding and expansion of numerous national and regional networks. With regard to that which concerns the participants as well as to that which concerns the active participation by other countries one may speak of a reinforcement of a European, if not on every point global dissemination of the idea. The cooperation with the European Union seems capable of being successfully implemented. This development will be documented in detail in the current volume of proceedings.
2. ***Consolidation and Differentiation of the Idea at the Project Level:*** Even now, 6 years down the road, new and stimulating project ideas are being created and presented.

The patient-related projects presented include ones focused on lifestyle, risk behaviour and coping behaviour as well as on chronic diseases. The patient-related level of intervention is also broadened by overlapping ideas such as interventions related to life stages in childhood, adolescence and old age. Here it can be seen that interventions concentrating on health promotion lead successively to a change in the patient's point of view. Thus, the current intervention comes to be seen in other, more consequential terms: namely, in relation to the future biography of the patient. Other project ideas, which pertain to intervention at the staff level proceed in terms of overlapping settings and introduce models of good practice with regard to prevention of violence and the importance of healthy food.

- 3. Thematic Concretization of the Concept of Health Promoting Hospitals:** A lively interest in thematic networks was already quite clear at the 5<sup>th</sup> International Conference in Vienna. In the interim between the two conferences, WHO-Euro and LBI (Garcia Barbero and Lobnig) created the framework for expanding the network idea (published in the Newsletter on Health Promoting Hospitals, June 1998). At the meeting in Darmstadt, the taskforce »Health Promoting Mental Health Services« was founded following the session of the working group »Concepts of Health Promoting Psychiatric Hospitals and Mental Health Promotion«.
- 4. Further Development and Reflection upon the Tools of the Concept of Health Promoting Hospitals:** Development proceeded also with regard to the development of specific instruments of the concept of health promoting hospitals and can be seen in the theoretical reflection on the processes of change in general, as well as in the issue of controlling the processes of change within organizations. Beyond which the position of health promotion, situated between the fields of primary care and hospital care, was addressed. The theoretical tools of the vision of health promoting hospitals increasingly include the concept of empowerment, which has evolved more and more into an integrative approach that can be used both in intervention at the project level as well as for the consequences to the organization and for evaluation issues.
- 5. Acquiring Partners in a Coalition to Implement the Vision of Health Promoting Hospitals:** Decisive to the sustainability of the projects of health promoting hospitals is the acquisition of coalition partners within specific institutions, as well as at the levels of health and research policy. This was one of the focal issues of the 6<sup>th</sup> Conference. It has become clear that in the field of research policy, the public health sector must be approached more aggressively. Other setting-oriented initiatives such as those advocating health promoting occupational health, healthy schools, etc. should be invited, as was partially the case at the Darmstadt meeting (see keynote lecture by Breucker). Furthermore the intersection of the concept of health promoting hospitals and quality assurance must be discussed and reflected upon, and once enriched by practical examples, then implemented. The coalition partners within the organizations, such as hospital management and other professional groups must be won over.

In summarizing the importance of the 6<sup>th</sup> Conference for the health promoting hospitals movement, it contributed to a greater practical consolidation of the health promoting hospital concept as well as to its expansion into national and thematic networks, also to gaining coalition partners beyond the confines of the current networks.

***Co-organizers and Sponsors of the Conference:*** Commission of the European Communities, Standing Committee of the Hospitals of the European Union, International Union for Health Promotion and Education Europe, International Union of Hospital Managers, Landeswohlfahrtsverband Hessen (State Welfare Agency of Hesse), Landesregierung Hessen (State Government of Hesse), Bundesgesundheitsministerium der Bundesrepublik Deutschland (Federal Ministry of Health of the Federal Republic of Germany).

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Hartmut Berger, Rainer Paul  
March 1999

*Hubert Lobnig, Karl Krajic, Jürgen M. Pelikan*

## ***The International WHO-Network of Health Promoting Hospitals: State of Development of Concepts and Projects – 1998***

### ***1. What is a Health Promoting Hospital?***

The concept of the Health Promoting Hospital (HPH) combines a vision, a concept and a set of feasible strategies that enable hospitals to improve their adaptation to demanding and rapidly changing internal and external environments and at the same time involves hospitals in promoting health. HPH target the health of individuals (patients, staff and population in the local community), but also the »health« of the hospital organisation in the sense of creating a sustainable organisation, capable of learning and adapting to changing environments, combining the need to adapt with the aim of maximizing health gain (see figure 1).

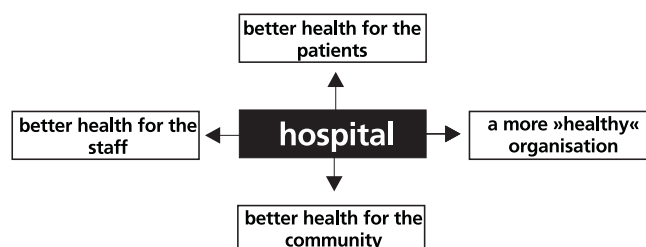


Figure 1: The four areas of health promotion addressed by Health Promoting Hospitals

The concept and the implementation strategies were summarized in the »Vienna Recommendations on Health Promoting Hospitals« (see box 1), which include the basic set of principles for the network (Pelikan, Garcia-Barbero, Lobnig, Krajic 1998a, to be downloaded at: HPH-Homepage of LBI, HPH Homepage of WHO-Euro).

Health Promoting Hospitals should:

1. promote human dignity, equity and solidarity and professional ethics, acknowledging differences in needs, values and culture of different population groups;
2. are oriented towards quality improvement, the wellbeing of patients, relatives and staff, protection of the environment and realization of the potential to become a learning organization;
3. focus on health with a holistic approach and not only on curative services;
4. be centred on people providing health services in the best way possible for patients and relatives to facilitate the healing process and contribute to the empowerment of patients;
5. use resources efficiently cost-effectively and allocate resources on the basis of contribution to health improvement;
6. Form as close links as possible with other levels of the health care system and the community.

Box 1: The fundamental principles of the Vienna Recommendations on Health Promoting Hospitals

## ***2. The first Model Project »Health and Hospital« 1989-1996***

In a first demonstration project »Health and Hospital« at the Rudolfstiftung Hospital of the City of Vienna, Austria an 850 bed public general hospital a HPH framework was developed and twelve sub-projects were planned, implemented and systematically evaluated. Most of these sub-projects used existing know-how on health promotion and organizational development. They were primarily oriented at promoting better health for patients and hospital staff and most aimed at (also) enhancing the overall hospital organization to become more effective, flexible and quality oriented, to increase organizational commitment of the staff members and to increase the potentials for organizational learning. There were also some attempts to increase the impact of the hospital upon community orientation of the model hospital. The model project was very well supported by its owner, providing excellent opportunities for carrying out a pilot project (additional staff, organizational consultants, external project management and evaluation). Final evaluation showed that most of the measures taken had been successfully implemented and most of the very concrete aims of the sub-projects had been reached (Nowak, Lobnig, Krajic, Pelikan 1998). One of the most evident successes was the enhanced protection of patients' health by reducing hospital infections and the spectrum of resistant germs through establishing a professional hygiene team. Another project changing the nursing model on many wards to team nursing improved quality of nursing services as well as staff satisfaction. Opening the hospital towards the local community proved, on the other hand, more difficult for a big, inner-city hospital without a clear catchment area, in a health

care system providing a sharp split between hospital, primary health care and community. The Vienna Model Project also considerably influenced hospital innovation as some successful models were also implemented in other hospitals in Vienna (project descriptions can be downloaded at the HPH-Homepage at the LBI).

### ***3. The European Pilot Hospital Project of Health Promoting Hospitals 1993-1997***

The positive example of the Vienna Model Project encouraged WHO, LBI and European experts to pilot HPH in 20 hospitals, different in types and with widely varying national health care and health promotion policies in a common framework of a European Pilot Hospital Project (EPHP). A summary of the results was published, including detailed case studies from all participating hospitals and a cross-analysis of the results (Pelikan, Garcia-Barbero, Lobnig, Krajic 1998a).

The specific goals of the EPHP were:

- to test and further develop the concept of Health Promoting Hospitals throughout Europe (in 11 European countries),
- through the development of comprehensive local projects (20 different hospitals),
- and the development of specific models of good practice for health promotion in hospitals in action areas selected by each of the hospitals.
- The project was also intended to spread information and networks for HPH in the participating countries.

A number of common structures on the European level provided a framework for collaboration. In nine semi-annual Business Meetings (obligatory participation), the project development was monitored and some technical support was provided by the LBI and WHO-Euro and other members of the group. 19 of the 20 hospitals participating in the »European Pilot Hospital Project of Health Promoting Hospitals« were able to successfully initiate and maintain developmental processes towards a »Health Promoting Hospital«. Only the participant in the Czech Republic had not been able to secure sufficient external and internal support for this development. 149 sub-projects, selected according to local needs and resources available, were documented until April 1997: 67 % explicitly aimed at improving the health of patients, 45 % addressed (also) the health of staff and as many as 36 % targeted (also) the health of the population in the community. 44 % of the sub-projects were (also) intend-

ed to contribute to the development of the hospital into a »healthy organization«. »Community« programmes, which had been especially difficult to realise in the Vienna model project, included inter-sectoral efforts like accident prevention programmes (in co-operation with schools, local government and local business); nutrition, alcohol, smoking and other health education programmes, programmes to improve co-operation with primary health care and community services, efforts to increase public participation in planning of hospital services, projects to improve public image of the hospital etc. (see for an overview of all sub-projects Pelikan, Garcia-Barbero, Lobnig, Krajic, 1998a, p. 423-439).

#### ***4. The European Project of Regional and National Networks***

Since 1997, National and Regional HPH-Networks have become the main actors for HPH. The national / regional networks project aims at:

- Extending the HPH network by involving a large number of hospitals as well as other institutions, professionals and policy makers.
- Improving the quality of health promoting hospital projects through local, national and transnational information exchange and enhancing active involvement and commitment through participatory regional and national networking.
- Fostering the influence of the Health Promoting Hospital in national health policy and hospital reform.

End of 1998, 22 networks of Health Promoting Hospitals exist throughout Europe. A list of the co-ordinating Centres can be downloaded from the Internet pages (HPH Homepage 1998, WHO EUROPE HPH Homepage 1998). A set of rules and regulations have been defined, providing the framework for transnational co-operation and some basic standards for the national and regional networks. But the specific strategies to involve partners must meet the needs, values and preferences of the nations and sub-national regions where the networks operate resulting in a considerable variation of involving hospitals and other partners. As a consequence, hospitals who wish to join the network now have to fulfil the specific criteria of the network in their nation / region (for information please contact the national / regional co-ordinator).

Initiated by WHO Headquarters, discussions on globalizing Health Promoting Hospitals were organized in International Conferences making obvious a great overlap between the experiences in Europe and the developments of Australia (Dwyer 1998) and Canada (Korn 1998) so that a further exchange

of experiences as well as of products (recommendations, guidance manuals) can be foreseen. Most recently transcontinental discussions have shown, that HPH could play an important role for health care development also in the developing countries (Hafez 1998) as both, health and hospital problems, in the developing world are not completely different from those in Europe (e.g. problems related to quality of care, communication between different level actors in the health care system). However, adaptations of strategies, recommendations and guidelines need to be further developed to better address the needs of countries in the developing world.

### ***5. The thematic task forces and networks***

Complementary to the regional and national networks, a framework for »thematic task forces and networks« has been set up, aiming at further development of conceptual issues in specific areas of HPH. In April 1998 a task force on »Health Promoting Psychiatric Hospitals« was set up with the former Pilot Hospital Philipphospital Riedstadt (Berger, Paul 1998) as co-ordinating centre.<sup>1</sup>

### ***6. Media of the Network***

In the HPH network a set of media were developed to support access and knowledge development.

- ***The International HPH-Newsletter*** contains conceptual and strategic contributions, HPH project reports, news from regional and national networks, and a calendar of important events and publications. Available at the HPH Homepage of LBI.
- ***The International Conference on Health Promoting Hospitals*** is the annual public forum for exchange of experiences and supports the continuity of conceptual development, provides public visibility and extends partnerships and alliances for HPH.
- ***The HPH DataBase*** was set up in 1997 providing an overview on the activities of the HPH member hospitals. In late 1998 a number of 119 hospitals from 18 countries have contributed data on 350 subprojects. A short version of the HPH DataBase is accessible on the Internet (HPH Homepage of LBI).

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## 7. Summary

The experiences of the International network of Health Promoting Hospitals project have proven, that it makes sense for the health promotion movement to invest in co-operation with hospitals, although the hospital is considered a very complex and difficult organization. Hospitals are open for health promotion, if it is understood in a way suiting hospital problems and resources – health promotion as well as health services should not miss this chance.

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# Health Promoting Mental Health Care

*Colin Hammacott*

## ***Cefn Coed Hospital A Partner for Comprehensive Care***

***Mr. Chairman, ladies and gentlemen,***

Firstly may I say how pleased I am to be with you today and indeed how delighted I was to receive an invitation to share with delegates at this 6<sup>th</sup> International Conference on Health Promoting Hospitals, the experiences of my hospital in relation to it being a Partner for Comprehensive Care.

Over the past eight years my hospital has developed a wide range of health promotion programmes aimed at improving the physical and mental health of all who come into contact with our services, although in the short time available today I will mainly concentrate on one specific project.

I have prepared handouts of my talk and these will be available at the end of this session and there is therefore no need for you to take detailed notes.

### ***My Hospital***

Cefn Coed Hospital is a 264 bedded psychiatric hospital serving the people of Swansea and its neighbouring towns, villages and valley communities.

Over the past ten years the hospital has developed a culture, aimed at raising awareness of health promotion issues, not only amongst its patients but also amongst its staff, visitors and the wider community which we serve and I will now attempt to inform you as to how that partnership process has developed.

### ***Our Programme History***

A psychiatric hospital with its deeply entrenched, negative historical attitudes to important health issues such as smoking, was hardly a suitable place from which to launch initiatives aimed at encouraging people to live healthier lifestyles and we therefore badly needed a means by which we could achieve our objective.

Fortunately, that came along in the form of Health Promotion Wales' Healthy Hospital Award which is awarded annually to the hospital which

above all others in the country is judged as having made the biggest impact in the field of health promotion and which has developed a creditable and sustained improvement in both the physical and mental health of its patients, staff and local community.

We have used this »national award for good practice« as a catalyst for all our health promotion work and we have developed our initiatives year by year in line with the criteria laid down within the award categories.

At first, our entry for the award was somewhat patchy and disjointed. It reflected the problems associated with a small number of interested members of staff attempting to undertake our entire programme of health promotion initiatives and as a result, they found it difficult to allocate sufficient time to the various initiatives.

We learned rapidly from our mistakes and decided to form a Healthy Hospital Committee and opened membership to any member of staff who had an interest in health promotion issues.

We now have a membership of twenty six consisting of both junior and senior members of staff, each of whom is a member because they wish to be so and no-one is there because they have been instructed to attend meetings.

Both as a committee and as a hospital we have grown in stature and gained both a national and international reputation in respect of our work. We have witnessed a change in attitudes towards our initiatives and have been able to take people along with us in our endeavours to encourage people to live healthier lifestyles.

Our traditional role as a psychiatric hospital has been to care for the psychological aspects of our patients health but now that role has developed into a more holistic approach to care.

We have achieved this by firstly writing a five year Health Promotion Strategy the contents of which has been fully adopted by our Management Board thereby ensuring that the costs associated with every initiative contained within the strategy are fully met.

The strategy itself is supported in turn by numerous sub policies on healthy eating, heart health, physical exercise, stress management, healthy sexuality, smoking cessation and oral health.

The acceptance of these policies at the highest level within our organisation ensures that Health Promotion matters have equal importance with other key organisational issues.

Our objectives are twofold, firstly to educate and raise the awareness of patients, staff and the local community in order that they can make informed choices in relation to healthy lifestyles and secondly to provide sufficient opportunities and ongoing support to allow them to change their lifestyles in

relation to smoking habits, attitudes towards sensible drinking, and management of stress.

### ***Patient Initiatives***

Using these policies as a basis for our programmes we have developed a wide range of health promotion activities for our patients including:

- Well Man Clinics for male continuing care patients (Health Checks)
- Well Woman Clinics for female continuing care patients (Health Checks)
- Smoking Cessation Classes
- Health Promotion Information Boards / Racks on every ward and department
- Stress Management / Anger Management / Relaxation Courses
- Annual Health Screening Programmes
- Routine Chiropody / Dental Examinations
- Healthy Sexuality / Contraception Classes.

### ***Staff Initiatives***

Our hospital staff are encouraged to participate in all our activities and it is important that we champion initiatives to improve their health as they are the organisations most precious resource and asset.

Amongst our health education programmes for our staff are:

- A Drop In Occupational Health facility where staff have access to an occupational health nurse with whom they can discuss their health concerns and receive fast track referrals or appointments for treatment.
- Stress Management Classes
- Smoking Cessation Classes
- Alcohol Awareness Training
- Health Education Fairs (Major Health Exhibitions)
- Heartbeat – our staff health promotion newsletter
- Manual Handling Training for all staff
- Cardio Pulmonary Resuscitation for all staff.

### ***Community Initiatives***

Our health promotion work does not stop at the hospital gates and for six years we have been actively engaged in a range of initiatives within the local community, particularly on the Blaen-y-Maes housing estate.

### ***The Estate***

The Blaen-y-Maes estate is well known in Wales as being an area of extreme social deprivation and poverty, with above average levels of unemployment, a high incidence of single parent families, a very low level of academic achievers within the scholastic framework, a high level of crime and at the time of our initial involvement in the area held the unflattering claim of being the second most deprived area in Swansea and one of the most deprived areas within Wales.

It was easy to demonstrate how the majority of local people and indeed the local press perceived the Blaen-y-Maes housing estate in that: the general fabric of the housing stock was poor and the City Council was at the time demolishing all of the old concrete dwellings and rebuilding traditional brick built housing on the same site.

There was a general untidiness and dereliction about many parts of the estate and houses were vandalised as soon as they became vacant, causing much damage and a precious waste of very limited financial resources.

Ugly graffiti abounded on walls and buildings and children's play areas became unusable because cars stolen by thieves who stripped them down and left them to the elements were a common sight on the estate.

The whole area gave a poor impression to strangers visiting the vicinity for the first time with cars vandalised and sprayed with paint and many horses left to roam freely or tethered to grass areas and allowed to defecate where children play.

This then was the Blaen-y-Maes housing estate at the time of our initial involvement in the area.

### ***Our Involvement***

Over the past six years we have carried out numerous initiatives with the local primary school including:

- Keep Well, Keep Warm Initiative where local school children worked with

my hospital on a programme aimed at preventing hypothermia in the winter months.

- Safe and Sound Project where we worked with local schoolchildren to reduce the incidents of accidents in the home.
- Community Clothing Shop of which I will now tell you a little more.

### ***Blaen-y-Maes Community Clothing Shop***

The concept of setting up a Community Clothing Shop on a deprived housing estate grew out of the need to directly tackle poverty at source by encouraging local people to help themselves out of the poverty trap through the provision of local community facilities which provided training opportunities for young mothers and as a by product good quality second hand clothing at very low prices.

Furthermore, this joint initiative between my hospital and a volunteer group was designed to offer young mothers on the estate the opportunity of work experience and training in a retail setting thereby equipping them with the necessary skills to improve their prospects of securing employment.

Our partners in this initiative are the Blaen-y-Maes Drop In Centre for Young Families who are a voluntary group whose aims are to safeguard, protect and preserve the physical and psychological health of children and parents of children, many of whom are single parents and suffer great poverty.

A decision was taken in conjunction with the staff of Cefn Coed Hospital who operate a health promotion community outreach programme to extend the facilities and training opportunities offered within the centre by opening a Community Clothing Shop in an adjacent premises.

There has been evidence since the publication in the United Kingdom of the Black Report in 1980 that poverty and ill health are inextricably linked and those within the hospital and Drop In Centre wished to take a pro-active role in affording young mothers and volunteers the opportunity of learning new skills.

In so doing they sought to provide a service for the local community which offered families good quality clothing at reasonable prices and as a result help to delivering them out of the hands of money lenders whose unscrupulous activities are prevalent on the estate.

As leader of Cefn Coed's Healthy Hospital Committee I engaged in detailed discussions with the Management Committee of the Drop in Centre and undertook to get the initiative started by securing support through partnerships with a wide range of local organisations.

### ***Aims of the Project***

1. The project maximises use of the local economy, brings good quality clothes into the range of affordability for local residents. Furthermore, it involves both mothers and volunteers in a wide range of activity requiring a variety of skills including:
  - Advertising and marketing
  - Organisation of the collection of clothing donations
  - Sorting out and grading garments
  - Washing / dry cleaning
  - Drying / ironing / pricing and presenting garments for sale
  - Sales and book keeping
  - Stock control
  - Serving customers
2. The initiative helps people in the estate to achieve their maximum social education potential, improve their practical, numeracy and literacy skills and help broaden their work experience.
3. The Community Clothing Shop empowers individuals to take more control of their lives, offer an opportunity to reduce their isolation and educate them in the art of participating as an effective member of a team working for the common good of the local community.

### ***Outcomes / Health Grains***

The Community Clothes Shop offers the local community an opportunity of tackling poverty in a direct manner, thereby bringing less pressure to families under financial stress and engendering a sense of personal achievement, self confidence and self respect amongst all those involved in this venture.

### ***Partnership and Alliances***

The Community Clothing Shop is a good example of how statutory, voluntary and business organisations can work together to develop local initiatives which empowers local people and affords them the opportunity of exercising a degree of control over facets of their lives by improving their skills, potential and economic circumstances.

Within this particular partnership, staff at Cefn Coed Hospital put together a funding bid and solicited and received support from a number of organisations.

- The City & County of Swansea provided a suitable rent free premises to house the Community Clothing Shop.
- Iechyd Morgannwg Health, the local health authority were persuaded to support the project through a grant of £ 4,000 to assist with support worker costs.
- A bid for £ 4,000 match funding found favour with Health Promotion Wales.
- FAB Alarms provided and installed alarm systems for the premises free of charge.
- Glan y Môr NHS Trust agreed to allow their staff to assemble all shop fittings.
- Cefn Coed Hospital staff purchased essential equipment i.e. washing machines, irons, ironing boards through a series of fund raising activities and continue to donate at regular intervals.
- Business in the Community (Wales) encouraged some of their constituent members to make small donations of equipment.

Over the past two years the majority of the old houses have been demolished and a local housing association in conjunction with the local authority has rebuilt the housing stock to a high standard.

The Community Clothing Shop was also a casualty of this redevelopment programme and following negotiations with the City & County of Swansea the Drop in Centre and the shop were re-housed in two adjoining bungalows on another part of the estate.

### ***Evaluation, Successes, Feedback and Reflections***

Since day one of operation, a survey has taken place during all hours of opening where volunteers note the gender of each customer, the number of children within their families, the area in which they reside, how they gained knowledge about the existence of the shop and how much money they spend during each visit.

From this survey we have been able to extract vital information on trading patterns, assess the geographical range over which the Community Clothing Shop has an impact and from how far afield it draws its customers and assess the benefits which the shop offers to those families who use the facility on a regular basis and we feel that the venture is having a good effect on the mental well being of the local community and recently one of our young mothers has gone on to find full time employment.

### ***The Future***

Whilst successful in its own right the Community Clothing Shop is inextricably linked to and an integral part of the Drop In Centre for Young Families and would experience considerable difficulty in operating without the support of its host organisation.

The existence of the Drop In Centre itself is dependent on their continued ability to acquire grant aid and therefore the long term future has to be viewed with a degree of caution.

We are pleased that the Community Clothing Shop has been an outstanding success and in a small way has contributed to improving the quality of life within the local community and helped to support the work of the Drop In Centre which is life line for many young mothers who rely on it for reason of support, training, problem solving and friendship.

That then ladies and gentlemen is a snapshot of the work that my hospital has been involved in with our patients, staff and the community and I hope you have found it of some interest.

*Angelika Dietz, Nina Jansen*

## ***Experiences with the Bielefeld Therapeutic Accord***

We would like to describe for you the therapeutic accord, developed in Bielefeld as a confidence-building-measure between patients (people who undergo psychiatric treatment) and professionals.

As of March 1st, 1994 users of the psychiatric clinic in Bielefeld are encouraged to enter into a written contract with the hospital, setting conditions for possible future admissions and treatment procedure. The agreements contain topics such as medication, the use of coercive measures and the patient's particular social situation and are concluded between the former psychiatric patient, a person of confidence appointed by the patient, the chief psychiatrist, the head nurse, and the social worker assigned to the patient's case, they enter into binding agreements concerning medication, use of coercive measures, and the patient's particular social situation. These agreements are in writing and are signed by all those participating in the discussion.

The so-called agreement-talks take place on the ward or department, on which the patient has been treated, normally outside a period of hospitalisation.

The written agreement was an idea from both former psychiatric patients and the professional staff. The former psychiatric patients wanted to decide in advance, when in good health, how they would want to be treated in times of acute episodes; they wanted to take more responsibility for coping with their illness and to be taken seriously as a negotiating partner. The importance of a written agreement was seen by professionals as a chance to build confidence between themselves and their clients, to ensure a respectful interchange with one another to guarantee respect for the patient's rights during acute treatment and to avoid, as far as possible, the use of force in coercive measures.

### ***Who has made use of the written agreement so far?***

The chance to conclude a written agreement with the hospital has been used so far by 75 former patients of the hospital, and a number of other applications are in hand. In the beginning roughly a third came from persons having contact with the Association of Former Psychiatric Patients; another third heard about the written agreement at an outpatient service or the rehabilitation-hos-

pital; a final third learned of it by hearsay in the hospital. Almost all these patients have had long years of psychiatric experience, with many hospitalisations and forced treatments. The vast majority has had experience with schizophrenic psychosis; a few have had manic-depressive illness, borderline disorders or neurotic disorders. It seems difficult for the manic patients to consent to specific agreements covering manic phases since these would, of course, entail constraints.

These circumstances make clear that therapeutic accords are binding for professionals. It also means more control and more commitment for patients. They can no longer pass over responsibility to professionals when they enter a psychiatric ward.

### ***What points are negotiated in the agreement?***

The spectrum of themes mentioned in the agreement, although fully acknowledged, has been weighted differently. Most discussions of the agreement have centred on drug therapy and the prevention of coercive measures in future admissions to the hospital. The spectrum of concern is very broad. One former psychiatric patient, a single mother with a five year old child, wanted it specified exactly how her child would be cared for if she were to be hospitalised with a psychotic episode. In another agreement, the focus was on the patient's social situation, the threatened loss of home should new hospitalisation occur and specification of ways to prevent this. One former psychiatric patient wanted to be admitted to the hospital when she felt that it was necessary. It had been her experience previously that although she had indeed sought professional help, her situation was assessed by professionals, on the basis of the impression she conveyed to others, as not being so very serious.

### ***What are the results of the negotiations?***

In most of the agreement-talks or contract-talks an agreement between the desires and needs of the psychiatric patient and what is presently possible in the hospital setting was achieved. Sometimes it was necessary to have a second agreement to find a consent. In some cases the different positions of the psychiatric patient and the hospital were set down in writing in the accords: for example a fundamental rejection of highly potent neuroleptics, and a fundamental rejection of use of restraints and isolation.

***How have patients with written agreement experienced their treatment?***

Nearly half of the persons who have so far entered into written agreements with the hospital have been hospitalised, some already several times, so that we now have experience with about 100 treatment cases at hand.

At this point, it would be useful to draw some general conclusions from the experience accrued so far, though we have not yet conducted systematic questioning of patients treated on the basis of an agreement. We have heard from former psychiatric patients that it was easier for them to be hospitalised promptly as soon as they felt their condition worsening. They felt more confident that they would be treated in accordance with their wishes and in accordance with the agreement signed. Nina Jansen will now tell you about her personal experience:

»My name is Nina Jansen, I am a member of the Federal Association of Former Psychiatric Patients and a member of the self-help-group of former psychiatric patients in Bielefeld. I participated in the development of the Bielefeld written agreement together with other former psychiatric patients and professionals.

I personally entered into a written agreement with the psychiatric hospital in Bielefeld on March 1<sup>st</sup>, 1994. It was the basis for treatment in the psychiatric hospital a few months later. Last year I concluded negotiations for my third written agreement.

The written agreement with the psychiatric hospital was very helpful to me. In the past I felt helpless when hospitalised and had no influence on the treatment process because in an acute psychotic crisis I was not able to tell what I needed or wanted. Now I know that my needs and wishes are discussed and written down. I know that the hospital is obliged to treat me as it is written down in the agreement.

As a result of this I feel more secure and less anxious. For example, because I can't see anything without my glasses, the agreement states how to get an extra pair of glasses.

A few years ago during a hospitalisation I didn't have glasses for about a week because no one realised that I'm nearly blind without my glasses and no one felt responsible for my situation.

During the preparation of my first written agreement I was stirred by intense feelings because it was the first time I really had to face the experiences I had been through in previous hospitalisations.

In the agreement-talk itself I felt respected and accepted as a negotiation-partner. I didn't feel as powerless as in the past. In later psychotic crises I was

able to agree much earlier to an admission to the hospital. I recognised a positive change in the way of thinking and handling of staff members. I think it also was much easier for the staff to treat me, because the treatment was discussed and decided together with me in advance.

I have given you an idea what my personal experiences with the written agreement were. They are not unique, many patients have similar experiences. The individual experience of former patients is especially important for the written agreement. It acts as a guideline for future treatment. »**Only we** know the inner view of our psychotic illness and **we** have to live with it.« The written agreement is an important step on the way to accepting psychiatric patients as the experts in their illness.«

### ***The written agreement as an instrument of quality management***

What new possibilities are now available for former psychiatric patients as users of the hospital to monitor the latter and change it in accordance with their wishes?

First, we want to discuss the so called »agreement-talk«. We professionals meet with former patients when in a stable condition to seriously consider their experience with previous hospitalisations, in particular, how they experienced coercive measures. These talks are an occasion for reflection for former psychiatric patients as users of the psychiatric hospital; their wishes and therapeutic needs are discussed and negotiated. The hospital must justify its therapeutic method and, if there is a discrepancy between the wishes of the former patients and what the hospital is able to provide, the latter must work on making relevant changes. Wide-ranging individual agreements alter the treatment standards of the hospital: for example, if the participation of family members and friends or if drug-free treatment has been agreed upon, or if special visiting arrangements beyond the usual visiting hours have been made.

### ***Amendments to the written agreement***

The written agreement has by now acquired a short history of its own. Since June 1<sup>st</sup>, 1995 we have been working on a new version. A revised preamble states that the specific points agreed upon in a written agreement should serve to build mutual confidence. The hospital commits itself to comply concretely with the agreed points, even when the patient is hospitalised under the psychiatric hospital law or the law on patient care. The hospital also commits itself to report on what it has done and to provide a thorough explanation if there

should be any divergence from the treatment agreements in the individual case. It is stressed that respecting and complying with the written agreement is a component part of proper treatment.

### ***Conclusion***

In short I would like to conclude: written agreements are a help for patients as well as staff members. For patients it is easier to go to the hospital on time, they feel more secure and confident. Written agreements are an important instrument for quality-management in the hospital. They refuse force and coercive measures in the hospital and insure a respectful interchange with one another.

It is now possible in several other clinics in Germany for psychiatric patients to enter into written agreements with the psychiatric hospital.

Last year we organised a nation-wide-meeting in Bielefeld to exchange experience with written agreements in different cities and hospitals. The results are now published in the book ***Behandlungsvereinbarungen***, Psychiatrie-Verlag.

Thank you for listening.

*Ian Ferris*

***The Learning Disability Directorate.  
The Development of Educational / Clinical Protocols***

***Accountability***

As a nursing profession we are accountable to society for not only the content and process of nursing practice but also for the effects or outcomes of nursing care. Professionally we strive to provide those interventions that achieve the desired clinical outcomes. However, making decisions about health care is a complicated process for health professionals, patients / carers and purchasers.

***Needs and resources***

The process involves weighing up the potential benefits and hazards of the possible interventions, against a background of limited resources and accommodating the needs of the population and particular individuals.

***Learning disability***

This is particularly true of services for people with a learning disability. Research has shown that the quality of health support for people with a learning disability differs with age. Once an individual leaves the education system access to health care becomes variable. Most people with a learning disability access their GP 4 times or less a year, as opposed to an average of 5 for the general population, although their health needs are greater.

***Consistency***

In addition to these issues it can be argued that as a profession we (nurses) lack inter-clinician consistency in delivering interventions. This can lead to variability in practice, and uncertainty in quality, efficacy and effectiveness of interventions. What is required are mechanisms for assuring excellence, or best practice in the clinical setting.

### ***Protocol development***

Within the Learning Disabilities Directorate the development of educational protocols has been seen as an integral part of the nurses role, allowing their skills and knowledge to genuinely affect the quality of care provision throughout a range of settings. These include not only the hospital based residential service but also the local community in social services and private dwellings. Within the past two years, five educational protocols have been developed to provide consistent, research and evidence based information concerning specific clinical situations, these are:

Epilepsy and the administration of rectal diazepam	Anaphylaxis	Percutaneous Endoscopic Gastrostomy
Medication Awareness		Epilepsy for people with learning disabilities

### ***Advantages / Disadvantages***

Protocols can provide a consistent approach to a health related area, be that clinical or educational. This can lead to:

1. The reduction or eradication of interpretation.
2. The provision of a consistent framework or content across a range of settings.
3. Provide a legal basis as regards best medical practice.

However, the plethora of protocols that have been developed in recent years has provoked a debate about their effect within the health field.

The advantages of their development can be summarised into five main areas (Paley, G. 1995):

1. Improving quality of care / life
2. The setting out of best practice
3. Managing or reducing costs
4. For legal protection
5. To address ethical and legal considerations.

However, others such as Mulhall, A. (1997) and Courtney, R. (1997) have

pointed out that there are reservations about their proliferation within the profession. They argue that protocols can lead to:

OHP 5

1. A restriction of practice development
2. Promotion of defensive treatment
3. Conflict with the concept of individualised care
4. Restriction in the use of clinical judgement.

Nurses must be vigilant that when developing protocols to ensure that these issues are addressed i. e.

- by ensuring that all protocols have a sound base in research and evidenced based practice and
- by including formal review and updating systems in each newly developed protocol.

*Hartmut Berger, Hans Gunia, Karl Nürnberger, Anke Teschner*

## ***Psychoeducational Family Groups Patients together with their Relatives***

### ***Initial Results***

The climate within a family determines to a large extent the course of schizophrenic disorders. Various studies have shown that psychoeducational groups and medication therapy represent the most effective intervention strategies in the relapse prophylaxis for schizophrenic disorders (for a summary of both please refer to Hahlweg et al., 1995).

On the basis of recent structural developments and the substantial organisational effort involved in operating separate groups for relatives and for patients, and encouraged by the experiences of others, we at the Philipps-hospital, began in 1996, combining both groups into a ***single psychoeducational family intervention group (PEFI)***.

We hoped for synergy effects of the individual interventions, as well as that the focus in problems in familial interaction would improve and for an economical use of resources. Moreover, the PEFI was to be tested within the framework of the foreseen psychiatric care system, and we wanted to see how long the effects achieved persisted and what the required topical and temporal framework would be. At first one PEFI group was implemented to test and validate the procedure.

Four patients (three of whom experienced a disorder for the first time, all F20, ICD 10) and six relatives (n=10) comprised the first family group. The relatives involved were all parents. The topics of the 90 minute meetings held every 14 days are listed in table 1.

1 <sup>st</sup> meeting:	Mutual getting to know one another, introduction of the concept, stating desires and needs
2 <sup>nd</sup> meeting:	Information about psychoses, categorisation, origin (vulnerability-stress-coping model), courses and prognosis, opportunities within the family (EE concept)
3 <sup>rd</sup> meeting:	Information about medication, physiological and biochemical fundamentals of medication therapy, side effects
4 <sup>th</sup> meeting:	Non-medication methods of treatment, living situations, stress management, perspectives following release, occupational and professional rehabilitation
5 <sup>th</sup> meeting:	Learning to recognise early warning signs and using them within relapse prophylaxis, crisis plans

6 <sup>th</sup> meeting:	Introduction of a problem-solving concept and communication exercises
7 <sup>th</sup> meeting:	Role playing with video feedback proceeding from the problem-solving concept
8 <sup>th</sup> meeting:	Role playing with video feedback proceeding from the problem-solving concept and concluding discussion

Table 1: Meeting topics

Methods: An external assessor interviews the participants before the group meets for the first time, and then again after the fifth and eighth meetings. Further interviews are planned 6 and 12 months later. At the same time points the participants completed questionnaires on their competency in dealing with different aspects of the illness (four-step-scale), as well as answering two questions each evaluating the individual evenings. The group supervisors were also interviewed.

Summarising the results, it is important to note, that the complete group seemed to be self confident at all the three meetings. They showed self confidence in the problem solving process inside their families. In the courses of the study we noticed slight trends towards increasing theoretical knowledge about the illness, growing confidence in dealing with relatives and increasing positive mind set about the problem solving process inside the family. If these trends get confirmed, the conclusion could be, that the participants build more confidence inside their families, as a result of their engagement in the group therapy.

In the evaluation of the meetings it can be seen that the first three meetings, which were devoted primarily to providing information, were experienced by the majority as positive. In the fourth and most of all during the fifth meeting there was lively and controversial discussion of crisis management and early warning signs, and thus naturally of the possibility of relapse. The participants correspondingly experienced these meetings for the most part as less than positive, but on the whole as particularly important. The final three meetings, in which conflict strategies were practised in role playing, were rated as positive and as important. The sixth meeting, which introduced a problem-solving concept, ranked best in both categories.

All participants regarded the opportunity to trade roles within the family as very important (for example, a son with a family conflict plays it out with other parents). Thus it was possible to work on conflicts without actualising the pertinent conflict issues.

The qualitative evaluation revealed that the participants had gained new competence with regard to new coping strategies and the ability to name early warning signs, as well as in various possible solutions to a threatening exacer-

bation. The relatives appear to have benefited more than the patients did and more than they otherwise would have in a group reserved solely for relatives.

On the whole the results have encouraged us to proceed with this approach at our hospital.

#### Cost-Benefit Analysis

##### *Expenses:*

Working hours for two certified psychologists

establishing and conducting the group:

DM 761.26

##### *Preparation:*

DM 358.26

Estimated cost of materials:

DM 16.20

Estimated cost of telephone expenses:

DM 30.00

##### *Total:*

DM 1,165.70

One day of complete inpatient treatment currently costs DM 356.08 and a day of a clinic treatment DM 224.17. A psychoeducational family group is cost-effective then if about three days of complete inpatient treatment or four days of day-clinic treatment can be saved in the process. Unfortunately the small size of the sample and the lack of a control group precluded carrying out a cost-benefit analysis.

Nonetheless the question naturally arises as to what had become of the four patients one year later. Two of those with a first-time disorder received neither inpatient nor semi-inpatient treatment upon conclusion of the initial group (April 4, 1996). One female patient with a first-time disorder was treated in an associated day clinic from about the middle of family group therapy on up until December 1996. One chronically ill patient spent 155 days in the hospital following completion of the therapy as opposed to 164 days in the year prior thereto. Compliance on the part of this patient seemed to have improved somewhat.

Thus we conclude that this type of intervention, whose efficiency has been empirically proven in the treatment of individual families (please refer to Hahlweg et al., 1995), constitutes a cost-effective alternative when carried out in groups. In addition, it offers novel therapeutic possibilities by its mixing of the different families.

*Hartmut Berger*

## ***Health Promotion – A Change in the Paradigms of Psychiatry***

Since the very first days of the emergence of psychiatric science, the pathogenetic paradigm has been dominating the debate on causes and treatment of mental/emotional disturbances. The increasing knowledge about the influence of psychosocial factors in the development and course of mental/emotional disturbances has led to a modification of this model and resulted in a multidimensional point of view, which leads to a major reform of psychiatric care. But this concept was still oriented to the pathogenetic paradigm. The usual biological treatments were only just completed by new psychotherapeutic and especially by psychosocial interventions. Only after it became clear that even widespread and developed psychiatric care can't prevent chronic mental/emotional diseases, the focus has recently shifted towards the individual aspects of these diseases, and to the resources allocated to these aspects; this has resulted in a number of innovations, like establishment of self help groups, and of needs and quality-of-life oriented therapeutic offers. But this change in paradigm can only lead to new insights (and strategies derived from the insights) if the disease model we now use is completed by a comprehensive point of view that sees health and disease not as opposites but as a continuum; if we not only ask how disease is created, but also how health can be maintained and promoted. For achieving these goals, we need to integrate the viewpoints of different scientific fields, as well as (among others) prevention strategies that are oriented to the circumstances and the behaviour of people, the promotion of self help, and the integration of therapeutic offers into every day situation.

### ***The Concept of Pathogenesis in Psychiatry***

Since the beginnings of the science of psychiatry the paradigm of pathogenesis has dominated the discussion of the nature and origin of mental disorders. After centuries of ostracism of the mentally ill in prisons and asylums the first textbook on psychiatry, authored by Pinel in 1793, represented an epochal stride forward. For the first time in history mental disorders were understood as illness. Pinel's concept of illness foresaw releasing the mentally ill from pri-

sons and affording them humane living conditions in newly established institutions. The resultant medicalization of psychiatry delivered, on the one hand, the impulse for refined systems of classification, which, among others such as the nosologies developed in the past century by Kraepelin, Kahlbaum and Bleuler, are still valid today. On the other hand, it paved the way for treatment methods that adhered above all to biological models, proceeding from Griesinger's hypothesis that mental disorders are located within the brain and are thus of organic origin. At the same time he, as well as a number of other authors, recognized that psychosocial factors are also involved in the origin and course of mental disorders. For this reason he advocated as early as 1845 the establishment of so-called city asylums, that is, the incorporation of psychiatric services into the life environment of the patients. Nonetheless, this demand failed due to the perseverance of psychiatrists such as Roller, who for their part advocated the segregation of the mentally ill in remote mental hospitals, following the then current stream of thought with regard to mental hygiene. The debate as to whether or not mental disorders result from physical functional disorders or from developments in the individual's life history, respectively from a combination of both, rages on today.

### *Development of the Concept of Pathogenesis*

The search for the causes behind mental disorders and the intervention strategies to be derived therefrom branched off into three main lines of development.

First of all, the putative organic causes of mental disorder were and still are being sought. Despite the fact that the extensive research in psychiatry has yet to deliver a convincing explanation, it has led to the discovery of the modern psychotropic drugs. This discovery, whose way-stations included the development of the so-called shock therapies such as electro-, insulin- and cardiazol shocks, culminated ultimately in the hypothesis that the morphological substrate of mental disorders should be sought in disorders of the neurotransmitter systems. A multitude of hopes rest at this moment upon this hypothesis and the related discoveries and progress in biomedicine. This is so despite the fact that the abundance of detailed knowledge among other things of the transmitter functions and neuronal networks has not led to any congruent theory.

A second line of development pursued the entirely novel etiological models and strategies of therapy prompted by Freud's introduction of psychoanalysis. Following early trials with hypnosis, psychoanalysis enabled for the first

time the treatment of mental disorders in a systematized manner and on the basis of a theory complete in itself, treatment employing mental means and techniques. Humanistic psychology, which evolved as an off-shoot of psychoanalysis, represented a whole new palette of methods of psychotherapy, among which conversation therapy is the most clinically relevant. Finally, behaviourism and learning therapy melded to produce the third school of psychotherapy, which is behavioural therapy. In the day-to-day practice of psychiatry, however, every method of psychotherapy led a decades-long, more or less wallflower existence. The empirical test of their efficacy was long in coming (please refer to Grawe). Furthermore, all methods shared a common strict orientation to the concept of pathogenesis. They were all developed exclusively for the treatment of mental disorders. Behaviour therapy in some aspects pursues this goal with great determination, declining even a theoretical concept (please refer here to Hautzinger). Psychoanalysis claims to have at its command useful instruments of study for the entirety of psychosocial life conditions. At the same time it continues in clinical practice to adhere to the traditional model of illness, having attached to it in the meantime the debatable concept of neurosis.

A third path of development was blazed by the discovery of the efficacy of environmental influences upon the origin and course of mental disorders. Like Griesinger before them, a number of other psychiatrists recognized the propitious influence of environmental factors. Bleuler, for example, at the University Hospital in Zurich, Burghoelzli, was a turn-of-the-century predecessor of the principles later developed by Jones in 1952 of the therapeutic community in which patients and therapists should encounter one another in the most natural environment possible, one without the stamp of clinical hierarchies. Another turn-of-the-century model in Saxony was the care of about 4,000 mentally ill patients within the family, the hope being that the social stimulus attached to being cared for at home would have a positive effect on the course of schizophrenia. In 1928 Simon introduced a form of environmental therapy in Gütersloh centred on a structured daily regimen in the form of work therapy. At the same time the community health movement in the United States aimed at the effective prevention of later deviant behaviour by establishing special residential homes for children from deprived backgrounds (Bloom). The first day clinics were established after 1945 in Russia and England (Wing) and blazed the trail together with the aforementioned therapeutic communities for methods of psychiatric treatment beyond the confines of the traditional institutions. This development was encouraged by the discovery of hospitalism (Goffman, Wing and Brown), that is to say that the fact of simple confinement to a mental institution, an environment usually barren of stimuli,

can result in severe subsequent mental disorders. The three great prospective longitudinal studies by Bleuler, Ciompi and Müller in the early Seventies revealed that schizophrenic psychoses most likely follow a positive course. This finding upset the previous conviction of primary chronicity. Together with the discovery of hospitalism it heralded a basic reform of the care structures in psychiatry from about 1965 on against the backdrop of the socio-political changes in the U.S.A. and Europe. The major goals of this movement, collectively designated as »social psychiatry«, were first of all the release of the mentally ill from the often too large and outdated state mental hospitals, in which, to quote the authors of the 1975 German Expert Commission on Psychiatry (Psychiatrie-Enquete) »inhuman conditions« prevailed. Second came the closure or at least drastic reduction in size of the great hospitals. Third, the establishment of outpatient and semi-inpatient clinical services within the natural living environment of the patients and fourth, improved funding. Fifth came the improvement of training and education, followed by the sixth goal, an increased number of personnel and finally the seventh aim, the demand for every type of prevention measure. Under the auspices of this movement highly controversial positions emerged. Critics of the then dominant ideology such as Laing, Cooper and Basaglia, considered the treatment and labeling of the mentally ill to be the decisive pathogenic agent and concluded that freedom itself would lead to healing, rejecting as a consequence any type of psychiatrization. Opposite thereto were reformers such as Bennett, Wing and Kisker, who pinned their hopes on the establishment of a community psychiatry. They hoped that this would result in improved care and prevention of chronic courses. Following the changes in the care structure within the past 30 years in almost all the countries of Europe and in the U.S.A. in the sense of its deinstitutionalization and re-communalization, it can be seen that although everywhere an effective community psychiatry service has been implemented to a satisfactory extent, the treatment and even some of the living conditions of the mentally ill have markedly improved, little could be done to change the chronicity of course. In addition new problems resulted from the diversification of services. Some patients became homeless, others found themselves in inadequately staffed nursing homes or in forensic psychiatric hospitals. This led the Expert Commission of the federal government of Germany in 1988 to the dispassionate statement that the reform of psychiatry in Germany had apparently bypassed the chronically mentally ill. A similar development has also been described for the results of the community mental health movement in the United States (Lamb in Hales and Yudofsky). Experience teaches us, then, that even this path leads only to those certain aspects of mental disorders that are open to a psychosocial intervention. Thus it too is

just as limited in its value as those paths already sketched out. All three lines of development have in common their orientation to a concept of illness, even then when, as Szasz has done, the concept of illness has already been completely negated. Nonetheless many a social psychiatric experimental field did afford the opportunity to leave behind the traditional perspective and to try out forms of treatment going beyond those already known. Thus a broad family members' movement and self-help initiatives have evolved, in addition to projects such as the Soteria projects which are oriented to the subjective needs of the patients, promulgating intense support and medication-free crisis intervention whenever possible, as well as self-encounter groups in the form of psychosis-seminars in which professionals are more likely to assume the role of learner. Common to these and comparable initiatives, a complete list of which cannot be given here, is their effort to leave behind the classic distribution of roles under the motto »deal with rather than treat« in favour of a patient – therapist partnership. They also attach the same importance to the subjective needs of the patients as to the objective symptoms. Thus at least in their approach they point beyond the traditional concept of pathogenesis. It must be noted, however, that doubts as to the mono-dimensional view of the dominant schools of psychiatric thought and the search for overlapping models of explanation had been voiced prior to the reform of psychiatry.

### ***Widened Perspective***

One of the first authors to look beyond the individuals schools of thought and develop an integrative perspective was Eugen Bleuler. Bleuler attempted to link his modified classical theory of mental illness to the discoveries of psychoanalysis. A short time later Adolf Meyer, the founder of modern American psychiatry, developed a holistic concept linking psychopathology to »understanding psychology« (McHugh and Slavney). Leif characterized it as »common sense psychiatry« because of its pragmatic approach. Especially in the United States this approach paved the way to an integrative psychiatry that considers equally the biological as well as the psychodynamic and the social aspects, and tilled the soil for an etiological concept of schizophrenia that is generally accepted today and known as the vulnerability-stress model (Zubin). Zubin represents with this concept the conviction that the pathogenesis of schizophrenia is multifactorial in nature. The psychosis manifests itself when environmentally caused stressors team up with a genetically anchored increased vulnerability.

Under the influence of the epistemology of Piaget and the systems theory of Maturana, Ciompi developed in 1982 the concept of affect logic. Here, the

psyche is considered to be an autopoietic system in which affective and cognitive aspects always act complementarily to one another and cannot be regarded separately from one another. Ciompi's theory surmounted for the first time in psychiatry the rigid dichotomy of illness versus health that had prevailed up to then. Ciompi does not take the next step, namely changing perspective, but continues to adhere to the traditional nosology.

This next step, the accession of a consequential perspective of systems theory following the abandonment of the illness theory, which moves the focus completely from the individual and their symptoms exclusively to the relationship between the patient and their family as well as between the therapist and the family, was taken by Selvini and Palazzoli in their systemic family therapy, adapted by Stierlin and Simor for use in Germany.

Closely related to the systems theory approach is the concept of ecological thought propounded by Dörner, which refers to Bateson and Bronfenbrenner and calls for a holistic view in which the individual is no longer separate and isolated, reduced to their mental symptoms, but a part of the psychosocial landscape surrounding them and engaging them in a reciprocal exchange. It follows then that psychiatric symptoms are no longer to be assessed only as deficits but also in certain circumstances as an attempt at protection, respectively problem-solving. Thus they are dismantled of their exclusive definition as indicators of illness.

Common to the approaches just touched upon is that none of them is capable in the end of shaking off the concept of pathogenesis. Not even one which, like the Milan School of Selvini and Palazzoli, negates the illness model. This is most apparent among the integrative concepts, which though they acknowledge new perspectives and incorporate them into the classical theory of illness and into the biological procedures, do not touch the core of the latter. The concept of pathogenesis, however, is incapable of dealing with the new psychiatric problems emerging.

### *Current Challenges*

The structural changes in the system of psychiatric care discussed here which have led, on the one hand, to shifting the care of the chronically ill to the out-patient area together with all the problems this entails, have, on the other hand, led to an enormously growing number of admissions of above all multiply morbid patients to hospitals in conjunction with increasingly short lengths of stay. This poses an entirely new challenge for the psychiatric services. In addition, current social-political changes bear consequences for

psychiatric institutions. Beyond the gate wait today an apparently burgeoning number of mentally ill criminals, in the face of whom, in addition, the traditional concepts of therapy have failed. Finally, we are confronted with an increasingly large number of substance abusers, who join the scene at increasingly young ages. Add to these the young who lack any orientation at all and are completely overwhelmed by the complexity of their life situation, who are at risk here, as well as with regard to deviant developments of every type resulting from unemployment that has now become structural. Beside and diametrically opposed to them stand the growing number of the geriatric ill. Finally the numerous wars and warlike skirmishes in the Third World have led there to an increase in the number of posttraumatic stress disorders and in conjunction with the economic problems, to a growing migratory movement with all the attendant subsequent problems. Common to the disorders mentioned is their chronicity or tendency to become chronic, as well as their, as far as we understand them, being rooted in multifactorial chains of effect. These two characteristics overtax the current nosologies. Beyond which these disorders can seldom be treated by the traditional repertory of crisis intervention techniques, but require instead and in growing numbers rehabilitation, substitution and nursing care rather than purely curative measures.

A further problem area is the increasing need on the part of the psychiatric care structures for management, by reason of the aforementioned diversification as well as regarding the decisions governing the types and breadth of programmes in view of scarce financial resources. Here too the conventional medical view of the world cannot provide a satisfactory solution.

With regard to the complexity of the coming challenges, a mono-causal cause-and-effect manner of thinking bears little promise. It is also unwise to delegate open questions to already existing, respectively emergent new sub-disciplines, despite the dissatisfactory state of the interdisciplinary transfer of knowledge (please refer to Hurrelmann and Laaser). Instead a basic rethinking is called for in terms of a holistic approach that would consider the total frame of life reference, such as that already called for by Engel and formulated by Antonovsky in his concept of salutogenesis. Transferred to the psychiatric plane this would mean essentially that we would no longer consider only pathological and illness-supporting environmental conditions but that we would look for the biological, mental and social factors that enhance health and health maintenance, respectively illness prevention and illness coping.

### ***The New Road to Health Promotion***

To consider health rather than illness is unknown territory for physicians in general and for psychiatrists in particular. Clinical routine is governed by the effort »to recognize illnesses and to either heal them or alleviate them or prevent their exacerbation« (definition of the SGB). The positive concept of health is not usually part of this frame of reference and if it is, then it is only as »terra incognita« beyond the horizon of illness and impairment. In a manner of speaking, health is a residual, distinctly separate from illness. When we more closely examine mental disorders, however, we will always recognize the smooth transition from pathological to healthy aspects and vice versa. Beyond this, the definition of what pathological behaviour actually is, usually depends, despite all efforts at operationalization, among other things on the evaluation of the actual life background. For example, behaviour that otherwise would be rated as highly crazy might make complete sense when viewed against the background of a conflict-loaded relationship that cannot be resolved in any other manner. Thus states of arousal or suicidal behaviour are often quite understandable when we look at the life circumstances. Vice versa, professional disregard for the subjective and objective reality beyond the pathological behaviour often results in feelings by the patient of not being understood, somewhat along the lines of the following exchange between psychiatrist and patient: The psychiatrist asks, »Do you hear voices?« The patient replies, »Oh yes, I hear you very well.« At issue here is the danger of talking on two different levels when substantial aspects of reality are excluded from a conversation, in other words when illness and health are regarded strictly separately from each other. Patients see this quite differently in any case: They often do not feel ill at all in the sense of the psychiatric definition, instead they feel hampered by an environment incapable of tolerating their peculiar ideas. It is also a common experience that persons who are severely ill in the psychiatric sense can cope astoundingly well in their lives, if they are allowed to do so and given healthy living conditions rather than forcible treatment. Everything indicates that the borders between mental illness and mental health are permeable and that mental disorder does not always contradict the ability to live life independently.

As a consequence, we cannot understand another person unless we have first rid ourselves of the concept of pathogenesis and perceived the entirety of our own biological, psychological and social references. This means we also have to perceive especially our own healthy aspects and resources and that only after such a holistic examination can we decide whether and if so, which, help is necessary and which natural resources are useful. In other words, the

recognition and treatment of illness is no longer the issue, but the focus on health and how to promote it. Both health and health promotion are equally important and must lead to a concept that encompasses treatment as well as health promotion. It must be stated here that such a holistic concept is something completely different from simply adding individual health-promotion measures to the traditional treatment catalogue. Basic questions as to the organization and self-understanding of mental hospitals necessarily arise.

In the sense of these paradigmatic changes in favour of health promotion as an integral view that regards literally the whole, the hospital is no longer an isolated expert business for the treatment of patients. It is instead a specialized and completely permeable component of a care structure responsible for a certain region, in which inpatient, semi-inpatient and outpatient specialist services are networked closely with non-psychiatric specialist services, general life assistance services, the administration and with civil and self-help initiatives.

Consequently the patient can no longer be passed along from institution to institution, much like the baton in a relay race, but must be accompanied (not just treated) in the form of well-dosed case management, in the dose that he needs and deems necessary. This requires reorganization and reallocation of the responsibilities of the health services. Once case management has been realized, it is not important whether the patient is cared for by a social psychiatric service, a psychiatrist in private practice or by the outpatient department of a hospital. It is important that all other instances acknowledge the responsibility of the case manager and respect the decisions made that are based on familiarity with the patient.

From the stance of health promotion, it is furthermore necessary to respect and support healthy living conditions that encourage development of personal competence. This, in turn, requires close co-operation with the community. It must be decided together with political representatives from the community along with those from community organizations and churches which resources can be activated (for example, participation of the mentally ill in sports clubs or in church activities) and how best to intervene to influence the situation as well as the behaviour in the sense of health-promoting effects (for example, expert advice by pastors and youth welfare workers, public lectures on health risks and coping strategies, cultural events).

Health promotion encouraged in this manner by a hospital poses a number of challenges: In its wake the classical relationship between doctor and patient will necessarily change in that doctors will no longer be asking simply about what isn't right or no longer functioning, but will be asking also about which abilities a patient still has and considering how these can be utilized. A manner

of proceeding that places so much emphasis on the subjective side will perforce entail consultations with the patient's relatives and friends that exercise an important bridging role. I am talking here, then, about a therapeutic procedure which will always and to the greatest possible extent, even in emergency situations, assure the patient of his informed consent and grant him choices. These choices may well, in individual cases, mean a decision in favour of or against a method of treatment that might not be the better choice in terms of therapy but that is indeed the better choice in the eyes of the patient.

Promotion of self-help is a related issue as is the development together with the relatives of strategies for coping with the illness which will include among other aspects information and exercises for improving communication within the family.

In addition to the promotion of the active participation by patients, the hospital environment must also be reconsidered. Structural requirements, therapy programmes, nutrition and communication must all be examined as to whether or not they promote health.

This includes the support of an active participation by all employees and introduction of a concept of empowerment, as well as promoting their independence by giving them more information, including them in the decision-making process, and finally by delegating responsibility to them.

A healthy working environment must be created that will further both the physical and mental health of the employees. Sports and health classes, the establishment of a programme of supervision and mutual cultural events will serve among other things to foster a sense of corporate identity. Closely related hereto is the promotion of communication structures and systematic programmes of continuing education and training.

The number of potential activities touched upon briefly here will require a basic revision of the organization's structure, as well as the willingness of those involved and of those responsible to agree to permit and promote such changes.

Beyond its solid effects in the everyday therapy situation, health promotion raises a number of questions, most importantly as to the conditions necessary to the genesis and maintenance of health and those necessary to coping with illness, furthermore, questions as to the relationship between social interventions and behaviour relevant to health. Finally, the effects of health promotion must be analyzed. Close co-operation with the emergent discipline of health sciences is thus just as important as the local co-operation with external research institutions. Above and beyond this it would be wise following the successful completion of the pilot phase of the HPH to incorporate the know-

ledge gained there not only into national but also into international thematic networks so as to make health promotion specifically effective.

In conclusion, I have tried today to present the concept of health promotion against the background of the historical development of psychiatry, not just as a new technology which will increase efficiency within the field of medicine, but as a completely new world of thought, a new path towards understanding and dealing with illness and health, which leads far beyond the horizon of the traditional concept of illness and bears fertile impulses for the future of public health.

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## ***The Psychiatric Hospital as a Health Promoting Hospital***

### ***Different problems need different projects***

Like other hospitals, psychiatric hospitals, too, have problems with hygiene, inefficiency, health risks and high costs. In contrast to general hospitals, however, they have to deal with specific problems resulting from the uniqueness of psychiatric disorders, the problems of treating mentally ill patients, and the necessity to cope with the social reaction towards them.

In this presentation I will describe the main differences between psychiatric and general hospitals and the consequences of these differences according to the aims of the Health Promoting Hospital Project.

The primary aims of the Health Promoting Hospital Project are the development of strategies to improve the quality of health care, the living and working conditions of staff, the satisfaction of patients and relatives, and also to extend the responsibility of the hospital across the narrow borders of acute clinical episodes by co-operation with the community to promote comprehensive concepts of cure, care and prevention (World Health Organisation 1991).

The differences between psychiatric hospitals and general hospitals are relevant for all of these dimensions.

### ***The patients***

#### ***The problem***

Compared with becoming a patient at a general hospital, being admitted to a psychiatric hospital has a completely different symbolic meaning as well as wider-ranging social consequences.

For the patient, crossing the threshold of the mental hospital does not only mean that (s)he is leaving the normal world, but also moreover leaving a normal social identity (Goffman 1961; Prior 1993).

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For the social environment (for example family, friends, neighbours, employers, colleagues) the person who becomes a psychiatric patient often loses confidence in his abilities to fulfil the demands posed by his / her various social roles (Miles 1981).

In addition to the direct burden of psychiatric symptoms (e.g. anxiety, hallucinations, depression) the loss of a normal social identity is a major part of the problem with which a psychiatric hospital has to deal. Patient-related health promotion within the context of a psychiatric hospital therefore includes on the one hand, controlling symptoms (e.g. by drug treatment) and preventing the patient from self destructive behaviour (e.g. misuse of legal and illegal drugs, suicide) or from being harmful to other people (e.g. aggression), but on the other hand also re-establishing a personal identity and, as far as possible, preparing the patient for re-integration into normal social life.

### ***The projects***

#### *Patient focused HPH Sub-Projects in two Psychiatric Hospitals*

Psychiatric Hospital Philipppshospital, Riedstadt	University of Leipzig, Department of Psychiatry
<ul style="list-style-type: none"> <li>· Psychoeducational groups for psychotic patients and their relatives</li> <li>· Psychoeducational groups for patients suffering from addiction</li> <li>· Horse riding as a new therapy for psychotic patients</li> <li>· Counselling Centre for patients who are foreign citizens</li> <li>· Implementation of an intensive rehabilitation unit</li> </ul>	<ul style="list-style-type: none"> <li>· Psychoeducational groups for psychotic patients and their relatives</li> <li>· Caregiver counselling for relatives of older persons suffering from dementia</li> <li>· Sheltered transitional group home for the re-integration of chronically mentally ill patients into the community</li> <li>· Focus groups with patients for quality management</li> </ul>

Beside psychopharmacological treatment the different types of psychiatric therapy are the primary means of fulfilling the tasks described above. Implementing new forms of treatment especially for patients who seems to be resistant against established therapies is one of the central issues of the patient related sub-projects (e.g. horse riding therapy in Riedstadt, outpatient behavioural therapy in Leipzig).

Because the diagnosis and the treatment of psychiatric symptoms is widely based on verbal communication, it is particularly difficult for patients who are foreign native speakers and who come from other socio-cultural backgrounds to communicate their problems and to understand what happens to them in psychiatric hospitals. Implementing a counselling centre for foreign citizens with psychiatric problems in Riedstadt is a further patient-related sub-project.

Living with mental illness is not only a problem of the patients but also a problem of the relatives and other people who live with psychiatric patients (Simon 1997). The Implementation of psycho-educational groups for different groups of patients and their relatives in Riedstadt and Leipzig aims at helping the patient to live with his illness and helping the relative, partner or friend to live with the patient.

In particular for patients with long term chronic mental illness the transition from the mental hospital to the community often fails because the patients don't have the ability to organise elementary life arrangements such as accommodation by themselves. The transitional sheltered group home planned in Leipzig will offer these patients an opportunity to learn to live outside the hospital step by step in a sheltered environment.

Involving the patients perspective into the process of quality management and quality control is a general target of the Health Promoting Hospital Project. In Leipzig this requirement will be met by conducting regularly focus groups (Morgan 1988) with staff members and patients to get in-depth information not only on the needs and wishes but also on the complaints of the patients.

### ***Staff and hospital organisation***

#### ***The problem***

People who are working in psychiatric hospitals are continuously confronted with what can be called the dark side of humanity. Psychiatric patients, particularly in acute illness phases, are not seldom aggressive and hostile and communicate in strange and bizarre ways or even refuse to communicate altogether. Furthermore some patients, in particular long stay patients, neglect their appearance and bodily hygiene, and reduce their activities to eating, drinking coffee and smoking. In contrast to other hospitals, some of the patients at psychiatric hospitals are not voluntarily hospitalised but admitted by legal authorities or relatives. These patients often don't feel ill and therefore they refuse any treatment or care. Aggressive behaviour against the staff is also a problem of psychiatric work.

Beyond the characteristics of patients, psychiatric staff members are confronted with the fact that the aims and methods of psychiatric treatment and care are less well defined than in somatic medicine. Due to the complex nature of mental illness, finding out what is helpful for the patient is often a process of trial and error with random positive or negative results. As a consequence of this less clearly defined expert knowledge, role and hierarchical structures of mental hospitals are often more diffuse compared with somatic hospitals.

### ***The projects***

#### *Staff focused HPH Sub-Projects in two Psychiatric Hospitals*

Psychiatric Hospital Philippshospital, Riedstadt	University of Leipzig, Department of Psychiatry
<ul style="list-style-type: none"> <li>· Active health behaviour / health promotion at the workplace</li> <li>· Socialwork counselling of the staff expressed emotion atmosphere within the wards</li> <li>· Team supervision</li> <li>· Ergonomic realisation of computer workplaces</li> <li>· Family centred working hours employees with families</li> </ul>	<ul style="list-style-type: none"> <li>· Team supervision</li> <li>· Involvement of staff members into the planning and implementation of a new acute care unit</li> <li>· Quality circles</li> </ul>

Because of the particular characteristics of patients and working conditions, psychiatric hospital staff members are vulnerable to emotional overload and burn-out. Training of physical and psychological relaxation techniques are therefore the central issues of the sub-project on active health behaviour in Riedstadt.

Since most of the psychiatric therapeutic methods are based on communication and interaction, a systematic reflection of the communication- and interaction behaviour of the team or the individual staff member is an important means of quality assurance in mental hospitals. Implementing and improving supervision techniques therefore is a further topic of staff related sub-projects in Riedstadt and Leipzig.

Dealing with patients in phases of acute psychosis is particular difficult if the hospital facilities don't meet the special needs of patients and staff in this situation. In many cases the use of inhuman means such as fixing the patient to the bed or administering high doses of antipsychotic drugs could be prevented if appropriate facilities would be available to hinder the patient being harmful to himself or to other people during the acute episode. By involving staff members into the planning and implementation of a new acute care unit in Leipzig it will be possible to create an environment which allows to deal with acute crisis in a way which is less painful for the patients and less stressful for the staff members.

Not seldom psychiatric staff members try to cope with their work-related emotional problems by alcohol- and drug abuse. Helping these people to give up their self-destructive behaviour and to develop more effective coping strategies is the central focus of another staff-related sub-project in Riedstadt.

In addition to its therapeutic effects for the patients, the theatre group established in Riedstadt can also be a means of dealing with work related problems for the staff members. In particular, problems and tensions which are difficult to talk about often can be more easily articulated in drama or comedy. In this way, the performances of the theatre group may enable the actors as well as the audiences to reflect critically about what happens at the hospital.

## *The Community*

### *The problems*

Modern psychiatric hospitals have at their disposal extensive expert knowledge on the diagnosis and treatment of mental illness. Particularly in rural communities with an under-supply of extramural psychiatric services, such as established psychiatrists or therapists, this potential could be a very useful resource for community health promotion, e.g. for the prevention, early detection and efficient treatment of mental disorders. Currently, these resources are hardly used because, due to the social stigma attached to mental illness, psychiatric hospitals and their inmates often become the object of suspicion and scorn. Called **booby hatch** or **madhouse**, the psychiatric hospital will be more frequently associated with fear and punishment than with therapy and health promotion (Prior 1993).

Beyond causing the waste of community health resources, this negative image of mental illness and the mental hospital has unfavourable consequences for the patients as well as for the staff members. For the patients, life experiences outside the hospital, e.g. for work, shopping or participating in

social activities, are often coupled with the risk of becoming mocked, refused or even victimised. Such experiences of devaluation are particularly harmful for the process of social and occupational re-integration of psychiatric patients. The stigmatisation of psychiatric patients can also be a problem for the staff members. On the one hand, it counteracts their therapeutic efforts, and on the other, particularly if they live in the neighbourhood of the hospital, they may become identified with the negative image of their clients.

### ***The Projects***

#### *Community focused HPH Sub-Projects in two Psychiatric Hospitals*

Psychiatric Hospital Philippshospital, Riedstadt	University of Leipzig, Department of Psychiatry
<ul style="list-style-type: none"> <li>· Medical emergency service co-operating with the hospital</li> <li>· Networking of a hospital ward with outpatient services</li> <li>· Theatre group with staff members, patients and people from the community</li> </ul>	<ul style="list-style-type: none"> <li>· Quality Circles with hospital staff and office based psychiatrists involved in the outpatient treatment of mentally ill patients</li> <li>· Organisation of exhibitions of mentally ill artists</li> <li>· Mass media project</li> </ul>

The creation of a medical emergency service which is located in the area of the Philippshospital, as one of the HPH-sub-projects in Riedstadt, will be an important step into the direction of integrating the resources of the hospital better into the system of community health promotion. It is assumed that offering the facilities of the mental hospital to the established medical doctors and to people living in the community who need medical help during the night or the weekend will lower the threshold to the utilisation of the psychiatric services if they are needed.

Quality circles with hospital staff members and office based psychiatrists involved with the outpatient treatment of psychiatric patients will be established in Leipzig for improving the management of the transition of the patient from inpatient to outpatient care.

Beyond the improvement of psychiatric outpatient care an important target of the HPH projects in both psychiatric hospitals is the reduction of the stigmatisation of mentally ill patients in the community.

The theatre group established in Riedstadt is playing an important role in the process of improving the public image of the mental hospital. The integration of the theatre group into the programme of the local adult education centre offers community members the possibility to actively participate in this group. It is the hope of the organisers that the experience of acting together with psychiatric patients and staff members will be a very helpful means of reducing prejudices and aversions against the patients and the institution as a whole.

In Leipzig the organisation of an exhibition of the work of Oswald Tschirtner, one of the most famous painters from the House of the Artists at the Psychiatric Hospital Gugging in Austria (Feilacher 1997), from May 19 to June 17, 1998, was the starting point of a series of cultural events with the intention of presenting the art-work of mentally ill patients to a greater public. It is expected that presenting the mentally ill patient as a person with a particular artistic talent can help to change the stereotype of the patient as a dangerous lunatic.

A further project which is planned in Leipzig is focused on the problem of communicating information about mental illness and psychiatric hospitals to the general public via mass media. Currently mass media reports are primarily concentrated on the sensational events such as bizarre or criminal acts of mentally ill offenders which enforce the negative public image of persons with mental illness (Wahl 1995). In co-operation with the institute of communication research at the University of Leipzig and representatives of mass media organisations, the aim of the project is the development of strategies to inform the general public about mental illness and its treatment in a more objective way.

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*Rainer Paul*

## ***Philipppshospital Riedstadt: What is Health Promotion in Psychiatric Health Care?***

The following case study provides subprojects as models of good practice from a psychiatric hospital on its specific way to a health promoting organisation. Doing so we try to give a practical answer to the question of what health promoting mental health work could be like.

### ***The frame for health promoting work in Philipppshospital***

Philipppshospital, one of the oldest psychiatric hospitals in Germany, has been in existence since 1533. Its modern history began with the erection of the new hospital in 1890. Until 1970, the hospital served a region of 800,000 inhabitants and provided more than 1,700 hospital beds. In the wake of the reform of psychiatric care in the Federal Republic of Germany in the 1970s, the catchment area was restructured and community-based psychiatric care facilities were established. Today, the hospital provides 303 beds, caters for 2,900 patients a year and serves a catchment area of 600,000 people. In addition to two departments of general psychiatry, a dependence unit, a geriatric psychiatry and a department for chronic ill patients have been established.

This development has led to a marked increase in admissions (+42 %), a lessened average length of stay (-50 %) and a decrease in the number of hospital beds (-28 %). At the same time, favourable new legislation has allowed the employment of more and better qualified staff.

The increased networking with external services demands new and different ways of co-operation and communication both inside and outside the hospital, which is seen not only as a challenge but also as a growing burden for the staff. As a consequence it has become necessary to consider the needs of patients as well as of staff members, to include both groups in actively designing the new concepts of therapy and to implement clear and feasible aims for the future of the hospital.

Altogether these developments have led to a need for change and integration in the hospital, for which the concept of the health-promoting hospital initiative seemed to be an ideal frame.

***The first steps of a developing and changing organisation***

<i>profession</i>	<i>involved</i>	<i>not involved</i>
Nurse / male nurse	18	82
physician	52	48
psychologist	83	17
social worker	55	45
technician	0	100
other medical staff	40	60
kitchen personnel	0	100
administration	27	73

Table 1 – Involvement (in percentage) of staff groups in the sub-project groups

The application to be a WHO-Pilot Hospital evoked general astonishment in the hospital particularly as regards the idea, that there might be a connection between the hospital and the world »out there«. Nevertheless, as shown in Table 1, a significant number of staff members of all professional groups participated in the subproject work. The WHO-project, confronted the hospital with a substantial challenge: To perceive itself as a part of an international movement.

***The awakened creative potential of the organisation:  
10 subprojects could be realized***

The developed 10 sub-projects addressed the subject areas patients, staff and the community, i. e. integration of the hospital into the region. They were chosen, because they give answers to some of the central questions of the hospital as an organisation (How to develop to be a learning organisation?), as an institution in the region (How to strengthen the ties to the local practitioners) and as a place for people (How to stimulate the resources of the staff and the patients?).

*10 Sub-Projects*

staff-focused: 4 projects	patient-focused: 3 projects	community-focused: 2 projects
Active health behaviour / health promotion at the workplace	Counselling Centre for patients who are foreign citizens	Emergency service for general medicine in co-operation with the local general practitioners
Ergonomic realisation of computer workplaces	Psychoeducational groups for psychotic patients and their relatives	Networking of a hospital ward with outpatient services
Social work counselling for the staff	Horse-riding as a new therapy (equestrian therapy) for psychotic patients	
Team supervision		
<i>general: one project:</i>	Drama work in psychiatric health care	

Table 2 – The 10 sub-projects of the Philipppshospital WHO-project

In the following we will describe in detail one sub-project-example for each intervention-area.

***Three Examples of our projectwork******1. Staff-focused sub-project: Team Supervision***

Supervision of the staff was introduced in all treatment units, in addition to traditional health education programmes (e. g. gym-exercises for the back for staff members). The objective was to enhance the self-reflexive potential of the organisation with particular emphasis on skill development among and support for the staff. The interprofessional teams on the wards (not only physicians, but all staff-members, who are engaged in the treatmentprocess) discuss treatment cases and if necessary the internal dynamics of the group, supported by an external adviser. However it is not possible to force staff-members to take part in these sessions as a constraint would contravene the principles of confidentiality and voluntary participation, as well as hinder the personal openness required for the success of such. A sub-project group of three persons has been active in promoting supervision work on all wards. The type of intervention of this group has been mostly information for those ward teams who showed interest. Another helpful method was to search and ask for expe-

riences of those ward teams, who had already participated and then to make their experience available to the others. Within a time interval of two years, nearly all units had succeeded in setting up at least monthly supervision sessions (Table 3).

<i>Medical teams and supervisory sessions</i>	<i>1993 (pre intervention)</i>	<i>1995 (post intervention)</i>
yes	6	14
without	12	4

Table 3 – Number of medical teams receiving supervision in mental health care units (N=18)

Compared to the period prior to intervention, the relationship of the teams who took advantage of supervision changed as opposed to that of teams who did not make use of the offer. This successful implementation was confirmed also by qualitative evaluation data: It became apparent that supervision can be carried out successfully only if the corresponding personnel conditions prevail (attendance by team members, corresponding planning of work schedules, less part-time work by team members). The information foundation available for supervision must also be improved; knowledge of the meetings, etc. The supervision received not only positive ratings, as exemplified by the premature withdrawal of two teams. Supervision can focus on covert conflicts within the team which, as in these two cases, could be avoided only by terminating the supervision.

This project has enhanced the integration of the treatment teams. Furthermore, better integration (e.g. the ability to manage as a team difficult situations with patients) has proved to be a protective factor in preventing violent conflicts with patients. Violent conflicts account for approximately 20 % of all accidents at work in a psychiatric hospital and represent a major cost factor. Prevention of violent conflicts with patients was defined by a sub-group of treatment teams as the project focus.

## ***2. Patient focussed sub-projects***

Five projects focussed on patient management, while others focussed on the implementation of new therapeutic approaches. With regard to the latter, success was achieved particularly in two sub-projects, the horse-riding therapy project for psychotic patients, and the psychoeducative groups for patients and their relatives. Specific importance was given to mobilising patients' resources for coping with their psychiatric disorders. This was especially highlighted in the project »Psychoeducative groups for patients and their relatives«. Here, the framework of the WHO-project helped to implement a

desirable treatment. The aim of the group is to achieve better compliance with medication, better coping with the illness as well as relapse prevention by means of providing information about the disorder (mainly schizophrenia). The project stands out because of its high level of acceptance both among patients and their relatives. Continued patient participation, beyond their stay in the hospital, demonstrates how well the project is received.

### ***3. Community-focused sub-project: Emergency service for general medicine in co-operation with the local general practitioners***

One problem of an institution with such a long history as a place for psychiatric patients like Philipppshospital is, how to lay down the walls in the heads of the peoples living in the neighbourhood or local community. There is a focus in traditional social psychiatric work which is leading to closer and more efficient networking between the in-patient treatment units and ambulant service structures, but this does not address the community as a whole. Therefore, an emergency care centre for the people of the region has been established in the hospital, which provides an after hours emergency care service for patients with general illnesses. The emergency centre strengthens the hospital's co-operation with the local general practitioners and proved to be successful in the better integration of the hospital in the local area. It has been hard work to make this service acceptable to the community. In the beginning, local residents were hesitant to utilise the emergency service and there were even protests against it. In the course of the project, acceptance of the service gradually increased. In the meantime, the emergency care centre has become an integral part of the health care network in the district of Groß-Gerau South.

Apart from the project foci discussed above, the context of the WHO project has enabled Philipppshospital to initiate wider-ranging project work. For example, the drama group at Philipppshospital involves patients, staff and local residents and has been a major success since September 1993. Several plays have been produced and the numerous performances have generated a great deal of interest in the community.

### ***Generalising effects of the project***

The initial information campaign and the project fair gave a crucial impulse for changing the organizational climate at the hospital. During that time, several initiatives were developed which were in line with the objectives of the WHO-project while not being part of the actual project work. These initia-

tives continue to exist today and have contributed to the success of the project and to improved communication within the hospital. Hence we can rightly speak of a »generalisation effect« in spreading the project ideas:

- Continuous in-house further training for the nursing staff (on different subjects; e. g. on death and dying);
- Renovation / decoration of the premises to facilitate better orientation and according to the principles of colour psychology;
- A psychotherapy unit was established;
- Additional reduction in number of beds in three treatment units;
- Further direct effects such as the opening of wards previously locked one result of the social-psychiatric initiatives;
- Art exhibition and foundation of a cultural association responsible for public relations;
- Further indirect effects such as the transformation of previously compulsory units into voluntary ones as a result of the stimulation of social-psychiatric initiatives by the project.

***Results of the HPH participation for the Philipppshospital  
as recommendations for other hospitals***

At the Philipppshospital, the WHO-project acted as a catalyst, and stimulated a whole host of developments, though not all of the latter were associated with the name of the WHO-project. Involvement in the WHO-project has revived an internal discussion which had come to a standstill; it has stimulated the creative potential of the staff and given a new impetus to the social-psychiatric reform.

Through the project-centred work we succeeded in establishing new treatment concepts firmly and permanently in the regular treatment programme of the hospital, but also in effecting wide-ranging changes in the organizational structure. According to the external and internal evaluation it can already be stated that

- Conflicts at the hospital were reduced, which facilitated a number of developments;
- Long-term motivation could be fostered among the staff, forming a prerequisite for the implementation of new services;
- Interests of the staff in terms of health-promotion were given substantial support;
- The management was facilitated in translating objectives into action that were developed independently of administrative directives;

- Public interest in the psychiatric hospital and its treatment profile was stimulated.

Last but not least, the international exchange in the WHO network has enhanced the conceptual debate at the Philipppshospital and led to concrete projects such as the opening of a day hospital for geriatric patients.

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*Andrea Sacher*

## ***Empowerment as a Health Promotion Process in Psychiatric Health Care: The Herner Model***

Empowerment is considered to be one of the basic concepts of health promotion in the understanding of the Ottawa-Charter. It is a central target of professional treatment to enable and strengthen people to create health supportive living conditions. Empowerment cannot be considered to be a method or a professional tool but it rather reflects a professional attitude focusing on promoting the self-organisation potential and social actions.

Empowerment also is the recognition of a person's own strengths and power. Contrary to expert-oriented prevention measures, empowerment starts with the individuals' and groups' abilities to organise and determine their living conditions themselves. This is the process which encourages people to take care of their own matters, discover their own strengths and competencies, take them serious and to come to appreciate the value of their own solutions. Empowerment also is the co-operation process of affected persons with equal or similar problems leading to synergies. It is, therefore, the duty of professional helpers and institutions to actively promote processes which lead to such solidary forms of self-organisation. This leads to a change of the professional understanding and a weakening of experts.

The empowerment-concept challenges the professional role understanding of persons in need. According to Rappaport (1985) there is always a conflict between the two models of how to consider persons with psychosocial problems and how to deal with them: the conflict between models which emphasise either the neediness or the rights of these persons, exclusively. Both models are one-sided approaches. Empowerment demands a holistic view of individuals with their weaknesses and resources and sensibilizes for required actions and contradictions.

Certainly, neglect of the resources and rights of the needy is only partly due to an intention, e.g. because of explicit power interests. The one-sided focus on weaknesses and deficits results in underestimation and lesser promotion of the other, competent and creative side of individuals or social systems. This imbalance causes the competent side to starve, and the individuals' identity as »needy and deficient« is, without intention, structurally strengthened. Therefore empowerment demands consideration of the needs as well as the rights.

Professionalism in this understanding means an awareness of the dialectical relation between rights and needs and not to look for one-sided, non-dialectical solutions.

For intervention on the community level or in institutions this approach means that, starting with the initial planning of a programme, citizens of the community or individuals in an institution must have the chance to participate in the programme as much as possible. The negotiation process of frames, contents, measures, and methods must be considered as a centrepiece of health promotion projects. For professional helpers it is thus required that they put their expert knowledge on a level with other views and evaluations and herewith increase influence and chances for creativity for the concerned individuals. Thus, resources can be made active, and self-organisation and self-responsibility promoted.

Within the setting of a psychiatric hospital the stretch ratio between needs and rights is a daily challenge. And for most employees it is usually difficult not to solve this conflict towards one or the other side. They must look at the contradiction that persons, even with few abilities or in an extreme crisis situation, need to have more rather than less control of their own lives. The demand for more self-determination does, however, not mean that their need for help should be neglected. It is therefore of importance for health promotion measures to consider the structural aspects in the relations between experts and the affected.

Hereafter, I would like to tell you about an approach to how empowerment processes can be initiated and demanded in the setting of a psychiatric hospital. To do this, I would like to introduce to you the Herner Model of subject- and autonomy-oriented psychiatry.

The psychiatric ward of the St. Marien-Hospital Eickel is located in the municipality Eickel which is part of the town Herne in the centre of the Ruhr-area. It works community-psychiatrically in the tradition of emancipated approaches to psychiatry. Local and regional traditions of neighbourhood and self-help potentials, which developed in the mining days, are especially valued. An intensive exchange on self-understanding and working methods with representatives of the French reform psychiatry »psychothérapie institutionnelle« has shown success for the past 10 years. Recently, the hospital management under Dr. Matthias Krisor has explicitly stated a »salutogenetically defined work order« and the »co-modelling of the institution by its users« (Krisor & Pfannkuch, 1997).

Herewith, therapeutic work gives prime consideration to a holistic view of the individual, based on resources and the living environment of the affected individual. On several levels, the standardised approach – active, knowing

professional treats passive, dependent patient – is kept to an absolute minimum. A changed sickness perception and reform of standard psychiatric structures make room for meeting subjects. Both, patients and professionals do not have strictly defined roles. The vast role potential of each person is used as a resource.

***Examples for the institutional application of empowerment are:***

***1. Studio events (»Atelierveranstaltungen«)***

The studio of the hospital in Herne provides a forum for encounters among patients, interested citizens of Herne, local mediators, and employees. These public events (lectures, discussions, excursions, festivities, exhibitions, etc.) usually take place at the premises of the hospital and thus are a decisive means of »publication« of the clinic. Mentally ill persons may be lecturers, auditors, or participants instead of being patients. The studio is also used for the practice of socially adequate exchange behaviour in »natural situations«. The exhibitions, for example, of the regional rabbit breeding association, which are done at irregular intervals, are liked a lot. At such an exhibition, the differentiation of psychopathological phenomena does not count, but only the knowledge of rabbit breeding and breeding successes. The criteria is always whether someone can make a contribution on the subject.

***2. The delegates***

Delegates are former patients or patients who have overcome their acute crisis and thus have become experts. They are experienced with their disease and with the institution and can pass this information on to the less experienced and also to professional visitors of the clinic or relatives. Thereby, they are much better able to represent the interests of their co-patients than professionals ever could. Hence, they give a role model which strengthens the fantasy to think a positive organisation of the own future is possible. With their resources they largely contribute to the social support, within the hospital and after the hospital stay. The delegates themselves grow with their duties: The feeling of being able to do something for others and to assume responsibilities helps them to gain more control over their own lives and their social connections. From the experience with the delegates, lately a model with so-called »crisis assistants« developed. It is based on the consideration of whether a more pinpointed accompanying of individuals suffering from long-term crisis by helpers with psychiatric experience would be beneficial for further de-

velopment of a violence-free psychiatry. Initial results confirm this assumption.

### ***3. Occupational Therapy in the Community***

Patients frequently experience the standard occupational therapy within a psychiatric clinic to be artificial and in fact mere occupation. The real world approach at the St. Marien-Hospital provides for occupational therapy within the community. The patients can take e.g. sports classes with associations or take classes at the Volkshochschule (Further Education Institute) of the community. Hence, they have a considerably higher number of impulses and leisure offers from which they can choose and which can continue to be of importance after release from hospital. Real social relations within the community put psychopathology in the background. Moreover, a network, valuable for the individual, may develop. This is independent of therapeutic efforts in rather informal networks which continue to work structuringly after a crisis.

These approaches of participation and empowerment on a structural level conform to community psychiatric trias: no admission ward, heterogeneity, and open doors on all wards.

#### ***1. Renunciation of an admission ward***

Usually, the presence of an admission ward is felt to be a burden by all persons involved, as it is a place where experience and conduct of the acute sick who are highly disturbed and which is reciprocally reinforced, is concentrated. This not only opposes demands of organised representations of those experienced in psychiatry but also the experience that especially those individuals acutely suffering need a supportive environment. In addition, the continuous treatment prevents a relationship breakage between patient and therapist and nursing staff which may be negative for the patients. It is also known that violence primarily happens on admission wards.

#### ***2. Heterogeneity***

The heterogeneous composition of patients on the wards with diseases differing in intensity and marking normalises and relaxes the atmosphere at the wards. Furthermore, the patient does not experience the categorisation according to symptoms which leads to further de-focusing on the clinical picture both in his/her own perception and in the perception through professional helpers. Results of the mixing are a more active self-help potential among the patients. Impulses and help offers from other patients are more readily accepted than professional offers.

### **3. Open doors at all wards**

Open doors at all wards must be evaluated in the context of the missing admission ward as well as the heterogeneous composition of all wards: They really and symbolically represent a new quality of patients and professionals, of users and institution. The technical solution of a closed door is replaced by a conversation, if necessary. Here also, the idea is to handle this »problem« in an every-day way. To the amazement of those who pleaded for the necessity of closed wards, suicides did not increase and use of medication was reduced. Fixings, escapes, bringing in of drugs have also decreased under the conditions of open doors.

All changes mentioned before contribute as a whole to a health supportive climate in the psychiatric hospital. This is achieved through a practically proven and theoretically founded concept with regards to understanding of persons, sickness and the professional attitude. Therefore the salutogenetic and subject-oriented approach at the St. Marien-Hospital differs from approaches which aim at health promotion through offers and projects without a change at the wards and in the professional-patient relationship. Classification as »subject-orientation« – or as in other connections the orientation at the »person«, names such as »citizen« and »user« – refer to the dissolution of the patient role which is one-sidedly pathology-oriented, but also of the expert-role.

Recognition as a subject and as a citizen with rights and responsibilities is a necessary condition for health promotion approaches. Many psychiatry professionals would agree, however, the institutional structures frequently talk a different language. Empowerment as a professional attitude in health promotion sensibilizes for these contradictions and also for development of a new expert type. Health promotion in the understanding of empowerment, and this is what I wanted to explain, requires less additional offers from the hospital but rather structural changes in the relationship among professionals and the affected individuals, in particular.

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*Hartmut Berger, Rainer Paul*

## ***From Establishing a HPH-Taskforce on Health Promoting Mental Health Services (HPMHS) to HPMHS Network Activities***

As Mila Garcia Barbero and Hubert Lobnig already reported in the ***Newsletter No 11***, the increasing interest on the issue of health promoting psychiatric hospitals led to the foundation of a taskforce on health promotion in psychiatry.

Establishment of the taskforce has been promoted by WHO-Euro through participation of Mila Garcia Barbero and on the part of the co-ordinating LBI through that of Hubert Lobnig. Our role as the local host of the conference gave us the opportunity to further that goal by means of various activities (e. g. keynote-lecture / H. B. chairmanship of the stream psychiatry / R. P.). All in all 12 founding members from six European countries have agreed on the necessity to establish a taskforce on health promoting mental health services.

Hartmut Berger, medical director of the Philipppshospital Riedstadt, was named as the co-ordinator of the taskforce and Rainer Paul, co-ordinator of the HP-Project Philipppshospital, as his assistant.

### ***Integrative Aspects of the HP Approach in the Mental Health Sector***

#### ***1. Organisational-Institutional Integration***

The diversity of the group of founding members, which encompasses representatives of the administrations, hospital carriers, hospital and outpatient services, shows that HP in psychiatry is not just a matter of hospital concern. The name of the taskforce, HP mental Health ***Services*** can thus be understood ***programmatically*** to be:

Mental health disorders require an integrated approach, since disease processes are often long-term and acute and sub-acute phases of illness alternate with phases which are relatively symptom-free. HP in the mental health sector must then be oriented to the needs of both outpatient as well as semi-inpatient and inpatient services, considering as well the social network of the patient. From the standpoint of the case history and the biography of the patient, health promotional effects can only be achieved if the settings in which

the patient moves throughout the course of his biography, interact. The interventions within these settings must be so tuned to one another that their immanent goal to promote health becomes the steering principle. The setting approach expands at this point into one of ***interacting settings***. The taskforce itself shall exercise a networking function among those institutions in the mental health sector which hold health promotion to be the core concept of their work.

## ***2. Theoretical-Conceptual Integration***

The field of mental health care is rife with many competing concepts and theoretical frameworks, a situation which has divided the professional community. The HP-perspective should be able to integrate biological, pharmacological, social, cognitive-behavioural, systemic, psycho-dynamic, social-psychiatric and community based approaches to mental disturbances such that a dialogue begins among these different approaches which does not foresee the domination one by another. HP should be able to function as a ***core concept for interacting theoretical frameworks*** in the field of mental health.

### ***Activities of the Taskforce***

Since the foundation of the group of interested hospitals and hospital carriers the Philipppshospital has embarked upon activities in ***four main areas***:

1. Making the ideas and aims of the taskforce visible to those, who may be interested:
  - Presentation at the Meeting of the German Society for Psychiatry, Psychotherapy and Neurology (DGPPN) in Essen, Germany, June 1998.
  - Establishing a symposium session on health promotion in mental health services at the Congress of the World Association of Psychiatric Rehabilitation, Hamburg, Mai 1999.
  - Establishing a symposium session on health promotion in mental health services at the 11th World Congress of Psychiatry, Hamburg, August 1999.
2. Seeking out and extending invitations to potential co-operation partners:
  - Spontaneous requests for information from partners in Austria, France, Germany, Italy, Poland and Wales-UK.
  - Co-operation sought with the German-Polish Society on Mental Health.
  - Contact to different organisations, which operate hospitals in the field of psychiatry in Germany and UK.
  - First contacts with some international active pharmacological companies which are interested in the field of concepts in health promotion in mental health services.

- Co-operation with the German Society for Psychiatry, Psychotherapy and Neurology (DGPPN).
- 3. Funding activities: One of the stipulations of the WHO is that the taskforce not levy additional fees and that it finance itself. For this reason our work currently focuses on establishing a sound financial foundation for the taskforce. We are actively exploring the interest of the international pharmaceutical industry in funding an HPMHS Taskforce.
- 4. Formulation of criteria for membership in the HPMHS-Network: Formulation of criteria is a long-term endeavour, we have concentrated upon the question, whether membership in the regional or national networks is necessary in order to participate in the network of health promoting mental health services. We received the clear answer from WHO-Euro in September, that the membership in the HPMHS-Network is not bound to membership in the national or regional networks. It constitutes a separate form of membership in the HPH-World. This now enables us to develop further membership criteria.

### ***Perspective for the Near Future***

Completion of the above-mentioned activities, which have a long-term perspective, depends upon the following tasks:

- Preparation of an information brochure and creation of the corresponding files for use in the HPMHS-Network.
- Establishment of an e-mail address.
- Analysis of the current publications from the group of HPH in psychiatry (editing of the abstracts from the international conferences held to date) with regard to models of good practice and in view of concepts that might prove useful to the mental health sector.
- Create excerpts from the HPH database from a psychiatric standpoint.
- Construction of a database of those interested in the HPMHS-Network.
- Formulation of basic principles: What is a Health Promoting Mental Health Service?
- Development of a practical and easy to implement manual of health promotion for use in the mental health sector.

### ***Outlook for the Preliminary Aims***

The work described aims to introduce a change of paradigms in psychiatry from the hospital model to a model which will take into account the promoti-

on and maintenance of the resources and abilities of the patient. We envision a fundamental change in the relationship between patient and professional such that both are open to criticism and to the concerns of the other. The professional should become an active partner to the patient, insisting upon participation and with a view which reaches beyond the confines of the institution and does not lose sight of the patient's own history.

We invite all who are interested in co-operative health promotional work within the field of mental health services to join the taskforce. In Swansea at the 7th International Conference a working group of the taskforce will be established to continue the endeavours with regard to content and organisation.

# Patient-centred Health Promotion in Hospitals

*Tony Barden*

## ***Health Care and Positive Living***

In 1987 Waterford Mental Health Association approached the Head of Adult Education, Waterford Regional Technical College to discuss the provision of Health Care Courses. Various options were explored and in 1988 the first course was designed and delivered, attracting 24 participants. The aim of the course was to provide participants with practical suggestions on healthy living and how to cope with stressful times in their lives. The Course approached health from a positive point of view and recognised that health is not only about bodies, but that feelings and relationships are just as important as physical well-being. The Course is about life choices and just as importantly, it is about obstacles preventing healthy living. Topics included:

- Recognising and coping with stress
- Addictions and their effects
- The needs of our bodies
- Health in the social context
- AIDS and related disorders
- Child development / child abuse
- Inter-personal communication
- Community medicine
- Holistic approaches to health
- Understanding relationships

This course proved such a success that it was decided to develop a further modular course.

## ***Diploma In Health Care And Positive Living***

Arising from the popularity of the Certificate Course, this modular course was developed with the same general aims, but the topics were developed in greater detail. Although health care professionals attend these courses, they are primarily intended as self-development courses for the community.

A variety of ten week modules are offered each term and students are assessed on the basis of attendance and the project submitted at the end of the module. Anyone who completes the Certificate Course and then completes five modules, would be eligible for the award of the Diploma.

***Modules:***

- Making choices and self-empowerment
- Exploring the self
- Practical Psychology
- Introduction to counselling
- Counselling continues
- Assertiveness
- Assertiveness continued
- Stress Management
- Child and Adolescent development
- Exploring play
- Effective communication
- Addiction studies
- Working with people
- Creating new choices
- Cooking for health and enjoyment
- Caring for the elderly at home
- Caring for the Mentally Handicapped
- Introduction to community development
- Sign language for the deaf
- Confident conversation
- Spirituality of the human person
- Foundation of ethics.

These courses were originally aimed at the Waterford area, but due to demand, were made available in Dungarvan in 1993. In 1995, courses were made available in Clonmel and Tipperary Town and in 1996, in Wexford.

The module on »Addiction Studies« has attracted a lot of interest and due to demand, was made available in five centres during the 1995 / 1996 academic year. A course has also been run for FAS trainers from the South East Region. Addiction studies courses are run by Addiction Counsellors from the Health Board Addiction Centres.

***Evaluation***

The Health Care and Positive Living initiative has been a great success. It started from an innovative idea, to meet the needs of all people in society. It now reaches out to people in the greater part of the South Eastern Health Board Region and has crossed all social divides. The objectives of the future

are to continue to implement and deliver the Health Care and Positive Living course as required. The modules proving to be most popular are:

<i>Module Title</i>	<i>E.N.R.</i>	<i>Male</i>	<i>Female</i>
Addiction Studies	142	31	111
Certificate In Health Care & Positive Living	130	10	120
Creative Stress Management	80	7	73
Practical Psychology	61	7	54
Assertiveness	52	13	39
Introduction to Counselling	42	5	37

Total Enrolment For All Courses: 679 – an increase on previous year of 182. At the moment the course is being delivered in eight centres: Waterford, Tipperary, Cahir, Clonmel, Dungarvan, Wicklow, Wexford, Gorey. Thirty-four courses in total over a period of 16,000 hours.

Mission Statement. To foster holistic health through the medium of continuing adult and community education.

*Anna Clarke, Leslie Daly, Denise Comerford*

## ***Smoking Rates Amongst Inpatients and Staff in an Acute General Hospital***

The overall aim of the study was to determine smoking rates amongst acute hospital inpatients and staff and determine the level of interest amongst smokers in stopping.

Data was collected by interviewer-administered questionnaire. All inpatients were included in the study, apart from those too ill to participate. A random selection of staff were also included.

Results: A total of 712 patients and 364 staff were eligible for inclusion in the study. Response rates were high, 98 % amongst the patients and 95 % amongst the staff. Median age of patients was 65 years and of staff was 35 years. There were more current smokers amongst staff (28.3 %), both male and females, than amongst the patients (24.2 %). When the age difference was adjusted for, the difference in the under 50's age-groups was not as marked. Within the different staff occupational groups, smoking rates varied. The allied services group (cleaners, porters, maintenance) had the highest smoking rates amongst the males (44.4 %), while the management/administration group had the highest smoking rates (37.5 %) amongst the female staff. Of the total 272 current smokers, 184 (67.7 %) might/definitely want to stop and 120 (65.2 %) of these might/would avail of help.

There were more current smokers amongst staff than amongst patients in this study. There is a need for smoking cessation advice and support for smokers for both patients and staff in a general hospital setting. On the basis of our findings a stop smoking advice service is being set up to help and support patients and staff who wish to cease smoking. A smoke free hospital policy has also been developed.

The overall aim of the study was to determine smoking rates amongst acute hospital inpatients and staff. The objectives were as follows: 1) to determine smoking rates amongst inpatients, 2) to determine smoking rates amongst staff, 3) to determine the level of interest amongst smokers in stopping smoking. The acute general hospital in which the study took place is a large teaching hospital with 1,800 whole time equivalent staff and 450 inpatient beds. A smoke free policy for the hospital was being developed at the time of the study.

### *Methodology*

**Patients** – The study population included all inpatients in the hospital on the day of the study. Exclusion criteria included those patients too ill to partake in the study. The patient study was carried out in June 1997 and repeated in January 1998 to exclude seasonal differences in smoking rates.

**Staff** – A one in four random sample was taken of all staff and those chosen were included in the study.

Data was collected by interviewer-administered questionnaire and took approximately three minutes to complete. The patient questionnaire asked details of ward patient was on, consultant, sex, agegroup and smoking status. If current smoker, respondent was asked whether they wished to give up smoking and if so, whether they wanted help. The staff questionnaire asked their occupation, sex, agegroup and smoking status. The staff occupations were divided into 6 groups – allied services (porters, cleaners and maintenance), junior doctors, administration/management, paramedical, consultant and nursing. Response rates were high, 98 % amongst the patients and 95 % amongst the staff.

### *Results*

A total of 712 patients were eligible for inclusion in the study and 364 staff. Median age of patients was 65 years and of staff was 35 years. This difference was significant. Forty six percent of patients were males compared to 33 % of staff. Regarding smoking status, there were more current smokers amongst staff (28.3 %) in both males and females than patients (24.2 %) and the patients were smoking less than the general population (29 %). When age was adjusted for, the difference in smoking rates between patients and staff was not as marked but overall still showed more current smokers amongst the staff. In the under 50's age groups, male staff were smoking more than patients but showed less of a difference and amongst the females, patients were smoking more than staff. Different smoking rates were seen across the different occupational groups of staff. Amongst males, the allied services group accounted for the highest current smoking rate (44.4 %). Amongst the females, the administration/management group had the highest smoking rates (37.5 %). With regard to current smokers attitudes to stopping, of the 272 current smokers, 88 (32.3 %) did not want to stop, 184 (67.7 %) might like/definitely want to stop. Although patients were more likely not to want to stop there was no significant differences between patients and staff. Of those who

wanted to stop, 120 (65.2 %) might or would avail of help but 64 (34.8 %) would not avail of any help.

### ***Recommendations***

It is worrying to see in the under 50's agegroups in both patients and staff that the current smoking rates are higher than the national average (29 %) in Ireland. There is a need for smoking cessation advice and support for smokers for both staff and patients in a general hospital setting. A smoke free policy must be developed and implemented if none exists following wide consultation with all staff and once implemented, monitored regularly. On the basis of our findings a stop smoking advice service is being set up to help and support patients and staff who wish to cease smoking. A smoke free hospital policy has also been developed.

*Melanie Perry*

## ***Alcohol Screening and Early Interventions in the Medical Setting***

Prism is a Voluntary sector, community alcohol advisory service based in Carmarthen and operating throughout West Wales. The Service has a high reputation for developing services that are innovative, locally accessible and seek to reach out into the community we serve. As a specialist agency working to reduce alcohol-related harm, we have long acknowledged the need to engage non-specialists in utilising the opportunities they have to discuss alcohol issues with their patients and clients. A traditional way of dealing with this issue has been to offer professionals short in-service training courses to enable them to update their information about alcohol and to consider how they might raise and respond to their patients' use of alcohol. Over some years Prism has felt that, in isolation, this provision has had limited impact on the practice of generic staff. They often return from a training course to a work environment hostile to drinkers and ignorant of the role that non-specialists can play.

A practical and novel approach to address some of the difficulties raised above has been the development and implementation of a project to enable nurses to identify and respond to early problem drinking in the medical setting. In 1995 the local Health Authority made funding available to Prism to develop and implement the Alcohol Screening Project. The project aimed to increase opportunities for early identification of and brief intervention for alcohol related problems in primary and secondary care settings. The rationale for the project was drawn from research findings detailed in the ***Effective Health Care Bulletin No 7***. The research highlights that, following the use of simple screening instruments, brief interventions can be effective in reducing alcohol consumption by over 20 % among those whose drinking is raised.

While the Screening Project was offered in Primary care and delivered by practice nurses, it has made its greatest impact in the Secondary care sector. It is the experiences of implementing the project in secondary care that form the basis of this paper.

Prism and the Llanelli Dinefwr NHS Trust worked in partnership to implement alcohol screening on two general medical wards in the Trust's Prince Philip Hospital in Llanelli, west Wales, UK.

The objectives of the project were to:

- Provide training and on-going support for ward nurses to enable them to use an alcohol screening tool and appropriately respond to patients' results,
- Screen patients and provide drinking advice to an identified proportion of those patients,
- Evaluate the scheme's effectiveness.

Nurses were trained to use a short questionnaire, based on the WHO Alcohol Use Disorders Identification Test (AUDIT). The questionnaire elicited the amount, frequency and pattern of alcohol consumption amongst patient admissions. Patients' answers to the questions are scored and depending on the score the patient was then offered some information about safer drinking in the form of a specially prepared booklet. The total score range was 0-12, which was sub divided into three categories of 0-4, 5-7 and 8-12. In addition to asking the three AUDIT questions nurses also ask the patient about weekly drinking. A score of 5 or more is deemed worthy of offering the patient some brief advice about drinking and their use of alcohol. A score of 8 and over indicated that the nurse might ask some other questions as a trigger to a wider discussion about the patient's use of alcohol. Staff used the remaining seven questions from AUDIT. An opportunity also presented itself to refer patients to Prism's specialist alcohol counselling service.

Detailed planning for the project began in September 1996 following protracted negotiations within the Medical Directorate where a range of barriers to the project was raised. The following were frequently cited barriers:

- Nurses will not have time to ask the questions.
- Nurses will not know what to say to patients.
- Nurses and patients will be embarrassed.
- Patients will feel insulted.
- Patients will lie about their drinking.

In March 1997 evening training sessions were held to:

- Inform nurses of the project.
- Update their knowledge of alcohol and in particular its short and long-term physical effects.
- Discuss the importance of our attitudes to drinkers and alcohol problems.
- Familiarise nurses with the screening form and scoring process.

To further enable the nurses to undertake screening and provide appropriate advice a booklet was written by Prism. The booklet gives clear information about alcohol, practical activities for the patient to help them consider changing their drinking and helpful tips for changing.

In the first year of the project 23 nurse were trained to routinely screen patients. 325 men and 336 women were screened. Of these patients, 209 men and 47 women scored 5 or more and were therefore offered targeted information about alcohol and a copy of the booklet.

To date we have had difficulty in following up patients following their discharge and proposals are being submitted to secure a small amount of funding to enable follow-ups to be undertaken. However, the impact of the project on nursing staff has been very positive and the barriers that were feared at the outset of the project have been found to be illusory.

Nurses have become more positive towards the alcohol issue.

Nurses are ideally placed to offer early interventions on alcohol when they are trained and supported.

Screening, using a simple tool, does not take too much time.

Patients are generally positive about discussing their drinking, except for women who appear to be more reticent according to ward staff.

Patients with high levels of drinking are being identified at an earlier stage in their drinking career than they would otherwise be.

An inter-agency group including Prism, nursing, health promotion and Social Services staff meets regularly and they are now considering plans to roll the project out to other wards and Directorates in the Trust.

The alcohol screening project in Prince Philip Hospital has demonstrated that a long term view on a well planned and supported project can improve the sustainability of the work, reduce hostility in the environment and empower and enthuse patient educators at ward level.

Nuffield Institute for Health (1993), Brief Interventions and Alcohol Use. *Effective Health Care Bulletin 7*

*Jacqueline Cobb*

## ***The Birth of the Accident Notebook – A Resource derived from Collaborative Working***

### ***Introduction***

Health Visitors and Linkworkers identified an area of need for child Accident Prevention intervention in Sparkbrook, a deprived inner city locality with a rich ethnic mix, within the City of Birmingham, England. The need has subsequently confirmed by a wider range of professionals within child service settings – School nurses, Practice nurses, Nursery staff and paediatric hospital staff. This paper identifies the development of a project sustained through collaborative working which involved the production of a new health promotion resource highlighting the exposure to accident risk for children aged 0-5 years and advice on related accident prevention.

The partners involved in the project were within Birmingham representing the Public sector:

- Birmingham City Council – the largest all-purpose local authority in the UK with a turnover of approximately £ 2 billion and a population of 1 million;
- Birmingham Health Authority – providing for the health needs of people within Birmingham and surrounding districts containing areas of some of the highest deprivation in the country;
- Birmingham Children's Hospital NHS Trust – a specialist paediatric referral centre with 270 beds, 50 specialities and employing 1800 staff;
- Southern Birmingham Community Health Trust – providing a wide range of health services within the primary care setting and from the Voluntary sector;
- Safer Sparkbrook organisation – joint financing body with the Health Authority;
- City Living Partnership – whose independent consultants held a training interest in community based initiatives;

The following child accident facts and figures demonstrate the associated need for Accident Prevention activity:

- 10 Children die per week in the United Kingdom as a result of an accident;

- 1 out of every 4 children attend an Accident & Emergency Department to receive treatment for accident injuries every year (Cohen, 1991);
- Exposure to Accident Risk is linked to Social Deprivation (Black, 1980);
- In Birmingham – Wards with the Highest Townsend Scores For Deprivation e.g. Sparkbrook, accounted for 32 % of Child Deaths whilst representing 23 % of the Child Population for the Whole City;
- Accident Injury is a Major Public Health Problem in Britain Today;
- Accidents are the largest single Cause of Death for Children aged 1-14 years;
- Children's Accidents fall into a pattern usually corresponding to the age stage of development;
- Cultural and Social Factors can Influence Accident Risk;
- The Emotional Cost of Child Accidents is often Underestimated.

### ***Aim***

The development and launch of a new health promotion resource on preventing accidents to children aged 0-5 years.

### ***Objectives***

- To assist practitioners in the field of child care to identify situations of risk for young children.
- To enable workers to share with parents / carers an assessment of the risks and ways of reducing or eliminating exposure.
- To establish as fact that Accident Risk and Prevention are contextual.
- To facilitate a consistent approach by workers in the field of Child Accident Prevention.

The methodology of the project focused initially on the development of a practical, visual resource depicting 46 Accident risk scenarios, covering age ranges 0-8 months, 8-24 months, 2-3 years and 3-5 years. This was followed by the introduction of a consultation process involving – health professionals, educationalists and those working closely with children and carers. This resulted in a number of amendments to the final product in response to recommendations from individuals who participated in the process. The next phase of the project was a staged implementation training programme, incorporating multi-agency evaluation. Planning activity subsequently occurred towards a city wide distribution programme in May 1998. The interest demonstrated in the resource at this stage led to the exploration of a wider marketing

strategy. Having developed the Accident Notebook, collaborative activity then concentrated on the implementation training programme. The Sparkbrook Locality invited 100 participants, allowing for 80 places for – Health Visitors, School Nurses, General Practice Nurses, Learning disabilities Nurses and Linkworkers within the Southern Birmingham Area. This gave the benefit of providing a local focus to the programme. There were 20 places allocated for – Paediatric Nurses, Liaison Health Visitors, Pre-school Workers, Education and Social services staff, which gave the benefit of providing a consistent approach in key workers. The programme duration spanned from the planning phase in June 1997 through to the operational phase between September and December 1997. The Format required each participant to attend two sessions of one and a half hours, the first at the commencement of the project and the second at the conclusion, involving multi-disciplinary group work and questionnaire completion. The Accident Notebook was distributed to participants at the first session and the criteria set for practitioner's use was that they were in regular contact with parents and carers of young children, they were motivated by and trained to help prevent accidents and that they were aware of the needs, sensitivities and expectations of parents and carers.

### ***Project Outcomes***

- 2000 copies of the Accident Notebook have been produced.
- Awareness of Accident Risk has been raised in local practitioners.
- Multi-Agency co-operation and Collaboration was achieved and continues.
- An Evaluation Report has been produced and findings to be include in a published article.
- A Dissemination programme is planned following the City wide launch of the Accident Notebook during National Child Safety Week in June 1998.
- National interest has been expressed in the Product.
- The Collaborative Partners are now exploring the development of a Parent's Companion Notebook, demonstrating safe practice.

A significant part of the project strategy focused on the implementation of a monitoring, evaluation and review process, this process should be constant to ensure that Accident Prevention in Birmingham proves innovative but also continues with tried and trusted intervention programmes. The key issues identified throughout the progression of the project were that there was legitimacy of purpose, the selection of the collaborative partners was appropriate, an identified source of funding existed and the need for consistency in approach should be recognised. In relation to the practical aspects of project

outcomes the following factors were raised; a credible consultation process should be undertaken, evaluation was an essential part of the process, outcomes needed to be measurable, realistic timescales would apply at all stages of the project, dissemination of information should occur and that development potential should exist for future projects.

Within the context of the World Health Organisation's Health for All 2000 declaration, the development of the Accident Notebook can be seen to demonstrate adherence to the major principles;

- The importance of addressing inequality in health status and access to services;
- Active participation in the community;
- The active collaboration between sectors and agencies working in the community.

This might then be viewed as reinforcing the validity of the project whilst reflecting the principles embodied in the Health Promoting Hospitals and trusts initiative.

*Esther-Mary D'Arcy*

## ***The Health Promoting Hospital and Continence Promotion***

The paper aims to show some aspects of a recent evaluation of the quality of life impact on the physiotherapy treatment of female urinary incontinence. It also makes recommendations as to how a health promoting hospital can have a role in helping to shift the emphasis from incontinence to continence.

Continence – described by Mantle (1994), as a human faculty of inestimable value to the individual – needs to be targeted if the incidence of incontinence is to be reduced. Irish figures show that one in four women and one in ten men suffer from incontinence and that only about ten per cent of people seek help. This under-reporting is, in itself, a health promotion issue.

The cost of incontinence is huge, both in terms of its impact on the suffers and the expense to the health service. Figures suggest that ten billion dollars per annum are spent on incontinence treatment in the US alone. Physiotherapy intervention has been shown to decrease the costs by 40 %. The study showed that physiotherapy is an effective treatment. It is cheaper and relatively risk-free alternative to surgery. The author recommends it as a first line approach to treatment. Looking at urinary symptoms in isolation is inadequate – both for assessing the impact on the suffer and for evaluating treatment outcomes. The paper considers quality of life as a more comprehensive way of assessing and evaluating.

There may be no other condition, which has so great an impact on the psychosocial life of a healthy person – as incontinence. The literature supports the authors findings of the length of time women wait before seeking help (up to 31 years) and the adjustment women make to their lives to accommodate their incontinence. Choice and the colour of clothes, diet, drinking habits, locating toilets in strange places are all cited. 97 % claimed it interfered with their life.

The brief of Health Promoting Hospitals is to influence patients, staff and the wider community. The challenge for those involved is five-fold: to promote continence, to identify and target those at risk, to increase awareness that treatment is available, to encourage people to come forward for treatment and to provide holistic effective treatment. A Health Promoting Hospital has a wide sphere of influence and a continence programme can reach school children, sports clubs, dancing schools. Information can be given at health

centres, occupational health departments, out-patient clinics, staff information centres and staff changing rooms.

In the wider context, the aim is to increase awareness at national and international level: to achieve Continence across Continents.

Mantle (1994), Focus on Continence. In: *Physiotherapy* 80:3, 126-131

*Catherine Bellew*

## *The Cardiac Link Project*

James Connolly Memorial (J.C.M.) hospital is situated in the North West of Dublin, Ireland. The hospital has a bed catchment of 150,000 people, with a bed compliment of 336 and a staff of 800. James Connolly Memorial has an active cardiology department with one Cardiologist and five Coronary Care beds and four telemetry beds.

With an increase in the number of survivors after a myocardial infarction much attention has turned to the quality of life experienced by individuals with this illness. It is generally agreed that the goal of Cardiac Rehabilitation programmes are to restore these patients to an optimistically productive and active life, and counsel and support their families in making lifestyle changes that may reduce the reduction of recurrence.

The hospital has close links with the nearby Mater hospital which has a large cardiology centre. Since 1993 our patients in J.C.M. have attended the Mater hospital for the cardiac rehabilitation programme.

The Cardiac Link Programme came about because a gap was identified in services for patients between discharge from acute and general cardiac rehabilitation programme in the Mater hospital. There was a general feeling by all that patients and their families lacked support and information services at a most critical time in their lives. I was released from my post as Staff Nurse in the Coronary Care Unit for 20 hours a week to set up a Cardiac Link programme. Hence my goal was to establish and evaluate this programme in J.C.M. Research evaluating such a programme in Ireland had not been reported previously.

In order to achieve this the following objectives had to be met. The cardiac rehabilitation nurse would act as a link between the patient and family from the time the patient was admitted. This was necessary to ensure that the patient and their family had the knowledge they required about their condition and to ensure that they felt supported during this significant life crisis. Another important objective was to ensure that the patients were equipped to enable them to make positive lifestyle behavioural changes as necessary. The family were a very important part of this process, both to provide support for their relatives and their awareness of their own risk factors.

As soon as possible after admission an assessment was made of the patients

risk factors, health beliefs and perceptions regarding the cause of their myocardial infarction. An individual programme was planned in conjunction with the patient, taking into account their beliefs and correcting misconceptions where necessary, e.g. if a patient was a smoker and felt that this had nothing to do with their heart attack, this needed to be clarified with the patient.

On discharge the Rehabilitation Nurse acted as a link for the patient and family ensuring continued advice, support and information. Contact was made by telephone to each patient in the experimental group at 1, 3, 9 weeks post discharge, this provided an opportunity to reinforce teaching already done and supplement areas not covered. Contact was also made at outpatient clinics.

All patients admitted during the study period were randomised into an experimental or a control group. Patients in the experimental group were seen by the Cardiac Rehabilitation Nurse and followed up after discharge. Patients in the control group were given the usual care. Medical and nursing personnel were not informed as to the distribution of cases and controls.

As stated previously an assessment was made as soon as possible after admission regarding their attitude and understanding to both the experimental and control group. A questionnaire was given 6-8 weeks and three months following discharge measuring: behavioural change, knowledge and satisfaction of service.

During the study period 34 patients admitted with a myocardial infarction were eligible for inclusion in the study. The inclusion criteria were that subjects had to be stable within the first week, orientated in time and place and available for follow up. The sample size was small due to time constraints. Other limitations included the varying roles of the Cardiac Rehabilitation Nurse which may have contaminated the study.

Patients in the experimental group appeared to have more knowledge about their condition than those in the control group. This is demonstrated by the fact that only 9 % of the control group were able to relate a damaged heart muscle to their condition compared to 50 % of the experimental group. As regards behavioural change, there was a sharp contrast in the groups in relation to making changes in their diet. Within the experimental group, 83.3 % of the subjects had made changes whereas in the control group only 27.3 % made changes. In addition, only 27.3 % of the control group were taking the required amount of exercise for their stage of recovery compared to 91 % of the experimental group. The majority of the subjects (92 %) of the experimental group felt they could contact the hospital if they required more information or support and indeed many of them contacted the Cardiac Rehabilitation

Nurse. This compares with only 28 % of the control group who felt that they could contact the hospital.

The project findings suggest that the Cardiac Rehabilitation Link Programme was effective in providing patient and family with the knowledge they require about their condition, convalescence activities and medication. In addition, the participants indicated that they felt more supported during this significant life crisis and were better equipped to make positive behavioural changes. The programme was developed with minimal resources and is now an integral part of our service with further on-going development. As a result of this project, a full-time Cardiac Rehabilitation post was sanctioned in the hospital.

Although more detailed research is necessary with larger groups, implementing this link programme is achievable and could easily be transferred to other hospitals, even in areas of financial constraint. In addition, this model could be adapted and used in other health care service settings.

*Catrin Gekle*

## ***The Integrated Concept of Oncology Care at the Kliniken Essen-Mitte***

One key health promoting project at our hospital is the establishment and development of an oncology department which focuses on a comprehensive understanding of the patient and his disease. This is a presentation about the experiences the hospital made on the implementation part. The project introduced a model of communication and co-operation of medical, nursing and psycho-social counselling staff that focuses on the patient. Communication and co-operation among different groups of staff should be a natural fact but, any one who has worked within a hospital knows, that theory and practise are often two sides and that the gaps between doctors, nurses and administration staff are a daily challenge to overcome. Furthermore the project involves the establishment of a day-clinic to reduce in-patient care to a minimum, to maximize quality of life for the patient and to lower costs. This was an important fact for the health insurances who support the project strongly but also want their interests to be taken in consideration. A further step was towards building a network and documentation system between in-patient and out-patient care. Oncology care is a very overlapping field as all sorts of physicians and hospital departments treat cancer patients; networking and close co-operation inside and outside the hospital is therefore a major task. Furthermore cancer patients move rapidly between the hospital and out-patient care and only a sophisticated documentation system makes it possible to treat the patient effectively and at a constant quality level. Moreover, the aspiration was the establishment of a comprehensive patient care programme. Apart from medical care, cancer patients often need comprehensive help and counselling to cope with their situation. To offer such help to the patient is not only health-promoting but indispensable for an integrative approach to the disease. An overview of our activities and what we learned as we went along is to give an insight not only into the bright sides but also on the problems we encountered.

### ***Activities and time schedule***

- Jan./Feb. 1996 choice of medical and nursing head of department
- 10/96 opening of the new ward
- 10/96 installation of a project-team with members of the medical, nursing, counselling and administrative staff and the top management
- 10/96-04/97 building works for the day-clinic
- 03/97 hiring of a special psycho-social counsellor
- 04/97 opening of the day-clinic
- 05/97 co-operation with an outpatient care provider
- 05/97 co-founding member of the oncological alliance of Essen
- 06/97 first steps to building a network and documentation system between in-patient and out-patient care
- since 06/97 establishing a comprehensive patient care programme
- 09/97 public information day at the ward & day clinic
- 03/98 establishing a quality circle.

***The concept has three pillars, which are described in the following:***

#### ***Medical Concept. The focal points are:***

- palliative tumour therapy
- tumour therapy with curative treatment intention (multimodal treatment)
- further development and improvement of existing therapy possibilities (new drugs, new perioperative strategies).

A further step was to define therapy standards and to build up an internal and external co-operation with other departments, hospitals and practicing physicians. The fact that basically everybody treats cancer patients has a major impact on the quality of oncology care. In consequence therapy standards and their implementation are an urgent need and of high importance for the best possible treatment.

#### ***Nursing concept. The focal points are:***

- maintenance of life processes and life quality
- helping to understand cancer and how to deal with it
- individualized care
- treating the patient as co-producer of health
- learning to live with limits
- care counselling.

These focal points mean flexible admissions and discharges, external activities

during hospital stay, buffets for breakfast and dinner, portable CD-players, creation of a personal environment etc. In addition to the pre-defined therapy standards on the medical side, the nursing concept involves the definition of nursing standards to guarantee and control a quality standard and to overcome staff changes smoothly. Furthermore the concept involves close co-operation with the out-patient care provider. Out-patient care has to begin where in-patient care stops and proceed accordingly (documentation).

***Counselling concept:***

- psycho-social diagnosis
- help with psychological and social strains (crisis intervention)
- support in conflict situations (family, partner)
- help in selecting rehabilitation offers
- practical help (e.g. administration)
- contacts and information about cancer groups
- legal information
- organization of cultural and educational events.

***What we learned ...***

- The oncology cases are spread over all departments. That means, the co-operation is to be established in a very sensitive way. Leading staff plays a vital role in the culture of the department. The project needed an understanding of co-operative leadership.
- The project-team was at first largely concerned with organizational issues. Limits of the existing building were set, but nevertheless a more cosy atmosphere was created through decorative elements (artificial flowers, pictures, lounge, TV/VCR set). Also requirements for good working conditions had to be set (special drug room, central work station/ward secretary).
- It was important to install the work group foundation right at the beginning. It was the right decision that important staff members of all areas involved were part of it. The involvement of top management was important because in the beginning a lot of general questions, problems and financial aspects had to be dealt with. Also the support of the top management became an obvious reality.
- Unforeseen circumstances can have a major impact. In our case, the head of nursing became ill which – at first – had a substantial influence on the progress of the project.
- The health promotion and psychological counselling for staff is vital.

- The day clinic was a good opportunity to create a non-hospital atmosphere because the building part underwent complete reconstruction and consists now of two spacious bright rooms with special furniture for chemotherapy, three separate rooms that also have beds, examination rooms and offices.
- IT-technology is indispensable for networks and not yet available as needed.
- Counselling for oncology could not be done besides existing counselling services by the same personnel. Time and special psycho-social abilities were needed.
- Out-patient care is a market that has in Germany rapidly grown within the last two years, especially in the private sector and the quality varies enormously. Therefore we chose a competent partner who co-operates closely (common documentation system, patients get to know the people who will take care of them during hospital stay, participation on ward rounds).
- The alliance of hospitals, physicians and health insurance is – to my knowledge – unique in Germany.
- The necessity of definition of therapy standards and establishment of a network for patients.
- Partnership instead of competition.

Today we are able to offer not only high quality medicine and nursing but comprehensive oncology care that focuses on the needs of our patients.

Nevertheless, after two years there is still a lot to improve and it needs highly motivated members of staff, close co-operation and a lot of energy and endurance to deal with the setbacks of everyday life at a hospital and to achieve the difference that makes a health promoting environment.

*Brigitte Hüllemann*

## ***Comprehensive Rehabilitation of Cancer Patients. Pilot Project: Project-Reorientated Hospital Service***

Many cancer patients have problems with their reintegration into society (working place, family, etc.), they have problems coping with the physical and psychological burden of cancer. The hospital's challenge is to assist cancer patients to reintegrate themselves into society and to do this as early as possible. The project has reorientated the routine services for patients with malignant tumours as well as for patients who are also seriously ill (physical illness, psychosomatic disorder). The spiritual dimension of disease is in no other field of pathology so evident as in oncology – the sense of life, the sense of death? It is a real challenge for all (!) staff members not to flee but to remain or to stay beside the patients even when no answer, no words are possible, just to stay and be an empathic partner. The cancer project turned us all more self-reflexive and serious and gives us not only more satisfaction in our job but also the chance for more satisfaction in our own lives.

As a pilot project we started weekly informal meetings with a group of cancer patients. We learned the needs, the problems and worries patients have with that life threatening disease. Cancer patients want (main topics):

1. Information about aetiology, prevention, therapy (included side-effects), and specially about nutrition, physical activity;
2. Psycho-social support, e.g. coping, family counselling, mutual aid groups;
3. Skills, e.g. physical activity to mobilise the frozen shoulder (after female's breast operation), muscle training against incontinence, self-examination.

By gathering these basic datas the following activities were structured:

### ***Methods***

Weekly:	Cancer-orientated information groups with different topics
	Coping-groups
	Breast-self-examination groups
	Graded physical exercise groups (daily)
	Relaxation-techniques groups
	Video clips with discussion.
On request:	Personal counselling (psychotherapy, hormono-therapy, sex-education)

Personal social counselling  
 Personal dietetic counselling  
 Personal physical exercise counselling  
 Personal counselling and supplying with protheses.  
 Three days a week 30 min. training and information for the medical staff:  
 Medical treatment, side-effects  
 Physio-therapy, dietetics  
 Psychological treatment, tending wounds, stomata, ports.

### ***Evaluation***

Special questionnaires: Patients questionnaire, increase in knowledge?  
 Staff questionnaire, most important issues?  
 Participant of the European study »Caring about Women and Cancer« patients-questionnaire, status quo of the present general treatment in Europe?  
 TQM:  
 KTL (catalogue of therapeutic services)  
 Overall quality screening (3-monthly, 3 % of the patients were screened)  
 Quality of environment (building and equipment)  
 General medical treatment (senior-, junior physician)  
 Psychological treatment  
 Nursing  
 Diet  
 Physical treatment  
 Over-all success.

### ***Results***

For the patients: Increasing knowledge of the disease, compliance self-examination;  
 Improvement of the patients' satisfaction, self-confidence, self-protection, self-responsibility;  
 Improvement of health orientated coping skills for the »body« (nutrition, physical activity, preventing of lymphatic oedema, relaxation techniques);  
 Improvement of health orientated coping skills for the »soul« (better understanding of the body's pain and spiritual needs, better understanding and acceptance of family-members' fears, anxieties and incapacities of

	impotence feelings, better coping with every-day-life needs at home and at the work, social reintegration).
For the staff:	Improvement of staff members' technical abilities, their special knowledge; Improvement of staff members' self-confidence, self-protection, self-responsibility, readiness and willingness to help; More job satisfaction; Improvement of corporate identity.
For the hospital:	Widened range of hospital services (enriched diet, special callisthenics, lymph-therapy, cancer orientated information and coping groups, video clips, exhibitions, breast self-examination lessons, supplying with protheses).

The pilot project reorientated the hospital services. It led to an increase in cancer patients' well-being, in their earlier reintegration into family and society. It also had favourable effects for the cardiac- and other patients of the hospital (increase in inter-individual understanding and support, promoting communication and relationship, more thankfulness and regardfulness for the body's needs). The atmosphere in our hospital grew to an atmosphere of humanity, hope and joy. The staff members got more job-satisfaction and acknowledgement, the hospital a growing number of patients, more economical security and acknowledgement by insurance companies.

*László Kautzky, Ilona Kondrát, Tamás Halmos*

## ***Patient Education and Chronic Diseases***

Acute disease management differs greatly from that of chronic illnesses. Chronic diseases are usually lifelong lasting states, which means, that they need a special approach. The traditional patient-doctor (nurse) relationship had to be changed radically, in order to achieve much better results in the treating process. In the past, the patient had no detailed information about his/her disease, and the contact between doctor and patient was rather hierarchical.

A few decades ago a new concept has emerged, which started to regard the **patient as partner** in this relationship. Many data proved the efficacy of this new concept.

In our hospital at present there are four chronic illnesses, where permanent education for the involved patients is a current project.

1. Diabetes and the Metabolic Syndrome
2. Asthma bronchiolite and chronic bronchitis
3. Chronic alcoholism, with different somatic complications
4. Hypertension.

In our present paper we introduce the results of our permanent efforts to improve diabetes care. It is well known that prevalence of this disease is – by estimation – 5 % in Europe. There are data from the USA, that above the age of 65, this number can be doubled! Apart from the diagnosed diabetics, a large number of individuals are candidates for the disease, they have a strong tendency towards having early diabetes (Impaired Glucose Tolerance = IGT). It is also generally accepted that abdominal (visceral) obesity, hypertension, dyslipidemia insulin-resistance and hyperinsulinism are components not only of Type 2 diabetes, but also of the Metabolic Syndrome, which often predicts non-insulin-dependent diabetes.

**Diabetes Mellitus** was the very first chronic disease, where the importance of intensive patient education was realised and accepted as an equal therapeutic tool in achieving continuously good results in the treatment. We introduced three different teaching forms, namely: 1. individual teaching, 2. small groups, 3. club activities.

Since club activities started almost 20 years ago, we will try to summarise our experiences gained from this teaching form. The design of our club-activities has been from the beginning as follows:

Two short presentations on various diabetes-related topics, specific complications, different therapeutic regimes, other diseases which frequently accompany diabetes like hypertension, lipid disorders, arterial occlusive diseases, etc. We also focus on different forms of prevention, including healthy life-style, healthy nutrition, etc.

After the two short medical presentations, our chief dietician gives a dietetic lecture, which is directly linked to the medical presentations (e. g. to diabetic nephropathy, the special diet for these diabetics is presented!).

Following the three presentations many questions are raised related to the topics by the audience. In the answers we usually try to give a broader overview on the problem asked.

Finally there are samples of healthy food available for tasting. This is generally sponsored by different pharmaceutical companies, which in reverse have the right to introduce some of their products in five minutes. They also have the right to exhibit their products on a table in front of the lecture hall.

Before the club activity starts there is about one hour time for checking blood sugar, sometimes for blood cholesterol, measuring blood pressure. In the hall there is the possibility to purchase healthy nutrients as well, for a reasonable price.

Our aim was to evaluate the efficacy of club activities, by using special questionnaires to gain information about the level of knowledge. We evaluated two questionnaires: the first at the beginning of their participation at the club events, and the second one after an average of five years of regular participation.

We also checked objective parameters like blood sugar profiles, Haemoglobin A1C levels, blood pressure, urine tests, blood lipids, Body Mass Index (BMI) ophtalmoscopic results, neurological status, etc. both at the beginning and at the second check-up.

Evaluating our results we have found that mean blood sugar profiles were slightly reduced among those who regularly attended these meetings.

- Haemoglobin A1C levels were not significantly diminished, from an average of 9,1 % to 8,6 %.
- Body weight reduction was successful in 32 %, and 48 % lost more than 8 kg during the investigation period.
- Blood pressure could be lowered significantly by 25 Hgmm systolic, and 15 Hgmm diastolic pressure at an average.

Evaluating the questionnaires the results were somewhat depressing. The general knowledge level increased only by 15 % and remained at the starting level by the rest of the inquired patients. The questions included dietetic, therapeutic data and tried to collect detailed information about the complications and the possible ways to avoid them. The average age of those patients answering successfully was significantly younger (42,4 year). The average age of the rest of the audience was 67,3!

We compared these results with those obtained in individual and small teaching groups. We could positively state that both the objective (somatic) improvements and the questionnaire results were significantly better. Over 65 % of the small groups, and over 75 % of the individually educated patients presented a much higher knowledge level. As a matter of fact the average age of these patients was 37,5. This meant that they were partly Type 1 patient and partly belonged to the Metabolic Syndrome group.

When summarising the answers, the best replies were given in the dietetic topic, the worst about avoiding and managing diabetic complications and about accompanying diseases.

Conclusion: In spite of having less good results among participants of the club activities, we decided to continue these meetings. Our reasons were following:

1. These events became very popular, patients can exchange their different experiences, have the possibility to buy healthy food ingredients can address questions to the experts and because it has been held for twenty years always on Tuesdays, they are able to schedule these activities in their usual daily programmes.
2. The patients insist on continuing these programmes, when asked about them.
3. Not only diabetics take place in these events – there are always people from the community and this means that club activities also have a certain preventive, advertising function in early diagnosis of metabolic and cardiovascular diseases.
4. HPH hospital and its staff approaches the population of the community. Though this the model-role of the hospital becomes a ***practical reality!***

Individual and small group patient education forms are much more effective in treating diabetes and accompanying diseases, but club activities also have certain important functions. We are convinced that this educational form should be continued.

*Tim Swales, Jill Dunk*

## ***Development of Nursing Support for Patients with Multiple Sclerosis***

Working to empower vulnerable groups of people, such as those with Multiple Sclerosis needs little justification. In February 1996 a specialist nurse was appointed to the Neurosciences Directorate at the Royal Preston Hospital.

The appointment was initially as a direct result of the licensing of Beta-interferon for this group of people. However as a result of patients comments and clinical audit data, the role has evolved in an attempt to meet the needs which were identified.

The purpose of the specialist nurse's role is to:

- Extend the degree of support for patients and their carers.
- Monitor those patients on Beta-interferon and assist in studies regarding efficacy.
- Take a specialist service into the patients home, whilst being able to maintain close links with the directorate and all the facilities it has.
- Enable patients and their carers to take control over decisions affecting their health by providing accurate and up-to-date information.
- To improve communications between Primary and Secondary care settings, including voluntary service organisations.

This paper describes the development of the Multiple Sclerosis nursing service through the use of clinical audit evidence and how identified health needs are being met.

### ***Introduction***

The concept of the Neurological Nurse Advisor has been pioneered within our Directorate over the last five to six years. We now have a number of these specialist nurses, each concentrating on a particular disease process. The idea is to give patients, their families and carers added support over and above the normal neurology service. We try to offer support in the patient's home, in the outpatient clinics and over the telephone.

In December 1995 Beta-interferon 1b obtained its European Licence. Prior to this the Regional NHS Executive, local health purchasers and all specialist centres within the North West Region had carried out a lot of background

work. Cost and efficacy were the two main areas of concern and so a »minimum data set« was agreed. This included the creation of an MS register of patients. A policy of this nature ensured that a set assessment procedure was adhered to throughout the region and strict monitoring of patients was maintained.

To this end a specialist nurse was appointed at the Royal Preston Hospital to monitor those patients who met the clinical criteria and wished to go onto treatment. It was necessary to obtain as much valid information as possible. To help with this a networking group was set up with all the other MS nurses in the region. Involvement with a charitable organisation at a national level was also undertaken.

This service was completely new, and so it was necessary to develop a care package for patients in-order to ensure a high standard of care was given to them. Administrative procedures had to be devised to enable the service to run smoothly and efficiently. This included the use of computer based information systems using spreadsheets and database.

The initial role was very specific but, as I will discuss, this soon began to change when it became evident that patients had many other problems that needed addressing. I also dealt with a small group within a much larger one. Our next challenge is to provide a generalist service that deals with all of the MS groups. The needs of these groups can vary a great deal. Because the service has been self-perpetuating in its nature, it has recently been necessary to employ a second nurse advisor in order to continue to meet the needs of this patient group.

### ***Meeting the Needs of Patients***

Through comments from patients, their families and the feeling nationally it was evident that service provision for MS patients was and remains very sketchy throughout the country. This was emphasised by the Patients Associations, ***Report on Providers: Views of Multiple Sclerosis Service Provision in the UK in 1997-1998***.

A joint publication between the MS Society and the National Hospital for Neurology and Neurosurgery, ***Standards of Healthcare for People with MS*** (Sept, 97),<sup>1</sup> gives a suggestion on how patients can be helped by a service that is properly structured, resourced and dynamic in its approach.

The idea of taking a specialist service into the patients' home is a good one. It reduces the strain on resources within the hospital but allows close links

1 For further information, we shall gladly send you a copy of this publication.

with a specialist centre and all this can offer. The fact that patients have particular specialist nurses they can turn to, helps to relieve their anxieties, which in turn optimises any help which is offered.

Rubin (1992a) conducted an exploratory study of patients perception of involuntary hospitalisation. The major concerns identified about participants being in hospital were:

- Coping with intense feelings / anxieties;
- Lack of personal freedom and choice;
- Boredom;
- Unhelpful medication experiences;
- Feeling of being trapped.

For all the participants involved involuntary hospitalisation was an emotionally painful time and a demanding experience.

It is hoped that our service reduces such factors. The reduction of stress for this group of patients can in itself have a positive affect on their condition.

Throughout the development of the service we have encouraged patients to take responsibility for their own wellbeing. MS effects people in many ways with drastically varying degrees of severity. Therefore the level of support patients require also differs accordingly. Each patient has to be taken as an individual even if a number of patients may have similar symptoms.

Providing a service that gives improved efficiency and flexibility of patient care, e.g. more freedom and choice for patients, whilst improving quality of life has, been one of our main priorities.

We are striving for this in a number of ways:

- Ensuring patients have access to relevant and upto date information through the use of information booklets, Internet, liaison with doctors during clinic visits, etc.
- Seeing patients in their own home whenever possible.
- Not dictating care, but encouraging a ***Caring Environment*** by offering support and advice whenever it is needed.
- Counselling patients, especially when first diagnosed.
- Giving patients confidence to develop a realistic yet positive attitude towards their illness.
- Ensuring continuity of care from diagnosis onwards.

### ***Progression of the Service***

The present service operates within a ring-fenced budget. However professionalism and the need of patients has meant that we optimise what we can provide. It has been important to have a clearly defined action plan whenever we have decided to add to the service. We feel that it would be unethical to provide incomplete care, which would ultimately be to the detriment of patients.

In order to validate what we were telling the purchasers, a clinical audit of GPs and patients was completed to show the need within the community at a local level.<sup>2</sup> This also helped us to identify areas for development.

One area, which can be re-engineered, is the administration of IV steroids. Our proposal is to fast track many patients on a day case basis. At present patients are admitted for three days.

Perceived benefits are as follows:

- Improved efficiency and flexibility of patient care, e.g. more freedom and choice for patients.
- Targeting patients more effectively enabling potential optimisation of treatment.
- Readily available education, support and counselling from a specialist nursing team. This will identify problems and facilitate a strategic approach to nursing care, e.g. referrals to physiotherapist, occupational therapist, continence advisor and social services if required.
- To provide added support to patients and complement services available in the community.
- Promotion of long term cost effectiveness through the reduction of inpatient stays.
- Better utilisation of beds, e.g. reduction of neurosurgical waiting list.
- Reducing waiting list for treatment.

### ***Social benefits***

- Minimal interference with family life, e.g. Treatment will last for a maximum of two hours enabling the patient to return home as soon as possible.
- Patients who are able to continue to work will not need to take the same amount of time off. This will only be appropriate for a small number of patients, but is an important factor.

2 Please get in touch with us for further information regarding this Clinical Audit.

- Childcare may not be affected. A patient will be able to receive treatment when their child is at school or nursery.
- There will be less stress involved for the whole family. Patients will have the added advantage of not having to find or finance added childcare.
- Partners who would normally have to take time off work will be less disrupted.
- Patients will not have to arrange for someone to look after their home, pets etc., whilst they are in hospital.

### ***The Future***

In his executive summary of the recent White Paper, ***The New NHS*** (Jan. 98) Tony Blair calls for health care provision to be qualitative and efficient in its approach.

There is great scope for specialist services to have a profound impact on the care patients receive. We have to strive for a seamless partnership between the Primary and Secondary health settings in-order to achieve this. Through this approach we will be able to increase services to patients, which will, in turn, enhance health promotion.

Rubin, W. V., Taynor, J., Panzano, P., Snapp, M. B. (1992a), ***Community commitment predicting differential outcomes: Preliminary results from a multi year study***. Paper presented at the annual NASMHPD Research Institute, Baltimore.

*Franz Pfitzer*

## ***Diminish Prejudice against Psychosomatic Inpatients***

Starting point: Both staff members and patients have experienced discrimination.

Objectives:      1. to fight prejudice and unfair treatment  
                      2. to enable patients to take action against prejudice and discrimination.

Participants: The whole staff of the psychosomatic ward. The staff works as a specialised team of five physicians, one psychologist, three nurses, one social worker and four non-verbal therapists i.e. music, art, dance and body therapy. We treat 35 inpatients for a period of usually eight weeks, i.e. 200 patients a year.

Change of our work:    – we made more use of the therapeutic community  
                                 – we altered our practice of group therapy and intensified it  
                                 – we employed a part-time social worker  
                                 – we redefined the role of the nurses who are now active observers of a patient's social reality.

For the staff of the whole clinic – intensified information about psychosomatic disorders, combining theoretical skills and knowledge with clinical demonstrations.

For our patients:        – special training groups to improve self-esteem and social skills  
                                 – help in »utilising« the therapeutic community  
                                 – two mutual aid groups of former patients are established.

Networks: with social workers, other hospitals, counselling centres.

Results:                    – the whole treatment team has become more sensitive concerning prejudice and injustice  
                                 – patients feel much better understood and regard our help as effective  
                                 – hostile rejection of psychosomatic patients within the clinic has completely disappeared.

*Sarifa Kabir*

***Assessment, Evaluation and Prevention of  
Accidents in Children age 0-16  
Building Alliances in the Community***

The Health of the Nation Document 1992 set out a number of targets to improve health, one of the targets was the Prevention of Accidents. One of the recommendations that was made was for Accident and Emergency Dept. to provide statistics and other relevant information to their local Community.

This Project demonstrates how it has continued the Audit and Evaluation work on Accidents. After gathering the information, Community Professionals have been informed on the results so that targets for Accident Prevention can be set jointly.

The Northwest Network Linking Health Promotion with Accident and Emergency Services has enabled the Project to identify current practices taking place, it encouraged the sharing of good practice in Accident Prevention. The Network has set a new vision for more effective joint co-operative work between those health professionals working in Accident Prevention, and a stronger link with other community and business professionals.

The setting up of this Network has enabled joint publication and comparison of the evaluation results with local Accident and Emergency Departments. It has enabled joint campaigns to take place. This has allowed much more information to be shared from Acute Hospitals with the Community Professionals as well as the general public.

Nurse Practitioners and Nursery Nurses from General Practice, Clinics and Health Centres have been encouraged to join the Project as they see many minor injuries and are able to influence the public through education on Accident Prevention.

A First Aid Trainer in the Community has been encouraged as this will allow much more information on the First Aid management of Accidents in the Community. Areas where this has proved to be useful is through the Schools and Youth Centres, with particular emphasis on Baby sitting courses.

The project has encouraged Health Visitors to look at Accident Prevention in a more systemic way and with the results given from the Accident and Emergency Dept. has enabled them to set targets on Accident prevention and to look into setting up Educational Videos for parents.

As a result of the work that has been carried out at the Royal Preston Hospital, a better understanding of Accidents has been established. It has encouraged as many people as possible to have knowledge on First Aid. The General Community is much better informed on local accidents and have an understanding of the campaigns in reducing specific accidents.

The most effective way to prevent accidents is by changing the environment or a combination of environmental change, legislation's and education. Current activity must involve all professionals, parents, carers and children. With the greatest emphasis made on Healthy Alliances between Hospitals and the Community. Joint Partnerships with all Professionals and Organisations will have the biggest impact on Prevention of Accidents.

An important part of the government health strategy is for hospitals to take a leading role in improving the health of patients, their staff and the wider community. As well as looking after sick people Health Promoting Hospitals have an enormous potential for spreading health promotion messages throughout the community and provide a genuine health improving service. Promoting health requires an organisational change within a hospital setting whereby health promotion activities are linked into the daily routine of the hospital. The development of this organisational change must take place at all levels from managers to staff, patients, visitors and the community.

### ***So what has the Royal Preston Hospital been able to achieve that is different***

The Accident and Emergency Department has been able to Assess and Evaluate Accidents in Children age 0-16. It has been able to collect not only statistics but valuable information giving the causes and circumstances of specific accidents. After the collection of this information, campaigns and raising awareness of specific categories has enabled the reduction of accidents and has improved the management of accidents in the First Aid situation.

The Health of the Nation Document 1992 suggested that every effort should be made to reduce the number of accidents in children. It recommended Accident and Emergency Departments provide statistics and other relevant information to their local communities.

Annual attendance of children age 0-16 in the Accident and Emergency Department at the Royal Preston Hospital is 15,000.

### ***Aims of the Project***

- To collect and analyse data relating to accidents occurring within the age group 0-16.
- To use the data gathered within this study to provide an outcome evaluation of interventions aimed at reducing specific accidental injuries.
- To use the Accident and Emergency Department at the Royal Preston Hospital as a central point to gather information on accidents in the North West of England.
- To maintain and expand the links made to other agencies and continue to share information collected on accidents with a view to reduce the number of accidents and improve the management of accidents in the first aid situation.

### ***Objectives***

- To identify the type of accidents and their circumstances attending the Accident and Emergency Dept. at the Royal Preston Hospital.
- To compare the findings at the Royal Preston Hospital with other Accident and Emergency Departments in the North West.
- To work together with other agencies in reducing accidents.
- To re-evaluate accidents that have been followed with campaigns and to continue to increase the awareness of creating a safe environment.
- Continue further campaigns on specific accidents.

The project has now been underway for the past four years. Initially a sample workload was evaluated; this enabled the development of a specific picture of the accidents that were occurring. The commonest types of accidents attending were

- Head injuries = Burns and Scalds = Ingestion of harmful products
- Hand injuries = Sports injuries = Limb injuries and animal bites.

Most of the injuries were occurring in the home environment, a high percentage of them in the age group 0-4. Which indicates health promotion information should be emphasised to parents and the carers of children.

A study on head injuries in 1997 showed that 20 % of all children that attended the Accident and Emergency Department at the Royal Preston Hospital had a head injury. Three times as many males attended than females. 30 % of the head injuries occurred in the home and 30 % of the head injuries occurred in the school environment. The most frequent mechanism of injury

were collision injuries. Some of the other injuries were caused by falling off the settee or chair and fighting. The most frequent injured area of the head was the forehead.

- 30 % had a laceration
- 2 % had a fracture
- 52 % had bruising/soft tissue injury
- 2 % required sutures
- 22 % required dressing or steristrips.

The most frequent treatment given was advice only on Head Injuries. 85 % of the children were discharged home. The head injury study did emphasize there was a need to encourage children to wear head protection helmets when riding their bicycles, roller blades and skateboards.

One of the most significant changes we have been able to achieve is the reduction in the incidents attending with ingestion of harmful products.

In 1995 when we carried out the first evaluation the incidents attending were 7-8 %. This was followed by a campaign to raise the awareness on storing all medications and harmful products in a safe place. The re-evaluation figures for 1996 brought the figures down to less than 3 %. This was very encouraging as it showed that when you raise the awareness of certain incidents the community is seen to respond. The evaluation figures for 1997 were also very encouraging. The incident of children taking a harmful product was less than 1 %. 1/3 of the total number had taken medications and 2/3 had taken household products.

This indicates the community is locking medications but still need to understand that there are many products in the home which can still be harmful to children. Some of the products taken were:

- Essential oils
- Bleach
- White spirit
- Nail varnish
- Household cleaning products.

It is important to continue informing the community to make sure that all medications are locked away and to be aware of the harmful products in the home.

One of the incidents we are most concerned about at the present time are the burns and scalds. The figures have remained stagnant for the past three years, we have not been able reduce the occurrence, but the management of the burns and scalds in the first aid situation has greatly improved. The public is bathing the injured site with cold water and applying a cold soak to the scalded area, we no longer get toothpaste, turmeric, sugar and ink applied to the scald site.

This indicates that some of the information on the campaign on burns and scalds is being taken on board but we have to look at ways of improving the awareness of the dangers of burns and scalds, and how and when they occur.

The most common age group still remains to be the 0-4 and the commonest place still remains to be in the home environment. Scalds to the hands seem to be the commonest site. Hot water, tea, and coffee seem to be the commonest cause of the scalds. Parents and the carers of children need to understand the dangers of hot water, tea, and coffee, and to make sure they are kept out of reach.

A hand injury evaluation in 1995 followed a campaign where posters and stickers were distributed in the local community, and in the schools. Trapped fingers appeared to be the highest category in finger injuries.

There has been a significant reduction in the number and severity of finger injuries attending. Car doors still seem to be the most common finger injury.

There are plans later in the year to work on a programme for baby sitters, this will involve some First Aid Training and an understanding of creating a safe environment in the home.

We have also set up a Data Base in the Dept. for evaluation of accidents for all age groups. The programme is near completion. The first assessment off the Data Base will be Burns and Scalds incidents.

As the project has developed from strength to strength it has enabled us to form the

- Health Promotion
- Links In
- Accident and Emergency Services
- North West Network.

In December 1997 a letter was sent to all the Accident and Emergency Departments and the Community Staff to identify 1-2 people in their department who were interested in Health Promotion. There was an overwhelming response to this invitation, 60 people attended the first conference. The purpose of the launch of the network was to begin to identify current practices taking place and how those present wished to progress health promotion in the future. It was recognised as an innovative event to encourage the sharing of good practice in Accident prevention.

The network has set a new vision for more effective joint co-operative work between those health professionals working in accident prevention, and a stronger link with other community and business professionals.

The work presented by the Accident and Emergency Department from the Royal Preston Hospital was very useful to everyone and it encouraged other Accident and Emergency Departments to look at ways in which they could

assess their accidents and share the information with their local community and with the North West Network.

All those that attended found it very encouraging to have support and ideas from professionals with the same interest in the North West Network. 20 people have been identified as the sub-committee who will meet on a regular basis during the year, they will decide on future conference arrangements.

Preston will hold the next North West Conference. Other Accident and Emergency Dept. will all then be encouraged to hold health promotion forums in their own area to present and share their work. Preston will still remain the headquarters for the North West Network.

It was suggested at the network that themes should be chosen for future forums. Following this suggestion Work Based Accidents have been chosen. An evaluation sheet will be sent to all the Accident and Emergency Departments for information to be collected for the first two weeks in September. The results will be sent to Preston for evaluation. Future plans of the network is to look at injuries to elderly burns and scalds sports injuries and head injuries.

As part of Child Safety week in June 1998, the Accident and Emergency Department at the Royal Preston Hospital is working with the Health Visitors, Community Nurses and School Nurses to emphasise issues on accident prevention. The title for this years campaign for child safety week is Safety First. It will emphasise issues such as First Aid, the first aid box, and head injuries. There will be a competition for children to enter to win a first aid box or a cycle helmet. They will write a story, a poem or paint a picture. The winning pictures will displayed in the Accident and Emergency Department.

The work evaluated from the Royal Preston Hospital has demonstrated that there is a need to continue to collect information on accidents and to share this information with the local community and extend the information further into the wider community around the United Kingdom.

It is important that parents and the carers of children understand the type of accidents that are occurring and how best they can deal with them in the first aid situation, and also how we can jointly prevent these accidents from occurring. It is important that parents and carers of children take responsibility of their environment, because with a little extra care and thought most of the accidents that attend Accident and Emergency Departments can be avoided.

Let's stop seeing these accidents. Think ... safety first.

*Jacqueline Cobb*

## *A Rare Combination*

Health Promotion is the key to a healthier future for our children. The quality of care given to the children and families in the city of Birmingham, England, would not be complete without the fulfilment of the responsibilities of collaborative partners in the delivery of health promotion advice and practice. Everyone has the right to information which can positively influence the health of the child and family. This poster presentation aimed to demonstrate the benefits to be gained through collaborative working, including improved access to resources, informed individuals and target audience, offering a highly visual representation of the evidence. The »**RARE**« relating to **R**esources, **A**ccess, **R**esearch and **E**ducation. How do we then deliver our health promotion message?

## *Accident Prevention*

Accidents are the largest single cause of death in children. Here we take our responsibilities very seriously, working together with colleagues from the City Council, Birmingham Children's Hospital NHS Trust, West Midlands Fire Service, Community Health workers, the Royal Society for the Prevention of Accidents (Rospa) and the Child Accident Prevention Trust to launch safety campaigns and develop resources and training events to inform both the general public and those working closely with children and families, of the latest safety advice and practical steps to be taken in keeping our children safe. The emphasis is on learning through joining in enjoyable events and activities with competitions, entertainers and visits by special guests to promote the road to safety.

## *Getting the Health Message Across*

Within Birmingham we are fortunate to have the support of the local media in widening the reach of our health promotion advice. The city's Children's Hospital often acts as a focal point for collaborative activity. Working closely

with Television, local radio and newspapers helps us provide information to meet the needs of our families at the right time. An example is through the delivery of an awareness campaign launched as part of a national Child Safety week event where Health Promotion and Accident and Emergency department staff were invited to speak on a live local radio show of the importance of sun safety at the beginning of the summer holidays.

A »Healthy Kids« Programme was developed to introduce local school-children to hospital familiarisation and Accident Prevention activities and involved hospital staff from the Accident & Emergency department, Trauma Unit, Outpatients Department and Play Departments. The programme ran successfully throughout the school year and has been further enhanced educationally by the linking of activities to the National Curriculum syllabus. Children who attended spent approximately one and a half hours within the hospital and in addition to the participative activities received a certificate, badge and Accident Prevention workbooks / leaflets. Many of the children produced colourful pictures depicting scenes from their visit which were forwarded to the hospital from the schools involved and have subsequently been used in exhibition displays. The centre piece of the poster presentation was the winning entry of a Walk Safely competition depicting the challenges of inner city life on children's safety through the eyes of a seven year old boy. The exhibition in addition highlighted the significance of developing systems to capture localised data collection on children's accidents through which to initiate programmes of intervention specific to the local needs assessment picture.

We will continue to strive to improve the health of our children and families, offering the best available advice whilst applying a strategic city wide, inter-agency approach to child Accident Prevention.

*Maria-Chiara Corti et al.<sup>1</sup>*

## ***Assessing Health and Physical Function of Older Persons to Identify Areas for Health Promoting Programmes: The PRO.V.A. Study***

### ***Introduction***

Physical disability is highly prevalent among older persons and represents a common and significant outcome of illness (Soldo 1985). In addition to being a serious consequence of disease processes, physical disability is an important predictor of further adverse outcomes including institutionalisation (Foley 1992), superimposed acute illnesses (Fried 1988), and mortality (Corti 1994). The consequences of physical disability, including personal, social and economic consequences, are important modifiers of the quality of life for individuals, families and the population at large (Institute of Medicine 1991). Research on the causal mechanisms underlying disability and on effective strategies to prevent disability has therefore been identified as a high priority in the field of geriatric research (Institute of Medicine 1991).

Although chronic diseases have been identified as the most frequent cause of disability in older persons, the pathway of the progression from disease to disability has not been adequately characterised. While first-generation epidemiological studies have found an increased risk of physical disability associated with self-reported chronic conditions (Guralnik 1993), the interrelationship of disease and disability and the complexity of this relationship has not been well defined.

### ***Rationale and theoretical framework***

A theoretical model, developed by Nagi (Nagi 1964) and adopted by the Institute of Medicine 1991, provides a conceptual framework to describe the

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pathway and postulates two intermediate steps in the transition from disease to disability:

Disease                      Impairment                      Functional Limitation                      Disability

Impairment refers to the physiologic function that is affected by the disease, while functional limitation characterises the effect of the severity of the impairment on the performance of determined activities. The operationalization of this concept has generated many ongoing second-generation epidemiological studies and, among them, the PRO.V.A. Study.

### ***The PRO.V.A. (PROgetto Veneto Anziani) Study goals and design***

The PRO.V.A. Study, a second-generation study has been designed to characterise the disease-disability relationship in a group of older Italian men and women. The PRO.V.A. Study has been initiated hypothesising that the causes and course of disability in men and women may be different and that the particular circumstances of an Italian population, may modify the trajectory of disability (e.g., socio-economic factors, family ties, health care delivery, and patterns of comorbidity). The study is an observational population-based Study designed to characterise the disease-disability relationship, to assess the health and the physical function of a representative sample of men and women age 65 years and older and to provide the Veneto Region with information to estimate future needs and for planning resource allocations. The Study has been promoted and funded by a grant from Fondazione Cassa di Risparmio di Padova e Rovigo in collaboration with the University of Padova and is supported by the Local Health Units (USSL) N. 15 and 18 of the Veneto Region. The study population consists of an age and sex-stratified random sample of 3,099 persons age 65 years and older, drawn from the local health units registries of two separate geographical areas around the towns of Camposampiero (Padova) and Rovigo. At baseline, participants will be interviewed at their homes and subsequently examined by nurses and physicians at the two study clinics.

### ***Study methodology and protocol***

The PRO.V.A. study has been designed to ascertain the presence of several chronic diseases and geriatric conditions from standardised questionnaires, physical examination, and medical records; to measure the severity of physiologic impairments with the use of biological, clinical and instrumental tests; to

evaluate the functional limitations utilising an extensive battery of physical performance tests and finally to estimate the degree of physical disability from self-reported information. A special focus of the Study has been in evaluating the synergism of cardiovascular and osteoarticular diseases in determining physical disability. Using the data collected, study physicians are trying to establish a causal link between disease and disability, to evaluate the impact that each condition has in affecting the physical function of each participant. The study data collection ended in April 1998 and preliminary results are available in a subset of 1,292 subjects from both centres.

### ***Preliminary results***

The study had a very good response rate to the interview (overall 86 %) and a good response rate to the interview plus visit (overall 68 %). Analyses were stratified by age strata (65-74, 75-84, 85 +) and by sex. Figure 1 shows the age and sex-specific prevalence of disability in Activities of Daily Living (ADLs).

<i>Age</i>	<i>Men</i>	<i>Women</i>
65-74	8.6	12.5
75-84	19.7	35
85 +	50	67.4

Figure 1 – Percent requiring personal assistance in ADLs by sex and age

Less than 3 % of the population was living in a nursing home, only 18 % of the participants lived alone and among those requiring help in ADLs, 93 % received personal assistance from a family member.

Cardiovascular disease, as ascertained by study physicians, were associated with ADL disability.

	<i>Non-disabled</i>	<i>Disabled</i>
Angina	4.2 %	7.2 %
Myocardial Infarction	2.6 %	6.4 %
Stroke	2.1 %	12.2 %
PAD	5.9 %	13.4 %
CHF	5.6 %	20.4 %

Figure 2 – Prevalence of cardiovascular diseases by ADL disability

The prevalence of conditions such as myocardial infarction, stroke, congestive

heart failure was three to five times higher among disabled participants as compared to non-disabled participants.

Osteoarticular conditions were also associated with ADL disability.

	<i>Non-disabled</i>	<i>Disabled</i>
Hip fracture	3.3 %	7.6 %
Hand OA	6.2 %	14.2 %
Hip OA	7.2 %	20.9 %
Knee OA	14.7 %	33.9 %

Figure 3 – Prevalence of osteoarticular conditions by ADL disability

In particular, hip fracture, hand osteoarthritis (OA), hip OA, and knee OA were more prevalent among participants with ADL disability.

Mobility disability such as stair climbing difficulties were also evaluated. Almost 35 % of men reported difficulty or inability to climb stairs. Among men with difficulty climbing stairs, 69 % reported foot pain, a symptom only reported by 30 % of those with no difficulty climbing stairs.

	<i>No difficulty</i>	<i>Diff. / doesn't climb</i>
Hip	44.1	56
Knee	43.8	56.2
Foot	30.7	69.3

Figure 4 – Percent reporting pain for  $\geq 1$  months during the past year, by difficulty climbing stairs: men

Among women, 52 % reported difficulty or inability climbing stairs. Hip pain was reported by 82 % of women with difficulty climbing stairs, while other 18 % of women with no difficulty climbing stairs reported hip pain.

	<i>No difficulty</i>	<i>Diff. / doesn't climb</i>
Hip	18.2	81.8
Knee	31.2	68.8
Foot	32	68

Figure 5 – Percent reporting pain for  $\geq 1$  months during the past year, by difficulty climbing stairs: women

With increasing age, men reported an increasing frequency of one or more falls during the previous year (16 %, 30 % and 40 % across the three age

groups) while this age-associated trend was not as evident in women (37 %, 39 %, and 44 %, respectively).

Among subjects treated for hypertension (26 %), only 70 % had blood pressure values within acceptable ranges (systolic less than 160 and diastolic less than 90), while 31 % of participants had systolic or diastolic hypertension.

### *Conclusions*

In Italy, the ageing of the population is an emerging public health priority for health care providers. In the year 2025, Italy is expected to have the highest world median age, with nearly half of the population over the age of 50. To avoid an unbearable burden of disease and disability on future generations, we must identify areas for intensive disability prevention programs. These preliminary results from the PRO.V.A. study have shown that disability is associated with conditions that are potentially preventable, such as chronic diseases and falls, or conditions that are treatable such as hypertension and chronic pain. Populations at high risk of incident disease and disability could be identified and targeted with primary and secondary prevention programs. Populations with prevalent disease and consequent disability could benefit from secondary and tertiary prevention programs. In conclusion, the PRO.V.A. study has the potential to provide an original contribution to clarify the mechanisms whereby diseases cause disability in older men and women, and it will offer unique opportunities for collaborative research and cross-cultural comparative analyses. If this approach will be appropriate we could succeed in improving our knowledge of the process whereby disease leads to disability and ultimately will improve our ability to prevent physical disability and its consequences, especially in terms of social, emotional and financial burden.

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*Mary Kelly*

## ***Developing a Patient Focused / Health Oriented Catering Service for Mothers***

The Maternity Unit in Letterkenny General Hospital, services the population of Donegal and has approximately 2,097 admissions and 1,526 live births annually with an average length of stay of four days.

The philosophy of the Unit is to provide a patient driven service, offering high standards of professional cover, equity in access, value for money and the commitment of a skilled and dedicated staff. The Unit also plays a vital educational role in the community, using its expertise to provide information on health promotion and health matters and to increase public awareness and knowledge on these subjects.

The above project reviews ward catering in the context of the needs of a Well Woman service and focuses on health promotion in relation to catering services in the maternity unit.

### ***Establishment of Project***

The establishment of the project must be seen within the framework of the overall health promotion project and within the total quality management initiative that is operating in the hospital. There are some additionally thirty quality projects running in the various wards and departments of the hospital.

### ***Purpose***

The purpose of the project was to review ward catering in the context of the needs of a well woman service and to focus on healthy eating and health promotion. It had a very simple beginning. A mother asked: Why do we have to have hospital or institutionalised catering facilities when essentially we are well women, with special and different needs from the rest of the hospital population?

### ***People Involved***

We put a team of people together, comprising of staff who are actually involved in the operational level of the service, with relevant midwifery staff, senior

catering people and health professionals We sought special advice from the maintenance, dietitian and finance personnel and, of course, most vitally, the mothers themselves and the quality co-ordinator.

### ***Pre Project Service***

The catering service provided to mothers before the project commenced, involved pre-plated meals delivered from the kitchen. This had several implications for mothers:

- Meals were required to be served immediately
- Timing of meals was similar throughout the hospital due to the nature of the production process.
- Mothers did not have any control over portion size
- If serving time did not suit the mother due to baby feeding or attending parenting classes or whatever, the ward waitresses were required to go to the main kitchen for another meal and this could be up to eight trips per meal-time.
- Because all meals were served at the same time, ward waitresses were not able to stay in the dining room with mothers during meal times. Hence, the atmosphere was very rushed and not very relaxing.
- There was no emphasis on healthy eating or health promotion and no dietary or service information was given.

### ***Pre Project Consumer Satisfaction Survey***

We carried out a survey of some 120 mothers and found that:

- only 40 % of mothers were satisfied with meal times.
- 22 % were always satisfied with choice of meals.
- 26 % were never satisfied.
- And in regard to portion sizes, over 50 % of the mothers had problems.

### ***Targets Set***

We set about setting straightforward measurable targets of 100 % satisfaction with meal times and portion sizes and that mothers should be able to choose their own meals, with the provision of healthy eating options. We also offered health promotional materials.

## ***Organisational Change and Development***

As you can imagine, there were major changes for many of those working in the Hospital.

***Multi-disciplinary team work***

Certainly, the establishment of the multi-disciplinary team concept worked extremely well. Once the group defined and agreed what the service should look like, there was the establishment of a common bond and trust.

***Changes from a pre-plated cook chill system to a bulk system***

There was significant change involved in moving from a pre-plated cook chill system to a bulk system. This required close attention being paid not only to the operational issues but also to financial and wastage problems.

***Greater choice of menu available***

More healthy options: The greater choice of menu and healthy eating options were much more straightforward.

Mealtimes more flexible: With mealtimes becoming more flexible, midwives and medical staff had to re-think their work patterns and adapt to the needs of the mother.

Re-design kitchen and dining room: There obviously had to be a re-design of the kitchen and the dining room areas. Institutional cutlery, cups and saucers were dispensed with in favour of those that mothers would be more likely to use at home.

Staff Training: Some staff training had to be undertaken in the use of equipment and customer services.

Change of staff duty rosters: To accommodate the changes, the catering staff had to alter their duty rosters. We were delighted at one of the meetings when the catering staff themselves produced a revised roster to accommodate the changes – particularly changes associated with flexible mealtimes.

***Menu cards***

Health promotional material: The menu cards and health promotional materials were supplied by relevant agencies.

Twenty four hour tea-coffee service provided: We set up a 24 hour tea and coffee service for mothers and partners.

Continuous evaluation: We carried out a further survey following the introduction of the service and this revealed dramatic improvement in patient satisfaction with the catering service. We achieved our target of 100 % satisfaction with meal times and moved to 90 % of satisfaction with size of portions. In the area of choice of menu, we are looking at it critically. Here we have only attained 75 % satisfaction rating. This is being actively looked at by the catering and maternity staff.

**Benefits to Mothers:**

- The flexibility and timing of meals allows for the protection, promotion and support of breastfeeding.
- The longer meal breaks facilitates mothers who are busy with their babies at traditional meal times.
- Meals are self service from a buffet style heating trolley, allowing mothers control over the size of portions.
- There are increased healthy options on the menu, which have been colour coded by calorie content. There is also a wide selection of fresh fruit.

An information section within the dining area is provided with health promotion and healthy eating information displayed. This is reinforced by the regular attendance of the health promotion nurse and other relevant professionals. An additional benefit was achieved for mothers with babies in the special care unit. The flexible meal times allow the mother to be positively involved with the care of her baby and to be present in the unit during medical ward rounds.

***Benefits to the Hospital***

Increased pride and motivation among staff: Most definitely, there was an increase in pride and motivation amongst staff with the introduction of the new quality service.

Multi-disciplinary team-work and project ownership: It clearly demonstrated that multi-disciplinary teamwork is an excellent way of getting things done and of achieving staff ownership of change.

Increased staff awareness of their customers needs: It clearly focused staff on who their customers are and their interactions with patients, relatives, other departments and services.

The concept of measuring satisfaction levels: The project introduced the concept of measuring satisfaction levels in the hospital. The project has dovetailed very nicely with other initiatives within the hospital. Examples of this being: the promotion of our breastfeeding policy, encouraging the avoidance of smoking before and during pregnancy and moving toward meeting the criteria of the European Baby Friendly Hospital Initiative.

Finally, the project by focusing clearly on clients needs and through the personal involvement and commitment by staff working in the multi-disciplinary groups, has clearly demonstrated marked improvements in the quality of care provided.

# Staff-centred Health Promoting in Hospitals

*Gregor Breucker*

## ***The Health Promoting Hospital and Workplace Health Promotion (WHP)***

In Europe, workplace health promotion is a relatively new approach and has made considerable progress over the past 10 years. The recent development was especially stimulated by European legislation which changed the framework conditions of health and safety in many Member States of the European Union. On this basis the European Commission supported the establishment of an European Network for Workplace Health Promotion (WHP). Members of the network are organizations from all 15 Member States and the countries of the European Economic Area (EEA countries). Recently the European Network adopted the Luxembourg Declaration on workplace health promotion in the European Union. The Declaration determines the agenda of the future activities and defines a common understanding of the concept and the priorities for action. WHP is a multidisciplinary endeavour to create working conditions conducive to health and thereby support healthy behaviour of all employees of an organization. By means of a two-year project the European Network will identify and disseminate models of good practice for WHP in Europe. For that reason a review of success factors for WHP was carried out and a quality framework was developed.

***Ladies and gentlemen, dear colleagues,***

First of all I would like to thank the organizers for inviting me to this conference. It is a pleasure to be here and speak to you about workplace health promotion (WHP). In my presentation I would like to address the following questions:

1. How has workplace health promotion been developed?
2. What is workplace health promotion and how can it effectively be implemented?
3. What is going on on an European level?

### ***1. How has workplace health promotion been developed?***

Workplace health promotion is a relatively new field within public health. Its origins date back to the late 60s and early 70s. At that time larger US corporations started to offer health education classes to their employees in order to control their health care costs.

Within the evolution of workplace health programmes we can identify several stages. In the beginning, single risk factor programmes were developed addressing either nutrition and healthy diet or smoking or exercise (Wilson, Holman and Hammock 1996).

In a second stage multi risk factor programmes were designed specifically addressing high risk target groups in a workforce. The underlying concepts were derived from behaviour change models whereas organizational health issues were constantly overlooked.

In the early 1980s, workplace health activities were characterized by the »wellness« programmes especially in western industrialised countries. »Wellness« programmes attempted to be more comprehensive in nature and included a variety of methods for delivering a wider range of interventions that targeted identified risk factors associated with employee health. Interventions included health screening, stress management courses, nutritional foodstuffs in canteens, exercise and back care programmes and health information seminars. However, the majority of wellness programmes still focused on individual behaviour modification without regard to the broader socio-economic, environmental and organisational influences on workers' health.

In the late 80s programme development began to consider organizational factors that could influence employee health. Comprehensiveness became one of the most used labels to describe these efforts.

A different tradition that would become very important for the European perspective on workplace health is closely linked with the quality of life and the work democracy movement. These activities all pursued the goal of designing a working culture which balanced business requirements with the needs of the workforce by ensuring a maximum level of worker participation. A common basis was the fundamental critique of the »Taylorism« which had become the predominant policy for work and job design in industrialised work.

This approach emphasized the role of organizational frame conditions for health and was strongly opposed to any individual-oriented approach which was classified as one of the »curing the symptoms« strategies. One of the re-

sults of this movement was an institutionalized set of rules and norms for health and safety at work.

There are a number of definitions available for the concept of workplace health promotion. They all differ in terms of conceptual broadness and make use of different conceptual models. They also differ with regard to the target audience they were made for.

The classic definition of health promotion given in the Ottawa-Charta (»... the process of enabling (individuals and communities) to increase control (over the determinants of health) and (thereby) improve their health ...«) is a rather complex approach and not easy to understand by the common stakeholders in the company setting (Statchenko and Jenicek 1990). For that reason several definitions tried to simplify the central message of the charter in order to ensure a maximum acceptance of the stakeholder audience.

One of these approaches was used by the European Network for Workplace Health Promotion. The Luxembourg Declaration for Workplace Health Promotion in the European Union starts with the following definition (European Network for Workplace Health Promotion 1997):

»WHP is the combined effort of employers, employees and society to improve the health and well-being of people at work.

This can be achieved through a combination of:

- improving the work organisation and the working environment
- promoting active participation
- encouraging personal development.«

## ***2. What is workplace health promotion and how can it effectively be implemented?***

On the basis of the available scientific knowledge and practical experience, the following factors can be identified for effective WHP activities:

- WHP is an ***interdisciplinary*** approach. It is a part of measures of different players in the company (occupational health and safety, human resources management, quality management, training etc.).
- WHP is based on the ***participation and co-operation*** of all players.
- WHP is ***comprehensive***: It combines ***activities*** which ***focus on the individual*** with ***activities*** which ***address*** the design of the working and organisational conditions. In addition, it links strategies to prevent stresses which are detrimental to health with approaches to expand health-promoting resources.

This concept of WHP is broad enough to include most of the current practised approaches in most European countries and can be applied to different

subsettings of workplaces. In addition it could be shown that this simple concept can be understood and accepted by the main stakeholders in the workplaces.

For example, in Germany almost 30 organisations in the private sector have formally adopted this approach as part of their overall company policy.

***At present WHP is used by different stakeholders for solving specific problems:***

- ***Strategies of health education at the workplace:***

This is still the most common approach in practice. The workplace is regarded as one of the most important settings to influence health-hazardous habits. Here, especially target groups such as male blue-collar workers can be reached in principle. Employers can be convinced much more easily to fund individual-oriented health activities than to accept organizational issues on a health agenda. But it is mainly the trend towards individualization in modern societies which has lend so much attraction to behaviour change approaches. And the foreseen changes with regard to new forms of work and work organisation gives even more support to this perspective. As the normal workplace (as part of a fixed organizational entity) is gradually disappearing due to the future options of IT applications (telework, virtual companies etc.) individual responsibility for health becomes more and more important.

- ***WHP as a part of extended and modern health and safety:***

Traditional health and safety mainly addressed occupational diseases and accidents in the past. Due to technological progress and the achievements of well-integrated health and safety processes in many larger organisations of industrialised countries the economic relevance of the targets of traditional health and safety is on the decrease. On the other hand, the consequences of work-related illnesses for important business targets are enormous. Back disorders for example, account for almost one third of all ill-health-related absenteeism or even more, in some cases. Work-related diseases have multiple causes which especially include factors related to the psycho-social work environment. Here, the methods and concepts of traditional health and safety are no longer sufficient.

These developments among others, led to the adoption of the framework directive on health and safety at work (European Union 1989). This European policy was transformed into national health and safety regulations and builds now a broad framework for activities to combat work-related illnesses. In this context, WHP is regarded as a new set of methods to reduce the burden of disease caused by the ›modern‹ determinants of health at an organizational level.

- ***Strategies to influence important health determinants at the workplace:***

From a public health perspective, any implementation of health promotion strategies in the context of workplaces should be based on the knowledge of critical health determinants. Here, in recent years, our understanding has significantly increased due to progress in a number of »neighbouring disciplines« such as social epidemiology, organisational and industrial psychology and sociology. There is strong empirical evidence that even within the context of an organisation whose members do not suffer from any social and economic deprivation, social gradients exist that affect the health and well-being of people along the continuum of occupational hierarchy (Marmot and Feeney 1996).

Furthermore, it has become evident that psycho-social characteristics of organisations significantly influence health and well-being as well as productivity and other inter-related variables. Job demands, the sense of control and the level of social support may explain the mechanism of the social gradients. WHP can assist in controlling the effects of organisational structures by influencing the level of social support, increasing individual coping capacities in cases where job demands can not be changed. Organisational approaches go beyond this concept and directly address the control structures and processes within organisations including job and work organisation design.

- ***Strategies to reduce absenteeism:***

In many industries and businesses absenteeism has become a major concern for employers, governments and employees' representatives. The current changes in the living and working conditions caused by fundamental social and economic processes lead to increased competition in the markets and an enormous pressure to reduce personnel costs. High absenteeism figures reduce the productivity potentials of companies and indicate a poor health management performance. Moreover, they often reveal organizational practices which are detrimental to health (poor management styles, insufficient communication and co-operation, a lack of employee and customer orientation). Many companies (for instance the entire automotive industry) have responded by introducing return-to work programmes as part of the human resource management. Sometimes these programmes implement a culture which is based on negative incentives to »punish« unwished behaviour (»deviated behaviour« in the language of traditional behaviour change models). Here, WHP is often implemented in order to ensure a long-term and sustainable development.

- ***Part of a strategy of organizational change:***

In almost regular cycles new management concepts are born which promise to enhance the performance and to increase the competitive edge. Apart from different forms of packing and marketing most of them stress the economic relevance of the human capital. The customer orientation requires a new thinking about the contribution of employees to economic success. WHP is seen as a further tool within human resource management to fulfil its new tasks. Compared to other change approaches, WHP does not impose a strong change requirement on an organisation. This reduces the entrance barrier on the one hand, but limits the scope of influence on the other hand.

***Current state of WHP***

On an European level an increasing interest in WHP can be recognized. Due to fundamental social and economic changes in the Member States of the European Union and the given top priority of competitive edge of European industry and the strong negative impact of long-term and structural unemployment on national and supra-national political agendas, the relevance of human capital and the processes for its management are increasing.

The level of implementation in practice varies remarkably. There is still a large group of organisations, mainly coming from the public sector and small and medium sized companies in the private sector, who have been targeted by WHP activities to a very small extent if at all. Small and medium sized companies are covered by health and safety provisions only to a limited extend. Due to strong economic constraints they are rarely willing to get involved in health activities which are mostly regarded as not necessary investments as regards economic performance.

Another group of mainly larger organisations from the private sector have started implementation or even have gathered experience with health activities which go beyond legal requirements. Often, these activities are behaviour-oriented and focus on individual lifestyles. In addition, they tend to be organized within single projects which often do not succeed in getting integrated into company practice after being finished. Only in a very few cases is top management involved and committed to ensure a continuous support. The general acceptance of these activities by employees and their representatives tends to be low, as they sometimes assume WHP activities to be an additional management strategy to solve conflicts of interests in a way which serves employers' interests more than those of their employees.

A relatively small group of companies has already made considerable progress in integrating health matters into their daily practice. Especially companies who went through a long-term change process in order to improve

business performance based on a holistic perspective have changed the role of health management. They normally place a great value on human resources and their management and are very interested in creating a working environment and a working culture which allows the workforce to develop all creative capacities possible. In these contexts, training and all other kinds of support systems get a very high priority. Managerial skills are part of all training levels and they especially include good communication skills.

Another example of these organisations comes from companies who have set up integrated management systems (either health and safety, environmental health and quality management systems). Health activities are managed on the basis of such integrated systems which always try to insure top management commitment and clear reporting routines.

Very often, WHP is not explicitly used to indicate a specific part of such an integrated system. Conceptually there tends to be a strong resemblance between WHP and such integrated approaches.

### ***3. What is going on on an European level?***

WHP is relatively new to Europe as a separate area of endeavour. In the late 1980s, issues addressed in the Ottawa Charter were taken up by institutions in the public health sector and some trade unions in various countries – mainly Great Britain, Scandinavia, the Netherlands and Germany. One visible expression of the commitment of the WHO Regional Office for Europe in Copenhagen was the 1991 establishment of a WHO Collaborating Centre (European Information Centre) at the Federal Association of Company Health Insurance Funds in Essen, Germany (Demmer 1995).

As early as in the 1970s a number of companies had shown great enthusiasm in starting up projects to humanize the world of work in some European countries, but later abandoned them because they did not coincide with company interests. For some time thereafter, the issue of occupational safety and health policy was relegated to the back burners of trade union activity.

In the late '80s the workplace returned to the fore, in terms of both occupational safety and health and health care policy. At the level of European occupational safety and health policy, this was due in large part to the EC Framework Directive on health and safety (Council Directive 89/391/EEC 1989). This gave rise to a widespread reorientation of occupational safety and health in the Member States. From the unions' point of view, these legal foundations together with various specific Directives (work on VDUs) represent the most fundamental reform of occupational safety and health law since the

foundation of the European Community. Along with the areas of prevention traditionally covered by occupational safety and health – accidents and occupational diseases – the extended commission is now to include the prevention of work-related illnesses. The existing technical and engineering-oriented conception of risks has been extended to encompass psycho-social factors as well. Furthermore, there are new provisions for extensive rights of information and co-determination for employees and their representatives.

It remains to be seen what practical changes these new legal provisions will make in the various national institutions responsible for occupational safety and health.

Between 1989 and 1997 the European Foundation conducted a number of research and development projects (European Foundation 1997a, Wynne and Clarkin 1992). Among them was a review of workplace health promotion activities in eight EU Member States, including a documentation of exemplary practices and the development of a training specification in workplace health promotion (European Foundation 1997b).

The European Commission's Directorate General DG V, which is responsible for public health programmes, set up a programme of Community action on health promotion, information, education and training based on the Community framework for action in the field of public health (Decision No 645/96/EC of the European Parliament and of the Council of 29 March 1996). This five-year health promotion programme is endowed with 35 million ECUs and supports international projects that provide added value in the field of public health.

### ***The European Network for WHP***

In 1996 an European Network for Workplace Health Promotion was established, in which all 15 Member States participate as well as the European Economic Area (EEA) countries. The Federal Institute for Occupational Safety and Health (BAuA) in Dortmund, Germany, in its capacity as the international liaison office, was entrusted with the task of setting up the network infrastructure (Federal Institute for Occupational Safety and Health 1996).

The principal objective of the network is to identify and disseminate good practice of WHP by exchanging experience and knowledge. In this way the Member States can be encouraged to place WHP high on their agenda and to incorporate workplace health issues in all respective policies.

In its first stage the network worked on the development of a common understanding of workplace health promotion. With the adoption of the

Luxembourg Declaration on Workplace Health Promotion in the European Union in November 1997, the network successfully established a framework policy for further action.

Within this policy document the following priorities were identified:

- to increase awareness of WHP and promote responsibility for health with regard to all stakeholders
- to identify and disseminate models of good practice
- to develop guidelines for effective WHP
- to ensure commitment of the Member States to incorporate principles of workplace health promotion in respective policies
- to address the specific challenges of working together with SMEs.

WHP is regarded as an organisational investment for the future success of organisations. In addition, WHP can significantly contribute to the social and economic well-being of the European Union which requires a healthy, motivated and well-qualified workforce.

Based on these principles and convictions the European Network has established a simple vision to guide future action: Healthy people in healthy organisations. This vision is directly linked with the network's mission: The European Network organizes and promotes good workplace health practice.

In order to implement this policy framework the Network partners have agreed to realize an Europe-wide project focusing on the identification and dissemination of good practice. To this end, quality criteria and respective methods have been developed. All partners have identified a number of models of good practice in their countries and documented them according to a set of criteria based on an European quality framework for WHP (Breucker 1997; Breucker/Anderson and Kuhn 1997).

In this way, an European collection of good workplace health practice will be established which can be used by experts and practitioners to implement WHP within organisations.

This two-year project will be concluded by the organisation of an European Conference which is to disseminate WHP to representatives of governments and social partners all over Europe.

In accordance with its priorities the European Network for WHP will also focus on the specific requirements of small and medium sized enterprises. For the biennium 1999-2000 the network organisations have decided to carry out another Europe-wide project which is being supported by the European Commission.

Small and medium sized organisations (SMEs) differ from larger organisations in many respects. This also includes the way in which health matters

are considered. For that reason, all stakeholders agree that SMEs require a unique approach to the maintenance and improvement of health. This was reflected in the Cardiff Memorandum established by the European Network as a platform for future action (Federal Institute for Occupational Safety and Health, Germany 1998).

Within the planned project the European Network will describe and compile the current practice of WHP in SMEs in the Member States. This will form the basis to identify and effectively disseminate good practice. In particular, the issue of marketing methods will be considered by means of the organising national stakeholder meetings in the Member States and other involved countries in Europe.

Ladies and gentlemen, I hope that my presentation was able to share with you the current priorities and issues of workplace health promotion activities. I think that the hospital setting is a challenge for WHP strategies and I am aware that much of your work has contributed to making hospitals healthier workplaces. Thank you very much for your attention.

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*Gordon Kirtley*

## ***Designing for the Healthy Organisation***

A healthy organisation is one whose members share a strong sense of identity – a clear self-image which gives individuals a sense of belonging to a team – a community working for a common purpose.

Buildings and architecture can play an important part in promoting that image by creating objects and places which give a focus for the organisation; places where people come together; objects which, in their beauty or cultural significance, become symbols of the life and identity of the community of people which makes the organisation. The church and state have always recognised the symbolic value of buildings – not only as places of assembly but as icons for a whole system of values – perhaps Christianity or Democracy – which are the foundation and guiding cause of the institution. More pragmatically, in commerce and industry, progressive companies understand the part that good design can play in attracting staff and encouraging high morale and commitment.

These concepts are equally important in the health sector – there is an important role for architecture and design in promoting healthy hospital organisations. This paper illustrates this argument by referring to two hospitals which Sheppard Robson designed for very different social and cultural settings.

The first, the Chelsea and Westminster Hospital is a 650 bed teaching hospital in central London – it was opened in 1993.

The second project is a 400 bed teaching hospital in Saudi Arabia, which we hope will start building next year. I chose this project because it presented such a challenge to us in developing our design philosophy in a society whose culture is so different and in some ways diametrically opposed to our European values.

### ***The Chelsea and Westminster Hospital***

The Chelsea and Westminster Hospital (see figure 1) is built on a busy street in a prosperous part of West London. It has a very tight urban site and one of our first decisions was to bring all of the available space into a large central atrium (figure 2) which is five storeys high and more than a hundred metres long. The



Figure 1: Chelsea and Westminster Hospital. Part of the west elevation

atrium helps people find their way around the hospital. It is full of activity; there is a snack bar, a flower shop, a pharmacy, live performance of music, comedy and mime – the staff restaurant is in the atrium and there is a large collection of art objects, many of which were specially made to exploit its scale and dramatic proportions (figure 3). Its presence is felt throughout the hospital and it has become an icon for its staff and patients extending even into the local community.

The following quotation is taken from an article in *The Sunday Times* which discussed the art programme in the hospital: »A walk through the hospital's vast, soaring atrium is a strangely wonderful experience – strange because this is meant to be a hospital and yet the place feels inviting and invigorating – many people come in just to have a coffee and enjoy the building.«



Figure 2: Chelsea and Westminster Hospital. The atrium

It is difficult to prove that good design is beneficial to health – even more difficult to show conclusively that a building can affect the health of an organisation. For what do we mean by the health of an organisation? How can we measure such a complex and intangible concept?



Figure 3: Chelsea and Westminster Hospital. Atrium with mobile

One very important sign is a sense of pride and ownership – a feeling that there is something special about your workplace – something which makes it different and gives you pleasure in saying »I work here – this is my hospital!«

The Chelsea and Westminster was built to replace several existing hospitals



Figure 4: King Saud University Hospital. The entrance plaza

in central London. Some, for example the Westminster Hospital, were long established institutions with a strong sense of their own tradition and identity. Moving to a new home was not popular with everyone and our client was determined to find a place in the new hospital for treasures which were valued for their place in the history of the redundant buildings. One of the finest examples is a work by Veronese which now occupies a focal place in the hospital chapel.

The Chelsea and Westminster makes no compromises as a modern hospital building – its whole conception marks a dramatic break with the tradition of hospital design in England. But functionality and architectural design do not exist in a vacuum. As clients and architects, we need to discover what is im-

portant to the people who make the community or organisation – what can we find that has real meaning in their culture?

### ***King Saud University Hospital, Abha***

In 1993, King Saud University commissioned us to design a new campus in the city of Abha in the south-west of the country. The University wanted a 400 bed hospital with separate medical colleges for men and women – gender separation is a central tenet of Islam as it is practised in Saudi Arabia and it was to become a key parameter in our design concept.

The Province of Asir is a unique part of the country – it is mountainous, relatively green and its high altitude gives it a pleasant, almost mediterranean climate. The local vernacular is quite distinctive – walls are protected from sun and rain by bands of stone which are set into the layers of mud as the building is constructed. The change of scale set a challenge, and in the elevations we used modern materials to develop a new interpretation of the local style (figure 4).

I referred earlier to the importance of gender separation – the hospital plan is dominated by two long, covered malls – one side of the hospital is mainly for women and the other for men. The central zone houses shared facilities such as X-ray, theatres and laboratories.

The malls (figure 5) are tall and narrow – in the tradition of an Arab souk – though again we used modern materials and the clinical functionality of the hospital will be right up to the best international standards.

In many ways, we were more pre-occupied with history and tradition than were the doctors who will run the hospital – perhaps our European perspective underestimated the extent to which technical modernity is valued in a society which we would see as socially conservative.

Designing this hospital was a real challenge – it forced us to revise our ideas about what was most significant and what had real value to our Saudi clients. We had to throw away many preconceptions – especially to recognise that, in modern day Islam, progressive design must recognise and celebrate the separation of men and women – because that is central to the Saudi's image of their society.

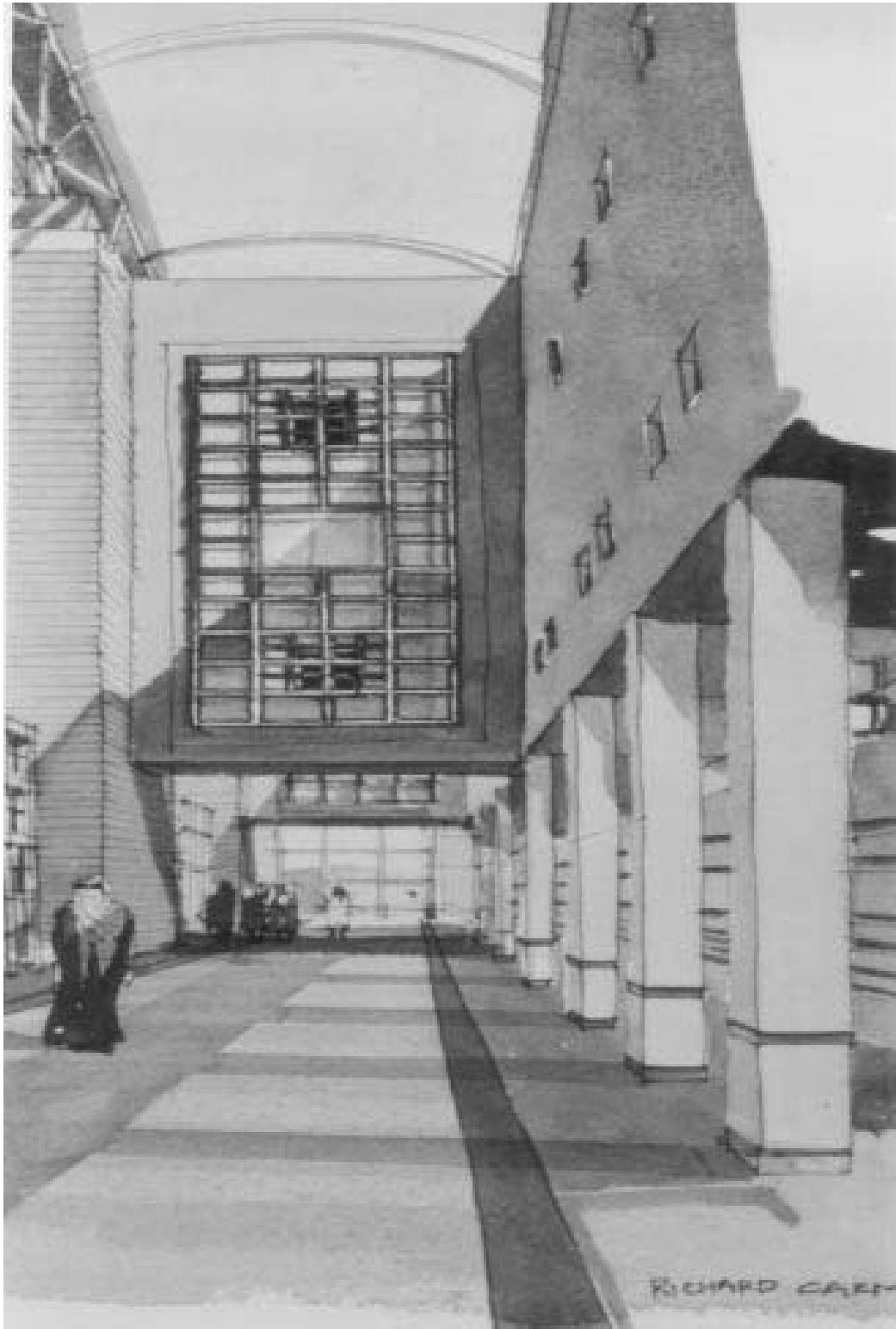


Figure 5: King Saud University Hospital. The mall

### ***Conclusion***

My argument is essentially anecdotal, but it is supported by a growing body of evidence that architectural design can make a real contribution to the self-image and the health of a hospital organisation.

Architecture can introduce an element of fantasy, something which fosters a feeling of pride and a sense of belonging – something to capture the nature and spirit of the hospital community.

*Elizabeth Anne Terry*

## ***Workplace Health Promotion: An Essential Ingredient for Health Promoting Hospitals***

In order to be advocates of good health, the hospital must be fundamentally a healthy workplace and hospital staff should enjoy a high quality of working life. If this is not the case, we cannot hope to achieve our vision as health promoters.

This paper presents one practical example of how a hospital which is working towards being a health promoting organisation is developing workplace health promotion. We hope to share some of the lessons learned along the way and our criteria for success.

Derbyshire is situated in the centre of the United Kingdom. Its population of 930,000 is mainly concentrated in several small industrial towns now characterised by high unemployment. These areas gained their past wealth principally through mining activities, general manufacturing, textile production and ceramics. The cathedral city of Derby, population 220,000 is still deservedly famous for its Crown Derby Pottery. As one of two acute hospital sites in this city serving the local population, the Derbyshire Royal Infirmary is a 581 bed inner city hospital with a £ 78 million annual turnover. It employs 3,234 staff.

By embodying the principles of Health Promoting Hospitals and the Ottawa Charter in our work and workplace logically we must carry this through to our workforce. Our own hospital mission statement declares that quality of care, quality of service and quality of work-life is the philosophy that underpins all that we do as a hospital community. But it is fundamental that we first apply those agreed principles locally to improve the quality of working life, health and well-being of our own staff, as our best resource. Once confident we are addressing their real health needs we can expand health promotion towards patients, visitors and the whole community. It is a duty to go beyond insulationist workplace health promotion. Our argument here is that workplace health promotion is the fundamental pre-requisite for advocacy for health.

Three years ago a working party, which later evolved and developed into the Quality of Work Life Steering Group, undertook a comprehensive participatory staff health needs assessment survey. It was a qualitative study drawn up on the agendas of staff themselves. We used focus groups, the messages

from them informed the written questionnaire and undertook further in-depth interviews. Triangulation of methodologies gave us a clearer insight into real and perceived health needs. The results and recommendations have provided the basis for a five-year action plan implemented by the Quality of Work Life Steering Group and co-opted project groups.

What have been the lessons learned along the way; the criteria for success? First, ask around. Someone, somewhere will have undertaken something like this before. Be humble; willing to learn. Do not reinvent the wheel and make sure you know what has already taken place. Secondly, gain commitment. One needs stated and practical commitment from the Chief Executive and Senior Management Team, from Staff Groups and Clinicians in order to conduct a comprehensive meaningful study. The Chair of our Steering Group (Deputy Director of Human Resources), had a direct reporting link into the Hospital Management Team so our Staff Health Needs Assessment Survey was kept high on their agenda. You need resources to follow that commitment too. Joint funding of the project helped to keep all parties interested and aid wider dissemination of the results and greater commitment to implement the recommendations. Think about time, that is, the timescale and time allocated to who is going to carry out this work. And when the going gets tough, someone has still got to be enthusiastic, so lay in some reserves of energy before you start. The third important consideration is communication. This is the type of project that can never be over communicated. It is best to use every channel available, both formal and informal, as frequently and opportunistically as possible. As Roger Plant (1987) says »Communicate and communicate like never before«. People need to know the intention of the project, what is happening, the results of the survey, what will happen next, whether it has all been worthwhile and what practical steps they are likely to benefit from themselves. Staff need to own the survey and its results, to appreciate the recommendations and be empowered to carry out the solutions. Never underestimate the importance of publicising and publishing your work. Whilst »communicate« meets an advocacy element as detailed in the Ottawa Charter, »involve and represent« addresses the »allowing people to be all that they can be by developing lifeskills and personal development« aspect. It was important to us to involve all professional groups and all echelons in the organisation, to affirm and value their experiences and contributions. By listening and giving permission to staff to form subgroups, many worthy projects were piloted and evolved. For example, the Policy on Physical and Psychological Health for Staff was developed, local rest and relaxation facilities were upgraded, a Social Committee formed to offer a wide range of events. Staff training on transition management took place and stress management options

available to staff have been better publicised. The Steering Group employed an independent consultant to devise, through focus groups and in consultation with the steering group, the questionnaire and then to conduct the survey. This gave an objective credibility to the results and recommendations which would have been more difficult to achieve in-house. »Involve and represent« also applied to our teambuilding activities. The Steering Group took time and space through an »awayday« off the hospital site to consider carefully how best to approach the implementation stage. Meetings were regular, well attended and well serviced in order to keep up the impetus. Where practicable, we valued continuity of staff group representation. Finally, provide refreshments. You may laugh! But this is about oiling the wheels, consideration and respect for all staff. We have found it a well appreciated small courtesy when people are giving of their time, expertise and most importantly their enthusiasm. It is a small cost but with a high return that goes a long way, just like a smile.

Some of the benefits our staff enjoy include the Rainbow Nursery with forty full time equivalent places for preschool aged children of staff. It is a product of our Family Friendly and Flexible Working Policies. We also run playschemes for older children during the school holidays. Our staff are entitled to a 5 % discount on over the counter medicines at our Pharmacy Shop. There is a larger discount on nicotine replacement products. There is a rapid film processing service and you can immediately purchase a pair of tights just when needed. We also have a hairdresser conveniently on site who can make you feel good and approach the rest of the day's work with confidence. Staff were asking for better rest and relaxation facilities. The Sensory Garden with its windchimes, fountain, cacti and aromatic plants provides a pleasant haven for staff to take a lunch break. There are garden benches and picnic tables in green areas and enclosed courtyards on the site. For those who wish to be re-energised at work, Squash Courts are available on site as are Fitness Classes, a Gym, Badminton Courts and a Hydrotherapy Pool. The Social Committee plans a comprehensive range of social activities for staff and their families. In addition to looking at the physical, social and emotional environment, we consider management style, communication, training opportunities and workload, all contribute to the quality of worklife for staff. Perhaps some initiatives are transferable to your own workplace.

Two years into our five year action plan we have recently assessed our achievements and carried out a process evaluation. We still have an agenda to pursue and other staff health needs have arisen during this period. The plan must be dynamic and responsive as well as being strategic. The time is ripe to

conduct a further survey employing these principles which have served us well.

In conclusion, we have shared this tale of workplace health promotion at the Derbyshire Royal Infirmary site, from May 1995 to 31 March 1998. Now we are part of a larger organisation and we look forward to pursuing workplace health promotion in the Southern Derbyshire Acute Hospitals NHS Trust. There are more staff to involve, geographically dispersed sites to cover and new working relationships to build. There are plenty of challenges ahead. At this Trust we do believe if we value our workforce, listen to their views, respond to their priorities, work in partnership and professional development, we hold in our hands the essential principles for expanding our vision to patients, visitors and the community so that we can become truly Health Promoting Hospitals.

Plant, R. (1987), *Managing Change and Making It Stick*. Glasgow

*Errol Walker*

## ***Workplace Health Programmes – Healthy Organisations, Healthy People!***

This paper briefly describes a research programme that was set up around workplace health programmes in the British National Health Service. It formed the basis of a paper given at the 6<sup>th</sup> International Conference on Health Promoting Hospitals. A longer version is available from the author.

### ***Research elements***

The health at work research study comprises a number of elements:

1. A baseline survey of health at work activity in (acute) hospital trusts (1994)<sup>1</sup>
2. A survey of health at work activity in community and ambulance trusts (1996)<sup>2</sup>
3. A survey of employees in 14 NHS trusts (1995)<sup>3</sup>
4. Assessment and monitoring of workplace health programme development and implementation in 12 NHS trusts<sup>4</sup>
5. Detailed evaluation of workplace health programme development in two NHS trusts<sup>5</sup>

### ***Surveys of health at work activity in trusts***

The first surveys (1 & 2 above) assessed the level and organisation of workplace health programmes. The two surveys showed the high level of workplace health activity. In 7 in 10 trusts workplace health was the remit of a committee or group. Human Resources departments were widely represented (97 %) on the committees, followed by occupational health (86 %), health promotion (78 %), and health and safety (77 %).

1 Seccombe & Patch (1995), Survey of hospital activity. London, HEA

2 Seccombe & Patch (1997), Survey of community and ambulance trusts. London, HEA

3 Bevan & Seccombe (1997), Working for your health: A survey of NHS Trust staff. HEA

4 HEA (1998), Fit to face the future: maintaining a healthy workforce in the NHS. HEA (1998), More than brown bread and aerobics: developing and sustaining workplace health

5 HEA (1999), Change and wellbeing: developing and sustaining workplace health in the NHS

The second survey also considered what factors influenced the development of workplace health. These included »compliance with health and safety legislation« (66 %); »reducing sickness absence« (54 %); »desire to follow good practice« and »reduce levels of stress« followed (52 % each). The factor considered most important by respondents was compliance with Health and Safety legislation, reported by 45 %.

Factors which held back workplace programmes included »financial constraints« and the »time constraints« on the people responsible for workplace programmes.

### ***A survey of employees***

The 1994 survey was used as the basis to select 14 trusts to take part in the more detailed study of workplace programmes. A staff survey was undertaken in the 14 trusts, as part of a needs assessment. Eight-and-a-half thousand questionnaires were returned (57 % response).

The survey covered a number of topics including:

- health and lifestyle issues (smoking, eating and drinking habits);
- workplace health and safety hazards;
- self-reported sickness absence;
- involvement in the workplace health programme;
- job and work satisfaction levels;
- staff attitudes to the organisation.

Staff reported little involvement in planning and developing workplace health programmes. They, considered workplace health to have low management priority.

Staff were asked in what ways the hospital could improve their health. Four of the top seven areas were in the areas of »management«, rather than around individual health and lifestyle areas.

### ***The in-depth studies***

The research programme assessed and monitored the development of workplace health programmes across 12 trusts, and with two trusts more in-depth studies were conducted.

From the assessment work a typology of workplace health programme was identified.

<i>Typology</i>	<i>Description of workplace practise</i>
Marginal Implementation (MI)	Limited, ad hoc, isolated activities with different purposes. The majority of trusts.
Instrumental Implementation (IS)	Limited, ad hoc isolated activities to achieve different specific outcomes. Other features of the trust have a <i>greater</i> negative impact on staff.
Integrated Implementation (IT)	A strong intuitive sense of the relationship between organisational and personal health. Sustained, directed effort which is an integral part of the trust's way of working.

The distinguishing feature between the Integrated and the Marginal categories concerns the priority given to workplace health. The features of the Integrated group include:

- good communications,
- integration of workplace into the organisation,
- staff involvement,
- ***tangible*** top level commitment,
- some sort of evaluation of programmes, and
- realistic goals.

However, it is less clear whether the environment has to be right for the development of workplace health or whether workplace health promotes the development of the organisation. In short, in organisations struggling with survival long term initiatives, like workplace health programmes, may have little meaning for them. No matter how good it may be in the long run.

This research reported here, takes place in a live setting, with no core funding of the organisation. A lot of interventions can be shown to be successful in the short term because they involve intense activity by outsiders in the organisation. Long term success is rarely sustained.

A significant issue for the research is where workplace health sits in the organisation. Does workplace health sit on the periphery of the management of organisational change or is it part of the process? The research findings suggest that for workplace health to have a chance of success then it must form part of the core organisational objectives. For many, getting it there is the issue.

The detailed work with the two trusts have identified that for workplace health to have a chance of success it requires a need for an emotional engagement and acceptance, and a rational clarification and diagnosis of workplace

health and its place within the broader organisational system. With blockages in these processes then sustainable change will not happen, and, at best, some good intentions will co-exist with some temporary activities.

Increasingly it seems that workplace health requires an organisational approach. We have noted how programmes flip from being substantive and central to being marginal and contextual. This is usually driven by changes in the organisation's context which affect the nature of the commitment given to workplace health programmes.

The organisation of workplace programmes may be viewed as being on a continuum from formal to informal. Thus, when matched against priorities such as health and safety, which have formal structures and requirements, workplace programmes will lose out in conflicts for action and resources.

### ***The individual in the organisational context***

The above set the organisational context. An aim of the research is to identify indicators that could be used to assess the development of workplace health. We have started this with the identification of the typology and its elements.

The employee survey provides some impact measures. The survey included questions that assess attitudes to the organisation and work. These include: intention to leave the organisation; level of commitment to the organisation; openness of the organisation; job and career satisfaction; involvement in workplace health planning and implementation; level of communication in the organisation.

The staff survey results have been analysed using the trust typology as the explanatory variable. We found that on a large number of the measures there were statistically significant differences in favour of the integrated trusts over the instrumental trusts. The data does not show a perfect association between the typology and the various measures. This is likely to be a reflection of the variation found in the real world. Further investigation is needed.

The principal finding from this research programme is that workplace health should be made an integral part of organisational development. The final report (***More to Work than this***) from this research is due for publication March 1999.<sup>6</sup>

6 Publications from the research can be obtained from the Health Education Authority's book distributors: HEA Customer Services, Martson Book Services, PO Box 269, Abingdon, Oxon, OX14 4YN.

*Hubertus von Schwarzkopf*

## ***Useful Health and Safety Regulations in Hospitals – an Occupational Health Campaign in Bremen***

### ***The problem***

For a long time the necessity of carrying out primary prevention in the field of occupational health has been obvious. The legal instruments for such have been adopted in the past years on the level of European and national laws. However we consider a deficiency regarding such primary prevention is still existing in health care systems such as hospitals, private practices and nursing and old-age homes.

In many public health institutions possibilities for individual health promotion are available. One can obtain different types of training against back pain, non-smoker courses, nutrition counselling etc. Many of these programmes do not pay sufficient attention to the social context.<sup>1</sup> Thus they are supporting a tendency to »Blame the victim«.

For occupational medicine the »widening option«<sup>2</sup> consists of two possibilities: protective prevention, and prospective prevention.

Protective prevention focuses on classic technical risks at the working site. In Bremen in each hospital a health promoting working group is present. Members of these groups form a co-ordination circle which plans conceptional steps and a time table for activities. This structure is at all of the hospitals' disposal for further conceptional development in the sense of a wider structural prevention.

Prospective prevention is a sum of procedures within the social context of an institution which needs support and co-ordination. In the hospitals in Bremen, we went after both types, one after the other. When we started in 1992 it was easier to start with the prevention of technical risks. Reaching acceptance in all ten hospitals, it was possible to co-ordinate all activities.

1 Horn, K. (1983), Gesundheitserziehung im Verhältnis zu anderen sozialisatorischen Einflüssen. Grenzen individueller Problemlösungsmöglichkeiten. In: **Europäische Monographien zur Forschung in der Gesundheitserziehung** 5, BZgA, Köln 1983, S. 49-71

2 Wenzel, E., Health Promotion and Lifestyles; Perspectives of the WHO Regional Office for Europe. Health Education Programme. Beitrag für die **11. Internationale Konferenz für Gesundheitserziehung**. Kopenhagen

### *The campaign*

Co-operation partners are:

- legal accident insurance organisations
- hospitals with their occupational physicians and experts in occupational protection and hygiene

We developed a concept based on statistical data, interviews with hospital employees in the field of occupational health and employees of representative sectors in hospitals. Further we made a review of the literature.

Unfortunately, research and experience have shown that compliance in adopting universal precautions is remarkably poor. »Training and education must begin at the medical school level with reinforcement through yearly workshops.«<sup>3</sup>

English applies adult learner theories to the problem. In her model, knowledge of correct procedures, provision of safe equipment and proper management predicted compliance with needle precautions. This approach could easily be expanded to include assessment of other factors considered important in learning new behaviours, such as beliefs and attitudes about the risks associated with the undesired behaviour, the probability that behaviour change will lead to the desired outcome and the ability to successfully accomplish behaviour change (self-efficacy).<sup>4</sup> Haiduven et al have introduced other important concepts that draw from both learning theory and the industrial hygiene model. Their programme demonstrated that knowledge of needle safety precautions (training), engineering controls (access to safe equipment) and motivation (feedback about injury mechanisms) can significantly reduce injuries.<sup>5</sup> At first our aims are to reach all employees of hospitals in Bremen. We looked furthermore for activities supporting the work done by experts in hospitals. Improved protection against infectious diseases should not only reduce accidental hazards, documented illnesses related to occupationally acquired infections and work-absenteeism, but improve the vaccination rate, especially for HBV in employees as well. Since it is possible to become infect-

3 Rampino, Robert D., Rampino, Carol D. (1992), Hospital Protocol for the Patient with Acquired Immunodeficiency Syndrome in Clinics. In: *Podiatric Medicine and Surgery* 9 (4) 1992, p. 917-932

4 English, JFB, Reported hospital needlestick injuries in relation to knowledge/Skill, design and management problems. In: *Infect. Control Hosp. Epidemiol.*, 1992, p. 259-264

5 Haiduven, D. G., De Maio T.M., Stevens, D.A. (1992), A five-year-study of needlestick injuries: significant reduction associated with communication, education and convenient placement of sharps container. In: *Infect Control Hosp. Epidemiol.*, 1992, p. 265-271

ed by means of a single exposure, the chance for exposure must be reduced to the greatest degree possible. The first step for a comprehensive approach is to reinforce information and training at the workplace. »The programme must be designed to be suitable to the level of the audience. Consequently, the format and content of each presentation may vary to reflect the composition of the specific audience. A program presented to post-doctorate researchers, for example, would take on a different flavor to a programme for housekeeping and maintenance crews.«<sup>6</sup>

### ***Method***

We decided to reach this aim by means of a campaign. The campaign's main goals are:

1. to develop a sound understanding of safety regulations by making the safest habits the easiest habits,
2. to establish a permanent curriculum for further education, and
3. to practice the most important steps for safer habits.

»Preventing needlestick injuries remains the highest priority for protecting workers from occupational infection with bloodborne pathogens. Application of engineering controls represents a giant step forward but does not replace the need for administrative improvements, behavioural interventions, training and personal responsibility.«<sup>7</sup> »A variety of soaps, detergents, germicides and protective gloves are available for use by health care workers. Appropriate handwashing and glove use will reduce the possibility of spread of infectious organisms from patient to staff, from patient to patient and from staff to patient. Both hand-washing and glove use can have adverse effects. Excessive hand-washing, mechanical irritation from scrubbing, use of germicides and wearing of gloves can result in irritant and allergic dermatitis. Dermatitis will result in an increased risk of infection to both the worker and the patient.«<sup>8</sup> It is necessary to postulate so-called Non-Touch-Techniques: »Techniques that have been adopted relate to the use of instruments rather than fingers for closing wounds. The adson forceps and needle holder should be used preferentially when closing a wound, including capsular, subcutane-

6 Rekus, John F. (1991), Bloodborne Pathogens. In: *Occupational Health and Safety* 60 (12) 1991, p. 30-34, 57

7 Borgatta, L., Fisher, M., Robbins, N. (1989), Hand Protection and Protection from Hands: Hand Washing, Germicides and Gloves. In: *Women & Health* 15 (4) 1989

8 see note 6

ous and skin closure procedures. A deliberate, conscientious effort should be made when passing sharp instruments from one person to another to point the sharp end away from the person's hand. Any approach to minimize the use of sharp ends should be employed. The recommendation by most authorities is to double-glove to reduce cutaneous hand exposures.«<sup>9</sup>

»Procedures involving blood or other potentially infectious materials must be performed in a manner that minimizes splashing, spraying or aerosolizing.«<sup>10</sup> The campaign includes three main considerations for the prevention of infectious diseases among hospital staff:

1. needlestick exposure and comparable injuries,
2. different methods of skin protection, and
3. protection against aerosols.

The three main methods of the campaign are:

1. using different and attractive media
  - stickers
  - posters
  - journals
2. promoting communication
  - outdoor seminars
  - working groups in hospitals
  - collegial information / orientation at the working place
3. introducing protective equipment in everyday practice.

### ***Realisation***

After a two-year period of planning and development, the campaign »Useful health and safety regulations in the health care system« was started in 1992 in different hospitals in Bremen. By those planned topics the duration was limited to five years in each institution.

In addition to the media, which were developed by a multiprofessional working group from different institutions, we considered institutional involvement and active participation of employees of the hospitals as of great importance. Each hospital selected up to 20 multipliers and sent them twice a year to two-day seminars every year on a new topic. These multipliers (doctors, nurses, technicians) organized the setting-up of the campaign in

<sup>9</sup> see note 3

<sup>10</sup> see note 4

their own hospitals according to their specific conditions. So the overall campaign is setting basic structure and each institution is able to change within this structure. We underestimated, when developing our programme, the importance of protective equipment. Besides media and communication, changing specific equipment also alters very concrete habits. »The plethora of new products coming on the market indicates that industry is responding to the demand created by the awareness of bloodborne pathogen risks among workers. Use of safer needle products and disposal systems may prove to be important components of needlestick prevention efforts.«<sup>11</sup> We introduced a new injection and blood sample collection tray with a closable liquid-tight puncture-resistant container to avoid ›recapping‹. In all public hospitals, gloves were purchased according to new European norms. Since we began, the hospitals are testing different products to protect and restore the skin, especially of the hands. We enlarged the topics from risks of infection to exposure to chemicals i.e., narcotic gases and cytostatica.

### ***Results***

Although hepatitis-B-vaccination is offered since about ten years, only two-thirds of the employees in hospitals participated. Via the campaign we reached a good proportion of them and many colleagues came for control. Thus sufficient protect is reached by 73,4 % of the employees. It was easier to get decisions regarding injection an blood sample collection tray by the administrations in the context of the campaign. In all hospitals the prophylactic treatment with zidovudine (AZT) after accidental exposure with HIV is well organized; also, meanwhile, multidrug therapy. There are problems in nearly all hospitals concerning the active participation of physicians in general. Critical points are the absence of a sound scientific evaluation because of the shortage of funds. However we are executing a small case-control study at present. Some results from the questionnaire developed for the case-control study (simple frequencies): The response rate was fortunately very good. 66,5 % of 200 subjects participated. The distribution by profession was the following: 59,1 % nursing, 23,8 % doctors, 3,3 % house keeping and maintenance crew, 13,8 % other professions such as technicians etc.

With smaller resources in all sectors of the health system this form of established campaign, with its inter-institutional capabilities might be a good

11 see note 7

example for primary prevention in the field of occupational health. This method is only successful with a high degree of involvement and participation in planning, realisation and evaluation. Other cities in Germany are also interested in our campaign. We are, at present, in the process of negotiation with them. This concrete example of prevention is capable of being transmitted in a modified fashion to other health concerns in hospitals and other institutions.

### *New perspectives*

Since 1997 we are preparing a new conceptional step. By examining the analyses of the working places based on the new European Worker's Protection Law – we learn how difficult it is to evaluate synergistically different risks at the working sites. Extremely difficult is the evaluation of risks caused by working-organisation and psycho-social burdens. These evaluations should not be done by experts, but in a form of active participation by the employees themselves; also, proposals for solutions and improvements should be worked out by them. All these procedures will take place in health circles which are formed by all hierarchical levels and all professions working in hospitals. In May, the opening conference of all ten hospitals took place. In the period from September to November, the internal moderators will be trained by external experts. Thus, at the end of 1998 the first circles will be established in hospitals. The activities will be continuously co-ordinated within the above mentioned structure, the working groups within the hospitals and the overall co-ordination-circle. This procedure should guarantee equal standards and help to avoid that health promotion for employees suffers from competition in the market for patients. Clearly pointed out to all participants – especially the managers of the hospitals – is that most decisions to be made with this background should be an integral part of organisation and personnel development.

*Detlef Schulz, Roman Golunski, Rainer Müller*

## ***A Pilot Project to Prevent Work-Related Accidents and Injuries among Employees in the Communal Hospitals of Bremen***

### ***Programme***

Due to a change in federal law which came into effect in August 1997 the German accident insurance institutions came to bear full responsibility for preventing work-related accidents and injuries. Already in 1996 the local institution (Unfallkasse Freie Hansestadt Bremen) in co-operation with the Centre of Social Policy Research of the University of Bremen initiated an explorative pilot project to analyse the conditions of developing a prevention programme for the 6,500 persons employed in 4 communal Hospitals in Bremen.

### ***Data and Methods***

The study still in progress is based on

- 16 personal interviews with experts in the hospitals: occupational physicians, administrators, nursing directors, works-committee members;
- Interviews with the hospitals' employees (nurses, kitchen staff etc.) using a self-administered questionnaire (still in progress);
- A secondary analysis of the data of the local accident insurance institution from 1994 to 1996: reports to the local accident-insurance organisation regarding work-related accidents, suspected occupational disease, road-accidents between home and hospital of the employees etc.
- A secondary analysis of data concerning absentee rates among hospital personnel;
- A secondary analysis of the employees' health insurance funds data (still in progress).

### ***First Results and Discussion***

The first results show that:

- The hospitals' administrators have little or no knowledge of relevant data.
- Senior employees (e.g. nursing staff) form an especially problematic group. In contrast to impressions often given by the mass media, older employees constitute a considerable share of employees in hospitals, at least in the communal hospitals of Bremen. They are especially affected by both saving incentives in health care and the bad situation on the job market. With increasing age and work-life duration, those senior employees are increasingly suffering from diseases connected with signs of physical and psychological fatigue. But in times of rationalisation in hospitals, there only few jobs left for those so called »impaired« persons. Strategies to prevent and/or to cope with this problem, e.g. changing work demands, promoting further vocational training etc., are still underdeveloped.
- Economic considerations prompt many hospitals to initiate management programmes (such as return-to-work interviews) to reduce high rates of absenteeism rather than working on reducing work-related illnesses.
- The secondary analysis of data concerning absentee rates among hospital personnel show, as expected, high absentee rates among nursing staff, which surprisingly hardly surpass those of the administrative personnel. Also striking are the very high rates in relatively small occupational groups as for example medical-technical staff or technical staff. Here, high rates can call into question the functionality of the department, as they can hardly be compensated for.
- The secondary analysis of health-insurance data is planned to confirm and to specialise the results obtained in the study thus far.

### ***Research Problems***

Hospital management looks upon all matters related to occupational hazard as the business of the hospital itself. The growing competition between hospitals has made the realisation of comprehensive projects to prevent work related accidents and injuries much more difficult. Members of the hospital management, even nursing managers give less and less detailed information concerning work routines, working conditions and occupational risks of the work. To make matters worse, an increasing number of hospital employees are no longer willing to participate in research projects, because they don't hold out any hope of any improvement in the concrete working conditions in hospitals which would result from a study.

*Della Thomas*

## ***Changing Societies and the Effects on Front Line Staff***

This paper aims to highlight the contributing factors associated with the increase in verbal aggression towards nursing staff working in the Accident and Emergency (A & E) Department and offer some suggestions to ease the problem. I will begin by setting the hospital context, define abuse and outline existing issues. I will then move on to offer some suggestions to solve the multi-faceted problems staff face.

### ***Setting the context***

Fife is on the East coast of Scotland about 15 miles north of Edinburgh and approximately 35 miles east of Glasgow. It has a population of around 335,105 people. The Queen Margaret Hospital is situated in the Fife town of Dunfermline and serves approximately 46,400 people. The Hospital, built in 1993, has 500 beds and employs 1,500 staff. The Queen Margaret began working towards the Health Promoting Hospital (HPH) concept in 1996 and is a member of the Scottish HPH network.

### ***Background***

The A & E department has around 30,000 attendees per year and a team of 25 nurses staff the department. Staff predominantly enjoy the buzz of the busy area; the uncertainty of who will arrive on their doorstep to challenge their skills and expertise; the constant variety of cases; the direct contact with patients and the satisfaction of helping someone along the road to recovery. But in common with other A & E units across the country, staff have been noticing a rise in the aggression and abuse they are having to tolerate and cope with, during their work. This aggression is originating from patients and those who accompany them to the A & E unit.

Health and Safety Executive figures show that nurses are doing one of the most dangerous jobs in the UK. Nursing staff run 5 times the risk of being attacked at work than the rest of the population.<sup>1</sup> The cumulative effect of this

aggression on staff, is a decrease in morale, self-esteem and job satisfaction and a feeling of victimisation.<sup>2</sup>

### *Defining and monitoring aggression*

Aggression ranges along a continuum of non-verbal and verbal abuse to actual physical violence. What constitutes aggression to one individual, during a defined situation may not always be the same to another individual or indeed that same person on another day. So the words, behaviour, attitudes or actions which constitute violence must be defined on an individual basis; by the victim. That is why several small acts of aggression, which the nurse may be able to shrug off and not feel worthwhile reporting, can accumulate so influencing their coping mechanisms, health and well being.<sup>3</sup>

Aggression towards nursing staff is not a new phenomenon. In the 1960's and 1970's there was evidence that staff were experiencing abuse, particularly in psychiatric hospitals. The Management of Health and Safety at Work regulations (1992)<sup>4</sup> has made the issue of management of violence more explicit.

A survey by the Nursing Times in 1997, with 500 A & E nurses in the UK, showed that 46 % had been physically attacked and nearly all of them had been verbally abused.<sup>5</sup>

During a three month period in 1996, 20 Queen Margaret Hospital A & E staff participated in individual interviews and focused group discussions, which aimed to reveal some of the problem areas in the A & E department. The results of this research indicated that 2/3 of staff felt that exposure to physical and verbal abuse was a significant problem. The majority of staff felt that aggression had increased over recent years and had now reached a peak. Almost all of the staff had experienced either physical or verbal aggression, and felt that its incidence was under reported.<sup>6</sup>

An abuse incidence reporting audit from 1 January - 30 June 1997 revealed

1 Scott, H. (1997), Why do nurses face violent assault in A & E? *British Journal of Nursing* 6 (10), p 540

2 Jenkins, M. Rocke, L. McNicholl, B. Hughes, D. (1998), Violence and verbal abuse against staff in accident and emergency departments: a survey of consultants in the UK and the Republic of Ireland. *Journal of Accident Emergency Medicine* 15, pp. 262-265

3 see note 2

4 see note 1

5 see note 1

6 McVea, J. (1996), An Assessment of work related stress in the Accident & Emergency Department. Queen Margaret Hospital NHS Trust. Unpublished

that 75 % of incidence were verbal, 6 % physical and 19 % a combination of verbal and physical abuse.<sup>7</sup>

### *Effects of abuse on staff*

Verbal abuse has been extensively researched concurring that the major sources of abuse are from patients, patients' families and physicians.<sup>8</sup> Exposure to verbal abuse has negative effects on the nurse's self-esteem, their morale, job satisfaction and patient care.<sup>9</sup>

Longer term effects indicate that nursing staff can then begin to question their ability to do their job as their self confidence decreases. Staff begin to feel insecure and a failure and ultimately this can lead to burn out.<sup>10</sup>

### *Action*

This unequivocal evidence has led to action being taken and considered in three areas of interpersonal, environmental and organisational support for nursing staff.

My work was commissioned to begin by addressing the interpersonal support and training requirements of nursing staff. This is perhaps because it is sometimes viewed that ultimately the nurse/patient relationship depends upon the nurse and the standards and behaviour of that nurse. Educational initiatives do enhance patient-staff relationships because they will prepare the nurse to take a proactive approach to dealing with verbal abuse.<sup>11</sup> However, this taken in isolation will not address the bigger picture. For that reason links have been made with environmental factors and organisational support, via the area of individual interpersonal support, for nursing staff.

7 Thom, A. (1997), Analysis of Incidence Reports Accident & Emergency. Queen Margaret Hospital NHS Trust. Unpublished

8 Leilra, P. (1991), Learning from incidents of violence in health care. An investigation of 'Case Report' as a basis for staff development and organisational change. *Nurse Education Today* 12, pp. 116-121. / Cooper, A., Anthony, R. (1996), Verbal Abuse of Hospital Staff. *Canadian Nurse* 96 (6), pp. 31-34 / Lipscomb, J., Love, C. (1992), Violence Toward Health Care Workers. An Emerging Occupational Hazard. *AOHN Journal* 40 (5), pp. 219-228

9 Cooper, A., Anthony, R. (1996), Verbal Abuse of Hospital Staff. / Lipscomb, J., Love, C. (1992), Violence Toward Health Care Workers.

10 Leilra, P. (1991), Learning from incidents of violence in health care. / Cooper, A., Anthony, R. (1996), Verbal Abuse of Hospital Staff.

11 Leilra, P. (1991), Learning from incidents of violence in health care.

The A & E staff had already received training in the management of physical and verbal aggression. Studies have pointed to the value of assertiveness training in responding to aggression,<sup>12</sup> so after consultation with the A & E charge nurses I developed a specific one day workshop. This workshop is underpinned by a process which helps staff to develop an awareness and understanding of why aggression exists in A & E, discussing a range of contributing factors. This leads on to an exploration of self-awareness, assertiveness and reflective practice techniques. This is done within a safe forum, in which discussion and sharing of feelings and personal ideas is encouraged.

The series of one day workshops have formed a rolling programme over the last year and common themes have emerged as staff have worked through their understanding of the reasons behind aggression in A & E.

The causes of aggression have been categorised in themes:

1. intrinsic to the patient and accompanying person
2. intrinsic to staff
3. extrinsic to staff and patients (environmental)
4. societal (including links with organisational support)

### ***1. Intrinsic to Patients***

Causative factors which I have classified as intrinsic to the patient are the common feelings and problems people who have been involved in an accident face, for example pain, feeling vulnerable, fear of the unknown, loss of control and anxiety or on the other hand, feeling that »they« should not have to wait around or feeling a more important case than others. These factors can, and sometimes do, lead on to aggression.

The problem can be eased by treating pain and symptoms as and when appropriate, explaining systems and procedures, keeping all parties up to date and informed, maintaining an understanding, yet assertive position, using active listening skills and being aware of situations or comments which could escalate and progress.

### ***2. Intrinsic to Staff***

An accumulation of events in A & E such as the effects of numerous aggressive incidents or low staffing levels can in turn lead staff to adopt a tone, body language, attitude or dialogue which is non-assertive, this may then exacerbate an already difficult situation.

12 Cooper, A., Anthony, R. (1996), Verbal Abuse of Hospital Staff. / Lipscomb, J., Love, C. (1992), Violence Toward Health Care Workers.

The problem is being eased by staff attending the workshop to help them improve their self awareness, self confidence and self esteem.

By practising debriefing and reflection alone, in pairs or in groups; staff have become more aware of successful responses and strategies, feeling more able and supported to recognise their own limitations and to request assistance when necessary. Low staffing levels and poor skill mix can also contribute to the problem, it is therefore important to review these periodically.

### **3. *Extrinsic (Environmental)***

Environmental factors influence all those who work in, or attend the A & E department. During the workshops staff indicated several environmental issues which had already been addressed to ease the aggressive atmosphere.

These included ensuring adequate sign posting to A & E, displaying waiting times and updating these constantly using static and crystal notices, providing personal explanations for the reasons behind waiting times in a calm manner; improving the children's play area and rearranging seating taking into account the personal space allowed between seats.

### **4. *Societal factors (including organisational support)***

Many other more complex factors were explored during the workshops as contributing to aggression in A & E from the broader societal scale. What we are actually striving for is a balance between the demands and expectations society places on us and what we can realistically achieve, along with an acknowledgement that there are some factors we cannot directly change or influence. To this end organisational support is essential.

There has been an escalation in the incidence of violence in society, due to, in part, the increased misuse of substances and availability of weapons.<sup>2</sup> This increase in violence generally, is translated into other public areas such as the A & E department.

Issuing staff with personal panic alarms and increasing the availability and response rate of the hospital security staff and the police force, supports staff at the front-line. The hospital has designed a series of clearly visible signs for use in the A & E which indicate,

- »The Queen Margaret NHS Trust will not tolerate violence/physical aggression or verbal abuse towards its staff. If this occurs the staff in the department are authorised to involve the police.«
- The downside of this however is that an increased police or security presence may create an aggressive environment, therefore increasing tension and further exacerbating the situation. For this reason staff attempt to diffuse difficult situations themselves as much as possible.

Generally speaking in the past the public have been very pleased with the NHS and its »free« care and treatment for all. In more recent years people have become more likely to expect certain standards from all public services and voice their concerns and discontent if their expectations are not met.

An efficient, effective complaints system and personnel is essential to provide investigation into, and explanation of, why services have not reached expectation. A & E staff themselves, may benefit from training in how to take and enable complaints and how to respond effectively to the angry complaining person.

A change in role for women in society has generally resulted in a shift from women in the home into the workplace. This can contribute to the pressure women feel when a child is ill and the need to accompany that child to the A & E unit, conflicting with demands and pressure of their work. A change in the perception of the concept of time for both genders, has created a cultural perception that there isn't the time to waste sitting around. A busy, fast-moving, modern lifestyle has increased the inconvenience of unplanned events. The British public who have culturally been renowned for their orderly patience in standing in queues are now not so patient! The concern for, and co-operation with others, has shifted to a culture which puts »me« first. This is reflected in the A & E situation when individuals do not appear to understand that others have to be, and have been, put before them in the queue.

It is difficult to suggest how A & E staff can solve these numerous and complex issues other than provide an efficient and effective triage system and waiting environment, ensuring where they can, that people are making the best use of the A & E service and not using it instead of a visit to their GP or for a second opinion.

### ***Redressing the increase of aggression in society***

The Zero Tolerance campaign began in Fife in 1995 aiming to reduce the amount of violence and abuse experienced by women in the domestic situation.

The results of the preliminary research into public awareness and attitudes to violence against women revealed that there were still groups of people within Fife who did not acknowledge that behaviours such as »slapping« and »pushing« were violent in nature and therefore were willing to tolerate them.<sup>13</sup>

The Zero Tolerance campaign can translate into the work situation. A & E

nurses should not have to tolerate violence and abuse which is societal, not medical in origin.

### ***Conclusions and recommendations***

Aggression in A & E is caused by many complex, inter-related factors and staff should be enabled to explore and develop an understanding of all of these.

Staff themselves can take responsibility for changing or improving some of the contributing factors to aggression, in order to eliminate or ease them, but the organisation and other areas of society must work together to change attitudes and systems which cause and contribute towards aggression.

Health Service organisations need to develop a policy of Zero Tolerance of violence and abuse which is societal in origin. This would support the attendance of training in communication skills which facilitate negotiation, conflict management and personal dignity. It would ensure that peers and managers support front-line staff during and following abusive attacks to enable them to manage the feelings of anger, anxiety and powerlessness that result from abuse.

13 Reid House Associates (1996), Evaluation of the Zero Tolerance campaign in Fife. Unpublished

# Community-centred Health Promotion / The Hospital and the Community

*Per-Gunnar Svensson*

## ***Health Promoting Hospital as an Ally for Public Health***

The Health Promoting Hospital has a key role in improving public health. Its role is many faceted and in particular related to the following aspects:

- To provide good examples of health promotion models as evidenced in areas such as food menus for patients, visitors and staff, provide smoke-free environments, etc.
- The use of its individual medical record system to collect public health data in such areas as socio-economic differences, trends, differences between geographical areas, etc.
- To provide to the public, media, decision-makers and others, information relating to the above-mentioned areas. This, in order to contribute to a more solid foundation upon which decisions on measures relating to public health may be based.
- To participate actively in public debate providing professional and expert opinions on improving public health.

I will now further elaborate each of these four key roles for the Health Promoting Hospital as an ally of public health.

### ***To provide a good example***

There are many ways in which the Health Promoting Hospital may be an ally of public health. One way is to provide a model for others, based on scientific evidence, ethics and commonly agreed values. These may be initiated through the introduction of non-smoking policies, nutritional standards, environmental awareness and in general a transparent organisation based on democratic values and equity in access.

Although the existence of a healthy workforce may be evidence of a good example of health promoting activities, contrary examples and negative results have, nevertheless, been reported by the Nuffield Trust. Financial constraints have in many countries forced services to be restructured, which has resulted in a rise in unemployment among health workers in many countries. Are hospitals providing outsourcing services to those that are forced to leave?

A lot of medical evidence is in support of non smoking policies and nutritional standards. More importantly, however, there is evidence for creating a

hospital in which the public will have confidence and one in which when it comes to policy-making, the views and opinions of other spheres of the society will have to be taken into account. Environmental issues are examples of many more such areas which should be used, for an integrated Health Promoting Hospital policy. Initiation of these activities may influence such policy areas as waste management, energy production for heating, assessment of the quality of building material, cleaning products, transportation for staff and patients, etc. What about collaboration with municipalities, another significant ally, who are responsible for, for example, spreading sand and salt on frosty pavements. Falls on such slippery surface cause a significant number of femur fractures in particular among elderly women.

A properly co-ordinated and managed public transport system to hospitals could result in savings of up to 25 %, as evidenced in a project conducted in Hamburg. In this case companies and environmental authorities should, perhaps, be our allies.

A comprehensive hospital policy has to consider knowledge and experience from other sectors in order to create hospitals that reflect the main relevant and available information and knowledge. This will provide one prerequisite for public trust in hospitals.

### ***Hospital support to provide public health oriented information***

Another way for a Health Promoting Hospital to become an ally of public health is in the provision of relevant information. Even though, by nature, the information in principle is collected at the individual level, it may well be aggregated and disaggregated in line with public health paradigms and criteria. This may, if well managed, promote better hospital management and procedures and ultimately, again if relevant and valid information is generated, influence general health policy.

Another reason for providing information relevant to the public is to create transparency in relation to individual hospitals and clinics, so as to create consumer friendly assessment of procedures and outcomes of specified medical regimes and clinical practices. Individual choice, where available, at national, county, and doctor-patient levels, as well as within hospitals and clinics, will be facilitated.

Although it is acknowledged that interpretation is often very difficult and includes many methodological problems of inference, information, if properly publicised, will create a better understanding of the functioning of hospitals.

Transparency of processes and outcomes are prerequisites of creating a more trustworthy image of Health Promoting Hospitals. This might need some regulatory and legal changes in some countries. When that is in place, hospitals have to create information systems that utilise the individual medical records for the public good. In order to accomplish this task, however, there will be a need for hospitals to rely on the application of a variety of competencies from many disciplines.

### ***Information to the public through the media and other sources***

What has been said before on availability of information is of special relevance in relation to the various media sources. Information has to be presented in a form that facilitates public understanding of inputs, processes and outcomes of Health Promoting Hospitals. This will create a more solid base upon which the individual as well as the public may make their decisions. The establishment of mutual interest between the public and hospitals, independent of any other factor, should provide the basic environment for creating such a well understood system of information. The information to be published should be clear and understandable and all problems of interpretation should be explained in common language. Regarding processes, i.e. clinical practice and management, a critical assessment procedure should be in place. A sound evidence-based **management** system should be established upon review, as is the case with evidence based medicine. Certain steps and criteria should be set up in order to create evidence based management of health services. These criteria, design and methodologies to be used for measurement, might differ to some or to a greater extent, in comparison to those applied in evidence based medicine. Too often, management practice is a reflection of the most up-to-date fashions, like in the clothing industry.

Caution, however, must be applied, whenever the question of a blueprint of policy and / or management is raised. I believe that no single management blueprint or policy model available, can be universally applied. I believe, on the contrary, that each country has to develop its own model based on its own history, basic values, financial constraints, available manpower, etc. Only at a very superficial level can blueprints, I believe, be applied.

### ***Health Promoting Hospitals to participate in the public debate***

In many ways this issue may be in conflict with the views of certain professionals regarding their roles. I would, however, like to make a plea to health

professionals that they according to their individual competencies and skills, participate more actively in public debate. The value of the professional status, the so-called »white robe status« is not to be underestimated. This role should, of course, be performed with great regard to ethics and based on professional evidence, in order that the value of its performance may be enhanced.

The role model approach, health professionals as peers, may be a strategic approach in drawing the attention of the general public, as well as the attention of special target groups.

I am looking forward to the development of indicators of the Health Promoting Hospital as an ally of public health whilst taking into consideration such aspects as:

1. The level on which health promoting behaviour are being practised. This may be illustrated in a summation or additive index of such behaviours although behaviours differ regarding their impetus. The latter may be an argument for consensus making in order to create a weighed index.
2. The level on which hospitals use their information for the good of public health approaches. Again consensus panel may be useful.
3. The level on which hospitals provide information and data relevant to public health in a way that is understood by the public, media and other important actors. A combination of experiment data and analysis of publicised material may be utilised.
4. The level on which hospitals demonstrate their participation in public debate in order to, based on empirical evidence, create an improved public health including less inequalities in health and in access to health services. Here there might be a need for developing a composite measure (qualitative and quantitative) on this dimension.

As obvious from what I have said before there is a need for some form of regulation or agreement, be it at governmental or other levels between concerned parties. Concerned parties and regulation may only be defined at a country level. But I imagine that most countries will need some formal action to establish the basis or criteria on which hospitals and health services will be assessed.

A significant factor is that health services need to improve their relations with the media. Public relations functions of health services are crucial in order to accomplish this.

Thank you for your attention.

*Svend Juul Jørgensen*

***The Health Promoting Hospital  
as Partner for Comprehensive Care.  
Experiences from Bispebjerg Hospital, Copenhagen***

The Danish public health care system has some national characteristics. There is a minimal – almost non existent – private hospital sector and the responsibility of providing hospital services is laid on the 14 counties with a population of 250,000-600,000. Each county runs its own hospital system, but highly specialised treatment for patients from all parts of the country takes place in the university hospitals in the three cities of Copenhagen, Århus and Odense. All citizens are secured by the public health service financed over the tax system. The local municipal authorities are responsible for the primary health care system.

Bispebjerg Hospital, a 900-bed University hospital, is part of the public hospital system in Copenhagen. The hospital was formerly owned and run by the City of Copenhagen but in 1995 it was given over to a newly formed organisation: Copenhagen Hospital Corporation (Hovedstadens Sygehusfælleskab).

Up till the formation of CHC hospital expenditure in the central Capital region had been increasing, and the fact that three different authorities (the State, the City of Copenhagen and Frederiksberg municipality) were responsible for the management of hospitals in the central capital region had made it difficult or impossible to adjust the structure to the actual demands.

The overall objective for CHC is to provide hospital services of high, well-defined and documented quality to the citizens of Copenhagen and to patients from other parts of the country who need highly specialised care and to do this with high efficiency.

***Bispebjerg Hospital as Health Promoting Hospital***

In 1994 Bispebjerg Hospital was selected as ***model hospital for health promotion*** in Copenhagen Municipality. This was done as part of the Healthy City

Plan 1994-1997 for Copenhagen, which in its turn forms part of the WHO programme »Health for All by the Year 2000«.

When Bispebjerg Hospital shortly later became part of CHC it was given the task to continue the development of prevention and health promotion in accordance with the overall objectives now set out in the hospital plan for CHC. The vision was that the activities in Bispebjerg Hospital should be spread to other hospitals in the corporation and influence the population in the hospitals environment positively – a process which is now in its very beginning. Entering the project phase as a model hospital it was found important to establish a detailed set of data regarding the general condition of the patients which could form the basis of relevant planning of health promoting activities.

A **»Patients' Health Profile«** describing not only health and living habits but also the social profile of patients in the referral area of Bispebjerg Hospital was established. The data collection was carried out in the autumn of 1995 using questionnaires and / or interviews. All patients in the hospital – including out-patients – were requested to take part in the data collection. The health profile gave important information on health, life style and social status for patients using the hospital's services.

It was found that 26 % of all male patients in the hospital had a critical alcohol consumption leading to a high risk of alcohol related diseases, 48 % of all patients were smokers, and 24 % were heavy smokers.

Concerning social conditions it was found that 63 % of all patients were living alone, 15 % rarely or never had contact with their family and relatives, 20 % of the elder patients could not count on help from family, friends or neighbours in case of illness, and 14 % of all patients felt lonely. Especially a very high proportion of elderly patients were living alone without any contact with family or friends.

13,6 % of the population in the age 18-66 were unemployed, 26 % of the same age group were on social welfare or social pension and 10 % of the total population in the region were immigrants mainly from Turkey, Pakistan and the former Yugoslavia. The social profile described in the Patient's Health Profile thus indicated a demographic and social structure comparable to other large cities. It was found that many patients in the hospital have weak social and family networks and get little support from their social environment, conditions known to lead to increased mortality, morbidity and increased length of hospital stay as well as increased risk of readmission.

The findings in this health profile explains why the Bispebjerg region uses approximately 2,400 bed days per 1,000 inhabitants per year compared to an average of app. 1,200 in Denmark as a whole.

A survey using the hospital's diagnostic registry revealed that approximately 1,200 admissions per year (1995: 1,233) out of a total of 30,000 are directly related to the abuse of alcohol and also that this group of patients accounts for a high frequency of re-admissions. However, this is only the top of the iceberg, as alcohol may be an important factor leading to a much larger number of admissions (e.g. trauma) and prolongation of hospital stay due to an increased risk of complications in alcoholics.

Concerning tobacco-related mortality and morbidity it is estimated that 19 % of the deaths in Denmark are caused by smoking, and that approximately 4,500 admissions per year to Bispebjerg Hospital are due to tobacco related diseases (lung cancer, COLD, arteriosclerosis etc.). So a total of approximately 20 % of all admissions are due to alcohol or tobacco abuse.

A high frequency of re-admissions can be due to in-appropriate use of the hospital capacity meaning that patients are discharged without having their health problems solved or their condition improved or stabilised sufficiently. It can also be due to insufficient social conditions or to the fact that abuse of alcohol, tobacco or drugs which caused the first admission is continuing. A reduction in the number of re-admissions would be an important factor in the aim to improve efficiency of the hospital and reduce the number of hospital beds needed.

### ***Programme for Health Promotion***

A programme for Health promotion, rehabilitation and prevention has been developed with the primary aim to improve the health condition of the patients in the hospital and the secondary aim to reduce the need of hospital capacity.

As health promoting activities should meet the same standards as other activities in the health care system we have followed these principles in the establishment of the programme:

- The programme should be evidence based and activities which are not based on evidence should be defined as research or development projects.
- The programme and its elements should be evaluated regarding the clinical acceptability and compliance. Is a negative result of the activity due to insufficiency of the programme or is it simply not being activated in the clinical activity?
- Documentation of outcome of the activity should be established and inefficient activities should be corrected or given up.
- The traditional way of thinking and acting in the hospital should be altered

as we turn it into a health promoting hospital with a comprehensive programme not only involving the diagnostic and therapeutic activities but also attempting to solve or diminish problems in the patients way of living, eliminate risk factors and even try to influence the patients' social conditions. It is therefore important that all units in the hospital are involved and develop and feel ownership for their programmes.

- The Health Promoting activity should not be an extra activity taken up besides the usual clinical practice. It must be integrated as a natural part of it in order not to make it an extra burden easily given up in a busy clinical situation.
- Research in health promotion and preventive medicine should be given priority. Firstly because we need more knowledge about risk factors and how to influence them. Secondly because the medical profession is reluctant in changing patterns and giving priority to health promotion and rehabilitation. This is one of the barriers we have to overcome, and the initiation of research and intervention studies has proven an important factor in turning the profession into a new direction.

### ***Programme for Health Promotion***

The programme following these principles consists of a general programme directed to all patients in the hospital and specific programmes for different groups of patients or diagnostic groups.

***The general programme*** covers the activities for alcohol, tobacco and social conditions. All patients admitted to the hospital will be questioned in detail about their smoking and drinking habits. In a test period in 1997 it was found that the patients as well as the hospital staff found this questioning acceptable and the patients regarded it as an expression of positive interest and concern.

Alcohol and tobacco intervention units have been established in the hospital as important parts of the health promotion programme. Patients with high alcohol consumption and / or heavy smokers are informed about the possibilities for help in these units, and patients who want help are referred for support or treatment, while patients unwilling to change their habits are informed about the increased risk and about the possibilities of support from the two units at a later time.

A concept for counselling sessions on alcohol and tobacco has been developed and several preliminary studies in the hospital indicate a very promising effect of this intervention. A randomised clinical trial with the purpose of

evaluating the effect of counselling sessions in the hospital is to be activated in the near future.

Patients with weak social networks have complicated problems which can only be solved by involving a wide range of supporting groups, social workers, patient organisations, mutual assistance groups of elderly persons, neighbourhood groups and the primary health care sector, but they also need support from the hospital such as a contact nurse and a doctor they can reach on the telephone. All the above mentioned bodies are important co-operating partners in the attempt to meet the needs of these patients.

All clinical units have been encouraged and supported in establishing *specific programmes* and to implement health promotion as part of the clinical activity or to improve programmes already implemented. It has been possible to give limited extra resources to the clinical units for the planning of these programmes and thus stimulate the process. Some examples are:

**Cardiology:** A rehabilitation programme for patients with ischemic heart disease including physical rehabilitation, specific medical and dietetical treatment has been established and will be implemented when the economic background is established. Systematic use of this comprehensive programme is expected to reduce mortality and the number of re-admissions to the hospital. A prospective analysis of the programme will establish documentation of the whole programme and the value of different elements.

**COLD:** A full programme for rehabilitation, cessation of smoking and physical training has been developed and is currently being tested in a randomised clinical study.

**Psychiatry:** Three programmes have been given priority:

- A programme for early identification and early treatment of young patients with schizophrenia designed as a prospective clinical trial.
- A programme for the prevention of suicide in youngsters who have attempted suicide or shown suicidal behaviour.
- A programme for pregnant women with schizophrenia or other severe mental diseases. Due to a changed pattern of treatment in modern psychiatry and the attempted re-socialisation of patients with mental diseases, a growing number gets pregnant. These women bear a high risk of complications during pregnancy and of giving birth to children with low birth weight. Also these women are unable to take proper care of the child. A high proportion of children born in families with one or two parents with mental illness develop abnormal behaviour in childhood, and approximately 40 % develop mental illness when adult. The programme has the character of a prospective study and a national centre for the treatment of these mothers and children is established in the hospital.

**Surgery:** A case based data base in the hospital has revealed a correlation between smoking and complications such as leakage of anastomoses in colorectal surgery and skin complications after mastectomy. There is a nearly linear correlation between deep skin necrosis and the amount of tobacco smoked per day. It is remarkable that deep skin necrosis was not found in patients who were non smokers. A programme for smoking cessation before surgery is designed as a prospective clinical trial and can be expected to reduce the complication rate and thus the length of postoperative stay in the hospital. The study is carried out in co-operation between the departments of anaesthesiology and abdominal surgery.

These few examples are characteristic for the spectrum of health promoting programmes as they are implemented in the clinical departments and units of the hospital.

### ***Co-operating Partners and Barriers***

The most important partners in the process of turning a hospital into a health promoting hospital are the many key persons in the organisation. It is crucial for the project to engage responsible and respected professionals in the project.

Definition of the programme according to the lines described above and a constant focus on the process from all management levels has been important. Close co-operation with central hospital authorities, the local municipal administration and the different elements in the primary health care sector is mandatory. So is collaboration with patient organisations as e.g. the Danish Heart Association, the Association for Lung Diseases, the Diabetes Association and the Cancer Organisation. The patient's point of view should be taken in consideration and the programme must be developed in full respect for it.

Cultural and professional barriers were apparent in the health care professions. These barriers can be overcome by meeting the standards of the medical profession as well as other health care professionals according to the principles lined out in this paper. An increasing political and professional understanding of the importance of health promotion and preventive medicine gives a good background for the further development and implementation of the programme. So the main items for the future will be further development of the health promotion programme and evaluation of its effectiveness.

*Benedicte Wetzel, Anne-Laurence Le Faou*

## ***The Hospital Beyond the Walls***

Assistance Publique-Hôpitaux de Paris (AP-HP) is a federation of 50 public hospitals which provides care to the metropolitan area of Paris with 30,000 beds and 85,000 employees. Its hospitals belong to the University Teaching Hospital of Paris. The health care services of the University Teaching Hospitals tend to emphasize high technology rather than preventive care. In fact, the concept of health promotion is not well developed in France. Nevertheless, a specific HPH programme in a new geriatric hospital of AP-HP, Vaugirard Hospital is being encouraged since 1993. In fact, Vaugirard Hospital has been participating in the WHO-HPH programme since 1993 and has been the only French hospital involved in this programme. In 1997, a national network of Health Promoting Hospitals, co-ordinated by the AP-HP International Affairs Division was set up to develop the concept of Health Promotion in French hospitals.

### ***I. The Vaugirard Hospital projects***

Vaugirard, the most recent geriatric hospital is located in the 15th district of Paris. It opened its doors in December 1991. It has 340 beds, 55 of which are intended for rehabilitation and 20 for acute care. As the 15th district is the most populated one, Vaugirard Hospital was built to meet specific requirements (one quarter of the population of this district is over the age of 60). In fact, the hospital policy stipulates that the ties with the population and the health and social services of the district must be continuously reinforced. Following board members' decisions to conduct a subproject, meetings were held with the staff in order to choose project members and appoint a committee leader. The different staff categories took part in the subproject committee so that the staff could be really involved. A schedule was drafted to provide a timeframe for the different stages of each subproject. An external institution, the Institute for Health Policy studies was designated to provide information and conduct the evaluations of the subprojects.

The Vaugirard team created a number of tools and services to promote health and well-being of elderly people:

- a) The gerontologic network between Vaugirard Hospital and the 15th district. The aim of this service is to encourage a partnership between the Vaugirard Hospital staff and the health professionals of the 15th district. The network co-ordinator is responsible for responding general practitioners (GPs) and families, giving information prior to an elderly person's admission to hospital, preparing the patient's discharge by contacting the different home aid organisations of the 15th district. A patient follow up booklet includes both, medical and social information which allows the various providers to follow up and co-ordinate care. A grid to evaluate the degree of autonomy is used to monitor the patient especially when the patient's situation worsens, thus making it easier to decide to readmit the patient directly. This avoids being admitted firstly to an acute care hospital only to be transferred later to a rehabilitation and long term care hospital. In this context of care co-ordination projects between the primary care system and Vaugirard Hospital, a day-care hospital called »Rainbow center« opened its doors in April 1994. It reached full capacity in September 1995 (20 beds). It provides care, rehabilitation facilities and curative workshops. Medical check ups are provided at the request of the GP.
  - b) A geriatric outpatient service allows the GP to seek a geriatrician's advice in order to deal with the elderly people who have several illnesses.
  - c) A guide listing the health professionals and socially-oriented services was sent to the GPs of the 15th district in January 1994. This guide describes the different activities proposed by the various organisations. They are grouped by category: care, delivery of meals, refurbishment, transportation, social life, practical needs (such as dentist and optician who make house-calls or even someone who looks after pets), accommodation possibilities and safety and security needs. For each of these categories, a sheet lists the organisations with their respective services. A more detailed description of the providers' services includes the legal status (public, private non profit making and private profit making) and consequently, the funding of this service (Social Security, the municipality, charitable organisations or private companies) and the cost of the service for the elderly person with the financial aid possibilities. In addition, this guide provides general information concerning the social and legal coverage of elderly people: additional coverage by social security, financial aid possibilities (companion and home health aids, home improvement for medical purposes) and information concerning the elderly person's legal rights (power of attorney for example).
- Vaugirard Hospital was a new experiment of a geriatric hospital inside Paris. In fact, most of the geriatric hospitals are in the country, thus limiting family visits and participation in the everyday life of the surrounding area. As a

result, AP-HP is converting acute care hospitals located within the city of Paris into long term care hospitals. Some of these hospitals will be renovated and redesigned with elderly people in mind whereas one hospital, Bretonneau Hospital has been torn down to be rebuilt using foreign experiments and Vaugirard pilot programme as models.

## ***II. The new project of Vaugirard Hospital: the hospital beyond the walls***

Taking into consideration the increasing needs, Vaugirard Hospital board managers have decided to provide services outside the hospital. A ground floor apartment was leased to accommodate a group of dependent elderly persons in order to allow them to stay in their district while being followed up by the hospital team. This project is quite new for geriatric hospitals.

The aim of this subproject is to allow very dependent people with severe neurological diseases and physical impairments to live in a less medical environment in comparison with long term care units.

The main activities are the following: a team of 2 auxiliary nurses and 2 people in charge of shopping and cooking managed by a housemother will make up the team. 8 elderly people will live in a elderly care equipped flat located in the 15th district. They will participate in the every day life: shopping, cooking, setting the table ... and will be encouraged to be personally involved in these activities. The volunteer associations and the families will participate in the organisation of this flat as well. The hospital staff, medical doctors, nurses, physiotherapists and workers will visit the elderly people if necessary.

A survey will be conducted to compare this new organisation to the traditional hospitalisation, including quality criteria and costs. In fact, it will be interesting to know if mini nursing homes correspond to future long term units.

## ***Conclusion***

This new project is a completely new approach to promoting the health and well-being of elderly people. It can serve as a model to reorganise the health care system in France and to encourage greater co-operation between the University Teaching Hospitals and the primary care system. We know that although the realisation of the need for health promotion is obvious, it will be difficult to implement programmes due to the fact that hospitals are under the

authority of a regional agency on hospitalisation whereas the ambulatory system is supervised by regional agencies of social security without a comprehensive co-ordination between both sectors. As a result, the concrete measures concerning Health Promoting Hospitals will still have difficulties being implemented. Nevertheless, the health authorities finance health networks' experiments in order to promote care co-ordination.

The positive point concerning the development of Health Promoting Hospitals is linked to the fact that quality of care standards, quality assurance programmes and accreditation procedures will help to generalise the Health Promoting Hospitals experiments within the French hospitals.

*Ulrich Schwabe*

## ***Networking In and Between the Settings »Healthy Hospitals« and »Healthy Schools«***

A hospital which wants to promote good health, develops into a networked system. This results from personnel and organisational development. People, competence tasks and structure are networked. As well as the internal networking process an external network also develops, based on results e.g. through customers, suppliers and business partners.

Following this thought is the conscious networking with other settings for good health, e.g. schools; beginning to use the health potential of both schools and hospital and thereby increase their efficiency.

New forms of communication accompany and support this process. This »Health communication« is necessary to bring a self-determining, participative process of change into motion. Healthy communication between people and their responsibility for the development of healthy organisations is the prerequisite for a healthy society.

Possibilities of health communication between the settings hospital and school will be introduced through practical experience.

For this I'd like to: Firstly deal with networking processes in the model project »Health Promoting Hospital« at the Magdeburg city hospital and secondly point out selected examples of the possibilities of network in the settings schools and hospital.

### ***Networking at the Magdeburg City Hospital***

On the 1st of July 1997, the City Hospital, the State Society for Health (inc.) and the Magdeburg Technical College (in the subject area social and health services) signed a contract of co-operation to shape the project hospital for the promotion of good health, which was began in 1995, into the next century.

Further co-operation partners are the Ministry of Employment, social welfare and health, health insurance companies, which help finance the project, the University of Magdeburg, the municipal accident association of the state of Saxony-Anhalt, sports clubs, the Fraunhofer Institute and Health pro-

moting schools. The project structure consists of a co-ordinating group, a project advisory group and the sub-groups.

A central co-ordinations group of appointed representatives of the Clinic, the State Society and the Technical College will steer the process of development of the organisation.

In the task agreement the State Society is responsible for the project advising, which has systematic developments of organisations as its goal. In this project advising, the scientific resources of the Technical College are included for reflection and evaluation.

Ideas for concrete work plans in the sub-projects, which now total 9, came from intensive dialogue with various co-workers, groups and committees of the hospital.

Work in the sub-projects is voluntary. Co-workers are however given time off from work for it. However also their free-time is used. Each sub-project has its own chosen project leader, who is from the hospital. The project advising is secured by employees from the State Society for Health, the Technical College and with support of students.

In these sub-project groups the problem areas will be designated and the causes of them will be investigated. Creative solutions will then be developed with modern communication and modern techniques. From this the groups, each member having equal rights and independent of their social and professional status, will create concepts for the realisation of their concepts. After agreement by the co-ordination group these projects will be realised step by step. Through this the participants will develop increased trust in their own capabilities to solve problems and can make them active in the future development of the hospital. Such form of communication, which aim for democratic participation and empowerment of those involved, form the basis for a healthy communication culture. The people, groups and organisations involved will be drawn into a healthy, effective and self-defined network process through this. Project information leaflets, project reports and advertising columns will serve to increase the informative nature and transparency in various departments.

In the connection of the sub-projects within the hospital those involved will gain experience in networking and co-operative collaboration will help to achieve goals which cannot be realised so well alone.

In the connection of the sub-projects with external partners those involved will use the resources outside the hospital and learn to network in the region.

1st example: »Decreasing rubbish«. To reduce the amount of rubbish in the hospital, the sub-projects »Enviroment and Health«, »Healthy Feeding« and

»Healthy Cure« should work together. Collaborators from different departments like administration, technical and medical supplying must agree and do the necessary steps to decrease the rubbish.

2nd example: »Back protection during patient transportation«. In this sub-project apart from the collaborators of the hospital, the Technical College and the Federal State Union, a registered health centre, a sport association, the Accident Union and the University of Magdeburg are also involved. They all try to reduce back injuries by training and teaching the right way to lift up and carry people.

3rd example: »Art as therapy in the therapy«. In this sub-project the collaborators and the patients of the hospital, representatives of the Technical College and from the Federal State Union work together with former patients, artists, teachers and representatives of the University of Magdeburg try to create new ways in the consulting of patients. This proposition will be extended to the collaborators of the hospital and interested children, youth and adults of the region.

### ***Network between Hospital and Schools***

Beside practical examples, I would like to present some ideas for the networking between the »Health Promoting Hospital« and »health promoting Schools«.

1st example: The sub-projects »Hospital close-up«, »Fan project« and »Art as therapy in the therapy« work together with the network »Health Promoting Schools« of Magdeburg. They help the children and youth to decrease their fear of hospital, to introduce them in the hospital's projects and offer them an interesting free time perspective.

2nd example: The sub-projects »Health promoting nurses' school«. This sub-project contains three important points:

- The nurses' school will be profiled as a »Health promoting nurses' school«;
- It will propose a formation in the direction health promotion;
- The students will work together in the sub-projects of the hospital.

To reach this goal, the nurses' school is a member of Magdeburg City Network »Health Promoting School«. Through this we are connected to the State

Network »Health promoting schools« in Saxony-Anhalt as well as the German and European ones.

***About the Development of the State Network  
»Health Promoting Schools« in Saxony-Anhalt***

Since 1993 a State Network for the Health Promoting Schools has been developed in Saxony-Anhalt. In 1993 started two model schools included in the European test model »Network Health Promoting Schools«. Until 1996 the number of health promoting interested schools was raised to 50 in Saxony-Anhalt.

In 1996 a new project was started between the Ministry of Education of Saxony-Anhalt and the Federal State Union for Health called Regional Support Centre (RUZ). The aim is helping the schools to built a network with other partners. In Saxony-Anhalt are the themes environment and health developed in more than 150 schools. In 1997 the demand increased so much that we had to organise six connection points schools and built up other small networks.

The work of these connection points is supply a join up. The centre is information, exchange of experience and helping schools which are not reaching the goals alone. To the City Network of Magdeburg belongs also the »Health promoting nurses' school« of the City Hospital. The sub-projects »Hospital close-up«, »Fan project« and »Art in the therapy« collaborate very closely with the networked schools.

With the networking of traditional health and learn institutions results various possibilities of reciprocal help within the different organisations. In this case, the schools and hospital will be developed as health centres for their region.

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## ***The Health Promotion Services Contracting in Primary Health Care***

The performance of primary health care obligations concerning health promotion should proceed first with detailed assignments of relevant tasks and services, for physicians, nurses and other primary health care staff, which are to be provided apart from previous routine health services.

Because of their specificity and complexity, health promotion services standards are not easy to establish. But such standards would allow evaluation of contracted services. Some attempts to develop such standards have already been undertaken by British authors,<sup>1</sup> and according to them, the quality standards should be worked out and established jointly with the health promotion programmes.

There is a need to establish health promotion posts, out-patient clinics or separate centres within primary health care facilities dependent on local needs and possibilities. The health promotion entities may function within the present general ambulatory services units, out-patient clinics for mother and child, specialist out-patient clinics and other primary health care departments covering 2,500-3,000 population.

### ***Stages of health promotion services incorporation within primary health care***

Incorporation of health promotion services within primary health care activity requires progressive developments, which for the sake of clarity, should be divided into several steps.

Stage I: Information and distribution of health promotion ideas: Incorporation of health promotion services as a permanent assignment for primary health care requires wide communication through properly trained staff with local community. ***The main assignments for this stage:*** Conducting an informative action within a local community on the role and plans of primary health care concerning health promotion services development. Addressees: local schools, various enterprises and institutions, health care facilities, and

<sup>1</sup> Speller, V., Evans, D., Head, M. J. (1997), Developing quality assurance for health promotion practice in the UK. In: *HPI* 12, 3, 215-224

members of NGOs, professional associations, as well as representatives of local administration, self-government and other authorities.

Stage II: Diagnosis of the health status and level of knowledge of local community on determinants of health and environments supporting health. ***The main assignments for this stage:*** Aggregation of data concerning health status and level of knowledge on health determinants and environments supporting the health of the local community. This will enable one to describe local health needs; assess preventive measures demands; estimate priority topics for health education and distinguish locally existing environmental health hazards. Identification of expectations and preferences of the recipients is a core factor for health promotion services quality assurance.

Stage III: Launching of interdisciplinary collaboration for health: The design of health promotion programmes should be at an advanced stage and ready for introduction. ***The main assignments for this stage:*** The priority aim of this step is to continue and develop new relationships for the development of local health promotion programmes and strategies. The persons who should be involved, are: physicians, nurses and other primary health care and specialist out-patient clinics professionals, as well as sanitary station personnel; employees of educational and social care facilities; representatives of local administration and self-government, as well as other local institutions and professional groups; representatives of local community.

Stage IV: Development of collaboration with local community: Activation of the local community for co-operation is the core issue for this stage. ***The main assignments for this stage:*** Development of educational and cultural activities connected with health promotion in local schools, nursing schools, cultural centres and other local settings; individual contacts (of physician, psychologist, nurse, social worker, etc.) with parents to discuss health consulting and preventive measures to control health threats; organisation or facilitating of meetings of local inhabitants with health promotion posts, out-patient clinics and / or local health promotion centre.

Stage V: Educational and preventive measures: In order to conduct preventive and health promotion activities on behaviours, attitudes and health needs of local community it is necessary to work out a syllabus of educational and preventive measures based on former information concerning specificity of life and local health problems (e.g. related to alcohol, tobacco, drugs, occupational and home stress, leisure time etc.). ***The main assignments for this stage:*** Educational and preventive activities of the primary health care health promotion post, out-patient clinic or health promotion centre should consider two following areas: (1) scheduling and implementation of educational programmes based on analysis of health status of local community and health

hazards; (2) scheduling and implementation of preventive programmes related to: dental caries and defects of posture in children and adolescents, accident and injuries at school and at home, drug and other substance dependence, cardio-vascular diseases, malignancies, osteoporosis, tensions and conflicts at home, family violence and schooling problems.

Stage VI: Establishment of a bank of information and analysis and evaluation systems; Monitoring of health status and health promotion programmes implementation process should aggregate information on: health status and health needs of local community covered by the health promotion facility; educational and preventive activities and their acceptability, efficiency and effectiveness; institutions and organisations dealing with health issues as well as those giving support in critical situations.

The data when finally worked out and analysed, should be accessible for the local community in various forms.

### ***Manpower and its eligibility***

In the case of the health promotion post or health promotion out-patient clinic it would be indicated to appoint at least two persons, i.e. a physician and a psychologist, sociologist, nurse or social worker. Having got adequate resources it would be advisable – depending on the needs – to extend the team (especially if it is large population) with epidemiologist, statistician, educationist. A professionally differentiated team generates more possibilities for meeting different needs and demands related to the local community health status and to health care performance.

The candidates for the appointment to the offices should have their own professional experience and health promotion theoretical and practical background. Medical professionals should have at least two years medical practice and proper knowledge in health education and health promotion, as well as organisational skills and other positive personality traits, e.g. assertiveness, high and adequate self-esteem, sense of personal effectiveness, good communication skills with other persons, openness, etc.

Candidates from other professions (e.g. psychologists, social worker) should also have at least two years professional practice connected with health issues and proper knowledge health education and health promotion. Sometimes it would be required that the candidates should have certificates confirming their attendance at health promotion, public health or diseases prevention courses or training.

***The scope of health promotion services to be performed  
by primary health care staff***

A contract on health care services is a civil law agreement between a health care institution and a certified medical professional for performing services. A contract on health care services consists of the number and variety of contracted services, the extent of the population to be covered with the services, times and places of the services provisions, the quality of the agreed services as well as the costs of wages and salaries. Contracting subject must have premises with specified space and equipment standards. Contracted services are subjects to the purchaser's substantial control.

Health promotion services can be also a subject for contract negotiated with a general practitioner or family doctor, a nurse or other medical professional of primary health care: (a) as a supplement of a contract for basic medical services (diagnosis, treatment) and (b) as a separate contract for provision of health promotion services within the primary health care facility, as a head or a staff of the health promotion post, out patient clinic or health promotion centre.

A **physician** accepting through signing a contract for health promotion services provision: (a) provides the services for the community covered by the health care facility and for persons visiting the health promotion post, outpatient clinic or health centre or at their homes. In order to perform the services a physician has to be in permanent touch with the persons and their families in order to be able to diagnose their; lifestyle (habits of nutrition, dependencies, physical activity, leisure time use etc.); environment and work, life and learning conditions; coping with personal and family problems; health status (body fitness, health hazards, hereditary, burdens infections diseases etc.). (b) keeps a record, a »Family file« containing data on; information aggregated by performance of item (a), and other depending on needs and situation of the family; framework of co-operation with a person and his / her family; record of undertaken activities (advice, consultations, referral letters to, e.g. psychologist, sexuologist, dietician etc.); record of undertakings initiated by the physician and performed by a person and his / her family. The record is simultaneously a basic document for the contract of accounting. (c) assumes health promotion undertakings for a person or a family – for instance – directed on change of his / her own or his / her family life style, which should lead to: commencement or increasing his / her / their physical activity; initiation of appropriate nutrition; compliance with indications for personal hygiene and sanitary conditions in their dwelling; prevention of communicable diseases (tuberculosis, viral hepatitis, AIDS etc.); diminishing of exposure to environ-

mental risk factors (alimentary intoxication, home accidents, etc.); early prevention of malignancies and in the case of appearance of such needs: to reduce, and consequently eliminate, smoking habit; to reduce and change alcohol consumption structure; to limit and change psychoactive substances use, including pain killers, sedatives and sleeping pills; to carry out sexual education and family planning. (d) implements health education activities: at health promotion post, out-patient clinic and / or health promotion centre; at schools, enterprises and leisure centres; at dwellings; at the housing estates clubs and so on. (e) collaborates with other persons and health promotion teams dealing with implementation of Healthy Cities, Healthy Schools, Hospital Promoting Health and other WHO projects.

A **nurse** may contract health promotion services provision as his / her individual activity within a population covered by a primary health care facility or as a member of a health promotion team led by – for example – a physician, psychologist, sociologist, which has functioned at the health promotion post, health promotion out-patient clinic or at a health promotion centre. The health promotion office may provide health promotion services for primary health care and also may be an element of one or more already established WHO projects at given location. A nurse may provide all health promotion services as indicated below or only its selected elements according to the local authority, local health authority or local community needs and demands and according to their financial possibilities.

A nurse accepting, by signing a contract for the health promotion services provision, should be able to perform: preventive activities – for instance – concerning dental caries and parodontal problems in children, adolescents and pregnant women; posture defects in children and adolescents; communicable diseases, health damaging lifestyles etc.; health education on: personal hygiene and housing sanitation; principles of healthy nutrition; breast feeding; family planning, etc.; care and advice for disabled persons: to ease their everyday life at home and in the community (psychological and social adjustment, house rearrangement for a disabled person's needs) in cooperation with local mental health out-patient clinic or a psychologist or sociologist and local housing administration; care and services for dysfunctional families, who are in a difficult situation; alcohol related problems; advice concerning psychological support, help in finding contact with out-patient clinic for alcohol-dependent persons, therapeutic groups, social care centres etc.; conducting purposeful education and training for individuals and groups (e.g. families) related – for example – to changes of behaviour and habits harmful to health, to integrate house inhabitants or family members in planning their security and prevention activities in their present life environment and taking common responsi-

lity for their surroundings; keeping records of provided services in the »Family file«.

A **psychologist** or **sociologist** may sign a contract for (a) separate health promotion activity within the community covered by a primary health care unit or (b) common health promotion activity as a member of the health promotion team (e.g. with a physician, nurse etc.) acting within the community covered by a primary health care unit. In both cases the contract may be »overall« in character and be related to all local community health needs and demands or the contract may be »partial« in character to cover selected health promotion objectives according to the local community health needs and demands relevant to the psychologist or sociologist profession.

A **psychologist** will be obliged to provide: (a) provision of health promotion services focused on psychological aspects for local community and patients and their families covered by the primary health care unit, with special attention to persons with high health-risk factors; (b) work with a patient and / or his or her family to minimize the psychological costs of illness, such as diabetes, heart disease, malignancy, physical disability, etc.; (c) continuation of psychological care for the families while their members are hospitalised and psychological support for persons admitted to hospital; (d) individual and group (e.g. family) work to cope with stress, developing tension and stress reducing techniques – for instance – relaxation training; (e) arranging group gatherings, interpersonal training related to health and modifying behaviour and habits harmful to health; (f) work with young individuals and family members focussing on their contacts with psychoactive substances (narcotics, alcohol, tobacco, medicines) to prevent self-mutilation and suicide, as well as to prevent negative influence of peer groups, religious sects etc. – if such threats appear; (g) healthy life-style shaping and empowering – for instance – related to leisure forms, every-day life-style etc.

A **sociologist** will be obliged to provide: (a) gathering of information concerning health status and level of knowledge on health determining factors, on available data and measures, particularly those resulting from his or her own surveys employing methods used in sociology; (b) collaboration with primary health care medical professionals, employees of educational institutions, social care centres, local administration and community representatives for exchange of information concerning health needs and health threats to the populations covered by the primary health care unit; (c) collaboration with a family doctor in the scope of psycho-active substances dependency (alcohol, drugs etc.), with particular emphasis on environmental interviews (in co-operation with social worker and social nurse) and arrangement of self-help groups development among: families living in the same housing estate and mutually

supporting themselves in health strengthening activities – for example – to reduce drug dependency, to learn effective leisure, healthy diet etc., through families experience exchange, common new ideas development, etc. The sociologist would play a role of co-ordinator of such family teams and a person suggesting new health-related initiatives; young people to be interested in health issues; primary and secondary school children and university students' motivation (especially if they all live in the primary health care unit catchment area) to be committed to health promotion activities, help for self-help groups and spread a healthy life style among peer groups and their families; (d) prevention of accidents and suicides, particularly within specific risk-groups through development (individual, with social worker, with social nurse) of environmental interviews in families, where accidents appear frequently and families in which attempts of suicide happened (with particular attention to such attempts among children and adolescents) and referral of the threatened persons to specialist out-patient clinics (psychology, psychiatry); (e) propagation of patient's rights through training for medical and staff; (f) management of surveys of community / patients opinion (satisfaction) on health care services accessibility, means of utilisation and evaluation, as well as propagation of the results among medical and regional self-government staff.

### ***Principles of financing health promotion services***

Remuneration within contract agreement for a physician, nurse, psychologist, sociologist, environmental nurse or social worker for health promotion services is to be based on general principles of health services contracting within the country. Responsibilities of staff including the contract may be a subject of full-time and self-dependent contract or a subject of part-time and additional assignments included with the basic primary health care services contract.

In the case of »part-time« contracting for health promotion services provision, remuneration for the services may be a subject of proportional payment of the basic salary (up to 30 per cent). In the case of »part-time« contracting for health promotion services provision, another form of remuneration for the services may be a subject for payment with use of the scoring method. The staff will be paid for the performance of particular assignments within a full-time contract for primary health care services, and then the aggregated scores are added to the basic (full-time) salary. The various examples of health promotion services assignments, which will be the base for payment, being a part of the »full-time« contract for the medical care services, may be taken from

the patterns for »full-time« contracts for health promotion services provision presented below.

### ***The proportional method***

Basic salary will be agreed and established for a given period of time in a contract for the health promotion services provision and performance of any additional tasks is added as a percentage of total programme assignments. For example: (a) basic monthly salary (within a contract agreement) may be established on the level of – for example – US \$ 300, which makes the staff signing the contract responsible for providing the following: to be present during working days and hours at the health promotion office (post, out-patient clinic, health promotion centre) and provide services within those premises or to perform his / her duties out-side the premises in the catchment area of the primary health care facility; to provide health care services for persons referred (e.g. by GPs) or coming direct to receive health promotion consultation; to keep records of performed services; to develop and continuously expand health promotion initiatives at the health promotion office location (at out-patient clinic, hospital); to perform other responsibilities specified in the contract-agreement. (b) additional services, not specified above (at item a), which can also be a subject of supplementary payment for the staff, and added to the basic salary (US \$ 300) for provision of health promotion services. For example: performance of specific additional programmes (on tobacco, alcohol, nutrition etc.); provision of advice and consultation at the health promotion office or out of the premises (at home, school, factory etc.) in a number beyond the limit, norms or standards delineated in the contract-agreement; undertaking of other than fixed in contract-agreement health promotion related initiatives and innovations.

### ***The point scoring method***

This method would be mostly implemented in the primary health care facilities, where all contract-agreements are based on the same method of scoring. In this case, remuneration for health promotion services would have to be based on the same principles. It is a quite common use principle, that the obtaining of a delineated number of points may be treated as a basic norm or standard, and any additional tasks performed would be on an extra-payment basis. It is obvious that some elements of health promotion services should be also assessed on a scoring scale and grouped as a minimal amount of points to be paid by contract, using the scoring method. In other words, for the performance of a given segment of a plan of work or programme, specific task or any separate additional job, which has not been included in the contract basic

responsibilities (but if quoted in the contract), should be fixed through a detailed number of points for payment. The way of settlement of remuneration for one scored point should be matched with the general principles of payment by scoring points within the health care facility.

***The provision of health promotion services as a part  
of a contract for general primary health care services***

***General Practitioner, Family Doctor***

(a) According to the act on the health care institutions (amended recently), a physician, and family doctor in particular, within his / her responsibilities should provide also the health promotion services for persons consulted at the primary health care facility. The physician contracting his / her health promotion services as a part of his / her primary general health care services, should also pay special attention to providing the services, while visiting homes, schools or other settings allocated to his / her catchment area. For those purposes, the physician should be in continuous touch with individuals and families to be able to recognise their: life style (physical activity, nutrition habits, leisure time utilisation, drug dependence etc.); environment and conditions of everyday life, work and schooling; coping with personal and family problems; health status (past diseases, genetic burden, health hazards etc.).

In order to create a record, which will be a basis for remuneration, a physician keeps a »Family file« containing information collected through the contract-agreement performance and other data relating to a subject or to family needs and situations; a framework of co-operation with a subject or family (priorities settlement); record of undertaken services (consultations, referrals, etc.); record of health promotion activities initiated by the physician or by a person or family members on the physician's suggestion.

For the development of the above services in a continuous and documented way, a physician may receive **3-10 per cent of total monthly salary**.

(b) A physician assumes activities directed towards the promotion of a subject and / or family's health, which should lead to: undertaking or intensifying their physical activity; implementation of appropriate nutrition; maintenance of personal hygiene and good sanitary condition at the house; prevention of communicable diseases (in particular: tuberculosis, viral hepatitis, AIDS etc.); control of health damaging factors within every day life, work and school environment (alimentary intoxication, home accidents, etc.); early prevention of malignancies (**and if there are such needs**); reduction and further elimination of cigarette smoking; reduction and change of alcohol consumption habit;

limitation and further elimination of psychoactive substances use; sexual education and family planning.

Verification of conducted activities may be based on a preliminary action plan implemented before health promotion interventions and evaluation surveys. For development of the above services in a continuous and documented way, a physician may receive **1-10 per cent of total monthly salary**.

(c) A physician collaborates with other health promotion teams (WHO Healthy Cities, Healthy School, Health Promoting Hospitals Projects, etc.) at the same local environment. For the development of the above services in a continuous and documented way, a physician may receive **0-5 per cent of total monthly salary**.

According to current information, the health care facilities or persons responsible for the contraction of medical services with physicians or other medical or para-medical professionals tend to pay for contracted health promotion services included into full contract-agreement for health care services up to 30 per cent of the total monthly contracted salary. The same principles should be used for the health promotion services contracting with nurses, psychologists, sociologists, environmental nurse and social worker.

### **Nurses**

The term »nurses« means the medical professionals graduated from the medical school for nurses and midwives, who work together with a physician (general practitioner, family doctor, medical specialist) or perform self-dependent duties at the primary health care out-patient clinic or other health care facility.

Remuneration for those staff responsible for the performance of health promotion services within the basic contract-agreement for general health care services may be based on the principles described for physicians. In the case of a self-dependent nurse, in particular, holding an academic diploma of master of nursing, it would be preferred to employ him or her on a full-time basis contract.

### **Sociologist**

A sociologist may work together with a physician, nurse, psychologist, environmental nurse and social worker on the ground of contract-agreement on a full-time or part-time basis. Calculation of the contract payments depends on the basis and is similar to the principles stipulated for other professionals mentioned above.

***Psychologist***

A psychologist may work together with a physician, nurse, sociologist, environmental nurse and social worker at the same health promotion office (post, out-patient clinic, centre). He / she may be employed on full-time or part-time basis. Remuneration should be based on the principles described for other professionals, depending on the basis of the contract.

***Environmental Nurse***

An environmental nurse may perform duties providing health promotion services at the relevant office and / or a district covered by the primary health care facility services on the basis of a full-time or part-time contract. Calculation of payments will depend on the basis and be similar to the principles stipulated for other professionals mentioned above.

***Social Worker***

A social worker may provide health promotion services delineated and agreed in the contract on a part-time or full-time basis. Remuneration will result from the basis and comply with the principles described for other professionals, mentioned above.

***Self-managed contracts for health promotion services provision***

Scope of health promotion services for the self-managed full-time contracts results from assignments described above. Detailed scope of responsibilities and assignments for the professional performing self-managed health promotion contracts will be agreed with a purchaser of the services.

Within the first stage of the health care system reform in Poland, the contracts for health promotion services provision will be undertaken mostly on a part-time basis, i.e. for health promotion services delivered as a part of general health care services. Nevertheless, there are already health care facilities in the country, where the health promotion out-patient clinics or health promotion offices, as mentioned at the beginning of this paper, are functioning (Health Promoting Hospitals, Healthy Cities).

*Mark Kennedy*

## ***Developing Health Promoting at the Primary – Secondary Care Interface***

Traditionally health promotion has focused on either a topic or settings based approach. The development of the Healthy Cities concept pre-empting the development of Health Promoting Schools, Hospitals and Health Centres. However as we develop these organisations independently they may become isolated as many health promoting settings are led by their own, and not shared needs.

The concept of developing health promotion at the interface between primary and secondary care removes this risk of isolation. Joint working in this arena is dependant upon the two separate organisations identifying, comparing and acting on ***shared need***, for the benefit of the population they both represent.

The initial stage involved a consultancy forum. The healthcentre was represented by two general practitioners, a practice manager and two practice nurses; the hospital by the health promotion co-ordinator, a service manager and a contracting officer. The various stages of the model are:

1. Perceived Needs – Identification of services or lack of services that were problematic to both organisations. Important that both areas benefit from proposed areas of working (3 were identified from initially 7 suggestions).
2. Fit within Service – Do the proposals overlap, are environmental factors in place to develop new services. Are referral mechanisms in existence already?
3. Human Resource Implications – Are existing positions available to cope with new proposals, are new staff required, Grading issues, support staff, who meets cost?
4. Identify Community Links – Are there avenues for the service to feed into community groups with related agenda?
5. Pursue Funding – Primary care and acute trusts have different avenues from which funding can be secured. Each assesses possibilities and identifies definite contributions, this can take some time.
6. Implement – Implement the new service initiative and as ever build in audit and evaluation criteria.

Following this approach, three topics were identified as areas within which both the hospital and the healthcentre wished to develop. These were Mental Health, Coronary Heart Disease, and Smoking Cessation.

### ***Mental Health Interface Project***

On brainstorming the ***perceived needs*** of both organisations the main issues identified were that, for the primary care setting, problems dealing with the various issues associated with bereavement (Loss, income support, career issues, isolation) were difficult to address within the time constraints of a modern healthcentre setting. Concern was also expressed that the practice can lose contact with patients recently bereaved, and consequently have little knowledge of how they are coping.

The hospital felt that co-ordinated training was required for nurses faced with the prospect of preparing the next-of-kin for the imminent death of their partner, and indeed the best way in which to break »bad news« (e.g. discussing cancer, loss of limb function). Both of these issues had previously been identified as high stressors in the nursing staff. In order to best meet both needs a linked service was developed.

Primary care appointed a »Stress Counsellor« and the Hospital appointed a Bereavement Nurse (following consultation with Macmillan Nurses) in order to provide a co-ordinated service with 2 way communication and feedback. Potential results of service development are:

#### *Primary Care*

Perceived reduction in anti-depressant medication.  
»Problem« patients receive greater input.

GP time allocation improved.

Specific referral point for bereaved.

Increased utilisation of voluntary groups.

#### *Hospital Setting*

Development of Liaison Service.

Nurses and doctors trained in breaking bad news.

Ward managers trained in Critical Incident Debriefing.

Establishment of Policy and Protocols.

Improved Service Delivery and Communication.

### ***Coronary Heart Disease Interface Project***

This second development followed the same initial process as the project described above. The common agreed need was for a service focusing on risk factor management associated with secondary prevention of Coronary heart disease. This would clearly develop the existing cardiac rehabilitation service within the hospital, and also encourage the development of a monitoring role for the practice nurse in the primary care setting.

Interventions within the programme are (Clinical management, prescribing and referral protocols developed for each of the areas):

- Smoking
- Diet
- Cholesterol
- Hypertension
- Physical activity

These would occur within the hospital setting and be made available to the healthcentre in various formats. The patients would undergo a »scoring assessment« with the main risk factors identified. »Motivational Interviewing« would be given, when appropriate, and the patient »tagged« for follow up by the primary healthcare team.

### ***Smoking Cessation – Laser Therapy Interface Project***

The final partnership project involved the provision of a smoking cessation service. Previously the hospital had implemented a Laser Therapy service for employees wishing to stop smoking. The resulting success rate of 46 % encouraged both parties to consider piloting the service with an identified population.

Laser therapy involves the same principle as acupuncture, however a harmless laser replaces the needles involved. It is thought that the therapy stimulates endorphin release, raising the individual's self efficacy and strengthening their willpower in order to overcome the cravings associated with nicotine withdrawal. Additionally to the laser, the therapist incorporates a patient centred motivational counselling approach with the patients. There is also a helpline available to patients using the service.

The GP's were invited to refer patients with known smoking related disease to the service over a six month pilot period. Specific referrals from Consultants within the hospital were also accepted. Seventy patients accessed the service. Success was measured by exhaled carbon monoxide measurement 6 months following the intervention. The results:

*Patient Pilot – Results at 6 months (n=70)*

Male				Female			
Age	N	Success - 6 months		Age	N	Success - 6 months	
40-50	4	2	50 %	40-50	6	3	50 %
51-60	19	12	63 %	51-60	12	7	58 %
61-70	10	6	60 %	61-70	9	4	44 %
71-80	6	3	50 %	71-80	4	1	50 %

Soft data e.g. ***was tobacco consumption reduced in those unable to stop*** was collected. Only individuals completely abstaining from cigarettes were considered successful. The mean success rate across the sample was 55 %.

This programme is currently the subject of a randomised control trial.

# Special Thematic Focus: Violence Prevention in Hospitals

*Marie Thérèse Hecht, Mathilde Kazes,  
Marie Agathe Zimmermann, Jean François Uhl*

## ***Violence and Insecurity in Hospitals How can Staff Protection be Improved?***

Criminality has been multiplied by four during the last years and drug addiction is found in 50 % of these cases. It is also said that violence has not really increased but that violent incidents are recorded more precisely. Nevertheless, that increasing level of violence in our society affects our feeling of safety.

Such incidents can also occur in hospitals where everyone in need of care is received and where an important supply of drugs is available. Only a few authors have researched this field and most of the data comes from Northern America, Scandinavia and the Anglo-Saxon countries. Most research on violence concerns psychiatric institutions. Until recently, that subject was taboo. For the staff, it was regarded as an occupational hazard and perceived as the result of incompetence. For the hospital, it was considered best to remain silent for the sake of keeping a good public image.

### ***Violence from the patient or the visitor against hospital employees***

Violence can occur in different areas of the hospital; however, some of them are especially dangerous, such as:

- Psychiatric units: The first papers studied patients' aggressiveness in order to identify subjects particularly prone to violent behaviour and prescribe a suitable treatment. Nowadays, the collection of data and the statistics carried out on injuries involving staff members demonstrate the importance of the environment for the staff's safety: it has been shown to improve control over aggressive tendencies.
- Emergency departments: In these departments, violence is linked to the incoming patient. Usually, the patient has been injured during a domestic or a street fight while intoxicated and he arrives accompanied either by family members or by other aggressive individuals. Because of its acute and severe anxiety, the family demands immediate care and that is not always possible because of other casualties that also require emergency care. This situation often leads to verbal abuse and an intensification of violence during which more injuries can occur.

- In geriatric units: Assaults by senile subjects are also frequent. Some patients are known to develop aggressive behaviour and the staff has been taught to deal with dangerous situations. Nurses must always be attentive and, after working in those units for a period ranging from a few months to some years, they have to change departments because of the resulting stress. In a German survey carried out in 1990 on the staff of a geriatric unit, 80 % of the employees reported injuries or verbal abuse at least once during that year.
- In the intensive care unit: Although violence is unintentional, nurses can be injured by a patient in a coma who will scratch or cling to them.
- In the other departments: All hospital employees are subjected to violence although some departments are more dangerous than others. Patients travel to different units for investigative purposes. The buildings are large and visitors are free to come and go.
- Feeling unsafe in the hospital: Thefts and damages occurring in the parking lots, in the changing-rooms or in the basements disturb the employees. The hospital staff works in shifts: the employees keep odd hours, coming to work either very early or very late, usually when it is already dark.

### ***Violence factors in hospitals***

- Admissions: Hospitals are supposed to admit all patients regardless of their condition, drunk, on drugs, violent or social outcasts. Body search is not allowed and anyone can walk in. Illness and death which are part of the hospital's practice contribute to further generate aggressiveness, verbal abuse and violence.
- Architecture of the building: The size and the architecture of the hospital, the hospitalisation period, but also the importance of the city and of the district influence the occurrence of violence, insecurity and assaults.
- Theft temptation: Usually, patients arrive carrying jewellery, watches, or money. As they are ill, they cannot take care of their valuables. Parking lots and changing-rooms are isolated. Drugs can be found in the dispensaries and treatment rooms. Employees are mostly female and work shifts. These last years, thefts of medical equipment are on the rise.
- Society: Violence can be explained by the increase of violence in society and also by the larger number of social outcasts. Some minorities are tempted to use the hospital as a hostage to publicise their ideologies such as their objection to abortion laws.

***Violence and insecurity in hospitals lead to the following negative consequences:***

- For the quality of care. Staff insecurity increases the work load and the employees who do not accept to work in such poor conditions demand preventive measures from the administration.
- For the public image of the hospital. Not very reassuring for the general public.
- For the hospital's income. It has to be insured against the increase of thefts and damages.

***Strategies for prevention***

- Analysis of work injuries: Keeping track of and investigating injuries improve their understanding. The frequency and location, the date of the occurrence, the meaning of the injury allow the implementation of a prevention strategy resulting in the improvement and progress of the prevention policy.
- The staff and the patient: Until recently, it was the aggressive behaviour itself that was to be taken care of and the staff had to limit the factors which may contribute to or provoke violence. A large enough staff that has received clear operating procedures and knows how to react in a violent situation, who has been educated and has received proper instructions works in a unit that is the safest. But it is not enough for a unit to develop a clear procedure and proper instructions. Other security and safety strategies are needed. Procedures must be organised with the help of the emergency and security staffs and written protocols should be circulated and applied.
- Ergonomics and architecture: The number of accesses, the sign system, the lighting, the choice and combination of colours, the good or poor condition of the building, the noise level of the entrance, and the equipment, all contribute to the level of violence encountered in hospitals.
- Security equipment: When the hospital is patrolled by a security team and security is monitored by a surveillance system involving cameras, it increases the impression of safety for staff and patients. The location of the department of safety is very important.

As all hospitals and public buildings follow fire safety instructions, likewise they must provide guidelines relating to dangerous situations. These guidelines must be written by various hospital workers such as the staff members

directly confronted with such situations, the security team, the financial and administrative managers, the team in charge of prevention and a legal advisor.

### ***Violence from the employees***

Violence involves either staff members or patients, but it can also affect the relationship between patients and staff. Usually, when violence is carried out by an employee it is considered as a serious professional offence. However, most of the time violence is not related to a psychological disorder but results from exaggerated stress and dysfunctional facilities. In geriatric departments, the staff must be patient with older individuals suffering from senile dementia. Everyday, they have to bear the same kind of situation without expecting any improvement. These units must handle difficult situations, especially when they belong to hospitals specialised in the care of senile patients. Nurses with a perfect record often say they do not understand their aggressive behaviour towards these senile patients. Their only way out is to move on to another department.

Harassment between staff members was extensively studied in Scandinavia, in Germany and in Austria. Professor Leymann coined the term of »mobbing« when verbal abuse, humiliations and harassment occur on a daily basis for more than six months. Harassment can be carried out by one or more staff members. The victim is not allowed to give her/his opinion anymore, to speak with her/his colleagues, and even to work. After several weeks or months, he or she begins to get ill and to exhibit psychological disorders. Then the aggressors can prove that indeed the victim shows an impaired behaviour and require the dismissal of that employee. When mobbing occurs, the victim has no legal resources and receives no help from the institution because of its severe dysfunction. The victim should receive help from a staff member not concerned by the conflict but in tune with the unit.

Violence in hospitals exhibits different shapes and its current level is on the rise. Whatever its magnitude, health professionals will not accept aggressive behaviour and patients are entitled to receive the best care available. Everyone demands safety. Hospitals managers should implement measures effectively suited to those situations. To meet that objective, they have to work with all the members of the staff, including the nurses and physicians, the architects and designers, the security, the town council, the patients' associations, and everyone willing to improve those conditions.

*Maria Lordan-Dunphy*

## ***Violence Against Women in the Home***

James Connolly Memorial Hospital is an acute general hospital situated in north west Dublin, Ireland, serving a population of 150,000. The hospital recognises that domestic violence has health as well as social implications. This presentation will describe how we plan to implement and evaluate a project on domestic violence in our hospital.

Recent research has demonstrated that domestic violence is a significant problem in the area where the hospital is based. It was decided therefore to develop a project to identify the extent of the problem and to put in place structures to provide an effective support system for women who present to our hospital Accident & Emergency department as a result of domestic violence. It is hoped that this will ultimately lead to a reduction in the number of women at risk from domestic violence in the hospital's catchment area. It is envisaged that women will be more likely to seek help if they receive a sympathetic response and adequate support when they present to the hospital. The need to train hospital staff in this area has already been identified by many researchers and evidence also suggests that women are most likely to disclose abuse in the A/E Department because it is anonymous and provides 24 hour cover (Goldberg & Carey).

I would like to present you with some facts and myths on domestic violence obtained from Women's Aid Ireland. It is widely recognised that domestic violence is a serious problem in Irish society. Between 1992-1996, Women's Aid, Ireland received a total number of 26,000 telephone calls from women who reported domestic violence. In addition their research carried out in 1995 demonstrated that 59 % of Irish women knew a woman who was in an abusive relationship and 18 % of women reported abuse in relationships with male partners. Some of the myths on domestic violence include the perception that battering only occurs in working class families, however the reality is that violence against women is not limited to any race, social class, age group or type of relationship (Levinson 1989). It can and does occur across all levels of society. Another common perception is that only a small number of women are battered or abused in their own homes. The figures outlined above demonstrate the appalling reality. From a European perspective it was suggested

(Dobash & Dobash 1979) that in Britain, 25 % of women had experienced abuse by their spouse/partner and that in Sweden one woman is battered to death every ten days (ROKS, 1990).

Violence against women violates human rights. It causes serious physical, emotional and psychological damage to women. It is a grave social and health issue which threatens the safety, equality and bodily integrity of every woman. It must be addressed and ultimately it must be stopped (Women's Aid, Ireland).

The main objectives of this project therefore, are to identify the women presenting to our hospital who are victims of domestic violence and to provide support, advice and assistance to create a safe environment for themselves and their children. The hospital decided to adopt a multi-sectoral and multi-agency approach to deal with the issue. A multidisciplinary team was set up in the hospital to plan the project. This team liaised with external agencies such as Women's Aid, Ireland the national agency on domestic violence, Contact Dublin 15, a local voluntary group set up to provide support for women who have been abused and the local police.

There were no structured guidelines for dealing with domestic violence in the A/E Department therefore good practice guidelines are being developed for all staff with the assistance of the Social Work department and Women's Aid.

Three hospital staff will be trained as trainers by Women's Aid. These trainers will co-facilitate training at local level with Women's Aid. All A/E staff will receive training.

It is also necessary to provide a suitable interview area for women to ensure confidentiality and safety. The committee are currently reviewing this area. A full time Social Worker has been appointed to the A/E Department to provide the necessary support and assistance to clients. A detailed database has been drawn up to document the number of clients who disclosed, the types of injuries inflicted, details of referral to Medical Social Worker and details of court orders obtained.

Evaluation of the project included collection of data from the previous twelve months to ascertain the number of documented referrals to the Social Work department. A review of existing domestic violence procedures was also documented. A staff questionnaire was developed to identify staff knowledge and ability to deal with cases of domestic violence prior to training. This will be repeated following staff training. Post project evaluation will include documentation of the number of cases presenting to the hospital A/E Department. These will be compared with baseline figures. The effectiveness of all project

interventions will also be evaluated. If possible the women who present will be followed up to ascertain if support provided was adequate.

It is hoped that this project will lead to the development of a model for other hospitals on domestic violence procedures. The project commenced in October 1997 and will be completed in late Autumn 1999.

# Developing Concepts and Tools for the HPH-Vision

*Cecily Kelleher*

## ***Health Promotion – Challenge and Opportunity for Medical and Nursing Care in the Hospital***

### ***Competing for Scarce Resources and / or Offering Partnership for Health***

#### ***Introduction***

The objective of this paper is to review the health promoting hospital concept as part of a more general health service policy in a time of increasing demand and economic constraint in health care delivery generally, but particularly in the hospital sector. The role of health professionals, particularly nurses and doctors, will be examined. Firstly, I will review the case for the health promoting hospital, arguing that it is intrinsic to the mission statement of any modern health facility and not an additional demand. I will then review issues of education and training of health professionals. Finally I will examine research issues, particularly from the perspective of my own research unit, including issues of evaluation and programme content.

#### ***The Case for the Health Promoting Hospital***

For the last century the health care system has been associated with the institution of the hospital as a place of treatment and care and as the situation where the most advanced services are offered. Most existing health care workers were trained in a hospital and at least half of all health care resources are spent in this setting in developed countries. If therefore the health promotion movement is to achieve a significant profile within the health sector itself then the hospital should be involved. In that sense it is a key policy issue for health care providers. Good services meet client need and the traditional approach must change if we are to go on meeting that need. The health promoting hospital initiative is crucially important for several reasons. In common with other settings-based approaches it seeks to re-orientate a service to a more proactive, positive approach and to involve all partners and players in that objective. Since the Budapest Declaration on Health Promoting Hospitals was formulated (WHO 1991) the movement has grown rapidly and as Pelikan et al. (1997) point out, the model first developed in Vienna was ex-

tended successfully first to 20 pilot sites and later through a network of 15 European Countries, Australia and Canada. This is therefore a powerful and developing movement. The same authors also refined the objectives and characteristics of health promoting hospitals which are broad-ranging, holistic and in line with the principles of the Ottawa Charter (WHO 1986). A health promoting hospital promotes patients' health by consciously improving and developing services, by providing those services in a humane and caring way and by using the point of contact as a window of opportunity for further support. The obvious vehicles for this are through continuity with primary care, rehabilitation and preventive programmes. Furthermore, of all settings the hospital is probably the most influential for health professionals themselves. Health and safety of workers themselves is therefore critical. Those employed in the health sector are workers first and foremost. If their own health needs are met they are more likely to adopt healthy lifestyles themselves and promote the benefits convincingly to their clients.

The reality in all countries however is that health service costs are escalating, in developed countries the ageing population will mean increasing pressure on the delivery of all kinds of treatment services in the next century. Despite the variation in how health services are delivered from country to country all modern health care planners are seeking more efficient means of service delivery and this is often perceived by consumers and providers alike as a reduction in resources and pressure on standards. Key questions to be answered therefore are (a) Can health promotion compete with other agendas? (b) Is there evidence of its effectiveness and (c) How do we evaluate that evidence? Let us examine the first question. In recent years public policy in health care has taken a much more strategic approach. In Ireland for instance our policy document, *Shaping A Healthier Future* (1994), stated that all services should be outcome-driven, should be measured in terms of health and social gain for clients. It also pointed out the major causes of morbidity and mortality had a strong preventable component related to lifestyle and socio-economic factors and that if targets for health gain were to be met then these issues were to be tackled. Accordingly health promotion is intrinsic to health policy and it follows therefore that re-oriented health services are a critical public priority, not an added imposition. The improvement of service management and the growth of health services research fits in with these principles. In other words, if a well managed institution is achieving its aims it will by definition be health promoting.

### ***The Role of Training and Education***

If this is so self evident then where are the barriers? It may seem clear to those attending this meeting but the reality is rather different for many health professionals and their clients and if we are to reach our goals for this concept then the process is also very important. We need to achieve a shift in attitudes if we are to achieve meaningful change and this may take time. Who are the key players in this setting? So far this has been positively supported by management and human resource services which is very encouraging. There is evidence that a range of staff groups are supportive, particularly nurses. However unless doctors are also widely involved there will be great difficulty in accomplishing the long-term objectives of the movement. For these reasons training programmes for doctors, nurses and other health professionals should have a strong health promotion component.

First, what do most health professionals understand by health promotion? In our own health board region our health promotion department conducted such an attitudinal survey (Jones 1996). Most people connected the concept with lifestyle advice but had a less clear concept of the wider organisational implications involved. If programmes developed are cosmetic, or solely based around lifestyle initiatives, they are likely to be unsuccessful and can invite antipathy from both patients and providers. There is also a perception that these initiatives cost money. Accordingly the concept has to be marketed differently as a re-orientation and if it is to be widely adopted will need to fit in with job roles of workers. Indeed quality assurance models encounter regularly this problem of not being able to adapt easily existing practices to a new approach (Ovretveit 1996). There are also likely to be key groups who are sceptical of health promotion and who therefore oppose change. The medical profession is one. In 1988 the Edinburgh Declaration suggested the need for a radical overhaul of medical education and Amos (1990) indicated that for the most part the involvement by doctors in so called health promotion was mainly in preventive services. There are plans world-wide for changes in medical education and in the United Kingdom a problem based approach is being more widely adopted. In Ireland too we are reviewing curricula. In my medical school I have responsibility for behavioural science and social and preventive medicine courses but while we have developed these considerably over the last few years, students remain sceptical about their relevance. It is not surprising given their career choice that they value biomedicine but they must appreciate social science approaches too. In integrated curricula there is scope for a holistic approach but there is a danger also of losing these concepts al-

together if the approach is solely clinical. This is a major educational challenge; however if this is not undertaken then the future will be very difficult.

Nursing education too is critical though as a caring profession its approach has always been more sympathetic to health promotion principles. Over the last two decades there have been major and sometimes controversial changes in nurse training and the development of degree programmes in many countries. A key challenge is to maintain the best of the vocational and practical apprentice ethos while at the same time strengthening the academic and critical thinking components. In Ireland I participated in the working party that recommended the introduction of the first comprehensive diploma / degree programme in Galway, a collaborative initiative between hospital and university. There is now a national movement towards such education which incorporates traditional nurse training but also places a stronger emphasis on community based training and on health promotion. Many other professional groups find interest in health promotion but often lack practical skills and appreciation of the core concepts. This is best tackled at primary training level though there also needs to be sound postgraduate and continuing education.

While of course there are established diplomas and master's programmes in health promotion not everybody needs to avail of these. In every service there needs to be a re-oriented approach so that we can do the usual things better. To take just two other examples from my own experience. We have recently developed out-reach and distance education programmes for both formal and informal carers (O'Donovan and Kelleher 1994). There is no greater gap in health service delivery than the provision of ordinary care and support for patients at home, in institutional care and in transfer from hospital. If there is not support for this sector then there cannot be seamless services offered that link hospital with community and indeed, because of the likely demographic changes this will be a huge future area of need. A Health Promoting health service bridges this need with resources and training. Also in Ireland we have the lowest breast feeding rates in Europe, a quite different problem in early life. If this is to be tackled specific appropriate education has to be provided, not just for the general public but also the health professionals they encounter. To meet this need we produced breast feeding education materials for health professionals in association with our National Health Promotion Unit (Becker 1998). All countries must pay attention to education and training at these levels as an investment for the future. In a given hospital right now there needs to be liaison with local health promotion services, a multidisciplinary committee and at least one dedicated officer with on-going training and continuing education being made available for staff.

### ***Evaluation and Research Intervention***

We also need to assess the parameters by which the initiative is judged to be successful and to date this setting has not been as well researched. A recent bibliography has been provided of research in this field but the body of research is not as great as in other areas of health promotion. Unlike other settings such as the school, workplace or community the impact or outcome measures may be different (Kelleher 1998). In those situations the direct objective is to support healthy lifestyles by means of personal development or supportive environment strategies and these are evaluated on this basis. In the hospital however the target groups are heterogeneous comprising those who are ill or sick, those who provide care and support in a working environment and finally the lay public for whom the hospital is a local resource and institution.

There are therefore three broad categories of research that contribute to our knowledge of what is effective or appropriate in the setting. Firstly any quality health service or clinical intervention that improves patient care and produces a health gain for that patient is health promoting and therefore relevant. That is obviously a huge database but most people in this audience will be readily familiar with relevant work in their experience. Second, projects that produce organisational change should contribute to the aims of a health promoting hospital. We need innovative study designs for this purpose including those that use community development principles and compare outcome with reference sites, economic or outcome based studies comparing usual with re-oriented care and finally comparative policy studies that share differing experiences of countries in the European region. Such studies may be planned and in train and if so I would be interested to hear of them. Targets to assess a health promoting hospital initiative should in the first instance be process based to see whether quality service provision has been achieved. Accordingly organisational change is a key goal. Within each service goals need to be set based on needs assessment. Many of the initiatives in this context are based around outreach lifestyle enhancement initiatives for patient groups. While this is a very important aspect it is too narrow a focus for the long-term.

Our research centre has undertaken several research projects in the hospital setting and I would like to conclude by summarising some of these as an example of the diverse potential for research in this field. We were involved for instance in three health services projects, to monitor patient support in gerontology services compared with general medical services (Kearns et al. 1998), to reduce incontinence rates in a physiotherapy programme (D'Arcy 1997) and to improve ante-natal decision to undertake breast feeding (Loh et al. 1997). All three studies showed that alteration in practice could be bene-

ficial and need not necessarily cost more. These are examples of health services research initiatives that contribute to health promotion.

Some years ago we elicited patients' and management's views of the Patient Charter concept, now widely applied as a means of empowering consumers in a health care setting (O'Donovan and Casey 1995). Managers were very frank that the charter was not assimilated into hospital practice and indeed some health professionals were very wary of its implications from a medico-legal perspective. We also found highly significant differences in awareness of the charter according to socio-economic means, just one further reminder of the importance of tackling wider social inequalities outside the control of the traditional health sector.

We have also surveyed various professional groups on their own lifestyle practices and their views on health promotion. Doctors for instance (O'Connor and Kelleher 1998) believed health promotion important, but only about a third routinely gave lifestyle advice. While smoking rates were low, appreciable numbers were stressed at work and used alcohol to cope. Nurses working in hospitals compared with community based or public health nurses also showed differences in lifestyle (Prendergast 1992) and the public health nurses were more likely to have training in health promotion skills. In a three year intervention programme at work, which included nurses, we found that student nurses were both more stressed and likely to take up smoking during training (Hope and Kelleher 1996, 1998) and indeed stress management programmes were the most requested by all nurses. A survey of laboratory workers (Walsh 1996) similarly showed that perceived stress was related to work practice. Good occupational health services can help to meet these needs.

### *Conclusion*

I have attempted in this presentation to argue that advocates of the health promoting hospital concept should make the case for it as a necessary development to meet health policy targets. We must not be complacent about the investment needed in education and training to meet these goals but at the same time we should not assume there is necessarily a huge resource cost involved though there will certainly be resource diversions required. There may be an opportunity cost but this is a matter for good management. Nor is good management synonymous with wasteful bureaucracy. The epidemiologist Geoffrey Rose pointed out (1990) that the Roman empire was run from one small office in the Forum. Finally we need to develop a research ethic that is

based on models of good practice and that shares our mutual experience in different settings. I am optimistic that we can see major developments in this setting that will profoundly influence our approach to patient care in the next century.

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*Bernard Honoré*

## ***Training: An Essential Condition for the Success of Any Health Project in Hospitals***

For a health project to change the course of hospital activities and to lead to real changes in its practice without damaging its mode of functioning a policy of initial and further education coherent with the project is essential. To establish real and lasting professional and institutional changes one must go beyond initial militantism and pilot experiments.

What should be the objectives for training in order to promote health from and within the hospital?

- Mainly looking for the conditions and the means which could allow the emergence of a new concept of the relationship between health and sickness and between curative, preventive and predictive actions.
- The development of aptitudes such as: Knowing how to detect, in hospital practices, to what degree each practice may be a source of health. Knowing how to spot what service would be prepared to elaborate a health project.
- Highlighting and circulating studies of health promotion in course of realisation so as to encourage the involvement of the different leaders and practitioners in a reflection about their practices and the organisation of those studies so as to make them relevant to a health project.
- The study of hospital environment not only in terms of needs but also in terms of resources.
- Training for interdisciplinary actions in the drawing up of projects, objectives, modes of actions, and evaluating procedures linked to actions of health promotion.
- Training for working in networks and partnership.
- Training for different aspects of patients education according to the different situations which they are involved in.

In an institution any training activity to promote health should have an overall training approach desired and elaborated by those who will be engaged in it. An internal or external facilitator should accompany a team both in the choice of ways and the means of its actions and progress.

Among the different methods of training which ones should be chosen, with what priority and how to articulate them into a logical process while taking into consideration the practical realities and constraints of a service?

Individual or group interviews on the theme: »What do you call health today?« can help to make people aware of the subject. It is neither an inquiry nor an audit but only an introductory reflection to the question of health starting from its different images.

A reflection about the meaning of health should be carried out first with the team of directors and managers. Like this, one can introduce the question of the links between a management approach and a health approach.

Interdisciplinary groups can be organised in different services to allow a critical approach to individual and team practices so as to show the possibilities they offer for the involvement of its actors in a mission of health promotion.

When and in what conditions should patients be invited to participate in such study groups? This critical reflection on practices will allow the study of the links existing between a health approach and a curative, a medical and a social approach.

- A training in the method of »total quality« will make sure the criteria of quality and those of health are brought closer together.
- A training in interviewing patients on their health specially on their admittance and on their discharge from a service will help people to express themselves on the diversity of health problems and not only on questions concerning their sickness.
- A particular attention to the incidence of a project of health promotion on the life of a service specially on the relationship with other services and the general hospital environment will avoid troubles which could result from the changing of attitudes, of behaviours and practices misunderstood by the actors and partners of the institution.
- The bringing together of trainees from different initial courses and diverse groups of reflection will prepare the undertaking of future actions in a district.
- Any practice of further education in the hospital should, at one stage or another, whatever its objective, invite participants to express the objectives of this training action in relation to a project for the institution integrating health promotion.

### ***A special training for the role of manager of health promotion is necessary***

The presence of »health managers« specially trained to facilitate relations for their mission of health promotion is essential so that actions undertaken can be co-ordinated, interwoven and integrated in the revival of hospital life and its relations with its environment.

These »health promotion managers« can be doctors , senior nurses, senior administrators trained in the different aspects of changes necessary today in a hospital so that it can promote health in a lasting way.

A long period of training (at least over two years and in 400 or 500 hours for working people) should allow these managers to acquire the knowledge, the methods and personal qualities to help them to play the part of a trainer of a trainer-adviser inside the institutions. Organised between several institutions and several professions this training should help trainees to study the difficulties they meet in the conduct of health promotion actions and look for the most satisfactory solutions according to the experience acquired by the participants working in different institutions.

To conclude this too brief presentation we think it is now the vocation of the Health Promoting Hospital network to stimulate the diverse aspects of training essential to the realisation of its project by creating an International Institute of further education for the promotion of health. The objective of such an institute could be to promote, to sustain, to advise and to validate the training programmes elaborated and put into practice in different institutions and different regions.

*Kevin Kane*

## ***Project Management: A Key Tool in Health Promotion?***

Objective: To test the hypothesis that the use of Project Management techniques will aid the work of Health Promoting professionals.

Successful Health Promotion requires the co-ordination of a team of health professionals over time to achieve a set of unified objectives by a specified end date within a budget and with maximum utilisation of resources. The desire to keep within budget, on time and cost whilst achieving targets means that some degree of managerial control needs to be established and maintained; yet, the multidisciplinary nature of health promotion precludes the use of traditional hierarchical managerial control techniques as managerial authority cannot easily be established across disparate professional disciplines.

Discussions with Health Promotion specialists suggested a number of practical problems they encountered in the actual implementation of a project, (as differentiated from the issues of gathering funds, political and organisation support, facilities and original resources etc.), and these problems centred on the planning, controlling and managing of the project to completion. Whilst many of those involved in Health Promotion do not lack managerial skills, these are often derived from the management of ongoing functions and not of the direction of projects with discrete beginnings, endings, and little managerial structures. It was suggested that one solution to the problem of managing health promotion is the use of Project Management.

At its core, project management is simply the planning, organising and managing of tasks and resources to accomplish a defined objective – usually with constraints on time and cost. A plan can be as simple as a list of tasks and their scheduled start and finish dates written on a notepad, or it might be something involving thousands of separate activities and involving hundreds of people and millions of pounds. Most project plans share some common elements, including breaking the project into easily manageable tasks, scheduling the tasks, and then tracking the tasks as work progresses.

Another way of looking at project management is by the questions it helps answer: What is to be done? Who is to do it? When must it be done? How much will it cost? What happens if work isn't completed on time? Project managers often divide the process of project management into three stages:

- Planning the project and creating a schedule: This is felt to be the most important phase of project management, it includes defining tasks and their

duration, setting up relationships between tasks, and assigning resources. All of the project's later phases are based directly on the information from this process.

- Managing Changes: This phase of project management is an ongoing process that begins once a schedule has been determined and ends when the project is complete. Managing a project includes tracking and adjusting schedule to reflect changes that occur as the product progresses.
- Communicating project information: In this phase project information is normally communicated to all the involved stakeholders; information is subsequently used to inform, persuade and involve others.

Project Management has been in existence since the 1950's but what has happened to bring it within the grasp of non-specialised managers and other professionals is the development of inexpensive software operated from standard personal computers. It is now possible for all professionals to learn and operate relatively sophisticated project management tools and techniques and thus to benefit from improvements in planning, control and communication.

In order to test the claim that using the planning and control techniques of Project Management will help in health promotion a series of workshops were developed and trailed; these were:

- a) A one-day workshop on Project Management Planning run with ten health professional from different organisations.
- b) A two-day workshop using both manual planning techniques and computer project management software, run with health promotion specialists from differing organisations.
- c) A two-day workshop with a group of 20 health promotion professionals from a specified organisation.

The one day workshop was highly participative in nature, involving participants in exercises and discussion of their own experiences, as well as input from the programme trainers. It focused on the key elements of planning and control via project planning techniques such as work breakdown schedules, Gantt charts and network analysis. This was practical and exercise / case-study based and did not assume any previous knowledge of project planning. Subjects such as: the difficulties of managing projects; the meaning of project management; manual techniques of network planning – including Gantt charts and network diagrams; group based applications of planning techniques were covered in the morning session. In the afternoon, individual and group plans, charts, schedules and graphs were developed and the project management software (in this case Microsoft Project), was demonstrated to the students.

Two further workshops were undertaken, this time with a second day added to allow the development of students understanding of project software.

The second day involved the utilisation of the tools and techniques of project management developed on day 1 via computer software in order to automate the production of plans, schedules, progress reports, networks and the like and so enable better control of large/medium projects, multiple smaller projects, or to save time on smaller projects. Topics included: the complexities of paperwork systems; using software to develop the project initially via clumping, sequencing and timing; producing charts, network diagrams, work-breakdown schedules, Gantt's and diaries; finally, the production of milestone reports, budgets and work allocations, and the handling of multiple projects and the setting up of Project Management systems were covered.

After a period of four months the outcomes for the participants were assessed via focus groups and questionnaires and the effectiveness of the following was measured and assessed:

- a) the training workshops,
- b) the utilisation of Project Management techniques in Health Promotion,
- c) the use of Project Management Software.

Almost all students were very positive about the training workshops and seemed to enjoy their exposure to these ideas, the practical nature of designing and producing charts and diagrams seemed an especially enjoyable part of the process. One student however, said that they found Project Management »too restrictive« and that it »constrained their flexibility and response to changing situations«.

The students, in the main, were positive about the usefulness of Project Management for managing in Health Promotion, and some had used the Project software to manage a conference, to produce some complex health promotion literature, and to develop a non-smoking policy in a large organisation. However, the point was made strongly that using these techniques on an individual basis, i.e. without organisational support or the agreement of all those involved in the project, limited the usefulness of the tools to planning and self-management. Whilst this was not a complete negative, the control and communicative elements in Project Management were not prominent, and had seldom been used.

It was suggested by the group from a specified organisation that they would use the techniques for managing projects from new, and would develop a methodology to cover its use – it was felt this would ensure that projects were properly planned and controlled from the start and would not be commenced if they did not have a good chance of success.

The results of the training seem to indicate overall a positive benefit to Health Promoting professionals from using the techniques of Project Management with particular benefit accruing from the use of Project Management Software.

*Hartmut O. Genz*

## ***The BGW Support Programme for Health Promoting Hospitals***

In the Federal Republic of Germany – unlike the regulations which apply in other countries – accidents that occur on the way to work or in the workplace are covered by a special, mandatory insurance. One of the societies responsible for this insurance coverage is the Berufsgenossenschaft für Gesundheitsdienst und Wohlfahrtspflege – which can be translated as Occupational Society (Trade Association) for Health and Medical Care. The society is one of the biggest national insurance companies and is responsible for the insurance of all social and medical institutions within the Federal Republic of Germany. There are approximately 5 million individuals insured in a total of 435,000 companies or practices.

The BGW's assignment encompasses compensation claims associated with occupational accidents and illnesses, and accident prevention. In 1996 a legislation amendment came into power in which the term ›prevention‹ was broadened. This amendment stipulates that in addition to the prevention of accidents and occupational illnesses »all suitable measures to ensure the prevention of occupational health hazards« are to be implemented (§ 14 SGV VII). In compliance with this requirement the BGW has developed actions for health protection in conjunction with accident prevention.

The projected measures for hospitals and clinics have been outlined below as an example. These measures become operational in January 1999 and will be proposed to the insured institutions. The basic concept of the BGW is to support projects for health promotion in central and critical areas and to inter-link the prevention of adverse working conditions and safety-hazardous behaviour.

### ***a) Moderator***

Internal company or institutional problem-solving groups can only function effectively under a methodically experienced moderator. As the cost of training for this position represents a considerable financial hurdle for most institutions the BGW is prepared to provide in-house training.

***b) Swift Implementation of the Recommendations***

This is a key area if the projects are to function properly. In order to support it the BGW will in certain cases provide financial support for specific solutions. The institutions must submit an application for these funds; the applications will be assessed on the basis of set criteria by a committee which is responsible for allocating the grant. The applicant must prove within four weeks that the funds have been utilised correctly.

***c) Decrease the Number of Meetings***

In keeping with »models of good practice« handouts and background information will be made available on particular topics. This will yield better solutions by giving the project groups faster access and a better understanding of the procedures.

***d) Increase Management Motivation***

Specific seminars and an effective publicity campaign will be utilised to increase motivation on the managerial level.

To ensure that this approach is widely distributed it is also planned to:

1. Support the work of the German Net HPH and ensure a high standard of implementation for these proposals by the associated institutions;
2. Organise information events for directors and training courses for safety advisors<sup>1</sup> and company doctors<sup>2</sup> in conjunction with the GN HPH;
3. Establish and develop suitable publication forms to describe the procedure of development of organisations and the effects that can be accomplished;
4. Produce specific reports about accident and illness rates in German hospitals.

Throughout the implementation of these measures the BGW aims to work closely with the German Net HPH and other involved institutions (e.g. International Net; EU, health insurance companies). After an initial period of three years a report on the effectiveness of the measures is to be presented to the self-governing body of the BGW who will decide whether health promotion is to be established as an addition to classic programmes for the maintenance of health and safety standards in the workplace.

Note: the concept of the prevention of occupational health hazards was decided in April 1998 by the self-governing body of the BGW.

1 A safety engineer responsible for advising company owners and executives as required by Federal legislation.

2 See 1 and responsibility for examining personnel in keeping with regulations.

*Margareta Kristenson, Johannes Vang*

## ***Are Measurements of Patients Self-rated Health Relevant to Clinical Decision Making?***

People who are unfamiliar with the concept of Health Promoting Hospitals quite often believe that the term simply describes a hospital which carries out health promotion projects in addition to the ordinary disease oriented activities which are typical for a hospital. This view is not only too narrow and limited in scope but also fails to catch the profound change of attitude and approach to all of the tasks and responsibilities of a hospital which the concept »Health Promoting Hospital« implies.<sup>1</sup>

The »Health Promoting Hospital« concept was developed out of the demand for a reorientation of health services towards health which was brought forward by the member states of the WHO at the Ottawa conference and expressed in the Ottawa declaration. The radical objective of the HPH movement is to act as a means and vehicle for the requested reorientation of health services towards health in all of the aspects of their activities.<sup>2</sup>

Many people believe that health services always strive for the attainment of health. Health services have almost exclusively addressed the problem of how to cure or ameliorate well defined diseases caused by known or partly understood pathophysiological disturbances. They have done this with great success with regard to some infectious and metabolic diseases and restored functions, fully or partially in a great deal of incurable degenerative diseases of the heart, the vascular system, the major joints and some mental disorders. Health services have therefore developed a strongly disease oriented approach to health. This approach has been fruitful in many ways but failed in a series of others.

In an ageing population, disease and dysfunction belongs to the »normal« state. Still, well being and abilities to cope with the daily life may coexist with established diseases. Health defined as absence of disease loses meaning in

1 **World Health Organisation.** Health Promoting Hospital Network Document: Aims, concepts, strategies and possibilities for participation in the International Network of Health Promoting Hospitals: general information. Copenhagen 1993, WHO Europe

2 Vang, J. (1996), On the scope and purpose of this conference. In: Vang, J., Kristenson, M. (eds.) (1996), ***Health gain measurements as a tool for hospital management and health policy.*** Proceedings of 3rd international conference on Health Promoting Hospitals. Linköping, Centre for Public Health Sciences, p. 1-8

people with chronic, incurable illness. Health defined as physical, social, mental and spiritual well being becomes the concern. The patient's self-rated health may become a more meaningful measurement of health than »objective« laboratory tests or electronic imagery.

The strictly disease oriented view of most members of the medical profession is mirrored by the »productivity« view of most hospital managers. Productivity measurements such as bed occupation rate, operations / year, visits / year describe only productivity and the size or the scope of the hospital activities. Such measurements reveal nothing about whether the mission of the hospital – to create health – was achieved nor does it reveal anything about the effectiveness of the hospital's work. To be able to discuss this, one would need to measure the patient outcome of the interventions. One would need to measure health or health gain in individual patients or groups of patients.

Broadening the scope of the hospitals from the narrow disease orientation to the wider perspective of health is therefore necessary not only because of the changing panorama of illness and the »ageing« of society but also in order to obtain reasonable good measurements of effectiveness and efficacy of the work carried out by the hospital.

To achieve a health orientation of health services, it is therefore necessary to develop and carry out formal measurements of health outcome within the clinical setting. We surmise that the best way to assess health gain is by a combined professional judgement and patient's self reported health status.<sup>3</sup>

Professional judgements of the outcomes are often seen as »objective« observations and they are given a particular weight. They are today usually included in the patient report. A professional observation is however a subjective observation as well, but subjective with regard to the professional. Objectivity rests often with the results of blood sampling or imaging. These reflect biological variations related to the disease but may not at all reflect the degree of illness. It is therefore important to add measurements of patients self reported health status, which better reflects the patients possibilities to cope with his / her problem, and the extent to which the treatment has affected the patients abilities to »live a normal life for his / her age and life situation«.

In order to explore the relevance of patients' self-rated health for clinical decision making, we have made a small pilot study involving 46 patients.

3 Kristenson, M., Sullivan, M., Wärnberg, Gerdin E., Vang, J., Measuring health gain. In: Vang, J., Kristenson, M. (eds.) (1997), *Outcome measures make sense, do they also make a difference?* Stockholm, SPRI and Centre for Public Health Sciences

### ***The Study***

One of the most frequently used questionnaires which measures health related quality of life is the short form 36 (SF-36).<sup>4</sup> This describes in 8 domains physical, social and mental health, and in addition also role function.

We have used this instrument in the setting of a hospital pulmonary clinic's ambulatory care unit. The aim was

- to study if measurements of self-rated health gave new information, which added to the information already registered in medical records;
- to assess if such added information had implications for the clinical decision making, and
- to see if assessment of this kind of information was feasible and accepted by patients and the personnel.

### ***Method***

46 patients were invited to answer the SF-36. The questionnaire was administered as part of the ordinary routines, and the questionnaires were collected by a nurse. We then asked one of the physicians from the pulmonary clinic to make a summary of the medical record. This was performed during about 5 minutes i.e. the normal amount of time the physician has before he sees a patient at the clinic.

The scores on SF-36 were thereafter compared to the information in the medical records for each patient. The comparison was done by the physician from the pulmonary clinic and was a retrospective evaluation. The comparison was performed according to the following criteria:

- I No additional information is gained through SF-36.
- II The SF-36 confirmed information already given in the medical record, but which is »veiled, hidden or silent« in the report.
- III The SF-36 added new important information.
- IV The additional information would have consequences for clinical decision making.

4 Ware, J. E. (1987), Standards for validating health measures; definition and content. In: *Journal of chronic diseases*, 1987 (40), p. 473-480

### ***Results***

No patient refused to answer the questionnaire. In two cases the answer clearly indicated that the patient had not understood the questions

1. In 21/46 no additional information was given.
2. In 5/46 the SF-36 confirmed information already given.
3. In 20/46 new information was received, and
4. In 9/46 this was judged to have had implications for the clinical decision at a highly specialised hospital.

The comment was made that in the cases 2 and 3 the information might have been even more important in a primary care setting.

Also, the patients were asked about their opinion on the questionnaires. They found the questions relevant and that they added information which are not routinely asked for by health professionals.

#### ***In summary:***

- In all cases the SF-36 gave a relevant and easily understandable summary of the patient's perceived health.
- In those cases when the information was hidden or even »silent« in the medical record the information was brought forward.
- The SF-36 health measurement was seen as a valuable and a feasible way of adding complementary information to ordinary medical records.
- In many cases the information obtained was obviously supportive for the clinical decision making process.
- The measurements gave complementary information of the efficiency of the clinic.

*Francesco Ceratti, Enrico Iemoli, Antonio Gallucci*

## ***An Organisational Model for HIV Post-Exposure Prophylaxis in Health Care Workers at Luigi Sacco Hospital***

### ***Introduction***

Luigi Sacco Hospital is a teaching hospital in Milan with 500 beds. 100 beds in three wards are available for infectious disease patients and therefore Luigi Sacco Hospital is regarded as an institution of reference in Italy for AIDS care.

Given the importance of prompt intervention after exposure to HIV, our institution has developed an organising model (OM) for our health care workers (HCWs). Since July 1997 we have offered the same intervention both to HCWs employed in public and private hospitals in Milan area or in public categories with the risk of HIV exposure.

### ***Objectives***

The principal objective of our OM was firstly to evaluate the effective risk of the exposure by the infectious disease physician on duty, who would then immediately offer the prophylaxis, if necessary. Moreover, we have developed a service with our laboratory of virology for the immediate detection of HIV antibodies in the patient source if his / her serology was unknown. Subsequently, all the subjects who had been offered the prophylaxis would be followed up to one month and their serology was checked for a one year period in a specific ambulatory.

### ***Methods***

In Luigi Sacco Hospital are employed 1,129 health care workers. Since January 1996 we have surveyed 204 risk exposures (89 during 1996, 87 during 1997, 28 until March 1998); 121 were nurses, 46 physicians, auxiliary staff 18, laboratory technicians 10, others 9 (Table 1).

	<i>1996</i>	<i>1997</i>	<i>1998</i>	<i>total</i>
Nurses	48	54	19	121
Physicians	20	20	6	46
Assistants	11	7		18
lab. Technicians	5	4	1	10
Others	5	2	2	9

Table 1

145 were percutaneous exposures with needles or with sharp devices, 31 were mucocutaneous, 18 cutaneous. 49 cases out of 194 (22 during 96, 24 during 97 and 3 during 98) were exposures to HIV. Four out of 49 were HCWs from other hospitals. In 26 cases (7 during 96, 16 during 97, 3 during 98) the HCWs accepted HIV post-exposure prophylaxis according to the current guidelines. 13 HCWs were treated with three drugs: Zidovudine (ZDV), Lamivudine (3TC), Indinavir (IDV); eleven with two drugs: ZDV+3TC or Didanosine (ddI); two with ZDV. Only 13 (52 %) completed the prophylaxis correctly. 22 (84,6 %) experienced side effects related to drugs that conditioned in 12 the therapy discontinuation (Table 2). Two patients had renal colics related to IDV. Up to date no seroconversion has been detected.

<i>Patient</i>	<i>ward</i>	<i>sex</i>	<i>exposure</i>	<i>therapy</i>	<i>therapy completed</i>	<i>side effects</i>	<i>follow-up seroconverts</i>
1	infect. dis.	m	needle	ZDV 3TC IDV	yes	no	-
2	infect. dis.	f	mucocutan.	ZDV 3TC	no	yes	-
3	infect. dis.	f	needle	ZDV ddI	discont.	yes	-
4	infect. dis.	m	mucocutan.	ZDV 3TC IDV	discont.	yes	-
5	infect. dis.	m	mucocutan.	ZDV 3TC	yes	yes	-
6	infect. dis.	f	needle	ZDV 3TC IDV	no	yes	-
7	medicine	f	needle	ZDV 3TC	no	yes	-
8	infect. dis.	f	non integral skin	ZDV 3TC	no	yes	-
9	surgery	f	needle	ZDV 3TC	no	yes	-
10	infect. dis.	m	needle	ZDV 3TC	yes	no	-
11	lab.	m	mucocutan.	ZDV 3TC	yes	yes	-
12	infect. dis.	f	needle	ZDV 3TC	no	yes	-
13	surgery	m	needle	ZDV 3TC IDV	no	yes	-
14	surgery	m	needle	ZDV 3TC IDV	yes	yes	-
15	lab.	f	needle	ZDV LMV	yes	yes	-
16	other	f	mucocutan.	ZDV 3TC IDV	yes	yes	-
17	infect. dis.	m	needle	ZDV 3TC IDV	yes	no	-
18	surgery	m	sharp device	ZDV 3TC IDV	yes	yes	-
19	intens. care	f	needle	ZDV 3TC IDV	yes	yes	-
20	infect. dis.	f	needle	ZDV 3TC IDV	discont.	yes	-
21	intens. care	m	needle	ZDV 3TC IDV	no	yes	-
22	infect. dis.	m	needle	ZDV	no	yes	-
23	intens. care	m	needle	ZDV	yes	yes	-
24	infect. dis.	m	needle	ZDV 3TC	yes	no	-
25	intens. care	m	needle	ZDV 3TC IDV	yes	yes	-
26	lab.	f	needle	ZDV 3TC IDV	yes	yes	-

Table 2

***Conclusions***

The availability of a prophylaxis after exposure to HIV and the opportunity of an immediate test in the patient source, if necessary, represent a safety measure for HCWs and an OM permits the application and the follow-up. During the last two years the acceptance of the prophylaxis after HIV exposure is on the increase. Our OM allows the immediacy of prophylaxis and counselling and guarantees the follow-up not only for HCWs employed in some health care facilities in Milan area but also for other figures at risk of HIV exposure.

*Giorgia Marcato, Margherita Boschetto, J. Patricia Burga*

## ***Health Care Quality in Preventing and Treating Bedsores***

This study is part of a bigger project »Changing demand of an aging population« running in our Hospital (one of the five subprojects implemented as a Pilot Hospital of a HPH Network), with the specific aim of prevention and treatment of bedsores. To achieve this goal a special multidisciplinary committee has been nominated to work out guidelines and procedures to improve standard quality.

In Padua Azienda Ospedaliera (Main Hospital) there are several wards where patients, especially elderly, are exposed to bedsores risk. According to AISLeC (Italian Nursing Association for Bedsores) researches, the incidence of bedsores in the last years is increasing due both, to the aging of the population and to an increase in chronic and degenerative diseases.

During recovery the developing of pressure sores brings a worsening in the patient's general condition, which implies a longer hospital stay with a consequent increase in social and sanitary costs.

### ***General Aim***

We decided to assess and estimate the needs of medical devices to prevent and treat bedsores. We started activating a routine monitoring of bedsores working at the same time on personnel education on prevention and on the definition of a protocol for treatment, matching the stage of a patient with the most appropriate medical device for preventing or eventually treating pressure sores.

### ***Methods***

A prevalence study has been held on a sample of five intensive care units and three medicine wards. On four consecutive Wednesdays (October '97) we recorded the total number of patient present at that day, the exposure to risk to develop bedsores according to the Norton scale, and the kind of lesions when present. On the base of these data was estimated:

1. the average prevalence of bedsore,
2. the distribution of lesion according to the grade scale of severity (Shea scale).

Meanwhile technical assessments on efficiency and reliability of new medical devices (in this particular case different types of mattresses) were tested in the same wards and intensive care units involved in the study. The verification was supported by the Clinical Engineering Unit of the Hospital. Lastly we developed a table matching patient conditions and the most appropriate protocol for preventing or treating bedsore.

### Results

781 patients were recruited in the study. 6.8 % of patients presented a high risk of developing bedsore, for 13.8 % the risk was mild, for 11.7 % the risk was low and in 67.7 % of cases the risk was zero (Table 1). The higher risk was among the intensive care units (Table 2). The average prevalence of bedsores was 7 % with a severity grade distribution of grade 1: 51 %, grade 2: 20 %, grade 3: 16 %, and grade 4: 13 %.

Inpatient Risk	1st day		2nd day		3rd day		4th day		Total	
	n° inpat.	%	n° inpat.	%	n° inpat.	%	n° inpat.	%	n° inpat.	%
high risk (score =<7)	18	9,0	11	5,3	13	7,0	11	5,8	53	6,8
medium risk (score 8-11)	28	14,1	29	14,0	22	11,9	29	15,3	108	13,8
low risk (score 12-14)	22	11,1	30	14,5	17	9,2	22	11,6	91	11,7
zero risk (score =>15)	131	65,8	137	66,2	133	71,9	128	67,4	529	67,7
Total	199	100	207	100	185	100	190	100	781	100

Table 1 – Inpatients risk of developing bedsores (Norton Scale)

Wards	Norton Scale				Total
score:	High Risk 5– 6– 7	Medium Risk 8– 9–10–11	Low Risk 12–13–14	Null Risk 15–16–17–18–19– 20	
Intensive Care Units	7– 4–11	14–17–12–17	16–12–17	13– 8– 5– 0– 1– 0	154
Total Intensive Care Units	22	60	45	27	
% of Inpatients risk	14,3%	39,0%	29,2%	17,5%	
Medicine Wards	17– 7– 7	7–11–16–14	10–12–24	25–46–61–55–84–231	627
Total Medicine Wards	31	48	46	502	
% of Inpatients risk	4,9%	7,7%	7,3%	80,1%	
Total	53	108	91	529	781
% total of Inpatients risk	6,8%	13,8%	11,7%	67,7%	100,0%

Table 2 – Inpatients risk of developing bedsores by specialities (Norton Scale)

The mattresses were divided into two categories: Low Tech (constant pressure supports): foam, silicon fibres, low air loss mattresses, High Tech (pressure relief): alternating pressure, air fluidized mattresses. The first were used for prevention, the other for treatment. These results were obtained both from testing each single type of device and from reviewing the existing literature compared to the technical information given by the manufacturer.

The scheme matching the clinical assessment of a patient according to the Norton scale and the kind of medical device is reported in Table 3.

Function of Mattress	Type of Mattress	Norton Scale	Shea Scale	Pathology
Preventive Mattress	Foam	medium / low risk (score: $\geq 12$ )		
	Empty Silicon Fibre	medium risk (score: 8-11)		
	Low air loss mattress	medium risk (score: 8-11)	and / or decubitus ulcer: 1°-2° grade	
	Alternating pressure mattress	high risk (score: $\leq 7$ )	and / or decubitus ulcer: 3°-4° grade	
Therapeutic Mattress	Air fluidised therapy units (beds)	high risk (score: $\leq 7$ )	and / or decubitus ulcer: 4° grade and over	Septic shock, Cardiogenic shock, Major burn (60-70% of body surface), Vertebral lesion (fracture), Multiple traumatic lesions

Table 3 – Medical devices according to the risk of developing bedsores, severity and pathology correlated

### Conclusion

The needs of medical devices was estimated on the basis of average stay of patients for each class of risk exposure in the sample, compared to the total amount of patients in the same classes obtained from the statistics for the whole hospital recoveries in 1996 (Table 4).

Due to the huge number of devices needed to integrate the availability

necessary to satisfy the demand especially for treatment of bedsore, we decided to rent the mattresses.

We also decided to carefully monitor during the entire year 1998, the use and efficacy of these devices to avoid unnecessary purchases. For this reason, two protocols have been studied: the first one to record the specific risk of each single patient and the device assigned. The second one to evaluate the efficacy in terms of prevention or therapeutic result. All the data collected are computerized in a data base managed by the Epidemiology and Infection Control Service of the hospital. Meanwhile a formative programme for nursing personnel has been projected and will start soon.

Wards	Risk	N° of recoveries in 1996	Average stay of the sample population	Annual estimate of days of stay	Estimated needs – medical devices
Medical and Surgical wards	low	6,222	26	161,772	approx. 80 mattress for preventive use (bought)
	medium	5,852	31	181,400	
	high	3,259	24	78,219	
Intensive Care Units	low	1,290	12	15,486	
	medium	1,332	21	27,980	
	high	628	22	13,827	
Total	low	7,512		177,258	150,000 days for low air loss mattress
	medium	7,184		209,380	
	high	3,887		92,046	

Table 4 – Estimated needs in terms of days: For renting and buying medical devices for different inpatient risks

*Bjørn Nygaard*

***Don't Use It if You Don't Mean It!***  
***On the Use of Economic Arguments in Health***  
***Promotion and Preventive Medicine***

The main issue of this presentation is a closer look at the economics of Health Promotion and Preventive Medicine (HPPM). The underlying assumption is that economic gain is often used in cases where this argument is not really valid. The reason for this is probably that the authorities are looking for means of reducing the expenditures in the public sector. All efforts with this goal in mind can easily be met with a positive attitude and provided that there are no critical investigations. However, sooner or later, the shortcomings of this approach will be disclosed. HPPM is too important to be destroyed through false arguments.

First, a brief look at some reasons for HPPM. Not all of them are necessarily conscious in the mind of health workers, but nevertheless often present.

- Personal gain (career/status)?
- Moralism?
- World Championship in duration of life and in public health?
- Save money?
- Welfare and life quality of the individual?

Of course there is nothing wrong in doing a good job and making a career. But that is also true for the salesman from The Coca Cola company. My contention here is that only the last two are legitimate reasons for HPPM. And I will try to show that the economic argument is grossly overestimated.

To avoid HPPM becoming a sheer waste of money, one should bear in mind some essential conditions:

- Cause-effect relationships must be clear,
- Statistical connections are not sufficient.

I sometimes wonder why HPPM based on mere statistical connections seem to be so attractive to health workers. But that way of working is of course seen also in other sectors. An example is the Vietnamese war. One of the American strategies was that if they merely managed to drop enough bombs, they surely would kill a lot of enemy soldiers.

There are of course cases where the cause-effect relationship is very clear. In Norway we are told that about 30% of the population has drinking water that

endangers their health. Each year 200,000-300,000 persons have to be home from school or work due to bad drinking water. The situation is worst in the rural areas. But this is seemingly not of particular interest to most health workers. They prefer working with change in life-style. Problems like bad drinking water are considered the matter of engineers from the technical departments.

We should not ignore severe difficulties with preventive measures:

- Often interfere with life-style
- High costs compared with the effect
- Effects come much later than the »investment«
- Diffuse effect of measures
- Side-effects
- Lack of motivation on the behalf of the individual.

What does the concept »Save Money« really mean? In my opinion at least one of the following conditions must be met:

- A specific budget can be reduced by a specified amount
- A specified amount of money on a specific budget can be reallocated for other purposes.

When do we save money? That is of course the most important question. The following examples illustrates how difficult the answer can be:

- Death accidents by retired and people living on social security?
- Lung cancer among smokers?
- Overdose – 25 year old social client, drug addict and »jail bird«?
- Suicide – newly educated doctor?

There is no general answer to these questions, it can be calculated different in various countries. Different taxation and insurance systems may also influence the results of the calculations. The extremely high tobacco taxation in Norway, are probably making the smokers »good business«.

Of the examples above, probably only preventing the doctors suicide may be profitable. But even that may be doubtful. We do not know very much about the costs of preventing suicide among young doctors. It is another story that we do not know too much about preventing this kind of suicide at all. But the main point is, that in strictly economic terms, it is not true that all human beings have the same value. And one should bare in mind the following »thumb rule« of health economy (»Nygaards law«): Dying is usually the cheapest!

However, lack of prevention do not necessarily lead to death. Will it not be profitable to prevent disability and sickness? In many cases that of course is true. But it is not self-evident, and must be calculated for each case. Times of

high unemployment may lead to different conclusions than in times when it is extremely low.

For the »mental welfare« of a society, it might be better to have people out of work because they are sick than perfectly healthy people being unemployed. Preventive measures must by their nature be considered as long term investments. And it is not an easy task to predict the unemployment rates for the next 20-30 years. We also know that it is not profitable to prevent cancer and coronary diseases. Health expenditures will instead rise because of prolonged duration of life.

On the other hand, if psychic diseases »vanished«, expenditures would decrease by 24%. But as they do not vanish by wishful thinking, the crucial questions remain: could they be prevented and how?

Even if we assume that some preventive measures are economically favourable, the question remains: Who must make the investments and who will get the gains? Usually it will be a public expenditure, but private insurance companies (and other private parties) will sometimes get the gain and increase their profit.

Financing HPPM should therefore be discussed more thoroughly from the viewpoint of »who will profit«. Furthermore, if economic arguments are going to be used, your HPPM project should be calculated in the same way as an ordinary business investment. That, of course, will be a new demand on health workers. It also implies that they predict in a reasonable way when and where the investment will »pay back«.

I am not sure if this is desirable. The economic factor may well come into conflict with fundamental ethics of health care. Health workers should mainly stick to the ethical dimension of their work. Economy is the strongest means of control we have. And it always works! The problem is that it has side-effects and the end result often is unpredictable.

But if you in spite of these warnings are sure about the economic factor, and are able to calculate it properly, don't hesitate to use it!

# Improving the Quality of Health Promoting Hospitals

*Brenda K. Stephens*

## ***Developing and Implementing Accreditation for Health Promoting Hospitals***

### ***Background***

Since 1988, all hospitals in Wales have been encouraged to incorporate a health promoting dimension to their work and to become health promoting organisations. During this period, our ***Healthy Hospital Award*** encouraged innovation and the development of good practice.

The Award was a peer-referenced competition, held annually. To enter, hospitals were required to submit a report on the health promotion activity undertaken in six topic areas. These were:

- eating for better health;
- smoke free;
- physical activity;
- occupational health;
- sensible drinking;
- promoting health in the local community.

A judging panel of senior health professionals reviewed the reports against three criteria, namely

- policy development and implementation;
  - provision of services and facilities;
  - provision of education and information;
- for patients, staff, and the wider community.

Hospitals were divided into four categories for judging. These were Acute and General hospitals; Community hospitals; Psychiatric hospitals, and hospitals for people with mental retardation.

After judging, certificates were awarded to mark each hospital's progress in developing its health promotion practice. Prizes were given to the best hospital in each of the four categories, and the over-all winner was given a trophy.

Each year the number of activity areas was increased as our hospitals de-

veloped their health promotion practice. By 1995 the list had been extended to include additional topics. These were:

- management structures to support health promotion;
- health and safety;
- AIDS and HIV prevention;
- stress management;
- cancer prevention;
- heart health.

A review of the Award, at the beginning of 1996, concluded that the time was now right to begin the process of transforming the Award into a more formal Accreditation System to ensure that we continued to progress the development of HPH in Wales.

### *Objective*

The objective of the ***Accreditation Scheme for Health Promoting Hospitals in Wales*** is to continue the development of hospitals in Wales by the move from a peer-referenced Award Scheme to a norm-referenced Accreditation Scheme.

### *Methods*

The first step was to move from a descriptive report of activity to a self audit check list. A first draft of the checklist was prepared for use by entrants for the 1996 HHA in place of the descriptive report. A subsequent evaluation undertaken with hospitals, and with the judging panel, showed that there was considerable support for the introduction of the checklist and for the move to an Accreditation System.

It was recommended that the checklist be extended to cover most aspects of hospital activity and that a good practice guide be developed to help hospitals improve their health promotion practice further. The ***Good Practice Guide for Health Promoting Hospitals*** was subsequently developed – in conjunction with hospitals in Wales – and published by Health Promotion Wales in 1997.

A Steering Group of representatives from the Welsh Office; Community Health Councils; Health Authorities; and member hospitals of the HPH Network in Wales, was then formed to assist Health Promotion Wales with the further development of the Accreditation Scheme.

The self-audit checklist was extended to cover the following 18 action areas:

Overall management	Heart health
Smoke free	Environmental care
Eating for better health	Health at work
Sensible drinking and drug free	Neighbouring communities
Physical exercise	In-patient care
Safe sex	Accident and emergency departments
Mental health and well-being	Maternity department
Oral health	Out patient departments
Cancer prevention	Children's services

Assessors were recruited and their training was piloted in April 1997. The peer review assessment team was comprised of senior representatives from the Welsh Office; the all-Wales Association of Community Health Councils; Health Authorities; Health Promotion Wales (HPW) and member hospitals of the HPH Network in Wales.

The extended checklist (comprising over 500 questions) and the external peer review assessment system was piloted with 16 hospitals between May and July.

There were three possible answers to each question in the checklist – yes / no / not applicable. Each pilot hospital completed the checklist and returned it to HPW for calculating an initial score and sorting out any queries.

A validation visit was arranged for each hospital. The visits varied in length from half a day to one day, depending on the size of the hospital – as did the number of assessors. The purpose of the validation visit was to meet staff and patients at each hospital and to seek evidence to support the answers recorded in the checklist.

Each assessor recorded their views and the information obtained at the visit was used to re-calculate the final score. For a hospital to be accredited for a three year period it needed to have a score in excess of 75 % for the overall management section; to score 70 % in five other sections and to obtain an overall score of 65 %.

## ***Results***

When the piloting had been completed, each hospital and each member of the review team submitted a written critique of the checklist and of the assessment

process. The results have since been used to form the final version of the materials for the Accreditation Scheme and to refine the assessment process and scoring system.

- The checklist was seen by all hospitals in the pilot scheme as a useful audit tool. 75 % of the pilot hospitals also reported that the questions in the checklist and the advice given in the ***Good Practice Guide*** provided ideas for future action.
- However, all respondents felt that the validation visits were too short – it was suggested that they should be a minimum of one day for small hospitals and up to three days for the largest hospitals.
- The pilot hospitals which achieved the standard were awarded a Certificate of Excellence, valid for one year. Hospitals which scored 65 % overall but failed to score 70 % in five sections were given a Commendation. Those which failed to score 65 % overall were given a Certificate of Audit
- The method of developing and piloting built up a strong sense of ownership, and support for the Scheme can be evidenced by the eleven hospitals which have already applied for to be Accredited.
- The Accreditation Scheme has the formal support of the Welsh Office and Health Authorities in Wales and will be formally launched in June 1998.

### ***Conclusions***

Collaborative development of the ***Good Practice Guide*** and the self-audit checklist produced ownership and support for the Accreditation Scheme. The Scheme provides a norm-referenced system which will accredit hospitals for a period of three years and provide the basis for bench-marking to further improve standards.

*Hubert Lobnig, Thomas Stidl*

## ***What are Health Promoting Hospitals Doing? First Results of the HPH DataBase 1998***

The International Network of Health Promoting Hospitals allows hospitals an active involvement in 18 national and regional networks throughout Europe. Member hospitals are developing and implementing subprojects on the four levels of HPH, covering the health of patient and staff, co-operation with the community and – in a metaphorical sense – the health of the organisation.

Since 1995 a subproject database was developed within the framework of the European Pilot Hospital Project. Starting in 1997 an International working group – Mila Garcia Barbero (WHO-Euro), Dominic Harrison (England), Irma Miseviciene (Lithuania) and Hubert Lobnig (Co-ordinating Centre, Vienna) developed a frame for a database for the European Project of National / Regional Networks of Health Promoting Hospitals. Aim of the International HPH Database is to:

- a) Provide a general and systematic overview on what is done in the member hospitals;
- b) Provide details for further research and analysis in subproject areas;
- c) Allow fact finding, comparison and benchmarking on specific issues and topics;
- d) Increase international information exchange and networking.

After piloting in twelve European countries data collection began in October 1997 in the National / Regional Networks. The Co-ordinating Centre compiled, summarised and subsequently analysed the data. At the International Conference 1998 in Darmstadt first results were presented.

118 hospitals from 18 countries have contributed data on 347 subprojects (not all member hospitals are included so far). Bulgaria, Germany, Italy (Veneto Region) and Poland are each involved with more than ten hospitals.

The four HPH project areas are represented as follows (N=347 Subprojects): Patients 245 (70 %), Staff 230 (66 %), Community 148 (43 %), Organisation 147 (42 %).

257 (74 %) of all the subprojects are now running, 51 (15 %) are finished and 20 (6 %) still in planning stage. As examples of the main issues for subprojects covering different areas we have listed the first five frequent issues for subprojects for patients and staff (Table 1 and 2).

<i>Issue</i>	<i>No of Subprojects</i>	<i>% (n=245)</i>
1. Patient satisfaction	107	44 %
2. Psychosocial aspects	71	29 %
3. Nutrition	59	24 %
4. Tobacco	42	17 %
5. Diabetes	33	13 %

Table 1 – First five subproject issues for patients

<i>Issue</i>	<i>No of Subprojects</i>	<i>% (n=230)</i>
1. Staff satisfaction	87	38 %
2. Inter-professional communication	63	27 %
3. Working environment	58	25 %
4. Psychosocial stress	51	22 %
5. Nutrition	41	18 %

Table 2 – First five subproject issues for staff

Some of the fundamental principles of developing and implementing subprojects are an active involvement of different professional groups (Table 3), building of alliances and co-operation with institutions and professionals outside the hospital and evaluation of their work.

<i>Disciplines</i>	<i>No of Subprojects</i>	<i>% (n=347)</i>
Nurses	209	60 %
Physicians	191	55 %
Other health professionals	149	43 %
Support staff, incl. administ. support	110	32 %
Management	109	31 %
Other	49	14 %

Table 3 – Disciplines actively involved in the subproject work

Extended partners from outside the hospital setting are integrated in many of the subprojects strategies and activities. A majority of projects have extended partnerships and are forming »healthy alliances« (Table 4).

<i>Extended Partner</i>	<i>No of Subprojects</i>	<i>% (n=302)*</i>
1. Health professionals outside the hospital	102	34 %
2. Other hospitals / health services	101	33 %
3. Other professionals outside the hospital	55	17 %
4. Media	48	16 %
5. Other health promotion agencies	43	14 %
6. Local / Regional government	42	14 %
7. Citizen groups	41	14 %
7. Schools	41	14 %
9. Universities	37	12 %
10. Health related companies	36	12 %

\* only 45 Subprojects (13 %) have no extended partners

Table 4 – Healthy alliances and extended partnerships approached in subprojects

Evaluation is a central step in project management, which is of utmost importance for HPH subprojects. To evaluate the activities set in the subprojects work a number of evaluation strategies are applied including »soft« but also »hard« methodologies (Table 5).

<i>Evaluation Strategy</i>	<i>No of Subprojects</i>	<i>% (n=319)*</i>
1. Interviews	111	35 %
2. Analysis of hospital data	101	32 %
2. Project group discussions	101	32 %
4. Systematic observations	79	25 %
5. Analysis of project documentation	74	23 %
6. Internal audit	47	15 %
7. Standardised tests	40	13 %
8. Economic evaluation	35	11 %
9. Focus groups	27	8 %
10. Clinical trials	20	6 %

\* Only 28 Subprojects (8 %) have no systematic evaluation applied or planned

Table 5 – Evaluation strategies applied in HPH subprojects

Full access to all data is given to the Network co-ordinators and to all hospitals having submitted information. Public access to selected data of the Database, especially to relevant data of the subprojects represented, is offered via Internet at the homepage of the Co-ordinating Centre ([www.univie.ac.at/hph](http://www.univie.ac.at/hph)). The complete Database is also available on disc (MS Access 97) at the Co-ordinating Centre in Vienna (contribution to costs: \$ 150).

The Database will be updated annually (January each year) and analysis will be presented at the International HPH Conference. As we can see today, the Database at the WebPage is accessed frequently and we are looking forward to presenting the updated version 1999 at the International Conference in Swansea, Wales, April 1999.

*Barbara Setzer*

## ***Quality of a Preventive Programme: VITAL-Therapie. The Goal-Oriented Analysis of the PROTOS-Study***

In the German tradition we have in-patient prevention and rehabilitation programmes with an average duration of 3-4 weeks. VITAL-Therapie represents such an in-patient concept. It is offered at the »Allgäuer Tor«, which belongs to WKA (Wittgensteiner Kliniken Allianz), a private clinic group. We empirically tested our concept by means of a prospective evaluation study called PROTOS (PROspective Therapieziel Orientierte Studie) in co-operation with the »Hochrhein-Institut«.

Patients were assessed on admission (T0), on discharge (T1), six months after treatment (T2) and one year after treatment (T3). The patients' perceived status was determined on all four occasions by the validated IRES-Questionnaire (Indikatoren des Reha-Status), which includes a global score for rehabilitation needs as well as sub scores for pain and symptoms, risk factors, occupational stress, restriction in daily life, psychological stress and social problems. Medical outcomes were measured by a doctors report.

Rehabilitation goals were determined and treatment was offered based on the medical examination and the patient's self-report (goal orientation). The study included 560 patients; female 56 %, male 44 %; average age 50 years. Average duration of the in-patient was 24 days.

The calculated effect sizes showed substantial reduction in risk factors such as cholesterol, body weight or blood pressure and reduction of e.g. psychological stress, depression tendency, sleeplessness, muscle weakness, rating of pain or myogelosis.

The symptoms of patients following an in-patient prevention therapy programme are substantial. Good long-term results suggests that imminent diseases might be avoided. That leads us to conclude that prevention and rehabilitation therapy demands serious consideration.

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Francesco Locati,<sup>2</sup> Antonio Bonaldi<sup>2</sup>*

## ***Appropriate Use of Emergency Care Unit***

### ***Introduction***

Currently patients attending the Emergency Care Unit of the hospital present both urgent and non-urgent diseases, the latter frequently in order to avoid a waiting list for consultation. A screening phase of the attending patients is needed to assure effective priority based on the severity of the illnesses.

### ***Procedures***

A plan for improving access to the health services and the quality of health care has been established taking into account: i) the correct use of the »triage« with the assistance of qualified and trained nurses in order to assure immediate care for urgent conditions, decoding the priority code based on well-defined protocols for non urgent patients; ii) the implementation of informatic supply in order to collect and process the data, arranging personal data of the patients; the system includes the requesting of instrumental and laboratory tests, the preparation of the admission sheet and the writing of lists regarding priorities; iii) the creation of a figure that co-ordinates the activities of the staff, the so-called »physician in shift«, that supervises the »triage« process.

### ***Results***

The main characteristics of the programme are illustrated Table 1-3. The flow chart of the information system according to output is reported in Table 1.

1 Emergency Care Unit

2 Medical Directorate – Azienda Ospedaliera Ospedali Riuniti di Bergamo, Italy

<i>Process</i>	<i>information</i>	<i>outputs</i>
<i>Triage</i>	private data modalities of access anamnesis nurse's clinical query	sending to proper specialist with clinical data attribution of priority index information about process
<i>surgeries</i>	anamnesis clinical examination results of instrumental tests request of instrumental tests and clinical consultations	request of tests audit of clinical information registration of activities
<i>instrumental tests, / clinical specialistic observation consultation</i>	observation diary results of tests and visits treatment	analytical display of tests and treatments
<i>outcome</i>	diagnosis admission, discharge, transfer	admission sheet discharge sheet and legal certifications clinical reports transfer sheet

Table 1 – Flow chart of organisation and information system

Table 2 shows the percentages of the daily mean access in the surgery rooms.

200 subjects

<i>surgeries</i>	<i>access</i>	<i>admissions</i>
Internal Medicine	28,0 %	32,0 %
Surgery	31,0 %	12,0 %
Traumatology	30,5 %	5,0 %
Intensive Care Unit	10,5 %	60,0 %*

\*10 % deceased; 30 % discharged or transferred

Table 2 – Daily mean access

Table 3 shows the results of about 500 questionnaires about customer satisfaction and other quality aspects.

*March 30-April 14, 1998*

distributed 500                      elaborated 197

mean age: 39 (sd 21)              male 166

*referral*

non responder                      5 %

self 80 %

practitioner                      15 %

other                      5 %

*knowledge about the criteria for priority indexes*

non responder                      10 %

yes                      38 %

*reception*

non responder                      10 %

good                      60 %

sufficient                      20 %

*relationship with professionals*

non responder                      10 %

positive                      95 %

*clinical informations*

non responder                      10 %

positive                      95 %

*satisfaction about the services*

non responder                      10 %

positive                      90 %

Table 3 – Questionnaires distributed to the patients

### ***Discussion***

The correct management of hospital admission improved the relationship with users. The major responsibility of the nurses in the »triage« process and the creation of a »physician in shift« produced a better organisation of the work with important advantages not only for the users of Emergency Care Unit but also for the personnel.

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Maria Lucia Di Vita,<sup>3</sup> Natale Lorenzi,<sup>4</sup> Antonio Goglio<sup>2</sup>*

## ***Infection Surveillance Programme and Quality Improvement***

### ***Introduction***

In the context of the continuous quality improvement activities started at the Azienda Ospedali Riuniti di Bergamo, relevant is the contribution offered by specific working groups.<sup>5</sup> One of the more active groups is the Committee of Nosocomial Infections Control and, particularly, a working subgroup called »Gruppo Operativo«. In-hospital acquired infections are one of the priority problems in the effort of improving health care, taking into consideration that they are the cause of around 50 % of all the main complications arising from hospitalization.<sup>6</sup>

### ***Methods***

The surveillance of nosocomial infections demands a systematic approach guaranteed by the presence of a multidisciplinary group of experts. A selected group of specialists called »Gruppo Operativo«, in the framework of the Committee of Nosocomial Infections Control of the Azienda Ospedali Riuniti di Bergamo, has started to manage in a more efficient manner the major problems related to the nosocomial infections. This group includes five

1 Medical Directorate

2 Microbiology Unit

3 Pharmacy

4 Infectious Diseases Dept., Azienda Ospedaliera Ospedali Riuniti di Bergamo, Italy

5 Bonaldi, A., Locati, F., Migliori, M., Salmoiraghi, M., Il sistema qualità nell'Azienda Ospedaliera Ospedali Riuniti di Bergamo. QA 1999 (in press)

6 Gaynes, R. O., Surveillance of nosocomial infections: a fundamental ingredient for quality. *Infect Control Hosp Epidemiol* 1997, 18, 475-478

7 Locati, F., Goglio, A., Grigis, A., Di Vita, M. L., In-hospital pseudo-infections due to contamination of medical devices marketed as sterile: A challenge for the quality control. In: Pelika, Krajic & Lobnig (1998), *Feasibility, Effectiveness, Quality and Sustainability of Health Promoting Hospital Projects*. Gamburg

health care professionals (hygienist, epidemiologic nurse, microbiologist, infectious diseases specialist, pharmacist) that regularly met and plan workshops with other professionals within the hospital. The main source of information is the Microbiology Laboratory, based on the availability of the data at a low cost and on the opportunity to detect alerting signals. Over a 3-year period, the major activities of the Gruppo Operativo have been devoted to the evaluation of relevant epidemiological events (epidemics and pseudoinfections), endemic events (i.e. multiresistant micro-organisms), requests of consultation for procedures, medical devices, preparation of guidelines.

### **Results**

**Relevant epidemiological events** – In a 3-year period a few outbreaks of pseudoinfections caused by intrinsic contamination of antiseptic solutions (*Burkholderia pickettii*, *Burkholderia cepacia*) and biological sample containers (*Fusarium verticillioides*),<sup>7</sup> and an epidemic of gastro-enteritis caused by *Salmonella* among personnel attending the cafeteria of the hospital, occurred. The epidemic of gastro-enteritis caused by *Salmonella* highlighted the importance of the co-ordination of different services, both inside and outside the hospital (i.e. administrative offices, local health services, etc.).

**Endemic events** – Outbreaks of multiresistant micro-organisms (*P. Aeruginosa*, *K. Pneumoniae*) occurring in wards in which critical patients are more often admitted (Intensive Care and Transplant Units), entailed a considerable effort both in terms of time and resources for the Gruppo Operativo.

**Requests for consultation** – The increasing presence of the Gruppo Operativo in different settings of the hospital stimulated the requests for advice and guidelines about medical and nursing procedures (Table 1).

<i>Department</i>	<i>Problem</i>
Cardiology	Colonisation of taps ( <i>Fusarium</i> spp.)
Renal Transplant Unit	Presence of <i>Legionella</i> spp. in the water supply
Industrial Medicine	Definition of biological risk in hospital
Neonatology	Preparation and conservation of milk for children
Urology	Preparation and administration of bacillus Calmette-Guérin in the bladder
Gynaecology	Evaluation of antiseptic vaginal washing
Pharmacy	Evaluation of intravenous infusion regulators
Odontology	Disinfection procedures for dental equipment

Laundry	Procedures for cleaning and disinfection of mattresses, pillows, blankets
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Table 1 – Requests of consultations (examples)

***Preparation of Protocols*** – The Gruppo Operativo, according to analysis of priorities, has outlined some specific guidelines about the prevention of the nosocomial infections, including guidelines for cleaning and disinfection of the operating rooms, hand washing, insertion of intravenous cannula, treatment of endoscopes.

### ***Discussion***

Nosocomial infections have become a problem affecting the quality of health care and furthermore they are the main cause of complications during hospitalisation. The introduction of a surveillance programme aiming at preventing and controlling in-hospital infections, therefore becomes a crucial step in order to guarantee an acceptable level of quality. The activity of the Committee of Nosocomial Infections Control and the Gruppo Operativo is part of this quality system introduced by the Azienda Ospedali Riuniti di Bergamo. In the context of educational activity promoted by the Azienda Ospedali Riuniti di Bergamo, the organisation of an intensive course for nurses, focusing on the prevention of nosocomial infections, in the framework of the School of Clinical Methodology and Continuous Quality Improvement of the hospital, deserves a special mention.

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## ***Adverse Drug Reactions Reporting System and Quality of Health Care***

### ***Introduction***

Adverse drug reactions (ADRs) are manifold and heterogeneous. It has been estimated that 3-6 % of all hospital admissions are caused by ADRs and that 10-20 % of inpatients experience an ADR during hospitalisation.<sup>3</sup> Drug-induced morbidity leads to increased suffering, prolongs hospital stay and causes a significant increase in overall medical expenses. The need to monitor ADRs and to prevent them is an important element of pharmacovigilance.<sup>4</sup> A variety of methods are utilised: the role of spontaneous ADRs reporting has been well established as being the principal source of alerting signals,<sup>5</sup> although the »under-reporting phenomenon« represents a severe limitation. Recently the European Community has licensed new dispositions regarding the registration and pharmacovigilance, creating the European Medicines Evaluation Agency (EMA).

### ***Methods***

In Italy the national pharmacovigilance system has been recently renewed according to the dispositions of the European Community (93/39/EEC). The organisational scheme is based on the activities of the regional offices of pharmacovigilance that receive the reports of all suspected ADRs from clinicians, pharmacists and pharmaceutical companies. The validation of the ADRs reported by health care professionals is the responsibility of the peripheral services of pharmacovigilance (Medical Directorate, Pharmaceutical Office). We shall describe the experience of the Azienda Ospedali Riuniti di Bergamo with pharmacovigilance activity, according to the new scenario. This activity

1 Medical Directorate

2 Pharmacy – Azienda Ospedaliera Ospedali Riuniti di Bergamo, Italy

3 Strom, B.L., Tugwell, P. (1990), Pharmacoepidemiology: current status, prospects, and problems. In: *Ann Intern Med* 113, p. 179-181

4 Rawlins, M. D. (1995), The challenge to pharmacoepidemiology. In: *Pharmacoepidemiol Drug Safety* 4, p. 5-9

5 Meyboom, R. H. B., Egberts, A. C. G., Edwards, I. R., et al. (1997), Principles of signal detection in pharmacovigilance. In: *Drug Safety* 6, p. 355-365

fits into the intensive quality improvement system launched by the hospital administration in 1995, based on the active participation of the health professionals working in the hospital.<sup>6</sup> In July 1997 the Medical Direction addressed a letter to all physicians and pharmacists of the hospital, informing them about the contents of the new law. Periodic up-to-date and possibility of consulting drug information service located at Pharmacy are assured.

### **Results**

The preliminary results of the pharmacovigilance programme activated by the Azienda Ospedali Riuniti di Bergamo related to the first six-months period are shown in Tables 1-4.

### **Discussion**

Effective pharmacovigilance is dependent on the availability of information on possible hazards associated with medicines in a representative population under conditions of normal clinical use. It requires a system for collecting and monitoring suspected ADRs, and processes for reviewing the many signals identified and deciding whether further investigation is necessary. A variety of methods, particularly spontaneous ADRs reporting, provide signals of potential hazards. Formal pharmaco-epidemiological studies, where available, are important to confirm or clarify such signals. Recently a new European system for drug regulation has been introduced in order to harmonise the existing national systems, co-ordinated by the EMEA, for drug registration and pharmacovigilance. Our experience reflects the need to promote the reporting of ADRs consistent with the principles of continuous quality improvement.

year	No. ADRs reports
1997 (July*-December)	17
1997 (January-June)	1
1996	—
1995	—
1994	2
total	20

\*letter to all physicians and pharmacists of the hospital about the new dispositions according to 93/39/EEC

Table 1: Frequency of ADRs reports at the Azienda Ospedaliera Ospedali Riuniti di Bergamo since 1994

6 Bonaldi, A., Locati, F., Migliori, M., Salmoiraghi, M. (1999), Il sistema qualità nell'Azienda Ospedaliera Ospedali Riuniti di Bergamo. **QA**, in press

Department	No. ADRs reports
Dermatology	14
Intensive Care Unit	1
Internal Medicine	1
Endocrinology	1
total	17

Table 2: Distribution of ADRs reports according to the Department of origin, July-December 1997

ADR	No. Reports
Exanthema	8
Contact dermatitis	3
Urticaria	2
Photodermatitis	1
Purpura	1
Disturbed liver function	2
total	17

Table 3: Distribution of type of ADR, July-December 1997

drug	No. Reports
Anti-infectives <sup>a</sup>	9
NSAIDs <sup>b</sup>	3
Iodate contrast media	2
Hormones <sup>c</sup>	1
Anticonvulsants <sup>d</sup>	1
Anti-asthmatic <sup>e</sup>	1

<sup>a</sup> amoxicillin, amoxicillin + clavulanic acid, lomefloxacin, trimethoprim + sulfamethoxazole, spiramycin, erythromycin, fenticonazole, fluconazole, terbinafine

<sup>b</sup> ketoprofen, acetylsalicylic acid

<sup>c</sup> octreotide

<sup>d</sup> phenobarbital

<sup>e</sup> bamifillin

Table 4: Frequency of culpable drugs, July-December 1997

*Anne-Laurence Le Faou, Danielle Chardon*

## ***The Quality Assurance Programme in Vaugirard Hospital***

Assistance Publique-Hôpitaux de Paris (AP-HP) is a federation of 50 public hospitals which provides care to the metropolitan area of Paris with 30,000 beds and 85,000 employees. Its hospitals belong to the University Teaching Hospital of Paris. The health care services of the University Teaching Hospital tend to emphasise high technology, rather than preventive care. In fact, the concept of health promotion is not yet developed in France. This paper deals with a specific experiment concerning a day care hospital in a new geriatric hospital of AP-HP, Vaugirard Hospital. Vaugirard, the most recent geriatric hospital is located in the 15th district of Paris. It opened its doors in December 1991. It has 320 beds, 55 of which are intended for rehabilitation, 10 for acute care and 20 for a day-care hospital. As the 15th district is the most populated one, Vaugirard Hospital was built to meet specific requirements. Furthermore, the data of the 1990 national census showed that one quarter of the population of this district was over the age of 60 (16.5 % above 65). The patients' quality of life is the major goal of Vaugirard Hospital, for medical care as well as for accommodation. The team tries to meet the standards of the hotel industry, global quality of care requirements (not only technical but relational care bedside manners) and provide social activities within the hospital and in the community.

Taking into consideration these aims, Vaugirard Hospital would like to become a reference in geriatric care.

As a result, the team decided to implement a quality assurance programme which takes into account:

- the patients' families (annual survey concerning the families' level of satisfaction). The results are presented to and discussed with the families every year in order to improve the weak points. This questionnaire is systematically given to the patients and their families when the former are discharged;
- ethical issues (linked to the problems encountered by dependent people such as patients' rights, difficulties in dealing with people with dementia). Requirements were defined by working groups and a resource centre was created to allow the staff to obtain information, discuss issues and determine guidelines;

- the AP-HP policy for the year 2000 which insists on co-ordination of care between specialities and cost-efficiency of hospitals;
- the Juppé plan (1996) requires that French hospitals become accredited by an independent national agency. Standards are being defined. This reform is encouraged by the new administration.

### *The stages of the project*

- Define the objectives:** obtain written procedures for admission, care, discharge and follow-up with the professionals of the community; for hotel services (hygiene, meal schedule etc.) to combat dysfunctioning.
- Analyse the present situation:** take into consideration some cultural aspects of the medical and nursing practice (no tradition of written procedures).
- Decide on a method to guarantee quality:** a task-force was set up. It is comprised of:
  - the project manager who is the director of the board of Vaugirard Hospital,
  - medical doctors,
  - chief nurse and nurse managers,
  - pharmacist,
  - equipment and maintenance manager,
  - catering team manager,
  - supplies manager,
  - computer department manager,
  - person in charge of public relations,
  - office staff supervisor, and
  - staff members involved in the quality assurance project.

Its objectives include:

- dealing with the needs and expectations of the patients,
- encouraging the training in quality procedures,
- making decisions on the programmes,
- appointing project managers and outlining their responsibilities,
- following up the programmes and measuring the results.

The first example of AP-HP policy is the information given to the patient.

### ***Guarantee the efficiency of the method by:***

Involving the board managers who are members of the task force, who are in charge of defining the project strategy, following up the stages of the project, deciding the evaluation method and thus, allocating funds to the project.

On a second level, encouraging the teams of the different departments to participate in concrete projects the aims of which are directly linked to the everyday life of the patients.

Using specific tools such as

- problem solving, process analysis, Pert diagrams etc. for the scheduling of the project,
- quality manual, charts etc. for the follow-up of the project by the board managers,
- indicators, control panels to check the results of the different stages of the project.

### ***Programmes***

a) The hotel services. Topics were chosen by the hotel team:

- the improvement of the evening meal service,
- the cleaning of the rooms,
- and the quality of food.

A group, made up of the catering team members worked together with the nursing and cooking teams as well as the chief nurse in charge of hygiene. A procedure manual will be published and distributed to the staff.

b) Good practices in hospital. The staff can spontaneously propose ideas concerning good practices which can be adopted as standards by the group.

c) One example: Respecting patients natural daily rhythms (for example, dinner served after 6.30 p.m. and served in courses, breakfast given when the patient wakes up).

### ***Method***

The work was divided into two parts:

1) Identifying the different stages of the stay at Vaugirard Hospital

- the admission,
- the stay: a typical day,
- the stay: an atypical day,
- the discharge.

2) Identifying what affects the patients.

Ad 1) The example of the admission and the general problems which affect the patients in a hospital:

- check the willingness of the elderly person to be admitted to a long term care unit,
- pre-admission appointment between the patient and / or the family and a nurse manager,
- orientation visit,
- arrival arrangements so that the patient can be welcomed in good conditions,
- means of transportation,
- welcome on arrival in the medical department,
- welcome on arrival in the patient's room,
- welcome on arrival by the medical and nursing staff,
- gathering of information concerning the patient's daily habits,
- modern conveniences the patient is accustomed to: TV, phone etc.,
- admission booklet given to the families (with practical information),
- a welcome gesture with a flower and a letter.

Ad 2) General problems which affect the inpatient:

- imposed routine (bath, meals, bedtime),
- noise (throughout the day and night),
- lack of real life atmosphere (smell of cooking, natural light, temperature variations),
- lack of co-ordination between the unit schedule and appointments with outside professionals.

This analysis has led to working groups who will deal with concrete topics for example the noise at Vaugirard Hospital.

### ***Conclusion***

The quality assurance programme is new in Vaugirard Hospital and aims to adapt the organisation of the hospital (administrative, medical, nursing) to the patients and not the contrary. This programme requires a specific method to lead to written recommendations of good practices which is being applied in Vaugirard Hospital.

# Addressing Allies for Change: Doctors, Nurses and Hospital Management

*Rainer Paul*

## ***Prisoners of Effectiveness or Allies for Change – Hospital Management Under Socio-economic Pressure***

The title of my talk was borrowed from a study of the leadership behaviour of corporate executives presented in 1990 by Kets de Vries. He referred to the executives as »prisoners of leadership«. Unlike Kets de Vries, who described the consequences of the individual psychopathology of the personality of corporate executives, I want to discuss the interaction between patient, staff and administration; and I do that from the standpoint of psychoanalytical theory. I thematize the interaction as an unconscious affect with regard to the aspect of anxiety in institutions. I hope to illuminate the conditions under which the administration can become an ally for change as well as the conditions which can hinder the achievement of that end. My presentation consists of ten theses:

### ***Thesis number one***

A major problem in hospitals is the defence against the psychotic anxiety called forth in the staff by interaction with patients. Although my current experience stems from my work in a mental hospital, I would like to emphasise that psychotic anxiety is provoked not only by encounters with psychotic patients. An example of an occurrence that unconsciously provokes psychotic experiences might be my knowledge as a patient that during an operation in a general hospital my body will be opened in surgery. Since at first glance this intervention seems to be the most natural and best one, as well as the next natural step given the corresponding indication, it indicates the enormous achievement made by the institution »hospital«: namely the defence against these fears.

### ***Thesis number two***

In an earlier talk at the 5th International Conference in Vienna I described the role of anxiety in institutions and hypothesised that organisations serve the defence against anxieties. Especially within the hospital, as I said before, one problem is the defence against psychotic anxieties called forth in the staff by their interaction with patients. Forms of defence observed include the elimination of any spontaneous decision, distancing from and denial of emerging

feelings, minimisation of the weight of responsibility by means of a chain of self-coverage- and inquiry procedures, etc.

***Thesis number three***

These and other types of defence slowly become part of the organisational structure and can hinder it from fulfilling its obligations. The inquiry procedures can, for example, hamper the necessary, rapid making of decisions.

***Thesis number four***

An organisation's executives, in this case the hospital's executives, are the focus of projections of anxieties on the part of the staff and the patients. Their ability to deal with such anxieties is challenged as well as subject to the constant pressure to regress to more primitive behaviour in order to defend themselves against these anxieties (executives are subject in great measure to regression pressures that can unsettle their personality structure and, as a reaction, lead to rigid management behaviour).

***Thesis number five***

In this instance the individual personality structure of an executive becomes more or less the predetermined breaking point of a differentiated attitude that deals with the anxieties of the co-workers. The individual personality structure governs both the disposition to regression as well as the type of regression.

Let me provide an example of the obsessive defence against anxiety that I encountered in my own work as a consultant. It can serve as a general example of regression on the part of an executive figure.

A corporate executive was given the task of restructuring what had originally been a division of the corporation into an independent company in the service sector. To his own surprise, the business became a huge economic success within its first fiscal year. This success was due primarily to the independent and creative activity of the staff made possible by the restructuring. In an alternating process of expansion and consolidation the business grew rapidly. Its staff, however, felt that the management had failed to provide them with enough support during the final phase of expansion. They complained to their superiors that the workload could no longer be accomplished and anxiety set in that they might be fired because the orders were not being processed rapidly enough. After the executive had hired new staff members, he too became anxious that the future course of the business might not justify the new hirings and that he might lose his own job. This anxiety soon became unbearable and the executive decided to institute a system of quality control that

consisted of a multitude of small steps and stemmed from the serial production sector. The sought-for transparency within the company was achieved, but this system of quality control costs working hours and led to a loss of confidence on the part of management, which the staff had previously enjoyed. As a result they began to distance themselves more and more from responsibility for carrying out their own jobs. The responsible executive now had more information about the work processes but at the same time a great deal more work himself, without, however being able to guarantee the success that had prevailed to date. The obsessive controls smothered the creativity that anxiety had fostered.

### ***Thesis number six***

Since executives are invested with the particular form of power, that allows them to control many and sometimes all, means of turning their ideas and fantasies into reality, the personal, mental reaction of an executive personality to projections of anxiety takes on a particular meaning for the organisation. In my example this is obvious in the type of quality control chosen by the executive of the company. The time-consuming controls that were divided into so small steps in the end destroyed the staff's creativity and willingness to assume responsibility.

### ***Thesis number seven***

If the executive level fails to carry out its obligation to contain anxiety that is, to withstand anxiety (in the before mentioned example this might mean withstanding staff complaints, or holding up under the stress after having hired new staff members), the consequences for the organisation are destructive. Vice versa, it can be said that the capacity of an institution to function depends on the solutions it finds for dealing with anxiety, respectively containing anxiety.

At this point the circle of anxiety projections can turn from the executive level to include the re-projection towards the staff, thereby closing. In the worst case, the staff are confronted by the anxiety they had first projected at the management without management in the meantime having dealt with or filtered that anxiety. In the best case, the staff is confronted by a form of the originally projected anxiety that has been altered so that the staff can benefit and anxiety can be contained.

In the example I cited, the original fear of being overtaxed was replaced by fear of controls. The uncertain success led to diffuse (psychotic) anxiety among both staff and management. In the course of defence there was a failure to transpose these diffuse anxieties into less diffuse ones: that is, fears of being

overtaxed or superfluous. By increasing the control activities these fears became consciously perceptible and capable of being consciously dealt with. However, the failure to deal with the psychotic anxieties leads to stagnation within the organisation.

The question arises now as to how to effectively change that situation. In answering it, the following basic complication must be resolved.

### ***Thesis number eight***

The means of power at executive disposal can make it quite difficult for them to reflect on their own mental reactions since reality and imagination can be mixed and references to one's own ideas can be found in reality (which is dreaded by one's own activities). In the situation described, the executive sees his control activities corroborated when they enable him to recognise potential failures of his company at an early stage, something that would not have been possible so quickly without the control system.

With reference to the title of this talk, I now want to address one type of regressive executive behaviour: the flight into ideas of economic effectiveness. To be more precise, I want to describe the requirement necessary to the executive co-operation in changes within a Health Promoting Hospital. One way of dealing with projected anxiety is to identify with the external enemy.

This may sound paradox, but management consciously decides to be the advocate of the institution, while it unconsciously employs the methods and means of the external enemy. On the executive level the administration is also disposed to this, independent of the individual personality.

Identification with the aggressor in this case means that the management identifies completely with the demands for economic effectiveness put by the health insurance companies. This is not to say that the service should not be offered economically. However, if the argument of effectiveness is used for defence purposes, it will completely paralyse the lively discussion of the obligations of an institution. Every new idea will have to surmount the argument whether or not it can be financed, which can lead to a ban on thinking and to a standstill in the learning capacity of an institution. If the ideas of effectiveness also become the basis of the activities of an executive, this person will no longer have any time for anything else, because time is precious. Isolation and a creative standstill will be the individual consequences, or to quote Nietzsche in »Human, Much too Human« (»Menschliches, Allzu Menschliches«), »A busy man seldom changes his mind«.

***Thesis number nine***

To implement the changes targeted in the framework of a Health Promoting Hospital it is absolutely necessary to recruit management as an ally. By now it ought to be very clear that exercises which are not part of the processes aiming at institutional changes will implement their own prevailing defence operations and cause the project of health promotion to fail, because they possess the institutional power to do so.

***Thesis number ten***

Executives do become allies in a process of social change when they perceive that their ability to contain social anxiety is strengthened and that destructive solutions, which threaten an institution's capacity to function, can be abandoned. »The understanding of this aspect of leadership behaviour and the leadership function is an important diagnostic and therapeutic tool in facilitating social change.« (Menzies-Lyth 1988, 78). Dealing with this defence formation represents, at the time an effort towards enlisting management as an ally and establishing the process of change.

In the example reported, this might mean reflecting, together with the chief executive, on how it came to be, that he abandoned his original confidence in his staff. It might be that the effectiveness of controls can be exchanged for an interaction based more strongly on confidence. Confidence is the most effective protection against the regression by executive personalities. The loss of trust in the interactions and in the involved persons precipitates a dynamic destructive paranoia mechanism.

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*Anita Mansfield*

## ***Hospital Managers – The Key Stake Holders in the Ongoing Success of Health Promoting Hospitals***

### ***Introduction***

The NSW Health Promoting Hospitals Project was jointly established in December 1995 by NSW Health and Wentworth Area Health Service.

The brief of the Project was to, by December 1998, develop a relevant approach to the Health Promoting Hospital concept for New South Wales. A lot of the initiatives developed under the framework of »health promoting hospitals« in Europe were not very helpful in guiding NSW or other Australian states, since much of what was new for Europe (staff health, patient education, waste management) was already well part and parcel of how our health services, and other organisations, organised their business.

There was an opportunity for the NSW Health Promoting Hospital Project to build on the experience of our European colleagues, to develop a framework for New South Wales' Health Services which celebrates, supports and guides efforts to improve the health of local communities. In NSW this has come to mean »working with mainstream health managers«, to reorient health services to those which have »improving the health of the local community« as their core business. That is, New South Wales's approach is one of »organisational development«, or »capacity building«. We want all health services in NSW to be »improving health«, not only providing good quality »treatment and care services«.

### ***New South Wales – the context***

New South Wales's 1986 Area Health Service Act, under which all public hospitals operate, clearly states that the role of Area Health Services is to »improve health« of geographically defined communities. Community Health and Population/ Public Health facilities are a part of Area Health Service's resources to improve health. At the end of the day, Area Health Services will have to justify their resourcing decisions in terms of expected and measurable impact on population health. This includes decisions to increase resourcing to clinical areas.

So, the NSW Health Promoting Hospital Project is located within a state that has a clear mandate to not only provide good quality treatment services, but also to generate and maintain effective population health initiatives.

### ***Project Strategies***

The New South Wales Project developed a number of strategies to involve and engage people from across the NSW Health system in the evolution of New South Wales' approach to the Health Promoting Hospital challenge. These strategies included running the Annual Healthy Hospital Awards, organising forums to encourage discussion and debate from managers and staff within health services, and directly involving managers of health services in the activities and discussions generated by the Project.

It is the last of these strategies that this paper will focus on: presenting the results of research conducted with managers of health services across NSW about what they identify are »indicators« of a »health promoting hospital«. It was through this research process that links were made with managers that put NSW Hospitals in a good position to move toward being »hospitals that promote health«.

The research was in two parts. The first is a qualitative study of what health service managers understand by »health improvement, and their services« role in working towards this end. The second part, currently underway, is a quantitative study of indicators identified in the qualitative study.

The theoretical background to the research led to the development of a »matrix«, which aimed to capture the changes that are made within organisations which are moving towards being better placed to impact on the health of the community.

Matrix of organisational development for health improvement

	infrastructure	maintenance and sustainability	increased problem-solving capacity
organisational commitment			
skills development			
resource allocation			

This matrix schematically represent the changes organisations can make in their structures (organisational support), skills and resourcing in an effort to contribute to improved health of communities.

Horizontal components of the matrix include those elements identified by Hawe et al (1997):

- i) Infrastructure development. This can include establishing structures, skills and resources aimed at responding to identified health issues experienced by the local community.
- ii) Maintenance and sustainability. This can be seen where preventing illness and disease becomes part of the role of established units or divisions of the organisation; where priorities and planning for health improvement is considered in the same forums that debate allocation of resources to treatment and care; where all staff are encouraged to increase their skills in identifying and responding to preventable illness and injury – where their traditional role was confined to treatment and rehabilitation.
- iii) Increased problem solving capacity of managers and staff. The experience of being involved in planned activity to improve health status leaves the organisation in a better situation to identify and address the next health issue.

This matrix provided a framework with which to map the experience and understandings of health service managers in relation to how they see their role in improving health.

### *Methodology*

A semi-structured interview process was developed which included a set of open-ended questions. A stratified sample was drawn from among the population of NSW hospitals. The original sample was adjusted to ensure representation from psychiatric, district and teaching hospitals. The sample size was 30, from a population of 209.

Interviews (telephone and face-to-face) were recorded. During the course of the interview managers were asked to rank their responses to questions about best practice. Transcripts were developed from the tapes, and these were sent to the interviewee/manager for clarification/ changes/ additions. Transcripts were then coded to identify themes arising within each question area. Elements identified in the transcripts were then mapped.

Managers were asked to identify elements which would assist us in developing indicators of »health promoting organisations«. The matrix discussed earlier was used to give shape to the elements identified by managers. The answers managers gave were mapped across the matrix.

### ***Results***

Using the headings within the matrix, managers identified that »organisational support« moved from »having policies which meet the legislated requirements of the Health Service act« in the first column, to »playing a role in broadly interacting with services that impact on local health issues« in the third column. The middle column, that indicates that an organisation is moving toward one which improves health, identified that a necessary step is to have processes that allow the organisation to identify and plan to address health priorities.

In terms of »skills«, managers identified that organisations move from collecting data and undertaking audits, to evaluating work processes, both internally and against other organisations. Steps that indicate the organisation is moving toward one which improves health include: that there are processes in place that support the organisation to identify and act on opportunities that arise spontaneously; that the hospital has a systematic approach to general quality improvement, and that staff's access to formal skills development is supported in an informal way in the context of their day-to-day work.

And finally, in terms of »resources«, organisations that are developing their capacity to improve health move from the legislative, short term focus of having efficient, effective treatments, to acknowledging that outcomes funding for health services should reduce (with improved population health), and the opportunity to establish joint initiatives for improving health, with other sectors, becomes a priority. Intermediary steps include that the organisation includes the community in implementing its programs, and that these programs include those which are designed to keep people from needing the services of a hospital.

### ***Discussion***

While the matrix used to order and map managers' responses was not a perfect tool, it did allow a measure of comparability, particularly between responses. The set of maps contained in the appendix can provide managers and others with a place to begin when sorting through how to identify where their service is on the pathway to being an organisation that improves the health of the population/ community it serves. They also provide us with a rough guide as to the barriers managers face when attempting to incorporate health improvement in their core business, and how their colleagues have begun to deal with many of these barriers.

The NSW Health Promoting Hospital Project has used this research process as an opportunity to raise awareness among managers of the work being done by colleagues. From this, a Special Interest Group has been developed by the Australian College of Health Service Executives – a key professional association interested in supporting the professional development of health service managers. This Special Interest Group will continue beyond the life of the New South Wales Health Promoting Hospital Project, and will provide ongoing support for managers – armed with well grounded indicators and, through the Annual Healthy Awards which the College will also continue, examples of current good practice.

Hawe, P., Noort, M., King, L., Jordens, C. (1997), Multiplying health gains: The critical role of capacity – building within health promotion programs. In: *Health Policy* 39, 29-42

*Monika Fröschl, Klaus Diethart Hüllemann, Eva Raab-Karkowski*

## ***STP-Network – Science-Theory-Practice Network in Nursing Management***

Since 1995 studies of nursing management have been newly established at the »Fachhochschulen« in Bavaria. German »Fachhochschulen« are universities with a special high practical field experience. All students are trained nurses. The four year programme qualifies for management positions in hospitals, nursing homes, other care facilities or in the private sector. Instruction is based on scientific findings, theory and nursing methodology as well as practical field experience. In the first three semesters basics of nursing management following three fields of studies are taught. These three fields are: anthropology, nursing science and management. In semester 4 and 5 a field placement internship (practicum) follows. In semester 6 until 8 advanced studies in nursing management similar to a graduate programme take place. In addition everyone chooses a field of specialisation. So far the two directions offered are hospital management and health promotion. The first students have now entered this period of specialisation. The first graduates will have finished in summer 1999.

To initiate a close co-operation between science, theory and practice we are now trying to establish a network connection between health promotion practice and theory. So far we are just at the beginning of this process. Contacts until today with health promoting hospitals exist mainly with the St. Irmingard Hospital in Prien. The specific aims of the network between the Katholische Stiftungsfachhochschule and the health promoting hospital are:

1. Initiating exchange programmes: Advanced nurses for health promoting hospitals have given and will give lectures at the Katholische Stiftungsfachhochschule, professors and students will join projects in the hospitals.
2. To define the special role of nursing in the health promotion process: Nursing theory and science especially in Germany is just beginning. In the very new field of health promotion nurses need to define their special role and define their qualifications for health promotion.
3. Initiation of health promotion for nurses: So far nurses suffer from many health problems such as back problems or burn out syndrome. For this reason many nurses leave their profession after some years.
4. Promoting the interdisciplinary approach in health promotion: As the

Katholische Stiftungsfachhochschule also offers studies in social work, there is a basis for defining fields of co-operation and competition between these two professions. So seminars will take place to find the possible fields of future co-operation.

5. Development and testing of models for good practice for health promotion in nursing in hospital
6. To define an appropriate nursing theory which includes the idea of health promotion.

So far nursing science especially in Germany is just beginning. As many models have been oriented towards the medical deficit model, a resource-oriented model adequate to health promotion needs to be newly defined. System theory and case management could show indicators for appropriate future directions.

*François Martin, Isabelle Aujoulat*

## ***Prevention in Hospitals – a Cultural Change for French Hospitals***

The history of the modern French hospital of the 19<sup>th</sup> and 20<sup>th</sup> centuries is based on the emergence of the anatomo-clinical link. The two major elements that have ensured its legitimacy are: the transformation of the hospital, from a home for the poor into an establishment providing care for the majority of people, and the progress of medical technology regarding the anatomo-physio-pathological description of morbidity processes.

The consequence of this has been a medical practice in hospitals focused on the disease rather than the person, with hospital organisation carried out like a nosological reference book in which the patient and the determinants of diseases are ignored.

It was necessary to wait for the hospital law of 1991 and the 1994 report of the HCSP, a national team of public health experts, on the health status of people in France (Haut Comité de la Santé Publique, *»La santé en France«*, 1994) before the fields of prevention and health education were considered to be legitimate activities among the services of hospital care.

For university hospitals, traditionally oriented toward research and teaching, the consequences of this are moderate. For general hospitals, however, directly concerned with the health needs of the community, the consequences can be decisive for their organisation.

The health problems of the community, in fact, are not only represented by diseases requiring technical, diagnostic and therapeutic action.

**Addictive behaviours**, linked to alcohol or tobacco consumption, for example, require the development of primary-secondary prevention actions in order to reduce the morbidity they cause. Empowerment and medical care of **patients with chronic pathologies** require the implementation and development of patient education programmes, which are hardly considered a priority in the current organisation of hospitals. Moreover, **precariousness** being a determinant of health, patients with low income or social difficulties should be paid special attention. As a response to this, the three dimensions of prevention (primary, secondary, tertiary) should be integrated in the organisation of health care services.

In a town of 48,500 inhabitants, 80 kilometres west of Paris, a ***Prevention and Health Education Unit (U.P.E.)*** was developed in 1995 within the general Hospital of Dreux. Different elements of strategic implementation directions were presented at the 5<sup>th</sup> Conference on Health Promoting Hospitals in Vienna in 1997.

Socio-sanitary data of Dreux are the following:

- The community around the Hospital of Dreux and surroundings includes 120,000 people. 25 % of the urban community (48,500 inhabitants) are immigrants and more than 20 % of them are in a situation of social precariousness.
- The Hospital of Dreux has 430 beds for short visits in general medicine-surgery-obstetrics, admits 22,000 patients per year, and the average length of stay is five days.
- 10 % of all admissions to the hospital are the result of social precariousness.
- 20 % of all admissions to the hospital are due to a health problem linked to alcohol or tobacco.
- Cancer morbidity (ENT, broncho-pulmonary, breast cancer) is 30 % higher than the French national average.
- The prevalence of tuberculosis is significant at 25 per 100,000 inhabitants. In considering these different data, the general objectives of the Prevention and Health Education Unit (UPE) are the following:
  - To ensure ***continuity*** between cure and prevention, hospital and community, the health and social fields.
  - To promote the ***comprehensiveness*** of patient care by giving priority to approaches of prevention, patient education and medico-social care for socially deprived groups of the community.

In terms of operational objectives, it is necessary to combine primary, secondary, and tertiary prevention actions:

- ***Primary prevention*** actions aiming at reducing the incidence of a health problem should be made available in socio-educational centres in deprived areas. The Prevention and Health Education Unit (UPE) of the Hospital of Dreux offers partners from within or outside the hospital access to a health education resource centre, which provides for services such as general documentation and research on bibliography, consulting in methodology, training, on-site health education interventions in different settings.
- ***Secondary prevention*** actions aim at reducing the prevalence of health problems by ensuring early detection of diseases. In partnership with the local health insurance centre (***Caisse primaire d'assurance maladie d'Eure et***

**Loir**), a thorough medical »check-up« including screening, blood analysis, dental care etc. is made possible at the Hospital of Dreux twice a month for socially deprived persons. For most of the beneficiaries, this is a way for establishing new links with the health care system as a whole, as a personalised follow-up is provided for by the Prevention and Health Education Unit. Also, given the importance of pathologies linked to tobacco, different structures for tobacco control are implemented both within and outside of the hospital.

- **Tertiary prevention** actions aim at improving the patients' quality of life by reducing the consequences, such as disabilities, of a disease. The concept of tertiary prevention is not given much importance in the organisation of health care services in France. Given the importance of problems regarding therapeutic compliance and the psycho-social aspects of care for patients with chronic diseases, the Prevention and Health Education Unit is developing patient education programmes, and has implemented a resource centre for patient associations and structures, to help promoting interactivity between medical personnel and patients.

Compared to these ambitious objectives, the human resources of the Prevention and Health Education Unit are small:

- one secretary acting as the librarian of the resource Centre,
- one co-ordinating nurse,
- one social worker,
- one half-time hospital practitioner trained in public health,
- and several temporary consultants such as a general practitioner, a nurse etc.

### **Results**

Three types of approaches to health problems were developed along the lines of the 1994 national report on the health status in France:

- An approach by **health determinant**, for problems linked to tobacco, alcohol and social precariousness.
- An approach by **pathology**, particularly for chronic diseases. These actions are carried out in partnership with patient associations concerned with HIV, diabetes, asthma, multiple sclerosis, and repercussions of head injuries.
- An approach by **population** is carried out for out-of-school youth under the theme of global health. Community health actions are carried out with immigrant women in disadvantaged neighbourhoods. Actions for medical and paramedical staff, as well as social workers have been carried out to prevent

the burn-out syndrome.

The **results** are assessable in terms of quantified activities and in terms of process for the implementation of networks of professionals.

In **terms of quantified activities**, the annual report of activities in each of the areas of primary, secondary, and tertiary prevention show that:

- 2,120 people have been reached by primary prevention actions, of which 400 are medical staff.
- 730 people with a health problem have been reached by the Prevention and Health Education Unit, of which 230 are patients.

In **terms of processes**, these different activities have allowed for the implementation of several local health networks working in HIV, tobacco, precariousness etc. These networks make it possible to bridge the gap between the curative and preventive, medical and social sectors, and between individual and community responsibility. The networks combine a number of medical staff, health professionals, social workers, and representatives of patient associations. The co-ordination and logistics are under the responsibility of the Prevention and Health Education Unit.

Since the French hospital law of 1991, there is a trend to move hospitals from cure institutions into health establishments. The activity of the Prevention and Health Education Unit at the Hospital of Dreux is the illustration of an attempt to put this trend not only into words, but to achieve a significant change in the paradigm of hospital organisation.

# HPH-Networking

*Mila Garcia Barbero, Oliver Gröne*

***Report on the WHO Workshop,  
April 29, 1998, Darmstadt***

***Introduction***

The Workshop was attended by representatives of 19 national / regional networks of HPH. In the introduction, Mila Garcia Barbero highlighted the importance of formal agreements between National / Regional HPH Networks and participating hospitals. This led to a discussion about possible barriers to join the network. Membership fee was identified as one such barrier. But as the fee is rather low, it was concluded that membership fee is more a symbolic burden. Therefore, a consensus was reached on maintaining the fee, and Garcia Barbero assured the plenary that individual solutions could be found for hospitals having problems in entering the fee into their accounts due to administrative reasons.

Then Rainer Paul, Philipppshospital Riedstadt (local host), gave a short welcome address to the participants. Hubert Lobnig, LBI/HPH Co-ordinating Centre, summarised the main activities of the co-ordinating centre for 1997-1998:

- Publication of the proceedings of the 5th International Conference on HPH;
- Publication of the »Review Book of the European Pilot Hospital Project«;
- Preparation of the 7th International Conference on HPH, Swansea, Wales, April 21-24, 1999;
- Publication of HPH Newsletters No. 11 and No. 12;
- Developing the HPH database;
- Presentation of HPH concepts and experiences at various conferences.

The HPH database and a first analysis of the data were then presented. Mila Garcia Barbero stressed the importance of a formal commitment by the member hospitals, as membership is combined with the responsibility to provide data for the database (as outlined in the »letter of understanding«). It was concluded that full access will only be given to those hospitals who contributed to the database.

### ***HPH Network Reports***

Each national / regional network co-ordinator gave a short presentation of successes and problems in his / her network during the last year. This included presentations from Austria, Belgium (French community), Denmark, Finland, France, Germany, Greece, Hungary, Ireland, Italy (Veneto, Piedmont, Lombardia), Lithuania, Poland, Sweden and the UK (England, Northern-Ireland, Scotland, Wales).

### ***Evaluation of Health Promotion Methods***

Brenda Stephens, co-ordinator of the Welsh HPH Network, presented an analysis on evaluation in the HPH network, which demonstrated that:

- There is a lot of evaluation on hospital subproject level;
- There is only some evaluation concerning the development of national / regional networks;
- Many co-ordinators have experienced great difficulties in applying evaluation schemes.

The participants discussed how to facilitate the application of evaluation methods. It was decided to encourage co-ordinators to exchange information on methods for evaluating projects, and to compare process and outcome of different methods.

It was also decided that small thematic networks (e.g. nutrition, diabetes mellitus) could better focus on technical aspects of HPH than the overall network and therefore facilitate the exchange of information.

The last question was related to improvement strategies for an exchange of information concerning effective health promotion interventions and strategies of implementation. It was concluded that the evidence of HPH as well as internal benefits of HPH could be better communicated by using marketing strategies, especially in media outside the network (e.g. the Journal of the International Hospital Federation).

### ***Conclusions***

- All member hospitals of national regional networks should sign the »Letter of Understanding«.
- The HPH database will be available on the www-Server of the LBI.
- Full access to the HPH database (via password) is limited to members who contributed data.

- Communication between the co-ordinators should be improved by Newsletters, the www, publications in scientific journals and in the HPH series.
- It was decided to facilitate the development of thematic networks.
- At the next Workshop of HPH Co-ordinators, technical issues (guide-lines, outcomes) should be discussed as well as network presentations.
- The 5th Workshop of Co-ordinators of HPH Networks will take place at the side of the 7th International Conference on HPH in Swansea, Wales, April 21-24, 1999. The 6th workshop will possibly take place in Greece.
- Members can send issues of general interest to WHO, for inclusion in the www.
- The name of the international network might be changed to include other institutions than hospitals. This discussion should be taken up at the next workshop.
- There is a need to reach agreement on what is meant by »health orientation« and how to measure it.

*Oliver Gröne*

## ***Managerial Experiences of Health Promoting Hospital Networks***

After the Pilot Phase of Health Promoting Hospitals was closed at the 5th International Conference on Health Promoting Hospitals in 1997, the National / Regional Networks were established with the goal to foster the development of Health Promotion within the Hospitals of the respective Region. Each National / Regional Network is coordinated by a National Coordinating Institution (NCI) which serves to facilitate and encourage the cooperation and the exchange of experiences between hospitals of a region or country.

In terms of the **structure** of the NCIs it is to consider, that many of them evolved from being a partner-hospital in the Pilot-Health Promoting Hospitals and are therefore located within a hospital. However, some other NCIs are also located at scientific institutions such as universities or organizations. Most NCI (Austria, Belgium-French Community, Hungary, Lithuania, Ireland, Italy-Piedmont Region, Sweden, United Kingdom-Northern Ireland, and United Kingdom-Scotland) have established a steering committee to plan the long-term development of the network. Some other networks (Germany, France, Ireland, and Italy-Piedmont) also have constituted task forces and working groups on specific problems, such as the application of evaluation strategies or funding mechanisms.

The most frequent **alliances** exist to regional / national governments (Austria, Belgium-French Community, Finland, United Kingdom-Scotland, United Kingdom-Wales, Ireland, Lithuania, and Sweden) or to scientific institutions (Austria, Belgium-French Community, Finland, Greece, Hungary, Ireland, Lithuania, and Sweden). Whereas most NCI show contacts to these partners, only one has contacts to the Healthy City Project (Ireland) and another one has contacts to the private sector (Lithuania).

A problem encountered in almost every network is to find additional resources for the initiation of projects, the distribution of materials, etc. Only a few National / Regional Networks receive **funding** or other support from the government (Hungary, Ireland). France introduced an interesting example, where the current network members developed a system of sponsoring for new network members. The Hungarian approach: to create a foundation to receive grants from banks, the private sector or other public institutions, was not successful.

Important indicators supporting the goals of the NCI (co-operation and exchange) are the techniques used to **disseminate information**. In Table 1, the most common methods are presented.

<i>Information Dissemination</i>	<i>Networks<sup>1</sup> (n=21)</i>
(Business-) Meetings	AUS, BUL, GER, FRA, UK-Northern Ireland, UK-Scotland, GRE, IR, LTU, ITA-Piedmont, POL
Conferences, Workshops	AUS, GER, UK-Northern Ireland, UK-Scotland, UK-Wales, HUN, IRE, ITA-Piedmont, LTU, POL
Publishing of Conference Proceedings	AUS, LTU
Newsletter, Bulletin	AUS, GER, FIN, UK-Wales, IRE, ITA-Lombardy (p)*, ITA-Piedmont (p)*, LTU, SWE
Information package, Model Documents	AUS, BUL, UK-Wales
Annual Reports	IRE, LTU
Project Publications	FRA, AUS
Internet Homepage	ITA-Veneto <sup>2</sup>
Poster Presentation	UK-Northern Ireland, SWE
Publication of Evaluation-Results	SWE (p)*, UK-Wales
Books	UK-Wales

Table 1: Information Dissemination<sup>3</sup> \*p=planned

There are different **evaluation approaches** on network level, although none of them are well developed yet. At this time there is not an evaluation system for the individual networks – most systems are applied only at hospital level. However, there are some interesting approaches.

Among the most developed tool applied is the **Hospital Accreditation Scheme** that evolved from the **Healthy Hospital Award** in United Kingdom, Wales. When a hospital applies to be formally accredited as a Health Promoting Hospital, an organizational evaluation process is undertaken. This is based on a standardized self-audit survey. Subsequently, a team of external assessors visits the hospital to validate the survey and to interview staff and patients. However, the German experience is that these visits are difficult to carry through, due to the financial implications.

1 Networks are indicated according to their country-abbreviation. The country codes used are (in alphabetical order): Austria (AUS), Belgium (BEL), Bulgaria (BUL), Denmark (DEN), Finland (FIN), France (FRA), Germany (GER), Greece (GRE), Hungary (HUN), Ireland (IRE), Italy (ITA), Lithuania (LTU), Poland (POL), Sweden (SWE), United Kingdom (UK).

2 <http://www.hatria.it/retehp>

3 According to the information given with the papers prepared for the 4th Workshop of National / Regional Health Promoting Hospital Network Co-ordinators, Darmstadt, Germany, 29. April 1998.

The German system consists of two peer-reviews from hospitals and one side-visit from a representative of the network to the applicant hospital. Afterwards a statement is given, if the hospital is to be accepted or not in the network. Due to the financial expenses this system proved to be not practical.

The Polish Network started a system of self-evaluation in 1994. However, it was not possible to apply it as almost every hospital tried to fill-up the self-evaluation form in a different way. A revised evaluation-scheme is now related to four groups of evaluation performers: The health promotion team self-evaluation, the hospital staff assessment of the health promotion activity, the inpatient observations, and the inpatients' families and local community representatives observations. This evaluation-system is going to be used to assess the performance of each hospital annually, although, it is not done for competitive purpose – hospitals are only compared with their last years performance and not with other hospitals. The approaches of other national / regional networks are still in their initial stage.

### ***Conclusion***

The comparison presented in this paper has to be regarded cautiously due to the diversity of approaches, projects, and terminology used. This variety makes it difficult to compare the information provided by the HPH database or the papers given at the co-ordinators-workshop. The diversity of responses shows the need of better classification and agreement of terms and reporting mechanisms. For this reason the tables, categories and summaries introduced in this paper have to be handled very carefully.

According to the ***problems encountered in national / regional networks*** it seems that they are very similar and refer most often to funding and the application of evaluation methods. However, the experience also shows that the change to a health promotion hospital is possible without great financial resources.

The ***Central Eastern European Countries*** face further difficulties arising from the drastic changes in the health care sector, which makes it more difficult to raise funds. Nevertheless, this climate of change should be used to orient the hospitals (and the whole health care system) more into the direction of health promotion.

There is a very different level of development between the networks. In some countries / regions they are already well developed while in other countries the development is still at the beginning. Furthermore, some countries have started to develop HPH, but hesitate to formally join the international

network. Up to this point 176 hospitals have formally signed the letter of understanding.

In many of the hospitals although some activities on HP are taking place, the concept of Health Promotion is not applied to the whole organisation. There is still a long way to go until the concept of health and not just curative medicine is considered as a fundamental criteria for any decision related to either patients, staff, the organisation, the environment, or the link to the community.

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## ***The Network of Health Promoting Hospitals in the Veneto Region, Italy***

### ***Introduction***

In 1995 the Veneto Regional Government funded a programme to establish a Regional Network of Health Promoting Hospitals. The timing of the initiative was extremely appropriate as far as in 1995 the National Health Service underwent a major reform, with emphasis on regionalization and introduction of several mechanisms of internal and external competition, mainly in the hospital sector. The Co-ordinating Centre of the Regional Network of Health Promoting Hospitals was established at the Local Health Unit No. 19 of Adria.

The Veneto Network of Health Promoting Hospitals aims to act as a focal point in population based health promotion interventions, because hospitals in the regional health care system: a) are owned by the Regional Government; b) have sensible human and financial resources; c) have contact with a large part of the population; d) represent the most important challenge in the re-orientation of the health care system; e) have strong links with the primary health care sector.

### ***The activities of the Veneto Region Network***

#### ***The strong points***

The Co-ordinating Centre of the Veneto Region Network organised several promotional activities for implementing the Network: a workshop on principles and methods of health promotion; the translation of many documents on health promotion; some business meetings and training workshops for the local co-ordinators of HPH and professionals who are involved in clinical activities; regional working groups and the preparation of three publications

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2 Veneto Region Network of Health Promoting Hospitals

on health promoting projects. Between November 1995 and March 1998, 17 out of 21 Local Health Units of the Region and the two Hospital Trusts officially joined the Regional Network with a decree of their General Directors. The Agreement between EURO/WHO and the Network was signed.

In 1997 the hospitals of the Regional Network developed 63 subprojects. These subprojects are planned according to the Ottawa Charter, the Budapest Declaration and the Vienna Recommendations. Consistent with the theoretical bases of the HPH movement, the specific objectives of the subprojects are addressed to patients, staff and community; the planned actions are consistent with the essential activities of the Ottawa Charter (to enable people, to advocate for health, to mediate); and the indicators allow the assessment of the used resources, the developed processes and the gained outcomes.

The subprojects implemented by the hospitals, deal with: smoke free hospitals and health care services; some clinical aspects (i.e.: prevention of hospital infections); health promotion in workplace; evaluation and improvement of patient satisfaction; continuity of care from hospital to primary health care services; diet and health; quality of life for the elderly; improvement of birth care.

Three regional working groups on »health in hospital workplaces« finished their task and three regional subprojects were established: the assessment of biological risk, antineoplastic drug preparation and the prevention of low back problems. These subprojects are being published and will be spread throughout all regional hospitals.

In March an Internet site about the activities of HPH in Veneto and Italy was edited by the Veneto Region Network: some information about the HPH programme, the projects developed by the hospitals of the Veneto Region Network and the Italian translations of the most important documents of WHO on health promotion are contained. This web site of the Veneto Region Network is now available: <http://www.retehp.it>

### ***The weak points***

In 1997 the Co-ordinating Centre of the Veneto Region Network highlighted two weak points: the difficulty of many hospitals in preparing periodic reports about their activities and the lack of commitment by the strategic management of some hospitals.

To overcome these difficulties, the Co-ordinating Centre plans in 1998 for a major involvement of the Hospital Regional Department and the General Directors of the Local Health Units and Hospital Trusts.

### ***HPH and quality: a question to explain***

The activities for health promotion and those for quality improvement fre-

quently overlap. In some hospitals of the Veneto Region Network health promotion activities are evident and integrated in the hospital Quality System, whereas in others they are blurred. Sometimes the subprojects are defined "health promotion projects" but they are only projects for hospital quality improvement, because they don't stimulate "the process of enabling people to increase control over, and to improve their health". In 1998 the Co-ordinating Centre of the Regional Network will help the hospitals to define subprojects coherent with the theoretical principles of health promotion.

### ***The activities for the development of the Italian Network of Health Promoting Hospitals***

In March 1996 the Service for the International Relations and European Community Policies of the Italian Ministry of Health designated the Veneto Region Network as co-ordinating institution of the Italian Network of HPH. Moreover, the co-ordinator of HPH Veneto Network was designated as focal point for the development of the National Network.

In order to achieve this objective, selected documents were mailed to regional Ministers of Health and meetings and contacts were held with representatives from hospitals of many Italian regions. The 1st National Conference of Health Promoting Hospitals was organised in Padova in January 1997 by the Veneto Region Network.

Particularly the Veneto Region Network supported the development of a regional Network of HPH in Piedmont and in the June 1997 the formal Agreement between the WHO Regional Office for Europe and the Piedmont Region of HPH was signed. In April 1998 the Milano Network was instituted with seven Hospital Trusts and a process to create a regional network is in progress.

The 2nd Italian Conference of Health Promoting Hospitals was organised in Torino in March 1998 by the Piedmont Region Network. During this Conference a formal Agreement for the creation of the Italian Network was signed by the Co-ordinators of the HPH Network of the Veneto and the Piedmont Region. The Italian Network of Health Promoting Hospitals will be implemented as a federation of the autonomous HPH Regional Networks formally recognised by the WHO Regional Office for Europe.

### *Conclusions*

In 1998, the main challenges of the HPH Veneto Region Network at regional level will be: a) the implementation of the local projects in all hospitals; b) the strengthening of the management commitment; c) the improvement of the documentation and evaluation of the project results over the hospital organisation and the health of patients, staff and community.

The birth of the Piedmont Region Network is very important for the development of the HPH Italian Network. The next steps for the Italian Network will be: to share information, to develop some common projects among the Regional Networks and to establish common forms for the evaluation of the health promotion activities in hospitals. In this developing period of the National Network, an important role will be the advocacy of health promotion principles in order to assure coherence between theory and practice.

In the next months an important challenge for the Italian Network of HPH will be the assistance of other Italian Regions in the implementation process of their networks: some hospitals from Regions joined separately to Italian Network and they should be the focal points for the development of other Regional Networks of Health Promotion Hospitals.

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## ***Priorities in the Hungarian Health Care System. The Role of HPH Network***

Up to 1955, life expectancy at birth and various significant mortality rates presented the same data as in neighbouring Austria. From this time on, life expectancy decreased and mortality rates increased steeply in Hungary. In Austria an opposite tendency could be observed. In the last decade of this century Hungary stood among the three leading countries due to the most important chronic non-inflammatory diseases and consequent death rates, which are the following:

1. Cardiovascular- and metabolic-diseases, mainly acute myocardial infarct, stroke, peripheral arterial obstructive processes, diabetes and end stage renal disease.
2. Different cancers: In the last decade, lung cancer became the leading tumour among men, which means more than 4,000 new cases pro year. Second, most frequently diagnosed cancer among male patients is the colorectal one. Prostate tumours are the third most frequent cancers among male patients. Among women, breast cancers are the leading ones followed by gynaecological and colorectal tumours to be observed most frequently.
3. Liver cirrhosis has been rapidly increasing in the last decade due – partly – to high alcohol consumption.
4. Chronic broncho-pulmonary diseases are the fourth cause leading to death in our country.

Regarding the four most important lethal causes, we can establish which environmental factors are – in part – responsible for achieving these sad results.

1. Unhealthy life style («sedentary» life-style) with less exercise.
2. Unhealthy nutrition: This means more total calorie intake than needed. The quality of food is also unhealthy. Fat content is very high, and stems mainly from animal origin (pork). Animal protein content is also high, it is not uncommon that the percentage reaches 25-30 % of the total energy intake. The quality of consumed carbohydrate is based on white bread, potatoes, rice, and the average meal is poor in fibres. Additionally, people eat too much sugar and drink more alcohol than recommended.
3. Smoking is an important risk factor in leading to early death. Unfortunately,

at present roughly 1/3 of the entire population still smokes and smoking habits have shifted to the younger generation and to females. It is not infrequent that pregnant women continuously smoke up to delivery.

4. Alcohol consumption is a growing problem in our country. Hungary was many decades ago a typical wine-drinking country. After the second world war, the drinking habits started to change and nowadays the majority of the population drinks beer as well as hard liquor. Apart from this, the quantity consumed has also increased significantly.
5. Over the last few years drug consumption has also become a rapidly growing problem. At present there are no exact data, but some hundreds of deaths per year are regarded as a consequence of this.

According to the above mentioned problems and taking the HPH philosophy as a model, we started to build up the **National Network of HPH Hospitals**. Up to now about 27 hospitals have joined the Network with different programmes. More than 80 different sub-projects have been listed and among them are many which focus on the above mentioned risk factors.

Unhealthy life-style and unhealthy nutrition are usually combined. These two risk factors lead to obesity. The fat distribution among these individuals is often typically abdominal, visceral. This means that the accumulated fat is deposited mostly in the abdomen. Visceral obesity, sedentary life style and unhealthy nutrition are often linked to hypertension, advanced blood coagulability, dyslipidemia. The cluster of these abnormalities are named the Metabolic Syndrome. These are strong risk factors towards acute atherosclerotic diseases, myocardial infarct and stroke. Programmes which screen hypertension, the typical signs of the Metabolic Syndrome, elevated blood cholesterol, etc., might be effective in decreasing lethal atherosclerotic diseases.

In order to achieve better results special club activities have been started in many HPH Hospitals, e.g. Diabetes Club, Anti-Alcohol Club, Anti Asthma Club, etc. In these club events a more detailed patient information has commenced, which is part of the promotion of a healthier life-style. According to our evaluation, these club activities are popular everywhere and despite the fact that the objective result is less efficient than the individual patient information form, it seems to be an integral part of HPH programmes in our country.

Healthy nutrition has been introduced in all of our HPH Hospitals. Animal fat has been avoided almost completely, total calorie intake has been reduced to the real necessary level, and adapted for each patient. The fibre content has been increased, to 25-30 grams daily. In many HPH Hospitals an ongoing sport activity was commenced. These programmes became popular

very soon not only among staff but also among family members, patients, and relatives as well. Anti-smoking programmes are unfortunately less successful. However in many hospitals these programmes have an underlying importance. We have been working hard for a few years to make a law passed through by the Parliament in defence of passive smokers.

Up to now, this draft has not been accepted. In the forthcoming year a new draft will be negotiated in the House of Representatives. There are too many invested interests and big money in this business to dramatically reduce the number of smokers and a strong lobby is working against it.

Unhealthy nutrition, sedentary life-style, smoking and increased alcohol consumption are all responsible not only for inducing fatal cardiovascular diseases but also for causing many different cancers, such as colorectal, lung etc. Different screening programmes, advertising healthy life-style, healthy nutrition and anti-smoking projects all focus on both the high cardiovascular and cancer mortality rates.

The constant problem in managing these programmes lies in the ***lack of financial sources***. The most difficult is to organize different screening projects, for these are rather expensive and their results can be evaluated at a later time. Unfortunately, the Life Insurance Company does not seem to be interested in the long term, they just look at the short time. In some cases International Pharmaceutical Companies support some of the screening programmes, where they hope to find potential business profits.

To summarise the different projects running in our HPH Hospitals: The leading concept among our HPH Hospitals is to serve as a model for a healthier life-style, including nutrition in order to achieve a healthier society. In 22 of our hospitals these programmes are popular and successful. These programmes are designed not only for staff and patients but for the surrounding community as well. By encouraging and organising these projects, the hospital demolished its own walls, and achieved strong linkages to the community.

Healthy Nutrition Programmes are successful in all of our HPH Hospitals. Healthy life-style projects are less successful, not only because there is a lack of certain sport facilities, but also since the concept of a healthier life-style has not yet been widely accepted by society in general. In order to make it more acceptable, active and continuous help by the media is necessary. Most of the written and electronic media are not interested in active publishing of these programmes, since we are unable to pay it!

To reduce the number of smokers seems to be a long lasting, difficult route, due to the before mentioned facts. By the way, in these aspects the media did not help us at all. For instance in TV performances many of the popular actors

usually smoke, which presents a very bad example, especially for the younger generation. Anti-alcohol programmes are efficient only in part, but this is valid for many parts of Europe as well.

There is at present no programme against drug consumption in HPH Hospitals, which can be attributed to the fact that anti-drug programmes are only just starting in Hungary.

Because of the above mentioned facts, a change in the concept of the Health Care System in Hungary should be a must. A shift from the pure treating activity to the preferred preventive concept has to be achieved in order to obtain a healthier society. The targeted programmes of many Hungarian HPH Hospitals seem to contribute to this effort. We are convinced that the HPH movement is an effective tool to improve the Hungarian Health Care System.

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Canisia Corleis, Klaus Elfes*

## ***The German Network of Health Promoting Hospitals***

The German Network (GN) of Health Promoting Hospitals (HPH) was founded at the Hildesheim Business Meeting of the European Pilot HPH/WHO project on 3rd November 1995. The Chiemsee-Conference of the founders was held on 26th February at the Frauenwörth Abbey, Chiemsee. The founders decided on the ***Chiemsee Declaration*** and on the ***structure*** of the GN (a registered association, office in the City of Essen, head of the office Wilfried Gill). The group of founders consists of the five German Pilot Hospitals and the six member hospitals (i.e. members of the international network only).

***Milestones:*** 11/95 Founding of the GN HPH; 01/96 Chiemsee Conference; 10/96 First National Conference (NC), Prien (Chiemsee); 10/97 Second NC (Essen); Third NC (Potsdam-Neu Fahrland).

How do applicants become a member of the GN? Applicants have to fulfil certain criteria according to the basic papers of WHO and the GN. There are then two peer reviews and a site visit.

Member hospitals: more than 30, associated members: 4.

*Margareta Kristenson, Johannes Vang*

## ***The Swedish Network of Health Promoting Hospitals. Aims, Strategies and Progress***

In Sweden the University Hospital of Linköping was one of the twenty European Pilot Hospitals which formed the first HPH network. It was the only Swedish hospital involved with the project and for a long time the only Scandinavian hospital in the network. Over the years a rising interest had developed amongst other Scandinavian and Swedish hospitals and in 1996 a national Swedish Network of Health Promoting Hospitals was initiated.

It is the aim of the Swedish network to support the reorientation of hospitals towards health and by mutual support and sharing of experiences to jointly develop concrete and practical strategies for health orientation in the daily work of the health organisations, and thereby focus on a health oriented management process, a learning organisation and on health supportive actions in the catchment area of the hospital.

The HPH-movement was initiated by a joint effort of the Hospital Programme and the Health Promotion Programme of the European WHO office in 1987 as a means to reorient health services towards health in agreement with the Ottawa declaration. The Centre for Public Health Science in Linköping, which is a collaborating Centre to WHO, specifically to the Hospital Programme of the European Office of WHO, was therefore asked by WHO to co-ordinate the national Swedish network.

In February 1999 the Swedish Network has 14 formal member hospitals. Another three hospitals are soon to become formal members. The members represent small and large hospitals, but also health care organisations, i.e. organisations with several hospitals and primary care settings. The hospitals actually included in the network are therefore approaching twenty hospitals. This is close to one fifth of all Swedish hospitals.

The network is governed by a presidium. Every member hospital has a seat and one vote in the presidium. Apart from the ordinary presidium member the hospital may assign any person they wish, to be their hospital delegation to the presidium meeting.

The co-ordinating secretariat is placed in a »staff-position« to the presidium. It is responsible for the Newsletter, the homepage, marketing of the network nationally, the interaction with WHO and the International Co-ordina-

tor, the Ludwig Boltzmann Institute in Vienna, interaction with Swedish central authorities and the dissemination of information within the network in Sweden.

The Presidium has elected subcommittees for the development of different areas of interest for the network members such as teaching materials, marketing development, sub-project follow-up, etc. The Presidium meets once a year in the springtime, but also convenes at the yearly Congress of Health Promoting Hospitals in the autumn.

To become a member of the network, the hospital management must sign the same general contract as in other countries, including the Budapest recommendation. While these principles are fundamental for health promoting hospitals, there is often a need for more visible examples of good practice. For this reason we, as was the case in the Pilot Health Promoting hospital project, also ask for submission of at least three subprojects. The three projects should address the three main topics of the health Promoting Hospitals:

- patient care
- health of the personnel
- health in the catchment area.

The sub-projects are not goals in themselves. They are instruments to develop and ingrain a health-orientation into the organisation. They should be designed and evaluated on that merit. The overall project is to establish a new frame of reference at all levels and thereby give the hospital a stronger emphasis on health. It is also the intention to develop sub-projects that are common for groups of hospitals. One such project is the development of patients' self-rated health measurements as a means to measure health gain and efficacy.

We consider it particularly important that a Health Promoting Hospital is an outcome oriented institution. By this we mean that patient management and hospital management should be governed, not only by evidence-based medicine, which is based on experiences from clinical trials elsewhere, but should also be governed by outcome measurements, evolving from routine outcome studies at this particular hospital / clinic. We stress, that professional judgements of outcomes alone are insufficient. The patient's own perceived health as evaluated by psychometric instruments needs to be incorporated in the evaluation of the outcome of medical interventions. What is measured and made visible is considered important. Measuring the patient's health related life quality and health gain makes the patient's views and the patient's health visible and important. We believe that measurements related to patient's health outcomes may help in causing a shift of attitudes, which will then change the frame of reference towards a health orientation.

It is our objective to establish the Swedish HPH-network as a learning organisation in two ways:

At the meta-level, the network itself acts as a learning organisation. A learning organisation is characterised by its ability for self-learning, to be able to constantly change as a consequence of self-learning from the feed-back signals from within the organisation and from the environment. A network exists as long as it is of value for the participants. Therefore self-learning is vital for a network. One might use the DNA-molecule as a metaphor. Just as the DNA molecule contains all the information necessary to create a new body, the network contains the values, the sense of purpose, the mission, the ideals, the norms, the culture, the methods which binds together the organisation. The network – DNA exists in all its members, the network can be re-created any time from any of its parts. But in the daily work all its parts act intelligently in different environments with different challenges and obstacles.

On the level of the hospital, each member hospital should develop into a learning organisation using the HPH philosophy as a guiding principle. In order to become a learning organisation the hospital needs a well-defined and visible goal: health gain. Furthermore it needs methods to achieve the goal and measurement methods to measure goal attainment. What makes it a learning organisation is, that the organisation is able to use this culture to develop its personnel and to take advantage of its potential for development as an organisation.

Therefore members of the network should learn from each other. This can be done by exchange of experiences, from studying each other's subprojects or developing joint projects or by site-visits. It is the networks mission to inform, to facilitate and to co-ordinate the hospital efforts.

Finally, as mentioned above, we are increasingly seeing health organisations, county health authorities, which are interested in HPH. We believe that a next step in the development of HPH would be Health promoting health care organisations. Hospitals as we know them now are a dying species. Home care, short-stay surgery, dry laboratories, modern digitised imaging which can be sent over large distances will eventually re-shape health services and create a different kind of caring chain. This development might, if driven by an outcome-governed management, provide the possibility for a transparent and flawless caring chain; from high tech hospital care to primary preventive measures in the local community.

*Anne-Laurence Le Faou*

## ***The French Network of Health Promoting Hospitals***

In 1998, five hospitals belong to the French network of Health Promoting Hospitals: Vaugirard Hospital and Robert Debré Hospital for Assistance Publique-Hôpitaux de Paris, Valenciennes Hospital, Dreux Hospital and Eaubonne-Montmorency Hospital. These hospitals have proposed three projects to be conducted and evaluated.

### ***For Vaugirard Hospital (AP-HP)***

A quality assurance programme which takes into account:

- The patients' families (annual survey concerning the families' level of satisfaction. The results are presented to and discussed with the families every year in order to improve the weak points. This questionnaire is systematically given to the patients and their families when the former are discharged).
- Ethical issues (linked to the problems encountered by dependent people such as patients' rights, difficulties in dealing with people with dementia. Requirements were defined by working groups and a resource centre was created to allow the staff to obtain information, discuss issues and determine guidelines).
- The AP-HP policy for the year 2000 which insists on co-ordination of care between specialities and cost-efficiency of hospitals.
- The Juppé plan (1996) requires that French hospitals become accredited by an independent national agency. Standards are being defined.

The quality assurance programme is new in Vaugirard Hospital and aims to adapt the organisation of the hospital (administrative, medical, nursing) to the patients and not the contrary. This programme requires a specific method to lead to written recommendations of good practices which is being applied in Vaugirard Hospital.

### ***A »nursing flat«***

The aim of this project is to allow physically and mentally dependent people to live in a flat accommodating eight people, rather than being in a long term

care unit. It maintains social integration on a human scale while providing the necessary specialised care.

### ***The origin of the project***

The Vaugirard Hospital team organised holidays for very dependent people at the seaside and in the country in 1993 and 1996. The teams noticed significant improvement in areas such as urinary troubles, morale and autonomy. As a result, the board managers decided to rent a normal flat, close to the hospital in order to integrate elderly people into the community.

### ***The objectives of the project***

Meet the specific needs of polypathologic and dependent elderly people:

- From wheel chair access ramps, doorways and elevators to the height of tables, beds, kitchen and bathroom utensils,
- Specific aid from the staff to limit dependency,
- Daily- life activities including cooking, shopping and tidying up, entertainment (arts and crafts, card and board games, etc.).
- Guarantee medical and nursing services to these patients on a 24 h basis. For example, rehabilitation services are provided in the flat. Additional services are provided by Vaugirard Hospital.
- Families are encouraged to participate in the day to day life of the flat (cooking, entertainment activities). Volunteers are encouraged as well.
- A care co-ordination project in the 15th district of Paris (with a new AP-HP acute care hospital, the Georges Pompidou European Hospital and private practice doctors as well as with the health and social professionals of the district).

### ***For Robert Debré Hospital (AP-HP)***

- A programme to treat dental diseases free of charge at the hospital through a network with school medical doctors and social security. This programme aims to treat children from the area surrounding the hospital, which corresponds to an underprivileged area. The dental diseases are diagnosed at school and the school medical doctor systematically refers the children to the hospital where they receive treatment with social security paying the hospital directly.
- A programme to study children's chronic diseases, the aim of which is to monitor 2,000 children with various diseases such as cystic fibrosis, neurological diseases (epilepsy) or asthma on a medical, social and psychological basis in order to provide suitable care.

- A programme to teach parental feeding at home to families whose children have a chronic disease. Nurses in private practice are also involved in the training sessions to ensure that the procedures are done appropriately. The aim of this programme is to shorten the length of stay in hospital and as a result, to improve the quality of life of the children.

***For the Emile Roux Hospital in Eaubonne-Montmorency  
(a suburb of Paris)***

- A programme of health education in the schools for 8 to 11-year old children, managed by the health professionals of the hospital. The same group of children will take part in the programme over a 3-year period.
- An awareness programme involving steps to take in the event of a risk of HIV contamination in a professional context for health professionals in the hospital and in the community (doctors, nurses and pharmacists).
- A training programme for general practitioners and pharmacists, managed by the health professionals of the hospital. They learn to prescribe and distribute drug substitutes to drug addicts.

***For the Valenciennes Hospital  
(in an underprivileged area in the north of France)***

- A programme of health education for adolescents who are hospitalised. The three main topics covered are: chemical dependency, nutrition and sex education including family planning. Professionals of the community are involved in these sessions not only during the patients' hospitalisation but also for consultation following their discharge.
- A co-operation programme between on one hand, the paediatrics department and on the other hand, community services, volunteer associations and children legal authorities in order to prevent reoccurrence of suicide attempts.
- A programme to monitor children with cystic fibrosis. This programme makes it possible for them to be hospitalised in the Valenciennes Hospital rather than in the Lille University Hospital, thus allowing parents to visit them more regularly.

***For the Victor Jousselin Hospital in Dreux (in the Normandy region)***

- A programme of health prevention and education in a specific unit created in the hospital for patients with chronic diseases as well as for people who want to take part in health education programmes (in the field of nutrition for example) or screening programmes.
- A programme through which people who do not have medical coverage or complementary insurance (social security covers 75 % of medical care and about 60 % in private practice) can have access to doctors, tests and treatments free of charge.
- A quit smoking programme for health professionals in hospital as well as for groups in the community requesting such programmes.

The work methodology of the group is:

- Meetings every two months,
- Publication of the projects,
- Preparation of a network presentation booklet in order to enrol new hospitals.

Conclusion: The French network of HPH is beginning to set up its activities. Although the French hospital policy is not health promotion-oriented, its members estimate that this project will give them the opportunity to develop their projects and exchange their experiences.

*László Kautzky, Tamás Halmos*

## ***Building Up the National HPH Network in a Changing Society***

### ***Introduction***

Health promotion has a long tradition in Hungary – nearly 100 years. Dr. J. Fodor was the first who recommended that health education in schools be a major task of public health and urged the whole society to increase the level of physical and mental health. Later on, owing to the great changes and crisis in the life of the European population in the first half of this century, these principles were forgotten for many decades.

The WHO – several years ago – renewed the ideas of health promotion education, as it became clear that the health level of a nation depends only to 20-25 % on the health services and the rest of it greatly influenced by the health policy of a nation and the knowledge level of the citizens (WHO conferences in Alma Ata, Adelaid, Ottawa, Budapest, Lubljana, Jakarta etc.).

### ***Hungarian pathways of health promotion. Preliminary history***

Hungary has been co-operating with WHO successfully for several decades, mainly in developing the new health policy. WHO started assisting the elaboration of the health promotion programme in 1998. This was a very serious step toward prevention and health protection, instead of giving priority only to curative medicine.

After the great political and economical crisis in 1989 – which caused a lot of trouble for countries involved – the Eurohealth Programme was initiated by WHO to assist health policies in the Eastern European countries.

In Hungary a new policy called »Health of the Nation« was started in 1989. WHO experts helped the policy decision-makers in the implementation of the new paradigm and in evaluating and monitoring the present health situation of the population. World Bank and Phare Programmes assisted the projects giving some financial aid in co-operation with other developed countries.

Hungary now reoriented – in the reform plans – the whole health policy in accordance with WHO-Euro projects, participating in Healthy Cities, Health

Promoting Schools, Healthy Counties, Healthy Villages and the Health Promoting Hospitals. This last programme was started immediately after the Budapest Conference accepting the Declaration (1991). The Korányi Institute joined immediately in the European Pilot Hospital Programme with five sub-projects, and became a model for the other hospitals.

### ***Difficulties of the new Health Policy and Health Promotion***

In Hungary, the parameters of health statistics are at present very bad. The health status of the population is awful. Life expectancy is very low, the birth rate decreases, the mortality rate is rising, the incidence of non communicable diseases are increasing, the health expenditure is about 6 % of the GDP, which is very low, and falling behind the level of the late seventies. A slow increase is expected. The sum of health expenditure is about 270 \$ / year / capita (1 \$ = 230 HUF). A healthy lifestyle is not felt to be worth doing anything about – there is no time for it during the struggles of daily life.

In Hungary there is a three level health care system: 1) Basic health care (family doctor), 2) Special consultative out-patient service, 3) Hospital service. Until some years ago, the hospital level dominated mostly and advanced level service were given by hospitals. It was significantly sponsored by the State in comparison to the two other levels. Approx. 100,000 beds were reserved for 10 million people. The infrastructure was of a relatively high level and standard. Many patients were sent to the hospital for treatment unnecessarily, instead of using outpatient facilities, but the basic health care level was under-developed and insufficient.

Several years ago the policy changed. The policy-makers turned the pyramid upside-down and started to develop and support basic health care and decrease the maintenance of hospital level. Nearly 10,000 beds were liquidated, several departments were closed, and closing hospitals caused a lot of trouble in the given territories, including unemployment among health care personnels. This reduction of bed numbers did not solve the expenditure of hospitals at all (the national unemployment is high, over 10 %). The average income is low. The national, minimal wage is about 20,000 HUF. The medical average income is 32,000 HUF only. The wages of paramedical persons and assistants are even lower. The whole sector is enormously underpaid, underfinanced. A lot of employees leave the health service and try to find other work. There is now an increasing difference regarding technically possible, medically needed and economically feasible services.

### ***Urgent problems in Health Care***

All of them have originated from lack of financial support and non-adequate organisations. Some well functioning structures were demolished without creating new ones instead. Resource finding is the most important step to cover expenses. According to public opinion the first two most important actions are: wage increase of health professionals and strict implementation of preventive medicine.

There are some problems in the Western world concerning health system, as well but they want to limit the presently high expenses. In Hungary the lack of money is the main cause of limitation. There is no method until now, to decrease the expenses of health services and increase the level of health standard in the same time. This is not »business as usual«. The market oriented economy aspect does not work well in health services, although everybody knows that there are prices of drugs, devices, buildings, electricity, water supply, wages of personnel and so on. This is a more complex process than the manufacture of a car or a box of washing powder. Health and health care are not goods, only in the sense of metaphora, but a humanistic service which uses many industrial products. This is a simple fact, but the present financial decision makers do not regard the health state of future generations. They do not accept that the profit is not there, although that is where the investment should be. To finance the Health Care System is long term use of money, without immediate extraprofits with high rates of interest. It needs at last 10-15 years, but the achievement is the health of a nation, which is indispensable to economic wealth.

The prices of products in every field are increasing, the hospital budgets remain the same, so many hospitals get to the edge of bankruptcy. How can such a hospital fulfil health promoting projects? They can hardly do their everyday duty in terms of curative medicine. They are forced with the danger of closing down some departments, decreasing some activities, sending away some manpower and so on.

An interesting fact is, that state owned hospitals are going to be restricted, but at the same time many private clinics are built with extremely high expenses and service prices for a thin layer of elite only. Time will tell, how they can survive.

There are many troubles with social insurance, as well. It is under reform, too. It is clearly seen that the Hungarian Health System is in a critical stage since many years. Owing to budget problems only fire-extinguishing programmes are running, but the Health Act contains and gives privileged places for health promotion and preventive programmes but for the time being all this ideology remains on a rhetorical level only.

### ***How to build up a HPH Network in a changing society?***

The above mentioned problems and pitfalls significantly impact the work of creating health promoting National Network. Fortunately, there are several enthusiastic, charismatic people who understood the basic significance of problem – despite the obstacles, pitfalls and lacking sources – and made a lot of effort and contribution for health promotion. The Korányi Institute served as a model for other Hungarian hospitals to follow, obtaining a lot of theoretical assistance from Ludwig Boltzmann Institute, Vienna, and from WHO Regional Office, Copenhagen.

Once one accepts the concept of health promotion it seems to be reasonable to try and disseminate the theory. The staff of Korányi Pilot Hospital started to organize the enlisting work and meetings, four years ago with the assistance a National Institute for Health Protection. They visited the counties in the countryside and called together several representatives of local hospitals. They presented the ideas and philosophy of Health Promotion, Health Education based on Ottawa Charter, and Budapest Declaration. Experts were invited to give presentations dealing with actual topics of health care. We were able to realize the great achievement and importance of health promoting activities and to convince the candidate members about the long standing advantages of this concept.

Up till now, owing to our efforts to recruit more members from among more than 100 hospitals 26 declared their intention to join the network. These 26 member hospitals launched altogether 86 health promoting subprojects which can be divided into twelve main categories:

- Healthy nutrition
- Anti-smoking programme
- Postgraduate training for nurses
- Hospital public health, hygienic projects
- Protection of environment
- Patient Club Education models
- Mental-hygienic survey
- Healthy lifestyle, sport activities
- Rooming-in, baby-friendly maternity
- Staff health care programmes
- Patient information system
- Co-operation with general practitioners.

One part of the programmes touched hospital staff only, the rest of it partly the patients and communities, as well. There are some common projects involving both staff members and patients.

Some years ago we circulated a handout containing all the programmes in detail. In 1996 we created a Foundation for Health Promoting Hospitals. Yearly we apply for financial grants to the Ministry of Welfare. When we gain some support, we dispense some amount of money among hospitals applying for it.

Otherwise the hospitals themselves have to find resources for their own programmes. Owing to the dramatic changes concerning the role of hospitals during the Health Reform the programmes have fallen behind. Individual efforts and enthusiasm keep the whole programmes alive for the most HP hospitals, so the future of the HPH Network is rather uncertain despite the fact that prevention and health promotion have priorities in the Health Reform Act.

The original concept was to provide better working conditions for patients and staff within the hospital. Later on, we came to the conclusions that the idea is to be transmitted over the hospital walls to the communities. The knowledge of better and healthier lifestyle is propagated and dissipated to the population in the neighbouring communities. The changing of old habits and traditions is not easy, the health promoters have to cope with this difficult task of motivation. They have to find their way from biomedical aspects to the psycho-socio-medical model of problem solving, and the best methods of total quality management. They have to find the objectives, the proper aims, the necessary methods to reach the desirable, good results and proper evaluation and feed-back.

The HP Hospital Network – as a new approach – wants to get a closer contact, common and joint activity with Healthy City, -Village, -County, -School etc. projects just to find the common pathway to walk on, aiming towards the better health state of citizens.

In December 1998, the HPH National Network Co-ordinating Centre edited and published a bulky volume of 30 presentations written by more than 60 authors consisting the wide spectrum of health promoting work. It was presented on the occasion of the National Meeting of the Hungarian HPH Network held in the, Korányi Institute. This book clearly shows what enormous efforts and decisive intentions were made that proves the motivation of Health Promoting activity of the vanguards in the Health Care Service during an era of worsening conditions.

»Sub pondere crescit palma«

*Zemyna Milasauskiene, Irena Miseviciene, Raimundas Sakalauskas*

## ***Perspectives for Developing a National Network of Health Promoting Hospitals in Lithuania***

The strategies planned for the New Health Policy implementation, among others, include healthy outcome-orientated programmes, investments in health promotion and clinical health care. The project of Health Promoting Hospitals (HPH) is one of the WHO-co-ordinated projects that answers the requirements of health policy strategy for the 21st century.

The project of Health Promoting Hospitals is aimed at the improvement of health care in hospitals, better satisfaction of the needs of hospitalised patients and enhancing of the quality of health services.

Kaunas Academic Clinic (KAC), as the first Health Promoting Hospital (HPH) in Lithuania, took the initiative to organise the National network of HPH in Lithuania. During the first Lithuanian HPH Conference (2-3 December, 1996) the decision was made to establish the Lithuanian HPH network. Eight hospitals have signed the agreement. The co-ordinating centre of the network was established at the KAC in Kaunas. On April 16-19, 1997, in the 5th International Conference of HPH in Vienna Lithuanian HPH network was approved as a member of European HPH network.

During 1997 the National Steering Committee was founded and the regulations of the Lithuanian HPH network were confirmed. In the same year the logo of Lithuanian HPH networks was created and the newsletter ***HPH News*** was published. The data about sub-projects (n=57) in member hospitals of Lithuanian network were prepared and sent to the co-ordination Centre in Vienna. Three workshops were organised on the followings topics: »Health promotion and disease prevention«, »Well-being of personnel and patients«, »Quality of Care in the hospital«. The experience of good practice was discussed and the subprojects with the best results were presented during the second National HPH conference.

The second National HPH Conference »Health and Hospital« was organised on November 28, 1997 in Vilnius. Nearly 200 participants from Lithuanian hospitals took part in this conference. Compared to the participation at the first National HPH Conference, the number of participants doubled and it is expected to increase HPH network membership by 20-30 %. Presentations during the second National HPH conference showed the importance of

the implementation of the WHO project of Health Promoting Hospitals. The need for high quality treatment and health care on the one hand and a small national budget on the other hand demonstrate this importance. Therefore, health care institutions, particularly hospitals, have to use their resources more efficiently. Hospitals reach a big part of the population – patients and their visitors. Hospitals have traditionally rendered services in diagnosis and treatment, both medical and surgical, of acute and chronic diseases. Hospital activities have so far been focused on diseases and health care, and not on health promotion. In future, hospitals must pay more attention to the patient's lifestyle before and after hospitalisation, to the health of the hospital staff, satisfaction resulting from work and the relationship between the hospital and the community. This will be particularly important in the nearest future when competition among hospitals will start and the patients will have the possibility of making a choice as to the hospital they prefer to be treated in.

To summarise, hospitals participating in the HPH project attempt not only to ensure high quality medical services, but also an improvement in personnel working conditions and satisfaction about the work done, improvement of projects directed to health promotion among patients and employees, a higher efficiency of hospital activities and better integration of the hospital in the social environment. Participation in this project offers Lithuanian hospitals better possibilities to co-operate with other European hospitals and share in their experience.

*Alice Grundböck, Peter Nowak, Jürgen M. Pelikan*

## ***Report on the Development of the Austrian Network of Health Promoting Hospitals***

### ***Which steps were taken to establish an Austrian Network of Health Promoting Hospitals***

In October 1995 the Austrian Federal Ministry for Labour, Health and Social Affairs has decided to support politically and financially the development of an Austrian Network of Health Promoting Hospitals, charging the Ludwig Boltzmann-Institute for the Sociology of Health and Medicine (LBISHM) with the co-ordination of the Network. LBISHM was formally acknowledged by WHO as the National Co-ordinating Institution (NCI) for the Austrian Network in January 1996.

The main activities of the LBISHM as Austrian-National Co-ordinating Institution are:

1. Development of concepts and strategic planning (in co-operation with the Steering Committee),
2. Alliance building,
3. Providing a secretariat and a technical infrastructure for the Network,
4. Executing networking strategies and developing mechanisms of quality assurance of health promoting hospital projects in Austrian Hospitals,
5. Organise co-operation and exchange with international partners: WHO, EU and HOPE, internal co-operation with other units of the LBISHM acting as international Co-ordinating Centre (ICC), co-operation with other European networks,
6. Fundraising to finance the networking strategies.

As a strategic body for the Austrian Network, a steering committee has been appointed, consisting of:

- Six representatives of the Federal Ministry of Labour, Health and Social Affairs, responsible for hospital affairs on the federal level and main sponsor of the network,
- Five representatives of three partner-hospitals (Rudolfstiftung Hospital, Vienna, University hospital, Graz and Psychiatric hospital, Vienna),
- Four representatives of the National Co-ordinating Institution (LBISHM).

Eight meetings of the steering committee have taken place since 1996. The representatives of the partner-hospitals of the Austrian Network for the steering committee are elected in the annual business meeting of partner-hospitals.

The following Figure 1 provides an overview of the important milestones of the Austrian Network of Health Promoting Hospitals.

<i>Austrian Newsletter:</i>	No 1, April 1996 No 2, January 1997 No 3, May 1997 No 4, March 1998 No 5, June 1998
<i>Workshops:</i>	1st Organisation of Hospital Hygiene, May 2-4, 1996 2nd Project Management for Health Promoting Hospitals Projects, Feb. 26-28, 1997 3rd as above, May 13-15, 1998
<i>Business Meetings:</i>	1st November 21, 1996 2nd November 28, 1997
<i>Annual Conferences:</i>	1st November 22, 1996 in Vienna 2nd November 27, 1997 in Graz 3rd December 3-4, 1998 in Linz
<i>Conference Proceedings:</i>	No 1: Published in October 1997 No 2: Published in November 1998

Figure 1 – Milestones of the Austrian Network

The official launch of the Austrian Network took place in November 1996 in conjunction with the first Austrian Conference of Health Promoting Hospitals.

In 1997, the second conference focused on the link between health promotion and quality assurance / management. Participation increased (1996: 153, 1997: 239), vocal presentations increased from 29 to 55, poster presentations from 26 to 32.

At both conferences, the Austrian Network managed to co-operate with different hospitals who took over the role of the local host. Further the conferences got (symbolic) support from the presidents of all nine Austrian federal states, the Main Body of Austrian Social Insurance and professional associations – this meant a backing by all of the most important actors in Austrian hospital policy. Also some specialised medical societies, interested in health promotion and disease prevention (e.g. for heart diseases, diabetes) gave credit and support to the Network. In comparison to the first two conferences, the

third conference will be extended to a two day event and will focus on the topic »The hospital as healthy workplace – tensions between staff orientation and cost effectiveness«.

The first conference proceedings »health promotion – a strategy for hospitals in times of change« were published in October 1997 right before the second conference. The book has 332 pages and consists of 36 contributions. The second proceedings will be published in autumn 1998.

Two business meetings around the conferences took place for hospitals interested in using Health Promoting Hospitals as a development concept. Six hospitals participated in the first business meeting, eight were at the second. The following hospitals are accepted as Partner-hospitals in the Austrian network:

- Rudolfstiftung Hospital, Vienna
- Psychiatric Hospital Baumgarnter Höhe, Vienna
- University Hospital, Graz
- Landeskrankenhaus Bruck / Mur, Styria
- Bezirkskrankenhaus Schwaz, Tyrol
- Diakonissen Hospital, Salzburg (private).

Two workshops on the issues »Organisation of Hospital Hygiene« and »Project Management for Health Promoting Hospitals Projects« were held. A total of 26 participants out of 18 different Austrian hospitals attended the workshops. As a result of the first workshop a list of Austrian associations in the field of Hospital Hygiene were investigated by the NCI and published in the Hygiene Monitor.

One of the Viennese hospitals (Rudolfstiftung) was already involved in the European Pilot Hospital Project and realised several health promoting projects. The result was the development of ten model documents which provide instructions for planning, implementing, realising and evaluating innovative projects (Figure 2). Up to now 68 hospitals have ordered 330 model documents.

Model document 1	How to develop a health promoting hospital – health promotion, organisational development and project management in hospitals
Model document 2	How to improve the organisation of Hospital Hygiene?
Model document 3	How to reconstruct a ward with the participation of the staff?
Model document 4	How to realise a back pain prevention programme?
Model document 5	How to implement healthy nutrition in a hospital?
Model document 6	How to implement interprofessional team meetings?

Model document 7	How to organise a training course for nurses in management position in the hospital?
Model document 8	How to implement volunteer support?
Model document 9	How to implement systematic support for trainees and new comers in nursing on the ward level?
Model document 10	How to implement patient-oriented team nursing on a ward?

Figure 2 – Model documents of the project »Health and Hospital« in Rudolfstiftung Hospital

To involve a broader publicity in the Network a newsletter is published twice a year. The aim of the newsletter is to provide continuous information on HPH in Austria and to facilitate communication between the members of the network. Four Newsletters were published and the distribution list increased from 1,800 persons to 3,100, representing many professional groups and organisational levels in the app. 300 Austrian hospitals and many other organisations in the Austrian health care system.

On an international level the Austrian and the German network translated in co-production the Vienna Recommendations on Health Promoting Hospitals into German.

### ***What are the aims and objectives of the Austrian Network of Health Promoting Hospitals?***

With reference to the objectives of national / regional networks of WHO-Europe and the Vienna Recommendations of Health Promoting Hospitals the following aims for the Austrian Network were developed for the support of Austrian hospitals:

1. Involvement of as many hospitals as possible in the realisation of health promoting strategies and projects.
2. Assurance of the quality of the developed health promoting strategies and projects.
3. Fostering the exchange of experiences and common learning processes between Austrian hospitals and co-operating partners.
4. Involvement of as many partners of the health care system as possible wishing to participate in the development of health promotion in hospitals.
5. Transfer of experiences of the HPH-Network into the Austrian Network of Health Promoting Hospitals and the Austrian health care system.
6. Transfer of Austrian experiences into the International Network of Health Promoting Hospitals.

The pursuit of these aims and objectives is designed to contribute to:

1. better health of patients,
2. better health of hospital staff,
3. better health of the population in the hospital's community,
4. »better health« of the hospital organisation in the sense of a learning organisation.

### ***Opportunities of participation in the network – the Austrian way***

The Austrian network decided to implement an open and interactive concept which has been translated into 15 different strategies (Figure 3). The aim was to offer hospitals different ways of participation with different forms of intensity and to assure the quality of the objectives of the network.

The Newsletter and the conferences are the kind of strategies which inform many hospitals and health care institutions and also give them the opportunity for participation.

For hospitals which are interested in special issues or in the realisation of their own ideas the strategies »HPH-Project Counselling Workshop« and »task forces« are possible ways of participation. The workshop is targeting all those who are interested in a quality assured realisation of their health promoting projects and want to achieve the recognition »health promoting hospital project« in the network. Task forces provide the possibility for exchange about specific chosen topics, developing common measures and comparing experiences in the realisation of these measures.

#### *Strategies centred around publications*

1. Information package
2. Austrian »Health Promoting Hospitals« Newsletter
3. Conference proceedings of the Austrian Conference on Health Promoting Hospitals
4. Distribution of Model documents on specific issues of health promoting hospitals
5. Publishing articles in Austrian journals for health, health policy and health professions.

#### *Interactive strategies*

6. Free Network-Infoline
7. Data base about health promoting projects in Austrian hospitals (in initial stages)
8. Annual National Conferences on Health Promoting Hospitals
9. Annual Business Meetings of partner-hospitals
10. HPH-Project Counselling Workshop
11. Offering formal recognition as »health promoting hospital project«
12. Offering access to the official status as »Partner-hospital of the Austrian and International Health Promoting Hospital Network«: a WHO network

*Optional strategies*

13. Workshops on special issues relevant to health promoting hospitals
14. Development of task forces
15. Development of further model documents

Figure 3 – Strategies of the Austrian Network

For those hospitals which want to engage themselves in health promotion more intensive and for a longer period of time, the strategy »recognition as partner-hospital in the Austrian network« seems to be the adequate option. Hospitals have to fulfil specific conditions to get accredited in this fashion for three years (e.g. forward a project plan to the National Co-ordinating Institution, specify two or three projects, participate in the HPH-Project Counseling Workshop twice per project, publish on the project in the newsletter, annual presentation of the project at the conferences, participate annually in business meetings, support the Austrian database of health promoting hospitals projects and pay a membership-fee for HPH-Network). The costs for the workshops and the conferences must be carried by hospitals. After three years the recognition can be extended.

The recognition provide hospitals with ongoing support for quality assurance of their health promoting projects and development of their organisation. Partner-hospitals can contribute to the development of the strategies of the network through participation at the annual business meetings and by electing representatives for the steering committee. Partner-hospitals have an privileged access to information about concept and experiences of Health Promoting Hospitals by regularly receiving all current information media of the Austrian and International Network of Health Promoting Hospitals. Furthermore they are allowed to use the logo of the Austrian network for public relation purposes.

### ***Challenges for the development of the Austrian Network***

Financing co-ordination and network activities: membership fees and sponsoring have to replace direct public funding but both strategies need considerable investment to be successful.

Health Promotion has to develop an explicit link to the quality improvement discussion which is currently very important in health policy and hospital development in Austria.

*Bencho Benchev*

## ***Bulgaria National Network of Health Promoting Hospitals. Development – Achievements and Principal Problems***

Bulgaria participates in the HPH project since 1994. A National Network has been established, comprising 16 hospitals – National Healthcare Centres; university hospitals; united regional hospitals; sanatorium – resort complexes; community hospitals. They implement 20 subprojects in general, directed at the patients and their relatives; the hospital personnel; the population served.

The project is accomplished through a standardised technology with regard to the working stages and steps. The project activities are orientated mainly towards a healthy lifestyle and creating a health consolidating environment in the hospitals.

The **project objectives** are to stimulate the hospitals in creating the conditions necessary for development of structures, programmes and activities in health promotion; to promote the inclusion of all professional groups of medical personnel in the health promotion activities; to organise the practical training of the patients and their relatives; to involve in the health promotion activities the population served by the hospitals, etc.

Since the beginning of the project implementation in Bulgaria the following more important **results** have been achieved:

- A pack of documents has been prepared, necessary for the project implementation in Bulgaria;
- Working plans on the project have been drawn up on a national and a hospital level – during the preliminary and the operational phases of the project;
- A National Network of Health Promoting Hospitals has been established, the participation criteria being complied with the WHO recommendations. A constituent working meeting of the National Network participating hospitals had been organised under the leadership of the Ministry of Health and Dr. M. Garcia Barbero participation of WHO-EURO.
- The ruling structures of the project have been formed on a national level as well as in the National Network participating hospitals;
- A choice of subprojects subject to realisation had been made in the National Network participating hospitals;
- Periodical working meetings with the persons in charge of subprojects in

the hospitals has been organised – planning by stages and reporting of the activities on the separate subprojects;

- Current progress in the project has been periodically discussed by the Project Co-ordinating Committee at the Ministry of Health;
- New participants to the National Network have been included as well as sponsors for the project realisation in Bulgaria;
- A technological scheme for the project realisation had been elaborated (description of the stages and the working steps);
- The evaluation methods of the separate subprojects has been elaborated;
- Training packs on the subjects of the project in Bulgaria have been designed and are currently being filled in;
- Several subprojects have been entirely completed in conformity with the technological requirements for realisation (training programmes for patients and their relatives regarding diabetes, bronchial asthma, myocardial infarction, rheumatoid arthritis; training programme for medical personnel regarding hospital hygiene organisation, nosocomial infections prophylaxis and control).

### ***Conclusions of the entire development of the project***

1. Despite the existing objective difficulties in the National Network participating hospitals (financial, organisational, etc.) the following stages of the project have been realised as a whole:

- the ruling structures of the project and separate subprojects chosen by the hospitals for implementation have been organised;
- an evaluation of the initial status of the projects chosen by the hospitals has been made;
- training standards in the form of Training Sets has been created within the framework of several projects (this activity being continued as regards to the other projects);
- an evaluation by stages of the subprojects under implementation had been made.

2. Several subprojects have been entirely completed in conformity with the requirements of the technological scheme for realisation.

3. With the aid of the project Centres for Patients Training have been created in several hospitals;

4. The created and up to now monitored and evaluated training instruments within the framework of the project in the form of Training Sets are composed of two parts (guidelines for doctors and nurses conducting the training, infor-

mation and advises for the patient) and help in making up for a deficiency in the medicative-diagnostic activity in the hospitals – the training of patients and relatives through training standards.

5. The progress in the project up to now indicated the need for including the problem of training patients and their relatives in the university medical education.

6. Within the framework of its possibilities the project contributes to the hospitals reform in Bulgaria as universally competent services in the field of health care (and not only activity in the framework of medication and diagnostics of the diseases);

### ***Principal problems in the project development***

Practically up to now the project does not dispose of financial funds of its own either in its base organisation (National Centre of Health Knowledge), or in the National Network participating hospitals. This appears a hindrance for issuing of already completed products of the project and the more accelerated completion of others.

At the present stage of its development the project already definitely needs financial support – not only for its base organisation, but for the successful development of National Network participating hospitals as well. Such financial support is necessary for creation in certain hospitals of financial funds of the project of its own for the purpose of:

- Establishment of Centres for training of the patients and their relatives in the hospitals;
- Realisation of hospital subprojects of national importance.

*Dominic Harrison*

## ***The English National Network of Health Promoting Hospitals and Trusts***

### ***Introduction and Aims of the English HPH/T Network***

The English Health Promoting Hospitals (HPH) network has renamed itself the English National Network of Health Promoting Hospitals and Trusts (HPH/T). This title reflects the commitment to include health care organisations (NHS Trusts) other than hospitals. These principally include Ambulance Service Trusts, Mental Health Service Trusts and Community Health Service Trusts.

The English HPH/T network is part of a European (and global) movement aimed at refocusing health care systems from illness to health through the development of organisational competencies in population health gain oriented interventions. This is in line with international recommendations by the World Health Organisation contained in:

- The European Strategy for Health For All (1984)
- Ottawa Charter for Health Promotion (1986)
- The Budapest Declaration on Health Promoting Hospitals (1991)
- The Ljubljana Charter for Health Care Reform (1996)
- The Vienna Recommendations on Health Promoting Hospitals (1997)
- The Jakarta Declaration on Health Promotion (1997)
- The revised Health For All Strategy for the 21 Century (1998).

Recent reviews of international health care reform agree on at least four areas of challenge that will drive health policy towards the next millennium:<sup>1</sup>

- The challenge to contain health sector costs.
- The challenge to increase the population health outcomes from health sector investment.
- The challenge to ensure that access to health is based on values of solidarity, inclusion and equity.
- The challenge to involve increasingly empowered health consumers.

<sup>1</sup> Seedhouse, D. (Ed) (1995), *Reforming Health Care. The Philosophy and Practice of International Health Reform*. Chichester. Williams, R. (1995), *International Developments in Health Care. A Review of Health Care Systems in the 1990's*. London. WHO (1997), *European Health Care Reforms. Analysis of Current Strategies*. Summary. Copenhagen

Health Promoting Hospitals represents a positive and integrated approach to these challenges, by working to improve the efficiency, effectiveness and health outcomes of health care. It achieves this through organisational development for health involving the systematic application of project based problem solving and the creation of a »learning organisation«.

The English National Health Promoting Hospitals Network is a confederation of regional and national institutions working together to promote the concept throughout the NHS in England. The Network receives **no** central funding from the NHS, but is recognised by the World Health Organisation. The English HPH/T Network is a member of the European Health Promoting Hospitals Network.

### *HPH/T and English Health Policy*

Since the election of the New Labour government in the UK in May 1997, a number of new policy initiatives have developed which have assisted the climate for development of health promoting hospitals and Trusts.

A new government Whitepaper on Healthcare system reform<sup>2</sup> focussed on:

- The abolition of the internal healthcare market in favour of partnership as the context of health care system provision.
- Public participation in health service strategy and planning.
- New healthcare standards, targets and review systems that focus on quality in terms of equity, effectiveness and efficiency (in that order)
- Close involvement of service providers in the determination and implementation of changes.
- The concept of Clinical Governance (good practice, ethical and effective management of health investment and treatment resources)
- The requirement for Health Authority purchasers of hospital and Trust services to establish Health Improvement Programmes (HIPs) as a health (as opposed to a health services) strategy for health improvement in the whole population. This will involve hospitals as partners with other sectors of society in health development beyond health service provision.

A new government Greenpaper (a paper for discussion) on national health strategy<sup>3</sup> (as opposed to health services strategy) was published. This revised the previous strategy for health in England. The document sets out a revised range of health targets focussed on:

2 DoH (1997), *The New NHS. Modern. Dependable*. London HMSO

3 DoH (1998), *Our Healthier Nation*. London HMSO

- The social and environmental causes of key diseases,
- The development of healthy settings in Workplaces and schools,
- The development of healthy communities (social capital for health)

The document makes an explicit commitment to develop and extend the Health promoting Hospital and Trust initiative.

### ***Milestones in the Development of Health Promoting Hospitals / Trusts in England***

The following summarises the evolution of the English HPH/T network:

- 1988 First discussions of the concept of Health Promoting Hospitals in England were undertaken in Liverpool following the Cities commitment to become a Healthy City in the European Healthy Cities Network. This drew from North American work focussed in California in »The Plaintree Model Hospital Project« (1986) which was »an innovative medical-surgical unit located at Pacific Presbyterian Medical Centre in San Francisco created to humanise, personalise and de-mystify health care«.<sup>4</sup>
- 1989 WHO held initial discussions on Health Promoting Hospitals with a small international group in London. This groups was later to develop the Budapest Declaration on Health Promoting Hospitals (1991) and to establish the European Health Promoting Hospitals Network.
- 1991 The Department of Health in London issued the Health of the Nation Consultative Greenpaper: This opened up discussions on the future strategy for Health in England.
- 1992 The Department of Health in London issue the »Health of the Nation: A Strategy for Health in England«. This suggested the development of a number of initiatives to create health promoting »settings« including Hospitals. Also, Health At Work in the NHS is launched – a national programme in England to improve the health of health care workers.
- 1993 Preston Acute Hospitals NHS Trust joins the European Health Promoting Hospitals network as England Pilot Health Promoting Hospitals.
- The National Health Service Management Executive for England established a »Reference Group« on Health Promoting Hospitals to »examine how best the concept of healthy hospitals can be developed and taken forward from the point of view of patients, public and staff.«
- The Health Education Authority and Preston Acute Hospitals NHS

4 Promotional Publication (1986), Program Plaintree, 20-40 Webster Street, San Francisco, California

Trust hosted the first English National Conference on Health Promoting Hospitals in Preston. The Conference is opened by a Minister for Health and proceedings are published.<sup>5</sup>

A number of Regional Health Authorities begin their own Health Promoting Hospitals initiatives. Trent establishes a Regional Health Promoting Hospital Network and Oxford and East Anglia Region establish a Health Promoting Trust Award scheme managed by the Centre for Health Promotion Research and Evaluation at Oxford University.

- 1994 In September 1994 the NHS Executive for England published a document on Health Promoting Hospitals. This was circulated widely to Trust Chief Executives, Health Authority Chief Executives and a range of professional and academic groups.

The document was the result of a multi-disciplinary collaboration and research project by the »reference group« that involved health promotion and public health specialists, general managers, nurses and senior DoH staff.

Following publication a national contact centre and listing database was established at the National Health Service Executive headquarters in Leeds. A networking factsheet was produced on a six monthly basis. Wessex Region developed work on standards for Health Promoting Hospitals.

- 1995 The second English National Health Promoting Hospitals Conference was held in Stafford. The development of the HPH concept in England is handed over to Regional NHS Executive Offices as part of the ongoing NHS reforms. No resources are provided for the initiative and there is little consistency across health regions.
- 1996 The third English National Health Promoting Hospital Conference is held in Sheffield, Yorkshire. A national network of Regional co-ordinators from a range of institutions is established. A decision is made to extend the Network to cover all Health Trusts and to rename the network the English Health Promoting Hospitals and Trusts Network (HPH/T).
- 1997 The English National Network, a federation of regional co-ordinators facilitated by the National Network Centre in Preston agree an »Agreement Document« with WHO-Euro. This specifies minimum standards for Health Promoting Hospitals in England, and details the roles and responsibilities of the various stakeholders in the initiative. The agreement document commits participating hospitals to a five year programme of organisational development for health.

5 Health Education Authority (1993), *Health Promoting Hospitals: Principles and Practice*. HEA

The Fourth English National Health Promoting Hospital Conference is held in St Albans, Hertfordshire. This is opened by the new Labour government's Minister for Public Health who gives a commitment to extend the initiative.

- 1998 The Department of Health launched a new government Greenpaper (a paper for discussion) on national health strategy (as opposed to health services strategy). DoH (1998) *Our Healthier Nation*. London HMSO. This revised the previous strategy for health in England. The document makes an explicit commitment to develop and extend the Health Promoting Hospital and Trust initiative.

### ***Achievements of the English HPH/T Network 1997/8***

During 1997/8, the English HPH/T National network has been successful in:

- Establishing government commitment at a national policy level to the concept and implementation of Health Promoting Hospitals and Trusts.
- Establishing a common national framework for the implementation and registration of hospitals and trusts into the English and European HPH/T networks.
- Establishing a national network of eight Regional HPH/T networks – each with their own meetings and approaches to HPH/T development within the National and European framework.
- Running a fourth national HPH/T conference, which was opened by the new Ministers of Public Health. This was organised by Hertfordshire Health Promotion Unit, Regional co-ordinating institution of the North Thames region.

During the last year, Regional HPH/T Co-ordinators have reported:

- An increase in enquiries about formal HPH/T membership as a result of the new Labour government health policy.
- Evolving commitment to formal membership of the HPH/T network.
- A high level of support for Regional network meetings.
- Involvement of NHS Executive Regional offices in HPH/T development.
- An increase in requests for management board briefings / training days for staff.
- An increase in structured sessions for learning shared problem solving at regional meetings.
- An increase in specific posts as HPH/T Co-ordinators in Hospitals and Trusts.

- An increase in Regional conferences on HPH/T.
- An increase in participation in the HPH/T audit programme administered by the South and **West** Region.

### ***Difficulties / Barriers of the English HPH/T Network 1997/8***

During 1997/8 the following issues were barriers to the uptake and network registration of NHS Hospitals and Trusts in England:

#### ***Infrastructure Funding***

Despite considerable support at conferences and in published policy documents, the Department of Health has not provided any central funding for the National or Regional HPH/T Network Centres. The infrastructure is therefore managed through allocative efficiencies in the sponsoring organisations, and a significant amount of voluntary work by national and regional co-ordinators. Whilst this does ensure sustainability of the project (it will not collapse if central funding is withdrawn), it does make progress difficult and slow. It also limits capacity for development to some extent, and contrasts sharply with central government support for Health Promoting Schools for instance which has received over £ 250,000 of central government funding support at national level.

#### ***Change Agenda***

Whilst the rapid health system reforms underway with the new government are supportive to the concept of HPH/T this also places an enormous competition on the time available for change initiatives. Some Hospitals and Trusts are unwilling to sign up to new initiatives whilst organisational and structural issues are uncertain.

#### ***Registering and Paying for HPH/T Network Membership***

There seems to be a certain reluctance by some NHS hospitals and Trusts to formally register and pay for membership of a national and European network of HPH/T. One regional co-ordinator has suggested that this may be in part related to the discontinuity between Department of Health policy support for the initiative and the apparent lack of infrastructure funding and ownership by the NHS Executive.

However, it is envisioned that the hospitals who are unwilling to register and pay for official membership of the HPH/T Network may be persuaded to join in the future.

*Jarmo Karpakka*

## ***Health Promoting Hospitals in the Finnish Network. Current Status 1997-1998***

The road of the Finnish network of HPH has been paved with many good intentions. Some of them have been realised some not. However, there is gradual progress and the functions of the network are being worked out. The network will be an open forum for exchanging ideas and good practice among HPH member-hospitals and affiliated members.

There are five hospital members in the network, three municipal hospitals and two private non-profit hospitals: Central Hospital of Central Finland (municipal), Joint Municipal Authority of Health Care in Raahe Region, Health Care Centre and District Hospital (municipal), Joint Municipal Authority for Specialised Health Care and Social Welfare in Kainuu, Kainuu Central Hospital (municipal), Meltola Health Promotion Hospital (private non-profit) and Oulu Deaconess Institute (private non-profit).

Central Hospital of Central Finland has a long tradition of health promotion in its activities. It is the only hospital in Finland with a full-time head nurse, Mrs. Maria Hallman-Keiskoski, co-ordinating health promotion activities within the hospital and with the surrounding communities. Raahe District Hospital was fused 1997 administratively with the primary care of the region (six municipalities) which has given an excellent opportunity to combine health promotion programs to the primary and secondary care. In Kainuu hospital district specialised health care and social welfare are under the same administration and Kainuu Central Hospital has always worked in close collaboration with the ten municipalities of the region that own the hospital. Kainuu Central Hospital has been involved with many health promotion programs that have been aimed at the population in that region. Meltola Health Promotion Hospital was established in close collaboration with the municipality of Karjaa and Samfundet Folkhälsan. The hospital is run and administrated by Samfundet Folkhälsan after Meltola District Hospital was closed. The activities have started in 1998 and are aimed at health promotion and well-being for the people in the Karjaa municipality. Oulu Deaconess Institute was established over a hundred years ago to educate nurses for open care in Northern Finland. Through this tradition Oulu Deaconess Institute has always worked in close collaboration with the people and municipalities of Northern

Finland for their well-being. Its health promotion activities have become more structured through the HPH-concept.

The network relies very much on close collaboration with The Finnish Association of Local Authorities. All the 450 municipalities in Finland are members of the association and its hospital department is involved with various developing projects and takes care of the interests of all municipal hospitals. Dr. Matti Liukko is in charge of the HPH-concept in the association and is the other Finnish national co-ordinator. The department publishes a bulletin called *Sairaalaviesti* (Hospital News) that has given the network one page for informing about HPH activities and experiences. Another important contact is The Finnish Centre for Health Promotion with its one hundred member associations. The Department of Nursing Science and the Department of General Practice and Primary Care in Oulu University have expressed their interest in co-working. Lately the Association for Pulmonary Disabled contacted the network regarding collaboration.

The network has organised – in 1997 – one open seminar on health promotion in hospitals with limited success. However, through feedback from different presentations in national and regional meetings there is a growing interest in the concept. At the moment the network will focus on the five member hospitals for benchmarking activities and finding possible common projects with the associations which have shown interest in collaboration.

*Yannis Tountas*

## ***Hellenic Network of Health Promoting Hospitals***

Greece participated in the European Pilot Project of Health Promoting Hospitals with Aretaieion University Hospital. The experience gained during that exercise lead to the formation of the Hellenic Network of HPH which is co-ordinated by the Institute of Social and Preventive Medicine.

At the moment the Hellenic Network of Health Promoting Hospitals comprises the following hospitals and scientific organisations: (a) Aretaieion University Hospital, (b) Ag. Olga Constantopouleio Regional General Hospital of N. Ionia, (c) Penteli 1st Athens Hospital of IKA, (d) IASO Obstetrics / Gynaecology / Surgery / Diagnostic / Care and Research Centre, (e) Evangelismos Regional General Hospital, (f) Sismanogleio General Regional Hospital of Attica, (g) Onasseio Cardiac Centre.

Scientific organisations: (a) Centre for Health Services Research, Department of Hygiene & Epidemiology, School of Medicine, University of Athens, (b) Hellenic Society of Quality Assurance in Health Care, (c) Hellenic Society of Health Promotion and Education, (d) Hellenic Hospital Association.

### ***Evolution***

The first efforts to establish the Hellenic HPH Network started in early 1997. Contacts were made with nine hospitals, eight situated within the greater Athens area, and one situated in Salonica, the second largest city of Greece. Apart from the hospitals, the above listed scientific organisations were also contacted.

Personal contacts were first made, and information material on the European Pilot HPH Project and the Aretaieion sub-projects were disseminated. Official letters were sent to the Boards of the Hospitals, and an official decision for participation was asked to be taken. Initial positive reaction was received from nine hospitals, those of the Greater Athens area.

The first meeting of the Scientific Committee of the Hellenic HPH Network, which comprised of one representative from each of the nine hospitals and from each of the scientific organisations, took place in early July 1997.

During the meeting the philosophy of the HPH was presented, together

with the preliminary results of the Evaluation Study of the Aretaieion Hospital's Participation at the European Pilot HPH Project. The WHO contract which set the rights and obligations of the network members was distributed, and thorough discussion followed on the organisation and financing of the network, the future activities and projects to be developed, as well as on the potential role of the network in the future.

Official decisions for participation at the Network by seven hospitals were eventually received during the period July 1997 to January 1998.

In the meantime, the programmes for which the hospitals expressed initial interest were:

- hospital environment – orientation and movement of users – signs,
- patient satisfaction,
- hospital staff satisfaction,
- training of nursing staff in patient education,
- disease management of hypertensive patients.

The second meeting of the Scientific Committee took place in October 1998. Summary protocols of the above projects were presented and hospital representatives were given the task to submit them to each hospital's scientific committee for consideration and final decision of the projects which each hospital will implement. It was also decided that there is a need for communication strategy in order to raise the awareness of the hospitals' community regarding the concept, practice and benefits of a HPH. It was thus decided that an information letter be distributed to every single member of the staff of all member-hospitals.

In March 1998, the third meeting of the scientific committee took place. During the period between the last two meetings, each hospital decided on the projects to implement, detailed protocols were developed, budgets were formulated, and 7,000 information letters were distributed to all staff of the member hospitals.

At the third meeting, the hospital collaborations were finalised and the inter-hospital projects were decided upon. Future steps for the co-ordination and implementation of these projects were concluded.

The projects which are being developed and the corresponding number of participating hospitals are:

- training of nursing staff in patient education (7 hospitals),
- hospital environment – orientation and movement of users – signs (3 hospitals),
- disease management of hypertensive patients (3 hospitals),
- health promotion needs of hospital staff (7 hospitals).

***Achievements***

- Raising awareness among hospital officials about the philosophy and benefits of HPH.
- Raising awareness of member-hospitals' staff.
- Involvement of hospital scientific committees in the selection of projects which interest them.
- Formation of inter-hospital collaborations.
- Start of implementation of four inter-hospital projects.

***Problems Encountered***

- Two hospitals did not join the Network,
- Hospital bureaucracy delayed the official decisions of hospitals to join the Network,
- Lack of common understanding of the concept of Hospital Health Promotion,
- Communication problems at the outset of the efforts to form the Network,
- Staff-shortage allows limited time of representatives to dedicate to HPH projects,
- Limited economic resources – difficulties in searching for sponsorships.

*Ann O’Riordan*

## ***Irish National HPH Network 1998 Progress Report***

### ***Evolution***

The HPH concept was formally introduced to Ireland in 1992 by the Dublin Healthy Cities Project. One of the main partners of the Dublin Healthy Cities Project is the Eastern Health Board, owner of James Connolly Memorial (JCM) Hospital, the first hospital in Ireland to join the European HPH Network. The Irish National HPH Network was the initiative of JCM Hospital, a participant in the European Pilot Project of Health Promoting Hospitals.

### ***Starting Point – Spring 1994***

#### ***Step 1. Gathering Support***

The initial step was to secure executive, political and financial support for this initiative. Meetings and discussions were held with various authorities. This was considered essential before widespread interest in the HPH concept could be initiated.

- Executive – Fortunately in our case, the Chief Executive Officer of the regional Health Board was already committed and supportive of the development of the HPH concept in Ireland.
- Political / Financial – Approaches were made to the Principle Officer of the Health Promotion Unit of the Dept. of Health. This generated agreement in principle to support the development of such an initiative in Ireland.

Further support and commitment to the concept was achieved through the organisation of a meeting with the various stakeholders and Prof. Pelikan from the European HPH Co-ordinating Centre. The stakeholders at this meeting were the Principle Officer of the Health Promotion Unit, Dept. Health, the Chief Executive Officer of the Regional Health Board; the Hospital’s Management Team and the Hospital’s HPH Project Co-ordinator.

An additional key supportive factor was the launch of the National Health Strategy in the summer of 1994. This clearly identified the need to reorient the hospital healthcare system and placed great emphasis on health promotion.

#### Outcome

- Commitment to joint fund and host the first National HPH Conference in 1995.
- Agreement (in principle) by the Health Promotion Unit, Dept of Health to support the development of a National HPH Network, depending on the interest generated by the conference.
- On-going commitment from the hospital's management team to support both the conference organisation and the setting up of a National HPH Network.

### *Spring 1995*

#### ***Step 2. Stimulating Participation***

The first National HPH Conference ***European Health Promoting Hospitals – An Irish Network*** was held in Dublin in April 1995. The conference was designed to give information, provoke thought, recognise existing hospital based health promotion activities and encouraged both networking and active participation in the setting up of a National HPH Network. Delegates were asked to complete and return a statement of interest form at the close of the conference. Based on the very positive responses received, a further meeting with representatives of the Dept. of Health and the Regional Health Board was organised. The main aim at this time was establish the initiative as a joint Health Promotion Hospital Services development.

#### Outcome

- Unfortunately, the initiative was viewed at this time more as a Health Promotion activity than a Hospital Services activity.
- However, on-going commitment was gained from the Health Promotion Unit to support the initiative and to provide seed funding in the event of a Network being established.
- Decision by the Eastern Health Board (EHB) to support and jointly organise with JCM Hospital the inaugural meeting of the Irish National HPH Network.

A prominent and well-respected healthcare professional (Prof. Risteard Mulcahy) was invited to chair the meeting and was subsequently elected as the Network's Interim Chairperson.

### ***Autumn 1995***

The inaugural meeting of the Irish National HPH Network took place in Dublin on September 5th 1995. Invitations were issued widely to hospitals throughout the country and to all the regional health boards. The meeting was well attended with representatives from 30 hospitals and seven of the regional health boards. The Health Promotion Unit, of the Dept. of Health formally declared their support and commitment to the movement, at this time.

#### **Outcome**

- Formal agreement to the establishment of an Irish National HPH Network.
- Agreement to participate in the WHO 5-Year Project on National / Regional Networks.
- Endorsement of membership criteria, in line with WHO suggested criteria.
- Election of an interim Chairperson and agreement to the selection of an Interim Steering Committee by the chairperson, JCM Hospital and Eastern Health Board.
- Consent to JCM Hospital being the interim Co-ordinating Centre and the Hospital Project Co-ordinator being the interim Network Co-ordinator.

The Interim Steering Committee met for the first time on the 19th of October. The composition of the selected committee reflected a variety of factors – geographical spread, type and speciality of hospitals, multidisciplinary representation and strategic partners. Broad terms of reference were accepted and membership process and criteria were formally agreed. It was agreed that the Interim Steering Committee would meet approximately every two months during the interim phase, 1995-1997.

### ***January 1996 – January 1997***

#### ***Step 3. Network in development***

The network was formally open for membership in January 1996 and three levels of membership were identified.

- ***Full membership*** – this is the most committed level. Hospitals are required to demonstrate that general approval for participation in the Network has been obtained. Outline a minimum of three activities and sign the WHO Agreement Document.
- ***Affiliate membership*** – this is often seen as the first step taken towards full membership. A member of the hospital's management team is required to

signify commitment and intention to proceed to full membership by endorsing the principles of the HPH concept.

- ***Associate membership*** – Any non-hospital organisation, voluntary group, professional body or individual concerned with health promotion can become a member by formally declaring their commitment to the principles of the HPH concept.

The Network had an initial membership (Jan 96) of seven full member hospitals, three affiliate and one associate member. This grew to a membership of 13 full members, five affiliate members and three associate members in January 1997. Membership includes a number of group hospitals, thereby bringing the total number of individual hospitals participating to 25.

### ***Achievements of the interim Steering Committee 1996-1997***

**Funding** – A finance committee was established in April 1996, to consider all financial aspects. The main source of funding focuses on increasing membership.

- a) All member hospitals both full and affiliate members are required to contribute financial to the development of the network. The annual contribution fee is based broadly on bed numbers. This contribution is in addition to the international contribution fee of \$ 75.
- b) Seed funding by the Health Promotion Unit for the next three-years has facilitated the appointment of a full-time national co-ordinator, secretarial support and covers essential running costs.

**Network Structure** – To facilitate the development of a long-term structure for the network, a sub-group was set up to consider all aspects and make recommendations to the Steering Committee.

- a) Initial recommendations were circulated at the end of October 1996. Final recommendations were agreed in principle by the Steering Committee in January 1997 and endorsed by the membership at the official launch of the Network in October 1997.
- b) A National Network logo was designed and selected by the membership in July 1996.
- c) Short and Long-term Network targets were developed and adopted in November 1996.
- d) Alliances with academic institutions were sought to provided the network with strategic and technical support. Two institutions have agreed to become core members of the network: Dept. of Public Health Medicine &

Epidemiology, University College Dublin; Dept. of Health Promotion, Clinical Science Institute, University College Galway.

Network Activities – To motivate interest and active participation in the Network a number of activities were successfully undertaken.

- a) Workshops – Two national workshops were held during 1996. The first in July 1996 introduced the HPH concept and outlined the recommended strategies. The second in November 1996 highlighted a common issue and concern of many hospitals; that of Hospital Smoking Policies.
- b) Seminar – a national HPH seminar entitled ***Creating the Links*** was held in conjunction with the official launch of the network in October 1997.
- c) Hospital visits & presentations – Recruitment during 1997 focused on direct contact with hospitals. The National Co-ordinator made contact with senior management personnel while the Chairman made direct contact with his medical colleagues. Hospital visits and presentations were then arranged, either jointly or individually. Since, July 1997, ten such hospital visits and presentations were organised.
- d) National Hospital Challenge Day – This event is co-organised with a semi-state sponsored body ***Saol Plus***. It aims to promote physical activity among all ages and social levels. Hospitals participate by competing with each other to record the highest percentage of participation in 15 minutes of physical activity on Challenge Day. In 1996, 22 hospitals participated, a further 10 hospitals participated in 1997, bringing the total number to 32.
- e) Communication strategies – The Co-ordinating Centre established two main communications tools in 1996, the HPH Bulletin and the National HPH Newsletter. The HPH Bulletin is issued every two months and provides brief day to day information on the development of the Network and issues related to it. The HPH Newsletter, a twice-yearly publication, aims to provide more detailed and strategic information to network members.
- f) Annual Report – Publication of the 1st Annual Report for the Network.
- g) Official Launch – The Irish National HPH Network was officially launch with the full support of the Minister for Health & Children on the 14th of October 1997, in Dublin.

### ***Main problems encountered 1996-1997***

Delays in relation to a number of issues:

- obtaining full regional support for long-term network structure;
- releasing of the interim Co-ordinator to the full-time national position;

- incorporating full academic and technical support for the Co-ordinating Centre;
- official launch of the Network due to a change in government.

Targets unattained due to resource difficulties:

- failure to publish the HPH Newsletter following the first issue in 1996;
- inability to organise any workshops during 1997;
- to develop the national HPH database and information / development manual.

### ***January 1998***

#### ***Step 4. Network in progress***

Membership now stands at 14 full members, 13 affiliate members and five organisations. Long-term network structures have been implemented, National Director appointed for three years. Regional development has commenced with recruitment, since November 1997, being focused on regional presentations as an effective strategy. There are eight regional health boards in Ireland and to date (April 1998), presentations have taken place in four regions and two are planned for May 1998. Three national projects are planned and the 2nd National HPH Conference will be held on the 16th of October 1998.

*Francesco Ceratti*

## ***The HPH Network in the Lombardia Region***

As from 1st January 1998 Lombardia Region has defined a new structure of health system, very different from those of the other Italian Regions; the main differences are:

- separation of Health System in structures providing specialist performances (hospitals included) and the structures granting primary care and purchasing specialist performances, identifying Service Trusts different between themselves;
- the hospitals are identified as trusts whose performances are purchased from trusts responsible for granting citizens' care (Local Health Trusts) and are placed in competition between themselves;
- equalization between public and private hospital structures as regards the selling of performances, subject to credit;
- identification, in Lombardia Region (about 9 million inhabitants), of 28 Hospital Trusts each of which generally comprises more than one hospital structure and the outpatients departments existing in the area surrounding the hospital;
- constitution of an organism coordinating the seven public hospitals of Milan in order to rationalize the investments of high technologies, the relationships with University, the institution of new activities.

This new, and deeply different from before, reorganization of Health service, required dealing with reorganization processes, ongoing at this time and that will go on for a long time, with the appointment of new general directors, on duty from the 1st of January.

This change, already announced in the second half of the last year, has actually been blocked, given the precariousness of the general directors at that time, the taking on of formal responsibilities as regards the constitution of the regional HPH net, considering that this responsibility has to last for years.

Nonetheless two precise initiatives have been assumed:

- Health Regional Assessorship sent a letter to all (public and private) hospitals of Lombardia Region to have a preliminary agreement about the participation to a Regional HPH Network;
- involvement of the public hospitals coordinating structure of Milan, with a

formal act to realize the HPH Network of Milan and the subscription of the Letter of Understanding.

The hospitals of Milan involved in this initiative are represented by seven Hospital Trusts with a total of 13 hospital structures, five of which centre on university teaching and with a total of 5,000 beds (Table):

Hospital Trusts Involved in the HPH Network of Milan

<i>Hospital Trust</i>	<i>Hospital</i>	<i>Features</i>	<i>Beds</i>
Luigi Sacco	Luigi Sacco	General hospital – Teaching hospital	502
Ospedale Niguarda Ca' Granda	Ospedale Niguarda Ca' Granda	General hospital	1,354
Istituti Clinici Di Perfezionamento	Istituti Clinici di Perfezionamento	Maternity and Paediatric hospital – Teaching hospital	480
	Centro Traumatologico Ortopedico	Traumatology hospital – Teaching hospital	189
	Regina Elena	Maternity hospital	64
	Vittore Buzzi	Children's hospital	175
Fatebenefratelli	Fatebenefratelli	General hospital	536
	I.O.P.M.	Maternity hospital	205
San Paolo	San Paolo	General hospital – Teaching hospital	486
Gaetano Pini	Gaetano Pini	Orthopaedic hospital – Teaching hospital	432
San Carlo Borromeo	San Carlo Borromeo	General hospital	667

*Raymond McCartney*

## ***Evolution of a Regional Network in Northern Ireland***

In 1995 a unique opportunity arose to make the concept of the Health Promoting Hospital accessible to an even wider audience.

Members of the sub-project teams began a collaborative venture, working with professional artists to produce a series of teaching aids in poster format which would represent the concept of the pilot project and the seven sub-projects.

The aims of this »visualisation project« were to:

- promote better understanding of the HPH in a wide range of staff,
- stimulate discussion and debate,
- involve more staff in achieving the aims of the pilot project.

The teaching aids were finally produced following a series of discussions and workshops during which artists and team members pooled their ideas. The result of this collaboration is a series of eight large posters representing the themes of the sub-project groups and the stages of change through which a hospital can grow and develop into a truly health promoting organisation.

To gain the widest possible audience and to meet the aims of the visualisation project, a series of workshops were held aiming to:

- assess the potential of the visualisation project in increasing understanding of the HPH concept,
- evaluate existing knowledge and understanding of the HPH concept,
- determine the most effective course for the future HPH.

Considerable efforts were made to enable staff to attend the workshops, however numbers were disappointingly low and consisted entirely of nursing staff. Nevertheless, those who participated were most enthusiastic. Overall participants found the workshops »thought provoking«, felt that they »broadened their ideas« and that their involvement in the workshops made them feel that their »opinions were valued«.

Participants also completed a questionnaire designed to assess their current involvement in health promotion activities and staff awareness of the Health Promoting Hospital pilot project.

Key findings were that 75 % of participants were aware of Altnagelvin as a pilot hospital.<sup>1</sup>

- Participants believed Health Promotion activity focused mainly on smoking prevention and cessation, nutrition and breast self-examination.
- Participants believed the methods of health promotion most commonly used were providing information leaflets and specific health education guidance.
- Few staff understood the implications of a settings approach to health promotion.

Since the workshops, the information gained has been used to plan the structure and strategy for health promotion after the end of the pilot project.

The visualisation project described above included a series of workshops which were used to evaluate existing knowledge and understanding of the HPH concept and in turn allow planning of the next stages of our Health Promoting Hospital work.

Guided by some of the findings from these workshops, a number of aspects of our health promoting hospitals project were reviewed and revised. The review examined existing structures and communications and the seven sub-projects which comprised the pilot project.

The revised structure includes a number of new features designed to strengthen the role of health promotion within Altnagelvin and to move health promotion work away from the project basis and towards becoming a fully integrated hospital activity. The Health Promotion Liaison Group has become a key structural feature of our revised approach. This Group now includes representatives from all clinical departments and meets on a quarterly basis. This Group is concerned with identifying Health Promotion issues which are relevant to the success of their clinical departments. The Group is also used to feed Health Promotion information back into the clinical departments.

During the pilot project a single representative from the Health Promotion Unit worked with Altnagelvin providing specialist input. This single representative has been replaced in the new structure with a Specialist Health Promotion Trust Team. Each member of this team brings a different area of specialisation and the specialist team is led by the Health Promoting Hospital team leader. The team leader has overall responsibility to nurture the HPH concept and activities and spends some 60 % of her time working exclusively

1 Jain, C. (1998), Art for Health's Sake: A Vision of the Health Promoting Hospital. In: *Feasibility, Effectiveness, Quality and Sustainability of Health Promotion Hospitals*. Gamburg, p. 234-236

with Altnagelvin staff. The other specialist team members spend a much smaller proportion of their time working with Altnagelvin and are required to attend at meetings and to offer specialist advice and support on an as and when required basis. All members of the Health Promotion Liaison Group attend the hospital's Health Promotion Liaison Group.

One of the most important developments following the review has been the appointment with Altnagelvin of eleven link nurses. The link nurses have a key role in bringing together the curative and preventative disciplines and at Altnagelvin the approach follows the model described in Sweden by Dudley.<sup>2</sup> The link nurses form a reciprocal link between health promotion services and hospital wards and departments. Within Altnagelvin, health promotion champions were sought in all clinical areas to become link nurses. A letter of invitation was sent by the Chief Executive to each department seeking nominations for link nursing positions. Anyone being nominated had to meet the criteria of:

- having an interest in health promotion,
- having an awareness of health promotion as a means of empowering people,
- wishing to explore the potential of health promotion in their clinical area,
- wanting to learn more.

A Health Promotion Forum has been created as an important part of the new structures where the link nurses come together with the Specialist Health Promotion Trust Team. The Forum is concerned principally with raising awareness of health promotion in the clinical areas by incorporating it more into the mainstream of hospital life. The link nurses are the key to dissemination of knowledge and skills through cascading health promotion experience, to their colleagues. They also have a role to increase feedback of information to staff on wards and to patients and their families.

A major review was conducted of the seven sub-projects through a series of meetings with the sub-project teams. Discussion centred on whether there was further work to do within the sub-project. As a result of these reviews the Alcohol Policy, Cardio-Pulmonary Resuscitation (CPR) and Child Education projects were discontinued. It was decided that the Alcohol Policy implementation was proceeding and that the sub-project was no longer adding value to the process. The child education project has been rested with a view to restructuring the programme content. The CPR project had achieved a very high level of success in that CPR training is now a fully integrated hospital activity and the work of the sub-project was viewed as complete.

2 Dudley, C. (1995), Health Promotion Link Nurses – A Concept in Networking. Proceedings of 3rd International conference on Health Promoting Hospitals, Sweden, 1995

Three new projects have been commenced; Stress Support, Back Care and Physical Activity. The Stress Support project will provide support and training in stress management for staff. The Back Care project will devise and implement a manual handling policy and strategy and seek to reduce injuries arising from manual handling duties. The Physical Activity project will seek to promote increased levels of physical activity among staff throughout the hospital.

Altnagelvin's participation in the EPHP has made a sustained impact upon the culture of the hospital. Much has been achieved through the work of the seven sub-project groups: Health Promotion has been incorporated into the mainstream of hospital life, the hospital provides a health promoting environment and through a number of the sub-projects, links with the community have been strengthened.

The recent visualisation workshops, whilst attended by only a limited number of staff, effectively illustrated the considerable awareness and understanding of health promotion issues within the nursing staff. The interest and enthusiasm shown was impressive. The success of the Pilot Project and the demonstrable enthusiasm for health promotion clearly indicate the need for a health promotion strategy to continue the work of the Pilot Project.

Altnagelvin is only now beginning to make progress with setting up a Regional Network. Two hospitals are now co-operating with Altnagelvin in the setting up of a network. Formal meetings have taken place with representatives from one of the hospitals and it is now proposed that the network will be commenced with two members – Altnagelvin Hospitals Health and Social Services Trust and United Hospitals Trust in Antrim. The continuation of the Health Promoting Hospital concept has been given a boost by the publication under the new Labour Government of their agenda for health and wellbeing (DHSS 1997).<sup>3</sup> The agenda entitled »Well Into 2000« highlights a theme that a wide range of bodies and individuals have an important contribution to make to improving health and wellbeing. Goals outlined for the improvement of health and wellbeing include the creation of healthy and supportive environments.

3 Department of Health and Social Services (1997), *Well Into 2000*. A Positive Agenda for Health and Wellbeing

*Sue Cruse*

## ***Evolution of the North Thames Regional Network of Health Promoting Hospitals and Trusts, England***

### ***Discussion Stage***

A Health Promoting Hospital interest group was established in 1994 with representation from six specialist health promotion units. This was convened by **Hertfordshire Health Promotion**, a specialist health promotion service serving the county of Hertfordshire. In all cases, the units were contracted to work with hospitals in addressing the national health promotion strategy, Health of the Nation, key target areas: Cancer, HIV / Aids and sexual health, Accidents, Coronary Heart Disease and Stroke, Mental Illness. The NHS Executive had identified Health Promoting Hospitals as a vehicle for advancing Health of the Nation and delivering on the targets.

The Health Promoting Hospitals interest group debated several issues:

- a) Health promotion as a core function of a hospital, along with the functions of care and cure.
- b) Health Promoting Hospitals as a quality initiative complementary to other quality initiatives such as Investors in People.

It was recognised that hospitals have key conditions for effective health promotion – opportunity and access as well as credibility and competence. Furthermore whilst a wealth of health promotion initiatives are underway in a hospital at any one time, the initiatives are rarely needs-assessed or effectively monitored in terms of process, impact and outcome measures.

Experiences and findings are publicised in a very limited manner thereby increasing the likelihood of duplication of effort and restricting opportunity for learning from other professionals.

Enquiries revealed that an organisational approach to health promotion was only represented in work focused on the promotion of staffs health. Health at Work in the NHS is a national initiative which involves NHS organisations in addressing staffs health and hospital groups were largely engaged in the development and review of policy, including notably smoking, alcohol, substance misuse policies.

The interest group noted that Health Promoting Hospitals would facilitate

a co-ordinated organisational approach to patient and visitors / community health promotion and would thereby allow effectiveness and efficiency issues to be addressed and benefits to the organisation and particular target groups to be demonstrated and disseminated.

The interest group viewed the role of its members as threefold:

- Initiator,
- Adviser on strategy development,
- Offering support, advice and consultancy on the implementation of the Health Promoting Hospital initiative.

### *Establishing the network*

Members of the Health Promoting Hospital interest group found considerable interest in the HPH initiative among the hospitals of the North Thames region. It was felt however that it would be useful to develop local expertise as well as process documentation in order to guide hospitals in engaging with the initiative.

Hertfordshire Health Promotion was nominated as the regional co-ordinating centre for HPH. Its organisational structure lent itself particularly well to advancing the initiative, it having a team of health promotion advisers dedicated to liaison with NHS Trusts. It was agreed that Hertfordshire Health Promotion would undertake initial pioneering work in the North Thames region and share experiences throughout the area.

The first NHS Trust to express an interest in HPH in Hertfordshire was the Ambulance and Paramedics Service NHS Trust. This led the interest group to consider the applicability of HPH to all NHS Trusts. NHS Trusts in the North Thames region include acute hospitals, community hospitals, community-based services, mental health, learning disabilities and ambulance and paramedic services. It was concluded that the initiative was relevant and useful to all NHS settings and a recommendation was made to the English National Network of Health Promoting Hospitals to this effect and subsequently to WHO Regional Office For Europe.

The North Thames interest group decided to develop itself into a network recruiting NHS Trust membership. Current membership of the Health Promoting Hospital / Trust network stands at 22, of which 16 are NHS Trusts.

In Hertfordshire a county network of all seven NHS Trusts was established in 1995 and this holds annual meetings. The subjects for the annual meetings have included a consideration of:

1. Models for advancing Health Promoting Hospitals / Trusts – a successful model has involved secondment of specialist health promotion staff into NHS Trusts and secondment of health professionals into specialist health promotion units.
2. Accreditation and peer review – however a system of self-declaration has been favoured.
3. Evaluative approaches – there is a particular interest in the use of story-telling.

The annual meeting is also used to share experience and thematic networks have been developed as a result of the identification of common ground.

### *Developing the network*

The North Thames regional network has established a newsletter to communicate widely about Health Promoting Hospital / Trust activity. The mailing list includes all NHS Trusts and health promotion units in the region.

There have been three regional Health at Work in the NHS conferences. Two have been held on the subject of stress support and the third dealt with critical incident de-briefing.

Hertfordshire Health Promotion, as regional co-ordinator, visits and advises from its own experience. The county of Essex has now also established its own network of Health Promoting Hospitals and Trusts.

The Hertfordshire network of Health Promoting Hospitals / Trusts hosted the fourth English national Health Promoting Hospitals / Trusts conference in November 1997, in which the North Thames regional network was actively involved.

The North Thames regional network has consulted with health promoting primary care pilot work which is under way in Hertfordshire and the decision has been taken to extend the regional Health Promoting Hospital / Trust network to include health promoting primary care in 1998.

*Luigi Resegotti*

## ***The Piedmont Network of HPH. Evolution, Targets and Problems***

First of all we felt we had to create a board of experts with first class scientific curricula, most of them being retired so that no personal career interest could interfere with their action.

This technical-scientific committee included: Prof. Guido Filogamo, a worldwide known anatomist, formerly Dean of the faculty of Medicine and Surgery of the University of Turin; Prof. Alessandro Calciati, oncologist, formerly head of the Department of Medical Oncology of the old S. Giovanni Hospital of Turin; Prof. Luigi Resegotti, oncohaematologist, formerly head of the Department of Haematology of the Molinette, S. Giovanni Battista Regional Hospital of Turin; Dr. Elena Coffano, Vice President of the Piedmont Branch of the Italian Committee for Health Education; Dr. Piero Zaina, formerly senior registrar at the S. Giovanni Battista Regional Hospital and district physician was appointed co-ordinator of the Piedmont Network.

Following the First Regional Meeting of HPH, held in Turin on June 26, 1997 for the official presentation of the newly founded Piedmont Network, the Technical- Scientific Committee promoted two important meetings with the Members of the Local Technical Committees. The first one took place in Turin on September 25, 1997 and was aimed at adopting a common methodology for designing projects correctly. During this meeting fairly clear indications emerged on the development of some issues already singled out, and several new topics were put forward by some Hospital which could be developed either by the Network as main projects or by single Hospitals as sub-projects.

The second meeting was held in Turin on December 17, 1997 and it was designed as a training session for the Co-ordinators of the local technical committees. At that time 21 out of the total 29 main hospitals and local health units operating in Piedmont as well as a private hospital connected with the National Health Service had decreed to join the Piedmont Network. 35 participants on behalf of the 21 Institutions from all over the Region took part in the meeting. 21 topics were put forward. Through a careful selection three main issues (plus a reserve one) were selected and three working groups were instituted.

**1st group:** Relationships between Hospital and Local Community. Integration between hospital, primary cure system and social welfare units. 14 participant Institutions;

**2nd Group:** Smoke free hospitals. 7 participant Institutions;

**3rd Group:** Humanisation of services. Removal of psychic distress. 11 participant Institutions.

The **4th issue** (the reserve one), Child abuse and violence to women, will be developed as a local project by some Institution due to the small number of participants.

Several Institutions participate in more than one group by means of different members of their staff.

During the same meeting, through its referendary, each group enlightened the problems they intended to deal with, the goals to be reached and the working schedule. At the end of the meeting, each group scheduled working meetings at due time in different sites, so to be able to present the first draft of their project upon the occasion of the Second National Conference of HPH in Turin.

For this purpose, the technical-scientific Committee joined with the referendaries of the three working groups at the beginning of March to evaluate the state of art and design guidelines for each project, taking into account the organisation and methodology difficulties encountered.

Beside these main projects, each Institution may develop local projects as well, among those previously suggested, specific for each Institution but hopefully in connection with other Institutions with similar interests.

So far 28 Regional Main Hospitals and Local Health Units plus the Umberto I Hospital of the Mauritian Order, the Waldesian Hospitals, two private hospitals connected with the National Health Service (Gradenigo Hospital and Rehabilitation Centre »Ausiliatrice«) and the private »Pinna Pintor« nursing house, formally decreed to join the Piedmont Network.

The first problem is the direct commitment of all the members of the local committees. We noticed a slight decrease in the participation in the subsequent meetings of the group and the complete absence of some Institutions which had presented their projects when they adhered to the Network. This commitment cannot be limited to the sole members of the Committees, but they must extend to all the figures (directors, managers, operators, patients, relatives, voluntaries) who must become partners in comparing different points of view in order to better define the problems and find adequate solutions.

It is quite obvious that a project cannot be developed without commitment

of the managers who must share the idea and want to solve the problem. Therefore, in the near future, we shall spread the information on the evolution of the HPH project, both directly to the local committees, the managers and the operators, and indirectly by publishing newsletters on the Piedmont CIES Magazine and involve more deeply the regional technical scientific committee.

The second problem concerns the organisation of the work beside that for the three main topics, namely the development of the individual projects that have been presented by single Institutions and have been already discussed by the Committee.

In order to avoid the autonomous and spontaneous proposals getting lost, we believe that as soon as the three working groups will have further implemented their programmes by reinforcing both the organisation and the methodology (possibly after summer), their experience may be exploited for extending the planning of the local projects specific for single Institutions possibly involving more than one institution on each topic (as already happens spontaneously).

*Zora Bruchacova*

## ***Evolution of the Slovak HPH Network***

In 1997 the Ministry of Health of the Slovak Republic in co-operation with the Phare project in Slovakia delegated Dr. Zora Bruchacova as a representative for the 5th International Conference on Health Promoting Hospitals and she became a National HPH Co-ordinator.

### ***Evolution of the network***

As the idea of health promotion was fondly accepted by hospital authorities in several hospitals, a network is being established of hospitals interested in joining the project of HPH. The Children's University Hospital in Bratislava has become the first member of HPH network. The representatives of this hospital joined the conference and workshop in Vienna last year so they got acquainted with the idea of health promotion and its goals. Thus the Children's University Hospital was designated as a National Co-ordinating Centre for Health Promoting Hospitals in Slovakia.

The management of three more hospitals expressed their interest to become a Health Promoting Hospital. The hospitals are in different regions of Slovakia thus the health promotion network will be covering the whole Slovakia through their activities. One of these hospitals is in Bratislava, it is the Institute of Preventive and Clinical Medicine working also as a Co-ordination Centre for Clinical Auditing and Evidence Based Medicine. The second hospital is in Nitra, in central Slovakia, it is specialized for chronic diseases and the third one is in eastern Slovakia in Vranov nad Toplou.

The three mentioned hospitals have not joined the network yet but they co-operate closely with the Ministry of Health of the Slovak Republic and expect to join the HPH network in a short time.

### ***Achievements***

We present the Children's University Hospital whose representatives got acquainted with the problematics of health promotion during the 5th Inter-

national Conference on Health Promoting Hospitals in Vienna last year. Katarina Vicianova, MD. has been designated as a local HPH co-ordinator.

The Children's University Hospital is the largest pediatric hospital in our republic with 528 beds, 257 doctors, 666 nurses and 445 other medical workers. The out-patient clinic serves a large area of Bratislava and western Slovakia, where several national centres are also working e.g. the National Centre of Diabetes mellitus Treatment, National Centre for Metabolic Diseases, Children's Cardiologic Centre etc. These centres are co-ordinating the diagnostic and treatment procedures of concerned pediatric diseases, promote prevention and screening methods, educate health workers and patients. The hospital is also the centre for pregraduate and postgraduate education of health workers.

In the past year there were several improvements introduced for the staff members and for patients:

- To create a healthy workplace: the hospital rented facilities for sporting activities which are available to every employee (swimming pool, gym).
- For patients: parents can be hospitalized with patients younger than 6 years, under special circumstances without age restriction. Mothers breastfeeding their children have the whole stay for free, the others have only to pay a limited amount for food.
- The playground has been built for children and toys and books for children were bought through sponsorship. The hospital environment is now re-decorated in more pleasant way – the surfaces are in different bright colours (not the »hospital white«), door windows and separating glass partitions are covered with pictures from popular fairy tales.
- The hospital management wants feedback on provided services: there are questionnaires distributed in out-patient and in-patient clinics where parents can anonymously express their opinion on the provided care.
- Psychological services are available for patients.
- Social work becomes a very important role: despite the serious problem of finding enthusiastic people to work in this area there are two new social workers in the hospital. Whenever a suspicion arises of child's abuse or improper home environment they deal with the case. They closely co-operate with the police as well as with other institutions.
- The hospital is usually not the place of the first contact with the medical care but as a specialized centre provides consulting on requirement.

In the hospital there is a Lactarium (Human Milk Bank). Every mother delivering her child in Bratislava gets an information about the possibility to donate the excess of human milk to the Human Milk Bank where it is pasteu-

rized and frozen and used for neonates and infants hospitalized in our hospital. We educate mothers that human milk is the best nutrition for neonates and infants and plays an important role in the treatment of a sick child. Every mother has free access to her child and is encouraged to participate in the care, to breastfeed if possible. Every baby gets preferably the milk from his / her mother.

We closely co-operate with other hospitals and promote breastfeeding. In Slovakia there are 6 Baby Friendly Hospitals. We are a part of IBFAN (International Baby Food Action Network) and monitor the International Code of Marketing Breastmilk Substitutes. We also promote creation of mothers support groups where mothers meet with specialists on children's nutrition and care. There is also a great campaign promoting breastfeeding and healthy nutrition in media.

Our hospital in co-operation with the Slovak Television (the state TV channel) prepared the series of presentations of various departments with the emphasis on the health promotion and prevention of diseases.

There is a wide range of other activities performed but we decided to mention these to illustrate the situation.

### ***Problems***

The major problem are finances. We are short of money in our health care system due to vast debts. Hospitals owe to distributors of materials, chemicals, drugs, formulas, disposal materials etc. who refuse to supply hospitals. Insurance companies owe to hospitals so there is a vicious circle where hospital is a debtor and indebted at the same time, nevertheless, it is the patients and health workers who bear the consequences. Health workers are under pressure to provide appropriate care in the limiting conditions and patient treatment is endangered. We would definitely need improvement in the information system i.e. computerization. Otherwise it is difficult to keep records and evaluate our activities.

As this is actually our first year in the Health Promoting Hospitals Network we have not started evaluating yet. We came here to learn more about ways of health promotion and to exchange experience. Back at home we will promote these ideas and try to build a working network in the Slovak Republic.

*Brenda Stephens*

## ***Report on the Welsh Network of Health Promoting Hospitals***

### ***Background***

Wales has a national health promotion strategy »Health for All in Wales«. It sets out targets for health improvement in Wales, and calls for all parts of our infrastructure to take appropriate action. The development of our hospitals as health promoting organisations is part of the national response to that challenge.

### ***Developing Health Promoting Hospitals***

Health Promotion Wales (HPW) has been assigned the lead responsibility by Welsh Office for the development of health promoting hospitals in Wales. In addition to being the Co-ordinating Centre for the Welsh Network of Health Promoting Hospitals, HPW is a WHO Collaborating Centre for Health Promotion and Health Education Development and is also a designated WHO Documentation Centre.

It was decided at the outset that all hospitals should be encouraged to become health promoting organisations, with the aim of making health promotion integral to their everyday work. The initial mechanism for taking this forward was the ***Healthy Hospital Award*** which utilised a combination of organisational development and social marketing techniques. The ***Award*** ran from 1988 to 1997, and has now been superseded by the ***Welsh Health Promoting Hospital Accreditation Scheme***.

During this period HPW has provided advice and guidance to hospitals seeking to improve their health promotion knowledge and skills. This support continues by means of:

- Training: skills development workshops on topics such as standard setting; evaluation; stress management; creating a smoke-free hospital etc.
- Consultancy: working with individual hospitals to review their developmental progress as health promoting organisations.

- Conferences: providing the opportunity for representatives from all hospitals in Wales to meet together to hear about examples of good practice, and to exchange information and ideas.
- Publications: our publications include
  - Creating a Smoke Free Hospital
  - Evaluation Handbook
  - Smoking Restrictions in Welsh Hospitals
  - Health Promotion in Nursing Practice
  - A Simple Guide to Stress at Work
  - Developing a Health Promoting Hospital-Checklists for Hospitals and Trusts
  - The National Standard for Hospital Caterers
  - The Health Promoting Hospital – a Good Practice Guide
- Newsletter: our Network Newsletter is published twice a year. There are also occasional mail-outs to all hospitals with regard to health promotion campaigns, new health promotion publications, resource materials and skills development opportunities.

We became formally linked with the WHO Health Promoting Hospitals initiative in 1990, and in 1991 Prince Philip Hospital, Llanelli, a winner of the **Healthy Hospital Award**, was accepted as one of the 20 hospitals in the European Pilot HPH Project.

### ***Evolution of the Network***

Since 1988, all hospitals in Wales have been actively encouraged to incorporate a health promotion dimension to their work, and the annual **Healthy Hospital Award** stimulated hospitals to increase the range and quality of this activity.

Hospitals join the Welsh Network of Health Promoting Hospitals by entry to the **Healthy Hospital Award**. From a modest start of eight hospitals entering for the Award in 1998, we currently have 59 hospitals engaged in furthering their development as health promoting organisations.

The Award was developed in partnership with hospitals, Health Authorities, and senior health professionals in Wales – including our Chief Medical Officer and Chief Nursing Officer – and with our Community Health Councils (the statutory bodies who represent the views of patients and local communities). This approach was successful in attracting and sustaining the active support and involvement of a wide range of hospitals.

The Award has been the development tool for the Network, and the cata-

lyst for improving the standard and scope of hospital health promotion practice in hospitals in Wales. This can be evidenced by activity in the areas of:

- Organisational development: providing the structure and the means to become a health promoting hospital e.g. team building; capacity building; resource allocation and development of action plans.
- Policy development: empowering change and shaping its direction.
- The implementation of new services and improvement in facilities: turning policy into action.
- Education and training for staff: facilitating improvements in health promotion practice.
- Research and evaluation: identifying good practice.

In 1991, following an evaluation of the Award, we produced the first ***Healthy Hospital Information Pack***. This gave examples of good practice by previous entrants. It also included a hospital health promotion Checklist which offered advice on action which could be taken on policy development; provision of services and facilities, and the development of education and information in all priority action areas.

The Checklist was re-developed in 1993 and 1995 with additional action areas being added on each occasion. In 1996 it was re-focused for use as a self-audit tool. Following evaluation in 1997, it now forms the basis of the documentation for the ***Welsh Health Promoting Hospitals Accreditation Scheme***.

### ***Achievements***

1997 was a busy year for members of the Network.

- Invited papers were presented at the 5th International Conference and at a WHO Workshop in Italy on ***Evaluating Hospital Effectiveness and Efficiency***.
- 16 hospitals took part in the developing and piloting of our ***HPH Accreditation Scheme***.
- Members also supported international and national initiatives such as »Europe Against Cancer Week« and »National No Smoking Day«.
- Communication skills continue to be developed. Many hospital newsletters now have regular articles on health promotion. In addition proactive communication has been developed with local media on reporting health promotion activity.
- Network members continue to share information and expertise with each other – and with colleagues from outside Wales.

- 170 delegates attended our annual Network Conference, held on 19th November. The Conference is a professional development event and the theme this year was »Making Good Practice the Norm«. The keynote speech was given by the Chief Nursing Officer for Wales. Ten invited papers were presented, and our principle speakers included Ann Kaskonas, Co-ordinator of the Scottish HPH Network.
- As usual, the Healthy Hospital Awards were presented at the Conference. 18 hospitals received Certificates of Excellence for their health promotion practice and a further 10 hospitals received Commendations.
- 4 hospitals had abstracts accepted for the 6th International HPH Conference.

1997 was also a busy year for the Co-ordinating Centre. Major achievements included:

- Wide distribution of the ***Good Practice Guide for Health Promoting Hospitals***,
- Piloting the ***Welsh HPH Accreditation Scheme*** and confirmation from the Chief Medical Officer for Wales that she wishes to become personally involved as an Assessor for the Scheme,
- Publication of the first edition of our Network Newsletter.

### ***Main problems encountered***

The main problems encountered in 1997 were:

- Difficulty in increasing the total number of hospitals in the Network. Although ten new members were recruited, a similar number were lost (either through resource utilisation pressures or closure of the hospital),
- Negotiating the transition from a peer referenced Award to a norm referenced Accreditation Scheme.

### ***Future plans***

Activities for the Network in 1998 will be:

- Implementation of the ***Welsh Health Promoting Hospital Accreditation Scheme***. It is planned to accredit up to 15 hospitals by 31 March 1999.
- Responding to an evaluation questionnaire on our ***Good Practice Guide for Health Promoting Hospitals*** which was published in 1997.
- Assisting with the development and piloting of a survey of nutrition policies in Welsh hospitals.

- Preparation for the 1999 International Conference on Health Promoting Hospitals.
- Publication of two further editions of the Network Newsletter.

Looking ahead for 1999, the development plan includes:

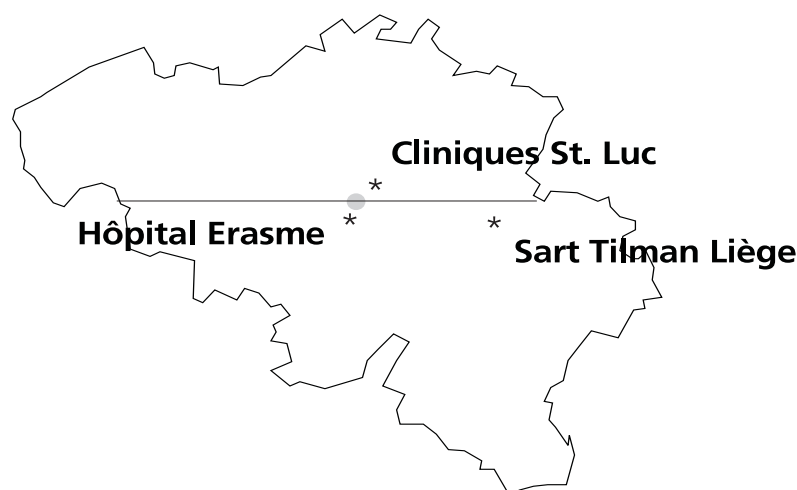
- Hosting the 1999 International Conference,
- Accrediting a further 15 hospitals by 31 March 2000,
- Promoting knowledge of good practice and of evaluated project,
- Strengthening information links with HPH networks in the UK and Europe.

*Jacques Dumont*

## ***Belgium 1997: The First Year of the French Community's Network of Health Promoting Hospitals***

The first year of real collaboration for the establishment of the network is now behind us; the annual congress of the European network gives us a perfect opportunity to evaluate the work achieved.

The network is developing in the French part of Belgium, where the separation of political and financial means is a daily reality! The hospitals depend on three different ministries, Health Promotion on yet other ministers, etc. Nevertheless, we have obtained an initial grant of 40,000 Euro from the Ministry of Social Affairs of the French Community of Belgium, to promote work in the three most academic hospital institutions (Sart-Tilman's Hospital in Liège, St. Luc Hospital in Brussels and Erasmus Hospital in Brussels). The co-ordination is provided by Erasmus Hospital in co-operation with the Promes Unit of the Free University of Brussels.



The objectives to reach after this first year were:

- Designation of a local co-ordinator in the three institutions.
- Elaboration of a plan for institutional working, to develop institutional processes and activities.
- Reflection upon the main concepts in use in this project.

- Inventory of the actions already in progress and which could be integrated into the process of health promotion.
- Investigation into the behaviours of general health (tobacco, nutrition, physical exercise, stress management, etc.) and needs / requests of staff, patients and hospital visitors; setting up of initial steps to implement themes defined by each institution.
- A wide review of the literature: The concrete production of this work is a file for all the hospital institutions of the French part of Belgium. These files will be given out during a meeting due to take place in October 1998.

These different objectives have either been achieved or are in progress; in short, the elements we wish to underline are the following:

- After a short starting process, the three institutions are well on the road to Health Promotion, a steering committee is in place in the three institutions and each committee includes a member of the Public Health School from the relevant university.
- **Literature review**, especially on the Health Promotion process in the hospital structures is very poor in the traditional research areas (Medline, public health documents centres)
- **The inventory of the actions** already in progress (131 actions for our 3 institutions) show us a wide part of patient education activities (63 %), 16 % for staff and less than 10 % for other categories (young parents, community and family). On the other hand, we note a lack of a structured evaluation here; this could prove an interesting orientation for the next years of our network.

It is important to note that hospital hygiene is not included in our inventory, this speciality being well developed in our country. We are now working in each institution to ensure the internal diffusion of information and the analysis of the process:

- An extensive research is in progress thanks to Liège university (Public Health School) to investigate staff needs in accordance with health Promotion.
- Other research is in progress thanks to the Free University of Brussels to assess health behaviour of nurses in academic hospitals.
- We are working together with other associations on specific projects and actions; the first concern being tobacco.

The steps for 1998 are:

- Opening of the network toward all the hospital institutions in the French part of the country;

- Delivering of the file;
- Carrying out of the inventory of the actions, of the different research;
- Development of common specific projects in staff health education, patient education and opening to the community (this is our only source of funding!);
- Development of actions and process in each institution.

The functioning of the network is now:

- A monthly meeting for the institutional relay;
- A quarterly or bimonthly meeting for the steering committee in each institution;
- A biannual meeting with the public health schools;
- In the future an annual meeting for all the members, but the most problematic area of difficulty for the moment is finding funding for the network!

*Bencho Benchev*

## ***Evaluation Methods of the HPH Project in Bulgaria. On a Hospital and National Level***

### ***Evaluation Methods of the Separate Subprojects***

#### ***For subprojects directed at the patients and their relatives***

1. Evaluation of the knowledge and skills level among the trainees.
  - 1.1. Defining of the knowledge and skills to be acquired by the trainees.
  - 1.2. Formulation of an inquiry (a questionnaire) – includes questions covering the knowledge and skills defined.
  - 1.3. Organising an inquiry among the trainees (evaluation of the initial level of knowledge and skills among the trainees). Evaluation of the study results – objectifying the choice of the training subjects.
2. Evaluation of the level of certain integral indices referring to the health status of the trainees – influence of the training on the health status:
  - 2.1. Making a list of such indices (for example for diabetes – mean value of blood sugar level; HbA1C – glycolized haemoglobin; the quality of patients lifestyle – evaluation) through a special questionnaire; lipid indices; number of the admissions to hospital (per year; number of the acute complications – hypoglycaemias, ketoacidoses per year);
  - 2.2. Determining the level of these objective integral indices prior to the training course (evaluation of their initial level).
3. Evaluation stages:
  - 3.1. First stage – initial status evaluation (item 1.3. and 2.2);
  - 3.2. Second stage – evaluation of item 1.3. indices immediately after the organisation of the training course;
  - 3.3. Third stage – determining the two types of indices status in 6 months – 1 year following the organisation of the training course. A parallel evaluation is made of the knowledge and skills level as well as the integral indices among the trainees. The results achieved by the second and third stage evaluation are compared with the initial status of these indices.

***For subprojects directed at the medical personnel in the hospital***

1. Evaluation of the conditions of work in the hospital, referring to such a concrete subproject:
  - 1.1. Making a list of such indices;
  - 1.2. Evaluation of the status of the separate indices of this list – determining the trends and priorities of the prophylactic activities during the subproject, for example for subproject »Control over the professional risk among employees in operating theatres / operating rooms« – characteristics of the anaesthesia system; mode of anaesthetics supply to the operating theatre; evaluation of the separate elements of the anaesthesia system hermeticity; characteristics of the ventilatory system in the operating theatre; halotane and nitrous oxide (laughing gas) content in the air of the operating theatres etc.
2. Evaluation of the knowledge, skills and motivation level among the medical personnel:
  - 2.1. Defining the knowledge, skills and motivation to be acquired by the trainees;
  - 2.2. Formulating an inquiry (a questionnaire) – includes questions covering the knowledge, skills and motivation defined;
  - 2.3. Organising an inquiry and evaluation of its results – objectifying of the training subjects.
3. Evaluation stages:
  - 3.1. First stage – evaluation of the initial level of the items 1 and 2 indices;
  - 3.2. Second stage – evaluation of the item 2 indices immediately after the organisation of the training course;
  - 3.3. Third stage – evaluation of the items 1 and 2 indices in a period of 6 months following the organised training course and the prophylactic activities planned to be realised. The results achieved in the second and third stage are compared with their initial status.

***Evaluation Indices of the Project on a National Level***

1. Centres for training of patients and their relatives established in the National Network participating hospitals.
2. Networks of subjects to be discussed established by National Network participating hospitals.
3. Monitored and evaluated education standards established by National Network participating hospitals.
4. The necessary conditions established for the active participation of pa-

tients and their relatives in the medication process and recovery, for close co-operation with the medical personnel.

5. Subprojects realised, which had led to reduction of the influence of harmful professional factors.
6. Realisation of joint initiatives with social and other health services and voluntary organisations in the field of health promotion.
7. Subprojects realised, which had led to a contribution of the hospital to environmental protection.
8. Conditions established to ensure treatment equality of all patients, taking into account as well, the specificity of their ethnic – cultural needs.
9. New participants involved in the National Network.
10. Realisation of new that are underway subprojects within the framework of the National Network.

*Dominic Harrison*

## ***The English National Network of Health Promoting Hospitals and Trusts – Evaluation Methods***

### ***I. Evaluation and evidence based Health Care in the UK***

There has been a widespread debate about the role of evaluation and evidence based health care, medicine and purchasing in the UK. This has resulted in a broad debate and a number of guidance documents about Clinical Effectiveness published by the Department of Health NHS Executive.

#### ***Clinical Governance***

A new government Whitepaper on healthcare system reform – ***DoH (1997) The New NHS. Modern. Dependable*** London HMSO introduced the concept of »Clinical Governance«. This includes the need to evaluate:

- Quality of health care.
- Effectiveness of health care interventions.
- Appropriateness of healthcare interventions.
- Acceptability of health services to the population.
- Participation of the public in healthcare decisions.
- Efficiency of health care interventions and resource investment.
- Equity of access to healthcare and equity in health status.

#### ***Health Governance***

This debate has rapidly lead to considerations of the concept of »Health Governance« which in many ways covers similar concerns but applies these to the determinants of population health rather than access to, or the application of health services. In this arena, the issues of evidence based health promotion have come under scrutiny. A contribution to this debate, drawing on work undertaken within the WHO-Euro HPH Network was made in the British Medical Journal in August 1997.<sup>1</sup>

#### ***The concept of evidence based health promotion***

General practices, health authorities and Trusts spend 7 % of UK GDP on

1 Speller, V., Learmonth, A. & Harrison, D. (1997), The Search for evidence of effective health promotion. ***BMJ*** 315, p. 361-363

health, but their annual reports would not look any different were all the patients to have died. It sometimes seems that whilst everyone knows what they are busy **about** in the healthcare system, what they are busy **for** seems less unimportant.

Ironically, the most frequently asked question of health promotion by all these agencies is – »does it improve health?« But planned health promotion interventions enjoy budgets of less than 1 % of the total UK total spend on health (Limb 1996). With such levels of investment it is inconceivable that they could be anything other than largely irrelevant to population health, except perhaps on a political and symbolic level. Yet researchers undertaking so called »effectiveness reviews« employed by the Health Education Authority, York University and the International Union of Health Promotion and Education (IUHPE) earnestly search for evidence of effectiveness solely within that 1 %, as if it might make a difference whatever the answer was.

Furthermore, it has been suggested that only about 1 % of the evidence already available on effective healthcare interventions has ever been used as a basis for routinised healthcare practice or purchasing (ECHHO 1997). Indeed Weiss (1991) convincingly demonstrates that there is evidence to show that research has »very little« impact at all on **any** public policy.<sup>2</sup> She argues that research rarely determines policy, rather it tends to be used to illuminate the consequences or support the advocacy of decisions already made on the basis of custom and practice, values or interests.

In searching for an evidence base for the practice of health promotion that is relevant, it may be necessary to problematise some of the questions traditionally asked and to look at the cultural whole system context within which both questions and answers are being framed.

With this in mind, evidence based health care and medicine and evidence based health promotion might best be seen as distant subjects in search of separate objects. Evidence based healthcare might ask: »What is the most efficient and effective (least cost greatest outcome) intervention that can be undertaken with this group or to this patient, that will restore or maintain health?« Evidence based health promotion should be asking: »What are the determinants of this populations health status and what are the most effective and efficient interventions to protect and improve it?«

Evidence of effective healthcare is generally narrowly focussed within the 7 % of GDP spent on health and as Schwartz & Bitzer (1997, 2) warn: »There is no common understanding about what constitutes »evaluation in health

2 Caplan, 1977; Bulmer, 1978; Weiss with Bucuvalas, 1980; Alkin et al., 1979; Deitchman, 1976; Dockrell, 1982; Knorr, 1977; Rich, 1977; Leff, 1985

care». Beginning with an acknowledgement of the essential judgmental nature of any evaluation activity, health care evaluation is defined in broad terms as a comprehensive scientific assessment of positive and negative effects of products, technologies, projects, models, institutions or programs in health care.«

Evidence based health promotion must look elsewhere, beyond healthcare and beyond the bounds of that which recognizes itself as health promotion. That health promotion is evidence based may logically mean there is:

**Evidence about** appropriateness, efficiency (technical, allocative, clinical, social or institutional), efficacy, effectiveness, equity, equality, productivity, sustainability or ethical behavior found in relation to a specific intervention in a specific context at a specific time.

**Evidence in relation to** input, process output, outcome or impact of a specific activity (it can also mean the opposite of these things, but there are few databases of that sort of evidence even though it is half of the reality that may be found).

**Evidence for** stakeholders with various interests and perspectives. Vang (1997) has characterized these as:

- The perspective of the patient and their expectations on the outcomes of care
- The perspective of the professional of the quality and process of care
- The perspective of commissioners and managers on the productivity, efficiency and cash-flow of care
- The perspective of politicians about the social institutions of healthcare and its relationship to broader societal management and objectives
- The perspective of NHS staff and Unions in their assessment of health care systems as workplaces.

All of these domains are valid and it should be noted that good practice in health promotion means involving the perspectives of all stakeholders. This is a very difficult process. As Smith & Cantley (1985, 37) observe: »There may well be disputes about which findings are relevant or significant. Success means different things to different groups of people who each have their own agendas or interests.«

Evidence based health promotion is of course not a science at all but an **applied** science. This means that it requires judgement in its application. Judgement depends on values and the privileging of one judgement or set of values against another requires power. The meaning and importance of evidence is thus really only amenable to political choice. Which choice is taken depends on whom amongst the stakeholders in a given situation has the greater positional power, which in turn is mediated through the nature of the

micro – political system of the healthcare system itself. Echoing Weiss (1991) we must conclude that application of relevant health promotion knowledge depends on stakeholder democratization in the social construction of meaning and significance – it is not so much that »knowledge is power« but that »power is knowledge« in the healthcare system.

## *II. Evaluation of Health Promoting Hospitals / Trusts in England*

### *National Level Evaluation – Organisational Change*

The concept of Health promoting hospitals and Trusts clearly implies different things to different stakeholders within the English healthcare system. Consequently each is looking for different types of evidence of effect.

From the perspective of the National HPH/T Network, it is **not** the point of the HPH/T movement to prove that health promotion is effective at improving individual or population health. There are already CD-Roms full of effective preventative interventions that could be purchased by Health Authorities or adopted by hospitals or Trusts. The problem is that such interventions are **not** so adopted and that the UK NHS continues, along with most other European countries to practice the provision of health services on an allocatively ineffective and inefficient model.

The principal aim of the HPH/T project is to realise a refocusing of healthcare systems from illness to health in line with the strategies identified in:

- The European Strategy for Health For All (1984)
- Ottawa Charter for Health Promotion (1986)
- The Budapest Declaration on Health Promoting Hospitals (1991)
- The Ljubliana Charter for Health Care Reform (1996)
- The Vienna Recommendations on Health Promoting Hospitals (1997)
- The Jakarta Declaration on Health Promotion (1997)
- The revised Health For All Strategy for the 21 Century (1998).

From the perspective of the National HPH/T network therefore evidence and indicators of changes in practice are what is relevant. These include: Whether health investment has been made; Whether an infrastructure for health promotion has been constructed within the formal or informal fabric of the organisation or social system. Other indicators may include:

- Written roles / job descriptions that include health responsibilities (not healthcare or disease treatment).
- Evidence of health related infrastructures such as policy on health or environmental audits that are routinised / integrated into core business.
- Formal health committees adopted.

- Changes in values / policies within the organisation such as a shift to equal opportunities, job sharing employment practices or »mental health days« as a right.

Much of this data will be searchable from the proposed WHO-HPH database of member hospitals and Trusts, which being in English, will form a key part of the evaluation strategy of the English Network.

### ***National / Regional / Local Level Evaluation Projects***

At a project level a wide range of evaluation methods and strategies are currently being adopted at all levels of the overall HPH/T projects. In general these fall into the taxonomy of categories listed in the table below:

<i>Aim / goal type:</i>	<i>Individual / Population Health Objective:</i>	<i>Outcomes / Achievement / Success measured by:</i>
Cognitive	To increase knowledge about health	Changes in knowledge
Affective	To change attitudes about health	Changes in attitudes
Behavioural	To change health related behaviour	Changes in behaviour / Lifestyle
Skills (social, inter-personal, psycho-motor)	To improve skills	Changes in skills levels
Empowerment	To improve self-esteem and foster personal growth	Changes in self esteem and acquisition of life skills
Conscientisation	To raise critical consciousness of the need for personal and social change	Changes in awareness meaning and perception
Equity of access to health services	To change the provision of health services to ensure equal access for vulnerable groups	Changes in service provision
Healthy Settings / organisations	To create health promoting social structures / organisations e.g. Schools, workplaces etc.	Changes in organisational roles, structures, norms etc.
Healthy Public Policy	To create health promoting policy in other economic sectors than health e.g. Transport, trade, employment etc.	Changes in legislation and regulation
Community, social, public, political, participation	To increase public participation levels in community, social and political changes / debate	Changes in the nature and quantity of public debates and public involvement from

		policy to service provision and evaluation
Social change lobbying, mediation, advocacy, enabling	To develop structures to allow individual, community and professional action to achieve health promoting change	Changes in political and social systems / agendas
Health Protection	To secure legal or fiscal controls, other regulations and policies, and voluntary codes of practice, aimed at the enhancement of positive health and the prevention of ill health	Changes in legislation and institutional policy and practice
Competency Building	Building competencies for health promotion action into organisations, institutions, social systems, groups, populations or individuals	Evidence of competencies in culture, policy and practice
Developing Social Capital	To increase the social capital for health available within a community	Changes in the co-operative community counter economy (increases in self help groups, social interactions, community events and community social structures)

In addition: The HPH/T accreditation / audit programme of South and West Region is set to expand to cover other areas of England. The Preston HPH Pilot site has, through the external evaluator at the University of Central Lancashire in Preston, used the Labonte Model of evaluation and Stakeholder project outcome assessment. This model is increasing in usage in the UK.

A full list of practical examples of evaluation methods cannot be identified however until hospitals and Trusts are fully registered as members of the network, and entered into the existing database.

ECHHO (1997), European Clearing Houses on Health Outcomes Conference: Outcomes Measures make sense – do they make a difference? International Meeting in Linköping, Sweden 12-13 June 1997 (in print)

Limb, M. (1996), Health of the Nation Under Scrutiny. *Health Service Journal* 14, 1996

Vang, J. (1997), Swedish Policy on the Evaluation of Hospital Performance. Workshop on Evaluating Hospital Effectiveness and Efficiency, Milan, 30 Sept.-2 Oct. 1997 WHO (in print)

Smith & Cantley (1985), *Assessing Health Care: A Study in Organisational Evaluation*

Weiss, C. H. (1991), Policy research: Data, ideas or arguments? In: Wagner, P. et al. (eds) (1991), *Social Sciences and Modern States*. Cambridge

Schwartz, F. W. & Bitzer, E. A. (1997), Systems Perspective of evaluation in Health Care. In: Long, A. & Bitzer, E. A. (1997), *Health Outcomes and Evaluation: Context, Concepts and Successful Applications*. ECHHO

*Anne-Laurence Le Faou*

## ***Evaluation Methods in the French Network of Health Promoting Hospitals***

### ***Introduction***

Since the recent hospital reforms in 1996, concrete measures concerning health promotion in hospitals still face difficulties in being implemented. Money devoted to hospitals is managed by Regional Agencies on hospitalisation whose role is to distribute money between hospitals according to quality of care and medical activities (defined by a contract between the hospital and the funding authorities and assessed by the DRG's system). To reach this objective, quality of care standards will be defined with the help of an independent national bureau in order to grant accreditation to hospitals («Agence Nationale d'Accréditation et d'Evaluation en Santé»). Under this new system, public and private institutions will be encouraged to work together.

But all these decisions will have difficulties in being implemented before the year 2000, because of the time necessary to set up the methods and tools which will be chosen as quality of care criteria. In fact, it will be interesting to add qualitative data like Health Promotion Projects to help the health care authorities to adapt the budgets. Furthermore, these Health Promoting Hospital projects could be included in the criteria for the accreditation of hospitals with specific activities like geriatric and paediatric hospitals as well as hospitals in deprived areas or serving populations with specific public health problems (drug abuse, rate of suicide attempts, etc.).

### ***The Evaluation Methods at the Hospital Level***

#### ***The hospitals participating in the network***

1) For Vaugirard Hospital – a quality assurance programme. This programme requires a specific method to lead to written recommendations of good practices. A task-force was set up. It is comprised of the:

- project manager, who is the director of the board of Vaugirard Hospital,
- medical doctors,
- chief nurse and nurse managers,

- pharmacist,
- equipment and maintenance manager,
- catering team manager,
- supplies manager,
- computer department manager,
- person in charge of public relations,
- office staff supervisor, and
- staff members involved in the quality assurance project.

Its objectives include:

- dealing with the needs and expectations of the patients,
- encouraging the training in *quality procedures*,
- making decisions on the programmes,
- appointing project managers and outlining their responsibilities,
- following up the programmes and measuring the results.

The first example of AP-HP policy is the information given to the patient.

The efficiency of the method is guaranteed by :

- Involving the board managers who are members of the task force, who are in charge of defining the project strategy, following up the stages of the project, deciding the evaluation method and thus, allocating funds to the project.
- On a second level, encouraging the teams of the different departments to participate in concrete projects the aims of which are directly linked to the everyday life of the patients.
- Using specific tools such as problem solving, process analysis, Pert diagrams etc. for the scheduling of the project, quality manual, charts etc. for the follow-up of the project by the board managers, indicators, control panels to check the results of the different stages of the project.

The »nursing flat«. The aim of this project is to allow physically and mentally dependent people to live in a flat accommodating eight people, rather than being in a long term care unit. It maintains social integration on a human scale while providing the necessary specialised care.

The evaluation method is the following:

- Quality of life criteria compared between the eight people in the nursing flat and 40 patients hospitalised in long term care units in Vaugirard Hospital,
- Cost of care (leasing of the flat, staff etc.) compared between the eight people in the nursing flat and 40 patients hospitalised in long term care units in Vaugirard Hospital.
- The programme of prevention of hospital-acquired infections.

A hospital committee is in charge of defining the rules and regulations. Cases are recorded and are systematically analysed by this committee. Standardised

procedures are set up by the different hospital professionals. A survey is planned to register the number of nosocomial infections after recommendations and a training programme of the staff.

2) For Robert Debré Hospital (Project Co-ordinator: Marie-Christine Grenouilleau, head of the board of directors). A programme to treat dental diseases free of charge at the hospital through a network with school medical doctors and social security. This programme aims to treat children of the area surrounding the hospital, which corresponds to an underprivileged area. The dental diseases are diagnosed at school and the school medical doctor systematically refers the children to the hospital where they receive treatment with social security paying the hospital directly. The aim is to treat 50 % of the children referred by the school health professionals.

The evaluation method will consist of a survey in order to compare the number of the hospital referrals to the children cared in Robert Debré Hospital.

- A programme to study children's chronic diseases, the aim of which is to monitor 2,000 children with various diseases such a cystic fibrosis, neurological diseases (epilepsy), asthma, on a medical, social and psychological basis in order to provide suitable care.

The evaluation method will consist of the intention of growth standards, psychological development and school integration.

- A programme to teach parenteral feeding at home to families whose children have a chronic disease. Nurses in private practice are also involved in the training sessions to ensure that the procedures are done appropriately. The aim of this programme is to shorten the length of stay in hospital and as a result, to improve the quality of life of the children.

The evaluation method will consist of a survey in order to know whether or not the parents are satisfied with the technical procedures they have to perform at home or if they would have preferred the hospitalisation of their child.

3) For the Emile Roux Hospital in Eaubonne, a suburb of Paris (Co-ordinator: Dr. Pierre Polomeni, MD, in charge of the network between the hospital and the community).

- A programme of health education in the schools for 8 to 11-year old children, managed by the health professionals of the hospital. The same group of children will take part in the programme over a 3-year period.

The evaluation method will consist of a satisfaction survey.

- An awareness programme involving steps to take in the event of a risk of HIV contamination in a professional context for health professionals in the hospital and in the community (doctors, nurses and pharmacists).

The evaluation method will consist of a survey in order to check the application of the guidelines.

- A training programme for general practitioners and pharmacists, managed by the health professionals of the hospital. They learn to prescribe and distribute drug substitutes to drug addicts.

The evaluation method will consist of a survey to measure whether or not the drug abusers participate in the new modalities of care set up in the Eaubonne area.

4) For the Valenciennes Hospital, in an underprivileged area in the north of France (Co-ordinator: Dr. Elisabeth Tassin, MD, Paediatrics Department).

- A programme of health education for adolescents who are hospitalised. The three main topics covered are : chemical dependency, nutrition and sex education including family planning. Professionals of the community are involved in these sessions not only during the patients' hospitalisation but for consultation following their discharge.

The evaluation method will consist of a survey in order to compare the number of the referrals to health and social professionals of the community after the health education sessions set up by the Valenciennes Hospital.

- A Cupertino programme between, on the one hand, the paediatrics department and on the other hand, the community services, volunteer associations and children legal authorities in order to prevent re-occurrence of suicide attempts.

The evaluation method will consist of regular meetings between the participants of the network in order to set up recommendations of good practice.

- A programme to monitor children with cystic fibrosis. This programme makes it possible for them to be hospitalised in the Valenciennes Hospital rather than in the Lille university hospital, thus allowing parents to visit them more regularly.

A satisfaction survey will be conducted for the children and their families.

5) For the Victor Jouselin Hospital in Dreux, in the Normandy region (Co-ordinator: Dr. François Martin, MD in charge of the unit of health prevention and education).

- A programme of health prevention and education in a specific unit created in the hospital for patients with chronic diseases (diabetes for example) as well as for people who want to take part in health education programmes (in the field of nutrition for example) or screening programmes.

The evaluation method will consist of the registration of the patients with chronic diseases as well as the number of people consulting for health education programmes.

- A programme through which people who do not have medical coverage or complementary insurance (social security covers 75 % of medical care and about 60 % in private practice) can have access to doctors, tests and treatments free of charge.

The evaluation method will consist of a survey in order to know how the patients arrive at this unit and what kind of solutions are found to give them social coverage after their visit to the hospital.

- A quit smoking programme for health professionals in hospital as well as for groups in the community requesting such programmes.

The evaluation method will consist of a survey to register annually the number of requests concerning these training sessions.

### ***The evaluation methods of the French network in 1998***

The work methodology of the group

- Meetings every two months (with systematic invitation of the medical doctor in charge of the French networks in the Ministry of Health, Dr. Pierre Larcher, Division of Health),
- Creation of a task force on projects' evaluation methods (weak points of the projects),
- System of sponsoring for new network members by the five first hospitals of the network.

The visibility of the project

- Publication of the projects (in the review of the National Committee of Health Education, the »Santé de l'homme«),
- Preparation of a network presentation booklet in order to enrol new hospitals,
- Participation of the AP-HP International Affairs Department at the annual national meeting of medical doctors (essentially in private practice but including national institutions) with a presentation of the national network and the co-ordinator's address and phone number).

Main problems encountered – the practical side of the evaluations.

### ***Conclusion***

The evaluation methods use quantitative as well as qualitative tools. A task force is beginning to work on the topic of evaluation in order to facilitate the integration of the new projects in the health care system.

*László Kautzky*

## ***Evaluation of Health Promoting Projects in the Hungarian HPH Network***

The evaluation of any process is an important step in quality control just to measure the success or failures of several aims and objectives, analysing the impact on different targets, the cost / benefit ratio, etc. using special indicators referring to that special intervention and outcome in order to improve the efficacy of the performance of Health Promotion and Education.

The analysis of results, outcomes, successes and pitfalls are especially important in Health Care System to gain feedback from health care providers, the targeted communities, authorities, as a tool of Total Quality Management (Deeming principle: »Quality sells the Goods«).

The visualisation of achievements is a difficult task sometime in a given issue or period of time. The methods are not well elaborated yet. Concerning the HPH concept there were some misunderstanding with it, mostly at the first time of the implementation, in the process of accepting a new paradigm such as health promotion in hospitals. There is a formula involving the several factors which can determine a change of process in the HP Hospitals:

$$R = \frac{\pm (C + P)}{T + I}$$

where **R** is behavioural Resistance to change, **C** is transformation of Culture, **P** is shift in Power Structure, **T** is period of Change, **I** is degree of Involvement (Planning for better Health, Annie & Ken Meharg, UK.). This formula is a very interesting one, but the concrete and virtual factors involved are not very easy to estimate.

The project evaluation is extremely difficult in a such a diverse series of programmes as the 82 subprojects in the cluster of 26 Health Promoting Hospitals making a Network. These projects form 13 main classes. Up to now there is no official, institutional evaluation / audit organisation and standard for Health Promoting effectivity from planning process to outcome, since this kind of activities is a new venture, which has no precedent in hospitals. as a setting approach. Each member hospital uses so-called self-controlled empirical methods, elaborating their own system determining the specific indicators or applying other appropriate, traditional parameters in the evaluation process, but of course there is a quality control in the Hungarian Health Care system in general.

Since there is no centralised database and no unified evaluation system we put a round question to Hospitals interested, trying to get a short insight into quality control and get some information regarding project evaluation. We got from this short survey only a glimpse of the issue and not the whole. Some of the indicators monitored:

**Healthy nutrition project:** calculating the energy balance, the components of foods, counting the bioavailability, questionnaires of patients satisfaction, written tests controlling the knowledge level, making comparisons between pre- and posttraining period, measuring objective parameters of BMI, body weight, blood lipids etc.

**Antismoking programme:** control of places reserved for smoking, quality and quantity of handouts, leaflets, written material of antismoking propaganda, number of presentations against smoking, membership of Hung. Antismoking Association, follow up the decrease of diseases associated with smoking, use of dermal nicotine containing plaster for nicotine addicts.

**Nursing postgraduate training:** number of attendants, results of exams (score), patient satisfaction questionnaires, control of curriculum of courses.

**Hospital hygienic measurements:** number of nosocomial infection (HB viral infection, or other), consumption of sterilisation and disinfective, cleaning material, samples for bacterial cultures, personal hygienic protective devices, selective waste product collection, air pollution control of the annihilator to meet the National Public Health Office's standards.

**Patient's Club Movement:** estimation of knowledge level of club members using questionnaires. From time to time measuring the difference between pre and posteducational level. Estimation of self control, patient follow up: Lab tests: blood sugar, Hb1Ac, lipids, BP, spirometry liver function tests etc.

**Baby Friendly Hospital:** Family centred maternity room: number of participants, attendants of rooming-in, use of mother's milk for new-born after birth, new-born-mother tender connection, fathers presence during birth.

**Patient information:** information leaflets, newsletter for patients and family members, use of local radio and video system, library, questionnaires for getting information from patient satisfaction (monthly evaluation and feedback). Documentation of nursing care plan of nursing (Orem system).

The above mentioned parameters represent only one part of the total subprojects. There are regular follow ups, but for final evaluation the time is too short, since the average lifespan of this Network is only 2-3 years. During the National Conferences held yearly we get some information concerning the hard work of member Hospitals in this field of Medicine, which can contribute to a better quality assessment of Health Care Management in the setting approach and to identifying the needs, sources, funds and instruments.

*Ann O’Riordan*

## ***Irish National HPH Network 1998 Progress Report – Evaluation***

To date the main focus of the Network has been on structural development and the recruitment of active partners and participants in the network. In view of this evaluation has centred mainly on process rather than outcome methodologies and is more quantitative than qualitative in nature. With the implementation of the long-term network structures and the availability of technical advice and support from the two core academic institutions, input into this vital area is planned for 1998.

### ***January 1996-1998***

#### ***National Level: Focus areas***

- Membership: numbers, type of membership; Hospital types & specialities;
- Hospital activities: subproject topics, development and evaluation outlines;
- Recruitment: response (in terms of membership) to various strategies
  - a) Direct contact with hospital personnel,
  - b) Hospital visits & presentations,
  - c) Regional presentations,
  - d) Network workshops / seminars;
- Feedback (verbal) via members with regard to communication methods
  - a) HPH Bulletin,
  - b) HPH Newsletter,
  - c) Annual Report,
  - d) Information / Workshop materials;
- Income and expenditure reviews, in terms of:
  - a) Cost effectiveness,
  - b) Productivity, in terms of recruitment and development,
  - c) Future developmental needs.

#### ***Hospital level: Focus areas***

- HPH Structures: Implemented or planned,
  - a) Steering Committee, composition, meeting schedules,

- b) Project Co-ordinator, background and time allocated.
- Communication Strategies: implemented or planned.
  - a) Internal Newsletter, Bulletin boards etc.
  - b) Hospital presentations,
  - c) Awareness activities & events.
- Sub-projects: Number, type, developmental stage, evaluation methods and results.

### ***Evaluation Results***

#### ***1. Membership***

Membership	Jan 95	Jan 96	Jan 97	Jan 98
European Member	3	7	11	14
National Full Member		7	11	14
National Affiliate Member		3	5	13
National Associate Member		1	3	5

#### ***2. Recruitment Strategies & Network Activities***

Strategies	Jan 95	Jan 96	Jan 97	Jan 98
National Conference	1			(planned) Oct. 16 98
National Workshop/Seminars	1	2	1	3 (planned)
Regional Presentations		2	1	3 (2 planned)
Hospital visits & Presentations		4	15	20 (to-date)
Public Presentations		2	3	1 (to-date)
Nat. Hospital Challenge Day		22 (Hosp.)	32 (Hosp.)	(planned) Oct. 1st
HPH Newsletter x 2 yearly		1	0	(planned)
HPH Bulletin x 6 yearly		3	4	2 (to-date)
Annual Report			1	(planned)

### ***3. Hospital level – development findings Jan 98***

#### *HPH Sub-Projects*

66 sub-projects have been identified.

30 are finished, many being absorbed into the hospital routine, some in second phases and a few being once of awareness activities.

16 new projects being planned or are under consideration.

#### *HPH Hospital Structures*

7 hospitals have HPH Committees

3 hospitals are using existing structures

4 hospitals plan HPH Committees

*Most committees have broad senior management representation*

4 hospitals have designated Co-ordinator

6 hospitals plan designated Co-ordinator

*Time allocation varies 1 day / week full-time*

5 hospitals have internal Newsletters

2 hospitals plan internal Newsletters

#### ***Targets 97-98 – Achieved to-date***

- Promote regional meetings to advance the HPH concept and facilitate recruitment.
- Increase membership by 20-30 % annually; 60 % reached in 1997.
- Procure essential infrastructure to support & develop the National HPH Network.
- Secure funding for the National Co-ordinating Centre until the year 2000.

#### ***Targets 97-98 – Partially achieved***

- Assist hospitals to implement structures & processes to support HPH development.
- Develop a national database to record all appropriate HPH activities by members.
- Organise a national conference annually and 2-3 workshops / seminars a year.
- Publish a HPH Bulletin x 6 yearly and a Newsletter twice yearly.

*Sue Cruse*

***Examples of Evaluation Methods  
in Health Promoting Hospitals / Trusts  
of the North Thames Region of England***

***Hospital Discharge Support Scheme***

This scheme involves older people in peer health promotion. Older volunteers visit older patients on discharge from hospital for a six to eight week period. The impact of the scheme on the patients well-being has been assessed using a questionnaire tool, the General Well-being Index. This index is used to assess well-being both pre- and post-intervention. Although some positive shift in well-being has been demonstrated, a tool is currently being developed which is specific to the activities in which the volunteers engage. It was felt that a general index, such as the one currently in use, did not account for the particular circumstances of a recently discharged patient, whose well-being may still be threatened by symptoms of physical ill-health.

***Physical Activity Promotion among hospital staff***

A campaign was inducted over a four week period using posters and other literature, which promoted the benefits of stair climbing. Surveys were conducted before the intervention, after two weeks and again after four weeks in order to compare the use of stairs against the use of lift. At the end of the information campaign, an increase of 20 % in the use of stairs was demonstrated in a three storey building.

***Critical Incident Debriefing***

An ambulance and paramedic NHS Trust introduced mandatory critical incident debriefing in 1996. This is conducted by members of a team of trained debriefers and occurs no more than 72 hours after a critical incident. It is a 24 hour, seven days per week service. An analysis of sickness absenteeism two

years after inception demonstrated a 2.5 % reduction in sickness attributable to the scheme. Furthermore, in this period, no members of staff have cited not being able to cope as a reason for leaving the organisation. Prior to that, a minimum of one per year cited this as their reason for resigning.

### ***Low Cost Home Safety Equipment Scheme***

This scheme aims to reduce the incidence and severity of home accidents amongst the under fives. The scheme involves Health Visitors in identifying families who would be unable to buy appropriate home safety equipment due to financial constraints. These families are given the opportunity to buy stair gates and fire guards at significantly reduced prices. The intervention is being evaluated through monitoring of accident data collected at accident and emergency departments and general practitioners surgeries. The Health Visitor also visits following equipment allocation to assess whether the equipment is in use and whether there has been an increase in accident awareness through other preventive measures having been taken in the home, for example electricity socket covers, the installation of smoke detectors.

*Piero Zaina*

## ***Evaluation of the Methods Used for the HPH Projects in the Hospitals within Piedmont***

It is too early for judging the methods used by single groups; therefore we must limit ourselves to report briefly on the sessions that took place so far, deferring the presentation of the protocols to the 2nd National Conference of HPH.

The Working Group on »Hospital and Community« recognised the need of standardising the composition of the local working groups in order to favour a homogeneous approach in any setting. It has been suggested that these figures must be included in the local teams:

- 2 or more generalists or paediatricians
- 1 representative of the voluntary service
- 2 nurses
- The referendary of the training area (health education)
- 1 representative of the health direction
- 1 representative of integrated functional units (e.g. mothers-children department, mental health department).

The exchange of information between Hospital and Local Community was found to be of paramount importance.

- 1) To adopt a »personal health sheet« in which the whole clinical story of the patient may be registered. This document should be synthetic and so easy to give all pertinent information at first glance. It is quite evident how difficult it may be to include the clinical and nursing dismissal letters, the clinic reports, the integrated home health service forms and any other social or medical document in a single sheet.
- 2) Therapeutic linkage between hospital and primary care. Adoption of a nursing dismissal letter with instructions for the management of single problems (e.g. laringo-tracheotomized patients, colostomized patients, patients with bed sores). Integration between hospital and local health district
- 3) Exchange of information between hospital and local community. Circulation of information booklets on the hospital and primary care services (lists of physicians and of their associations). Projects and technical interventions under evaluation.

The working group on »smoke free hospitals«. It adheres to the first phase of the project put forward by the Italian Association of Hospital Pneumologists (AIPO) in 1997 which is based on the epidemiological evaluation of the prevalence of smoking within the health staff and the perception of the no-smoking policy of health institutions by the consumers.

Two questionnaires have been taken into account as a tool of investigation: one questionnaire to be given to the health staff; the other to be given to the consumers of the health structures: wards, clinics, day hospitals.

Following the epidemiological phase an educational and a clinical programme will be started. A third epidemiological phase similar to the previous one aimed at verifying the impact of the action carried out will conclude the research: the action will be programmed and scheduled, the operative goals the instruments and the resources will be defined and the subjects to be involved and the organisation will be designed.

The whole programme ends with an evaluation phase using progress indicators. We believe that the guidelines of the Ottawa Chart will thus be accomplished.

Working Group »Humanisation of Services«. It uses the »quality tree« included in the »General reference scheme of the Chart of Health Services« (as published in *Gazzetta Ufficiale* No 125 of 31.05.95) to check the impact of the patient with the health structure. A first draft of a working programme to be presented at the 2nd National Conference of HPH has been prepared:

- 1) to identify the moments of impact of the patient with the health structure;
- 2) to single out among the former those which produce anxiety in the patients;
- 3) to define the priorities which should be faced, both at the moment of admission and at the emergency unit;
- 4) to identify the causes of anxiety;
- 5) to define the corrective action and the priorities;
- 6) to start experimentation;
- 7) to carry out the evaluation process.

It has been evidenced that the priorities vary according to the type and the size of the Institution, however, with similar causes of anxiety in all settings. It is planned to present a project of admission protocol at the 2nd National Conference of HPH.

*Carlo Favaretti, Paolo De Pieri*

## ***Veneto Region Network of Health Promoting Hospitals – Evaluation Methods***

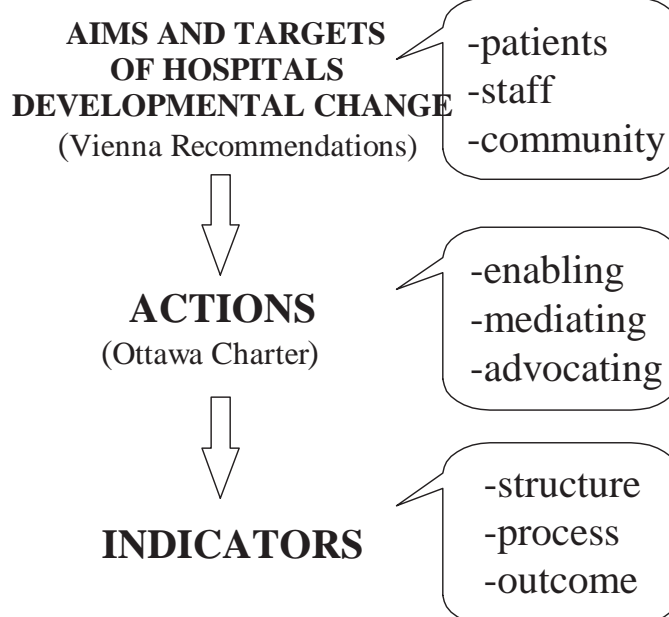
We have developed evaluation methods at two levels: single hospital level and regional network level.

### ***Hospital level***

The planning and evaluation of the HPH Project and the different sub-projects follow this scheme.

As shown in the figure, for the different actions towards patients, staff and community appropriate indicators of structure, process and outcomes are selected.

The general schemes prepared for regional subprojects (subproject chosen by groups of hospitals and planned by ad hoc teams) are the following.



<i>Actions (towards patients, staff, community)</i>	<i>Indicator</i>	<i>Type of Indicator</i>	<i>Instrument of Evaluation</i>	<i>Criterion of Evaluation</i>
Structural action	% of rooms for isolation	Structure	Archive of the project	The needs are met
Organisational action	% of accident notification forms completely filled	Process	Routine collected register	At least 90 % of forms are fully filled
Educational action	% of modified knowledge	Process	Questionnaire	+20 % of right answers

Note: examples after different projects

### ***Regional Network***

At the moment the principal efforts have been made in documentation rather than in evaluation of the regional network. In addition, it seems easier to evaluate specific subprojects than the overall regional project.

Until now we asked the hospitals to write two periodic reports: one in form of progress report, the other as control report to estimate the costs of the activities. We are discussing the feasibility of an accreditation programme.

### ***National level***

After the 2nd Italian Conference of HPH, the two regional networks in action in Italy (Veneto and Piemonte) will meet to agree on a set of common indicators and common way to document activities. In this process the Milano Network and hopefully the Lombardia Region Network will be involved.

*Brenda Stephens*

## ***Welsh Network of Health Promoting Hospitals. Evaluation Methods Used for Health Promotion in Hospitals***

### ***Introduction***

Evaluation of health promotion activity by hospitals in the Welsh Network of Health Promoting Hospitals is undertaken both at hospital and at national level as follows:

- All hospitals are encouraged to set aims and targets for each of their projects, and to ensure that activity is evaluated to inform future action. This evaluation is usually carried out within the hospital, with advice on methodology being given by either the local Health Promotion Unit or by Health Promotion Wales (the Co-ordinating Institution for the Welsh Network of Health Promoting Hospitals).
- Hospitals' work may also be evaluated externally. For example, Health Authorities may jointly commission Health Promotion Wales (HPW) to undertake an all-Wales survey into the development and implementation of ***Smoke-free Hospital*** policies, or ***Diet and Nutrition*** policies etc.
- In addition, each hospital can apply for evaluation of its progress in developing as a health promoting organisation against an agreed set of standards, i.e. it can apply for accreditation as a Health Promoting Hospital. This is a new norm-referenced scheme which has been developed and piloted in Wales. It replaces the Healthy Hospital Award.

### ***Evaluation Methods Applied at Hospital Level***

Hospital health promotion activities may be undertaken either because they are

- the subject of an NHS policy directive (e.g. developing and implementing No Smoking Policies in hospitals) or
- local priorities determined by the Local Health Authority (e.g. to address a local health problem), or
- priorities determined by the NHS Trust of which the hospital is a part (e.g. provision of training for staff on non-manual handling), or
- to meet a need identified by the hospital (e.g. to improve patient nutrition).

Whilst the evaluation method will differ for each of these, they also share a number of basic requirements for any evaluation:

- **Baseline data of the existing situation** – so that the current situation is clearly known, and future change can be measured. For economy in use of resources, it is suggested that wherever possible, hospitals generate base-line data from existing information, and also use (or adapt) pre-existing information collection as far as is practical. However, where no information exists, a base-line survey is recommended. The basic idea is that assembly of the base line information and the subsequent information collection should be kept as simple as possible – and in proportion to the size of the project being undertaken.
- **Agreed aims and targets for the activity** - so that it can be seen whether the activity has been effective. The aims and targets set should be: simple, measurable, achievable, realistic, timely.
- **Agreement on what information should be collected, at what intervals and by whom** - so that quantity and quality of activity is recorded to provide the basis for evaluation. It is essential that the base-line data, aims and targets, and range of information to be collected are agreed by both the funders and the managers of the project.

A hospital wishing to evaluate its overall progress in making health promotion integral to all aspects of its work, can undertake a hospital-wide audit using the **Good Practice Guide for Health Promoting Hospitals** together with the self-audit Checklist which has been developed for this purpose.

### ***Evaluation Methods Applied at National Level***

Evaluation is undertaken at National level when:

- Health Authorities commission HPW to undertake surveys to establish compliance with required policy development and implementation by all hospitals. Projects which exist to meet national health gain targets are of long duration and are evaluated at regular intervals. The surveys undertaken provide information to Local Health Authorities and the Welsh Office on compliance with the process and on reported behaviour change.
- Where a hospital applies to be formally accredited as a Health Promoting Hospital. Application for Accreditation as a Health Promoting Hospital is an organisational evaluation process whereby a self audit survey is undertaken by the applicant hospital, against an agreed set of standards. The hospital is then visited by a team of external assessors who validate the survey by examining written evidence and interviewing clinicians, senior managers, staff and patients. If successful, the applicant hospital will be accredited for a three year period.

*Christina Dietscher, Karl Krajic*

***The 2<sup>nd</sup> Thematic Meeting on Globalising HPH  
Provided Further Arguments that HPH Can  
Contribute to Hospital Development  
in Developing Countries***

For the 2nd time »Globalising Health Promoting Hospitals« was part of the annual International Conference on HPH in May 1998, Darmstadt (DE). The aim of the workshop was to discuss the needs of hospital development in developing countries in order to adjust the concept of HPH to the conditions in these regions. The meeting was organised by the Co-ordinating Centre with support by WHO-HQ (Geneva), in close co-operation with Dr. Ferdinand Siem-Tjam, Division of Human Resources, Development and Capacity Building, WHO Geneva, who also acted as chair. The meeting was well attended by participants from Asia, Africa, Australia, Europe and South America. In the opening, Dr. Siem-Tjam stressed the importance of globalising HPH, as by far the largest part of the world population is living in developing and third world countries. Four speakers from India, Mongolia, Palestine and Thailand presented concepts and experiences of (hospital) health care in their regions and discussed needs and problems of hospital development.

Dr. Fathi Arafat, President of the Palestine Red Crescent Association, presented a hospital project of this organisation: In a region without substantial medical infrastructure and suffering from difficult conditions (war, political tension, almost no resources available). A number of hospitals were built up in order to improve the safety of the people in the region. Dr. Arafat emphasised that these hospitals, beside the medical care they provide, also play a very important psychological role, as they allow people to feel comfortable about treatment being available if necessary. His conclusion was that the most important factor of success for such projects is the strong commitment of the people involved.

Dr. T. S. Mukhar, National Institute of Health, Mongolia, reported that Mongolia has already started to take over the HPH concept: He presented the HPH project which is currently being set up in a University Hospital as one of the initiatives of the Healthy City project in the capital Ulan-Bator. The following list of subprojects, carried out as part of the local HPH project,

shows how the comprehensive HPH concept has been adapted to the needs of this particular hospital:

- Training Centre for Community and Staff
- Repairing parts of the hospital
- Installing waste management
- Setting up a disinfection unit
- Improving freezing system.

Dr. H. S. Misra, Chief Medical Officer at IFFCO Hospital, Bareilly (India), introduced the concept of health care delivery in this remote Indian region. The results of a study on the concept show a very good health situation in the region. The most important reasons for these promising results are:

- the good primary care provided in the region, and
- the good communication between different levels of health care.

Dr. Boonchai Somboonsook, Bureau of Environmental Health, Ministry of Public Health, Thailand, explained that the most important health care problems in his country are the inefficient health care system, the low quality of services provided and the low accessibility of emergency services. Given this background, the concept of HPH is supporting hospital reform in Thailand mainly by:

- improving the quality and standards of health care services;
- promoting health care networking at all levels of health care;
- promoting staff health.

Thailand, too, already uses the HPH concept. A pilot HPH project was started at Makarak Hospital, province Karnchanaburi, applying a number of subprojects:

- Self Reliance of the Elderly: supporting the health and social situation of elderly people;
- »5 S« for a supportive hospital environment: a TQM project for hospital staff;
- Home Health Care: a network together with the local community;
- Child Health Centre: co-operation between hospital and community in order to combine kindergarten and health care;
- Environmental health in the hospital: new waste water treatment plant and waste incinerator.

As a result of the meeting, it was concluded that HPH can well play an important role for health care reform in developing countries, as both health and hospital problems seem not so different from those in Europe (e.g. quality of

care, communication between different levels of hierarchy in the health care system). The meeting also encouraged the interest in the HPH concept: A South American conference delegate expressed her interest in a deeper involvement with the HPH movement in her region. The newly set up HPH homepage of the Co-ordinating Centre should also facilitate global information, diffusion and exchange of information and expertise on HPH.

*Hari Shanker Misra*

## ***A New Concept in Health Delivery in India***

The place known as IFFCO Township where this study has been done is situated in the plains of holy river Ganga (Ganges) about 300 kms from New Delhi and 200 kms from Agra the city of Taj Mahal. This township was established in 1986. Its population in 1996 was 3,127. A giant fertilizer plant producing 5,000 tons of Urea per day is situated here. Employees working in this plant reside in this township. It is a mini township with facilities of intercom at all public places and houses, hygienic residences, own water supply, own electricity supply, school, club and other recreational facilities. This township has a centrally located 26 bedded hospital with four doctors, ten para-medical personnel and ten supporting staff.

To assess the effectiveness of medical services in the township this retrospective study has been done from 1987 to 1996. This study has been done by asking each head of the family to fill a questionnaire having questions about incidence of disease, prevalence of disease, death in the family, cause of death, birth in the family etc. This information, then was confirmed with hospital records.

When this paper was presented in the conference, it was appreciated a lot because of three very important factors:

1. Our India is a tropical country where communicable diseases are much more common in comparison to temperate countries.
2. Remote situation of IFFCO Aonla Township which is 30 kms from nearest higher centre. As a result of which at times it is difficult to make available specialised medical services to the patient.
3. Annually expenses per person are only \$ 35 (=1400 Rupees).

This study has been done on IFFCO employees and their dependent family members residing in this township. Results would have been much better provided some of the social and attitudinal factors would have been different.

No child or adult has suffered from polio myelitis, tetanus, rabies, encephalitis, diphtheria, meningitis, cerebral malaria, tuberculosis. Only one person suffered from myocardial infarction. No person has died of any communicable disease. All cases of death occurring were due to instant death in road accidents, old age, genetic or congenital diseases and cancers.

Important factors contributing to such health of residents are free medical treatment, good status of living, awareness of people, fast communication at

different levels, efficient transportation of patients in case of need, highly motivated medical staff and complete follow-up of patients.

Indicators of Health						
Parameters	IFFCO Aonla	India	USA	Switzerland	UK	Japan
Maternal mortality rate per 1000 live birth	0	4.6	0.08	0.05	0.08	0.11
Perinatal mortality rate per 1000 live birth	9.26	46	10	N.A.	10	5
Infant mortality rate per 1000 live birth		74	7			4
Child mortality rate	9.16	99	9	N.A.	8	6
Death rate per 1000 population	1.19	10	9	N.A.	11	8

#### Mortalities from 1987 to 1996

Causes of death	Number of Deaths
Senility	14
Motor vehicle traffic accidents	4
Malignant neoplasm of larynx	1
Accidents caused by fire	1
Accidental poisoning	1
Homicide	2
A V Malformation in brain	1
Ventricular septal defect	1
Malformation in G.I.T.	1
Cerebral palsy cause: difficult labour	1
Thalassemia	1
Renal failure	1
Tubercular meningitis	1
Diabetes mellitus	1
New born	3
Total	34

If diseases and complications are prevented, expenses on medical services are much less. If sincere primary/secondary care is provided to people with concern and accountability, and for secondary/tertiary care patients are referred and transferred to the right place and that quickly, results are comparable to the best set-ups. This study can be a model and opens the doors for further study and improvement.

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