

Pathways to a Health Promoting Hospital

Experiences from the
European Pilot Hospital Project
1993-1997

The Health Promoting Hospital Series

Series Editors:

Jürgen M. Pelikan, Ludwig Boltzmann-Institute
for the Sociology of Health and Medicine
WHO Collaborating Centre for Hospitals and Health Promotion

Mila Garcia-Barbero, World Health Organization
Regional Office for Europe

Vol. 2

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Foreword

J. E. Asvall

The health-for-all policy has shifted the concept of health care from the traditional idea of curative medicine to a full range of services covering health promotion and protection, disease prevention, diagnosis, treatment, care and rehabilitation. Accordingly, the patient encounters a wide range of health care providers, and also takes on a different role - moving from the dependent person to a client receiving advice, and to a consumer obtaining health products, often for self-administration.

Thus we need to look today at health in a broader context, one that brings the patient into focus as a partner involved in decisions related to his or her health. This necessarily calls for:

- tackling the priority health problems of the individual and the community to secure high quality outcomes while advocating health promotion and the empowerment of the citizen;
- creating minimum distress by providing clinical and curative care as close as possible (due account being taken to quality concerns) to the patient's own environment;
- involving other sectors that have a bearing on health and community development, including recognition of informal care services; and
- enhancing community participation.

European health care systems face new challenges, including financial and economic constraints that necessitate more effectiveness and efficiency, and greater demands from an increasing number of groups, including the elderly and chronically ill. On the other hand, the rapid development of scientific technology and the shift from traditional, curative medicine have reoriented health care systems to an approach that stresses health promotion and disease prevention as well as diagnosis, treatment and rehabilitation. This entails a wide variety of services and new roles for health care providers carried out in settings closer to the people.

In recent years, health promotion has undergone many important changes and become part of many health policies. Governments are looking at the WHO strategy for health-for-all as the framework for health gain, equity and accessible care. Health promotion strategies that were limited to certain settings and health professionals are becoming part of a broader multi-sectoral, multi-disciplinary approach. The WHO Regional Office for Europe has promoted many of these initiatives, such as health promoting hospitals, health promoting schools and healthy prisons and enterprises. Hospitals – traditionally a place for cure and care activities only – have a very interesting potential for contributing actively to health promotion as well, but this requires a different understanding of their role.

This book summarizes the work of the first twenty pilot hospitals that embraced the idea of a hospital as a setting for health promotion, and provides a good overview of the multiple programmes hospitals can undertake to improve the health of their staff, patients and relatives.

Introduction

Mila Garcia-Barbero

Hospitals in Europe need to make important changes to adapt to the challenges that are presented to them by the health care reforms in every country. Many governments are reviewing their health care systems, focusing on effectiveness and efficiency to increase availability, patient satisfaction and quality of care. The Ljubljana Charter (WHO-Regional Office for Europe 1996) on Reforming Health Care is based on the principle that health care should first and foremost lead to better health and quality of life.

Hospital reforms are driven mainly by four factors: the rapid development of high technology, the need to reduce costs, the new market orientation and the higher demands and expectations of the population. A substantial part of the health care reform debate revolves around the moral imperative of maintaining health as a social good, and the fiscal imperative of controlling costs (Saltman, Figueras 1997).

The development of high technology for diagnosis and treatment is changing the face of hospitals, diminishing the number of beds needed (Figure 1.) and the length of stay (Figure 2.), which provides opportunities for increasing hospital admissions. This increases hospital expenditure, extending the number of interventions and performing more complicated and costly ones (Figure 3.). While hospital expenditure increased steadily during the 1980s, along with expenditures on health, the trend now is to prevent further increases or even to decrease spending (Figure 4.).

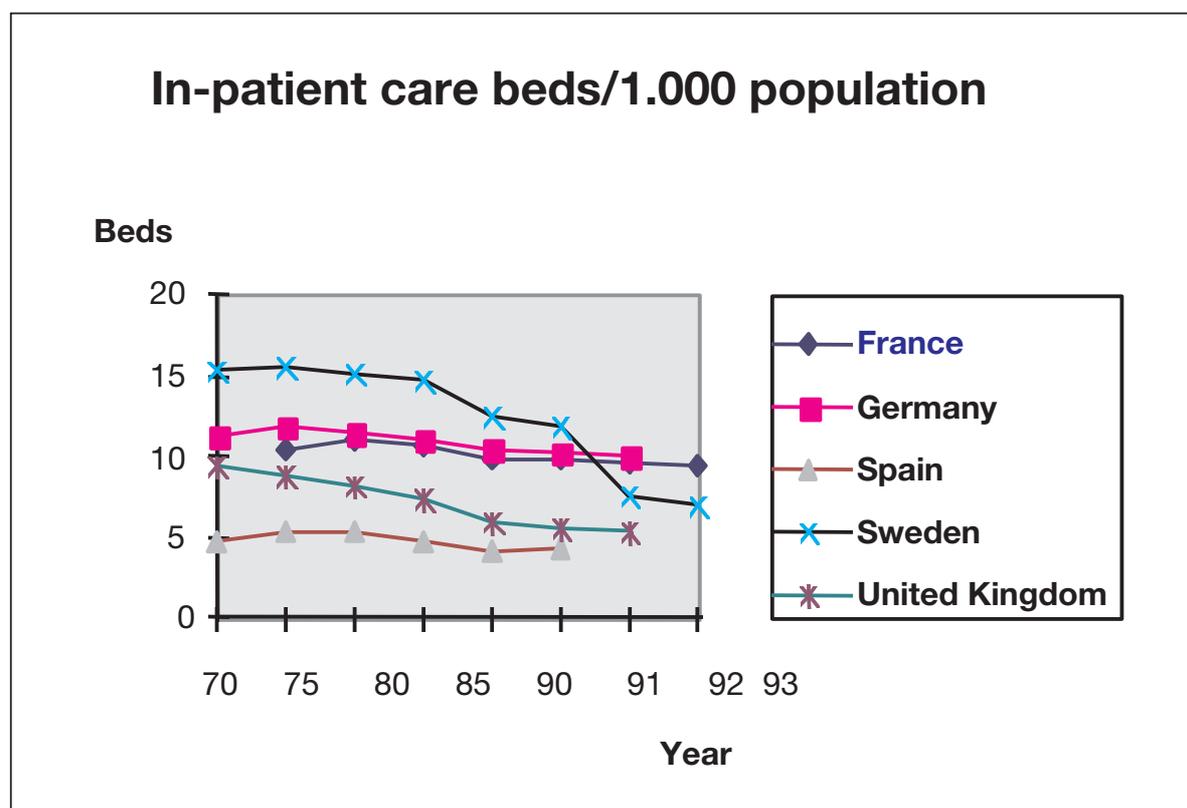


Figure 1: Decrease of in-patients care beds in selected European countries

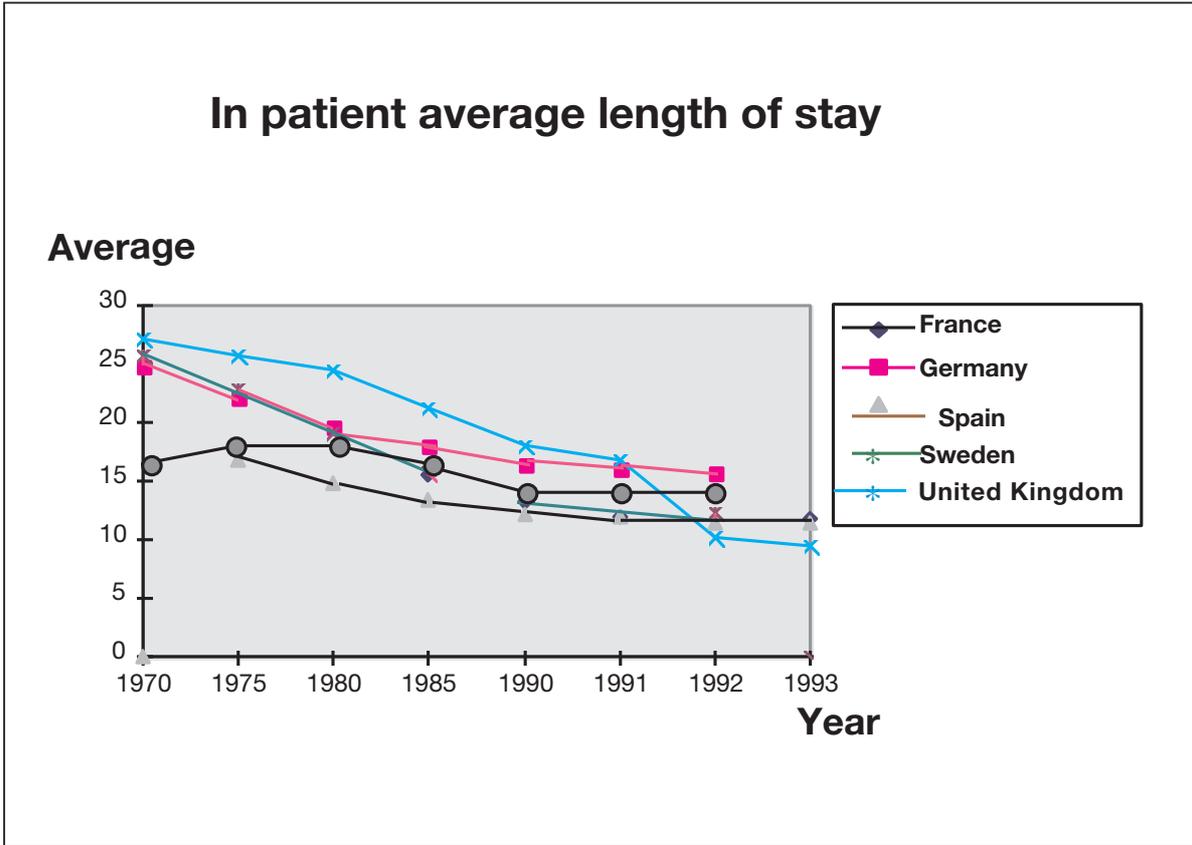


Figure 2: Decrease of in the average length of stay in selected European countries

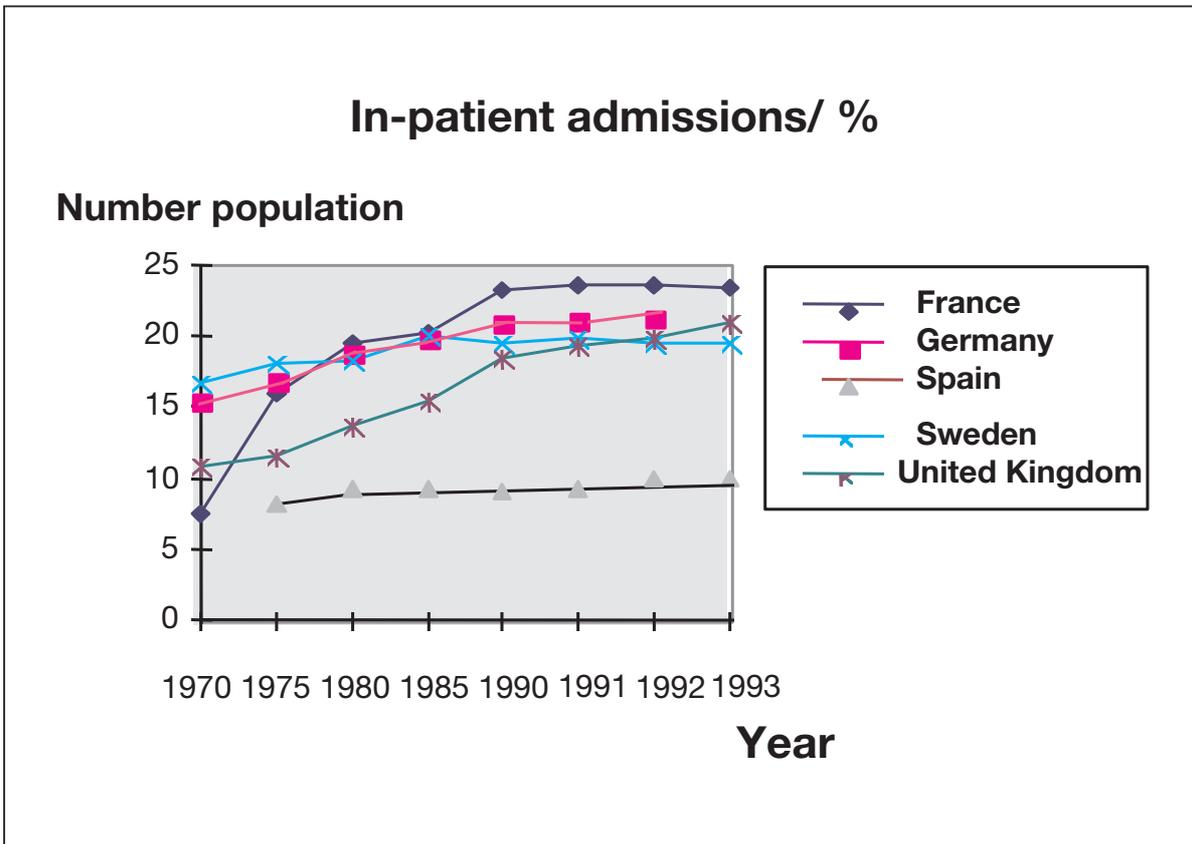


Figure 3: Increase of in-patient admissions in selected European countries

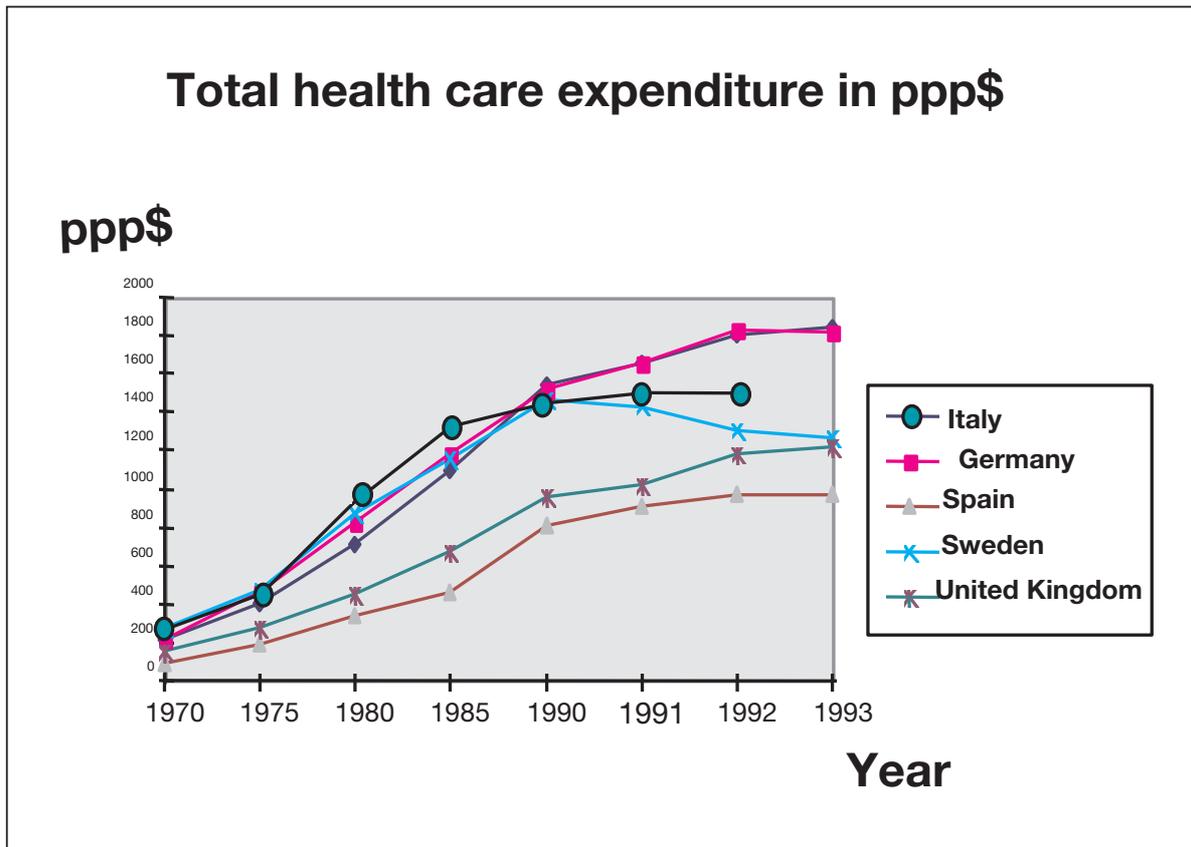


Figure 4: Increase of total health care expenditure in proportional part of gross national product in selected European countries

The second point are the increasing demands of the population, including requirements for information and participation in the decision-making process. This increases pressure for a change in the relationship between patients and health care practitioners, managers and administrators. The traditional paternalist approach to patients has to change into a partnership. Charters and bills of patients' rights are being passed or used in several countries in Europe, forcing health systems to take new approaches to health care (WHO-Regional Office for Europe 1997a).

The third point is the need to direct the health care sector toward a market-oriented system, focusing on the relations between resources and providers, purchasers and users. Efforts in this area focus on the outcomes, efficiency, effectiveness and efficacy of care.

As main consumer of health care resources in the health care system, hospitals are encountering a difficult situation in most countries. The time when hospital budgets could cover every need, and losses were covered by insurance or the state is coming to an end. Hospitals must be accountable for their expenditures; they have to provide better services at minimum cost, and they have to comply with the increasing demands of patients, relatives and the community. Further, patients' freedom to choose different health institutions and the packages offered by health insurance schemes put extra pressure on hospital management.

In response to the changing environment, hospitals are embarking on new trends of

development that mark a break with the past. This development is moving in two different and almost opposite directions: towards a highly technological institution, devoted exclusively to diagnosis and treatment, and towards health centres providing health promotion, disease prevention and rehabilitation as well as curative services (Garcia-Barbero 1994).

Growing competition between secondary and tertiary care, and ambulatory care providers threatens the revenue basis of hospitals and diminishes the differences between the levels of care. Primary care practitioners are performing interventions that were reserved for hospital personnel ten years ago, and hospitals provide services traditionally carried out by primary care providers. Hospitals tend to either increase their outpatient and ambulatory services in an effort to check the flow of patients towards alternative provider settings, or to become highly technical institutions with which primary care cannot compete.

In addition, the new philosophy of moving hospitals as close as possible to the population they serve, not only in physical terms, but also in meeting patients' and community needs, makes them redefine their functions and roles and even their physical structures and architectural design. Such terms as "hospitals without walls", "hospitals without beds", "day-care hospitals", and "hospitals at home" indicate clearly the direction of the shift in hospital structures. The big hospitals that were built in the 1960s and have around 2000 beds are being transformed into reference centres. New hospitals are smaller and closer to the communities, with fewer beds and better and more comfortable day-care facilities. Some hospitals are converting some of their facilities into residences or hotels where patients who need treatment that does not require hospitalisation can stay between sessions. The day care hospitals are trying to accommodate patients who need some kind of supervision during the day – such as chemotherapy, minor surgery or some diagnostic procedures – but do not need to stay in the hospital unless complications arise.

General hospitals are being split into two types: the acute and the chronic. The acute hospitals try to maximise the use of their high-technology equipment, reducing the number of beds and the length of stay to the minimum possible, while those for chronic care provide better hotel facilities and care better fitted to the needs of their residents.

To facilitate the new hospital orientation towards the broad concept of health, to generate health gain in line with the WHO health for all strategy (WHO-Regional Office for Europe 1992), the WHO-Regional Office for Europe (WHO) started a project in 1989 called Health Promoting Hospitals (HPH), building a network of hospitals that have incorporated the idea of health promotion into their practice to a larger or smaller extent. The term may be confusing and many hospitals will argue that their function is not health promotion. Through health promotion, the project is trying to promote total quality management of the hospital. The concept of the Health Promoting Hospital is based on the Ottawa Charter for Health Promotion (WHO-Regional Office for Europe 1986), which calls for restructuring the health services and providing supportive environments, with the aim of complementing curative care by many services to ensure the well-being of hospital staff, and patients and their relatives.

The HPH project seeks:

- to incorporate the concepts, values and standards of health promotion into the organizational structure and culture of the hospital;
- to facilitate and encourage cooperation and the exchange of experience and programmes between the participating hospitals;
- to broaden the focus of hospital management and structures to include health care, not just curative care;
- to develop documented and evaluated examples of good practice for the use of other institutions; and
- to identify areas of common interest in which to develop programmes and evaluation procedures (WHO-Regional Office for Europe 1997b)

The concept of a hospital as a health promoter does not mean that it has to change its main function from curing to health promotion, but that it can incorporate into its culture and daily work the idea of health promotion for its personnel, its patients and their families.

The first attempts to connect hospitals with health promoting policies date back to the late 1970s, when the American Hospital Association issued a statement encouraging the development of health promoting services within the hospitals; by 1979, 32 public health units were introduced in Quebec hospitals (Pineault R. et al. 1990) and the Australian Health Targets and Implementation Committee indicated the need for a better distribution of resources and services to promote the health of the community including the hospitals (Tyler, James 1988).

Hospitals are obviously not the main agents in health promotion. As institutions in which a large number of people work and visit for care, however, they can reach a large sector of the population. As centres that practice modern medicine, research and education, and accumulate a lot of knowledge and experience, they can influence professional practice in other centres and social groups. As producers of large amounts of waste, they can contribute to the reduction of environmental pollution; as consumers of large amounts of products, they can favour healthy products and environmental safety.

The hospital can be a centre of excellence for the development of concrete programmes that focus on improving the quality of health care working conditions and satisfaction for staff, patients and relatives through an ample spectrum of strategies. The variety of possible programmes is almost infinite, ranging from the provision of health promotion services for healthy lifestyles, health education programmes (including psychological aspects of patient rehabilitation programmes), open facilities for physical exercise and space for meetings of patients and relatives through the improvement of board and lodging facilities, to the reduction of environmental pollution through better control of hospital waste.

In summary, the concept of a hospital as a health promoting institution, which could suggest a complete change of functions, seeks to improve the performance of hospitals by broadening their scope through a comprehensive approach to health gain for staff, patients and their relatives.

References

- Garcia-Barbero M. (1994): The Health Promoting Hospitals Movement. *Journal of European Private Hospitals*, April 1994: 33–36
- Pineault R. et al. (1990): Health promotion activities in Quebec Hospitals: A comparison of DSC and non-DSC hospitals. *Canadian Journal of Public Health*, 81: 199–203
- Saltman R.S., Figueras J. (ed.) (1997): *European Health Care Reform: Analysis of current strategies*. WHO Regional Publications, European Series, No 72. WHO-Regional Office for Europe, Copenhagen
- Tyler C., James R. (1988): What should hospitals be doing in health promotion services? *Australian Health Review*, 11: 182–185
- WHO-Regional Office for Europe (1986): *Ottawa Charter for Health Promotion*. Copenhagen
- WHO-Regional Office for Europe (1992): *Health for all targets. The Health Policy for Europe*. European Health for All Series, No 4. Copenhagen
- WHO-Regional Office for Europe (1996): *The Ljubljana Charter on Reforming Health Care*. Copenhagen
- WHO-Regional Office for Europe (1997a): *European Health Care Reforms. Citizen's Choice and Patients Rights (Document ICP/CARE 94 01/CN01)*. Copenhagen
- WHO-Regional Office for Europe (1997b): *Health Promoting Hospital Network Information Package (Document ICP/DLVR0301)*. Copenhagen

Structure, Process and Outcome of the European Pilot Hospital Project – A Summary

Jürgen M. Pelikan, Hubert Lobnig, Karl Krajic, Christina Dietscher

Introduction

Which questions are going to be discussed?

WHO-Regional Office for Europe launched the European Pilot Hospital Project of Health Promoting Hospitals (EPHP) as a specific action programme within the International Network of Health Promoting Hospitals with the aim to test the feasibility of putting Health Promoting Hospitals into practice. The project formally started in Warsaw, April 1993, and ended with the 5th International Conference on Health Promoting Hospitals and the final Business Meeting of the project in Vienna, Austria in April 1997.

This chapter will focus on the following aspects of the project: Firstly, the project will be characterised by a short chronology, a description of the vision and aims, and the partners and the techniques will be chosen. Secondly, the success of the project will be discussed and thirdly, the question will be addressed what hospitals, health politicians and health promotion experts can learn from the experiences of the EPHP¹.

The following description and analysis is very much related with the specific character of the EPHP, which can be described as:

- primarily a project of social innovation, accompanied and supported by consultation and research – not a research project in itself;
- a project attempting to realise, document and evaluate the implementation of health promotion in hospitals, not a study on the effectiveness or even the efficiency of health promotion;
- a European network of co-production, a virtual organisation, an alliance of 22 very different partners;
- a project developed with the partners' own resources, supported by international leadership and co-ordination, but not by international funds – the partners used their own budgets;
- a learning consortium, mainly using exchange of experiences and mutual counselling, supported by some analysis of documented data and not a multi centre study with an experimental design.

These principles also have an impact on the methodology applied and the analysis which are presented in this chapter. Firstly, the approach focuses on summative documentation and evaluation of the European Pilot Hospital Project, based on various data which were collected during the project: interim surveys focusing a variety of

¹ The analysis presented in this chapter has been supported by the “Hochschuljubiläumsstiftung der Stadt Wien”, Vienna Austria, in the framework of a project named “Das Krankenhaus als Setting für Gesundheitsförderung”, Nr. 00243/96.

aspects of the participating hospitals and their sub-projects, meta-analysis of records and reports, analysis of presentations and minutes of Business Meetings, papers presented at International Conferences and reports published in the International HPH Newsletter and several interviews.

As the evaluation is summarised by the team of the Co-ordinating Centre which was involved also as co-ordinator of the project, its character can be seen as internal evaluation. Internal evaluation benefits from direct access to considerable knowledge of the measures taken, activities set and impacts which were achieved. In addition, internal evaluation provides relevant impact for the organisation itself, as it addresses the questions which are of utmost relevance for the most important stakeholders (see Love 1991). On the other hand internal evaluation faces the problem of a less distant perspective to what is evaluated and therefore often may be less critical to what was achieved. The authors tried to handle these problems by presenting drafts of this analysis at the 5th International Conference on Health Promoting Hospitals (Pelikan et al. 1998), where delegates of the pilot hospitals, WHO and international experts were present and considered critical remarks for the further analysis of the material.

Related with the specific character of the EPHP it also becomes evident, that there was a preference for qualitative methodology. Quantitative data are used to support the evaluation in illustrating specific developments. In addition the analysis focuses on process rather than on outcome in developing a pilot scheme for Health Promoting Hospitals, where the question on how specific results were achieved becomes of central importance.

To conclude the methodological remarks: as the project design focused a complex, open and dynamic multi-organisational co-operation project, evaluation strategies based on experimental design or clinical trial studies could not be applied.

The concept: What is a health promoting hospital?

On a general level, health promoting hospitals aim to develop the hospital into a more health promoting setting, following the principles of the Ottawa Charter for Health Promotion and a model provided by the Budapest Declaration on Health Promoting Hospitals (see Appendix). There are four basic principles which can characterise this reorientation:

- Reduction of disease + *improvement of health*
- Extension of target groups: the health promoting hospitals concentrate on four main areas of project development: Patients + *staff* + *population in the community* + *hospital organisation as a social system* (see Table 1).

Table 1: The four areas of Health Promoting Hospital projects

Programmes for hospital patients	Programmes for hospital staff
Programmes for the local community	Programmes for developing the hospital into a „healthy“ organisation

- Combination of personal + *organisational development* strategies;
- Development through introduction of new services + *reengineering of existing services*.

What does this mean in practice? The following list shows possible health promotion interventions within the hospital for patients, staff, the community population and the development of the hospital into a healthy/health promoting organisation, as they were also implemented by the hospitals participating in the EPHP.

What can be done to improve patients' health?

Develop/re-engineer core services of the hospital: medical (diagnostic and therapeutic), nursing and hotel services, oriented at the following aims:

- Reduce risks;
- Improve the quality of professional interventions;
- Improve the quality of life and well-being of patients in the hospital.

Accept responsibility for the health of patients after discharge:

- Extend rehabilitation measures to improve healing and recuperation processes;
- Extend educational measures: inform, consult, train and empower for prevention and coping with chronic disease and disability;
- Co-operate with other providers in the health care chain;

Increase health gain/ outcome orientation:

- Select services according to the health gain they provide;
- Re-allocate available resources towards those areas that will provide a maximum of health gain.

What can be done to improve health of hospital staff?

- Put health of staff on the agenda of the hospital;
- Develop (re-engineer) hospital work so that health risks are reduced and health potential of the personnel are fostered;
- Offer compensatory programmes where necessary.

What can the hospital do to improve the health of the population in the community?

- Develop (re-engineer) the hospital to reduce ecological risks for the community;
- Offer community-oriented services and programmes;
- Provide a database as a basis for community action programmes;
- Form healthy alliances.

What can the hospital do to become a more „healthy“ organisation?

- Develop (re-engineer) the hospital into a „learning organisation“ with better coping abilities and strategic orientation;
- Improve the co-production between hospital units, professions and levels of hierarchy;
- Improve cost-effectiveness and efficiency of hospital services.

The European Pilot Project of Health Promoting Hospitals

Setting up the project – chronology of the development of the EPHP

In a first phase of the project, the concept of health promoting hospitals was outlined and an international network was initiated.

- In 1988, following a first international consultation on the possibilities of Health Promotion in and by the hospital at the WHO-Regional Office for Europe in Copenhagen (Milz/Vang 1989), WHO Regional Office for Europe invited the City of Vienna and the Ludwig Boltzmann Institute for the Sociology of Health and Medicine (LBI) to prepare a first Model Project in a Vienna hospital.
- In 1989, a next international workshop was held in London/Bloomsbury for further discussion of the concept.
- In the same year, after a preparatory study, the model project „Health and Hospital“ was initiated (see Nowak et al. 1998).
- In September 1990, the social kick-off meeting for the International Network of Health Promoting Hospitals took place at a joint workshop of WHO-Euro and the City of Vienna, involving a group of interested international partners, including hospital managers, medical directors, representatives of health care authorities, (co-ordinators of) Healthy Cities Projects, experts in public health, health promotion, nursing and organisational development. A common social frame of reference for the international project of Health Promoting Hospitals as a Multi City Action Plan of the Healthy Cities Project was developed, the LBI was appointed as Co-ordinating Centre.

In a second phase, the concept was detailed and interested hospitals for the European Pilot Hospital of Health Promoting Hospitals were recruited.

- A common concept was developed and criteria for participation were set up in a meeting in Budapest (1991), where 44 experts from 10 countries developed and launched the "Budapest Declaration on Health Promoting Hospitals" (see Appendix). The Budapest Declaration also included the first explicit commitment of project partners (hospitals, WHO, LBI) to participate in developing models of good practice within the International Network of Health Promoting Hospitals.
- Two further preparatory meetings (Barcelona 1991 and Milan 1992) were organised to discuss the next steps and to recruit additional partners; an Advisory Board was set up at the Meeting in Milan to support WHO and the Co-ordinating Centre LBI in recruiting partners, in defining an application and screening procedure for potential members, and in starting a final snowball process for recruiting interested hospitals (see list of members on page 38).
- In the following an application process started in many European countries; the application involved the formal acceptance of the Ottawa Charter and the Budapest Declaration on Health Promoting Hospitals, as well as the development of a project plan; applications were screened by members of the advisory board, WHO and the Co-ordinating Centre.
- At the 4th Preparatory Meeting (Dublin, September 1992) a formal decision for a two-pronged strategy – the European Pilot Hospital Project (EPHP) as a means to

test and further develop the potential of the concept of Health Promoting Hospitals – and a more open network strategy – was taken.

- The final recruitment and screening procedures for the EPHP were carried out between September 1992 and April 1993.
- In April 1993 the first Business Meeting of the European Pilot Hospital Project was held in Warsaw. The most important issues of the meeting were the negotiations between the partners on common goals and structures of the project; 17 accepted and 3 potential partner hospitals participated.
- Last decisions on participation were taken between May and October 1993.
- At the 2nd Business Meeting in Hamburg in October 1993, a final discussion of the concept led to an agreement for a 4-year project period with 20 participating hospitals, which was signed by the partners in the following months.

This phase of recruiting partners was followed by the implementation and realisation of the project (1993-1997). Table 2. gives an overview of the most important milestones of the European Pilot Hospital Project.

Table 2: Central Milestones of the EPHP 1988–1997

Date, venue and number of participating countries / hospitals / institutions		Title of Event
1988 Copenhagen 5 countries	WHO-Euro Consultation	„Hospitals and Health Promotion“
4/1989 London 7 countries	Joint Workshop WHO-Euro/ Bloomsbury Health Authority	„The Health Promoting Hospital“
11/1989	Official start of the Vienna WHO-Model Project	„Health and Hospital“
9/1990 Vienna 10 countries	WHO-Euro Workshop	„Hospital and Health“
6/1991 Budapest 10 countries	1st Business Meeting HPH	„Next Steps on the Way to the Health Promoting Hospital“
9/1991 Barcelona 7 countries, 7 hospitals/cities	2nd Business Meeting HPH	„Health Promoting Hospitals as a Means for Reorienting Health Services“
3/1992 Milan 12 countries, 40 hospitals/cities	3rd Business Meeting HPH	„Specific Areas of Concern for Health Promoting Hospitals: Occupational Health and the Relationship to the Community“
9/1992 Dublin 12 countries, 65 hospitals/cities	4th Business Meeting HPH	„Improving the Implementation and Outcomes of Health Promoting Hospitals: Project Management and Evaluation“
4/1993 Warsaw 14 countries, 78 hospitals	1st International Conference on Health Promoting Hospitals	„Establishing New Structures of the Network: The European Pilot Hospital Project + Tobacco Free Hospitals“

Table 2: Central Milestones of the EPHP 1988–1997 (Continued)

Date, venue and number of participating countries / hospitals / institutions		Title of Event
4/1993 Warsaw 11 countries, 12 hospitals	1st Business Meeting of the EPHP	„Setting up the European Pilot Hospital Project: Developing Common Goals, Strategies and Structures“
10/1993 Hamburg 11 countries, 20 hospitals	2nd Business Meeting of the EPHP	„Next Steps in the Development of the Pilot Hospitals and the European Project: Consultation, Documentation and Evaluation“
4/1994 Padua 16 countries, 90 organisations	2nd International Conference on Health Promoting Hospitals	„Developing Health Promoting Organisations by Strengthening Intersectoral and Community Action of Hospitals + Healthy Nutrition Policies for Hospitals“
4/1994 Padua 11 countries, 20 hospitals	3rd Business Meeting of the EPHP	„Exchange of Experiences: Visibility, Involvement of Staff, Evaluation, Partnerships“
10/1994 Glasgow 10 countries, 19 hospitals	4th Business Meeting of the EPHP	„Mid-term Perspectives: Did We Realise 50% of Our Intentions in the First Half of the Project – or More?“
5/1995 Linköping 17 countries, 130 organisations	3rd International Conference on Health Promoting Hospitals	„Health Gain Measurements as a Tool for Hospital Management and Health Policy + Regional and National Networks as Strategy for HPH“
5/1995 Linköping 11 countries, 20 hospitals	5th Business Meeting of the EPHP	„Overall HPH-Project Evaluation and National/Regional Networking“
11/1995 Hildesheim 11 countries, 18 hospitals	6th Business Meeting of the EPHP	„Health Promoting Hospitals in Practice – Developing National/Regional Networks“
4/1996 Londonderry 19 countries, 160 organisations	4th International Conference on Health Promoting Hospitals	„Health Promoting Hospitals: A Vision for Development in Times of Change“
4/1996 Londonderry 10 countries, 19 hospitals	7th Business Meeting of the EPHP	„Fund raising, Sustainable Development, Economic Evaluation of HPH Projects“
10/1996 Prien 10 countries, 19 hospitals	8th Business Meeting of the EPH	„Quality of HPH Projects, Final Documentation, Future Developments of the EPHP“
4/1997 Vienna 31 countries, 170 organisations	5th International Conference on Health Promoting Hospitals	„From Projects to Networks: Effectiveness, Quality Assurance and Sustainability of Health Promoting Hospital Projects“
4/1997 Vienna 10 countries, 19 hospitals	9th Business Meeting of the EPHP	„Final Business Meeting of the European Pilot Hospital Project of Health Promoting Hospitals“

Why a European Pilot Hospital Project of Health Promoting Hospitals?

During the preparation of the European Pilot Hospital Project, a step by step approach was applied, from a rather open network with different levels of commitment and "status" in the network ("model hospitals", "potential model hospitals", "participation with individual projects" and "observers"; cf. WHO-Euro & LBIMGS 1991) to a closed Pilot Hospital Project for 20 partners and an open network for other hospitals and partners who could not participate in the EPHP.

Why the decision for a European Project and not just model hospitals in a loose network?

- The closed project structure allowed for manageability of co-operation and frequent exchange in a larger group.
- The project structure was considered a means of guaranteeing quality, as it allowed mutual learning and support by the 20 hospitals within an European exchange, supported by WHO's leadership and expertise and facilitation of LBI as Co-ordinating Centre.
- The specific reputation and support offered by WHO in providing the status of a Pilot Hospital (and not that of a "normal member") was seen as an additional stimulus for involvement and investment in the project.
- As hospital environments are very dynamic, the continuing structures of the EPHP and the stable European support were considered an important means of achieving high quality and sustainable results.
- The concept and framework were designed to be open enough to allow for individual specifications of HPH projects on the local level, according to the specific needs and interests of the pilot hospitals in their environments.
- The project design made it possible to get clear results within the project period.

The Partners of the EPHP: 20 Pilot Hospitals, WHO-Euro, LBI as Co-ordinating Centre

The 20 European Hospitals and why they participated in the EPHP

20 Pilot hospitals from 11 European countries (see Figure 1) and thus from different health care systems signed the agreement of the European Pilot Hospital Project. The participating hospitals' sizes and specialisations are very diverse, covering a range from big inner city university hospitals to small rural rehabilitation centres (see Tables 3 and 4). This diversity in hospitals was chosen to test whether the concept of „Health Promoting Hospitals“ is feasible in different types of hospitals and in different European health care systems.

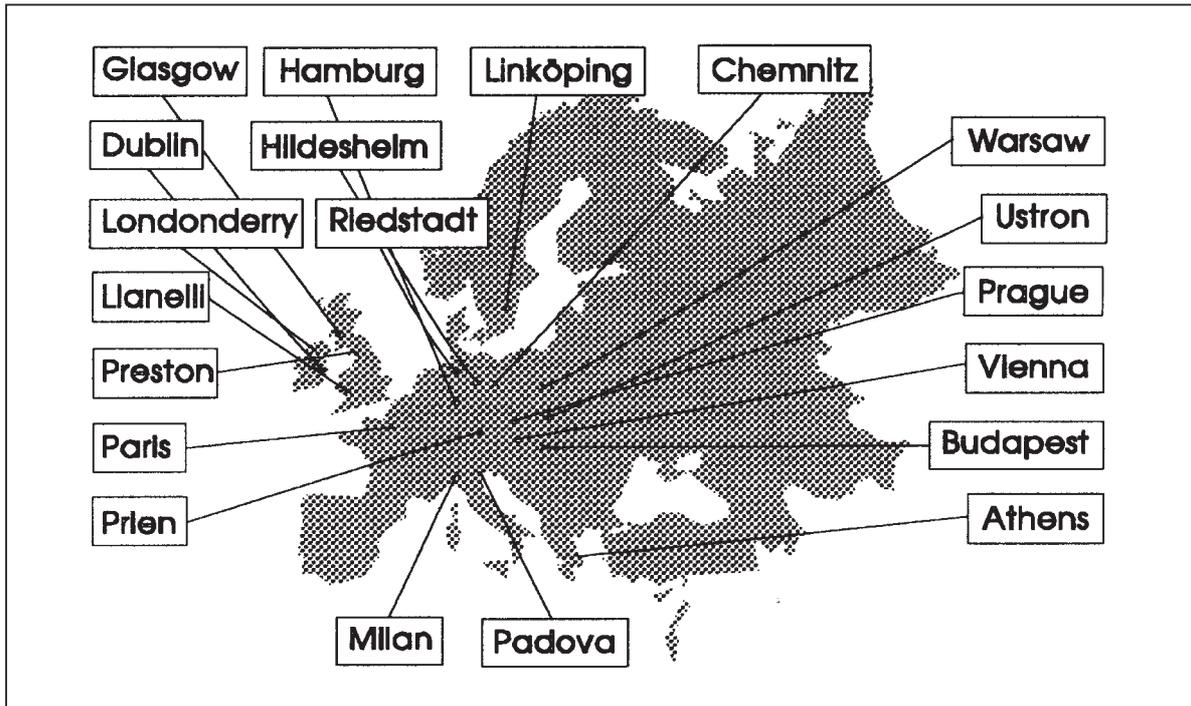


Figure 1: European map and the Pilot Hospitals

Table 3: Size of participating hospitals (by number of beds)

Size of participating hospitals	Number
–200	2
201–500	9
501–1000	5
1001–2000	2
2001+	2

Table 4: Types of participating hospitals

Type of participating hospitals	Number
General	12
Specialised	8
Children	2
Geriatrics	1
Intensive Care	1
Psychiatry	1
Pulmology/Cardiology	1
Rehabilitation	2

The Pilot Hospitals had a number of common motives to join the network, such as the intention of improving services for their patients, further developing the working environment for their staff, being prepared to accept more responsibility for the health

of their patients and their community, and also wishing to co-operate with WHO, other European hospitals and international experts. Some hospitals aimed at innovative changes in their hospital organisations, others rather were looking for a common European umbrella for already established ongoing health promoting and quality development project activities.

The common concept and aims of the European project were agreed upon in 1993 in a process involving not only the hospital management, but also the staff of participating hospitals. A formal consent was requested as part of the application procedure.

The overall aim on the European Project level reads as follows: „The European Pilot Hospital Project is an International Project designated to support the development of Pilot Hospitals for Health Promoting Hospitals as Models of Good Practice, following the concepts for Health Promoting Hospitals developed in the 'Budapest Declaration on Health Promoting Hospitals'. The European Pilot Hospital Project will assist the participating Pilot Hospitals in developing towards Health Promoting Organisations for patients, personnel and the community.“ (WHO-Regional Office for Europe, LBI for the Sociology of Health and Medicine 1993).

In addition, the project aimed at developing knowledge on how and with what impacts health promotion can be linked with the hospitals as the central institution of the health care sector and how the experiences from different types of hospitals and in different health care systems can be compared. As the transfer of the experiences was seen as very important from the beginning, creating visibility was an essential task for the hospitals involved as well as for WHO and LBI. Thus the partners involved aimed at providing other interested institutions and experts access, and at contributing to the development of national/regional networks of Health Promoting Hospitals.

But there were also several specific motives, based on national and local challenges they were facing, such as health care systems becoming more competitive, hospitals facing a shortage in specific health professions (e. g. nursing), rising expectations of consumers and politicians, rising professional expectations for quality assurance/quality improvement, as well as the fact that national health care policies are increasingly oriented towards health gain.

What were the tasks in the European Project and how were they distributed?

The Pilot Hospitals agreed to develop local projects, based on a set of common provisions to meet four basic challenges of all projects and to safeguard a minimum of comparability of the projects.

a) How to initiate the developmental process for a Health Promoting Hospital?

The Pilot Hospitals agreed to develop comprehensive Health Promoting Hospital projects, aiming at the development into health promoting settings. The main strategy was to define, initiate and conduct action programmes in all developmental areas of a Health Promoting Hospital (see Table 1.) and to use participatory organisational development and project management techniques. Concerning project management, that included defining goals, strategies, schedules, defining specific space, time and resources for the realisation of the project, selecting specific areas for

action (at least 5 innovative sub-projects; see below) and defining criteria for success. The hospitals also agreed to conduct their projects in co-operation with external partners (mainly from social sciences, health promotion, evaluation research and/or organisational consultancy), in order to support the initiation and realisation with their expertise and protect the developmental process against the pressures of everyday hospital routine.

b) How to sustain a comprehensive developmental process within the whole organisation?

The hospitals agreed to use a participatory design in defining problems and solutions, including all groups affected by the activities, design decision-making processes as transparently as possible, select areas for action which relate to the problems the staff perceives as important, set up interdisciplinary, interprofessional and inter-hierarchical project groups, use top-down and bottom-up strategies simultaneously, regularly report on project development through internal newsletters and public presentations and develop innovative media of internal communication.

c) How to achieve the status of a model of good practice?

The hospitals have agreed to pay special attention to demonstrable goal achievement: set up documentation and evaluation from the very beginning, document and evaluate results, as well as process and procedures, and discuss successes and also failures.

The hospitals also agreed to create visibility for processes and results: inform and involve decision makers on the local, regional and national level, organise public presentations, present concepts and experiences at meetings and conferences, open up the project to public media, and publish articles in professional journals.

d) How to collaborate in a joint European Project?

The 20 Pilot Hospitals have agreed to participate in 9 semi-annual Business Meetings, to report on their local projects at these meetings, to discuss their experiences with the partners and to contribute to a final report². The hospitals have also agreed to share the task of hosting the 9 Business Meetings among each other; four of the twenty partners have already hosted preparatory meetings for the project.

Not only the hospitals but also WHO and the Co-ordinating Centre took specific responsibilities and provided specific contributions.

The Department of Health Services and the Department of Lifestyles and Health of the WHO Regional Office for Europe, Copenhagen, were active in recruiting hospitals, provided strategic leadership and gave WHO reputation as a central asset of the project. More specifically WHO-EURO agreed to:

- provide political and strategic leadership and to give technical support to the project;
- co-ordinate the project in co-operation with the Co-ordinating Centre;

² The Case Studies and the overall analysis chapters are summarised in this publication which was previously called „The Review Book“.

- organise semi-annual Business Meetings and an annual conference on Health Promoting Hospitals in co-operation with the Co-ordinating Centre;
- monitor and evaluate the project in co-operation with the Co-ordinating Centre.

The Ludwig Boltzmann Institute for the Sociology of Health and Medicine, and the WHO Collaborating Centre for Hospitals and Health Promotion supported the project by providing co-ordination, technical support and expertise. This was made possible through funds granted by the Austrian Federal Ministry for Health. The Co-ordinating Centre (LBI) confirmed to take responsibility for the following functions:

- giving advice and technical support in co-operation with WHO-EURO;
- providing administrative support (project secretariat) and raising funds for the project administration;
- organising semi-annual Business Meetings and an annual conference on Health Promoting Hospitals;
- issuing an international circular letter and a series of working papers on Health Promoting Hospitals;
- preparing a final publication on the European Pilot Hospital Project.

Structures and techniques used in the development of the European Pilot Hospital Project

As described above, a number of common structures on the European project level, as well as on the local project level were set up. As tools and media for the project they provided the central framework of what can be seen as a soft bench-marking process involving the pilot hospitals as the central group where the projects were put in practice with WHO and LBI giving strategic leadership and support.

Business Meetings

Nine semi-annual business meetings in the project period from 1993–1997 were defined as central milestones of the European Pilot Hospital Project. Participation in these meetings was declared obligatory for the participating hospitals. As a standard, a delegation of two persons per hospital was recommended and the duration was one and a half days. The hosting of Business Meetings rotated between the participating hospitals.

The functions of the Business Meetings can be summarised in the following points:

- Discussion of open questions of the European project, decision-making on common goals, standards and procedures;
- Discussion of general issues of the further development of the Health Promoting Hospitals concept and movement;
- Regular reports of progress and problems in the local overall project and sub-project development and discussion of so-called "Progress Reports" provided by every hospital. On this basis the Co-ordinating Centre and WHO provided a summary report on progress and problems;

- Bilateral and multilateral exchange of experiences gathered on the local level (overall projects and sub-projects);
- Mutual consultation;
- Technical support and supervision provided by WHO, the Co-ordinating Centre and members of the group;
- Peer review of the local projects that hosted the meeting by the delegates of the other hospitals;
- Support of the local project through the momentum an international business meeting creates (European and WHO recognition of local work becomes visible).

Participation of the hospitals in the business meetings was very regular – only one hospital was absent more than once, and most hospitals were present at all meetings. The issues discussed varied according to the state of project development – at the beginning the common goals and the form of co-operation on the European level became predominant topics; in a later phase the project implementation on the local level was discussed; starting from the second Business Meeting, documentation and evaluation were important issues, and finally questions of quality assurance and the sustainability of Health Promoting Hospitals projects became of importance (see also the titles of the meetings given in Table 2).

Presentations at International Conferences on Health Promoting Hospitals

The Pilot Hospitals had confirmed they would present their experiences at the Annual International Conferences, in order to make their experiences also available to other hospitals and organisations outside the European Pilot Hospital Project and to expose the projects to external discussion and allow for an exchange of experiences. Table 5 shows the number of pilot hospital presentations at the International Conferences³. As expected, an increase in the number of presentations is visible in the course of the project:

Table 5: Presentations of Pilot Hospitals at International Conferences (IC)

Conferences	Number of presentations	Number of presenting Hospitals
IC 1993, Warsaw	2	2
IC 1994, Padua	15	11
IC 1995, Linköping	16	8
IC 1996, Londonderry	27	14
IC 1997, Vienna	39	19
Total	99	

³ The papers of some of the conferences have been compiled in the following publications: Padua, Zeni, Briani 1994; Linköping: Centre of Public Health Studies, 1996; Vienna: Pelikan, Krajic, Lobnig 1998.

Publications in the International HPH Newsletter

As another medium for presenting experiences and for raising public interest in local experiences within the European Pilot Hospital Project, the International HPH Newsletter published by the Co-ordinating Centre LBI and distributed to more than 2000 interested institutions and experts in Europe and overseas was used. Table 6 shows the amount of pilot hospital contributions between 1993 and 1996⁴.

Table 6: Presentations of Pilot Hospitals in HPH Newsletters

Newsletter Edition	Number of Pilot Hospital Presentations
No1/April 1993	1
No2/September 1993	6
No3/March 1994	1
No4/September 1994	5
No5/May 1995	3
No6/December 1995	3
No7/April 1996	4
No8/October 1996	4
Total	26

The EPHP Circular Letter

In addition to the HPH Newsletter which functions as a means to widely distribute information on health promoting hospitals issues (e. g. information on International Conferences), the Circular Letter was a more “technical” medium, used by the Co-ordinating Centre, in co-ordination with WHO-EURO:

- to prepare and assess Business Meetings and International Conferences,
- to regularly report on news and activities and,
- to distribute “technical” information.

During the project, a total number of 27 issues were distributed to the pilot hospitals.

Bilateral Networking

In some cases bilateral networking between pilot hospitals took place. An example for this type of co-operation are the visits of Koranyi Hospital, Budapest, to the public project presentations of the hospital „Rudolfstiftung“ in Vienna. Another example is the „art for health“ project which was originally implemented at Altnagelvin Hospital, Londonderry, and then transferred to the Municipal Hospital of Chemnitz, Germany.

⁴ We did not add issue 9/10 (1997) to this list, because this issue provides a short report about all 19 hospitals.

Peer Review

Peer review, as a means of quality assurance, was part of the process the pilot hospitals went through. The hospitals agreed to “receive visitors from other Pilot Hospitals and present their HPH-Project (excluding responsibility for costs of travel or accommodation)” (WHO-Regional Office for Europe, LBI for the Sociology of Health and Medicine 1993).

However, due to financial difficulties, these site visits only took place during Business Meetings where the local hosts presented their approaches and projects, which were discussed with the delegates from the other hospitals.

Organisational Support Structures for the European Pilot Hospital Project

An Advisory Board was set up in March 1992. It supported WHO and LBI in selecting the hospitals for the project. The members (in alphabetic order) were: Dr. Carlo Favaretti (Adria); Prof.Dr. Tamas Halmos (Budapest); Mr. Kieran Hickey (Dublin); Mr. Helmut Hildebrandt (Hamburg); Prof.Dr. Klaus-Diethart Hüllemann (Prien); Ms. J. Spray (London); Ms. Brenda Stephens (Cardiff); Prof.Dr. Johannes Vang (Linköping).

After having completed the task of selecting pilot hospitals, the members of the advisory board became active in three Task Forces, supporting the co-ordination of the project in the areas of documentation/evaluation (chair: Ms. Brenda Stephens, Cardiff), fund raising (chair: Mr. Kieran Hickey, Dublin) and national/regional networking (Chair: Mr. Leslie Honeyman, Glasgow). After the task forces achieved their aims⁵, the co-ordinators took on other responsibilities in the network.

Project Structures on the Local Project Level

On the local hospital level, the project was developed and carried out by applying techniques of project management and organisational development, requiring specific roles, functions and media (see Grossmann & Scala 1993, Lobnig, Pelikan & Nowak 1998). Below, more general descriptions of these instruments are presented; the 19 case studies collected in this book provide specific examples of how these principles were put in practice.

Project co-ordinator and project team

Every hospital had to nominate a formal project co-ordinator whose task was to take over internal and external responsibility for the project activities. Table 7 shows the year in which the project co-ordinators had been finally appointed and the amount of working time the project co-ordinators had been granted for this job in the course of the project.

⁵ The evaluation task force provided a statement of expertise, which suggested that evaluation efforts should be primarily on the level of the local projects and the European approach should provide support. The fund raising task force developed a paper on how to raise funds for HPH networks which was piloted in Austria and Ireland. The national/regional networks task force was supportive in preparing the concept of national networks and very soon this agenda was taken over by WHO-Euro, leading to the European Project of Regional/National Networks of Health Promoting Hospitals.

Table 7: Project Co-ordinators allocated working time per week^a

Year of beginning of work	1991	1992	1993	1994	1995
up to 5 hours	1	2	3	2	
6–10h		2	2		
11–20h	2		1		1
21–30h			1		
31–40h		1	1		

^a 17 hospitals are represented; in 2 cases no information was available.

According to the figures in Table 7, most project co-ordinators fulfilled their function in addition to their regular work. More than half of the co-ordinators spent up to 10 hours in project co-ordination, whereas only 2 persons were full-time co-ordinators.

One of the aims of the project was to involve the different levels of hierarchy in the development of the project. Table 8 shows how different professional groups were represented in the overall steering project committees.

Table 8: Participants of the Project Committees

	1993 ^a	1996 ^a
Hospital Owner	9	9
Medical Director	14	13
Nursing Director	11	12
Administrative Director	13	11
Member of Medical Staff	12	13
Member of Nursing Staff	10	11
Member of Administrative Staff	10	9
Member of Technical Staff	5	7
HP Specialist	9	10
Others	8	8
External Institutions	14	13
Total	18	17
Missing	1	2

^a The figures represent the number of Pilot Hospitals in whose Project Committee the functions are directly represented.

As can be seen in Table 8, most of the project committees were composed of members from different hierarchical levels and professional groups of the hospital. In most hospitals, both management and external institutions were represented in the project committee.

Not only the composition, also the size of the project committee and number of meetings varied considerably between hospitals during the process of the project (Table 9).

Table 9: Size of Project Committees and average number of meetings

	Size 1993	Size 1996	Average number of meetings 1993	Average number of meetings 1996
up to 5 participants	3	3	11,7	9,7
6–9 participants	10	5	7,8	7
10 and more participants	4	8	4	5,5
Total	17	16		
Missing	2	3		

In the course of the project, a tendency towards increase in the size of committees can be observed. Concerning the average number of meetings, it is not surprising that committees with fewer members were able to organise more meetings.

Co-operation with external institutions

According to the agreement, the pilot hospitals confirmed they would look for specific support from external institutions for the development of their projects, as a means for quality assurance. Table 10 provides an overview of the types of external institutions involved and of the services they provided.

Table 10: Co-operation with External Institutions: Number and Types of Services^a

	Total Number	Concept development	Types of services			
			Evaluation	Organisational Consultation	Project Management	Knowledge and Skills
University/Academy Scientific Institution	8		4	3	3	4
(Private non Profit) Consulting Firm	4	2	4	2	3	2
Health Promotion Unit Others	3	2	3	2		
	5		3	1	3	5
	4		1	1		1

^aFor 4 of the 24 nominated external organisations, the type of service provided could not be specified. 7 hospitals co-operated with more than 1 external institution.

Exactly half (12) of all external institutions were located in the scientific area (universities and scientific institutions), followed by health promotion units (5) and consulting firms ranging last (3). This can be explained by the fact that the types of services most often required – „evaluation“ (15) and “Providing knowledge and skills” (12) – can be regarded as scientific types of services. External institutions were less often used for providing organisational skills such as „organisational consultation“ or „project management“ (each 9) or „concept development“ (4).

Local project marketing: local HPH Newsletter, HPH-Section in internal newsletter and public presentations

In order to create visibility for the project, the participating hospitals had confirmed they would use different types of media for presenting their projects: Public presentations for interested experts, professionals and people from the hospital community; an internal HPH Newsletter and/or an HPH section in the regular hospital newsletter were used to raise project awareness in the hospital. Table 11 gives an overview of how these instruments were implemented.

Table 11: Numbers of public presentations, HPH Newsletters and HPH Sections in Hospital Newsletters 1992–1996

	Number of Public Presentations	Issues of HPH Newsletters	Number of HPH Sections in Hospital Newsletters
1–5	7	5	5
6–9	5	2	0
more than 9	4	7	5
total	16	14	10
no information	3	5	9

Has the EPHP been successful?

As for any other project, successes of the European Pilot Hospital Project can be assessed according to the criteria of:

- **Feasibility:** has it been possible to carry out the project plan?
- **Quality:** has it been possible to conduct the project according to pre-defined standards?
- **Effectiveness:** has it been possible to reach the effects the project set out to attain? Cost effectiveness and efficiency might be included in this question, if the project aims and design ask for this.
- **Sustainability:** are the effects proving stable/sustainable?

Implementing health promotion in hospitals: Has it proven feasible?

Implementing health promotion strategies and using health promotion as a developmental strategy for a wide range of hospitals in all parts of the European region has proven feasible to a very large extent. Several indicators support this assertion, but there is also some evidence of difficulties.

Has it been possible to find the necessary partners and resources for the European Pilot Hospital Project?

- **Recruitment process:** At least in some countries, there were more hospital candidates than positions available in the project – a selection process was necessary. Even after the formal start of the project, several hospitals continued pressing for inclusion.

- *Geographic mix:* Hospitals from 11 countries have been participating (5 in Germany, and 4 in the UK, in others less). European countries not represented were Belgium, Bulgaria, Denmark, Finland, Netherlands, Norway, Portugal, Romania, Spain and Switzerland. No representatives from the new independent states.
- *Types of Health Care systems:* National Health Systems seem to be better represented (UK, IRL, I, S, GR, PL, H, CZ) than systems with a stronger insurance or private sector (exception: Germany, Austria).
- *The mix of different types of hospitals* (according to specialisation, size, ownership) seems to meet European distribution fairly well, although medium sized to large public hospitals seem to be over-represented (exception: Germany).
- *Resources:* 21 of the 22 partners (19 of the 20 hospitals) found the necessary resources/sponsors to secure their continuous participation for the whole period. In the course of the project interest, enthusiasm, dedication and also probably a bit of stubbornness on the part of the protagonists of the project have proven to be a most important, indispensable resource for the project. Only Prague has not been successful in allocating resources for the project – although several initiatives were set up to assist in raising local support (e. g. linkage with the National Centre for Health Promotion, assistance in negotiation with the Ministry of Health by WHO and LBI). In our perspective, the main reasons why Prague decided to leave the project were a lack of resources and professional capacities for the realisation of the project, as well as reforms in the local health care sector, which made it unclear whether the hospital should be closed or change its type considerably.

Besides this general success in finding resources for the local projects, the amount of additional resources which the hospitals were able to raise or provide to buy professional support for developing innovative projects, for doing systematic evaluation studies and for extensively participating and contributing in international meetings, varied substantially. Most hospitals had to conduct their projects on re-allocated own resources and also on the enthusiasm of health promotion activists and staff involved in sub-projects. So it was not surprising that fund raising was an important issue in several Business Meetings.

Has it been possible to develop and realise sub-projects?

Implementing health promotion by initiating new services and developing or re-engineering established services and procedures are at the very heart of HPH-projects. So one central question to raise is whether the hospitals were able to successfully define and implement sub-projects. The second question refers to the scope of sub-projects realised – were the hospitals able to develop programmes to improve the health of patients, staff, population in the community and the development of a healthy organisation, as suggested by the comprehensive approach of health promoting hospitals – or were they just continuing their normal, primarily patient-oriented activities under a new heading?

Incidentally, the hospitals have developed many more sub-projects than agreed upon. In 1995, at a peak of the project activities, the hospitals have reported on 180 programmes they were running or planning to run (instead of the required 100 sub-projects).

Table 12: Number of Sub-projects realised by the Pilot Hospitals 1993–1997

Number of Sub-projects	Number of Hospitals
5 sub-projects	4
6–10 sub-projects	11
More than 10 sub-projects	4

15 of the participating hospitals exceeded the number of the 5 sub-projects agreed upon in the agreement. More than half carried out between 6 and 10 sub-projects, and 4 hospitals carried out more than 10 sub-projects. At the end of 1996, 149 sub-projects were formally included in the reports. Of these 149 sub-projects, only 13 (around 10%) had been cancelled, 40 had been finished, 95 were still reported as ongoing and one was still in the planning phase. The high rate of ongoing sub-projects can be considered as an indicator for the degree in which sub-projects have been integrated into the hospital routine and thus show the sustainability of the innovations brought about by the project.

What types of projects did the hospitals carry out?

- 101 sub-projects aimed (also) at improving the health of patients.
- 67 sub-projects targeted (also) the health of hospital staff as main area.
- 54 sub-projects tried (also) to contribute directly to the health of the population in the community.
- 65 sub-projects aimed (also) at the development of the hospital into a healthy organisation.

An overview of the titles of the sub-projects carried out by the hospitals is added as an appendix to this book. A more detailed overview of what the sub-projects focused, how they were implemented and what the results were, can be found in the 19 Case Studies included in this book.

How successful have the projects been in involving relevant groups?

The experiences of the Pilot Hospitals prove that it is possible to involve all relevant professional groups and all levels in the hierarchy in HPH projects. But it also became quite obvious that the amount and stability of involvement varies between the different professional and hierarchical groups: HPH projects have been quite successful with the nursing profession, hospital management (including medical directors) and of course health promotion/prevention/ rehabilitation and counselling specialists, such as nutritionists, psychologists, etc. It has proven more difficult to include clinicians (especially those in the very core of clinical diagnosis and intervention) and the large and important group of administrative and technical personnel and hospital workers.

We have also learned that the possibilities of co-operation between the hospital and external partners and involvement of groups and organisations in the community in Health Promoting Hospital projects vary to a wide extent between the hospitals. We suggest explaining this diversity with logistics and the financial assets, which provide

some options for hospitals relating with the community. On the other hand those partners who could already build upon traditions of co-operation in the health care sector and multi-sectoral action have achieved more success in this area than those who had to start from the very beginning.

We would like to highlight at this point once more the importance of the Healthy Cities project for Health Promoting Hospitals. The Healthy Cities project was very helpful in recruiting partners, and it was helpful again by providing in some cases a network of partners for the hospitals which were used to co-operate for better health in the community.

How can the quality of the Pilot Hospital Projects be summarised?

How were the procedures of trans-national co-operation realised?

Participation in all 9 Business Meetings was excellent – there were only very few cases when a partner hospital did not succeed in participating. Regular international reporting on progress was another requirement which was excellently fulfilled in the course of the project, starting at the second Business Meeting; written reports as well as oral reports on progress and problems in the different areas of the local projects were provided.

A synopsis of these reports was edited in the form of a summary progress report by the co-ordinating centre available at the Business Meeting, the discussions were summarised in the minutes of the meetings.

Annual site visits by designated referees – a part of the agreement which had raised lively discussions – have not been realised due to lack of specific resources for this task.

To what extent did the local Pilot Hospital projects realise the standards agreed upon?

- A *joint project committee* could be established in all participating hospitals. The committees varied in size and intensity of joint work, but in most cases a good balance between representing all relevant groups and keeping a workable size could be achieved (see Tables 8 and 9);
- *Project Co-ordinators* were nominated in all participating hospitals (see Table 7), though with varying definitions of this job – in some cases they had too little time for the project, in some cases they were too low in the hierarchy to have easy access to decision making procedures, in some cases they had to deal with too many competing priorities and had too little support inside the hospital;
- The involvement of *external institutions* supporting the projects in all Pilot Hospitals brought about a wide variation of roles of external experts in the projects – varying from minimal counselling in specific areas to full project management (see Table 10). Several Pilot Hospitals seem to have managed to establish this co-operation rather late, which was problematic for instance for evaluation;
- The standard of at least one major annual *public presentation* for creating visibility was fulfilled by nearly all Pilot Hospitals – several partners used this instrument more often and seem to have had good experiences (see also Table 11);

- The standard of establishing an *HPH Project newsletter* or HPH-Section in a Hospital Newsletter was fulfilled by 75% of the participating hospitals (see Table 11), but discussions were also raised at Business Meetings as to whether other media like audio or video tapes would also be acceptable;
- Methods of *organisational development and project management* were used in nearly all of the sub-projects. Most of them were realised by project groups, bringing together the people concerned, and most seemed to have had at least a minimal project plan.

Nevertheless, the experience of working with groups, at times very large and heterogeneous, seems to have been mixed, and the quality of project management (especially the clear definition of feasible aims, targets and schedules) seems to have varied greatly;

- Given the open character of the HPH vision and the intended maximisation of variation, the minimum standards agreed upon concerning *documentation and evaluation* were rather formal and abstract – the realisation of plans and the implementation of interventions or solutions was to be documented and evaluated according to locally pre-defined standards, adequate to the problem approached and the intervention planned. To safeguard scientific standards for evaluation, the Pilot Hospitals agreed to get themselves expert support – and most of the partners have done so in this area.

The result can be summarised as follows: Evaluation has been conducted and has provided results till now in 93 of the 149 projects. Only 3 projects were finished and not evaluated, but 38 were still ongoing and evaluation was – as we understand – planned. In the case studies within this book several models of good practice of sub-project evaluation are provided.

How were the commitments to support regional/national and the International Network of Health Promoting Hospitals realised?

This can be judged as a major area of success. Six hospitals are now actively involved in the co-ordination of National or Regional Networks.

In seven more cases the external institutions the Pilot Hospitals have been co-operating with are now acting as co-ordinators, and the other six hospitals have been at least actively involved in setting up and developing national/regional networks (Table 13).

As a result, National/Regional Networks in all countries involved in the project have been set up – with the exception of the Czech Republic.

The aspect of involving in international networking can also be considered as an area of success. Including the 5th International Conference on Health Promoting Hospitals, there have been nearly 100 oral presentations from Pilot Hospitals at the conferences, plus approximately 70 poster presentations. In the HPH newsletter, 26 articles on Pilot Hospital projects or sub-projects have appeared since 1993 (see also Tables 5 and 6).

Table 13: Participation of Pilot Hospitals and External Institutions in the development and co-ordination of Regional and National Networks (state of 1998)

	State of Network Development	Participation of Hospital	Participation of External Institution
Vienna	existing	very active	co-ordination
Prague	not existing	none	none
Paris	existing	very active	co-ordination
Riedstadt	existing	very active	none
Hildesheim	existing	co-ordination	none
Prien	existing	co-ordination	none
Hamburg	existing	very active	active
Chemnitz	existing	very active	none
Athens	existing	active	co-ordination
Budapest	existing	co-ordination	active
Dublin	existing	co-ordination	active
Milan	existing	active	active
Padua	existing	very active	active
Ustron	existing	very active	none
Warsaw	existing	very active	co-ordination
Linköping	existing	very active	co-ordination
Preston	existing	very active	co-ordination
Londonderry	in development	co-ordination	active
Glasgow	existing	co-ordination	active
Llanelli	existing	very active	co-ordination

Effectiveness and Cost-Effectiveness of the European Pilot Hospital Project

Effectiveness on the regional/national and international level

We have already underlined the important role the Pilot Hospitals played for National and Regional Networking and we would like to add that without this work and without the hospitals' willingness to expose their experiences to an international public, the International Network of Health Promoting Hospital would not have achieved the importance and results which can be observed to date (cf. Doherty 1998, Kickbusch 1998). In addition the practical experiences which were made within the Pilot Hospital approach led to the threshold of globalising HPH experiences (Pelikan, Lobnig, Krajic, 1997).

Effectiveness on the local project level

It depends very much on the aims and objectives defined, whether local projects can be assessed as being effective as the Pilot Hospitals have defined and specified the vision of the Health Promoting Hospital for themselves, combining the European approach with national and local pre-conditions. We have the impression that most hospitals have managed to initiate a process of re-orientation that expanded their operational criteria from the status quo they were at the beginning of the process. Most have at least tried to cover all four areas of HPH – trying to promote the health of

patients, of their staff, of the population in the community – although this might have been a difficult area for many – and most seem to have tried to become a „healthier organisation“. We are quite convinced, that already the participation in the European Project has made a significant contribution in the direction to becoming more oriented towards a strategy to create a health promoting hospital. Unfortunately attempts to raise sufficient resources for a systematic monitoring and evaluation of the organisational development processes have been successful only in very few cases (see as examples the case studies of the hospitals in Vienna, Hamburg, Hildesheim, Riedstadt, Athens and Preston in this book).

Effectiveness on the sub-project level

Effectiveness of sub-projects depends to a large extent on the specific problems the hospitals wished to tackle with their projects. As already mentioned, sub-projects are attempting to implement specific interventions, measures and solutions in the hospital organisation or in the networks between the hospital and its community. As the sub-project evaluation gives recognition primarily to the local circumstances, environments and criteria for success, the evaluation is strongly linked to the formulating of aims and targets by local stakeholders. For more detailed information concerning concrete examples of sub-projects and their impacts we would recommend referring to the 19 case studies compiled in this book.

However, on a meta-level the first question that can be addressed is whether the implementation process was effective. We have heard about the good ratio of success already.

The second question refers to the fact that it can be evaluated whether the sub-projects contributed to the solution of the specific problem they were addressing – whether they were able to change lifting procedures, or could change the micro-biological situation of the hospital, or increase the level of patient information. The sub-projects had their specific criteria of effectiveness, and so unfortunately we cannot provide a quantitative answer to this question on the meta level of the EPHP.

We can offer some conclusions based on indirect reasoning that seem plausible to us: Given the large number of ongoing projects or programs and the fact that hospitals are running these programmes from their own budgets, we can guess that these projects have been sufficiently successful. They could have been successful either in reaching their defined aims or at least in achieving positive unexpected side effects, so that hospitals continue to run the programmes implemented.

The third question would refer to the effects of health promotion in an emphatic sense – questioning the specific contributions they provided to the health of the target groups. Here again we have to draw attention to the fact that this has not been a multi-centre basic science research project with the necessary limitations in the design and sufficient funds to conduct this kind of thorough enquiry. To date, one cannot expect clear and evident results or answers in this area and in most cases we would also argue that they are not necessary. Much of what the hospitals have been doing was using established techniques for well analysed problems, but within the specific conditions of their hospitals.

Cost-effectiveness and efficiency of Health Promoting Hospital Projects

The analysis of efficiency and cost-effectiveness of health promotion interventions faces a number of serious and unsolved problems, as they very often bring about intersectoral and multi-level outcomes (Drummond, Stoddard 1995) which can not linearly be combined with economic figures. In the framework of the EPHP these specific types of evaluation have not been part of the initial agreement, and thus cost-effectiveness studies have not been carried out extensively. Furthermore, studies on efficiency of health promotion interventions conducted by the hospital – compared for instance with health promotion interventions by primary health care providers – could not be measured, as both the resources and the technology for such complex comparative studies have not so far been made available. In this area more research is needed.

Factors that have proven problematic in the course of the EPHP

After the attempt to discuss the complexity of successful and not so successful aspects of the project, we would like to focus on those factors which we think have proven to create difficulties. Although we have outlined that the EPHP was a successful project to a very large extent, we must also name some factors which we and our partners felt to be rather problematic, at least at certain times of the project's development:

- An open vision as provided by Health Promoting Hospitals creates difficulties in setting up clear evaluation criteria;
- The heterogeneity of the projects proves an obstacle for work on specific content areas;
- The heterogeneity of the participating hospitals and health care environments restricted possible exchange;
- The project's lack of ability to raise specific international funds was disappointing;
- The organisation of meetings with 2-3 delegates from 20 hospitals are very time-consuming and also resource-consuming and the great number of partners could not always be involved equally;
- In some countries low national political support for health promotion set clear boundaries for the projects;
- Support by WHO and the Co-ordinating centre could have been more extensive.

What can be learned from the EPHP? What factors lead to success and sustainability of Health Promoting Hospital Projects?

In a final analysis we would like to draw attention to those factors we would consider as decisive for the success of the EPHP. The high percentage of ongoing sub-projects and the involvement of nearly all Pilot Hospitals in the development of national/regional networks of Health Promoting Hospitals can be regarded as indicators for the sustainable development that was initialised by the European Pilot Hospital Project. What are the reasons for this success, and what factors can be adopted by those who want to learn from the EPHP?

Success factors on the European project level

Finding potential initiating partners

For the EPHP it was the WHO-Regional Office for Europe, which supported the project in at least four important areas.

- The reputation and credibility of WHO acting as initiating partner legitimised the vision of HPH;
- The vision of the Ottawa Charter for Health Promotion could be used for the concept of HPH;
- WHO provided experience and support through the Healthy Cities Project;
- WHO recruited the co-ordinating centre (funded by the Austrian government) for project management and facilitation.

Providing a concrete methodology and an open vision

Partners participating in a project need clear orientation and expectations about the process they are undergoing. The EPHP could refer to:

- The open vision of Health Promoting Hospitals as it was stated in the Budapest Declaration on Health Promoting Hospitals, allowing for adaptations to local needs, problems, aims and resources;
- The first WHO model hospital, the Rudolfstiftung Hospital of the City of Vienna, provided a practical and tangible example for interested partners;
- In a process involving all partners, a project methodology (agreement on standards for local projects) could be agreed upon.

A carefully conducted preparatory and initiation phase

In order to create identification with the project, it was important to involve relevant project partners into the development of the project design and the formulation of the agreements. This process can be described as the enterprise to keep the balance between creating an overall structure that is comprehensive enough to create „common space“ for the project as a whole, but leaving enough space for local interests and developments on the level of the local projects.

It proved to be very supportive to create new social settings (like the Business Meetings and International Conferences which supported the EPHP) where the necessary partners shared roles and responsibilities to co-operate with the project on the different levels of the international, the national and the local level.

Agreement on co-operation and co-ordination structures

As the central result of the initiation phase an agreement was set up, clarifying the expectations and responsibilities of the project partners and defining the procedures on how the process should continue developing. The most important aspects of the project agreement of the EPHP were:

- Define specific requirements for the Pilot Hospital projects: project committee, co-ordinator and external institution; local media; public presentations, newsletters, sub-projects as specific action areas;

- Creating visibility: “enhance your self-respect by finding other people who observe and respect what you are doing“;
- Organise feedback and participate in trans-national co-operation.

Sufficient support during the course of the project

The above mentioned factors are quite substantial, but additional factors contributed to the success of the EPHP. The following aspects should also be mentioned:

- Creating stimulating environments for the project through professional process management and facilitation;
- Keeping going/expanding – do not stop: do not restrict yourself to core activities;
- Steps in expansion – reaching beyond what was already achieved:
 - Do not stick with one model project, go on to a European Pilot Hospital Project;
 - Create public interest for the project;
 - Do not create only a European Pilot Hospital Project, but establish also International Conferences and Newsletters;
- Make your project visible;
- Create possibilities for participation for others through national and regional networks;
- Create cognitive support structure: reports, database, expert partners;
- Assure financial support.

Success factors on the local and sub-project level

In two evaluation workshops with delegates from all Pilot Hospitals in 1996 the following success factors for (sustainable) Health Promoting Hospital projects on the local and sub-project level were defined:

- Top Management Support;
- Appropriate project structures (teams, co-ordinators, etc.);
- Provision of resources;
- Grass roots participation;
- Effective communication strategies;
- Good information for hospital staff;
- Vehicles for transfer of project results and methodologies;
- Incorporation of programmes into daily routine work;
- Supportive, accepting (political) environment of the project;
- Professional evaluation to legitimise expenses and to support decisions concerning the project;
- Finishing running projects and bringing about new ideas.

Conclusions

The European Pilot Hospital project has proven that health promotion specified in the open vision of the Budapest Declaration is a strategy for hospital development meeting the needs of hospitals throughout Europe. The Health Promoting Hospital concepts supports hospitals to cope with the challenges they are facing by initiating a developmental process directed at health as a highly valued goal, but open enough to enable necessary local adaptations. The European Pilot Hospital project has also proven, that it makes sense for health promotion to invest in co-operation with the hospital. Although the hospital is considered a very complex and difficult organisation, it is one of the most important organisations of modern society and central for the orientation of the health care system. The Pilot Hospital Project has provided strong evidence that hospitals are open for health promotion – health promotion should not miss this chance.

The experiences of the Pilot Hospital Project as a network of co-operation and a trans-national consortium for learning has provided very valuable insights for the initiators of any other project or network trying to work with hospitals. The good experiences as well as the problematic ones provide a variety of learning opportunities as can be seen in all case studies compiled in this book. We are quite aware that much of what we have been saying remains sketchy and abstract – so if you want to know in more detailed what the Pilot Hospitals have been doing and experiencing in the last four years, we invite you to read the reports on the experiences of the Pilot Hospitals in this book.

Concerning the future of the Health Promoting hospitals two challenges can be seen: The central focus of the International Network is now turning towards the national and regional networks project, access and involvement is now provided for a considerable number of hospitals (see Garcia-Barbero 1998). It will be a challenge to create strategies for assuring and further developing the quality of the Health Promoting Hospitals approach in this new phase and it will be a challenge to create opportunities for combining the knowledge and analysing the experiences and to integrate mechanisms of a learning organisation into the International Network of Health Promoting Hospitals.

References

- Centre of Public Health Studies (Eds.)(1996): Health Gain Measurements as a tool for Hospital Management and Health Policy. Proceedings of the 3rd International Conference on Health Promoting Hospitals. Linköping, June 1–2 1995; Linköping: Centre of Public Health Studies
- Doherty, D. (1998): Challenges for hospital policy in Europe – What role can hospitals play? In: Pelikan, J.M.; Krajic, K.; Lobnig, H. (Eds.): Effectiveness, Quality Assurance and Sustainability of Health Promoting Hospital Projects. Gamburg: Health Promotion Publications, 36–44
- Drummond, M., Stoddard, G. (1995): Assessment of health producing measures across different sectors. In: Health Policy 23, 219–231
- Garcia-Barbero M (1998): Evolution of health care systems. In: Pelikan, J.M.; Krajic, K.; Lobnig H. (Eds.): Effectiveness, Quality Assurance and Sustainability of Health Promoting Hospital Projects. Gamburg: Health Promotion Publications, 27–30

- Grossmann, R, Scala, K. (1993): Health Promotion and Organizational Development. Developing Settings for Health. WHO-Euro, IFF: Vienna
- Kickbusch, I. (1998): Reorienting Health Care Settings. In: Pelikan, J.M.; Krajic, K.; Lobnig H. (Eds.): Effectiveness, Quality Assurance and Sustainability of Health Promoting Hospital Projects. Gamburg: Health Promotion Publications, 31–35
- Lobnig, H; Nowak, P., Pelikan, JM. (1998): Umsetzungsstrategien des Gesundheitsfördernden Krankenhauses: Projektmanagement, Organisationsentwicklung und Networking. In: Pelikan, J.M., Wolff, S. (Hg.): Das Gesundheitsfördernde Krankenhaus als Projekt. München-Weinheim: Juventa Verlag (in press)
- Love AJ (1991): Internal Evaluation. Building organizations from within. Newbury Park: Sage
- Milz, H., Vang, J. (1989): Consultation on the role of health promotion in hospitals. In: Health Promotion, vol.3, no.4, 425–427
- Pelikan, J.M., Lobnig, H., Krajic, K. (1997): Health Promoting Hospitals. In: World Health 50, 3, 24–25
- Pelikan, J.M.; Krajic, K.; Lobnig, H. (Eds.)(1998): Effectiveness, Quality Assurance and Sustainability of Health Promoting Hospital Projects. . Proceedings of the 5th International Conference on Health Promoting Hospitals, Vienna, April 16–19 1997; Gamburg: Health Promotion Publications
- Pelikan, J. M.; Krajic, K.; Lobnig, H., Dietscher, C. (1998): The European Pilot Hospital Project on Health Promoting Hospitals – a summary. In: Pelikan, J.M.; Krajic, K.; Lobnig, H. (Eds.): Effectiveness, Quality Assurance and Sustainability of Health Promoting Hospital Projects. Gamburg: Health Promotion Publications, 13–26
- Sol, N., Wilson, P.K. (Eds.) (1989): Hospital Health Promotion. Champaign Illinois: Human Kinetics Books
- WHO Regional Office for Europe, LBI for the Sociology of Health and Medicine (1991): Next Steps on the Way to the Health Promoting Hospital. Minutes of the 1st Business Meeting of the International Network of Health Promoting Hospital. Vienna: LBI for the Sociology of Health and Medicine
- WHO Regional Office for Europe, LBI for the Sociology of Health and Medicine (1993): The Agreement of the European Pilot Hospital Project. Vienna, Copenhagen
- Zeni, L., Briani, M. (Eds.)(1994): Proceedings of the 2nd International Conference on Health Promoting Hospitals, Padova, April 15–16 1994: Padova: Medical Directorate, Hospital and University Medical Centre

**Case Studies
from the
European
Pilot Hospitals**

Case Study Rudolfstiftung Hospital, Vienna, Austria WHO-Model Project „Health and Hospital“

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Hospital Owner:	Municipality of Vienna	
Hospital Ownership:	Public	
Specialisation:	General Hospital	
Beds:	760	
Staff:	Medical Staff: 330, Nursing Staff: 1.000, Other Staff: 670 (medico technical, administrative), Total Number of Staff: 2.000	
Utilization:	Average Utilization of Beds/Year: 90 %, Average Stay in the Hospital/Day: 10,1	
Patients:	Number of Inpatients/Year: 30.000, Number of Outpatients/Year: 100.000	
Number of Departments:	48 (13 departments equipped with beds; 35 outpatient departments)	
Location of Hospital:	Inner city	
Catchment Area:	Regional, Number of Population: whole city of Vienna 1,6 Mio people	
Other Functions than Medical Care:		
Teaching:	Medical Students, Postgraduate, Nursing Education	
Research:	Partly Clinical Research, Basic Science Research	
Subprojects:	<ol style="list-style-type: none">1. Training of Diabetics2. Health at the Workplace3. Organization of Hospital Hygiene4. Reorganization of a Ward5. Healthy Food in the Hospital6. Nursing7. Volunteer Patient Service8. Patient-oriented Team Nursing9. Cooperation between Central and Clinical Departments10. Mission Statement Rudolfstiftung11. The Out-Patient Clinic as Interface between In- and Outpatient Care	

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The Rudolfstiftung Hospital and its Environment

The Austrian hospital system has been in a process of ongoing reforms during the last ten years. These can be summarized as :

- development of a new financing system in the direction of service and diagnosis related financing – limiting the costs of the hospital sector;
- decentralization and development of more autonomous decision making structures;
- development of quality assurance and quality management;
- implementation of new information systems;
- reduction of capacities of hospital beds in certain areas.

The main reference in these developments for hospitals was and still is the question of quality management.

By the time of starting the project, health promotion was more or less an unknown concept in Austria. A few people in the Federal Ministry of Health and some scientists had already been interested but no national policy of health promotion had been implemented. In 1992 the social insurance took over health promotion as an area of responsibility, but until now this engagement did not lead to an extensive development of health promotion policies in Austria.

The City of Vienna is the biggest hospital owner in Austria (10.000 beds) and was interested in health promotion since the starting of the Healthy Cities programme, were Vienna was one of the first cities joining the network.

The Rudolfstiftung Hospital of the City of Vienna is one of six general hospitals in Vienna. The Rudolfstiftung Hospital includes all medical departments except psychiatry and paediatrics.

Story of success

Starting the first European Pilot Hospital Project

After a first consultation on health promotion in the hospital setting in 1988, WHO looked for a research institution which could carry out the development of concepts, and the implementation and evaluation of a first model project on health promotion in hospitals. Here the Ludwig Boltzmann Institute for the Sociology of Health and Medicine (LBI) proved an ideal partner with wide experience in the fields of hospital research and the development of innovation projects. The Municipality of Vienna has already been involved in the „Healthy Cities“-Programme and therefore agreed to act as hospital owner and client for this new project. After having worked out first conceptual drafts on the basis of a pilot study, a number of hospital administrations were contacted to find a suitable hospital in Vienna for carrying out the pilot project.

The medical director of the Rudolfstiftung Hospital was interested in plans for reform right from the start. During preliminary meetings with the joint management, heads of the medical departments and the elected representatives of the staff, it became clear that a positive attitude alone would not suffice to carry out a reform project of such dimensions. The final decision about the hospital's participation was

reached during two staff meetings in which all employees had a chance to get to know the concept of the project and to vote on whether to participate or not.

One reason for the wide acceptance the concept of „Health Promoting Hospital“ found amongst the staff, was due to the fact that beside the patients, the staff themselves were to be a target group of health promotion. The employees themselves, on different levels of the hospital hierarchy, were to develop projects to improve their own situation at work and thus improve the quality of medical and nursing care offered. The fact that the hospital management was open to reforms was influenced by the fact that they expected to improve their future competitive strength by taking part in an international model project in the face of oncoming political reforms by the Vienna Hospital Compound.

A formal arrangement between the four partners – WHO-Euro, the City of Vienna, the LBI and the hospital management – agreed upon carrying out a Model Project with a running period of at least five years. Details concerning the process and the progress of project work, especially concerning the provision of necessary resources, had to be negotiated anew every year with the Municipality of Vienna and the Vienna Hospital Compound.

The primary goals of this project were outlined by WHO: The Hospital Rudolfstiftung was to be developed into a „health promoting“ organization for its patients, visitors and personnel and to become a model and advocate for the principles of health promotion in the region (Pelikan & Krajic 1993). Furthermore the project was to take into consideration the principles of the Vienna Hospital Reform – increasing efficiency, improving quality, considering consumer’s interests, increasing the motivation of its personnel, decentralisation etc.

The project at the Hospital Rudolfstiftung therefore had the character of a model, both as a WHO „Health Promoting Hospital“, as well as within the objectives of the Vienna Hospital Reform. For this reason social-scientific research as a constant accompaniment of the reforms played such an important part. The comprehensive documentation and evaluation of the project’s progress were to ensure not only feedback and control of the project’s own functioning and results, but was to open up perspectives for transferring these new experience to other organizational contexts. As the first „Pilot Hospital“ of WHO’s „European Network of Health Promoting Hospitals“ which now counts 20 hospitals, the project was of special interest for international discourse on the subject.

Facilitating an innovative process

The Model Project’s aim was to set a process of organizational development in motion at the Hospital Rudolfstiftung. This was to bring about a continuous self-reflexive (trans)formation of structures within the routine work of the hospital. The LBI provided organizational counselling based on the principles of „systemic organizational development“ and „project management“ methods (Lobnig, Nowak & Pelikan 1996).

Organizational development implies a process of change, organized along rational lines, where conflicts and meanderings are inevitable and whose aim it is to effect long term changes. For situations which pose complex problems with a demand for

quick solutions methods of „project management“ have proven very effective. Project management provides methods to structure the process of organizational development, to ensure the continuation of innovations beyond the project phase for the day to day organization and work, and to keep the process of change transparent to the people involved.

The leading strategy of the Vienna Model Project can be summarised as follows: To influence the development of the whole organization by carrying out subprojects. Changes within the organization on the part of the personnel are invariably linked with discovering new competences or strengthening assets little used before. Therefore it was necessary to link organizational measures with measures of personnel development (Pelikan, Lobnig & Nowak 1993)

Methods from the empirical social sciences were employed to assess problems and evaluate the models in practice. Evaluation required the development of a system of documentation, which could be used to collect data on the extent and the quality of results in single subprojects (evaluation of results), as well as documenting important decisions taken in the course of the project (evaluation of the process) (Lobnig & Nowak 1993). Following basic principles of organizational development and health promotion, ways of participation were chosen: Evaluation of the Model Project was not to be carried out externally, but was to involve all participants (Baric & Baric 1995; Guba & Lincoln 1989).

Project structures

To co-ordinate the overall project a Joint Project Committee was set up, consisting of the medical director, director of nursing, administrative director, two personnel representatives from the Rudolfstiftung Hospital and three members of the LBI responsible for the project. This committee met every three to four weeks for approximately one and a half hours to look over the project's development and to discuss and take any necessary decisions. All decision-making processes were finally consensual ones. The Project Committee, acting as client of the project, decided on the subprojects to be carried out, called for participation in special courses and model wards, and appointed project groups to plan and carry out working priorities and specified model parts together with the involved heads and departmental leaders. It supervised and co-ordinated the progress of the project by receiving regular reports from the subproject groups and the special clients, and by providing feedback for the people working in the project.

To guarantee productive discussions, the meetings were chaired by the project director of the LBI. To ensure transparency in the decision-making processes, agendas and minutes of the decisions taken were kept and were also given to the individual project co-ordinators and consultants.

Participation and work in the Joint Project Committee was considered a positive experience by all involved. In an atmosphere of mutual acceptance, differences and conflicts could be expressed and solved. These in their turn were valuable experiences for the work of other decision-taking committees within the hospital. However, the frequent project meetings were sometimes considered an additional burden by the members of the hospital.

Public Relations

Project Newsletter

Since January 1990 a „Project Newsletter“ was published every two months as a medium of information and communication for the hospital owner, project staff and the personnel of the Rudolfstiftung Hospital and it has also been sent to observer groups outside the hospital (institutions and individuals who are important for the transfer of the results). The editorial work is undertaken by a team of project staff from the Rudolfstiftung Hospital and the LBI. The newsletters contain reports on new experiences and results of project work, information on relevant decisions by the Joint Project Committee, an outline of meetings and sessions on the situation of projects in other hospitals and on recent developments in the International Network of Health Promoting Hospitals. Currently the information sheet is sent to more than 600 individuals in and outside the hospital.

Public presentations about the project

Public relations as such took place at annual „Public Project Presentations“, where Subproject Groups presented their results, and hospital owner, management, project co-ordinators and personnel representatives could take stock of what the project had achieved so far. Invitations went out to the staff of the hospital, to people with special interest in issues of health promotion and especially to representatives from the press and other media, to become acquainted with the Vienna WHO-Project and discuss special points of interest in workshops. Preparations for these „Public Project Presentations“ had an additional strategic importance for the project’s progress, beside being a stimulus to work out precise and presentable results of the work in progress: They provided feedback „from outside“, which strengthened the project team and often gave the impetus for new ideas.

Information material

To improve public „visibility“ of the Model Project, special folders in German and English describing the overall projects and the subprojects were produced, as well as summaries of annual reports and a documentation of the annual Project Presentation. In addition, a number of 13 ‘how to do manuals’ on selected subprojects were issued. Those manuals provided expertise and knowledge for other hospitals, who wanted to implement similar projects. They included a summary of the model and the evaluation results and a step by step guide for putting the model into practice. The guidance manuals provided a valuable input for the Austrian Network of Health Promoting Hospitals, and hospitals and other institutions in Austria and Germany have ordered a considerable number of copies to date.

Eleven stories of realisation – The Subprojects

Introduction – Developing „Subprojects“ and Models

The development, trial and implementation of innovations was carried out through subprojects, according to clearly defined goals, within a given frame of resources concerning time, working hours and financing. Choice of such subprojects was in-

fluenced by the following strategic considerations: Whilst working on internal issues and problems of the hospital itself, general principles of WHO's concept of health promotion and the Vienna Hospital Reform were to be put into practice. The reason for restricting the subproject issues to internal hospital problems at the start was, that only a hospital which itself worked according to health promoting principles could credibly act as a public promoter of health promotion. Issues which (also) sought to improve the working conditions of the personnel were given priority: Only „healthy“ – in the all-encompassing meaning of the word – personnel could be expected to be open for innovations in health promotion as part of their daily routine. As concerns the introduction of new (public) services, caution is necessary in the face of recent debates on the necessity of limiting hospitals expenditure and services.

To take stock of the problems within the hospital an „information round“ was carried out during the initial project phase, including all wards, out-patient clinics and sub-units of the Rudolfstiftung Hospital which had declared interest to participate in the project. Individual- and group discussions were carried out to assess the needs and problems of the staff. The results of this inquiry were presented to the „Joint Project Committee“, which sorted the shortcomings, difficulties and interests into principal problem areas.

On the basis of this problem analysis, nine Subprojects with clearly defined goals and frameworks were established and mostly realised by the end of 1994 in the first phase of the project.

Overview of the Subprojects

Health at the Workplace

Organization of Hospital Hygiene

Reorganization of the Ward

The Out-Patient Clinic as Interface between In- and Out-Patient Care

Healthy Food in the Hospital

Training of Diabetics

Nursing

Support for Patients by Volunteer Services

Organizational Development, Project Management and Health Promotion

A tenth Subproject was planned, but could not be put into practice because of limited resources. Subproject 9 was carried out to a lesser degree and will therefore not be described in detail. In 1995 three additional project issues were established for a two-year running time (1995/1996).

Patient-Oriented Group Nursing

Cooperation between clinical and central departments

Mission Statement – Rudolfstiftung

The criteria for setting up a subproject were:

- Socio-technical possibilities of solving the analysed problem area;
- Chances of reaching a consensus among the staff concerned;
- Practicability within a limited space of time;
- Availability of necessary resources.

This selection also meant that some problem areas for which the Rudolfstiftung Hospital was in need of solutions had to be excluded from the agenda of the WHO-Model Project – the problem of emergency beds, the universally lamented lack of space etc.

Planning and implementing each model was the work of Subproject Groups established especially for this task, whose members came from different professional groups and levels of the hospital hierarchy. This ensured that the focus on the problem and the competences for solving the problem would be supplied respectively by the decision-making bodies, experts and the staff whom it concerned. Participation in a Project Group was on voluntary principles. Hospital staff could use up to two hours of their weekly working time for project work. Each Subproject Group could make use of an external organizational consultant from the LBI to support them in solving any task on hand.

Project Group work began with a „start up meeting“ (one to two days long) to give the new group members a chance to develop working structures and durable co-operative relations. The conceptualisation of solutions to problems was a next step, following the results of the general description of the problem which took place at regular subproject meetings.

Subproject 1: „Health at the Workplace“

The improvement of working conditions in the hospital must be a major point of interest in any reform which aims at improving or ensuring the quality of medical and nursing services – to raise the levels of motivation and job satisfaction and thus to increase the work efficiency of the employees. The concept of health promotion at the workplace was to be put into practice through a process of organizational development comprising four essential goals:

- decreasing health hazards;
- improving the individual handling of stress;
- changing organizational structures of work process with the aim to protect and promote health;
- establishing health standards and values as part of the daily routine.

Measures of realization

1. Analyses and improvement of routines for handling dangerous substances in different hospital units and working processes (Pathological-Bacteriological Institute, operation theatres, cleaning):

The following measures were put into practice:

- technical-structural changes (e.g. a suction apparatus to reduce the hazard of anaesthetic gases in the operation theatre);

- reorganization of work places or work processes (for instance in the Pathological-Bacteriological Institute);
- toxicological analyses concerning the use of specific detergents and cleaning agents;
- the production of information brochures on potential health hazards and necessary precautions.

2. The introduction of interdisciplinary team meetings at one institute and four wards: The most important aim of this measure was a qualification programme (*communication training*) to prepare *assistant medical directors* and *head nurses on the wards* for their function as chairpersons of team meetings. These meetings across professional groups had a positive effect on the daily routines on the ward. By mutually co-ordinating the different work routines and procedures these became less strenuous, and the transparency and thus the acceptance of decisions was increased. Evaluation results show that it is of little use trying to devise a uniform design for all ward meetings. The integration of interdisciplinary meetings into the daily routine of the ward can only be successful if each unit builds its own organizational and didactic methods of putting its specific aims and tasks into practice.

3. Various prophylactic measures to prevent illnesses of the apparatus of locomotion and support – back pain prevention:

- carrying out ergonomical consultations at three model wards, During this consultation areas of stress in the course of daily routines were first identified. Then clients were advised on choice and acquisition of technical aids and were introduced to their use;
- introducing courses for the prevention of back pain: The courses were well received by the personnel, featured simple exercises and ergonomical advice (e. g. on how best to lift weights) and provided psycho-social counselling;
- offering further professional training to develop body-consciousness, applying the „Feldenkrais-method“. Evaluation showed, that an increased body awareness among the personnel led to a better interaction with the patients.

4. Working out a concept to establish a permanent „Occupational Health Team“. This team, consisting of a doctor, two occupational health assistants (nursing personnel, physiotherapist or ergo-therapist) and one secretary is to co-ordinate all issues of occupational health of the hospital employees. However, due to limited resources this concept could only partly be put into practice.

Subproject 2: „Organization of Hospital Hygiene“

It is the job of hospitals to restore people´s health or to strive to alleviate pain and suffering of patients in its care. However, even in the most modern hospitals patients fall prone to nosocomial infections, i.e. infections contracted as a result of the treatment patients receive in hospital. A first estimate of the additional costs for the Rudolfstiftung Hospital, comparing it with international data, came up with an additional expenditure amounting to 13 000 days of treatment per annum as a result of hospital infections. Not only patients are at risk however, but doctors and nursing personnel as

well. The risk of being infected with hepatitis B is 10 to 12 times as high among health services employees than among the general population.

The costs for the national economy brought about by the longer duration of stays in hospital, by temporary or permanent invalidity are severe. In the USA this amounts to of approximately 4 billion dollars per year as a result of nosocomial infections. Not to mention the individual patient's personal suffering and inconvenience.

A number of hospitals in the USA, Germany and Austria achieved positive results by introducing so called „hygiene teams“. Teams of experts from the hospital worked out better ways of controlling infection and better measures to ensure hygiene, thus clearly lowering the rate of hospital infections.

The subproject „Organization of Hospital Hygiene“ at the Rudolfstiftung Hospital set out to establish a „hygiene team“ and connected it with an all-encompassing structural reform of the whole domain of hospital hygiene.

Hygiene Team

Since the autumn of 1991 a hygiene team, consisting of a doctor in charge of hygiene and two hygiene nurses has been working full time. It works in close cooperation with the entire team from the Bacteriological Institute. Its activities concentrated on research and analysis, information to colleagues and the board of directors and on motivation of the entire staff.

Its main tasks include:

- planning, introducing, carrying out and evaluating measures to improve hygienic conditions;
- emergency measures in the face of hospital epidemics (fire fighting function);
- recording and control of hospital infections;
- counselling of all units of the hospital concerning questions of hygiene;
- supplementary training for hospital personnel;
- working out recommendations to improve the technical infrastructure, medical technical equipment and facilities.

Organization of Hygiene

The full-time hygiene team, its incorporation into the structural management of headquarters and its relation to the different hospital units, is defined by the so-called „Hygiene Statute“, in turn part of the institutional rules. In accordance with the institutional rules a „Hygiene Commission“ (decision-making body), and a „Hygiene Advisory Board“ is responsible for planning, implementation and ensuring the organization of hygiene. To ensure close cooperation between the hygiene team and the different hospital units and to help the spread of new hygiene measures, a net of „hygiene contact persons“ was set up.

Measures

- compiling a list of antibiotics for internal use, to reduce resistance to the most important pathogenic hospital germs and the cost of medication;

- developing a list of disinfectants, adapted to the special needs of each hospital unit;
- working out guidelines for hand hygiene and disinfection of skin, surfaces and instruments („hygiene plan“);
- working out guidelines for handling vein catheters and urine catheters.

Answering queries concerning hygiene from staff members has become one of the main tasks of the hygiene team. Demand for consultations is high and is still rising steadily and thus demonstrates the importance of the hygiene team’s work within the hospital.

Subproject 3: „Reorganization of a Ward“

Wards are the central functional units of a hospital. The majority of hospital staff work in wards and patients spend most of their time during a hospital stay in wards. However, the ward itself should be, but seldom is a health promoting environment for employees, patients and their relatives.

At the Rudolfstiftung Hospital the Neurological Department was chosen to be developed into a model of good practice for health promotion. The aims of the corresponding subproject „Reorganization of a Ward“ comprised the architectural alterations and innovation of the ward, increasing the efficiency of working processes and improving the working conditions for personnel and the general conditions of the patients’ hospital stay.

Following a period of problem analysis, the subproject group responsible for drawing up concepts and putting the model into practice worked out detailed plans for future reforms:

- architectural alterations of the ward with regard to functional, ergonomical and more patient-friendly standards;
- setting up a ward secretariat;
- working out guidelines to clarify the competencies of each professional groups;
- reorganizing nursing routines, introducing patient-oriented group nursing, improving nursing schedules, modified working-hour models, practical instruction and integration routines for new staff;
- developing interdisciplinary structures of communication and cooperation;
- improving doctors’ work organization ;
- devising a concept for doctors’ further and advanced training and
- introducing offers of continuous physiotherapeutical care for patients.

Nearly all of these plans for innovation were put into practice. The rebuilding and reorganization of ward space improved patients’ comfort and amenities for more privacy, facilities for physically handicapped people and higher sanitary standards. Setting up a conference room for the ward staff was a prerequisite for better interprofessional communication. This in turn made it easier to organize work with the patients more efficiently. The introduction of a ward secretariat was a great help in relieving nursing staff from tasks beyond their professional responsibility. More

time could now be spent on patient oriented group nursing. In general, these innovations led to more job satisfaction for the ward personnel. However, after completion of the subproject, some of the reforms were cancelled again due to lack of resources. The ward secretariat was closed, which made clear division of competences and patient oriented nursing more difficult, besides leaving the staff disappointed.

Subproject 4:

„The Out-Patient Clinic as Interface between In- and Out-Patient Care“

Following models of „step by step care“ out-patient clinics of public hospitals should be used only when other possibilities and offers of out-patient services have been exhausted. However, in reality this is not the case. Contrary to the aims of health policy in Vienna, there has been a steady shift of medical care towards hospitals. The out-patient clinics play a vital role here, as it is their job to take decisions on whether a patient is admitted to hospital, treated within the premises and facilities of out-patient care, or referred (back) to doctors outside the hospital. To deal with this problem of hospital out-patient clinics being constantly overburdened, a subproject was set up at the Surgical Out-Patient Clinic. The general goal was to reduce the number of new patients and to increase the amount of treatment co-operation with primary health care facilities. By reorganizing internal structures and work routines one hoped to increase efficiency and raise the standard of provided care.

Measures:

- increasing capacities and improving the quality by reorganizing internal work procedures (computer equipment, establishing a secretariat)
 - creating an additional post for a senior doctor to have more experienced physicians present;
2. Improving cooperation with medical services outside the hospital:
- a record of services currently offered by medical facilities in the catchment area of the hospital to facilitate referrals (back) to doctors outside the hospital;
 - collecting data on the experiences of primary health care partners and their wishes for better cooperation and information;

Evaluation of this project showed that a high percentage of patients (39%) came to the clinic with complaints whose treatment was not specifically a function of the surgical out-patient clinic. This underlined the purpose of the project and a group of practitioners outside the hospital was found for improving the co-operation. Concerning measures to increase internal work efficiency, the installation of a secretariat proved a particularly good innovation. There was less administrative work to do for the nursing staff, leaving more time for patient care and reducing the number of nursing working hours per week. The continuous presence of a senior doctor at the out-patient clinic reduced the waiting periods for patients, especially for the difficult cases. All in all, by carrying out the model project, there was a definite reduction in the number of patients (a reduction of 7.3% in 1994 compared with 1990) as well as in the number of treatments (a reduction of 20% during the same period).

Subproject 5: „Healthy Food in the Hospital“

Hospital food does not have a very good reputation. Although one knows that many of the widespread diseases of our time – diseases of the heart and circulatory system, diabetes mellitus, diseases of the digestive system, gout, constipation, malfunctions of the lipid metabolism, high blood pressure etc. – are affected by bad nutrition and bad eating habits, most large hospital kitchens pay little attention to the quality of the meals. It is a fact that food, which is chosen according to dietary principles, well and tastily cooked and served attractively, increases patients' well-being and has a positive therapeutic effect. In addition, the hospital should increase peoples' awareness about healthy diets by providing exemplary meals. Finally, better quality meals for the personnel would be another important factor in improving their working conditions.

A number of reasons influenced the decision to introduce a subproject „Healthy Food“ at the Rudolfstiftung Hospital. The dishes offered were not up to dietary standards and technical devices in the kitchen area needed improvement. Patient consulting about healthy diets was hardly practiced, due to administrative overwork of the dieticians. The situation of the staff and their wishes were hardly taken into consideration in planning canteen menus. To solve these problems three programmes were developed and tested:

Programme 1 – Improving the quality of dishes „New types of food – new dishes“:

The main goal of this programme was to develop higher quality menus for the patients and personell according to dietary principles. This required a fundamental reorganization of the kitchen management and it soon became evident that the work process themselves also required restructuring. Devising new meals and menus meant that the kitchen staff needed special additional training. For instance cooking staff had to be schooled in the preparation of new dishes.

Programme 2 – Improvement of individual choice and accessibility to meals:

To improve the individual choice and accessibility to meals for the patients on the 28 wards, a computer-based network with Bar-code-scanners was introduced. A first step to support healthy choices by the personell was taken by introducing a salad buffet. Further steps (e.g. vegetarian menu) had to be postponed for economic reasons. An easier and unbureaucratic access to the menus was made possible for the staff.

Programme 3 – Promoting consciousness about healthy food:

The introduction of computer aided kitchen management allowed a shift of work resources. The dieticians were able to devote more of their time to teaching and consulting. They were also able to produce a general brochure on „Healthy Food“ for use in the hospital as well as two information sheets for patients with diseases of the kidney. They have also increased consultation services in wards and have begun to develop a supplementary training programme for the staff.

Evaluation of the subproject showed positive effects in all areas: more than 80 % of the patients judge the quality of the meals as satisfactory. The staff on the other hand consumated twice as many dishes since introducing the above mentioned measurements.

Subproject 6: „Training of Diabetics“

Diabetes mellitus is a complex disease with various effects on the quality of life of those affected. As the course of this illness is to high degree in the hands of the patient, proper training programmes are a vital part of any treatment. Diabetics should learn to judge the effects everyday situations can have on their illness, to recognise danger signals and to handle crises. The aim is to teach those concerned how to control the course of their illness themselves.

At the Rudolfstiftung Hospital training for diabetics was introduced as an independent unit co-operating with the ward and the out-patient clinic of the 1. Medical Department. The goals of the subproject were to guarantee a continuous institutionalization of high quality services and to gain experiences, which also could be applied in other areas of patient education and training.

The training was carried out for individuals and groups and included information about background and causes of diabetes, the course of the illness, treatment options and how to control ones blood sugar level. Additionally information on „healthy food and nutrition“ is given and ways to avoid and handle crises are presented.

Measures taken by the subproject:

- integrating the training staff into the regular staff by creating regular jobs;
- specifying roles and job profiles for the „diabetes training nurses“, the „dieticians“ and those doctors working in the diabetes training team;
- preparing a concept for a second „follow-up training“;
- improving the location of the out-patient training programme;
- developing information material for diabetics in hospital; and
- improving the competences of the members of the training staff by supplementary training.

As a result of the regular jobs created for the staff of the training team, the personnel fluctuation became significantly lower. More continuity among the staff led to more continuity and better developed programmes. About 700 patients are involved in diabetics training programmes per annum, most of them being treated in wards. A greater focus on out-patient training is being prepared as well as a programme for General Practitioners doctors outside the hospital.

Subproject 7: „Nursing“

Hospital nursing has become a public issue in Austria and other countries during the last few years as a result of an acute lack of trained staff and a high rate of fluctuation compared with other professions. There are signs of change in the image of the profession, demonstrated by efforts to introduce planned nursing, develop nursing standards, try out patient oriented models of nursing, changes in working hours and reforms of nursing training and supplementary training. All this shows the urgent need for reform as well as the motivation of the profession's representatives to deal with the problems.

As a result of a first problem diagnosis several problem areas in the field of nursing at the Rudolfstiftung Hospital became visible:

- continuing strain and overwork of nursing staff;
- lack of innovation to improve the quality of nursing;
- uncertainty concerning the nursing staff's professional role and duties; as opposed to those of other professional groups;
- demotivation of many nurses;
- a basic shortage of qualified personnel; and
- a high fluctuation, especially among trained nursing staff.

Measures

- a) Area of special interest „Delimitation of the Nurses' Role and Interdisciplinary Cooperation“:
 - research on the amount of work done by nurses not related to nurses' specific qualifications;
 - development of a work plan to reduce these non-professional aspects of nurses' work;
 - testing a model to clarify the nurses professional roles and competences as opposed to other professions, and to increase interdisciplinary co-operation at a pilot ward.
- b) Area of special interest: „Better Integration and Practical Instruction of Student Nurses and New Staff Members at the Ward Level“:
 - drafting job descriptions for the practical instructors within staff;
 - developing concepts related to structural prerequisites for ward-specific practical instruction;
 - setting up organizational structures and co-operative structures to facilitate practical instruction.
- c) Area of special interest „Magnet Hospital Rudolfstiftung“:
 - developing leadership training courses for head nurses on the ward levels;
 - introducing organizational consultation to improve management structures of nursing.

Evaluation results so far indicate very positive outcomes: an increase of nurses' job satisfaction, decreasing fluctuation rates, less tendency to change jobs, and a general improvement in the working atmosphere on the ward. The leadership training courses play a central role in helping head nurses to organize better working conditions. Programmes which help develop leadership qualifications are therefore one of the central strategies to improve job satisfaction, motivation, team work and high quality nursing.

Subproject 7.4: „Group Nursing“

One of the reasons for the call for innovation in the field of nursing is, that the traditional organization of nursing in the form of „functional nursing“, gives too little room for patients' needs and wishes. „Group nursing“ on the other hand, allows for more focus on the patients themselves and gives space for more participation of the

patient in their own healing process. It is a form of nursing carried out by a team of nursing personnel (trained nurses, assistant nurses and trainees) in charge of a small group of patients.

At the Rudolfstiftung Hospital the model patient-oriented group nursing was first put into practice as part of subproject 3 „Reorganization of the Ward“. Experiences made here supported previous expectations: It had a positive effect on the patients as this new form of nursing allowed closer personal contact between nursing staff and patients, people were better cared for and this improved psychosocial care of patients and their relatives. Nursing staff were closer at hand for the patients and the nurses were in better command of their work. They had more information about the patients' condition, about the results of examinations and treatment. The organization of the entire ward became less strenuous for the head nurses, who could rely more on the individual nursing teams to take decisions on everyday nursing tasks. The nursing teams were more autonomous, nurses felt to have greater competence and responsibility which in turn improved staff motivation.

A special project group at each ward has proved helpful in planning and implementing this model project. Experiences so far show, that setting up new concepts for working schedules and time shifts is the focal point in a successful organization and introduction of patient-oriented care. In the everyday working of the ward more importance was given to the first admission interview of nurses. Nursing documentation has gained in importance as a result of decentralised responsibility for the different nursing groups.

Subproject 8: „Support for Patients by Volunteer Services“

Volunteer services have already become an essential part of hospital routine in several countries. Experience shows that the incorporation of volunteers has a number of positive influences. On the one hand medical care and nursing are complemented with additional services, which meet patients' needs for communication and personal attention. Support by volunteers relieves the hospital staff and widens the range of hospital services. Volunteer helpers introduce new competences to hospital work: a strong personal commitment, „normal“ interpersonal relationships, support in everyday things and their own personal experience.

The model at the Rudolfstiftung Hospital set out to establish a team of volunteer helpers at four model stations and to develop ways of organizing work which would allow the model to become established within the hospital routines. Volunteers were recruited with the help of public relations: Calls for volunteers appeared in all Viennese newspapers and the radio broadcast information. Out of 180 volunteers 40 were chosen and received an initial training. To co-ordinate the work of this relatively large number of external people with daily work processes at the wards, a „full-time co-ordinator“ was introduced. Her job was to co-ordinate the activities with the wards, to look after the volunteers and to plan and carry out training. The bureau headed by the full-time co-ordinator became the heart of the organization of the volunteer service. To ensure the incorporation into the work of individual wards, a focal person from both the medical and the nursing staff was recruited.

Experiences with this model project are positive so far. Volunteers are engaged in the following activities:

- communication; talking with individual patients and encouraging communication among the patients;
- helping patients with everyday tasks such as putting their locker in order; changing the position of the bed etc.;
- doing errands for patients – phone calls, shopping;
- escort services; helping people getting up from their beds, encouraging them to move around and to go for walks in the park;
- giving information concerning services inside and outside the hospital;
- helping patients to communicate wishes and problems to doctors and nurses.

Both patient surveys and interviews with hospital staff indicate the successful implementation of the volunteer team. The services offered by the volunteer team were readily made use of by the patients. Doctors and nurses consider this additional service for patients as a useful help: volunteer helpers have proved able to work independently. They provide an extra service without encroaching on the actual medical and nursing work. It is seen as an important future challenge to keep up the motivation of the volunteers and the recruitment of additional members of the volunteer team.

To make sure that the support for patients by volunteer services will continue after the model project has terminated, an association „Support for Patients by Volunteer Services at the Rudolfstiftung“ was founded in June 1994, supported by the Rudolfstiftung Hospital and the City of Vienna.

Subproject 11: „Cooperation between clinical and central departments“

A smooth, well functioning co-operation between the different wards and units of a hospital is essential to ensure high quality care. However it was seen, that this co-operation doesn't always function as well as it should in the Rudolfstiftung Hospital. This is especially true for co-ordination and communication between clinical and central hospital units (e. g. laboratories, x-ray department).

In improving communication and co-operation between wards and central units more specified referrals could be made and thus reduce the amount of queries and referrals back. Reducing work for the central units would in turn benefit patients by reducing time spent waiting for examinations and medical reports, allowing treatment to begin earlier and reducing the overall time spent in hospital.

Trying to create ideal conditions for co-operation between clinical and central hospital units a model project was set up, first including two units – the 4. Internal Department and the central X-Ray Institute. The project's aim was to develop a solid co-operative relationship between these two units and to use the experiences of this project to plan a reform for the entire hospital organization. Within the model project itself, efforts were made to improve the quality of referrals, the co-ordination of examinations and the quality of medical reports.

Measures:

- setting down fixed rules for filling in the referral forms: Forms to be filled out completely, for example the referring doctor had to specify the exact problem he wants clarified;
- training the doctors in teaching on the possibilities and limits of X-ray examinations;
- devising an information brochure on „possibilities and limits of X-ray examinations“;
- setting down fixed rules for sending medical reports: developing criteria for dividing reports into „acute“, „subacute“ and „routine“ reports;
- introducing written summary reports on medical operations and examinations;
- collecting the different x-ray examinations patients are in need of, to carry out all examinations at one go;
- applying the collected experiences in co-operation when establishing the electronic network between X-Ray department and the wards.

The first phase of the model project brought positive results for the working atmosphere as personnel from both units came together to discuss problems. Possibilities to get to know and to understand the problems and needs of the other unit were opened. Results so far from the parallel evaluation show that the frequency of queries by phone between the two units has sunk drastically in pre-/post-test. The staff consider this to be a considerable help to ease their work load. By a better co-ordination of referrals and medical examinations between the two units waiting time for patients has also been reduced. These results encouraged the X-Ray-Institute to start a similar development with all departments of the hospital.

Subproject 12: „Mission Statement – Rudolfstiftung“

The Austrian public health service has reached a stage of change and restructuring which will also include old-fashioned organizational structures in hospitals. Measures to decentralize the hospital system will trigger off changes towards an economic orientation of hospital management. As a result of cuts in health policy and more service-oriented accounting, hospitals are now more competitive and each hospital has to present itself as a modern service institution. In the future, hospitals will need clear goals and values to adapt themselves to changing social conditions. In this sense the incorporation of health promotion into the basic goals of a hospital can strengthen the position of the hospital in the new market. Developing a „mission statement“ should help clarify this position. A „mission statement“ is an instrument of management planning. It sets down principles and norms for a specific organization. Externally it has a public-relation function, internally it strengthens the staffs' orientation and motivation. In the context of health promoting hospital the process of developing a mission statement itself should be a means of empowering the staff to create for themselves the framework of their own „healthy“ organisation. Therefore this process should also be a measure for promoting health.

To allow for a high level of participation of staff members, a project group with members from all professional groups was set up. The model has been put into practice along the following lines:

- working out relevant themes in a project group of 27 people from all professional groups and from all levels of the hospital hierarchy;
- forming working groups for each main theme, sending out invitations to all staff to work in the working groups;
- definition of central messages for the different working groups;
- collecting the first results from the different working groups by the project group, formulating a first draft of the mission statement;
- discussing the first draft of the mission statement with the management and staff, revising the draft and developing projects to incorporate the mission statement into everyday life;
- final editing of the mission statement; and
- public presentation of the mission statement and the „incorporation projects“.

In the beginning of October 1995 the project group arranged a full day workshop where eight themes, relevant to developing a mission statement for the Rudolfstiftung Hospital were set down:

1. „*Collectively instead of individually*“. Main area of interest: organizational development, interprofessional cooperation, styles and systems of leadership.
2. „*Staff: satisfied – creative*“. Main area of interest: developing personnel, work on satisfaction of staff.
3. „*Patient and relatives as partners*“. Main area of interest: treatment of patients and their relatives.
4. „*Quality*“. Main area of interest: quality ensurement and quality management
5. „*Use of resources – clarifying costs*“. Main area of interest: economy, being aware of costs.
6. „*Active education*“. Main area of interest: integrating the nurses training college, questions on the function of training.
7. „*Public relations*“. Main area of interest: representing the hospital internally and externally.
8. „*Service programme and focus of services / Partners for co-operation*“. Main area of interest: future developments in the field of medical care, nursing and psycho-social areas; cooperation with extra-mural institutions.

What have we learned?

The Vienna WHO-Model Project played an important part in helping the Rudolfstiftung Hospital to develop toward a health promoting organization. As we were constantly accompanying and facilitating the project, we would like to summarize our experiences as recommendations we consider crucial for setting up a Health Promoting Hospital project.

1. Establish a broad acceptance of the health promotion policy within the management, the owner, the staff and the broader public – by public presentations and participative decision process at the start of the project.
2. Stay in close contact to the problems and needs of the main target groups – staff, patients and community without losing contact to management and owner of the hospital and their perspectives.
3. Identify someone or a group of persons in the hospital who can be the co-ordinating and leading person/group for an ongoing process and appoint a project co-ordinator.
4. Establish an inter – professional committee for developing and deciding the Health Promotion strategy, including the management of all professional groups, staff council and health promotion experts.
5. Make sure that decision making is transparent and keeping to the facts.
6. Identify solvable health problems in the organisation to start with.
7. Establish project groups for each problem area which can represent all different perspectives for solving these problems – give a place and time that people can learn to work in this new co-operative structure.
8. Establish clear roles and co-operation structures within the project groups (co-ordinator, experts etc.; who is inviting to the meetings? who is preparing the agenda?) and for the co-operation of persons and institutions (who is the client? who is deciding what?).
9. Make sure that you have the resources (time, money and manpower) to establish each health promotion project before starting the project and establish a realistic frame-work for the work of the project group.
10. Involve experts, expert knowledge and existing models of good practice from other hospitals whenever possible, but always approach the directly affected persons as the first „experts“ in the field.
11. Make use of external facilitators for the social process of the initiatives if conflicts are expected.
12. Develop acceptable communication strategies and media to ensure ongoing information and support of the whole organisation for the health promotion initiatives – newsletter, regular presentations, internal and external public relations.
13. Review and evaluate all health promotion initiatives on a regular basis – develop a set of targets and indicators to allow this evaluation process to be simple and effective in producing plausible data. Make progress evaluations to be able to change the direction of the development al process.
14. Make sure that persons committed to the project and investing their time get rewarded for their enthusiasm – do not forget that they should be able to enjoy their health promotion work.
15. Make the results accessible for discussion and for transfer to other parts of the hospital, the local or even the wider community. A network of Health Promoting Hospitals offers mutual exchange and consultation. The network can learn from your experiences as well as you can learn from the experiences of the others and

it can provide a political lobby as well as a conceptual basis for reform and change in the health care sector.

References

- Baric L., Baric L. L. (1995): Health Promotion and Health Education. Module 3: Evaluation, Quality, Audit. Cheshire: Barns Publications
- Flemming R., Lister G. (1995): European healthcare trends: towards managed care in Europe. Coopers & Lybrand, Solutions for Business
- Guba E.G., Lincoln Y.S. (1989): Fourth Generation Evaluation. Newbury Park, London, New Delhi: Sage
- Lobnig H., Nowak P. (1993): Evaluation von Gesundheitsförderungsprojekten im Setting Krankenhaus. Wien: Working Paper des Ludwig Boltzmann-Institutes für Medizin- und Gesundheitssoziologie
- Lobnig H., Nowak P., Pelikan J. M. (1996): In: Bellabarba, Schnappauf (Hg.): Organisationsentwicklung im Krankenhaus. Göttingen, Stuttgart: Verlag für Angewandte Psychologie
- Ludwig Boltzmann-Institute for the Sociology of Health and Medicine (1996–1997): Wie man im Krankenhaus ... einführt. Modelldokumente 1–10. Wien: LBIMGS
- Nowak P., Pelikan J. M., Lobnig H. (1994): Organisationsentwicklung einer Krankenhausstation. Organisationsentwicklung 13, 3, 12–21
- Pelikan J. M., Krajic K. (1993): Gesundheitsförderung im und durch das Krankenhaus – Konzepte und Strategien, Netzwerke und Projekte. In: Pelikan J.M., Demmer H., Hurrelmann K. (Hg.): Gesundheitsförderung durch Organisationsentwicklung. Weinheim, München: Juventa Verlag
- Pelikan J. M., Lobnig H., Nowak P. (1993): Das Wiener WHO-Modellprojekt „Gesundheit und Krankenhaus“ – Konzepte, Strategien und Methoden. In: Pelikan J. M., Demmer H., Hurrelmann K. (Hg.): Gesundheitsförderung durch Organisationsentwicklung. Weinheim, München: Juventa Verlag

Hospitals in Germany – A Changing Scenario

Gunar Baugut

What does the scenario of hospitals in Germany look like? What are the important developments in this area and what is their significance for the development of health promoting hospitals?

To make the point right from the start: The organizational and financial conditions are not in favour of health promotion. There are still only few hospitals in the German network of health promoting hospitals, they however are playing an increasing role.

Capacities and performances in German hospitals

As we wish to be brief, we will document the facts – relevant for our argumentation – in a checklist of theses. In general the year of reference is 1994 (Reister 1996), if not, a different year is mentioned.

- a) Looking at the costs hospitals are the most important part of the German health system. The ratio of the costs of hospitals in relation to the overall expenditure for the entire health system in Germany is 37.6 % (Jelastopulu, Kaiser 1996); this still increased in the last years, whereas the ratio of most comparable countries has been reduced.
- b) The number of hospitals is decreasing; the number of hospital beds declining more strongly than the number of hospitals.

Number of hospitals	- 3.1 % 91/94	(2,337 in 1994)
Number of hospital beds	- 7.1 % 91/94	(618,176 in 1994)
- c) The reduction of hospital beds in German hospitals is at the high ratio of 60 %, compensated by additional institutions and additional beds in the rehabilitation sector.

Number of rehabilitative institutions	+ 12.5 % 91/94	(1,329 in 1994)
Number of rehabilitative beds	+ 19.8 % 91/94	(172,675 in 1994)
- d) It is a clearly defined programme of health policy in Germany to reduce the capacities in the hospital sector in favour of the outpatient sector; in fact the number of hospital patients is increasing and only the duration of stay in hospital is slowly decreasing.

Hospital patients	+ 5,0 % 91/94	(14,5 million in 1994)
Length of stay	- 13,4 % 91/94	(12,7 days in 1994)
- e) Hospital staff has increased only slightly; seen in context with the decreasing number of hospital days the staff ratio per patient and day has been rising distinctly:

from 17.1 to 19.1 for the medical staff
from 58.5 to 67.5 for the nursing staff
from 157.0 to 173.4 in total;

measured in terms of full-time equivalent per 100 occupied beds within the period from 1991 till 1994 (Deutsche Krankenhausgesellschaft 1996).

The development mentioned, refers to the whole of Germany (after the unification) and that is why only the last four years could be taken into consideration.

The accessibility of hospitals in Germany in terms of kilometres and hours is not as good as in the years before; but as in most comparable countries where the number of hospitals was also reduced, the German hospitals – in this comparison – still have a rather good accessibility.

German hospitals have the reputation of a good quality of performance; this can be verified by the mortality figures for mothers and neonatals; within an international comparison the standard of hospital performances and their quality in Germany is continuously high (Huber, Köse, Schneider 1993).

In the beginning of 1991, within the process of the German unification the new German states (Brandenburg, Mecklenburg-Vorpommern, Sachsen, Sachsen-Anhalt, Thüringen), and in addition Eastern Berlin, adopted legal regulations for financing hospitals from former Western Germany; previously they only had been modified by temporary regulations. There was an extremely high demand for redeveloping the hospital buildings and the medical equipment; in response an investment program was installed that enables the realisation of technical needs for restructuring to take place step by step.

Between 1993 and 1994, i.e. in a very short time, a radical change took place in the five new German states – with regard to the capacities as well as to the performance figures:

21.9 % of the hospital beds were reduced

7.6 % more hospital patients were treated

23.0 % of the length of stay was reduced: from 16.1 to 12.4 hospital days
(Reister 1996).

The new states adopted the structures of the Western Germany health system more quickly than expected. In the years before the unification outpatient health services had been the major task of polyclinics. These existed in connection with general hospitals, not only with university clinics and they even existed as autonomous units integrated in companies of different branches. They were like an institutional bridge between the extra- and the intramural health services. By closing the polyclinics this connecting function was destroyed in most cases (Schneider et. al. 1992). As of 1993 the possibility to offer services for ambulant patients, described by the legislation in the terms of „prehospital diagnostics“ and „posthospital treatment“ and, in addition, „ambulant surgery“ was introduced in the unified Germany; for the states of Western Germany this was an innovative action and for the states of the former German Democratic Republic this was only a modified revival of an organizational solution they had already had before.

Financing hospitals

The health expenditure in Germany for 1993 had a share of 8.6 % of the gross national product (Jelastopulu, Kaiser 1996). This percentage is an average one compared with other Western industrial states. In this context we must mention that the health expenditure ratio had remained almost stable since 1980 (8.4 %). Contrary to this re-

lative stability there has been a remarkable increase in the share of hospital costs in relation to the total health expenditure. Between 1991 and 1994 hospital costs have been rising by 6.4 % annually and by 20.4 % within the span of the three years. The cost of the hospital sector in 1994 was 96 thousand millions for the treatment of 14.6 million hospital patients (Reister 1996).

In 1996 Germany started introducing a fee-for-service system with the aim to restrict or limit hospital expenditures. In a first step the legal regulations described 42 fee-per-case categories and additional 142 fee-per-treatment categories. The evaluation of these categories was defined by „scores“. The fee is the result of the number of scores for the entire case multiplied by the value of the score that is negotiated between hospitals and health insurance on a regional basis. Fees per treatment are in most cases for surgical operations in those cases where a fee per case has not been defined or is not adequate. In addition to the fee per treatment the other hospital activities are compensated on a reduced fee per day basis (Baugut 1993).

The introduction of a partial „cheaper“ fee-per-case system in 1996 overlapped with a global overall budgeting in the hospital sector. That is why it is not possible to recognise the effects of the new fee-per-case system. The partial fee-for-case system covers only about 20 % of the hospital performances, whereas a rest is calculated by a fee per hospital day as before. This system induced different shifts between the fee per case and the fee per hospital day sector and as a result the desired incentive to become more effective and efficient was neutralised. There were several new legislations, decrees, and regulations one following another, and it is hard to come to an evaluation as to the effect of the different programmes of health policy. The hectic changes are a problem. Nevertheless, it shall be documented by a study whether these changes in hospital financing had effects and how they can be evaluated.

Health Promoting Hospitals in Germany

Within the framework of organizational and financial development for Health Promoting Hospitals in Germany the following facts can be used as an opportunity for further development:

- *Reduction of hospital beds*
Fewer hospital capacities create a pressure – on the one hand to concentrate on the core-competencies of acute diagnostics and therapies and on the other hand to offer or at least use complementary services of rehabilitation and care for the elderly.
- *Shortening the length of stay*
These cuts in the length of stay lead to a higher intensity of performances day by day. This makes it harder to use a hospital stay as a process of learning to motivate patients towards a healthier life style.
- *Intra- and extramural networking*
Up to now hospitals still hesitate to offer services for ambulant patients.
- *Competition between hospitals*
In regions with a high hospital density the reduction of hospital beds leads to a superseding competition that makes it more important for hospitals in Germany to gain a distinct profile of performances. Since competitive prices hardly play any

role it is a chance of marketing for hospitals to offer services in addition to normal curative diagnostics and therapies. These additional services can be integrated within an entire concert of a health promoting hospital.

- *Competition between health insurances*

The Health Reform Act in Germany introduced a competition not only between hospitals but also between health insurances. Prevention and other health promotive activities had been used as a means of competition between the health insurances in the meantime, but the Health Reform Act of late 1996 cut down the financing of health promotion by the health insurances.

Since 1993 a pilot project of the World Health Organization (WHO) has included 20 hospitals from all over Europe. Five of them are German hospitals, one of them from the new states. Until 1995 six additional hospitals have sought recognition as health promoting hospitals by WHO and succeeded. In the middle of 1997, that is two years later, a German network of health promoting hospitals attracted 14 new members, resulting in a total number of 25 members. Compared with the number of hospitals all over Germany that is hardly more than 1 %. But it should be taken into account that there are other German hospitals which perform health promotion in an exemplary manner, but until now have not applied for membership in the German network.

What are the prospectives for further development?

- The experience within the German network of Health Promoting Hospitals, in connection with the international network together with WHO, will encourage a multiplication of the HPH-ideas.
- The financial restrictions for German hospitals are not only a hurdle, but can be an incentive to become more creative and imaginative in finding new ways towards health promotion for the benefit of patients and staff.

In German health policy, health promotion continues to play a minor role; research and training in the field of public health at German universities will encourage the dissemination of the idea of health promotion and help it to be considered as an important means on a practical and a political level.

References

- Baugut G. (1993): Entwicklung und Berechnung von Fallpauschalen: Vorschlag der Arbeitsgruppe 'Entgelt-systeme'. In: Arnold M., Paffrath D.: Krankenhausreport 93. Stuttgart, Jena: Gustav Fischer Verlag
- Deutsche Krankenhausgesellschaft (1996): Zahlen, Daten, Fakten '96. Düsseldorf
- Huber M., Köse A., Schneider M. (1993): Wirtschaftlichkeit und Leistungsfähigkeit deutscher Krankenhäuser im internationalen Vergleich. Augsburg (BASYS)
- Jelastopulu E., Kaiser R. (1996): Leistungs- und Wirtschaftlichkeitsvergleich der Krankenhausversorgung. In: Arnold M., Paffrath D. (Hrsg.): Krankenhausreport 96. Stuttgart: Gustav Fischer Verlag
- Reister M. (1996): Statistische Krankenhausdaten – Ergebnisse aus der Erhebung der Grund- und Kostendaten für die Jahre 1991 bis 1994. In: Arnold M., Paffrath D. (Hrsg.): Krankenhausreport 96. Stuttgart: Gustav Fischer Verlag
- Schneider M., Biene-Dietrich P., Gabanyi M., Huber M., Köse A., Scholtes L., Sommer J.H. (1992): Gesundheitssysteme im internationalen Vergleich – Ausgabe 1992. Augsburg (BASYS)

The Health Promoting Psychiatric Hospital – What is the difference? Experiences from the Philipppshospital Pilot Hospital Project in Riedstadt

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Hospital Owner:	Public
Hospital Ownership:	Public
Specialisation:	Psychiatry
Beds:	309
Staff:	Medical Staff: 116, Nursing Staff: 244, Other Staff: 220, Total Number of Staff: 580
Utilization:	Average Utilization of Beds/Year: 80 %, Average Stay in the Hospital/Day: 38
Patients:	Number of Inpatients/Year: 2.873, Number of Outpatients/ Year: 1.216
Number of Departments:	8
Location of Hospital:	Suburbs/rural
Catchment Area:	Regional, Number of Population: approx. 600.000
Other Functions than Medical Care:	
Teaching:	Postgraduate, Nursing Education
Research:	Clinical Research, Other Health Research: Epidemiological Research
Subprojects:	<ol style="list-style-type: none">1. Networking of a Hospital Ward with Outpatient Services2. Environmental Movement in the Hospital3. Medical Emergency Service Cooperating with the Hospital4. Team Supervision5. Staff-Training to Create a Low Expressed Emotion Atmosphere within the Wards6. Socialwork Counselling of the Staff7. Family Centered Working Hours for Employees with Families8. Ergonomic Realisation of Computer Workplaces9. Active Health Behaviour/Health Promotion at the Workplace10. Horseriding as a New Therapy for Psychotic Patients11. Psychoeducational Groups for Patients Suffering from Adiction12. Psychoeducational Groups for Psychotic Patients and their Relatives13. Implementation of an Intensive Rehabilitation Unit14. Counselling Centre for Patients who are Foreign Citizens15. Theatrework in Psychiatric Health Care16. Childcare during Working Hours

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In common with other hospitals, psychiatric hospitals 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 and the necessity to cope with the social reaction towards them. The following case study provides an example of a specific psychiatric hospital on its way to becoming a health promoting organisation.

Philippshospital, one of the oldest psychiatric hospitals in Germany, has been in existence since 1533. Its modern history begins with the building 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. At the same time structural reorganisation at Philippshospital radically reduced the number of hospital beds.

Today, the hospital provides 303 beds, caters for 2,700 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 unit and a department for chronically ill patients, has been established. Furthermore, it has a nursing school with an enrolled list of 100 students and employs approximately 580 people.

The context of health promotion within the Psychiatric Hospitals in Germany

The historical context

Although psychiatric disorders had been understood as a mere manifestation of physical malfunctioning, and, accordingly, had been treated exclusively with somatic therapies for hundreds of years, the spirit of the enlightenment opened new perspectives for an understanding of the mind. This more enlightened view on the troubles of the mind was voiced in the first textbook on mental disorders, written by Pinel in 1793 (see Haenel, 1992, p. 446). Here, it was first recognised that mental disorders are diseases in themselves, which consequently require a specific treatment whose procedures aim directly at the mind. Its aim was to strengthen the morale of the patient, which had apparently been weakened by the disease. Strictly speaking, the procedure of moral treatment was an early manifestation of health promotion, to be achieved more or less directly by developing what we would today call the individual's coping capacities.

The experiences gathered along this route gradually increased public awareness of the role of the social environment in causing mental disorders and subsequently led to intervention strategies that placed an increasing importance on health promotion in the overall conception of psychiatric interventions.

In the following, this development will be illustrated by discussing some of its milestones in more detail. In the early 19th century, a passionate debate over the proper place of treatment ensued soon after the psychiatrists of the first generation had transformed the hitherto common prisons into infirmaries, which finally took account of basic human needs. As early as 1845, Griesinger, one of the leading representatives of German psychiatry, demanded the building of so-called "town asy-

lums". In the current understanding, they can be conceived of as psychiatric units at the patients' place of residence. His suggestion was motivated by the conviction that the integration of the mentally ill into their natural living environment would benefit the course of the illness. His view was in sharp contrast with that of his opponent Roller, who in 1868 vehemently advocated the separation of the patients from their relatives (see Haenel, 1992, p. 447). The debate centred exclusively on secondary and tertiary prevention and finally ended in favour of the segregation of the mentally ill from their environment in the newly erected mental homes. This result reflected the perception of the world at that time which drew heavily on the emerging hygiene theory. The negative consequences of this segregation only became apparent many years later, at the beginning of the 20th century. There were several attempts to counteract these destructive effects. The Erlangen psychiatrist Kolb introduced a so-called 'open care for the mad' in 1908, and Simon developed occupational therapy in Gütersloh in 1920. Like their predecessors, they first and foremost argued the cause of health promotion; like today, it was hoped that creating the respective structural prerequisites would positively influence the course of specifically chronic mental illness.

The Community Mental Health Movement, which evolved in the US and in England in the 1960s, is another example of an influential initiative motivated by health promotion. The cause of mental disorders was believed to be found exclusively in the social environment of the individual. This radical suggestion shook the foundations of traditional psychiatry. Although it failed to achieve its aim to eradicate mental illness by creating a favourable social environment, it contributed substantially to the discovery of the role of social factors in the causation of psychiatric disorders. One of the phenomena thus revealed is the so-called 'hospitalism', i. e. the damaging effect of the low-stimulus milieu of large institutions (Goffman, 1961; Wing and Brown, 1970). Irrespective of the fact that the Community Mental Health Movement failed to achieve its principal objectives, it did pave the way for the concept of health promotion in psychiatry. With its numerous structural challenges and socio-political initiatives, it has definitely contributed significantly to the improvement of psychiatric care, initially in North America and later in the Western European countries. The development briefly outlined here has resulted in a situation where one can no longer imagine psychiatric care without health promotion as a central aspect, even if it is not explicitly named as health promotion practice.

The reform of psychiatry in Germany

In the early seventies the parliament of the Federal Republic of Germany initiated a reform of the mental health care system in Germany by implementing a commission of experts, who were given the task to survey the situation of psychiatric patients². In their first report in 1975, the authors of the Psychiatric Survey maintained that psychiatric treatment was inadequate due to the antiquated building and estate of the hospitals; their size, location, as well as their inadequate staffing and services. In the

² „Bericht über die Lage der Psychiatrie in der Bundesrepublik Deutschland zur psychiatrischen und psychotherapeutisch/psycho-somatischen Versorgung der Bevölkerung.“

following years great efforts were made to improve facilities by establishing psychiatric wards in general hospitals, reducing the size of the large psychiatric hospitals and in particular, through the establishment of community-based psychiatric services.

Furthermore, the expert commission concluded in their report in 1988 that there were still serious gaps in services, especially for the chronically mentally ill and their relatives. The main objective during the past 15 years has been, above all, establishing external facilities (e. g. day care units, psychiatric clinics) and an organisational structure (e. g. smaller wards, patient speakers). Less priority was given to reforms concerning the atmosphere and the therapeutic procedures. Nevertheless psychiatric hospitals were forced to develop a new staffing structure (more therapeutic working team members). The interests of the staff and their possible contribution to maintaining their own health were not considered in the reform efforts. It was only recently and on the odd occasion that any consideration was given to the personnel in the hospitals.

The above-mentioned developments, the increasing involvement of the hospitals in the reform process, the establishment of ambulant services and the problems resulting from changes of the structure of patients / staff, confront psychiatric hospitals with new tasks. While the services for the chronically ill are increasingly being transferred into the hands of community-based psychiatric facilities, such as housing communities, day-care-centres, working facilities and on-call services, the tasks to intervene in crises such as those of the seriously ill have steadily increased in the hospital-sector. Whereas the average length of stay has decreased, the rate of re-admission has increased – a development, for example, particularly noticeable in the Philipshospital during the past six years. At the same time, there is increasing occupational stress and strain on the staff, especially on the nursing services, which lead to job-dissatisfaction and increasing risks of illness. Furthermore, the new and growing co-operation with the ambulant services require new and different approaches from the hospitals' organisation and all professionals involved.

This situation calls for a new therapeutic orientation:

- developing clear aims and objectives for the future corporate identity of the hospital,
- better exchange of information within the hospital and with the outside partners,
- establishing a new and predominantly horizontally structured organisation with stronger responsibility at the ward level,

resulting in continuous discussions on:

- therapeutic perspectives,
- implementation of health security measures for the staff, and furthermore,
- introducing supervision and discussions based on individual cases, which should also include the external service representatives.

Additionally a closer collaboration between the hospital and its external partners has been developed. A deeper involvement of patients and their relatives in the treatment process, instructions and education on maintaining good health and strategies to support coping and self-help are needed. As well as this, involving political authorities

and the use of non-professional resources in the neighbourhood should become important responsibilities of the reformed psychiatric services.

The institutional context of Philipphospital

During the reform process Philipphospital was very active in the re-development of patient care and organisational structures: Two psychiatric wards were founded, the catchment area was redrawn, the hospital was renovated and internally reorganised and finally, community services were established. The hereto related networking of the hospital with external services has led within the past five years to radical changes, including shifting chronically ill to community based institutions. The existence of such ambulant services lowered the admission threshold to the hospital and opened it to other groups of patients, a trend visible in the increased number of admissions of drug-addicted patients and neurotic patients. As a result, 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, favorable new legislation has allowed the employment of more and better qualified staff.

The increased networking with the external services demand new and different ways of co-operation and communication both inside and outside the hospital, which is not only seen as challenge but also as a growing burden to the staff. As a consequence, it has become necessary to consider the needs of patients as well as of staff members and to include both actively in designing new concepts of therapy and in implementing 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 proposed concept of a health-promoting hospital seemed to be an ideal frame. It provides a fresh look from outside, which can stimulate the internal discussions and provide a public view of internal processes through the duty to report on and evaluate the project work.

The difference between psychiatric hospitals and general hospitals: Different projects for different problems

The patients

Patients in psychiatric hospitals face a very different situation to patients in somatic hospitals both on the level of social consequences and that of illness related symptoms. For the patient, crossing the threshold of the mental hospital means not only leaving the normal world, but also in addition leaving behind a normal social identity. For the social environment (for example family, friends, neighbours, colleagues) the person who becomes a psychiatric patient often loses confidence in his/her abilities to fulfil the demands posed by the various social roles. In addition to the 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 cope.

Patient-related health promotion within the context of a psychiatric hospital therefore includes, the control of symptoms (e. g. by drug treatment), the prevention of self-destructive behaviour (e. g. misuse of legal and illegal drugs, suicide) and the pre-

vention of harm to others (e. g. through aggression). It also includes the re-establishment of the personal identity and, as far as possible, the preparation of the patient for re-integration into the normal social life.

Psychopharmacological treatment and different types of psychiatric therapy are the primary means of fulfilling the tasks described above. Implementing new forms of treatment, especially for patients who seem resistant to established therapies, is a primary concern of one of the patient-related sub-projects – equestrian therapy.

As the diagnosis and the treatment of psychiatric symptoms is widely based on oral communication, patients of a foreign native language and those who come from foreign socio-cultural backgrounds find it particularly difficult to communicate their problems and to understand what happens to them in psychiatric hospitals. A counselling centre for foreign citizens with psychiatric problems therefore was set up as a further patient-related sub-project.

Living with mental illness is also a problem for relatives and people from the patient's social network. The implementation of psycho-educative groups for patients and relatives is the third patient-related sub-project, aiming at helping patients to live with their illness and helping relatives, partners or friends to live with the patient.

Staff and hospital organisation

People who work in psychiatric hospitals are continuously confronted with what can be called the dark side of humanity. Psychiatric patients, particularly in phases of acute illness, are often 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 the level of eating, drinking coffee and smoking. In contrast to other hospitals, some of the patients in psychiatric hospitals are not voluntarily hospitalised but have been committed by legal authorities or relatives. These patients often do not feel ill and therefore refuse any treatment or care.

Moreover, the psychiatric hospital's 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 will help a patient is often a process of trial and error with random positive or negative results. As a consequence of the less clearly defined expert knowledge, professional roles and hierarchical structures of mental hospitals are often more diffuse than those of somatic hospitals.

Because of the specific characteristics of patients and working conditions, psychiatric hospital staff members are specifically vulnerable to emotional overload and burnout. Training in physical and psychological relaxation techniques is therefore a central issue of the sub-project on active health behaviour.

As communication and interaction is the basis of all psychiatric therapeutic methods, a systematic reflection of the communication behaviour of staff members and teams 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 addition to its therapeutic effects on the patients, a drama group can also be a means to work on 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. Performances of the drama group may enable the actors and the audiences to engage in critical reflection on what happens in the hospital.

The community

Modern psychiatric hospitals have at their disposal an extensive expert knowledge on the diagnosis and treatment of mental illness. Particularly in rural communities with a deficit of extramural psychiatric services, 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 due to the social stigmatisation of mental illness, through which psychiatric hospitals and their inpatients 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. Beyond the waste of community health resources, this negative image has unfavourable consequences for patients and staff members. Patients undertaking activities outside the hospital, e. g. work, shopping or participating in social activities, often bear the risk of mockery, refusal or even victimisation. Such experiences of devaluation particularly harm the process of social and occupational re-integration of psychiatric patients. Stigmatisation can also be a problem for the staff members by interfering with therapeutic efforts or, particularly if they live in the neighbourhood of the hospital, they may be identified with the negative image of their clients.

The creation of a medical emergency service, which is located on the hospital's grounds, was an important step towards better integrating the resources of the hospital into the system of community health promotion. It is assumed that offering the facilities of the mental hospital to the general practitioners and to people living in the community who need medical help during the night or over the weekend will lower the threshold to the utilisation of the psychiatric services when needed.

Beyond its positive effects on the patients and staff members the drama group also plays an important role in the process of improving the public image of Philipphospital. The integration of the drama group into the programme of the local adult education centre offers community members the opportunity to actively participate in this group. It is hoped that the experience of acting together with psychiatric patients and staff members will be a helpful means of reducing prejudices and aversions towards the patients and the institution as a whole.

The development of the overall project and the sub-projects

The story of a successful beginning

The application

The application as a WHO-Pilot Hospital evoked general astonishment in the hospital particularly the fact, that there might be a connection between the hospital and the

world “out there”. Based on the reform of psychiatric care opting for a gradual opening-up of psychiatric hospitals, the community – slowly and not without protest – found increased access to Philipppshospital, and the patients also established links with the community. But with the planned WHO-project, however, the hospital was confronted by an even greater challenge: not only it had to perceive itself as part of a community but as a part of an international movement. As if the latter were merely an illusion, the management did not have any objections against the application, though they were dubious in their expectations of success, and were thus not really anticipating the obligations connected with such a project. The staff council supported the application, taking a wait-and-see attitude and not really getting involved with regard to its contents: In informal discussions one realised that the general feeling concerning the application was “a few loonies reach for the stars”.

However, the discrepancy between the open acceptance of the application and the rather distant informal view on the project was taken as a serious problem of information policy by the co-ordinator of the project. The application procedure elicited a high degree of interest but also created tensions, resulting in statements such as “We will apply” and “We take up the challenge of an evaluation.” entering the internal discourse of the hospital.

Once the application had been accepted, a meeting was held to inform staff members and to take a vote on the implementation of the project. The meeting generated a great deal of interest (30%) on the part of the entire personnel and resulted in the formal acceptance of the WHO pilot project in Philipppshospital. The acceptance of the application forced the decision-makers to take a stand. Subsequently, initial opposition as well as unexpected support became apparent. The management took great pride in their hospital, having been chosen for the WHO project and were determined to ensure its successful completion.

With the success of our project proposal, the cognitive dissonance described above contained the risk of rejection of the project work as being out of proportion to the hospitals activities: Statements such as “We have different concerns”, or the perception of the WHO signet as an award that had not been deserved but that could now be used as an excuse to rest on one’s laurels were the two extremes of possible negative reactions. The public interest in the project (e. g. on the part of the press), generated as a result of our public relation efforts, clearly indicated the recognition of our hospital in the community.

Another consequence of the successful application was that even motivated staff members felt themselves excluded from the project and asked for more opportunities to participate in the project. This tendency was counteracted by means of an information campaign, and the staff members in question were asked to participate. A suspicious attitude also resulted in a situation in which individual departments or occupational groups felt left out. In summary, the successful application spontaneously laid bare the informal communication structures both within the hospital and between the hospital and the community. The manifold tensions in these communication structures became apparent.

The project work turned out to be an unexpected gift: it showed that, through the first discussions, a process had been initiated which made us hope that it was a change to-

wards becoming a health-promoting hospital. Now it was necessary to implement appropriate structures for the project, which would enable the fledgling process of change to find concrete expression and allow those interested to become involved.

Making the project a common issue

With support of the respective decision-makers, a first task was defined as contacting and informing all personnel. To achieve this we relied on the pre-existing organisation and communication structures: the ward teams, the staff conference, the technical team etc. Information sessions were held within staff meetings or during the breaks. This enabled us to reach as many staff members as possible. In addition, an inaugural newsletter containing information about the project was distributed.

The information campaign was a difficult task as the project co-ordinator, who was in charge of public relations activities, was perceived as part of the administration and not of medical services. Nevertheless, the campaign turned out to be a great support for the further development of the project. Participation in group discussions was high: almost every staff member got involved. The groups provided a forum for expressing dissatisfaction with the management and the hospital as a whole. This dissatisfaction, however, was used constructively by inviting the staff to contribute to improvements through participating in the WHO project. A variety of project ideas were developed, some of which addressed current problems of the hospital, while others expressed the interests and desires of the staff. In the end, about 40 project ideas were gleaned from this initial information campaign.

Project structures take shape

Many staff members were initially sceptical as to whether they could manage the project work in addition to their everyday tasks. To alleviate the problem, the management suggested an arrangement that allowed the project teams to allocate some of their working hours, a total time of 3 days a year, i.e. 12 meetings of 1 1/2 hours each, for the project work.

The following organisational structures were established to coordinate the project work process:

1. Project Co-ordination
2. Steering Committee
3. WHO-Plenary
4. Sub-Project Groups

These structures were put into place within a time frame based on the respective current requirements (see Figure 1).

The project co-ordinator, an assistant to the medical director, was named by the hospital management. His position bore the advantage of short decision-making routes but at the same time had the disadvantage of the co-ordinator being perceived as dependent upon the medical director. While the advantages proved useful in the initial phase of the project, the disadvantages appeared as the project progressed. The difficulties of the project co-ordinator once the project has been successfully launched lay primarily in the lack of clarity regarding the authority to make decisions. The

long-term consequence being then, that the necessity of a project co-ordinator became outlived as the sub-project leaders of the respective sub-project groups directly consulted the decision-makers.

The project ideas, which resulted from the initial information campaign, were selected in a two-step process: First, the 40 project ideas were examined by the steering committee and the project co-ordinator, according to the criteria of the Budapest Declaration and the Ottawa Charter. Some of the ideas then were translated into projects. Following this, internal criteria (e. g. support and participation of occupational groups that previously had not shown much initiative or felt little involved and recognised) were applied. Projects of central importance such as 'supervision as a means of improving the internal infrastructure of the hospital' received particular attention and support. Finally, 25 potential sub-projects focusing on different aspects of planning, realising and documenting the project work were identified.

These 25 sub-projects were presented to the staff on the occasion of an internal PR-event called "project fair". Project objectives and tasks were given to the group or the person, which initiated the project idea. The event was aimed at informing the internal public on the variety of project-ideas, discussing the ideas in small groups and giving the group's activists the opportunity to recruit new participants for the group work. Those staff members, who could not take part at the project fair had the opportunity to inform themselves through a "project catalogue", which listed all the project ideas and the sub-project activists in detail. The project catalogue was circulated as a "newsletter" in the hospital.

Subsequent to the "project fair", 10 groups were constituted, which then became involved in the project work. The management and the steering committee laid down a number of rules for the group formation: in order to be accepted as a sub-project team, the groups should be prepared to:

- elect a spokesperson (sub-project leader)
- participate regularly in a plenary of sub-project groups, called "WHO-plenary"
- write and submit reports on the group meetings to the project co-ordinator.

There was no attempt to constitute sub-project groups "from above". Rather, the groups evolved from the communication process within the hospital, i.e. staff members formed project teams around common interests. Table 1 gives an example of the applied scheme of the sub-project work, which was given by the project-coordinator to the project-groups and to the internal public to inform on the work of the sub-project-groups. An assessed form of such schemes was circulated as a "project catalogue", so that everyone had the opportunity to be informed of the results of the project-fair and on the sub-projects, which were running.

However, the public relation work described above could not assure the participation of occupational groups that had previously been little involved in the discussion. An assessment of the participation in project work reveals that we did not succeed in encouraging technical and administrative staff nor the staff members of the kitchen (see Table 2). The sub-project groups are mainly supported by the medical staff. In particular, the degree of participation of the nurses is not satisfying. Most notable is the high level of participation of the most dissatisfied group – the social workers.

Table 1: Example for a sub-project scheme from focus 2: Patient-centred projects

<p><i>Project:</i> Counselling Centre for patients who are foreign nationals</p> <p><i>Occasion / Idea / Objectives:</i> The development of our patient structure in the recent years has shown that approx. 12% of our patients are foreign citizens. There are no services for these patients that aim at alleviation of their difficulties in using our hospital. Hence, relevant services should be developed.</p> <p><i>Tasks of the project group:</i> Co-operation with the wards, development of a concept for a counselling unit at the hospital, realisation of the project, accompanying research and evaluation.</p> <p><i>Content:</i> counselling of foreign patients, mediation in the event of language and/or cultural barriers, counselling of the nursing staff, specific training for the nursing staff, specific training and counselling of administrative staff</p> <p><i>Contact persons:</i> Mr. Ceylan, Mr. Dehghan, Mrs. Eskandari, Mr. Ernst, Mr. Giardino, Mrs. Graul-Dehghan, Mr. Paul</p>
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Table 2: Involvement (in percentage) of staff groups in the sub-project groups

Profession	involved	not involved
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

The „other medical staff“ are mainly physiotherapists, who have started the sub-project group on equestrian therapy. Thus dissatisfied occupational groups were successfully included in the project but few or no employees whose occupation is ‘indirectly’ involved in patient care became involved. The poor participation on the part of the nurses should be seriously taken into consideration. The fact, that power and control may have played an important role in this reluctance to participate has been mentioned in informal discussions (i. e. „We are not the ones who decide things here.“).

After the project groups were constituted the WHO-plenary was established. This plenary of sub-project members met on a six-week cycle and was facilitated by the project-coordinator. Usually one or two members of the sub-project groups and the members of the learnership of the hospital took part. The aim of the WHO-plenary was to supervise the work of the sub-project groups throughout the course of the project. Another aim was to find out, how to undertake successful sub-project work (learning from each other) by reviewing and discussing the actual sub-project work.

The project co-ordinator stimulated and supported the work of this group by setting a sequence of „milestones“ (tasks, challenges) to continuously develop the project as a whole (see Figure 1).

Date	“Milestones“	What was accomplished?	Overall project structure
12. 92– 2. 93	Preparation phase	proposal drawn up	<ul style="list-style-type: none"> ● preparation group chairman: Medical Director
4. 93	Recognition as a Pilot Hospital HPH	5 innovative health-promotion projects recognised	<ul style="list-style-type: none"> ● steering committee in charge: Medical Director, participation of the Comercial Director, Nursing Director and Staff Council ● external evaluator
5. 93 10. 93	Information campaign	Information of the staff by means of group discussions focusing on particular topics and newsletter 1 Information phase- 40 new project ideas	<ul style="list-style-type: none"> ● project co-ordinator
10. 93 from 10. 93	“Project fair“ constitution of the sub-project-groups	Selection of 25 project ideas 10 sub-project groups	<ul style="list-style-type: none"> ● election of group speaker-persons ● WHO-plenary (meeting four times a year)
5. 94	First public presentation	Identification with the project enhanced	
12. 94	First survey of the entire staff	Written information given concerning the planned survey, encouraging confidence; distribution of questionnaire	<ul style="list-style-type: none"> ● neutral and well-known, confident, involved
3. 95 10. 95	Public presentation of the sub-project groups		
9. 95	health day at Philipphospital	Feedback for the staff on the staff survey, justifying confidence	
3. 96	Second survey of the entire staff		
9. 96	Open hospital day	presentation of successful projects	

Figure 1: Milestones, project achievements and relied elements of the overall project structures.

Two elements of our projectstructure have yet to be mentioned : That is the steering committee and the external evaluation.

The *steering committee* is the most important and at the same time one of the most problematic elements of our project-structure. We have not been able to create a continuing steering committee under particiaption of the staff council as fundamental conflicts have developed between the management and the staff council during the project-time-frame. This is one of the problems which has had a long running and unfortunate influenced the work of the project-groups.

The *external evaluation* was undertaken by the team of Prof. Dr. Angermeyer and his co-worker Dr. Kilian, who were located at the beginning of the pilot-hospital work close to Philipppshospital at the „Zentral-Institut für seelische Gesundheit“ (Central institute for mental health), Mannheim and work now at the University Hospital, Leipzig. Their informal commitment and high standard of professional work have very helpfully assisted the project work to date. They developed an evaluation strategy, which was based on the theoretical framework of the empowerment-concept and which addressed the staff of the hospital as a whole. (Details will be reported under the chapter “Evaluation of the overall project“.)

Successes in the realisation of the sub-projects

Five sub-projects had been already implemented prior to the information campaign and the project fair. After that, when the staff became involved, ten projects were selected. The 10 sub-projects addressed three subject-areas: Patients, staff and the community, i. e. integration of the hospital into the region (see Table 3). They were chosen, because they give answers to some of the central questions of the hospital as a organisation (How to develop to a learning organisation?), as a institution in the region (How to strengthen the ties to the local practitioners) and as an place for people (How to stimulate the recources of the staff and the patients?). In the following we will describe in detail one sub-project-example for each intervention area.

Table 3: The 10 sub-projects of the Philipppshospital WHO-project

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 assesment of computer workplaces	Psycho-educational groups for psychotic patients and their relatives	Networking of a hospital ward with outpatient services
Social work counselling of the staff	Horseback riding as a new therapy (equestrian therapy) for psychotic patients	
Team supervision general: one project:	Drama work in psychiatric health care	

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 inter-professional teams on the wards (not only physicians, but all staff-members, who are engaged in the treatment process) discuss treatment cases and, if necessary, the in-

ternal dynamics of the group, supported by an external adviser. However, it is not possible to oblige staff-members to take part in these sessions as constraint would contravene the principles of confidentiality and voluntary participation, as well as hinder the personal openness required for success. 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 – giving to those ward teams, who showed interest. Another helpful method was to search and ask for experiences of those ward teams who had already participated, and then to make their experiences available to the others. Within a time interval of two years, nearly all units had succeeded in setting up at least monthly supervision sessions (see Table 4):

Table 4: Number of medical teams receiving supervision in mental health care units (N = 18)

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

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 also confirmed 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, correspondent planning of work schedules, less part time work by team members). The information basis 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.

Patient-focused sub-project: Psycho-educative groups for patients and their relatives

Three projects focused on patient management, while others focused on the implementation of new therapeutic approaches. Two of the latter sub-projects were particularly successful: The equestrian therapy project for psychotic patients, and the psycho-educative groups for patients and their relatives. Specific emphasis was placed on mobilising patients' resources for coping with their psychiatric disorders. This can be specifically highlighted in the project „Psycho-educative groups for pa-

tients and their relatives“ where the framework of the WHO-project helped to implement a most desirable treatment. Success depended on the co-operation of all involved as well as on a high degree of motivation, stamina and endurance, on the part of those close to the treatment units. By providing information about the disorders (mainly schizophrenia), the group aimed to achieve better compliance with medication, better coping with the disorder, as well as relapse prevention. The project stands out because of its high level of acceptance among both patients and their relatives. Continued patient participation, beyond their stay in the hospital, demonstrates how well the project is received.

The concept and work of this sub-project group:

Psycho-educative groups are disorder centered groups in which patients and/or family members receive intense training in recognition of causes, course and prognosis of their diseases, treatment strategies, effects and side effects of medication therapy, the ability to deal with early warning signs and styles of communication in dealing with the patients.

The sub-project group’s active members presented their idea at the project fair in 1993 and won over a sufficient number of colleagues interested in joining the project group. With 8–14 members the group has worked continuously since inception of the project in 1993 up to the present on the implementation of psychoeducative groups at Philipppshospital. Up to now it has implemented successfully psycho-educative groups at nearly every inpatient ward.

In the patient-family groups planned by Philipshospital and initiated in 1994 within the scope of the WHO-project, effects were expected in the areas of improved insight into the disorder, increased medication compliance and a reduction in the number of relapses. It was hoped that the inclusion of family members would contribute to their increased social support by improving intrafamilial problem-solving skills.

Psycho-educative groups use group settings, open to current or prior psychiatric in-

Table 5: Structure and course of group sessions of the sub-project psycho-educative groups for patients and their relatives

1st session	Mutal getting acquainted, introduction of the concept, expression of desires and needs
2nd session	Information on psychosis, categorization, genesis, course and prognosis, opportunities for the family
3rd session	Information on medication, physiological and biochemical basis of medication therapy, side effects
4th session	Non-medication treatment methods, living arrangements, coping with stress, perspectives following release, professional rehabilitation
5th session	Recognition of early warning signs and their use in relapse prevention, crisis plans
6th session	Introduction of problem-solving concepts and communication exercises
7th session	Role games proceeding from a problem-solving concept
8th session	Concluding discussion

patients and their families. Each group consists of 10-14 members and meets once a week for a total duration of eight weeks. As the concept is based on a continuous process (see Table 5), participation over the whole period is required necessary. All groups are led by either a doctor or a psychologist.

Who participates at psycho-educative groups? As an typical example the membership structure of the first patient-family group, which consisted of four patients and six family members : three of the four psychotic patients were admitted for a first time. One of the patients had had more experience (first manifestation of schizophrenia in 1972). All patients suffered from a schizophrenic disorder (ICD 10: F20). The patients (three men, one woman) had an average of 31 years of age, with occupations ranging from unemployment, social pedagogue, sacristan and schoolgirl. The family members were the parents, whose occupations ranged widely: from painter to bookseller.

What were the first experiences with the group work? The experiences from the patients' point of view and that of their relatives were surveyed in an initial evaluation study. The patients and their relatives professed to feel better informed about the disorder and the patients mentioned to feel more secure in their communication with their families. Surprisingly, self-assurance and trust in the problem-solving capability of the families has grown considerably.

Alltogether evaluation results clearly indicate successes and the continuing engagement of the WHO sub-project group helped to make this work routine, now becoming a part of the daily management of psychiatric disorders in our hospital.

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

One problem of an insituition with such a long history as a place for psychiatric patients like Philipppshospital is, how to figuratively remove the walls of the institution in the mind of the local population. There is a focus in the 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 did 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 better integrating the hospital in the region. 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 was even protest against it. In the course of the project, acceptance of the service increased gradually. 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 initiatives continue to exist also today and have contributed to the success of the project and an improved communication within the hospital. Hence we can rightly speak of a „generalisation effect“ in spreading the project ideas:

- a 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 principles of colour psychology;
- a psychotherapy unit was established;
- additional reduction in size of beds of three treatment units;
- further direct effects, such as the opening of wards previously locked, resulting from 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.

Evaluation of the Overall Project

Due to the variety of sub-projects at Philipppshospital, the evaluation of the overall project was a particular challenge. Hence, the external evaluators Prof. Dr. Angermeyer and Dr. Kilian focused on the total effect of the project on the staff and proposed a design with a threefold repetition of measurement.

The theoretical model of the evaluation study: From operationalising the objectives of the Budapest Declaration to the empowerment concept

The ‘empowerment concept’ was the central theoretical concept underlying the evaluation study. We have assumed that the latter enables an operationalisation of the essentials of the Budapest Declaration. “In its broadest definition, empowerment is a multi-level construct that involves people assuming control and mastery over their lives in the context of their social and political environment” (Wallerstein, 1992, p. 198).

The evaluation study combines the theory of empowerment with the well-established transactional stress theory of Lazarus and his co-workers (Lazarus and Folkman, 1984). Based on a general model of the stress and coping process, the general hypothesis postulates that in the field of human services staff participation has a twofold influence:

- serving as a barrier against the perception of occupational stress and acting as a buffer against the negative outcome of perceived stress;
- influencing job satisfaction and corporate identity in a positive way.

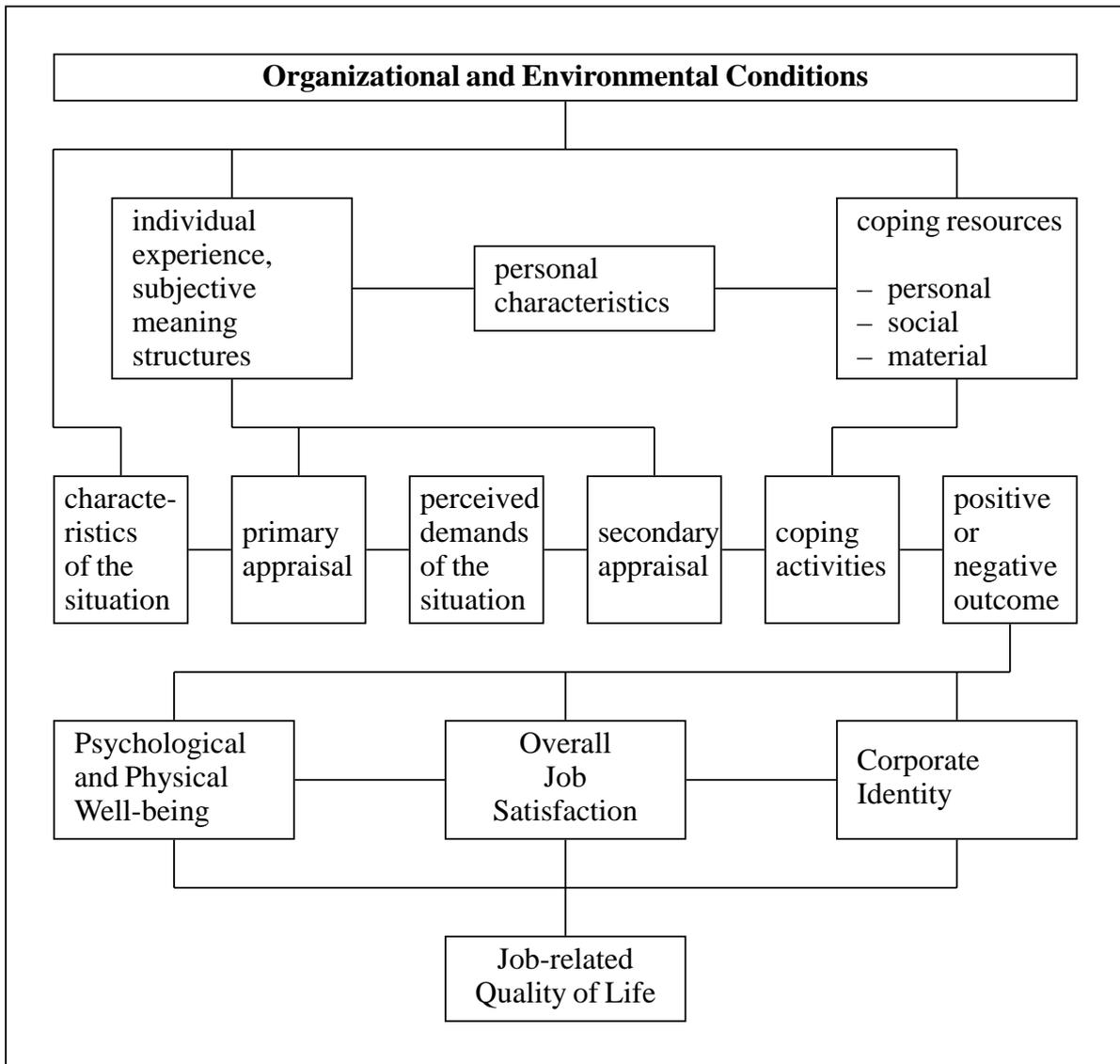


Figure 2: The impact of the stress and coping process on job-related quality of life

The theory of empowerment suggests that providing possibilities for active participation to people in different settings, like the community or the workplace, would help them to overcome feelings of powerlessness and learned helplessness and therefore to *reactivate their hidden competencies for actively coping with stress and health hazards*. With regard to *job-related participatory self competence*, we can assume that dealing with occupational stress in a more adequate manner will not only lower the negative effects of stress on health, but will also increase the subjective satisfaction with working conditions and the corporate identity of the staff members.

In the light of this empowerment-model of health promotion effects, the WHO-project was expected to have the following impacts on health gains for the staff (see also Figure 2):

1. The more staff members participate actively in the process of improving their working conditions, the less they will perceive those working conditions as stressful and the more they will deal with job stress in an active, problem-focused manner instead of coping in a passive, emotion-focused manner.

2. A reduction in perceived stress and an increase in active, problem-focused coping will reduce the frequency and the intensity of symptoms of illness and distress.
3. Reduced experience of occupational stress and as a consequence, the reduction of stress-related symptoms of illness and distress, will positively influence subjective quality of work as well as the corporate identity of the staff members (see also Kilian et al., 1997)

Realising the survey: How to gain the support of the staff for an evaluation study?

The plan to involve the entire staff of Philipppshospital in a survey on job satisfaction, work-related stress and health issues turned out to be an ambitious objective. The intention itself was already a strong impulse for changes in the organisational structure: for the first time, all staff members were asked about their opinion and it was assured that the results of the study would have consequences for the organisation of work at the hospital. Consequently, staff members reacted with caution and wariness, but also with positive expectations. Until now, two surveys have taken place, one in December 1994, the second in March 1996, and the third will be undertaken in February 1998.

The first survey finally made the project visible for everybody in the hospital, as every staff member was personally invited to participate in the study. Internal public relations and the identification of the staff with the project were facilitated by:

- the attempt to gain the confidence of the staff necessary for their participation and the provision of detailed information on the survey;
- the approval of the survey and the suggested procedure of investigation on the part of the entire management, the staff council and the data protection official;
- the opportunity for every staff member to express his/her opinion;
- feedback concerning the acceptance of the project, which was considered within the further project work;
- the necessity of modifying individual sub-projects as a consequence of the results of the survey.

Achieving a high level of confidence within the staff members was particularly necessary because, for methodological reasons, the results of the questionnaire at the different times of measurement were to be assigned to the individual respondents, which was not possible without personally relying the submitted questionnaire. In order to still assure the anonymity of the results, a procedure was developed which was well-received by the personnel: The hospital pastor acted as a confidante for collecting the questionnaires. He separated the name sheets from the actual questionnaires and then coded the latter so that the data were made anonymous before they were passed on to the external evaluators.

We achieved a response rate of 40 %, which we regard as a considerable success. The group of assistant nurses did not participate sufficiently. We think this is due to the applied method, because within this professional group, some staff are often not capable of reading German with full confidence or ease.

Table 6: Questionnaire returns by occupational groups in %

Profession	% return
nurse	39.6
assistant nurse	6.5
physician	59
psychologist	58.3
social workers	84.5
technician	32.4
other medical staff	52
kitchen personnel	41.5
administration	30
Total	40

Forms of feedback on the results of the evaluation as an impulse for the entire project

The feedback of the evaluation is of the utmost importance to the transformation process on becoming a health-promoting hospital with self-reflexive internal structures. By doing so, the following questions seemed to be relevant:

- On what, how and to whom should feedback be given?
- Which conclusions should be drawn from the results?
- How will the consequences of the survey become visible to the staff?

At the start, feedback was only given internally to the management and to the WHO-plenary, where the results were met with restrained scepticism. The management further raised the question as to whether all the data collected had to be included in the report and how the individual results should be understood. A public discussion of the possible consequences the results should have for the hospital did not take place adequately. Thus the consequences derived from the results by the management were, when implemented, not connected with the survey. To state one example, an internal training for the nursing staff was implemented, because they had rated their training opportunities as insufficient in the survey. Among the staff, however, it was felt that the study remained without consequences as the new training programme was not explicitly portrayed as a result of the survey – an impression that proved fairly resistant to attempts to clarify the matter.

We found a form of feedback that was suitable to generate great interest in the project among the staff. The results were presented in the context of a ‘health day’ in September 1995. On the same occasion, some of the sub-project groups presented the current state of their work, and new health promotion courses (e. g. „Back-School“, „Relaxation Training“) were introduced. The form of the presentation has had a negative effect on the reputation of the project as a whole: The all in all positive results (e. g. on job satisfaction) had not been taken seriously by a great number of staff members. Within the questionnaire, staff members were asked to judge their opinion concerning the WHO-project (Table 7).

Table 7: Attitude towards the WHO project according to occupation (on a scale of 1 = more negative to 7 = more positive)

Profession	Attitude
nurse/male nurse	4.7
physician	5.5
psychologist	4.7
social worker	4.6
technician	4.1
other medical	5.5
kitchen personnel	4.6
administration	5.0

The highest rankings were found among the medical professions. This might be due to the fact, that the successful projects were indeed those settled in the medical sector and also from the fact that the initiative and involvement with the project as a whole was in the aegis of the medical director. Nonetheless, administration also gave the project a high ranking, which is interesting compared to the rather low participation of administrative staff in the project (see also Table 2). This shows the lack of success in transforming a basically positive attitude into a practical involvement.

Considering job satisfaction in relation to the different occupational groups, on the other hand, a less positive picture must be drawn (Table 8).

*Table 8: Dimensions of job satisfaction on a scale from 1 = very dissatisfied to 7 = very satisfied for different occupational groups
(*** = significant difference on .01 level analysis of variance)*

Dimension of job satisfaction	mean by occupational groups		
	doctors, psychologists, social workers, ergotherap., motion therapists	nurses and male nurses	technicians, administration, catering
qualification	4.53	4.37	4.49
work efficiency	3.81	3.49	3.66
staff participation	4.01	3.45	3.94
technical equipment/design***	3.07	2.72	4.5
working hours***	5.07	4.25	5.97
breaks***	5.24	3.27	5.70
co-operation with colleagues	5.19	4.94	5.43
information	3.57	3.56	3.32
safety	4.52	3.71	5.02
catering ***	2.77	2.88	5.13
distribution of responsibilities	3.43	3.75	3.94
time for patients	3.53	3.27	3.76
staff rooms***	3.13	2.89	4.20
further training	4.19	4.31	3.05
health promotion	2.89	2.78	2.86

A remarkable result of the study is that members of the therapeutic occupations are generally more dissatisfied than their colleagues from other occupational groups. They are more dissatisfied with the technical equipment, the employees' quarters and the meal service than either technical or administrative employees. Most dissatisfied is the group of nurses. The predominant feeling of having to work under unsafe conditions is particularly alarming.

Job satisfaction quite strikingly corresponded with job strain and the opportunities available to cope with the latter (Table 9).

*Table 9: Dimensions of job strain on a scale from 1 = very low to 7 = very high for different occupational groups (anal. of var.:*** = significant difference on .01 level, ** on .05 and * on .1 level)*

Dimension of job strain	mean by occupational groups		
	doctors, psychologists, social workers, ergotherap. motion therapists	nurses and male nurses	technical staff, administration, catering
time pressure	4.49	4.66	4.33
overtime***	3.28	3.48	2.45
unclear instructions***	3.64	4.45	3.45
excessive demands**	4.57	4.56	4.32
bad organisation**	3.94	4.55	3.70
accommodation***	4.50	4.97	3.51
work climate*	3.54	4.09	3.42
demands on work performance	3.12	3.14	2.98
work against one's convictions***	3.94	4.86	3.50
technical equipment**	1.79	2.30	2.26
information management*	3.61	4.38	3.63

These results correspond impressively with the reported job satisfaction and again several particular stress factors for the group of nurses can be seen. They, more than any other professional group feel burdened by work against their personal convictions, by unclear instructions and by exclusion from transmission of information, indicating severe deficits in the organisational structure of the hospitals' occupational groups. In addition, the group is also burdened by the need to adapt to the constantly changing demands on their work.

The results can be summarised as follows (see Kilian and Paul, 1996): The greater the opportunity of a staff member to influence work routines and occupational settings

- the fewer the health problems
- the greater the job satisfaction
- the more easily one perceives one's work with the patients to be successful
- the greater the likelihood of wanting to start working in psychiatry again.

The results of the evaluation study thus confirm the path taken by the WHO project. At the same time, the results drew attention to the extent to which the organisational

structures affect the capabilities of individuals to cope with occupational strain. This information demonstrates also the absolute necessity of the health promoting hospitals project at Philipppshospital. First and foremost lies the challenge as to how organisational problems can be overcome and whether or not the enthusiasm of staff to participate in this vital and painful process of change can be revived for this purpose.

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 on the regular treatment programme of the hospital, but also in effecting wide-ranging changes in the organisational 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, firming as 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 to translate objectives into action that were developed independently of administrative directives; and
- 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.

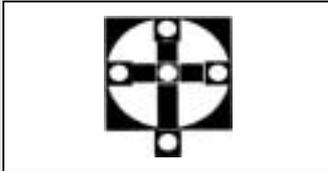
References

- Bauer, M., Berger, H. (1988): *Kommunale Psychiatrie auf dem Prüfstand*. Stuttgart: Enke
- Bauer, M., Engfer, R. (1990): *Entwicklung und Bewährung psychiatrischer Versorgung in der Bundesrepublik Deutschland*. In: Thom A., Wulff, E. (eds.): *Psychiatrie im Wandel*. Bonn: Psychiatrie-Verlag, p. 413–429
- Berger, H., Paul, R., Gunia, H. (1997): *Gesundheitsförderung als Beratungsform: Psychoedukative Gruppen in der Behandlung schizophrener Patienten*. In: Pelikan, J. M, Wolff, S. (eds.): *Das gesundheitsfördernde Krankenhaus als Projekt* (in press)
- Carver, C. S., Scheier, M. F., Weintraub, J. K. (1989): *Assessing coping strategies: A theoretically based approach*. In: *Journal of Personality and Social Psychology* 56, p. 267–283
- Cooper, B. und Bauer, M. (1987): *Developments in mental health care and services in the Federal Republic of Germany*. In : *International Journal of Mental Health* 16 1–2
- Deutscher Bundestag (1975): *Bericht über die Lage der Psychiatrie in der Bundesrepublik Deutschland – zur psychiatrischen und psychotherapeutisch/psycho-somatischen Ver-*

- sorgung der Bevölkerung- (“Psychiatrie-Enquete“). (Bundestags-Drucksache 7/4200) Bonn
- Deutscher Bundestag (1979): Stellungnahme der Bundesregierung zum Bericht der Sachverständigenkommission über die Lage der Psychiatrie in der Bundesrepublik Deutschland (BT-Drucksache 8/2565) Bonn
- Goffman, E. (1961): Asylums. Essays on the social situation of mental patients and other inmates. Washington
- Haenel, T. (1992): Psychiatriegeschichte. In: Battegay, R. et. al. (eds.): Handwörterbuch der Psychiatrie. Stuttgart: Enke
- Kilian, R.; and Paul, R.(1996): Staff empowerment as a measure of progress in occupational health promotion: theoretical foundations and baseline data from a Health Promoting Hospital. In: Centre for Public Health Sciences: Health Gain Measurements as a Tool for Hospital Management and Health Policy, Linköping
- Kilian, R, Paul, R., Berger, H., Angermeyer, M. C.(1997): Empowerment und Gesundheitsförderndes Krankenhaus. In: Grundböck, A., Nowak, P., Pelikan, J. M.(eds.): Gesundheitsförderung- eine Strategie für Krankenhäuser im Umbruch. Wien: Facultas, p. 137–142
- Lazarus, R. S., Folkman, S. (1984): Stress, Appraisal, and Coping. New York: Springer
- Paul, R., Berger, H., Kilian, R. (1996): Health Promotion in a Psychiatric Healthcare Institution. In: Newsletter Health Promotion Hospitals 8; p. 4–5
- Pearlin, L. I., et. al. (1981): The stress process. Journal of Health and Social Behaviour 22, p. 337–356
- Rappaport, J.: (1981): In praise of paradox: A social policy of empowerment over prevention. American Journal of Community Psychology 9, p. 1–25
- Rappaport, J. (1987): Terms of empowerment/Exemplars of prevention: Toward a theory for community psychology. American Journal of Community Psychology 15, p. 121–148
- Rotter, E. B. (1966): Generalized expectancies for internal versus external control of enforcement. Psychological Monographs: General and Applied 80, p. 1–28
- Seligman, M. E. P. (1975): Helplessness. San Francisco: W. H. Freeman
- Wallerstein, N. (1992): Powerlessness, empowerment, and health: Implications for health promotion programs. American Journal of Health Promotion 6, p. 197–205
- Wallston, K. A., Wallston, B. S. (1982): Who is Responsible for Your Health? The Construct of Health-Locus-of-Control. In: Sanders, G. S., Suls, J. (eds.): Social Psychology of Health and Illness. New Jersey, p. 65–95.
- Wing, J. K., Brown, G. W. (1970): Institutionalism and schizophrenia. A comparative study of three mental hospitals. Cambridge: University Press
- Zimmerman, M. A. (1990a): Toward a theory of learned hopefulness: A structural model analysis of participation and empowerment. In: Journal of Research in Personality 24, p. 71–86
- Zimmerman, M. A., Rappaport, J. (1988): Citizen participation, perceived control, and psychological empowerment. In: American Journal of Community Psychology 16, p. 725–750

„Health promoting hospital“ and organization development: Case study on the concept of St. Bernward Hospital, Hildesheim

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Contact:	St. Bernward Krankenhaus Treibestraße 9 D-31132 Hildesheim Tel: +49/5121/901561, Fax: +49/5121/901342
Hospital Owner:	Bishop of Hildesheim; Congregation of the Merciful Sisters of St. Vincenz v. Paul
Hospital Ownership:	Private non profit
Specialisation:	General Hospital
Beds:	560
Staff:	Medical Staff: 110, Nursing Staff: 350, Other Staff: 390, Total Number of Staff: 850
Utilization:	Average Utilization of Beds/Year: 80 %, Average Stay in the Hospital/Day: 8
Patients:	Number of Inpatients/Year: 21.000, Number of Outpatients/Year: 15.000
Number of Departments:	13
Location of Hospital:	Inner city
Catchment Area:	Regional, Number of Population: 500.000
Other Functions than Medical Care:	
Teaching:	Medical Students, Nursing Education, Other Health Professions: Midwifery, Child Care, Anaesthesiology and Intensive Care
Research:	Clinical Research
Subprojects:	<ol style="list-style-type: none">1. Health Consulting - Promoting Health by Information, Consultation and Environmental Changes2. Health-Oriented Quality Management in the Operating Theatre3. Interdisciplinary Co-operation within and among Wards and Departments4. Admission Unit - Reception of Patients in the Hospital5. Development of a Health-Promoting EDP-Infrastructure

Pilot hospitals in the context of national health systems

Since the mid-Eighties, the German Health System has faced an – ever accelerated – period of reform. A series of reform laws and acts – especially during the last two years – are signs of a reform of the Health System, operated by the legislative bodies, which, ultimately, aims at a re-structuring and re-orientation of the system. Looking back, the reform is on the one hand characterized by a re-orientation of the services on offer, whose central concepts are prevention, prophylaxis and also health promotion. On the other hand, the reform stands under the heading of „cost cutting in the health system“. Hospitals (like other organizations in the health system, too) are asked to provide autonomous solutions, more management and the development of new methods. Thus, the reform is for a General Hospital like St. Bernward Hospital, also a chance to broaden the range of services in the out-patient, pre- and post in-patient area – besides the in-patient core tasks, to orient itself more towards the health of the customer and to implement new forms of cooperation with the local health system.

„Fighting the cost explosion“ shows, however, the reverse side of the reform. German hospitals face a situation where ever increasing administrative efforts are necessary without gaining any entrepreneurial space in which to manoeuvre. Additionally, there are comprehensive payments of the budget and uncertainties in the investment financing. Hospitals are directly and indirectly affected by the regulations of the legislative bodies through the self-administration of health insurances, practitioners and hospitals. Currently, a strong and not always comfortable pressure to adapt has resulted and results from it for all German hospitals.

In recent years, the hospital management at St. Bernward Hospital has tried to deal in an pro-active way with the external regulations. Thus, performance structures were differentiated – e. g. in the area of surgery by building up vascular surgery, accident surgery and children surgery. Additionally, St. Bernward Hospital meanwhile offers short-term care and out-patient care. The range of out-patient operations is being constantly extended.

In order to analyse the internal situation, an economic efficiency audit was carried out in 1990. The findings were that:

- the internal structures are undergoing a change
- the medical institutions all tread new paths in different ways and with different dynamics
- work structures, organizational regulations and operational solutions have mainly „organically grown“ and thus appear to be irregular and expensive, disordered and arbitrary („island solutions“)
- superior over-all concepts with a „guiding character“ do not exist.

Against this background and because of the economic situation of the hospital, the hospital management decided to introduce organizational changes quickly. As a first step, from 1989 onwards, members of the middle management were trained in „Management and Leadership“ seminars in cooperation with the University of Hildesheim (WBO-Team). Only one year after the consistent running of „Management and Leadership“ seminars did it become obvious that the willingness to take part in Fur-

ther Education and Continued Education was growing especially in the care area and that it was connected to a noticeable increase in competence. In 1992, the hospital management learnt about the field of work on „Health Promotion in Hospital“ by WHO. The hospital management of St. Bernward Hospital visited Vienna in order to get further information from the Rudolfstiftung hospital of the City of Vienna (a hospital which was already involved in the development, see the contribution of Nowak et al. in this book). In December 1993, St. Bernward Hospital applied for admission as a pilot hospital in the international network of „Health Promoting Hospitals“. The application was proceeded by a clarification of the contents and strategies as well as a clarification within the hospital (information at different levels, shop assembly, voting).

With the personnel development process, launched by the management seminars, the hospital management was able to start the project „Health Promoting Hospital“ in a positive light. The high motivation and the demands of the employees could be used as a potential for the process of organizational development. Strong impulses for improvement were especially seen in the employees. The cooperation in the international network of „Health Promoting Hospitals“ offered a favourable organizational framework to take up these impulses. The aim of the projects was to improve the processes and structures in the hospital.

The sub-projects were worked on and put into practice autonomously by the employees concerned together with interested colleagues. The focus is placed equally on the change of structures as well as on the development of employees' abilities. Sustained effective modernization is aimed at, through and with the employees themselves.

All employees – regardless of their occupational position – should have the possibility to name conflicts arising in their place of work, to recognize structural shortcomings and to cooperate in the development of practical and effective solutions for these problems. One advantage of this project lies in the fact that different occupational groups work together in order to bridge tension in the workplace. Here, it is very helpful to get to know the standpoints of different occupational groups directly within the project groups and to have to deal with different interests and attitudes.

The WHO project „Health Promoting Hospital“ with its over-all targets – promotion of health and well-being of the patients, health promotion of employees and health promotion as a part of the guiding idea and philosophy of the St. Bernward Hospital – came at just about the right time for St. Bernward Hospital. Especially in its project structure, it made an important contribution to the internally desired and externally required organizational development.

Project structure and project process

Reasons and decisions for the project

Facing the changes in the health system, it became more or less a condition for survival to create the personnel conditions for more flexibility, improvement of quality and for high performance ability and willingness in the whole hospital. The major aims and reasons for the decision were:

- to develop perspectives for the improvement of structures
- to improve the involvement and motivation of employees
- to test new solutions in the guidance of employees
- to solve urgent problems and to develop creative potentials

Basically, there would have been different possibilities, to pursue these aims (e. g. quality circles, organizational re-structuring, etc.). Organizational development in connection with the strategic aim of health promotion was very attractive because it also allowed for a normative and qualitative broadening of the range of action. Even though its concrete meaning was still unclear, this orientation offered points of contact for all occupational groups in the hospital, the patients, the health insurances, and the public. Linking with the European network offered a framework for orientation with a consistent attitude and conception for checking the success of the project. Linking the aims of organizational development with health promotion thus led to the following guiding targets for the project:

- Promotion of health and well-being of the patients, carefully directed support of recuperation processes, quality improvement as well as the promotion of skills and competence of employees
- Health promotion of employees and, in this context, the prevention of work-related illnesses as well as the reduction of fluctuation in certain areas of the hospital and finally a reduction in the number of sick persons
- Health promotion as a part of the guiding idea and the „philosophy“ of St. Bernward Hospital

In retrospect, it has proved to be important that the tasks and projects in the project were not completely new, but were formulated in the context of the existing concerns and tasks for development of the hospital. It was about the linking of organization, development of new tasks, motivation and cooperation with the employees across occupational groups. The positive decision for the project came about because the project frame of a „Health Promoting Hospital“ offered an convincing and also innovative and challenging framework for working on the mentioned tasks.

Topics for sub-projects

Even if the project „Health Promoting Hospital“ was also considered to be a „strategic“ project, it should unfold concrete effects in the sub-projects for every-day situations and at the same time – pointing even further than that – be an example and motivation for the development. Accordingly, five specific sub-projects were developed in the project period of mid 1993 to mid 1997:

- Reception in the hospital – or putting people in the centre
- Health guidance and health information
- Cooperation across disciplines and departments
- Development of an EDP infra-structure under consideration of health promoting aspects
- Health promoting quality management in the operation theatre and in anaesthetics

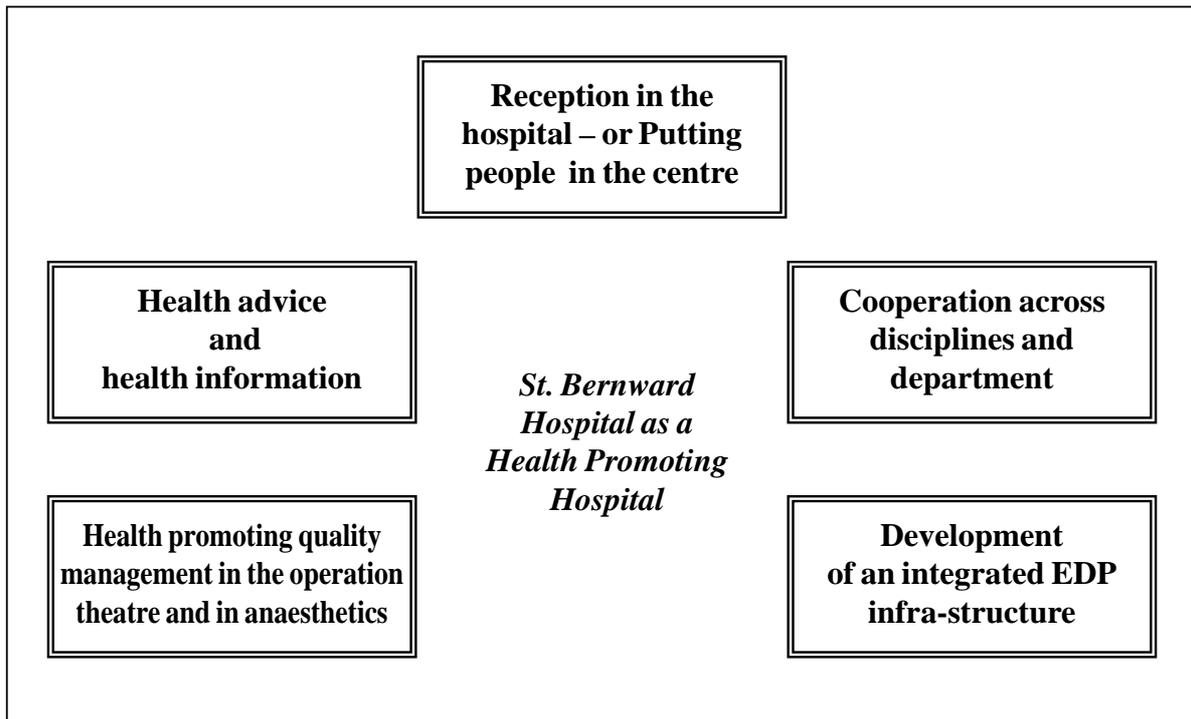


Figure 1: Overview on the sub-projects

A sixth project was planned to test structures and methods for the hospital as a „learning organization“, but this had to be deferred due to lack of time. The sub-projects were started one after another with a pause of several months in between in order not to overload the hospital’s infra-structure.

Structure, management and course of the project

After the decision was made to start the project in the intended form and to orient towards organizational development, first of all, the *framework* for the execution of the project had to be created. Here, practical answers to the following questions, among other things, were required:

- What exactly are the *aims and expectations* with regard to the results?
- What are suitable *forms of work* (project group, leading, steering, ...)?
- Who can make which *decision* (competence of project groups)?
- When and to what degree is *feedback* necessary (internal communication)?
- Which *resources* can be used?
- Which *budgetary framework* is necessary and how can the funds be raised?
- For what is external *expert’s knowledge* necessary?
- How is the *course of the project* to be steered?
- Where is the border line between *project and every-day life*?

The project leaders devoted major attention to the design of this project framework – throughout the whole project. The project management was constantly checked and newly adapted.

Sub-project groups: formation and tasks

The sub-project groups were the most important carrier of the project. At the beginning, these groups were openly advertised with short descriptions in the whole hospital. Since work in the project groups was designed to reach across departments and hierarchies, no limitations concerning the tasks, occupational groups or other criteria were made. This led to a broad participation but it was also discovered that project groups were partly:

- too large in order to work really effectively
- composed one-sided with regard to professional expertise
- over-emphasizing the „social“ aspect of participation over the factual aspect of the task solution. Because of these experiences, the composition of the project groups was more selectively influenced for later sub-projects (e. g. by directly addressing individual employees or by hints to the groups to optimize their composition). At the end of the project, the conclusion was drawn from these experiences that it is generally better to influence the composition of the project groups with regard to aims and tasks of the projects right from the start. Openly advertising the project allows, however, the involvement of persons and perspectives who might otherwise be easily overlooked.

Advice and moderation

Project groups can come to good results all by themselves on the basis of a clear target, appropriate resources and project-related abilities with those involved. In the context of the project „Health Promoting Hospital“ it was decided to provide support by an external professional facilitator from the beginning. In practice, this has revealed to be helpful in different situations. On the one hand, it became obvious that the project work was accompanied by much uncertainty. What are the „real“ aims? How far are we allowed to go? With what can we work? Who do we have to involve? What rights do we have? These or similar questions were asked in the initial phases of all the single projects. With the help of external facilitators, this (necessary) uncertainty was able to be used in order to form groups who also „keep on the ball“ in unclear and discouraging situations. Furthermore, the moderation and also the external consulting with contents, served the purpose of searching systematically and creatively for new paths even if traditions appeared to be over-mighty. Facilitation on the sub-project level served the purpose of accelerating, slowing down, broadening or concentrating the work processes according to necessity. The focus of the external support was mainly put on the area of process control and steering. Nevertheless, it was again and again necessary to integrate expert knowledge into the project groups with regard to factual problems (e. g. with questions of quality management, EDP organization, etc.).

The steering committee (project management)

External facilitation and consulting was not only used at the sub-project level but also for the project management of the over-all project. The hospital management and the external group of advisors were represented in the steering committee by three

persons respectively. Here, all essential decisions were made, the targets defined and the results evaluated. With such a form of cooperation between leading people in positions of responsibility and advisors, management tasks and advising functions are easily blurred. Thus, it was necessary to clarify the different roles and functions right at the beginning and to keep them consciously separated again and again during the working process. The advisors in the steering committee took on different areas of responsibility: over-all steering of the project process, guidance of advisors and moderators and evaluation of the project.

In order to support the clarity of roles/responsibilities and the efficiency of the project leaders, a (group) supervision was carried out with the whole steering committee. Expectations, fears and contributions of the individual members of the steering committee were topics of the supervision. Individual interviews, carried out once a year, were aimed at contributing to a) supporting the self-reflection and b) drawing the attention to possible „blind spots“ in the project management. With these measures, we succeeded in checking the view on one’s own managerial work again and again, to broaden it and to experience the differences of the respective (occupational) perspectives towards the events of the project.

Project structure

On a whole, the project structure can be represented as shown in Figure 2.

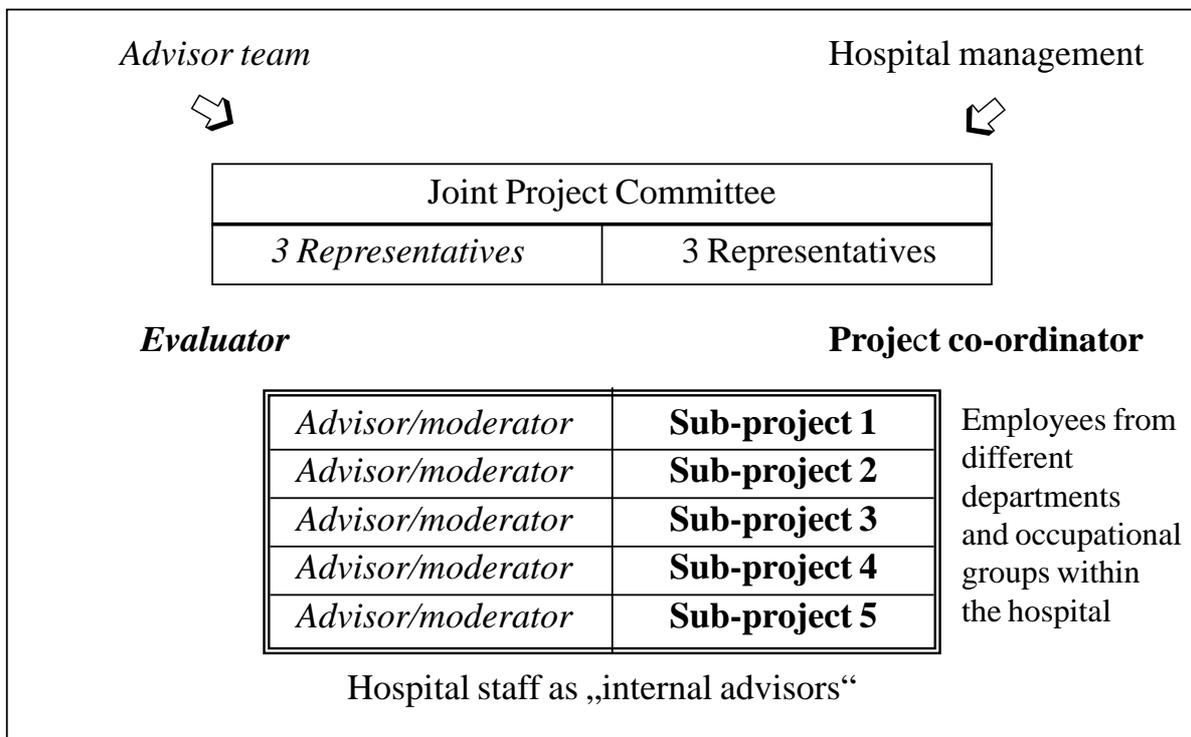


Figure 2: The project structure

External consultation

What were the tasks of the external advisors and what qualifications or abilities were necessary for them? Their most important task consisted of supporting the project

groups in their working process, that is to say of bringing a number of individual people with different education, jobs, abilities, interests, hopes and fears together in a group which is able to function and proceeds in a target-oriented way. Advisors steered clarification and work processes, advised with the definition of aims as well as with the development of working forms, exercised, where need arose, provided certain techniques and supported with minutes, reports and presentation tasks. It was *not* one of their tasks to define the *contents* for the aims, tasks and possible solutions. They were, however, to insist that the respective individual and external requirements be considered and checked before solutions were accepted.

The most important qualifications which the advisors needed for this tasks included:

- the ability to steer group development and work processes
- to proceed systematically orientated towards targets and solutions
- to be able to maintain a distance between personal interests and convictions
- to pay attention to the development of individuals as well as of organizations (or structures).

Clarity in the role as an advisor and reliability with regard to the tasks was as equally important as the knowledge of the conditions and specialities of the hospital. The advisors orientated themselves by taking a systemic view on the organization and on advice. All advisors held professional qualifications and several year experience in the field.

Support by external advisors was offered to the project groups throughout the whole project. Partial tasks were worked on autonomously in small working groups.

Evaluation

Special weight was given to the scientific evaluation of the process of the project. The professional evaluation had to fulfil two functions:

- a) to produce continuously relevant information for the project management
- b) to enable to make well-founded judgements of the project results and effects.

From an organizational point of view, the evaluation was assigned to the advisors' side. The scientist, however, who was exclusively working on the evaluation, had his workplace in the hospital. Thus, a compromise was found – an altogether very successful one – between the need for contact as close as possible to the field of work and the necessity for professional distance to the process .

From a methodical point of view, the following procedures were combined:

- Monitoring and documentation of the project measures in all projects as well as in the project management
- Interviewing the staff in the sub-projects about their experiences
- Interviewing the (patients') relatives and visitors to the hospital
- Interviewing the senior executives and staff in the hospital about the project
- Advice, guidance and documentation of the presentations/public relations of the project

- Interviewing the members of the steering committee and feedback of the results into the steering committee
- Writing of interim reports for the steering committee
- Writing of a final report

Project aims and tasks

Formulating the topics and tasks for the individual sub-projects was, as it was soon revealed, not sufficient to define the tasks and expectations for the project groups. First of all, each project group had the task of taking stock of the situation and producing a report together with a report concerning the individual project task. This was then discussed by the project group and the steering committee in order to determine further work instructions. At the beginning, the free room for individual focal points was consciously set relatively broad. This approach did, however, not prove to be successful in all cases. On the one hand, it promoted uncertainty in the project groups. On the other hand, it was time-consuming and did not necessarily lead to sufficiently exact target formulations. As a result, the steering committee agreed to allow „10 wishes“ for each project group. Thus, the target expectations of the project management became much more concrete. The project group and the advisors were able and had to discuss these targets with the steering committee in order to make them even more feasible for the project work. The following procedure proved largely efficient: a negotiable free space remained between the necessary target expectations towards the project groups and their own focal points, which was obviously necessary for the motivation and creativity of the project group. The jointly defined project targets formed at the same time the basis for the ultimate presentation and evaluation of the project results.

In order to be able to follow and control the process of the project work at the level of the steering committee, two methods were chosen:

- a) project presentation and discussions between project group and the steering committee
- b) regular „application“ for measures to the steering committee

Especially the second method seemed to be rather formal for some persons involved and to formalize the decision-making process. The advantage of this regulation lay in the fact that it created a very clear structure, that it made responsibilities transparent and that it ensured the support by the hospital management. A disadvantage consisted in the fact that the smooth process of the project measures being put into practice was sometimes delayed. The documentation and evaluation were, however, essentially promoted by this clarity. On the whole, the balance for the partly formalized systematic project structure for a project of such a range was positive, even if this meant greater expenditure and higher cost in some respects.

The project results of one sub-project showed clearly that the selected form of project group and the project work were only partly suitable for the given task. Whenever it was about a sustained change in structures (e. g. in the organizational process), where strong interests and sometimes long conflicts were present, the limits of the capacity of influence of the project group were soon reached. Support given by the steering committee or the hospital management only partly led to better results. In

such cases, in terms of structures, status and detailed knowledge, the project group was not capable of getting the relations on the right track. This insight serves to remind us to create a clear picture of the possibilities and limitations of a project group in a concrete situation even before the project starts. It is true that in such cases project groups can obviously successfully clarify conditions and find/think up better ways and discuss them in talks. But often they are not able to put them into practice by themselves. The project management also drew appropriate conclusions from this at the end of the project work and chose other interventions – on the basis of the preparing project work thoroughly.

Landmarks, milestones and key situations: presentations, business meetings

Besides the internally agreed „landmarks“ in the process of the project (stock-taking, target agreements, individual project steps, practical measures for putting them into practice, measures of public relations, etc.), important external turning points were set:

- by public presentations of the project (interim) results as well as
- by reports on the project work during the bi-annual international business meetings.

The public as well as an interested specialists' public from the surrounding areas were informed about the project work on several occasions. The project groups were thus „forced“ to present their work and their results which thoroughly released energy. On the other hand, this also led to complaints about the fact that presentation requirements pushed the actual work into the background.

Looking back, we can recognize that the efficiency of the project work could have been increased by a more precise time-structuring. Sub-projects partly needed some time to orientate themselves again and again and to mobilize new energy for the project work. Here, shorter deadlines and more intensive work rhythms (the project groups had about one working day per month for the project work at their disposal) would have been advantageous. Especially in times of hectic changes there was also the danger that the project work would be „overtaken“ by changes in every-day life or that it would be pushed aside. All in all, the „constraints“ of making public presentations proved to be a helpful frame condition for the projects. The outside world was informed about the targets and the process of the work. Parts of the staff who were not actively involved in the project themselves, could also take part in a very limited way in the project. The interest of the public was used to support the sincerity of the projects and thus one's own commitment.

Public relations

The content of the sub-project work did not only, however, come to the public notice through events. The house magazine of St. Bernward Hospital informed regularly with a special supplement. Posters (developed and awarded in a poster competition together with the local Art and Design College) contributed to keep the project constantly present. Not least did the actual practical work in and from the sub-projects draw attention again and again to the project:

- the opening and presentation of the re-decorated Central Emergency Admissions area
- the opening of the Health Information Centre and the cooperation with the sports club as well as with a health insurance
- the newly tested medicine guidance
- the introduction of quality standards
- the introduction of EDP workplaces in the wards
- the running of training measures, etc.

Conferences and similar events were used as well as news coverage in order to keep the public informed of the most important ideas and results from the project work.

The work of the sub-project: results and effects

What concrete results, changes, improvements or progress did the projects bring about – especially with regard to health promotion and organizational development – to St. Bernward Hospital, to its patients, staff or to the regional environment? Were there any expectations that were not met?

Participation of employees and structural changes

The project groups developed structural changes in several sub-projects or contributed essentially to them – mainly with the admission of patients (I) and with quality management in the operation theatre (V). The first sub-project served to re-design the diverse casualty wards into one modern „Central Emergency Admissions“ (and – as a perspective – be further developed into a „Central Emergency Area“).

Before, problems existed in (emergency) admissions in several respects:

- a clear spatial orientation for the patients and the accompanying persons was lacking
- separated casualty wards hindered internal cooperation
- the entrance area appeared not very much welcoming due to short-comings in construction

In the view of the hospital management, the modernization of the entrance area was – because of its „business-card-function“, overdue. The Health Structure Law (GSG) required that unequivocal and justifiable decisions concerning the in-patient, pre-in-patient and out-patient treatment had to be made during the admission.

The project group developed a vision of the future Central Emergency Admissions (Table 1).

A test run was developed and was successfully carried out together with the group responsible for putting the Health Structure Law (GSG) into practice in the Admissions area. The group developed great élan and commitment, exceeding their normal working hours by far, and especially so after the first results became visible. In the course of the project work, the group decisions became even more motivated and clearly defined:

Table 1: Vision of the sub-project „Central Emergency Admissions“

<p>Flexible and inter disciplinary composed teams</p> <ul style="list-style-type: none">– with high specialist competence– in medical and care respects– managed with productive leadership who are led productively– with a high degree of ability to cooperate <p>pursue high quality requirements during the admission of patients (according to corresponding standards)</p> <p>and work in rooms which are equipped in a modern way and can be flexibly used.</p>

- the clearer the problem became as a result of previous action
- the more the needs and wishes of the individual members were considered
- the better the problem was analyzed and the targets defined
- the more committed the persons involved were towards the problem
- the more proposals for solutions were made and possible measures foreseen
- the more exact the members of the group could check the success of the measures.

This observation was also made in the other project groups. Wherever the task, the composition of the group and the environment was favourable for concrete execution, effective structural development steps were successful. The contributions to *organizational* development are summarized in Table 2.

Table 2: Organizational change of the sub-projects work in the admission area

<p>The project group solved, among other things, the following problems for the hospital:</p> <ul style="list-style-type: none">● The construction measure „Renovation“ was planned, guided, and successfully completed. Afterwards, the entrance area was bright and friendly.● The waiting room for patients was made more attractive (additional space was gained by building a wintergarden with children’s corner, TV set, books, flowers and suitable pictures).● As a result of the projects, patients were welcomed by a permanently present skilled employee at a nice wooden counter.● The treatment rooms were made more easy to survey and more modern.● The focal point was: health promotion in the admissions area.
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New offers of health promotion for patients and the public

The focal point of the project work lay in the development of offers of health advice and health promotion for patients as well as for the public outside the hospital. In order to meet this purpose, the second sub-project group developed „Health Information Centre“. This newly created, institution was then equipped with qualified per-

sonnel and received the task of launching a range of offers, as broad and attractive as possible. Here, the willingness and experience of the staff at St. Bernward Hospital could be used, who had already carried out information events for the public in individual cases. The qualitative and quantitative leap consisted mainly in the fact that these events were now offered in cooperation with a sports club and a health insurance. For all partners involved, health promotion became thus a trade mark for their activities in public.

At the same time, the quality of the offers was improved. In courses on how to deal with diabetes, participants were for example not only informed, but could try out and experience in practice how they could better deal with the illness in every-day situations. Comparable offers were developed for heart-blood-circulation diseases and for the prevention of sport accidents. For the patients in the hospital there were, among other things, offers for advice on medical preparations.

The Health Information Centre contributes actively to the profile of St. Bernward Hospital. It makes a concrete contribution to the further development of the hospital towards a regional „Health Centre“. That is why there is the intention to extend these activities into an individual area of business.

Improvement of health promotion for employees

According to the targets set by the WHO project, also those tasks were tackled which focus on the health of the employees. Here, improvements were reached in completely different contexts:

- In the course of the re-organization and re-design of the Central Emergency Admissions the equipment and position of the workplaces was checked with regard to how far unnecessary strains for the employees could be prevented.
- The sub-project „Cooperation across disciplines and departments“ developed and tested a new working hour system served at improving the working conditions of the staff. The clarification process of how far this model should be transferred to other departments in the house, is still going on.
- The project group, who developed health promoting approaches in connection with the introduction and use of EDP also dealt mainly with ergonomic aspects. Procedures and instructions, which served the health of the staff or could help them to care for their own health, were designed for the start into the EDP time as well as for every-day use. Here, high value was set on steps which are appropriate, suitable for every-day use and can be realized with little expenditure. Appropriate information in good time, participation with regard to the position of the equipment, the function, the organizational execution as well as preparation and training proved to be the essential factors. Here, the experience causes us to reflect that health promotion can generally only flourish with connection to technology, organization, knowledge and action.

Improvement of internal communication

Generally, the projects and the work in project groups contributed to a better and closer understanding and cooperation across occupational, status and department bor-

ders. This is one side of the coin. On the other hand, the projects did not only have promoting but also burdening effects on the internal communication. Some employees who were not actively involved in the project groups felt that the project work was rather a burden than a help. In some cases, this caused conflicts which could not be resolved completely. However, these experiences remain as a summary:

- Because of the WHO project, more staff than before dealt with the questions which concerned the whole hospital, its profile and its future role.
- Additionally, the encounters in the project groups contributed to promote effectively the internal transparency of the hospital for the benefit of manifold cooperations and „short ways“.
- The joint work on the sub-projects promoted mutual understanding and the possibility to look at facts from the perspective of other occupational groups and departments in an impressive way. On no account does this mean that all persons involved agreed afterwards. But the willingness and ability to reach agreement or compromises increased noticeably. Cooperation relations for the future arose from the cooperation within the framework of the project. This belongs to the most important effects of the project work beyond the WHO project, since it increased sustainably the „potential for problem solving and cooperation“.

„Interfaces“: projects and their project environments

One problem or management task became extremely obvious during the project work: the design of the borders and links between every-day-life and the projects. This was, on the one hand, true for the management where one had to take care that by line and project management certain processes and function were not „doubled“ (especially at the highest steering level). On the other hand, it became clear how much depends on a good flow of information in such large projects. It was even more important to keep an eye on the transitions between project work (as a special situation) and every-day life at staff level. This became especially evident whenever the persons involved in a project – out of their „normal“ surroundings and taken away from the information normally available – doubted the scope and the freedom of the innovation tasks or they argued with real or imaginary „counteractions“. Since participation had a central value, these „interface problems“ could not be avoided. We would not even have wanted to avoid them, since they could also be used for important clarifications and „loosening up“ of perspectives. Nevertheless, this area remained a sensitive zone.

Quality development

Even though contributing explicitly to quality development was only partly a prime target of the WHO project, this aspect played an important role in several sub-projects. Guidelines, standards and procedures for safeguarding quality were developed for:

- the procedures at the Central Emergency Admissions
- different training measures in the area of EDP
- procedures and equipment in the operation theatres.

Thus, the WHO project prepared ideally and technically the introduction of a comprehensive quality management at St. Bernward Hospital. Some results could be directly adopted. Others broadened the methodical approach of quality management. Thirdly, the project experience formed a positive precondition in our house for the future introduction of quality circles in different areas (which then also no longer require external moderation). This example revealed one aspect of the long-term effects of the project.

Remaining tasks

At the end of the WHO project the question arose – as with other projects as well – What can and is to remain or even extended; what was only reasonable and necessary for the duration of the project? As we can see from the results and effects of the sub-projects, there were and are a number of sustained effects, which are continued or are to be further used. Progress in the area of internal communication, organization culture or human resource development continue to have an effect in other contexts. Three aspects should finally be highlighted:

Continuation and care of the results under normal conditions

Projects are projects. That is to say they have a limited task, a certain risk of success and an end. Not everything that is done and developed in projects has later to become a part of every-day life. Thus, it is clear that the project groups do no longer work together in the way they did after the WHO project finished. In most cases there is neither the necessary energy nor the constant challenge to do so. The projects did not only cost money and time, but also power. The fact however, that they also gave courage and motivation, is not questioned.

Some of the results have meanwhile become a part of normal life. They are part of St. Bernward Hospital (as, for example, the Health Information Centre). Quality standards are being applied, and will be further developed, should there be a need. Advice and training are continuously offered. A post-checking at the Central Emergency Admissions revealed that some of the formerly damaging conditions have actually effectively improved. One of the central experiences also of this project is, however, that the results have to be maintained in a (target) orientated way if they are to last. After finishing the project phase, someone has to look after the observation of regulations, the continuation of standards, the application of procedures and their adaptation, and to see that information and communication contacts do not break apart. In most cases, former project participants do this work. Thus, the identification reaches further than the end of the project time. A strong formal structure is no longer necessary for it.

Project efficiency with different targets

The chosen project structure was not equally efficient for all tasks. This has already been mentioned. Especially far-reaching structural changes (measures) require other (power) potentials and procedures. Also, if it is the case of massive interests, existential questions and the dissolution of long-existing conflict, openly composed

project groups soon reach their limits (even if they have an official task and the support of the highest execution level). Even with the expressed support by the steering committee, such experiences could finally not be prevented. Limits to the efficiency of projects were also soon visible when their work was based on preconditions or was closely related to developments which themselves are only little assessable and which the project group can hardly influence (as, for example, with the setting up of a EDP infrastructure). Highly efficient, though, seemed to be projects, which were about new ideas, niches, re-design of working conditions and questions of quality.

Project culture in the hospital every-day life

Projects and project management appear – facing the various and often very short-term changes in the health sector in general and in hospitals in particular – to be an indispensable tool. Projects

- create a level of „medium complexity“
- mobilize resources from the system for facing new tasks
- represent a framework for addressing „old problems“ or new challenges *systematically*
- are institutionalised laboratories, which connect working and learning, organize knowledge in a new way, broaden or link it and work out decisions in a new way
- create new room for experience, in which employees can experience themselves as competent, can perceive synergy effects by combining different knowledge and resources, can feel „in charge and responsible“, can venture new things.
- radiate on the main organization in that the effects which the individual projects unfold do not stop at project borders.

The WHO project has – transported through all concrete tasks – essentially contributed to unfold this tool in and for St. Bernward Hospital. It remains to be hoped and expected that this will linger on for a longer time and will benefit the further development – regardless of the kind of challenge this might be.

References

- Wagner, E., Corleis, Sr.C., Kreye, U., Asselmeyer, H. (1996): Der Mensch im Mittelpunkt: Durch Organisationsentwicklung zum Gesundheitsfördernden Krankenhaus. In: Bellabarba, J., Schnappauf, D. (Hg.): Organisationsentwicklung im Krankenhaus. Göttingen, Stuttgart: Verlag für Angewandte Psychologie, S. 215–228
- Wagner, E. (1997): Organisationsentwicklung im Krankenhaus. In: Zwierlein, E. (Hg.): Krankenhaus der Zukunft. Management im Gesundheitswesen. München u.a.:Urban & Schwarzenberg

People-centred for more than 20 years: St.Irmingard Hospital Prien am Chiemsee. A participant in the European Pilot Project on Health Promoting Hospitals¹

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St. Irmingard Hospital, Prien/Chiemsee

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Hospital Owner:	Fessler Klinik-Betriebs-GmbH & Co KG
Hospital Ownership:	Private non profit
Specialisation:	Usual care and early rehabilitation, cardiology, oncology, psychosomatic
Beds:	213
Staff:	Medical Staff: 22, Nursing Staff: 23, Other Staff: 107, Total Number of Staff: 152
Utilization:	Average Utilization of Beds/Year: 98 %, Average Stay in the Hospital/Day: Med.Dep. 9, Rehab.Dep. 24, Psychosom. Dep. 40
Patients:	Number of Inpatients/Year: 3.100, Number of Outpatients/Year: 200
Number of Departments:	5 (2 dep. usual care, 3 dep. rehabilitation)
Location of Hospital:	Inner city
Catchment Area:	National and regional, Number of Population: 1,6 Mio. regional
Other Functions than Medical Care:	
Teaching:	Medical Students, Postgraduate, Other Health Professions: Physiotherapists
Research:	Clinical Research, Other Health Research: Epidemiological Research, German Cardiovascular Preventive Study
Subprojects:	<ol style="list-style-type: none"> 1. Energy Pollution Commission 2. Initiative to Improve Public Acceptance of Psychosomatic Disorder 3. Effective Communication Strategies for the Patient-Doctor-Relationship 4. More Colours and Flowers in the Hospital 5. Self-Management Training for Patients with Hypertension or Metabolic Disorder 6. Seminars for Trainers for Outpatients with Cardiovascular Diseases 7. Early Integration of Cancer Patients 8. Self-Measurement of Blood-Clotting-Time 9. TQM – Total Quality Management 10. Doctor-Patient-Seminars and Seminars for Patients and Other Persons 11. Improvement of Healthy Food and Prudent Diet for Patients and Staff Members

¹ We would like to express our thanks to Ms. Ann O'Riordan for supporting the editing of the english text version.

Background

Our hospital's pathway to the WHO Health Promoting Hospitals initiative started from an annoying or at least an irritating event. It is a very personal story and here it is. To keep it short, we read in a lecture published by the WHO Director, Dr. Ilona Kickbusch in 1989, that the medical profession was failing in the field of health promotion, consequently the „reorienting of health services“. This irritated us, as we were already well known for our expertise and experience beyond that of traditional curative medicine. For example we were:

- principal investigator in the multi-centred German cardiovascular preventive study (1977–1990/94), (Hüllemann 1986, DHP 1998);
- founder of the first German outpatient heart group (Heidelberg 1968) (Hüllemann 1979), of which there are now more than 4000 in the country;
- responsible for establishing our own institute for research and counselling in the field of management and social sciences and;
- instigator of many structured initiatives in the hospital, later to be termed sub-projects in the WHO-project.

The subprojects selected for the WHO European Pilot are listed below in Table 1.

Table 1: Subprojects in the WHO European Pilot Project

<ol style="list-style-type: none">1. Energy Pollution Commission2. Initiative to Improve Public Acceptance of Psychosomatic Disorder3. Effective Communication Strategies for the Patient-Doctor-Relationship4. More Colours and Flowers in the Hospital5. Self-Management Training for Patients with Hypertensive or Metabolic Disorder6. Seminars for Trainers for Outpatients with Cardiovascular Diseases7. Early Integration of Cancer Patients8. Self-Measurement of Blood-Clotting-Time9. TQM – Total Quality Management10. Doctor-Patient-Seminars and Seminars for Patients and Other Persons11. Improvement of Healthy Food and Prudent Diet for Patients and Staff Members

On the strength of our background, we presented a paper at the WHO-conference „Investment in Health“ (Bonn 1990). This paper covered many of the topics mentioned above as well as our health promotion initiatives at the university, the patient's bedside and our post graduate activities and patient-doctor-seminars. As a result of this paper, Dr. Milz (a former WHO consultant in Copenhagen) introduced Prof. Hüllemann our hospital's medical director to Prof. Pelikan. Following this meeting, Prof. Hüllemann was invited to attend the WHO meeting in Budapest on Health Promoting Hospitals (Budapest Declaration).

In summary, for us being a member of the prestigious WHO-project was a reward. It fits quite well with our concepts and activities. We believe that with WHO and the European HPH Network behind us, we can better implement the vision of human centred medicine inside and outside our hospital. Nevertheless, it can also be stated that without WHO and the European network, our hospital would still have pursued further initiatives and activities in the field of health promotion. Last but not least, we should mention that our frustration at the very beginning with Dr. Kickbusch's paper (... medicine fails in the field of health promotion ...) has changed to admiration for Dr. Kickbusch, as her initiatives are guided by respect for humanity.

Introduction.

St. Irmingard Hospital is a small hospital with only 213 beds. It mainly caters for patients with cardiac diseases, cancer and psychosomatic disorders. Most of our patients are either in the acute or early rehabilitation stage of their diseases (heart transplant patients, cancer-patients who need chemotherapy), however, some are in the final stages and are quite seriously ill.

Our hospital has developed close links with Munich University (lectures, seminars and examinations for medical students) and runs several postgraduate seminars for physicians, social workers and physiotherapists. The hospital promotes a very stimulating atmosphere with regard to *open communication* between all levels of the hospital hierarchy, different medical professions and somatic and psychotherapeutic medicine (Hüllemann 1997). The background to our hospital's activities is the silent but permanent presence of two key questions:

„Why should we do *that* in *this* way?“ and „Do we always *know* what we are doing and know *the implication* of our actions on patients and other people?“

These questions have ethical implications and inspire our team to do their job in a more reflective manner.

Hospital personnel accept that the daily work of the hospital focuses on assisting the patient's repair mechanisms. Nonetheless, physicians, nurses, social workers and other staff members feel that there must be *something more* beyond repair and healing. Since, joining the WHO Health Promoting Hospitals initiative at the Budapest Business Meeting in 1992, we now stress this *something more* as *health and health-gain*.

Before joining the HPH-project, those staff members who were highly inspired to go „beyond medicine“ felt isolated working in the traditional medical field. The group forming process experienced with the other European Pilot Hospitals became, so to speak, for the staff of St. Irmingard a European family forming process. International „official“ acceptance of our initiatives to go „beyond medicine“ (health promotion) has now become visible and been baptised by WHO.

Many of our original initiatives were restructured as HPH subprojects and received names, in fact even the whole hospital got a new surname „European Pilot HPH“. Furthermore, all activities received the required support. To be an active member in a subproject was highly motivating and inspirational to the creation of new subprojects. Although, we had no extra money, we experienced growing „extra motivation“

so to say. It was like the snowball effect that can be seen on the dance floor, when new couples are continually being invited to dance, so in the end „*the whole hospital is dancing*“.

We started with more than 10 subprojects. All are ongoing and have become a routine part of our services (with the exception of one subproject that could not be structured successfully). This subproject was named „effective communication, selection criteria and strategies between doctor, nurse and patient“. Some of the subprojects selected for the European Pilot Project are described in the following chapter.

European Pilot Subprojects

The following is a brief account of a selection of our subprojects. They outline how we planned, implemented and evaluated our health promotional activities, while also describing the effective changes created by them within the hospital.

Early integration of cancer patients

Many cancer patients have problems with their reintegration into society (working place, family etc.). They also have problems coping with the physical and psychological burden of the cancer. The hospital's challenge is to assist cancer patients with this reintegration process and to do so, as early as possible. This subproject succeeded, not only, in reorienting the routine services for patients with malignant tumours but those of our other seriously ill patients (physical illness, psychosomatic disorder).

In no other field of pathology, is the spiritual dimension of disease in greater evidence than that of oncology – the sense of life, the sense of death? It is a real challenge to all staff members to stay and not to flee. To remain at the patient's bedside even when there are no answers, no words of hope and just become an emphatic partner. The cancer subproject helped us all to become more self-reflective and serious in our work. It increased not only our job satisfaction but gave us the opportunity to achieve greater satisfaction in our own lives.

In the pilot project phase, we organised weekly informal meetings with a group of cancer patients. From these meetings, we learnt about the needs, problems and worries experienced by patients living with such a life threatening disease. We discovered that cancer patients require attention to be given to the following:

- information – on the aetiology, prevention and therapy (including side-effects) of their disease, along with information on particular topics such as nutrition and physical activity;
- psycho-social support – not only individual support to cope with their diagnosis but family counselling and mutual aid groups;
- development of personal skills – often patients require assistance with developing new skills such as, self-examination or physical activity to mobilise a frozen shoulder following a mastectomy or muscle training in the case of incontinence.

With the basic data gathered from these group sessions, we structured the following programme which is outlined in Table 2. The programme includes a 90-minute group information session weekly, a further 90 minute coping session weekly for psycho-

therapy patients with a chronic medical disorder, a daily hour long graded physical training session, a one hour breast self-examination session for female patients every fortnight plus weekly viewing of video clips and a 30 minute relaxation techniques class. On request patients can also obtain information on mutual aid groups, receive personal counselling over a two-hour period daily and have access to social and physical counselling (specialised for cancer patients). In addition, a few patients may be introduced to art therapy.

In summary, we have succeeded both in widening the range of our hospital services and improving our patient's satisfaction, while also developing a prototype for other hospitals.

Table 2: Intervention programme outline for the Cancer Subproject

<ul style="list-style-type: none"> → information groups – 90 min/week → coping (psychotherapy of patients with chronic medical disorder) – 90 min/week → graded physical training – 1 h daily → information on mutual aid groups – on request → social counselling – on request → physical counselling (specialised for cancer patients) – on request → female breast self-examination – 1 h a fortnight → relaxation techniques – 30 min/week → video clips – once few patients only → (art therapy) – for few patients only → personal consultation – 2 h daily – on request

In addition, many of the subprojects qualitative targets were achieved. These include:

- development of a curriculum for the information groups (materials: slides, transparencies, video clips etc.);
- an organizational concept for the goals and objectives;
- professional coordination for the implementation of the programme;
- recruitment, training, support and supervision of staff members;
- coordination of cancer services with the other hospital services; and
- evaluation of the subproject.

The success of the subproject was evident by the encouraging results achieved through three different evaluation processes, patient questionnaires, staff questionnaires and data obtained within the TQM process. The results demonstrated not only personal gains achieved by staff members such as a sense of life and death, increased job satisfaction and an enhanced corporate identity but an improvement in patient-satisfaction and perhaps better medical outcomes through the use of less pain relief drugs. Patients also reported a greater degree of independence in running their

own lives with an increase in self respect, which more than any other factor (e. g. socio-economic factors) influences the everyday fibre of people's lives. In addition, we have experienced growing patient interest in our hospital. This is evident through the growing number of cancer patients seeking admission to our hospital.

Doctor-Patient Seminars and Seminars for Patients and other Persons.

This subproject has two distinct parts, a) doctor-patient seminars and b) seminars for patients and other persons.

a) Doctor-patient seminars (early evening or Saturday morning)

These seminars sought to strengthen our hospital/community links by enabling former patients, outpatients and their relatives to obtain knowledge and skills in handling a specific sickness.

The subproject successfully established seminars for laypersons, widened the range of our existing hospital services and started a snowball effect towards health promotion in the community, by educating former patients as health promoters. The following quality targets were successfully achieved by this subproject:

- development of an organizational concept for the seminars;
- recruitment of speakers and trainers of excellence (mostly physicians and other specialists in our catchment area);
- organization of the necessary infrastructure (rooms, exhibitions, screening etc.);
- co-operation with organizations such as the Health Insurance (AOK), the German Heart Foundation and the German League against High Blood Pressure (the local administration representatives often chaired the seminars).

These seminars have proved to be very successful, with more than 12.000 patients and their relatives participating to date. Furthermore, many flyers and a booklet have been issued.

b) Seminars for patients and other persons

Expansion of the subproject was achieved with the development of weekend and one-week seminars at the Abbey of Frauenwörth. The Abbey is situated on a lovely island in the Chiemsee and the seminars were organized in co-operation with the St. Irmingard Hospital. These seminars are offered to former patients and other persons (e. g. family members) interested in health and health promoting activities. They go far beyond medicine and include spiritual contemplation, physical exercise and cultural activities. However, the seminars do cover some medical topics such as the management of high blood pressure and diabetes.

Participants receive training in cooking a prudent diet under the supervision of a dietician, attend relaxation technique classes, graded physical activities and discussion groups dealing with a variety of topics (i.e. religion) and last but not least participants have access to personal counselling. The seminars are divided into two main categories, the cardiovascular system and tumours. A third group of seminars has been developed for clergymen and women in religion.

Diminish prejudice against psychosomatic patients (by F. Pfitzer)

Our medical director, Prof. Hüllemann, kept all staff regularly informed on the development of Health Promoting Hospitals initiatives. Consequently, many staff expressed interest in the initiative and asked how best could they become involved. This was true particularly amongst our staff working in the psychosomatic and psychotherapy wards, although, we knew that there was no extra money for special projects. We wanted to find a project that would incorporate our normal work of treating psychosomatic patients on the one hand, and ourselves as members of the hospital staff and „society around us“ on the other.

In several therapy groups, patients discussed very strongly the problem they had with being psychosomatic in-patients. Some didn't even dare tell their friends for fear of being rejected as mentally disturbed. Other patients were afraid of losing their jobs, if their employer found out that they were in-patients or being treated over a long period of time. Furthermore, other patients complained that they felt rejected by „coronary patients“ in the dining-hall, as they were being told „you are not depressed, you should pull yourself together „ and asked „ don't you want to move to another table?“ In addition, two physicians attached to the psychosomatic ward reported having overheard colleagues in other wards making nasty remarks about our patients.

We asked ourselves „ *what did all these events have in common?*“ We decided that it had a lot to do with a lack of information and prejudice. People with psychosomatic or irrational problems are often viewed as either insane or lacking insufficient will power. We considered it part of our job to do something about this and felt that it would be very compatible with the hospital's health promoting ideal. Consequently, the psychosomatic ward staff proposed a subproject termed „ diminish prejudice against psychosomatic patients“, which was approved by our medical director.

Our staff work as a specialised team. So, a specialised team as described in Table 3 undertook the subproject work. Since 1989, the Psychotherapy and Psychosomatic wards have been lead by Dr. Franz Pfitzer, a specialist in neurology, psychiatry and psychotherapeutic medicine. The department caters for 35 in-patients, usually for a period of 8 weeks and that gives us an annual rate of approximately 200 in-patients.

Table 3: Specialist team for the subproject „Diminish prejudice against psychosomatic patients“

Discipline	No.
Physicians	5
Psychologist	1
Nurses	4
Social worker	1
Non-verbal therapists	4
(i. e. music, art, dance and body therapy)	

According to psychodynamic thinking, our therapeutic work is defined as focusing on the patient's symptoms, his past, and the therapeutic relationship. Using this fo-

cus and a teamwork approach all the various treatment activities are shared and integrated amongst the members of the specialist team. The subproject set out to achieve three general aims and objectives:

1. To increase the effectiveness of medical and psychological treatments.
2. To improve patients self-esteem and social skills.
3. To increase knowledge, skills and motivation among non-psychiatric members of the health system.

In order to increase the effectiveness of our treatment, all staff including the non-verbal therapists received additional training, although, the standard of care was already above average at the start of the project.

In keeping with the slogan „*Nothing is as convincing as success*“, we thought that our goal „to diminish prejudice against our patients and the psychosomatic ward“ would best be achieved, if people, like friends and employers were able to see the effectiveness of psychosomatic treatment. We started by collecting more data on our patient's social backgrounds, diagnosis, treatment and treatment outcomes. Our initial goal was to find out whether any special sub-group of patients had poor treatment results and required additional effort. No easy answer could be found to this query.

The result of this investigation was, that we became more interested in the field of psychotherapeutic clinical quality management, although, this activity did not address the project objective of diminishing prejudice. Feedback from our patients indicated their appreciation of the attention paid to the possible injustices suffered by them. Unfortunately, we have been unable to evaluate this adequately.

With regard to prejudice and the hostile remarks of clinic members not attached to the psychosomatic ward, we thought that this was most likely due to a feeling of uncertain or a lack of understanding about how to get along with psychosomatic patients. So, we intensified our efforts to train other staff members by using morning conferences and other similar activities. We tried to link theoretical teaching skills and knowledge on psychotherapeutic approaches more with clinical demonstrations. Although, we didn't do a pre-project survey, hostile remarks have now disappeared completely. In fact, two doctors from other wards have even started psychotherapeutic training.

It was considered very important that patients themselves should become active against prejudice. To improve *self-esteem* and *social skills* amongst our psychosomatic patients, seminars for patients on topics like anxiety and depression were introduced in 1992. These seminars are now ongoing. In 1993, a patient group to improve self-esteem and social skills was established, this is also an ongoing activity. Our medical director assistance was important in helping other patients within the hospital to define themselves as „healthy normals“ and to get along better with our psycho-somatic patients by shared activities such as the dining-hall, café, spare time activities etc. In addition, a mutual aid group of former patients has been active since 1992.

Networking with other institutions and professional groups has been an important part of this project. In order to improve the knowledge and motivation of non-psy-

chiatric members of the Bavarian health system, we established regular meetings of social workers from different hospitals in the area. We either improved or established contacts with surrounding hospitals and centres for marital and educational counselling. Furthermore, we offered regular training programmes in contextual family therapy treatment and an annual training seminar on psychiatric topics for non-psychiatrists. Following a short review, these project activities are now part of the hospital's routine services and activities.

Outpatient Heart Groups

The aim of this sub-project was to establish a physical exercise programme for cardiac patients within the hospital. The continuation of physical exercise after the early rehabilitation phase is extremely important for the cardiac patient. The programme contains graded physical exercise and is available to patients with various heart diseases. The programme, as shown in Table 4, runs twice weekly and operates under medical supervision. In addition to physical exercise, patients receive training in self-control of heart rate and strain limits and information on how to live with their chronic disease. The programme was developed with the collaboration of the Community Education Centre, St.Irmingard Hospital, general practitioners, junior hospital physicians, coaches, and physical educators. Insurance and patient fees meet the cost of the programme.

Table 4: Subproject Outline for Outpatient Heart Groups

Aims	Participants	Methods
1. Continuation of physical exercise twice a week (with early rehabilitation) 2. Medical supervision 3. Self-control training (heart rate, strain limits) 4. Information on how to live with a (chronic) disease	Patients with various heart diseases	Graded physical exercise

Another essential component of the subproject was the training of physical educators for the Outpatient Heart Groups. This postgraduate training was carried out with the co-operation of the Association for Outpatients Cardiac Rehabilitation and Prevention in Bavaria. Two training courses were obligatory and all students who pass an examination are awarded a certificate at the end. We used this procedure as part of our evaluation.

Both activities – the outpatient heart group and the postgraduate exercise training – were viewed as training multipliers. As St.Irmingard Hospital is a health promoting hospital, we are responsible for the programme and its organisation and so all participants receive health promotion training.

Energy pollution commission

This is our ecological subproject. Not only do hospitals cause pollution but they also waste energy. To investigate the problem in our hospital, we set up a commission. Practically every professional group in the hospital sent a representative to the commission. Below is a list of the commission's achievement to-date:

- Decrease in the use of disposable articles, (i.e. milk in glass bottles, no tetra packs);
- Separation of plastics, glass, paper, compost and so on;
- Reduction in the consumption of raw materials (i.e. mud-baths and packs);
- Using less water in the WC;
- Increased usage of energy saving electric bulbs;
- Introduction of special measures in the laboratory and medical service.

Total Quality Management (TQM)

After joining the Pilot HPH-project, we embarked on a hospital-wide total quality management (TQM) programme in co-operation with the Federal Bureau for the Employees of Germany. Hospital representatives were sent for TQM training to three external scientific institutions that work in association with the Federal Bureau of the Employees (Berlin).

Our representatives received basic instruction in the aims, goals and targets of TQM and a manual that had been prepared by the external scientific institutions. Every 3 months, a random sample of patients receive a patient satisfaction questionnaire covering the services provided by the hospital and another random patient sample is documented by medical staff according to a standard procedure. Here diagnostic and therapeutic procedures are documented, along with their aims, goals, targets and associated successes and problems.

All collected data were analysed and evaluated by an external scientific institution. The feedback of results provided the hospital with a baseline for management decisions. For example, we learnt from the feedback data that patient satisfaction was poor in relation to nutrition. In an attempt to solve this problem, management decided (after a year of consultation) to co-operate with an external consultant. In the end, a new project started with the name „better nutrition, better service, better satisfaction and more cost effectiveness“. The result was the employment of a new chief/cook, who is currently undertaking a part-time (weekend-training) degree in kitchen economics. This project is now finished with fairly good results achieved (TQM proved).

Another part of the TQM programme is a quality circle. The quality circle prepares (among other things) data that can assist management decisions and influence how departments work.

Coordinating Centre of the German Health Promoting Hospitals Network

At the beginning of 1995, our hospital (together with other German pilot hospitals) started the development of a German Network. In summer 1996, St.Irmingard Hos-

pital was confirmed as the National Coordinating Centre by the WHO – Regional Office for Europe.

Special advantages of our institution:

- Early association with the development of the Health Promoting Hospitals Project from the Budapest Business Meeting / Budapest Declaration.
- Member of the advisory board for the development of the European Pilot Hospital Project.
- First German hospital to participate in the European Pilot Hospital Project.
- Twenty years expertise in the management of big projects, e. g. our institution took part in the German Cardiovascular Preventive Study (12 years, sponsored by the Federal Ministry of Health and the Ministry of Research and Technology – DM 100.000.000). The director of St.Irmingard Hospital was one of the principal investigators in this study.
- Close connection with Munich University.
- Expertise in organizational development (personal union with a consulting institute “Institut für systemische medizinische Forschung – Diagnostik, Management und Beratung“)
- Major publishing activities in scientific journals.

Moreover, as a specialised hospital, we have practically no problems associated with competition. It is a strictly neutral institution to all network members and to those interested in the network.

One could ask, what are the benefits to Prien of investing in these activities? And we would answer: there is no greater target for us to reach, than to achieve a more human centred hospital, a human friendly hospital – *medicine should not be as cruel as it often is.*

To be a member hospital in the WHO-network and the national coordinating centre, we can achieve greater public credibility and influence over the reorientation of the medical system towards a vision of humanity. Our experience over the last 20 years has convinced us that it is possible to provide, not only a high medical (technical) standard while using resources cost-effectively but also to create and maintain a warm hearted atmosphere.

To-date, 26 hospitals have become official members of the German Network and more than 100 hospitals are interested in the network. Most applicants join the network via the association “Deutsches Netz Gesundheitsfördernder Krankenhäuser“. Exceptions can be made in certain cases where the hospital either does not wish to become a member of the association or is prevented from joining by its legal constitution. The office of the association is located in the City of Essen. All applications for membership are investigated and looked into by two peer reviews. A visit to the respective hospitals is a necessity. The office in Essen does the whole organizational work, except in the case of applicants that do not want to be a member of the association or are members of a thematic network, then the national coordinating centre in Prien does the organizational work. Following approval of full membership by the

board of the German Network, an Agreement Document must be signed between the hospital, WHO and the national coordinating centre in Prien / St.Irmingard Hospital. Arising from our experience in the European Pilot WHO-Project, one wonders whether more than 10 (20) hospitals can best be coached or managed by one office. It seems more sensible, that in the future regional offices should be established in several parts of Germany to act as regional focal points for about 10 hospitals.

A regional network and office „Berlin-Brandenburg“ was founded in August 1997, with a membership of five hospitals and three other hospitals interested in joining.

Considerations

In the future the German HPH Network may have the following structure:

1. Regional offices for about 10 (20) hospitals and other institutions;
2. The „*German Network of Health Promoting Hospitals*“ association's main registration Office located in the City of Essen;
3. The national coordinating centre in Prien/St.Irmingard Hospital, as an umbrella organization to enable and maintain the network as a powerful movement within the health system and society in general.

The main targets of the German Network should be quality, service and a truly humanitarian hospital, befitting all human beings (Hüllemann 1996). In summary, the European Pilot Hospital Project has been a fascinating and successful initiative. In addition, for us the staff members of St.Irmingard Hospital, it has been a privilege to be a member of the Pilot Hospital Network.

However, in 1996 we had one major question: Could we persuade anyone from the European family of Pilot Hospitals to come to the 6th Business Meeting, in a convent on a small island near our hospital? It was with great joy that we were able to welcome all the hospital representatives here.

The HPH Project is a collaboration of effort and dreams of health gain and good fellowship. The bottom line is not money; it is the dignity and right of each human person to health. This is the contribution that health promotion can make to the future.

Since our hospital was confirmed as the National Coordinating Centre by WHO, we feel honour bound to keep the HPH initiative alive and even to facilitate its growing into a powerful movement. It is inconceivable to us that all doctors, nurses and social workers in a wider sense, will not join the network of Health Promoting Hospitals sooner or later.

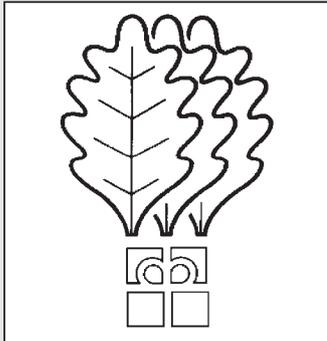
References

- DHP (1998): Die Deutsche Herzkreislaufpräventionsstudie (DHP) Huber, Bern
- Hüllemann, K.-D. (1975): Ambulante Dauerbehandlung von Herzinfarktpatienten in einer Sportgruppe. *Sportarzt und Sportmedizin* 26: 91-95
- Hüllemann, K.-D. (1986): Herz-Kreislauf-Prävention. In: Gross, R.W.J. (Hrsg.): *Wege der Gesundheitsforschung*, Springer Heidelberg, New York, S.9-23
- Hüllemann, K.-D. (1990): New Perspectives out of the Experience with Chronik Illness – Health Promotion by the Physician in Research, Teaching and Management. Paper presented at the WHO-Conference “Investment in Health“, Bonn/Germany

- Hüllemann, K.-D. (1996): Organisationsentwicklung in einem Krankenhaus. In: Hauser, A., Neubarth, R., Obermair, W. (Hrsg.): Management-Praxis, Handbuch sozialer Dienstleistungen, Luchterhand
- Hüllemann, K.-D. (Hrsg.) (1997): 1. Nationale Konferenz 24./25.Okt.1996 in Prien am Chiemsee (Kloster Frauenwörth/Fraueninsel), Mitgliedskrankenhäuser, Grundsatzpapiere. Selbstverlag Med.Klinik St.Irmingard, Prien
- Kickbusch, I. (1989): Gesundheit als Herausforderung. Vortrag Kongreß 13.-16. Juni 1989 in Hamburg, organisiert vom AOK Bundesvorstand, AOK Hamburg, WHO Regionalbüro Europa

Becoming Healthy: Lessons from a 230-bed Hospital. The Diakonie Krankenhaus Alten Eichen, Hamburg

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Hospital Owner:	Evangelisch-Luth. Diakonissenanstalt Alten Eichen
Hospital Ownership:	Private non profit
Specialisation:	General Hospital
Beds:	230
Staff:	Medical Staff: 37, Nursing Staff: 139, Other Staff: 141, Total Number of Staff: 317
Utilization:	Average Utilization of Beds/Year: 81,4 %, Average Stay in the Hospital/Day: 9,8
Patients:	Number of Inpatients/Year: 6.500
Number of Departments:	8
Location of Hospital:	Inner city
Catchment Area:	Regional, Number of Population: approx. 1,7 Mio
Other Functions than Medical Care:	
Teaching:	Postgraduate, Nursing Education
Subprojects:	1. Environmental and Health Protection 2. Health Promotion for Employees 3. Nursing 4. Health Promotion for Patients 5. Nutrition 6. Improvement of Working Conditions 7. Patient Charta 8. Transportation Services

Alten Eichen is the biggest corporate sector of the Evangelisch-Lutherische Diakonissenanstalt Alten Eichen and was founded in 1867 by citizens of the city of Altona – which today is a part of the city of Hamburg – as a foundation. Apart from the hospital with a nursing school the foundation runs different services: a private college of education, an old peoples' home, a day centre for in-patients, a rest home, the deaconesses mother house, accommodation for employees as well as other social and deaconal facilities. The Diakonissenanstalt is managed by a community of deaconesses headed by a Principal (the pastor) the Mother Superior (the deaconess) and the commercial managing director.

Today's building of Alten Eichen hospital was constructed in north western Hamburg in 1970 and extended in 1991 and is newly equipped with 230 beds and 307 full time employees. Most patients come from the north western districts of the city of Hamburg.

In 1995 the four departments with beds i.e. internal medicine (118 beds available), surgery (74), plastic surgery (30) and interdisciplinary intensive care unit (8) have taken care of 6.100 in-patients which means an average occupation rate of 81,4% calculating 68.300 actual days and an average stay of length of 11,3 days. The hospital is an academic teaching hospital and has gained a high reputation in the branches of internal medicine (specialized in gastroenterology, diabetology, infectology, sleeping laboratory, and emergency medicine), general surgery (abdominal surgery with a minimum of invasive operations, accident surgery treatment of industrial accidents, endocrine surgery and proctology and plastic surgery (the whole field of plastic and restoring plastic surgery). Each specialized department is directed by a senior consultant. The medical director of the hospital is at the same time senior consultant of the department of internal medicine; the senior consultant of the anaesthesiology is at the same time deputy medical director.

On the hospital ground, four specialists have settled with whom Alten Eichen cooperate intensively (radiology, analgetic therapy, neurology and cardiology). We are also planning to co-operate with an ear, nose and throat specialist, a day clinic and an organization for out-patients' care and a department for short term care will be opened at Alten Eichen.

As the hospital is part of the foundation, the hospital management consists not only of the managing director, the senior consultant and the nursing manager of the hospital but also of the principal and the mother superior. The principal, the mother superior and the managing director are at the same time members of the management of the Diakonissenanstalt Alten Eichen.

The hospital's way to the project

The first impetus to participate in the European Pilot Hospital Project was given to the hospital by the project convocation, published in the newsletter of the Hospital Association of the city of Hamburg in autumn 1991. Further information on the aims and contents of this WHO-project was given by Hildebrandt GesundheitsConsult GmbH, a private consulting company. In the beginning of 1992, the hospital management started a contract with the consulting company in order to prepare a problem analysis including the development of a concept to participate in the Euro-

pean WHO-project. For the directors, a special motivation to take part in the project resulted from the changing situation of the Public Health Services in the Federal Republic of Germany. (Godo, Hildebrandt, Mursa 1993):

- The Diakonie Krankenhaus Alten Eichen was affected more and more by the general negative discussion about the German hospital sector. In addition high turnover-rates, a general lack of nursing personnel and declining applications for apprenticeship places influenced the working atmosphere rather negatively.
- The corporate identity of the hospital is characterised by the classical image of nursing as an expression of active christian brotherly love. This can be seen by the large number of deaconesses among the nursing personnel of the hospital. Changes within the foundation and in the structure of the employees (rising number of non-deaconal personnel) made an examination necessary, question what is special about the work in Alten Eichen, and how can new targets be formulated together with the employees?

The 'Diakonie Krankenhaus Alten Eichen' is part of the 'Hamburg Health Service' and has not been yet affected by the Hamburg Hospital Requirement Plan aiming at reducing capacities. On the way to new contracting procedures with health insurance hospitals will be put under considerable pressure to obtain attractive performance contracts which may guarantee their existence. Especially small hospitals like Alten Eichen, can help themselves by building up a high reputation through performing outstanding patient care. Compared to basically client-orientated strategies which aim primarily at improving the quality ratings of a hospital that can be evaluated by patients (hotel services), the idea of the 'Health Promoting Hospital' means a more general strategic re-orientation through considering the goals of the Ottawa Charta on Health Promotion (1986) for daily practice. When implemented carefully, the Health Promoting Hospital was also seen as an attractive option to improve the reputation of Alten Eichen.

In the beginning of 1992, a first inventory was taken by the external consulting company leading to a problem analysis. The company investigated the problems in individual talks and group discussions with managers, employees' representatives and employees from different departments, wards and professional groups. These discussions had three aims:

1. Presenting the aims of the WHO-project and options for a possible membership of Alten Eichen.
2. Interviewing participants concerning their ideas about the need for health promotion, the problems they face, their ideas and proposals for projects and their views on strong and weak elements of Alten Eichen.
3. Providing examples for the working style of the project and the participation of employees and management in the planning and implementation of the project.

The results of this first analysis were presented at an employees' meeting where the attendants also were asked if they would be willing to participate in the project. The echo was very positive and the participants hoped to receive support to solve their problems currently existing in Alten Eichen. Most of the problems were related to two issues:

1. The quality of work in relation to the *health condition of the patients*: how can patients be provided with high quality care, how can they experience enough courage and joy of life in the hectic every day hospital work?
2. The working and organizational culture, the high turnover rates, the working conditions and the *health of the employees*, but also with the quality of management, the decision-making processes, the hectic work in daily practice, the loss of meetings with colleagues (e. g. for dinner).

In general, the participants had the opinion that the motivation and the needs of the employees should be seen as starting point and as potential for a process of quality improvement by means of a systematic organizational development. In the discussions it was seen, that the conditions of the employees are directly connected with the improvement of the patients' health. Measures to improve only the health conditions of the patients would put even more stress on the employees and are, therefore, bound to fail from the beginning.

To summarize it up, the following three problems were the main incentives to participate in the European Pilot Hospital Project:

1. Promotion of health and well-being of the *patients* by: psychological and social support of the recovery process, quality improvement and control (medical effectiveness), arranging of health promotion facilities for the time after the hospital stay
2. Promotion of the *employees'* health and well-being by: reduction of the sickness figures and staff turnover, support of well-being and motivation, avoiding work related illness.
3. Health promotion as a part of the *corporate identity* of the hospital by: development of a corporate image including a definition of goals of the work in the hospital, its special deaconal task and the need to improve organizational procedures, communication, management and team structures.

The WHO project in process

Organization of the process by the WHO project management

When the project was started, a project committee was set up as the basis for all decisions and activities of the project. The members of this project committee represent the three 'pillars' of the hospital (the medical, nursing and administration branch), the employees' representatives and the external consultant as a facilitator. The participation of the executives should also demonstrate the importance of the WHO project. Their leading position in the hospital hierarchy should guarantee that the process and the results were accepted by the departments and that the application of the results was not blocked later by a lack of acceptance. Employees taking part in the project should have the guarantee that their activities were backed by the senior management.

The tasks of the WHO project management meeting include decisions on the themes and issues, aims and targets and participants in project groups and the management and co-ordination of all ongoing activities. It decides on proposals for changes com-

ing from project groups and – in case of acceptance – formulate recommendable applications for the hospital management and observe the application of these proposals. This interdependent cooperation between the staff in the project and the hospital management makes it possible to realise proposals between the decisive structure of the WHO project and the decisive hierarchy of the hospital without disregarding the formal decision structure. Through this, a possible collision between the formal line and the WHO project acting as staff division could be avoided. (Oppolzer 1995, 169). In May 1995, the WHO-project co-ordinator was assigned as a part-time job, 20 hours a week, limited until the end of the pilot phase in 1997.

Milestones of the project process

At the beginning of the WHO project a concept had to be developed considering patients and employees projects on a parallel basis. Furthermore the solving of structural problems which had so far discouraged organizational change was put high on the agenda. However, the desired changes could not be achieved in short term perspective and only through changing the primary structure (line function). Flexible secondary structures (i.e. project groups) had to be established in which proposals could be worked out and which should allow a successive transfer into the primary structure, which also was aimed to be changed in the long run. The flexible project structure had to be integrated into a common framework, a corporate task, a goal, or a vision. The participation in the WHO project and the method of organizational development were the efforts that most of the employees had agreed to be a feasible and attractive way of reaching these aims. Central aspects of the project group work in Alten Eichen are:

- goals accepted by the project group participants
- transparency of the tasks
- a clear schedule for regular meetings
- internal and external transparency of the work by protocolling each group meeting
- coping with resistance
- making the work more concrete through written proposals
- final written report on the process and results
- internal and external presentation of improvement proposals

Project phases

The whole project can be subdivided in different phases. The tasks of the projects of the *initial phase* (Nov. 1992 to Dec. 1993) were defined by the results of the above mentioned preparing talks in the preparatory phase. During the *second phase* (Dec. 1993 to Dec. 1994) we have taken up the results from the initial phase but also worked on the results achieved and the new problems addressed by other project groups. The project of the *third phase* (Jan. 1994 – Dec. 1995) concentrated on two basic issues on which the previously implemented projects group ‘Health promotion for employees and patients’ in the first phase had worked on and achieved some solutions: a more varied and more healthy nutrition for employees and patients as well as health

promotion services offered for employees and patients. During these project phases (see Figures 1. and 2.) the WHO project could be established and the first positive results of the project work were achieved. The project group members learned and applied the instruments and methods of organizational development. The first employees' and patients' surveys were made and first results of the scientific research were presented to the employees and the public. The aim of all these measures and procedures were to develop Alten Eichen towards a 'learning' organization and to achieve sustainable results (Figure 1).

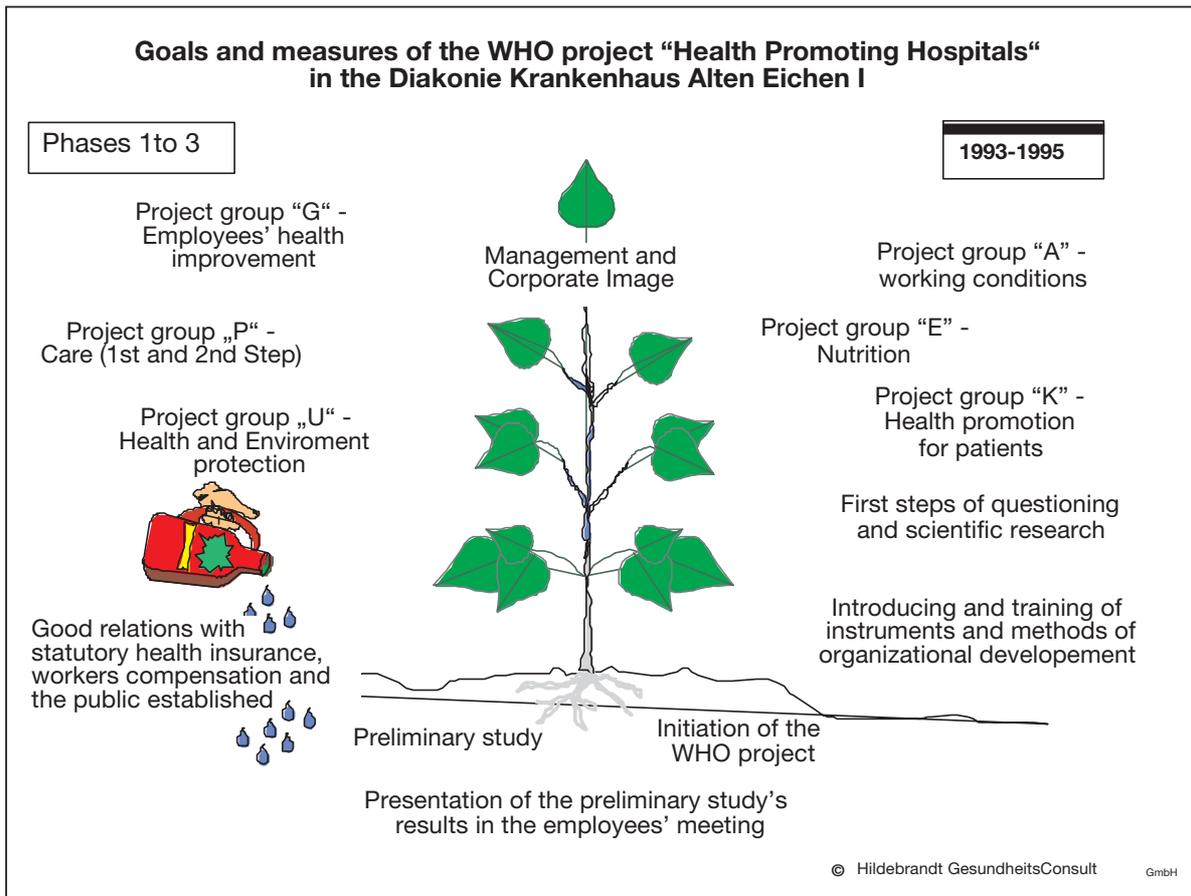


Figure 1: Goals and measures of the WHO project "Health Promoting Hospital" Phases 1 to 3

The results and experiences formed the basis of the subsequent phase (phase 4 and following), which will be timely separated from the pilot project and future project groups will rely on the results of former project work. The external demands are the changing competitive structures and the legal framework as well as the innovative experiences within the Health Sciences and Public Health. To increase efficiency, some projects will be formulated more precisely and supported by expert groups who will continue to work inter-disciplinarily but with a stronger thematic orientation, aiming at producing results within shorter times. The methods learned so far will also be applied in other branches and projects outside the WHO project and thus providing new impetus for the further development of the hospital. A first project group including hospital employees, employees of a health insurance and a patient

consultant finished its work on the subject of patients' rights in February 1997. Further work concentrated on creating a new corporate image that might be the basis for future activities. For the characteristics of the process of the project group work applied in Alten Eichen see Oppolzer 1995, 174 pp and Figure 2.

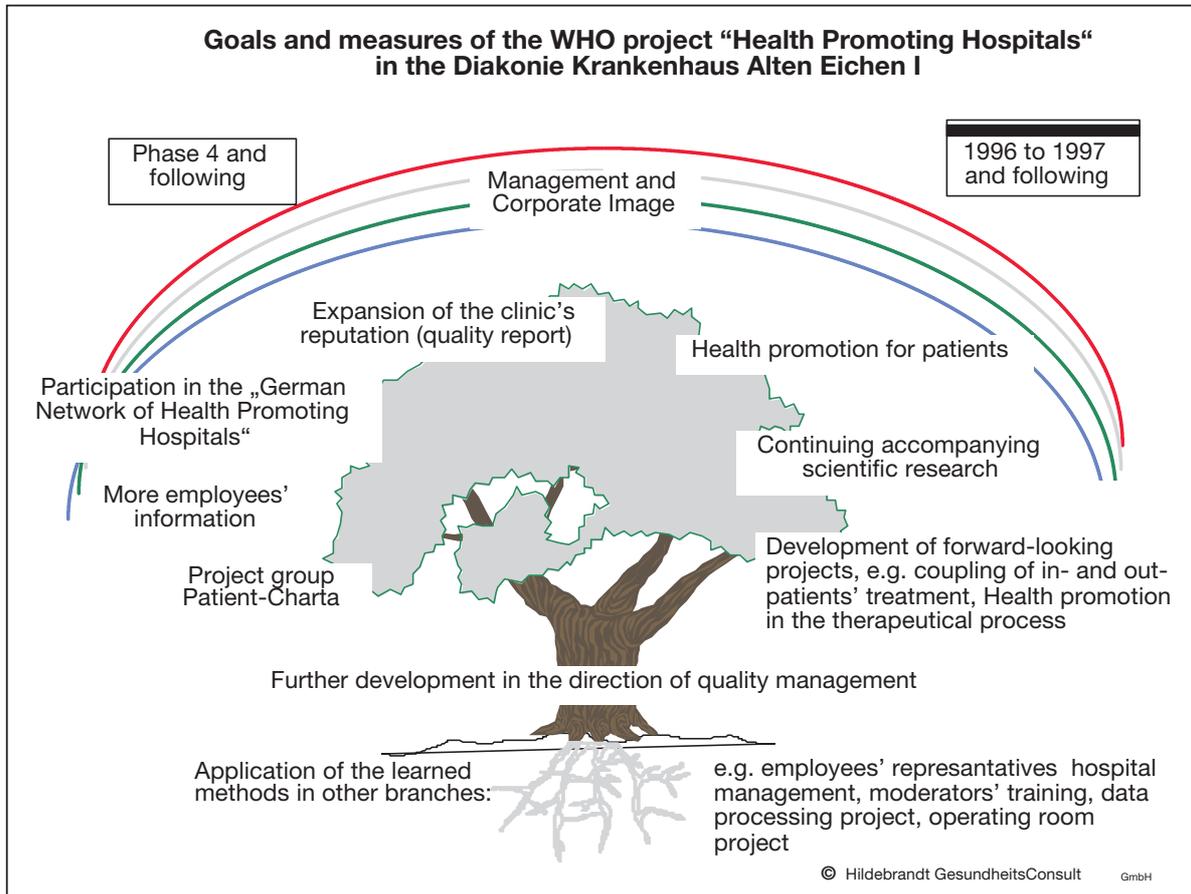


Figure 2: Goals and measures of the WHO project "Health Promoting Hospital" Phases 4 and following

Communication

The project results are summarized on a blackboard and twice a year they are presented to all interested employees. Once a year the presentation is also open to the wider public. Since 1996, a monthly circular letter is published to inform the employees continuously about the WHO-project. All project team members are invited to an annual meeting aiming at an exchange of experiences of the project work. Employees who are not working in the project at present can get in contact with the project work again and be newly motivated. To the external public the project was intensively documented by annual presentations, within a Business Meeting of the European Pilot Hospital Project in 1994, in several publications in the medical press and by publishing several evaluation studies.

External consultation

From the beginning, the project work was intensively supported by external consultants. Consultation included the project design individually created for Alten Eichen,

process consultation and quality control of the project. In addition the consultation supported the project through facilitating project management and project group meetings and through co-ordinating the evaluation. The consultants met regularly to improve the co-ordination, synchronize planning and to mutually support and coach each other. As the character of the project groups will change in the future, facilitators will also have a stronger responsibility for expertise.

Documentation and accompanying scientific research

The WHO project in Alten Eichen is documented by project reports (Diakonie Krankenhaus Alten Eichen 1993a-1997). In addition Professor Dr. Dr. Alf Trojan (Hamburg University, Institute for Social Medicine) and Professor Dr. Alfred Oppolzer, 'Hochschule für Wirtschaft und Politik' (College of Higher Education for Politics and Economics), Hamburg, were involved in the scientific research (Höppner 1996; Hildebrandt GesundheitsConsult GmbH 1994; Nickel, Trojan 1995; Oppolzer 1995, 1998; Schneiders-Kastning 1996; Trojan 1995). The evaluation addresses to the overall project and also specific aspects. The 'questionnaire on quality of hospitals in Hamburg from the patients' view' (by Trojan) and the 'questionnaire on quality of hospitals in Hamburg from the employees' view' (by Oppolzer) are instruments widely applied in the evaluation of the Alten Eichen project. Repeated questioning should show changes within a specific time, which later on will be associated with project work results.

Fundraising and external cooperation

Part of the concept developed together with the external consultants was the establishment of strategic and operative partnerships in order to raise funds and to receive additional scientific advice. Several sponsors were found, which also invested considerably in material and personnel, e. g. some statutory health insurances (AOK, BEK, DAK, HEK,)¹ and others (e. g. BGW², the Conference for Health Promotion Hamburg, the Kroschke-Foundation). In this way, the internal project budget could be doubled up and a sustainable network of an cooperation with external partners was established.

What was achieved?

By the end of the pilot project phase in the middle of 1997, eight project groups have finished³:

In the following we would like to describe in more detail three examples of the project group work. The sub-projects 'Health promotion for employees', 'Health pro-

¹ Allgemeine Ortskrankenkasse (AOK), Barmer Ersatzkasse (BEK), Handwerker Ersatzkasse (HEK), Berufsgenossenschaft für Gesundheitsdienst und Wohlfahrtspflege (BGW)

² The "Berufsgenossenschaft für Gesundheitsdienst und Wohlfahrtspflege" (BGW) is one of the statutory professional cooperations. The BGW is responsible for the health care providers. One part of its area of responsibility is the employees health prevention. It is also a insurance for occupational diseases.

³ The project group work, project themes and selected measures in 'Alten Eichen' are documented in the project reports. (Diakonie Krankenhaus Alten Eichen 1993a-1997; Mursa, Martini 1997)

Table 1: Project groups in Alten Eichen

<ul style="list-style-type: none">● <i>Project group ‘G – Gesundheitsförderung für Mitarbeiter und Patienten’ – Health promotion for employees and Patients (Nov.1992 – Apr.1993)</i>● <i>Project group ‘P – Pflege’ – Nursing (Jan.1993 – Dec.1993 and Apr.1994 – Dec.1994)</i>● <i>Project group ‘U – Umwelt und Gesundheitsschutz’ – Health and Environment protection (Jan.1993 – June1993)</i>● <i>Project group ‘A – Verbesserung der Arbeitsbedingungen’ – Promotion of working conditions (Dec.1993 – Jul.1994)</i>● <i>Project group ‘K – Gesundheitsförderung für Patienten’ – Health promotion for patients (Feb.1995 – Dec.1995)</i>● <i>Project group ‘E – Ernährung’ – Nutrition (Jan.1995 – Nov.1995)</i>● <i>Project group ‘Patients-Charta’ (Oct. 1996 – Feb. 1997)</i>● <i>Project group ‘Reorganization of the internal transport services’ (Jul. 1997 – Oct. 1997)</i>

motion for patients’ and ‘nursing’ have started working on improving the situation of employees and patients through organizational change in central parts of the patients’ care. Therefore, they are most suitable to give an example of the project work but independent of this selection, the work of the other project as well as the results they achieved are of the same importance.

***Project group ‘G – Gesundheitsförderung für Mitarbeiter’
(Health promotion for employees)***

The project group G was one of the first WHO project groups consisting of 10 team members representing the most important branches and the different levels of the hospital. The task given by the WHO project management implied four different aims:

1. Identifying employees’ health problems through applying a questionnaire;
2. Developing proposals for staff health promotion programmes including financial planning, financial calculation and application to external sponsors
3. Identifying health promotion programmes also valid for patients.
4. Developing of a plan of work to examine the causes for the sickness rates and to start a programme aiming at reducing them.

The project group started a survey of the employees of the hospitals in February 1993, including questions referring to the general condition of the employee, his or her psychological and physical stress and the interest in specific programmes, e. g. health promotion classes. The return rate was 40 % (160 out of 396) (Diakonie Krankenhaus Alten Eichen 1993a). The results showed clearly the key points of interest of the employees regarding health promotion programmes: more than 50 percent (52 %) of the employees questioned said: ‘back muscles training’, 39% mentioned ‘re-

laxation through self-hypnosis' and 36 % were interested in 'gymnastics'. This was confirmed also by a high participation in these courses. The high interest in a better and more varied nutrition was later taken up by the project group E and realised by introducing an alternative vegetarian menu for employees. A vegetarian menu for patients, developed by a line function expert group, was introduced in September 1996.

Evaluation of the courses and seminars

In 1995 a scientific research about the six courses held until February 1996 on the subjects of 'back muscles training', 'relaxation through self-hypnosis' and 'how to cope with stress' was made (Trojan 1995), which had been ordered by the BGW⁴. Course participants (employees from Alten Eichen) were asked with the help of a questionnaire about their impressions regarding the courses. Altogether 160 questionnaires were analysed. Most important results:

1. Content and conception of the courses were judged very positively, participants felt that their expectations regarding the courses were more than fulfilled. The participants were shown new views on their problems and they were able to set new goals for their behaviour. However, new goals regarding the working environment hardly appeared (Trojan 1995, 20) and also the application of the planned behaviour changes in every-day's working life seem to be a problem. Apart from the behaviour changes it would be necessary to reduce the problems caused by the work itself (e. g. lifting and carrying patients in the nursing department as well as sitting too long in the administration branch).
2. The courses have reached their target groups, most importantly very strained staff members have participated. However, only very few nurses were able to take part in the courses, which may be caused also by the shift work. The target group 'patients' has not been reached by the courses. The female course co-ordinator in the hospital has approached the target groups with an information on the blackboard or directly by asking interested staff members which the right time for the courses would be for them. In this way, she assured a sufficient demand. The final number of participants in the courses (8 to 12) met the expectations of the organisers. In the course of time, it has been shown, which were the best days and times for the courses. However, the organisers did not succeed in scheduling the courses so that many of the shift employees were not able to participate (Trojan 1995, 23). Although many employees suffer from stress and backache as also was shown in the primary survey, staff members are not too keen on the courses and have to be persuaded for to take part. However, this seems to be more generally the case with health promotion activities: it needs considerable information and persuasive work to motivate people to do something for their health (Trojan 1995, 24). Finally it also turned out, that financing the courses was not very difficult as within those courses who were organised by a health insurance they were free for its members and other participants got 90 % back from their insurances. The courses organised by the adult education centre were also paid to an extent of 90%, sometimes even 100 % by health insurances.

⁴ See footnote 2.

3. In the further course of the investigated period (autumn 1993 to spring 1995), the employees' interest to participate in the 'back muscles training' had decreased considerably and the interest in the 'relaxation training' courses has not reached the expectations either. The motivation to participate in the courses might be increased by better information about the courses already held. It would be especially helpful if the participants told their colleagues how useful the courses were for them. Furthermore, the attractiveness could be increased by considering in the 'back muscles training' the special back aches and the typical psychological stress of the professions (Oppolzer 1995, 102). A reason for the decreasing number of participants could also be the parallel introduction of internal further education offers, competing the health promotion activities.

Project group 'P – Pflege' (Nursing)

A considerable number of organizational changes of the everyday life within the whole hospital have resulted from the work of the project group P – 'Pflegeteam' (nursing). First, – as an experiment – breakfast was served to the patients one hour later so that they could sleep longer. Then, the early morning washing of patients was taken out of the night-shift and the early morning shift was reorganised to cope with this extra work. The project group analysed the problems following this change and – after the management and the employees had agreed the new system was piloted on three wards. These were the first elements of a new system of individual nursing introduced in 'Alten Eichen'. Further steps were taken to develop a standard concept from this individual nursing, i. e. a specialized qualification programme especially for the nurses and a facilitation of the internal process. At the moment a special 'guidance group' (in line function) is co-ordinating the further measures concerning the new system of individual nursing. Furthermore, in October 1996 a core working time was piloted on a ward. Some of the staff members continue to work along the classical shifts⁵. During the core time, the ward team is supplemented by two additional registered nurses and a trainee or a nursing aid. The changes in the work flow with still the same number of employees made it possible to introduce a specialized nursing system improving the quality of nursing. A more effective work of the employees means better results without any further costs (Diakonie Krankenhaus Alten Eichen 1993b).

The project group 'P' followed its mandate in three phases including 40 meetings using the motto 'health promoting improvement of the nursing situation for employees and patients with the aim of a specialized, patient-orientated nursing.' As a first step, the preparatory work had to be done to establish the thematic and personnel framework for the planned changes (modification of the hospital day plan, more internal trainings, relief of the personnel from activities which had nothing to do with their job). Apart from that, existing obstacles for the redesigning of the work on the wards were eliminated and the acceptance of the new model of specialized nursing was promoted (Oppolzer 1995, 149 pp).

⁵ One registered nurse in the night shift from 9.15 p.m. to 6.15 a.m. and 2 registered nurses plus one trainee or a nursing aid from 6.00 a.m. to 2.30 p.m. and 1.15 p.m. to 9.45 p.m.

In the first phase of the evaluation the application of a holistic nursing was judged as a decisive contribution to improve the health of employees and patients. According to the evaluator 'the holistic nursing made it possible to reduce the work intensity and the work load, to improve through its holistic and qualifying tasks the measures of coping with possible stress and the motivation as well as the satisfaction with the work. Holistic nursing prevented health problems due to work and efficiency restrictions and smoothed the way for new sources of improving the productivity and quality of the care' (Oppolzer 1995, 157).

Project group 'K – Gesundheitsförderung für Patienten'
(Health promotion for patients)

Patient surveys as incentive for project group work

In summer 1994, the institute of social medicine of the Hamburg University coordinated a patient survey ordered by the hospital project management. (Nickel/Trojan 1995). Its aim was to portray the experiences of patients during their hospital stay and to discover starting-points to develop and apply health promoting measures for patients. In summer 1996, a second survey was done (Sturm, Hildebrandt, Trojan 1997:101). A part from investigating the patients' satisfaction and possible weak points, the questionnaire could now also be used as an instrument for quality assessment. ('questionnaire on the quality of hospitals in Hamburg from the patient point of view').

All patients having spent more than 2 nights in the hospitals were asked during a period of 4 weeks (first survey: N = 157, second survey: N = 233). They were again questioned 2 to 6 weeks after having left the hospital. The following quality dimensions were judged as health promoting points:

- amount of social support (information, emotional)
- leaving the patient a scope of the activities (transparency, waiting times, possibility to influence the activity)
- characteristics for the success of the therapy (mood, health promotion, acquisition of personal abilities, attractiveness of the hospital)

In the first survey the technical quality of care and the psychological and emotional support were judged positively. The greatest need for action was seen in the branches of information and advice concerning the disease, acquisition of personal abilities, transparency of the organization, regulations on the wards, patients' recreation rooms, etc.

As a direct consequence of the survey project group 'K – Gesundheitsförderung für Patienten' (Health promotion for patients) was established in 1995 (Sturm, Hildebrandt, Trojan 1997:100).

Project group 'K – Gesundheitsförderung für Patienten'
(Health promotion for patients)

In the project group 'K' nine team members were involved (the hospital chaplain, two nurses, a social worker, a nursing aid, the deputy nursing manager, a nursing teacher, a physician and a protestant hospital aid). The group was facilitated by an ex-

ternal consultant, accompanied scientific research was applied. Aim of the project was to develop and implement concrete proposals for changes (for special health promotion programmes) reflecting the information of the first patient survey. The group presented its final report in 1996 (Diakonie Krankenhaus Alten Eichen' 1996). The whole group met 11 times and specific targets were developed by single participants or by sub-groups between the plenary project group meetings. The goals of the project group were to check the quality and procedure of the patients' care in Alten Eichen concerning its health promotion and to formulate proposals for organizational and textual changes and for special offers. The mandate was

- to evaluate the patients' survey by the medical-social institute of the Hamburg University (Trojan) and to compare it critically to the experiences of the members of our own project groups, to develop proposals for changes.
- to prepare an extended cooperation between Alten Eichen and welfare associations or self-help groups and a cooperation contract with the self-help committee of the General Medical Council.
- to plan a project group 'patients charta'.

Key point of the project work was the restructuring of hospital wards and the edition of an information brochure for patients and a information brochure about self-help groups. The patients' information brochure was distributed in all patients' rooms on one of the pilot wards and were distributed to all wards in 1997. The brochure informs about the ward team (e. g. with photos), the organization of work and the facilities of the hospitals in order to make the hospital more transparent to the patients (Diakonie Krankenhaus Alten Eichen 1996; Schneiders-Kastning 1996). The project group developed a comprehensive concept for the restructuring of the patients' recreation rooms and corridor corners on the wards. The concept was piloted on different wards (surgery, internal medicine), which were selected as there was seen a considerable need for action. The experiences on these wards should have left also to better guidance for the implementation on other wards. A workshop about patient-orientated conversation took place during the doctors' training. The initiation of a 'patients charta' was highly recommended and realized in the end of 1996 (Mursa/Martini 1997).

Evaluation of the project

The results of the patients survey 1996 show that the transparency of the organization has improved and that the patients have received more information about possible help for their disease compared to the baseline. However, the interpretation of the relationship between measures of the project group and the results of the survey are difficult. (Sturm, Hildebrandt, Trojan 1997:101).

Evaluation of the process of the project groupwork

Process evaluation aimed at analyzing the chances and risks and the quality of the sub-project work, active participation in meetings and analysis of minutes and documents was applied (Schneiders-Kastning 1996).

The working methodology applied suggested to divide the meetings into parts referring different aspects of project work: at the beginning an organization of work is

clarified, then thematic discussions start and at the end it is decided which homeworks are to be distributed and should be done. The project group meeting is the forum in which plans can be developed, problems discussed, already developed subjects presented and adapted by the team members. Three patterns were seen, how the project work was carried out (Scheiders-Kastning 1996:116 pp):

- detailed analysis of problems and possible restrictions in advance,
- spontaneous individual proposals of ideas and
- transfer into project group proposals.

Empirical observation so far confirmed, that the given structural framework can substantially influence the project group results either positively or negatively. Concerning the specific needs of hospitals a holistic focus of the project group, integrating multiprofessional perspectives, should be an appropriate media state for carrying out complex projects. It prevents the concentration on strictly clinical subjects. To open the scope for the choice of subjects is also considered very positively as it might lead to creative solutions without excluding certain aspects from the beginning. In the practice it was seen that only feasible projects were initiated and that project group members tended to develop low-cost proposals as they saw more chances to apply them (Schneiders-Kastning 1996, 150 pp).

Final Evaluation

When balancing the project, results on different levels associated with the specific project work experiences can be observed. The results described in the following are partly on the basis of the evaluation of the project phase (Oppolzer 1995)⁶.

Concept and Approach

The WHO project in Alten Eichen follows the stringent concept of 'health promotion by organizational development' (Grossmann, Scala 1993) which relates the different activities within a more comprehensive approach. Concerning the thematic issues as well as following the chronology, project activities followed a vision promoting continuity and consistency of the whole project. Besides, we have succeeded in the course of the project to turn the general goals of the whole project into specific targets most of which have been realised. (Oppolzer 1995, 188).

External consulting and moderation

The external consultants have played a decisive role in the project. They assured, that the requirements concerning the content as well as the background conditions have been taken into account. Furthermore it was as factor for the success, that within the long accompanying process the problems and the proposals for solutions have been coordinated in a co-operative and participating way between all partners involved in the project (Oppolzer 1995, 165).

⁶ The results of the overall-evaluation will be published by Oppolzer in the first quarter of 1998.

The consultants and facilitators succeeded in combining the knowledge of the specific issue (i.e. health promotion) with the knowledge of change methods (i.e. the process of organizational development) and thus positively influenced the contents, the processes and the results of the project. On the same hand, the external consultants have seen themselves as advocates, the managers of the content of the project itself. The project process has shown that it is an advantage for the quality of the consultation when the consultants and facilitators have profound knowledge in the field of organizational development and project management and also in the field of health promotion so that the project management is not restricted to formal aspects, but also considers the specific context of health promotion.

Fundraising and external cooperation

External consultants and the hospital management have to a considerable extent succeeded in gaining external cooperation partners (e. g. professional associations of nurses and physicians, health insurances) who support the project activities (e. g. employees' survey, facilitation, consultation, health reports, evaluation, presentation, public relation). This also brought about a considerable expansion of funds available for project activities. For specific projects, the internal budget could be doubled. The accompanying scientific research was financed by funds of the 'Norddeutscher Forschungsverbund Public Health' (North German scientific compound on Public Health) and the 'Berufsgenossenschaft für Gesundheitsdienst und Wohlfahrtspflege' (BGW)⁷.

The employees' experiences with the project work

The employees of Alten Eichen have made specific positive and negative experiences with the project work, as the results of subsequent analysis of project documentations and project team meetings suggest.

Interdisciplinary cooperation and testing of new working methods

It was judged very positively, that team members could experience the cooperation with different departments and different working methods and thus learned to know new approaches of problem solving and a deeper understanding of the complexity of changing processes. Together with the experienced interprofessional cooperation this led to good preconditions for the work of the project groups: to be prepared to take responsibility, to set up transparent formal ways for application procedures, to transfer results to concrete action and to establish good internal communication strategies.

Problems of the project group participants

However the stringent framework and the limited possibility to apply the results themselves were judged negatively by the project group members. Besides this, experienced recognition and support by the hospital management and by the colleagues were seen as too low. A lack of personnel and the necessity to take over the col-

⁷ See footnote 2.

leagues' work have prevented many employees from taking part in the project. In some project groups, the continuity and concentration suffered by the fact that often only half of the participants were present at the meetings, some arrived later and others had to leave earlier or were called out of the meetings.

Application of the results

Participants have further criticised the somewhat unclear distribution of responsibilities concerning the project within the hospital management and demanded a faster and less bureaucratic way of decisions-making. At the interfaces between the WHO project structure and the every-day-work in the hospital frictions and delays became obvious. Participants felt frustrated by the fact that the effective application of measures sometimes took a lot of time. Reasons for this might be in the specific structure of the Alten Eichen management, where managers do not only come from the different departments of the hospital but also from deaconal institutions: However, participants felt also a lack of acceptance of and support for the project by some employees and in certain departments and units.

Central 'motivators' for the project participants in Alten Eichen were:

- lectures from other hospitals, e. g. model wards for specialized care
- travelling abroad, e. g. to visit Swedish hospitals
- a quality competition of the project group 'P' on the third rank of the Golden Helix Award
- certificates and thank-you letters at the end of the project work
- rewards for the participation, e. g. the participants were offered theatre tickets

The employees and the organization have learned to become more conscious about their specific needs and problems and they have learned to cope with their problems more effectively and goal oriented. On the other hand the employees have gained a considerable additional potential of experiences and skills from the recent years' project work (e. g. a fruitful knowledge of teamwork) which might lead to better coping with future challenges.

Experiences of the hospital management with the project

The decision of the hospital management to participate in the European Pilot Hospital Project was seen as a step in the right direction to detect and promote innovation potentials in Alten Eichen hospital. However, the great response from the employees, the complexity of the organizational proposals and its practical application has repeatedly also caused problems for the capacities of the hospital management. Although all the members of the hospital management have been continuously been informed by minutes and documents about the project group work, frictions between the expectations of the participants that the results would be put into practice quickly and the reaction time of the hospital management were experienced. The chosen organizational structure:

1. presentation of results by the project groups,
2. decision by the monthly meeting of the project management,
3. application to the hospital management for decision,

caused delays. The rather long lasting operational procedures were not understood by the employees. Although all members of the hospital management identified themselves with the WHO project and made every effort to support quick decisions and reactions, this criticism has not been invalidated.

Altogether the hospital management has noted that a large number of proposals for improvements has been applied in the course of the project which would not have been possible without the method of organizational development. Therefore, the hospital management has decided to keep up this concept after finishing the project, to improve the existing organizational structures and to improve the satisfaction of employees and the patients. For this reason, the Diakonie Krankenhaus Alten Eichen has decided to join the 'German network of health promoting hospitals'.

Transparency

The visibility of the project measures and the results were not sufficiently organized so that non-involved employees had the impression that nothing essential had been changed by the project. As a consequence the motivation of the employees to actively participate in project groups, to develop project ideas and to support colleagues participating in the project declined. In the beginning of 1996, the project management decided to publish a monthly information brochure for the employees. Small steps and results should become visible and comprehensible for all employees in order to reach a better transparency of the project. A general information for the employees were published in the summer of 1997, which described the whole project in Alten Eichen (Diakonie Krankenhaus Alten Eichen 1997).

Participation of physicians

The physicians so far hardly participated in the work on project group level. However, this must be seen as a problem because physicians are highly responsible for the efficiency of the hospital processes but they tend not to involve themselves too much in non-medical related topics. During the project several efforts were made implement projects concentrating on medical topics. A sub-project on health promotion in the therapeutically process should analyse and improve standards for the different surgical tracers. The aim was to introduce psychological and social aspects as part of standards for the treatment and thus to improve the outcome of the therapy and to reduce the costs. Another project was planned to improve the communication and cooperation between the hospital doctors and their colleagues outside the hospitals which are sending patients to the hospital and which are responsible for post hospital treatment. However, both projects had to be cancelled as they were judged as minor priority by the medical management or to be treated by the wards themselves.

Cost-benefit analysis

The project tied up quite enormous funds, but due to the reforms of the health sector in Germany, the available capital has been reduced and public investments have been cut. Therefore, a considerable competition between the budget of the HPH project and those of other projects outside the HPH context was existing and therefore cost benefit-relations became very important. Due to the partially intermediate character

of the projects results, a direct cost-benefit analysis is very difficult. However, the management has prognosticated several long-term advantages for the hospital. Apart from the aspects mentioned above, a return of investment is also seen in other areas: increasing applications for vacancies in the nursing sector and an increasing number of temporary employees. Oppolzer could show lower sickness figures and absenteeism rates related to other hospitals of the same size (Oppolzer 1998). The second employee survey showed a growing satisfaction with the own work, the cooperation with colleagues and an improved relationship towards the disciplinarians (Oppolzer 1998).

Lack of internal acceptance

During the development, the project had to cope more and more with problems of acceptance of the project and active participation. Several reasons for this can be given:

- The project is now promoted and supported only by some of the hospital managers and has become a game-ball for different interest groups. The dissociation of some of the managers (e. g. the medical director) from the project lead to a considerably declining interest of the physicians staff to take part in the project groups.
- Economic measures demanded by the changes in the health care sector have lead to a decline of funds available and, therefore, higher competition between the HPH project and alternative initiatives was generated.
- The lack of capital also lead to an increasing work load in the hospital. This made it difficult for the employees to participate in project group work as they have to justify this to their colleges on the ward.

Recommendations to other hospitals

The analysis of the pilot phase showed some key factors for the success of the health promoting hospital project. Regarding the process of organizational development, the goals of the 'health promoting hospital' show some similarity with those of Total Quality Management (TQM) (Martini 1996):

- Quality improvement by enlarging the performance spectrum and promotion of the recovery process,
- reduction of sickness rates, increase of the staff-motivation and reduction of personnel expenditures,
- organizational development and improvement of the internal communication and
- health promotion as a part of the corporate identity for the hospital.

To realize these goals, certain key factors are recommended to consider carefully.

Commitment of the managing directors

In case of a positive decision, the whole management must support the vision of the 'health promoting hospital', which should be part of the existing corporate image of the hospital. As the project is orientated towards health gain, each of the subprojects implemented has to be questioned about their contribution for better health. Through this, the efforts can be coordinated and it is assured, that the projects develop in the

same direction. Therefore, the concept of the 'health promoting hospital' should not be seen as a project but as a strategy implemented on the highest level. This means that the responsibility cannot be delegated to lower organizational levels, but the hospital managers have to be active promoters of the concept themselves.

Long-term process

The implementation of the 'health promoting hospital' should be considered as a long-term process. Experiences of successful industrial and service companies have shown that the full implementation of TQM will be reached after 5 to 10 years (Stauss, Friege 1996). The problem that desired changes of the organizational structure and the internal processes can be forgotten easily should be counteracted by transparency and regular information. If the change processes are not any longer the main focus, employees tend to get frustrated. A long-term enterprising vision of the hospital is needed as well as individual results and small steps which should be repeatedly presented to the employees.

Communication system

The hospital needs an effective management-information system reaching all employees. All relevant information should be passed on to the employees regularly so that they understand the single steps and results of the project.

Motivation and incentives

In classical service companies, a lack of quality can be measured and evaluated and the employees can be motivated to improve the quality by financial incentives. In the health services, this is not possible as the hospital follows the zero-mistakes-system. The employees have to be motivated differently. An incentive could be through empowerment, i.e. by delegating decisions to the employees and let them more substantially participate in development processes. This requires a new, clear delegation structure with clear aspects for improving motivation.

Satisfied customers

The satisfaction of patients becomes more and more the central competition factor at least in German hospitals. Hospitals have to start to observe their patients continuously. This goes beyond looking only for single problems and increases the need for applying questionnaires providing relevant feedback and showing organizational problems and changes. These patients surveys could provide important evaluation data for the measurement of ongoing service activities and for assessing new initiatives.

Future perspectives

Regarding the current framework of the national health system in Germany, a certain 'restriction' of the whole project and the work of the project groups is indispensable. Apart from its original goals, the HPH project must respond increasingly to the economic situation of the hospital. The motto could be 'to combine profitability, quality and health promotion!'. In other words, new projects must not only lead to quali-

ty improvement and health promotion but also to reductions of costs. New project groups or 'expert commissions' will have lower budgets, shorter time, clearer task structure and a more effective application. The project group 'patients' charta' was the first to work within this frame. For the next years, we are planning the project themes: 'Cooperation with general practitioners' and 'Diagnostics & Therapy & Standards'. Furthermore, all the projects still in process will be continued. The external financing of health promotion projects has been considerably restricted by the deletion of § 20 SGB V (Article 20 of the social legislation) which expressly demanded the financing of health promotion by the health insurances. As a consequence, the possibility for the statutory health insurances to finance such projects has been considerably restricted. However, new ways of fundraising have to be developed.

The WHO pilot project itself officially finished by a large final meeting and transferred into the next phase. The hospital Alten Eichen continues its activities within the above mentioned framework as a member of the 'German network of health promoting hospitals' and tries to keep up the positive results and changes achieved so far.

References

- Diakonie Krankenhaus Alten Eichen (1993a): Projektbericht der Projektgruppe G: 'Gesundheitsförderung für Mitarbeiter und Patienten'. Ergebnisbericht, Hamburg (*Report of the project group G – Health promotion for employees and patients*)
- Diakonie Krankenhaus Alten Eichen (1993b): Projektbericht der Projektgruppe P 'Pflege' (1./2. Phase). Ergebnisbericht, Hamburg (*Report of the project group P – Care, 1st and 2nd phase*)
- Diakonie Krankenhaus Alten Eichen (1995): Projektbericht der Projektgruppe P 'Pflege' (3. Phase). Ergebnisbericht, Hamburg (*Report of the project group P – Care, 3rd phase*)
- Diakonie Krankenhaus Alten Eichen (1996): Projektbericht der Projektgruppe K 'Gesundheitsförderung bei Patienten'. Ergebnisbericht; Hamburg (*Report of the project group K – Health promotion for patients*)
- Diakonie Krankenhaus Alten Eichen (1997): Das WHO-Projekt "Gesundheitsförderndes Krankenhaus" im Diakonie Krankenhaus Alten Eichen, 1992–1997
- Godo I., Hildebrandt H., Mursa W. (1993): Auf dem Weg zum Gesundheitshaus – erste Schritte eines evangelischen Krankenhauses zu einem Pilotkrankenhaus im WHO-Netzwerk 'Health Promoting Hospitals. In: Pelikan J.M., Demmer H., Hurrelmann K. (Hg.): Gesundheitsförderung durch Organisationsentwicklung. Weinheim/München, Juventa (*The way to a healthy hospital – first steps of a Protestant hospital to become a pilot hospital in the WHO network of 'Health Promoting Hospitals'*)
- Grossmann R., Scala. K. (1993): Health promotion and organizational development.
- Hildebrandt GesundheitsConsult GmbH (1994): Arbeitsunfähigkeitsanalyse Diakonie Krankenhaus Alten Eichen. Hamburg (*Analysis of sickness figures Diakonie Krankenhaus Alten Eichen*)
- Höppner H. (1996): Global gedacht – Vor Ort gemacht: Gesundheitsförderung im Krankenhaus. Eine Befragung von 20 AkteurInnen zum Verständnis von gesundheitsfördernden Maßnahmen und ihrer Struktur. Diplomarbeit, Hamburg (*Thinking globally – applying it at home: Health Promotion in hospitals. A questioning of 20 persons taking part actively in order the make health promoting measures and their structure understandable, dissertation, Hamburg*)

- Martini O. (1996): *Becoming Healthy – Lessons from a 230-bed Hospital*. Report on the 4th International Conference on Health Promoting Hospitals, Londonderry
- Mursa W., Martini O. (1997): *The Patient Charta of Alten Eichen as Part of the Strategy towards Patient Orientation*. Report on the 5th International Conference on Health Promoting Hospitals, 16.–19. 4. 1997, Vienna
- Mursa W., Rosenthal T., Martini O. (1997): *Gesundheitsförderung und Patientenrechte: Organisationsentwicklung durch Projektarbeit im Diakonie Krankenhaus Alten Eichen*. In: *das Krankenhaus*, 90. Jg. (1998), H.1, p.26–31
- Nickel S., Trojan A. (1995): *Zwischenbericht der quantitativen Patientenbefragung 1994 im Krankenhaus Alten Eichen*. Arbeitspapier Nr. 1, ed.: Institut für Medizinsoziologie am Universitäts Krankenhaus Eppendorf, Hamburg (*Intermediary report on the quantitative patients' survey 1994 in the Diakonie Krankenhaus Alten Eichen, working sheet no. 1, Hamburg*)
- Oppolzer A. (1995): *Begleitforschung zur Dokumentation und Evaluation der Organisationsentwicklung im Diakonie Krankenhaus Alten Eichen unter dem Gesichtspunkt der Gesundheitsförderung für Mitarbeiterinnen und Mitarbeiter*. Langfassung, Hamburg (*Accompanying research on the documentation and evaluation of the organizational development in the Diakonie Krankenhaus Alten Eichen considering the employees' and patients' health promotion – extended edition, Hamburg*)
- Oppolzer A. (1998): *Begleitforschung zur Dokumentation und Evaluation der Organisationsentwicklung im Diakonie Krankenhaus Alten Eichen (Hamburg) unter dem Gesichtspunkt der Gesundheitsförderung für Mitarbeiterinnen und Mitarbeiter*. 2. Teil, ed.: Berufsgenossenschaft für Gesundheitsdienst und Wohlfahrtspflege, Hamburg
- Schneiders-Kastning P. (1998): *Gesundheitsförderung im Krankenhaus für PatientInnen – Chancen und Grenzen von Projektarbeit*. Diplomarbeit, Hamburg (*Hospital Health promotion for patients – chances and limits of the project work, dissertation, Hamburg*)
- Stauss, Friege (1996): *Zehn Lektionen in TQM*. In: *Harvard Business Manager*, Vol. 18, No.2, p. 20–32
- Sturm H., Hildebrandt H., Trojan A. (1997): *PatientInnenbefragungen als Anstoß für Verbesserungen im Krankenhaus*. In: Gundböck A., Nowak P., Pelikan J.M. (Hg.): *Gesundheitsförderung – eine Strategie für Krankenhäuser im Umbruch*. Projekte aus Österreich und Deutschland. Wien, Facultas-Universitätsverlag, p. 94–106
- Trojan A. (1995): *Evaluation der Kursangebote für MitarbeiterInnen im Diakonie Krankenhaus Alten Eichen*. Arbeitspapier Nr. 2, ed.: Berufsgenossenschaft für Gesundheitsdienst und Wohlfahrtspflege, Hamburg (*Evaluation of the courses offered to the employees of the Diakonie Krankenhaus Alten Eichen, working sheet no. 2, Hamburg*)

Steps towards promoting a healthy lifestyle, inspired by the Klinikum Chemnitz's radical change from planned to market economy

Konrad Schuhmann



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Hospital Owner:	City of Chemnitz
Hospital Ownership:	Public
Specialisation:	General Hospital
Beds:	1993
Staff:	Medical Staff: 301, Nursing Staff: 1.263, Other Staff: 1.060, Total Number of Staff: 2.624
Utilization:	Average Utilization of Beds/Year: 85 %, Average Stay in the Hospital/Day: 11,8
Patients:	Number of Inpatients/Year: 49.000, Number of Outpatients/Year: 3.000
Number of Departments:	18
Location of Hospital:	Inner city
Catchment Area:	Regional, Number of Population: 300.000 for general patient care, for specialisations: 2,4 Mio
Other Functions than Medical Care:	
Teaching:	Medical Students, Postgraduate, Nursing Education, Teaching other Health Professions: Midwives, Physiotherapists
Research:	Partly Clinical Research, Other Health Research: Public health
Subprojects:	<ol style="list-style-type: none">1. Health Promotion for Staff on Workplace2. Efforts Directed at Ensuring that Hospital Will Enjoy an Ever Greater Acceptance among the Children and Youth of the Catchment Area3. Conceptual Framework for Establishing a Complex Quality Management Concept4. Ways and Means for Putting Care in the Chemnitz Municipal Hospital on a Professional Basis5. Introduction of an Effective Patient Information and Conselling System6. Public Relations Work for Health Education

The “Health Promoting Hospital” project

The Klinikum’s radical change from planned to market economy

The Klinikum Chemnitz [Chemnitz hospital complex] has some peculiarities in comparison to German hospitals as a whole.

There was a drastic decrease in the number of beds available in the years between 1991 and 1994. While in 1991 there were 3226 beds available, distributed across nine hospitals over the whole town of Chemnitz, this figure fell to 2847 in 1992, and still further to 2076 beds in 1993. This last reduction could largely be attributed to the exclusion of one location with 335 beds and the closure of a specialist clinic with 60 beds. The entire reduction in bed numbers (1993 beds were retained in 1996) represents a fall of 36 % on the figure for 1991. It is not difficult to see that this development has brought considerable internal organisational problems in its wake, as the bed numbers cut were by no means unused bed capacities. We have had to deal with staff cuts, alterations in function and work distribution, and complete restructuring of entire areas.

At the same time as this development came the introduction of new examination and treatment methods, which had thus far not been possible, the introduction of a system of nursing documentation, conversion from a well-established system of functional nursing based on the division of labour to patient-oriented nursing, and updating practically all the technical medical equipment in all areas, in order to conform to the requirements of *Medizinischen Geräteverordnung (MedGV)* [regulations on medical equipment]. This last point in particular cost us vast amount of time and money over a relatively short period, and we had little influence over the whole process. Deadlines were set for the “periods of grace” for the old equipment, non-compliance would have led to divisions being closed. This particularly applied to anaesthetic and respiration equipment and all the monitoring equipment, to name but the most important. In addition, the German hospital building regulations must be taken into consideration at every stage of reconstruction. In essence this means that the electric, sanitation, heating, ventilation and gas systems must be completely renewed.

But something also needed to be done in order to accommodate some 47,000 patients per year. In 1990, there were still no patient rooms which had a telephone or a television, and there were many wards housing ten to twelve patients.

The way towards becoming a pilot hospital in an international network of Health Promoting Hospitals

A meeting of WHO in 1992 in Magdeburg on the theme of “Health 2000” sparked the thought that, from many points of view, this could be a sensible approach for our Klinikum. Firstly we recognised that in the future hospitals would no longer be able to remain detached from this part of health care. In addition, existing elements which were no longer practised in the hospital after the takeover by the federal German health care system, were to be reactivated, as we already had good experiences in these areas. Outpatient operations, and caring for in-patients both before and after their hospital stay are not new concepts for East German hospitals, after a five-year

break, they merely needed to be re-organised and tailored to modern regulations. Hospitals always used to take an active role in promoting a healthy lifestyle as well. Contact with schools, looking after unions, mass screenings, series of lectures, etc. all formed part of the hospitals normal routine. The difficulty in reactivating these programmes was largely that earlier they were a statutory requirement, and now they are to be on a voluntary basis.

The chance of gaining a good reputation was also not underestimated, as this meant that we could get a head-start in the forthcoming competition among hospitals.

The first attempt:

A few initiators (in management) and lots of insistent people (at ground level)

At the beginning with the situation was extremely bad, as there was hardly a single employee who was enthusiastic about the change, about doing things purely on the basis of idealism. It was considered that the project's success was only a dream, and most of those who should have supported the project were sceptical.

The *Allgemeinen Ortskrankenkasse Chemnitz* (AOK) [general regional health insurance company in Chemnitz] was obviously interested in the project, and its managing director considered it logical that the company's slogan "the healthy insurance company" was also used to support our project. It should also be noted at this point that, both in the hospital and the health insurance company, the proponents of this project were, and still are, very much in the minority. Initially, the initiative came from two people, the administrative director and the representative of AOK health insurance. They jointly made up the project management and sat on the project committee, which also included a medical director, a nursing director, two district management representatives, co-ordinators and external advisors (a total of ten people). During the early stages of the project, the administrative director left our Klinikum, so the nursing director took over his project management responsibilities, and the new administrative director joined the committee.

The majority of the approx. 3,500 staff that work in the Klinikum, either tends to think in terms of economic viability, and wants to calculate what level of success justifies what level of additional work, or is simply not prepared to invest time and energy in additional work. Those who advocated the project considered it to be a question of confrontation between those in favour of change and insistent people, i.e. those living in the past. Once it became clear that the consensus was that implementing the project could be a good idea, we went about establishing the problems and objectives of the project by systematically surveying staff, patients and relatives.

The questionnaires principally concerned how satisfactory the hospital was as a working environment (for staff), or as a place to stay if needed (for patients and relatives). There were project groups, whose principal aim was to evaluate the answers given in order to ascertain what objectives work would have in the future. In doing so, the personal interests of the staff involved and affected were combined with the statistical results which corresponded to these interests, in order to formulate new task structures. The tasks largely dealt with problems that were not necessarily new, but, with the aid of this project, could either be addressed again, or at last approached

logically. The project management's vision of where the concept of promoting a healthy lifestyle would lead was presented at the first project presentation in April 1994, as following: We, at the Klinikum Chemnitz...

- want to do more than just treat illnesses;
- want to prevent or slow down illnesses and reduce suffering;
- want to promote a better way of life – even for those who are (chronically) ill;
- want to make the Klinikum Chemnitz a place that the public can trust and
- want to promote our own health during our everyday work and feel good doing so.

Even the application to participate in the WHO project at the end of 1992 anticipated working on five sub-projects from the following areas:

- Patients and knowledge about their illness
- Nursing
- Quality control (primarily medical quality control)
- Working with the press and the public
- Working with children and young people in the Klinikum's catchment area

Staff from all areas of the hospital were impressed by these ideas, which were considered visionary. It soon became clear that in order that the work was approached sensibly and across all areas, other members of staff and certain people in the hospital area would have to be consulted, as we would need to rely on their help, opinions or advice. So we ended up with five project teams.

Team 1 was concerned with the objectives, the results of the patient questionnaire about how informed the patients were, and with how the patients felt about how much the patients knew about their illness, and the treatment they were given. It was well known that there were great differences in these opinions, therefore the decision was made to investigate the experiences of the first groups, and then to apply these methods to other patient groups.

Team 2 was not so directly concerned with the results of the patient questionnaire, rather it took a more global approach to the results of the questionnaire as a whole. Thus the hypothesis was formed that improvements in many aspects of both patient and staff satisfaction could be made by structuring patient care better, which could be achieved by improving nursing standards, by completely handing over nursing care, by improving communication levels between doctors and nurses, and by nursing according to logical processes.

In Team 3 the initial ideas were so comprehensive that there was hardly anyone who dared to do the work. As the first person to initiate the idea had left the hospital, the team had to find out exactly what was possible within the scope of the project. The group followed the initial vision of "Total Quality Management" and quickly established three very realistic, embryonic quality control projects. This made very intensive work possible in this group as well.

Team 4 concentrated on the theme of "working with the public to promote health". This team's primary aim was to change the unknown, strange image of hospitals to a well-known, trusted part of the public life of our town. The second stage of the project was to utilise this trust to better promote healthy living in the community.

The fifth team basically concentrated on the same points as the following group, but with the more defined target group of children and young people, and therefore used different means to obtain its objectives. There were also the most people interested in this target group, including teachers at the vocational college and a grammar school, and staff of the health authority and the AOK, the health insurance company involved.

After the project presentation in 1995, a member of the Klinikum's staff realised that although the patients, the people in the hospital area, the public and the ecology had been cited as target groups, the staff of the hospital itself had not been. As, according to the Budapest Declaration, this group definitely had to be addressed as well, it was considered what the best approach might be. Extensive consultation with different units resulted in a sixth part of the project, which was concerned with the specific problems of promoting health among the hospital staff. The individual topic areas were defined by the staff themselves. However, a pre-condition to being involved was that the majority of the team accepted the necessity, and all occupational groups on the unit were represented. This sixth project group began their work in 1996.

The second attempt:

The start of the projecting and development of organisation

This preparatory stage took us nearly a year (1993). This was also linked to the fact that the process of being recognised as a pilot hospital was a relatively slow one, and we had no power to influence this process. It was also a good thing that we had not yet started to work intensively on the themes of the project, as we were also charged with the task of finding an scientific institution to co-operate with, and evaluate the project. We found such an institution in the shape of the *DKI Deutsches Krankenhausmanagement Beratungs- und Forschungsgesellschaft mbH* [German hospital management consultancy and research company] and developed a “guiding principle” to which to conform. At the beginning of 1994, we then had to address certain questions on the success of the project and the development of the organisational process. Above all, we wanted to avoid the common mistake of doing a lot, but neglecting documentation, especially of what are considered less important matters. The first question put to all staff involved in the project was to complete the sentence: “I would be satisfied with this project, if ...”.

It was and still is of particular importance that those involved defined their objectives precisely, ascertained their approaches and measured their level of success. Hence there were impartial observers to the project who posed questions at every stage. This was a new approach for most of the staff, as many had neither previous experience of nor particular enthusiasm for these aspects of scientific work. The results were written down and used as a methodical basis for the documentation of the sub-projects, they were also made available to all parties involved in the project, both as a reference and as a starting point for further work.

In summary, four stages could be defined which characterised the path towards promoting a healthy lifestyle, “from a hospital to a centre of health”.

Development of organisation, including management areas

From the very beginning of the project, the members of the project committee felt that they were directly responsible for ensuring that the Klinikum's application to take part in the WHO project was successful. Thus it was a case of finding allies among the staff who could help achieve the objectives and ideas formulated in the application. An ordered, controlled approach to this proved inappropriate. However, the external advisors provided a solution for the problem of how to develop the organisational structure. This approach was discussed and immediately adopted, not only in the five project teams, but also in the management committee. After all, this committee also needed to improve its pre-conditions in order to release human resources. Eight key points concerning the development of the organisational structure were suggested to the project committee by the project advisors. After a detailed discussion, the majority verdict was that adhering to the points would be advantageous to the project, but could cause problems in certain areas. As an example, the quality objective of "open, but target-oriented working practices" was rejected by individual members of the committee, as excessive openness would necessarily lead to an increased workload, for example, for working out the formation of the group itself, and this could then distract from the original objectives. Further project committee sessions also proved that the conditions for non-directive co-operation within this committee and in its work with the project teams would have to be introduced gradually and worked upon.

Clarifying the "double misunderstanding" between management and ground level

"What are we working towards?" – When the project team members met, there was a certain dilemma, in that the objectives of the project had already been set by the hospital management when the project application was made to the WHO, and it was only now that they needed to ascertain whether these objectives, either in their existing form or somewhat modified, would be accepted by a large enough proportion of the Klinikum staff and the external co-operation partners. There was a chance that the project would succeed at the Klinikum Chemnitz, as there was only a broad framework definition of the projects objectives. Involving the ground level staff could result in encouraging the project teams to utilise the remaining free rein that they had,

- to find their own objectives, approaches and methods within the framework conditions provided;
- to develop the given topics further, according to their own needs;
- to encourage decentralised initiatives.

It would have been even more logical to allow the whole Klinikum staff, not only those in the project teams, to vote on the project and the project objectives. This democratic approach to legitimising the project democratically was successfully adopted in another pilot hospital in the WHO project. However, the Klinikum Chemnitz is so large (3,500 members of staff) that this approach – formally involving all the members of staff – was not practicable. However, the Klinikum Chemnitz aimed to

utilise communication, and gain support for the idea of promoting healthy living through the project teams. One of the particular aims of this approach was to clarify, or at least to suppress, the “double misunderstanding”, which goes along the lines of: “Those at the bottom only do the bare essentials; those at the top don’t trust them with anything better!”

Founding the teams and developing organisational structures

Many of the conceptual starting points helped the project teams to consider themselves not merely a contractor for a task allocated by the management committee, rather they could choose their own independent approach to the function and the task of the project team. An initial declaration of expectations was also a factor in this. In addition, initiative was encouraged by giving the project teams opportunities, which they used,

- to set up several teams for specific tasks within the project sub-group;
- to formulate their own list of obligations;
- to elect their own team speaker from within their own ranks.

Visions, concepts and activities

The approach to develop organisational structures adopted by the Klinikum Chemnitz could briefly be described as follows: visions were developed and communicated, implementation concepts were worked on, allowing the practical measures to develop within a certain framework. The art is in producing, and making use of, the freedom required for initiative to develop and in cultivating the opportunities for personal and organisational development.

Successes and setbacks in implementing the project

In the following, three selected sub-projects are described in more detail, one concerns the process, one results and one implementation.

1. Example of the “life” of the “Work with children and young people” project group

We set our sights on children and young people outside the hospital. We wanted the children and young people in our catchment area to learn to accept the Klinikum Chemnitz, and to convert this acceptance into a certain level of health-consciousness in this age group.

In other words – children and young people should trust their hospital.

Therefore, when planning the WHO project in our Klinikum, we decided to make work with children and young people a sub-project within the framework of the “Health-Promoting Hospital” project. This was because we recognised that building up the level of trust that children and young people have in the hospital would not only be a rewarding exercise, but would these days be practical indispensable. We wanted to remove, or at least reduce, children’s fear of the big, anonymous hospital

and of sick people. They should realise that you can get certain illnesses that can only be treated in hospital. The children also needed to recognise that it was worth having a healthy lifestyle in order to avoid certain illnesses.

We offered them contact with the hospital, and visits to the wards. This gave them the opportunity of finding out what it was like to stay in a hospital and, we hoped, to provide them with an answer to the following questions:

- What would happen to me if I had to go to hospital?
- Why should I visit people who are ill?
- How can I stay healthy?

Formation and development of the project group

Before beginning working on the project, we needed to find committed and motivated staff to join the project group. We sent out circulars (with little response), made personal contacts (with some success) and made contacts on others' recommendations (also with some success). The eventual team consisted of three senior nurses, a public relations officer, a hospital librarian and two art teachers, one from a grammar school and one from a vocational college.

A co-ordinator also had to be named, as it was considered crucial to the success of the project that somebody motivated the group and encouraged group work. We considered that this function should be fulfilled by a member of the hospital staff. Our project was led by the public relations officer of the Klinikum Chemnitz gGmbH, who already had contacts outside the hospital, which could be used when representing the hospital.

The group's first meeting resulted in a pool of ideas for the project. Every member of the group decided to work on the activities that he felt that he could work best on.

Before beginning work on the project we needed to present a request to the education authorities in question (primary education authority, secondary education authority, etc.) in order to gain their approval.

Once this approval had been gained, the heads of the schools were asked whether they were prepared to participate in these activities.

It is also particularly important to find appropriate teachers who understand how to make children enthusiastic, and who are committed to implementing the project. Regular contact to these teachers is beneficial, and is very much to be recommended.

Core ideas and implementing them in practice

In order to convert our plans into reality, we needed the support and acceptance of the hospital management. We worked on three concepts for involving children and young people according to their age, and converted these into reality.

We work for you
We work with you
Project days in the hospital

The project team members arranged numerous individual activities to fit in with these themes, most of it in free time. This meant that the financial cost of activities was limited to purely material costs.

We work for you

Making greetings cards

Kindergarten and primary school children made cards for annual events such as Christmas and Easter. This amounted to about 2,000 cards for each event for our Klinikum. We also offered older schoolchildren the opportunity of handing out the cards made in their schools to the patients themselves.

This idea was always very popular among the patients. In some cases they wrote back to the children who signed the card to thank them personally.

The schools and kindergartens were always happy to participate in these activities. Making greetings cards from children and young people, to the patients of the Klinikum Chemnitz has become an established tradition in the town. More and more schools have registered an interest in making cards with the co-ordinator at the Klinikum. We were also told by the schools that there was also a positive response from the parents of the children who made the cards.

Setting up changing galleries

During the course of the WHO project, our Klinikum obtained 200 picture frames, which are regularly filled with pictures from pupils from various schools.

The pictures cheer up patients, visitors and our members of staff. The children change the pictures in the hospitals themselves, and there are no set intervals at which the pictures are changed. This means that the children get to know the hospital from the inside, they can then put their prejudices into perspective, and reduce their fears, as:

“What you know is less frightening than what you don’t know”

Reading books to patients

Children come into the hospital and read out books on the ward. This provides a welcome break for the patients everyday lives.

Our Klinikum has patient libraries and qualified library staff, so a librarian instructs the children in how to read out the books.

The children learn to empathise with the patients as necessary, especially when reading to sick children, they also enjoy the attention and satisfaction of their audience.

Plays, choral recitals and concerts for the patients

The idea of these activities is that the children and young people provide variety for the patient in their everyday life in the hospital, which can become very monotonous. This activity is also popular with children of all ages. The patients enjoy the variety and the children appreciate the recognition of their efforts.

These presentations also encourage between ill and healthy people, which helps to break down the fears that the children and young people have.

Making wooden toys for the different children’s wards by pupils at vocational college

One aim of the “Health-Promoting Hospital” project idea, in particular the involvement of children and young people, is to motivate young people at vocational college to do something for sick children in hospital for ethical and or moral reasons. An art

teacher from the vocational college was working on the project, which made it possible to develop the contents and objectives of a curriculum. This curriculum concentrated the “working with wood and wooden materials” topic into the more concrete “Inventing, developing and making wooden toys for sick children in hospitals”. The pupils set about the challenge with enthusiasm, creativity, and admirable commitment, and created toys which provided a great deal of pleasure among the patients of the children’s clinic.

We work with you

This idea is linked to the goal of bringing children and patients together and creating a distraction for both parties.

Silk painting with patients

The idea that children provide a welcome distraction for the patients by being creative together was realised with the co-operation of an art teacher from the vocational college for health and social work. The pupils learn to work with all sorts of different groups at the college. This could then be put into practice at the hospital, and help the patients learn to paint on silk in a relaxed atmosphere.

These activities are also carried out by grammar school pupils at the hospital.

Organisation of craft shows and children’s fairs in the hospital

The children’s fairs in the children’s clinic at our Klinikum have become an annual tradition, and also a distraction from worries and fears for parents and relatives. For the children it is a day filled with exciting experiences, such as games, creative activities, and limited sporting activities. The fairs have mottos, such as “Indian fair” or “A day with jesters and clowns”, and include all sorts of highlights that children love, give the sick children to move about freely and forget their illness for a while.

On these occasions, the help of students from the vocational college for health and social work proved invaluable.

Project days in the hospital

Project days are a good opportunity for the hospital to be effective as a health-promoting institution. We open the hospital up to children and young people, with the aim of dispelling their fears of the hospital, and encouraging them to lead a healthy lifestyle, in addition the “bigger ones” are offered the chance to attend vocational talks.

In order to familiarise this age group with health-conscious behaviour, to make them aware of the dangers of accidents and other accidents, and to teach them what to do in an emergency, we offer a range of topics for the kindergartens and schools to select.

To do this, we use books as teaching and reference aids, carry out practical exercises, let the children know where they should go to if they want questions answered, and visit selected areas of the hospitals (wards and departments). They are introduced to the theory before visiting the wards and departments. In addition to promoting a healthy lifestyle and dispelling fears, careers in medicine are also dealt with.

The positive response can be measured by the increased number of people signing up for the project days, this, in turn, provides motivation for the members of staff involved at the hospital.

Effects and value of this work

By putting our ideas into practice we have succeeded in giving many children and young people an insight into the hospital, and helped to dispel their fears.

We were able to increase health awareness, largely thanks to the project days. This has been indicated to us by teachers, and sometimes even by parents.

For the hospital, the value of the work is principally the positive influence on the patient environment, which increases patient satisfaction. It has also increased job satisfaction and morale among the staff.

We can also prove that, as a result of the four-year project, the Klinikum has achieved a higher level of acceptance among the population of the surrounding area.

The basis of the entire success of the project was the foundation of a harmonious group which has learnt how to support one another and motivate one another again and again.

Problems

The main problem encountered by this project group was uncertainty as to the budget available. This affected not only staff costs, but also financial resources. Although the meaning for the Klinikum was acknowledged verbally, realising the steady increase in demand proved to be increasingly difficult.

A further problem that should not be underestimated was how the project phase could be extended to make the hospital into a permanent “health cabinet” institution. Linked to this was the need to involve more members of staff who are not only interested in the project, but also have enough resources available. This can generate minor jealousy among those who are forced to partially give up a project that has become dear to them, and in some circumstances the person taking over has been less than understanding about this. In such cases it is necessary to appoint a person who is trusted by both parties, so that the disagreement does not have a negative affect on the success of the project.

2. Particular successes of transferring to the whole Klinikum using the example of the “Patient-oriented nursing” group

The topic of patient-orientation would appear to be self-evident, if you believe the opinions expressed at demand forums. However, in reality, more and more psychological phenomena are being observed and described which indicated that these demands are not being met. Burn-out, job dissatisfaction and high levels of fluctuation are being observed with increasing regularity, particularly in nursing.

The second project sub-group consisted of nurses, paediatric nurses and nursing teachers, and they set themselves the objective of highlighting problems, reserves, and development trends encountered in realisation of an integrated system of nursing care, and thus deriving guidelines for future action. Initially there was some hesita-

tion, and uncertainty as to whether they could do justice to these high aims within the confines of such a subject. By the end of the project it was considered that the members of the individual working groups knew how to make their ideas and visions about an integrated system of nursing in the Klinikum known.

The working groups were concerned with:

1. Working on the standard of nursing at the Klinikum
2. Working on a folder of information for the patients in wards for seriously ill patients
3. Forming a therapeutic team on intensive therapy wards
4. Improving education for nursing students at the Klinikum

The first working group could be seen to have the most measurable use in the Klinikum. In April 1995 the process of testing individual wards on the four nursing standards of basic care. At the end of the project in June 1997 the following 106 standards had been implemented in a binding fashion in some 80 wards across the hospital:

Basic nursing	17
Prophylactics	5
Treatment nursing	43
Nursing according to clinical image	35
Structure	3
Emergency nursing	3

The major success in the introduction of these new methods of defining nursing and keeping written records was that each standard was developed by a small group of members of staff (eight to ten) in conjunction with vocational teaching and directly checked in practice in small test groups. Once an acceptable result had been achieved in this test phase, which also included some minor adjustments, the standard was then implemented into the daily life of the hospital. This method did mean that the major part of the work had to be done by relatively few members of staff with a certain expert status, but this did mean that acceptance increased during the test phase. This recognition can be seen in the fact that what began as a small group over time developed into a number of groups, which each addressed specific topic areas. Well over 100 of the nursing staff are still working on this area of the project today.

Problems

Naturally such a project has negative aspects as well as positive ones. There were two particular problems, which are included as examples:

staff motivation and communication between the vocational groups.

When an idea is to be extended from a small group to the entire staff, who is selected to implement the project is of particular importance. It is also a pre-condition that there is basically positive motivation towards the project, but it must also be guaranteed that whoever is charged with the task is released from other responsibilities. The size of the hospital has little effect on the intensity of the work, but does affect its duration. During the introductory phases, total concentration on the objectives is indispensable. In addition, implementing the changes quickly and logically reduces the possibility of forming implementation varieties to which particular occupational groups, who are sticklers for occupational tradition, adhere particularly strongly.

Insufficient communication, or no communication at all between the various people or groups involved in the treatment process at a hospital often represents a problem but is often tolerated. However this is an easy problem to overcome, as the basics for communication are part of the training programme for most of the occupational groups in the hospitals. However they had not been trained to communicate with one another, but alongside one another, with the patients. This was, and still is, the case in our Klinikum. Therefore we addressed the problem as part of the project, defining new duties in various working areas, together with doctors and other groups both inside and outside the hospital and we then began to work on processing the work.

3. Particular “outcome” successes, using the “quality control” project group as an example

The third project sub-group, as described earlier, dealt with quality control in the areas of hygiene and ecological problems. The working group selected three points of emphasis for practical implementation from the multitude of possible measures:

- The introduction of a logging system for infections contracted in the hospital (described as nosocomial infections);
- checking and optimising the use of disinfectants and
- centralising the preparation of cytostatics in the central pharmacy.

This not only provided a challenge for the members of this project group, but also involved a large number of members of staff across the whole hospital in realising them.

More detailed information on the three goals:

Logging and evaluating nosocomial infections

Systematic and continual logging of the occurrence of hospital infections should be a part of every hospital quality control system. On average, 5 to 7 % of all patients treated in hospitals in Germany contract an infection in hospital, in addition to their original illness.

“Nosocomial” infections, or infections contracted in hospital not only cause additional suffering for the patients, who came to hospital to get better, they are also an important economical factor for the hospital.

A temporary working group made up of representatives of all specialist disciplines, the central pharmacy, the microbiological laboratory areas and the EDP division was set up in preparation for the logging of n.i. (nosocomial infections) in the Klinikum. This working group worked on a computer-based logging system and the information materials required. This information not only includes the patient’s details, but also the risk factors in favour of infection, both in terms of the patient’s condition and the diagnosis and treatment. This information allows a distinction to be made between avoidable and unavoidable infections.

It must also be stressed that not all infections contracted in hospital are avoidable, due to the large number of influential factors. Only some 35 % of n.i. can be avoided, these are those that result from an area that can be controlled by logical discipline and

correct treatment methods. In order to guarantee a uniform definition of n.i., the definitions used by the Centers for Disease Control (CDC) for the individual illnesses were adopted.

The group was advised by the Klinikum's central hygiene commission in June 1994 and presented with the logging conditions, which were then confirmed by the committee. Logging could then begin at the Flemmingstraße unit, and was later (September 1995) adopted in all units. All wards were given information materials, and the doctors and sisters were given an introduction to the system.

Although, during the preparatory phase, the members of staff responsible for supporting the implementation of the project were nominated by the head doctors of each specialist discipline, the result was by no means satisfactory and needs to be worked on further. The rate of infection for 1995 remained the same as the previous year, at 1%, in 1996 it was 1%, which did not approximate to the rates found in the literature for the individual specialist disciplines. The distribution of the four most frequent hospital infections confirmed the frequency distribution found in the literature.

Despite some introduction to the project, logging infections contracted in the hospital has not yet become a natural part of the doctors' daily routine. It must be emphasised that the word 'nosocomial' has no connotation of blame attached to it, it merely expresses the link between the occurrence of an illness and a medical measure or a stay in hospital. Naturally, part of every doctor's duty is to minimise this risk where possible and maintain the highest possible standard of treatment at all times.

When taking up the issue of logging n.i. in this project sub-group, the members of the working group were very optimistic that the staff of the Klinikum would understand their objectives, and be prepared to support this target actively.

As early as 1860, the surgeon Theodor Billroth said:

“The time will soon come when our colleagues and students will make strong demands of us and our way of working, where a simple remark about the success of this or that operation will not be enough. On the contrary, any doctor that can not back his experiences up with statistics will be considered a Charlatan”

(Th. Billroth “Chirurgische Erfahrungen” [surgical experiences] Zürich 1860)

Although our goal of implementing appropriate measures to reduce the rate of infection, which had been ascertained correctly, by 1 % was not achieved, we did succeed in fulfilling the most important conditions for logging nosocomial infections.

Optimising the use of disinfectants

Our goals were to:

- Reduce consumption of disinfectants by at least 5 % within a year,
- Reduce the number of different disinfectants and excess packaging and
- Optimise the disinfection plan.

We then examined the range of disinfectants to ascertain which could be removed, and, with the approval of the hospital's central hygiene commission, removed one hand disinfectant and one surface disinfectant. In addition we decided that, in the fu-

ture, instead of using the uneconomical two-litre packet of surface and instrument disinfectant, we would only order the five-litre canisters. In order to reduce the amount of disinfectant used, the staff were continually trained, the supply of dosing aids was improved and it was ensured that the standing times for solutions that were ready for use were optimised.

We succeeded in reducing the consumption of disinfectants by a total of 7.18% in 1993, in comparison to 1993. This represents a saving of over 2,000 litres of concentrated disinfectant. This meant that the initial goal was achieved. The next phase was to set up checklists for the use of instrument disinfectants, in order to optimise their use in all wards and divisions. This involved checking the exact dosage, time taken to have an effect, and, for example, questions concerning health and safety at work and acceptance of the disinfectants among the staff.

A total of 91 checklists were given out, these were filled in by the members of staff responsible, and passed on to the hospital hygiene division to be evaluated. A member of staff in the hospital hygiene division made a statistical analysis of all the figures, in order to be able to derive recommendations for the optimisation of instrument disinfection from them. The recommendations were implemented both by the hygiene commission of the unit in question, and also by the hygiene experts, who were on hand to provide advice. In addition, the disinfection plans in the wards and divisions were worked on.

In the following years, the hospital succeeded in reducing the consumption of instrument and surface disinfectants still further, while the amount of hand and skin disinfectants used, remained the same or increased slightly. In total, 5,400 litres less disinfectant was used in 1996 than in 1993, at the start of the project, this represents a total saving of 18.9% (see Table 1).

This reduced consumption not only reduces costs, but it also better for the environment, as less air and water pollution is generated. The use of larger containers is one example of a practical way of avoiding excess waste, as a waste sticker is stuck to the empty containers, and they are then used to collect and dispose of used hypodermic needles.

Table 1: Consumption of disinfectant in litres

	1993	1994	1995	1996	Difference 1993–1996
Instrument disinfectant	10,292	9,450	9,512 (–8.18%)	7,349 (+0.66%)	–2,943 (–28.6%)
Surface disinfectant	8,876	7,899	7,153 (–11.1%)	6,051 (–9.44%)	–2,835 (–31.83%)
Hand / skin disinfectant	9,430	9,198	9,395 (–2.46%)	9,790 (+2.14%)	+360 (+3.82%)
Total disinfectant consumption	28,598	26,547	26,060	23,190	–5,408 (–18.91%)

Centralisation of preparation of cytostatics

The third task was centralising the preparation of cytostatics, which was undertaken in seven different locations.

The Klinikum Chemnitz is a hospital that distributes patient care across many building complexes over the whole town. Some areas, such as administration, stock-keeping, and pharmacy occur only once and are responsible for all locations. However, on the basis of exaggerated safety requirements, preparations for the chemotherapy treatment for cancer patients are made up from concentrates in all seven locations. These preparations are different in that both the measurements, and the time for which they are available must be carefully monitored. This means that it is often preferable to mix the preparations up in situ. However, this has the disadvantage that the waste generated is categorised as highly problematic and special, and therefore expensive, precautions must be taken to dispose of it. A lot of concentrate is also wasted, as it is not possible to use up large quantities effectively.

At the end of 1992, 750 to 800 preparations were made up per month in the central pharmacy. This supplied two different units. Our goal was to supply all units from the central pharmacy. This was achieved by the spring of 1997 by investing in two additional workplaces with conditions suited to preparation, and by organising an efficient system of information technology and transport. In addition, we could also provide individual cytostatics solutions that were ready for application to two external clinics which are not linked to our hospital.

An efficient working division was created. The staff at the pharmacy can process more than 40 different chemicals, and are currently preparing some 1,700 infusion and injection solutions, which equates to more than 20 000 preparations per year.

What criteria underscore the advantages of centralisation?

- ***Staff safety***

- Improved personal protection by working at a safety workbench.
- Only a few trained staff who are used to the routine have to handle the cytostatic agent concentrate (1 chemist, 4 pharmacy engineers working part-time).
- The medical staff now has very little contact with the cytostatic agent concentrate, their time is also saved, which is beneficial to the patients.

- ***Increased safety of therapy for the patients.***

- ***Cost reductions***

- Technical equipment and maintenance only necessary in central workstation (burners, boxes, etc. no longer needed at the individual units).
- More economic purchase of larger containers of standard cytostatics, using them for several preparations. This represents a significant reduction in the costs of medications.
- By means of aseptic work, the agents which have been opened or prepared with solution can, according to their physical and chemical stability, mostly be completely used up.
- Saving on supplies, such as gloves, needles, and hypodermic syringes, and

- ***Reduction of environmental pollution***

- Waste contaminated with cytostatic agent concentrate is separated, collected and safely disposed of as special waste using Pacto-Safe.
- As there is a significant reduction in left-over cytostatics, the amounts of special waste can also be drastically reduced.
- Waste that is not contaminated with cytostatics (such as solution bottles, cartons, packaging materials) is divided in the pharmacy into cardboard / paper, white glass, brown glass and waste made from plastic, film, etc. and then disposed of separately.

Of course there are also disadvantages and problems inherent in supplying different clinic locations from one central unit. So, before we began supplying the non-central units, we carried out detailed personal talks with the doctors and nurses at the units in question in order to ascertain the exact timing of the operation. Initially there was a great deal of scepticism, and the staff at the units had to get used to the new way of organising the system.

We have also been able to pass on the experience gained during our project to other hospitals, (e. g. Klinik Innenstadt München [Munich city centre hospital], Klinikum Zwickau [Hospital complex in Zwickau]).

However that was not, and should not have been, the end of it all. Especially in the area of avoiding pollution, everyone involved should take up the challenge of implementing new knowledge and observing the continual implementation processes which have already been introduced. All too often, people are blinded by their work, or too comfortable in routines, which means that environmental pollution can be generated, or simply taken for granted. When dealing with the problem of quality control, we gave intensive thought to how these matters could be continued. The logical consequence of our first success in the project work was to produce ideas as to how an environmentally-friendly approach could be encouraged in the hospital, producing a system of environmental protection that was systematic, as comprehensive as possible, effective, and involved all members of staff.

These considerations resulted in the suggestion, made in November 1994, that an environmental commission be founded in the Klinikum. The project group's application document indicated that it was not a question of simply taking over models from other hospitals, but of finding our own approach. This commission began work in December 1995.

When deciding on the composition of this environmental commission, we wanted to avoid being overwhelmed by bureaucracy, and therefore we considered it important that the decision-makers themselves sat on the commission. In addition, the commission also included a representative of both the town's health authority and of the waste disposal authority, in order to maintain a close connection with the community.

The weak points that were anticipated when the project began were confirmed, and we began working on a solution to them. In the meantime the work has been recognised, as the hospital management has decided to found a separate division for hospital hygiene and environmental medicine, and to appoint a senior doctor to run this division. In this respect the work of this project group proves what sort of visible outcome can be achieved.

The whole hospital needed to make an effort to ensure and develop quality control. With our work we are trying to contribute a small piece to the jigsaw of quality control. The more members of staff contribute to the work, the more successful the project will be overall.

Outlook: Developing organisational structures and management to bring the vision closer

The aim of the Klinikum Chemnitz and the community around it is “to do everything that promotes health!” The change between plan and market economy is a very difficult time, but despite this, what began as three people working actively on developing the sub-projects, became ten, then fifty, and now well over 100 people are involved. However, it must be admitted that there is a certain level of ignorance about the project, as was revealed by a recent survey, in which nearly 10% of those questioned admitted that they had not previously heard of the project.

Health policy can sometimes dictate a strict cost-saving regime, and following such a regime can mean that no resources remain for promoting a healthy lifestyle. This means that the hospital becomes fully reliant on external resources from industry and other institutions promoting health, which can generate new, almost incalculable conditions in the community. Continuing to fight the withdrawal of financing sources can take up energy, and enthusiastic people can be discouraged. There is a clear danger of things developing in this way, even if advocates of promoting a healthy lifestyle are warning against it.

The plans will be particularly successful if, in the remaining time that the project has to run, until 1997, these efforts do not stagnate, are then continued and expanded by stages, which could then lead to a further development of the whole organisation of the Klinikum Chemnitz towards promoting a healthy lifestyle.

Health Promoting Hospital: Report of Vaugirard Hospital

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Hospital Owner:	Assistance Publique-Hôpitaux de Paris
Hospital Ownership:	Public
Specialisation:	Geriatric care
Beds:	340
Staff:	Medical Staff: 7, Nursing Staff: 273, Other Staff: 70 (Administrative: 33; Social and educational workers: 6, workers: 31), Total Number of Staff: 350
Utilization:	Average Utilisation of Beds/Year: 95,2 %, Average Stay in the Hospital/Day: rehabilitation units: 47,2 days, long term care: 752 days; acute care unit: 29,4 days
Patients:	Number of Inpatients/Year: 793, Number of Outpatients/Year: 246
Number of Departments:	1
Location of Hospital:	Inner city
Catchment Area:	Regional, Number of Population: 200.000 in the 15th district of Paris with 16% above the age of 65
Other Functions than Medical Care:	
Teaching:	Postgraduate, Nursing Education
Research:	Clinical Research, Other Health Research: Public Health Research
Subprojects:	<ol style="list-style-type: none">1. The Gerontology Network between Vaugirard Hospital and the 15th District of Paris2. A resource data between the professionals of the district and the Vaugirard Hospital staff3. The programme to improve the staff working conditions4. The partnership between the volunteer associations and the Vaugirard Hospital5. The new concept of the life of elderly people in hospital6. Prescription guidelines for the elderly7. Staff exchange programme8. Vaugirard Hospital beyond its walls9. Quality Assurance programmes

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Introduction

Assistance Publique-Hôpitaux de Paris (AP-HP) is a federation of public university 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 emphasise high technology rather than preventive care. In fact, the concept of health promotion is not very developed in France. This report deals with a specific Health Promoting Hospitals (HPH) programme 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. 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). It must be pointed out that the board managers have wanted Vaugirard Hospital to become a model of good practice with the help of the health and social professionals of this district.

It is important firstly to situate Vaugirard Hospital within the context of the French health care system in order to explain how its health promotion experiment fits in this context.

After the presentation of the French health care system, this paper will describe the Vaugirard Hospital subprojects the Vaugirard Hospital board managers implemented during the 1993-1996 pilot HPH programme and their evaluation. Finally, the paper will deal with the subprojects which have been newly developed since the HPH programme. 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.

Health Promotion in the context of the French Health Care System

The French health care policy does not refer to the World Health Organisation's (WHO) main principles which include: health promotion involving the population as a whole. It is particularly aimed at effective and public participation. Health professionals play an important role in nurturing health promotion and enabling it to develop (WHO, 1986a). Also, the French hospital policy has never so far mentioned the Ottawa Charter on Health promotion (WHO 1986b). The WHO principles that needed to be applied in hospitals were developed in the Budapest Declaration of Health Promoting Hospitals. Nevertheless, health education has been one of the hospitals missions since 1970 and is part of the specific role of the nurses according to the regulations. In addition, medical services directly linked to preventive care are organised. They represented 2.1% of the total sum for medical commodities in 1995 (Annuaire des Statistiques Sanitaires et Sociales, 1997). This percentage refers to the services which are free of charge for the patient such as programmes to protect mothers and infants, programmes in schools, workplaces... (Occupational Medicine is compulsory in France and financed by the employer). However, this 2.1% does not take into account all the preventive activities of professionals. In fact, medical doc-

tors in hospitals, general practitioners (GP), midwives, physiotherapists and other professionals practise preventive medicine in the context of their normal office visit, for example: immunisations, prenatal and postnatal care, rehabilitation, hygiene and diet advice programmes. Social Security does not classify these acts as preventive measures but as normal medical acts. Nevertheless, the French health insurance system is starting to recognise the medical and financial advantages of these preventive programmes. It now promotes flu immunisation programmes for the elderly and breast cancer screening to name a few. These programmes are free of charge for the patients. Although the term health promotion is not very often used at the present time, new reforms have been implemented in order to encourage the co-ordination of care among health care providers. The aim of Assistance Publique-Hôpitaux de Paris is to implement the same policy at a local scale between hospitals and the ambulatory system.

Since the beginning of cost-containment measures in health care in the late nineties, hospital reform has been the major issue of the health authorities in France. In fact, in 1994, hospital expenditures still represented the greatest part of the health care budget (48.3%). As a result, new measures are implemented in order to reduce costs while improving quality of care. Hospital reforms, including the reform programme of 1996 (the “Juppé” plan) will be presented in order to follow how the Health Promoting Hospitals principles can be put into practice in this context. In addition, it must be pointed out that the reforms of the ambulatory system are important to take into consideration (27.6% of the health care expenditures). In fact, the co-ordination between the primary care sector and hospitals is not very well developed in France. Furthermore, there is little co-ordination between home aid services and primary health care professionals. As a result, people tend to go directly to hospitals. As the health policy in France focuses essentially on reducing the health insurance system debt, it is therefore necessary to describe the organisation of the Social Security system, which will help the reader to follow the evolution of health care reforms, especially for hospitals.

The French social coverage system

Funding

Social Security, an insurance system, is the basis of the funding of the French health care system (73.5 % in 1994 versus 76.5% in 1980). The main principles of Social Security are: accessibility, mandatory participation for everybody, solidarity, equality. 99 % of the population is covered. Furthermore, people who receive a poverty allowance are automatically covered as well as people receiving unemployment benefits. In addition, income tax has been raised to help finance the Social Security system since 1991.

In 1994, 7.9 % of the health care expenditures was paid by non profit making insurance companies, 3.3% by profit making companies, 0.8% by the state and 14.5% by the patient.

Social Security not only manages the money for medical care but for retirement benefits, family allowances, disability allowances, workmen’s compensation and professional diseases. Only unemployment benefits are paid by a separate organisation.

The position of the health care system within the social coverage system

The reform which was passed in 1996 led to a modification of the French Constitution in order to grant Parliament the responsibility for voting the annual budget allocated to Social Security expenses. Previously, there was no fixed limit to Social Security expenses and as a result, the expenditures well exceeded the funds available. This was especially true for medical care. Consequently, medical expenses represent 10% of the GDP in France and the French system ranks first in Europe for medical expenses. On the other hand, the Social Security reimburses the least in comparison with its European counterparts. Since 1996, a public health reform is being implemented to adjust the funding and to guarantee access to care.

Starting in 1998, taxes will replace the health insurance principle in order to set up universal coverage and to collect more money (including salaries, retirement allowances, unemployment allowances and savings account).

The health care reforms

Hospitals and reforms in France

The French hospital system is divided into:

- public hospitals (65 % of hospital beds);
- private non profit making hospitals, originally religious (15 % of hospital beds)
- private profit making hospitals (20 % of hospital beds).

There are three different kinds of hospitals: acute care hospitals, rehabilitation hospitals and long term care hospitals. The coverage is about 90 % for hospitalisation costs and the patient does not need to pay in advance. The remaining 10% is generally covered by a complementary insurance company which can be non profit making or profit making. The care provided in long term care hospitals is reimbursed completely but the room charges have to be paid by the patient. If he/she cannot afford these charges (generally, his/her apartment is a financial guarantee), his/her relatives are required to pay. If the family is unable to provide funds, a community aid coming from *taxe d'habitation*, a local tax paid by both, renters and owners (not to be confused with property tax), helps to pay and sometimes pays the total sum (about US \$ 2250 per month). The amount is calculated on a sliding fee scale, according to the financial resources of the family.

Hospitals funding is the first important point

Since 1985, public and private non profit making hospitals have received funds based on an annual global budget, disbursed monthly by the Social Security. Hospitals then allocate their budget among the different divisions. This often leads to the maintaining of many specialised wards, although their activities could be done in other hospitals in the same region. Private profit making institutions are paid by the Social Security as well, but on the basis of fee for service. As a result, hospital expenses amounted to 48.3% of the health care expenditures in 1994. In order to reduce these costs, the Health Ministry would like in the near future to set up the Diagnosis Related Groups (DRGs) system to pay the acute care hospitals.

The number of hospital beds is a major issue

In 1970, a fundamental law (31st of July 1970) was passed through which the Ministry of Health tried to organise the distribution of public and private hospital beds by using ratios theoretically based on population: bed to population, equipment to population according to the 22 administrative regions of France. The goal of this law was to offer the same hospital and technology facilities throughout France for the medical, surgical and gynaecology-obstetrics specialities. The first regions to be well equipped served as models on paper for the other regions. The figures gave rise to decisions whose aims were to continue the process of equal distribution according to population. However, the criteria of demography, epidemiology and economic data were not taken into consideration and therefore, the needs of the different regions were not met. Due to increased health care expenditures, problems with the distribution of beds and equipment regardless of the needs led to a new law on hospitalisation (31st of July 1991). The term assessment „évaluation“ was used for the first time in the law itself. It was decided that the regional health authorities were better informed than the Ministry of Health to make decisions concerning bed distribution. As a part of this law, a Regional Scheme of Health Organisation „Schéma Régional d'Organisation Sanitaire“ became compulsory in each region. The underlying aim of the scheme was to restructure hospitals in order to cut costs while responding to the needs of the population.

The contents of the documents showed that only a few regions reached the decision to close wards. Consequently, the Ministry of Health decided to restructure specific areas. For example, it decided to close maternity hospitals or wards in which less than 300 deliveries a year are performed.

Hospital reforms are a part of the agenda (law on hospitalisation 24th April 1996)

Money devoted to hospitals is managed by Regional Agencies on hospitalisation (created in 1997) 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 hospitals. In fact, private or public geriatric hospitals receive the same money from the Social Security, even if the living conditions of elderly people can be very different.

Private practice system and reforms

The description of the French ambulatory system (1945–1993)

There is a contract between the Social Security, and private practitioners (General practitioners or GPs and specialists). This contract allows a lot of freedom for both, the patients and the practitioners. This ambulatory system is liberal, based on 5 principles :

- Freedom for the patients to choose the practitioner, either GPs or specialists;
- Freedom for doctors to set up practice where they wish;
- Freedom for doctors to prescribe;
- Professional confidentiality;
- Practitioners have the right to receive payment for medical acts directly from the patient at the end of the office visit. As a result, patients are reimbursed according to the rate which corresponds to the medical act performed. The Social Security generally reimburses 70% of that sum. Insurance, whether profit or non profit making, generally pick up the difference. It is important to know that patients with certain diseases, for example cancer, AIDS and also chronic and costly illnesses, are 100% covered. Consequently, elderly people can receive medical care free of charge very easily.

The reforms in private practice

Since 1993, reforms are being implemented in order to co-ordinate the care given to the patients in private practice, to avoid incompatibility in prescription and duplication of blood tests, X-rays and medication. The final aim is to contain costs.

a) The national control of the volume of prescription

To curb the increase in the number of prescriptions, a specific percentage is set by the Parliament every year to put a cap on the increase.

b) The patient health care booklet

The patient health care booklet was created to re-enforce the role of the GP who is responsible for the patient's file. The booklet was planned as a link between the GP and the specialist, each one having to fill it in after each office visit. In 1999, the patient health care booklet will be replaced by a smart card and the medical offices will be equipped with computers. As a result, over-prescription will be identified individually. Also, the principle of direct payment between the medical doctor and the patient will disappear, thus transforming the liberal system.

c) The prescription standards

This new measure to cut costs and to avoid over-prescribing consists in a list of illnesses and unnecessary medication or tests not to be prescribed. For example, practitioners are not allowed to prescribe a combination of cortisone and antibiotics for a common respiratory infection or sleeping pills for over a month.

Doctors are controlled by the Social Security physicians. The number of medical prescription mistakes, their medical consequences and their financial importance are

calculated. This can lead to penalties for the physicians. This system will be extended to different diagnostic, therapeutic and screening procedures and application of the prescription standards will be re-enforced.

The future of the 1996 reforms

It is obvious that a large part of the „Juppé plan“² will be implemented due to the Social Security deficit. The „Juppé plan“ involves a new tax to eliminate the former deficit: 0.5% of the income is allocated to a new fund to reimburse the 250 billion Franc deficit and the corresponding interest for 18 years. Consequently, the new administration under Mr. Jospin, the new Prime Minister, created new means to diminish the Social Security charges. For example, the family allowances' system has been modified. From now on, these allowances will be distributed according to a sliding fee scale, not only to make the system fairer but also to cut costs. Concerning the health care system, the situation is more complex. People working in the health sector represent 7.4% of the working population in France (1.65 million people) so that they contribute to the funding of the system (Credes 1995). Furthermore, the health sector is the sector where the most significant number of jobs have been offered between 1982 and 1992 (20% increase within 10 years). As a result it will be difficult to close hospitals and reorient staff to prevention.

*Conclusion*²

Health policy decisions have not been devoted to health promotion because the French health care system still focuses on curative procedures. Nevertheless, in September 1996, a national conference on health took place for the first time in France in order to define health priorities. To aid its 72 members in this task, a two-volume document called „Health in France“ was used. It was published for the first time in 1994. The description of health indicators (mortality, morbidity) revealed that prevention measures were not sufficiently developed in France. The second national conference on health took place in July 1997, thus leading to a concrete health policy. The delay in implementing health promotion policy in France can be shown by the:

- lack of trained professionals (due to delay in the setting up of effective training programmes);
- absence of teamwork in this field (sociologists', economists', public health physicians' teams work without a multidisciplinary approach);
- absence of prestige of these quality procedures in comparison with sophisticated care in hospitals.

The public health culture has not been promoted in France for the last 20 years. In fact, there has been confusion among health professionals about the true meaning of public health. In the past, health policies corresponded to laws governing hospitals and private practise in the way they are financed and not to the defining of health priorities. The reasons which can explain this situation are the following:

² based on – Idly, Durand-Zaleski, 1997

³ Social Security and health care reforms while Mr. Juppé was prime minister between May 1995 and May 1997

- historical context: during the 18th and 19th centuries, hygiene and infectious diseases control measures were very prestigious but after the nineteen forties, the importance of these specialities decreased drastically;
- political factors: the role of health professionals' corporatism limits the public health approach. In addition, the system is complex. Administratively speaking, the regional health authorities depend directly on the Ministry of health. At the same time, they have to contend with political concerns:
 - the status of „civil servants“ in public hospitals prevents them from being laid off;
 - the mayors of the cities (or their representatives) are still chairmen of the hospital board of directors. As elected officials concerned with the economic and social aspects of the community, they fight the closing of hospitals or even wards.

On the other hand, the positive aspects which demonstrate a rapid evolution of the health care system include :the existence of institutions (National School of Public Health, National Network of Public Health, National Committee on Public Health, National Committee on Health Education (with regional and county committees), National Agency on Accreditation and Health Evaluation and National Agency on Blood Security) as well as regulations and new budgets allocated to these organisations. This new policy is being encouraged by the government, whether conservative or liberal.

But the realisation of the need for health promotion by the health authorities, concrete measures concerning health promoting hospitals still face difficulties in being implemented. Taking this situation into consideration, the Vaugirard Hospital experiment appears quite innovative. However, many hospitals have developed HPH projects on their own and are willing to exchange their experiences. As a result, the setting up of the national network of HPH hospitals will correspond to a new step.

The Health Promoting Hospital Programme of Vaugirard Hospital

The Vaugirard Hospital as a Pilot Hospital

Concerning the overall project, the Vaugirard Hospital was one of the geriatric pilot hospitals responsible for improving the geriatric care in the federation of AP-HP hospitals. The International Affairs Department of AP-HP decided to encourage Vaugirard Hospital to participate in the Health Promoting Hospitals programme in order to benefit from health promotion experiments of foreign countries. In addition, this agreement gave the opportunity to the Vaugirard board managers to promote their activities. It appears that due to the Health Promoting Hospitals programme, the Vaugirard Hospital team was encouraged to manage projects and conduct evaluations to justify medical activities, thus qualifying for additional budget.

Although obtaining funds was a real incentive for the board managers, the results of the projects' evaluations were on great interest for the medical team. Without the active participation of the staff at every level, the objectives could never have been reached and Vaugirard Hospital would not be the model hospital it is today. The external institution (the Institute for Health Policy Studies of the Broussais Hôtel-Dieu School of Medicine, University Paris VI Pierre et Marie Curie) helped Vaugirard Hospital to organise the surveys, draft and prepare for the conferences. In addition,

it was designated to provide information and conduct the evaluations of the subprojects. This work methodology was very effective to check up on the different stages of the projects. The co-operation between Vaugirard Hospital and a university team was quite new for a geriatric hospital, thus demonstrating that health promotion projects are making headway in France.

Vaugirard Hospital staff has encouraged health promoting programmes. 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. Meetings took place during work day. 14% of the staff has actively participated so far and their experiences have been published in the Vaugirard Hospital's newsletter and in nursing journals („Soins“).

The Vaugirard team created a number of tools and services to promote health and wellbeing of elderly people :

- The gerontology 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 coordinator is responsible for responding 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 coordinate 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 coordination 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.
- 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.
- A guide „Grow older at home“ 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), who manages this service (Social Security, the municipality, charitable or-

ganisations or private companies), the cost of the service for elderly people and the financial aid possibilities which are available. 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 elderly people's legal rights (power of attorney for example).

Vaugirard Hospital has developed five sub-projects within the HPH programme: 1) a gerontology network between the health professionals of the 15th district and the hospital staff; 2) a resource data between the professionals of the district and the Vaugirard Hospital staff; 3) a programme to improve the staff working conditions; 4) a partnership between the volunteer associations and Vaugirard Hospital; 5) a new concept of the life of elderly people in the hospital.

1. The gerontology network subproject corresponds to a model of good practice. In fact, since 1994, the day-care hospital is an alternative to traditional hospitalisation and enables the patient either to stay at home or to leave the hospital more quickly after a short stay. In 1995, the Vaugirard team conducted a survey in order to compare the day-care hospital patients' profile with patients admitted to the rehabilitation units. The presentation of the results has given rise to new modalities of care for elderly people and more specifically, to a new subproject called „Vaugirard Hospital beyond its walls“.
2. The resource data between the professionals of the district and the Vaugirard Hospital staff corresponds to the patient follow-up booklet and the guide „Grow older at home“. A survey was conducted in 1995 to know whether or not the GPs of the 15th district were aware of the Vaugirard Hospital services and used the resource data. In addition, the GPs were interviewed on their expectations concerning a district's geriatric hospital. The results made it possible to identify the number of GPs participating in the gerontology network. Moreover, the information gathered led to a new stage of promotion of the Vaugirard Hospital services. For example, a public presentation of these results was organised in April 1997 with the health and social providers as well as the elected officials of the 15th district to encourage their participation in the network.
3. The programme to improve staff working conditions is one of AP-HP's priorities. In Vaugirard Hospital, many programmes are being conducted for example the prevention of accidents at work (especially professional diseases), tobacco use (Vaugirard Hospital is a non smoking hospital), back pain (with specific programmes and new equipment which facilitates the moving of patients) and the implementation of flex-time. Due to the fact that in France, no gerontology speciality exists, a survey was conducted in 1997 to find out what type of training sessions would be useful for the hospital. As a result, a new subproject on „Ethical issues in Vaugirard Hospital“ was implemented to help the staff deal with geriatric related problems and to develop teamwork.
4. The partnership between the volunteer associations and Vaugirard Hospital is an asset for the hospital. A survey was conducted in 1997 to gather information on the different volunteer associations which participate in the everyday life of Vaugirard Hospital.

Volunteer work is not developed in France but the board managers have wanted volunteers to take part in the care. The results allowed the Vaugirard Hospital team to learn more about the specialities of each group and their degree of involvement in the hospital.

5. The new concept of the life of elderly people in hospital corresponds to a new policy for a geriatric hospital. Vaugirard's aim is to set up a system whereby elderly people in hospital are treated like guests at a luxurious hotel. The families are warmly welcomed into the hospital. There are no set visiting hours. Therefore, the family can see a relative at any time. Furthermore, elderly people find a warm atmosphere. For example, floors and corridors bear the names of the district's streets to increase the feeling of staying in the same environment and to make the memorisation of the building easier. A social activities manager, together with the care teams, put on various activities daily. An annual survey concerning quality of services is conducted to adapt this policy. The results are presented to the families during an annual meeting. These results and the feed back from the meeting lead to practical measures.

The evaluation of each subproject follows.

The Gerontology Network Between Vaugirard Hospital and the 15th District of Paris

In 1995, the Institute for Health Policy Studies and the Vaugirard team conducted a survey in order to determine the day-care hospital patients' profile in comparison with patients admitted to the rehabilitation units. The aim of the study was to determine who could benefit from the day-care hospital services within the gerontology network.

The following data were collected : socio-demographic criteria, housing, social contacts (family members, home help aids...), present health problems, degree of autonomy, relations between the GP and the Vaugirard Hospital team and admission procedures to the hospital.

Methods

Information from patients followed in the day-care hospital and patients hospitalised in rehabilitation units was analysed to describe and compare their socio-demographic and medical characteristics. All the 84 patients followed in the day-care hospital in 1995 were included in the survey. Information was obtained from a questionnaire filled in by the medical staff for each new patient followed that year. For the 160 patients in the rehabilitation units, data was gathered via several regular one-day surveys. Data was obtained from medical records, nursing records, interviews of auxiliary nurses and nurses.

Exclusion criteria were for the day-care patients those who refused to participate and two patients who were already recorded in the rehabilitation unit. The exclusion criteria for the patients of the rehabilitation unit were five patients who had previously been admitted to the day-care hospital, patients having already taken part in a one-day survey, either because they were still hospitalised or had been readmitted and patients who refused to participate.

Finally, the following results concern a total of 82 patients followed in the day-care hospital and 155 inpatients. Statistical procedures using t test and CHI square test were set up to compare characteristics of the 2 populations. We decided not to match or adjust the two groups for any criteria taking into consideration the fact that all these patients lived in Paris and were followed in the same geriatric hospital.

Results

Socio-demographic data (Tables 1 and 2)

Table 1: Distribution of the population by gender, marital status and social network

Characteristics	Day-care group		Inpatient group (IG)		p
	n	%	n	%	
Gender					
male	20	24.39	30	19.35	NS*
Marital status					
married	24	29.27	26	14.77	0.017
widowed	41	50.00	78	50.32	
divorced	8	9.76	9	5.81	
never married	8	9.76	32	20.64	
unknown	1	1.21	10	6.45	
Isolated					
Yes	45	54.88	107	69.03	0.017
No	37	45.12	44	28.39	
Unknown	0	0	4	2.58	

* NS : non significant difference

In the day-care hospital group, mean age is 82.22 (SD: 5.97) versus 84.71 (SD: 7.84). The results are significantly different, ($p = 0.013$). We observed that less people receive daily visits in the inpatient group (52.90% versus 60.98% - $p = 0.014$). Most of the time, families only (68.75%) visit their relatives at home rather than neighbours, volunteers or friends. In addition, nearly 61 % of the day-care group patients and nearly 53% of the inpatient group patients have someone present everyday.

People live essentially in the 15th district of Paris (more than 90% percent in both groups) where Vaugirard Hospital is located. As a result most people from both groups live in flats. However, there is a higher percentage of inpatients living in old people's home compared with the day-care group patients. It must be pointed out that a large percentage of elderly people live in buildings without elevators.

The number of patients who have 100% coverage is different between the 2 groups. Medical coverage is significantly higher for the day-care patients (90.24% versus 68.39% - $p = 0.001$). In France, 100% coverage theoretically corresponds to a list of 32 severe illnesses or to very expensive treatments.

The admission procedure to hospital (see Table 3).

Table 2: Housing of the population

Characteristics	Day-care group		Inpatient group (IG)		p
	n	%	n	%	
Living in the 15th district of Paris	75	91.46	141	90.97	NS
Housing					
House	1	1.22	1	0.65	0.055
Flat	79	96.34	132	85.16	
Nursing homes	1	1.22	3	1.93	
Old people's home	0	0.	7	4.51	
Other	1	1.22	1	0.65	
Unknown	1	1.22	11	7.10	
Elevators					
Yes	51	62.96	81	52.26	NS
No	13	16.05	31	20.00	
Unknown	17	20.99	43	27.74	

Table 3: Admission procedure to hospital and characteristics of the day-care hospitalisations

Characteristics	Day-care group		Inpatient group (IG)		p
	n	%	n	%	
Origin of the patient					
Rehabilitation units	12	14.63	0	0.00	0.001
Acute care hospital	6	7.32	131	84.52	
Gerontologic outpatient service (GP referral)	62	75.61	18	11.60	
Other	2	2.44	6	3.88	
Frequency of day-care hospitalisations					
1/week	13	15.85			
2/week	35	42.68			
3/ week	27	32.93			
not on a regular basis	4	4.88			
unknown	3	3.66			
Transportation of the day-care group patients					
Ambulance	5	6.10			
Medical vehicle	66	80.48			
On foot	4	4.88			
Other	6	7.32			
Unknown	1	1.22			
Transportation set up by Vaugirard Hospital					
Yes	69	84.15			
No	10	12.20			
Unknown	3	3.65			

The results corresponds to the organisation of the French hospitals whose regulations stipulate that patients admitted to rehabilitation units have to be firstly addressed by medical doctors working in acute care units.

Medical data (Table 4)

Table 4: Medical data of the population

Characteristics	Day-care group		Inpatient group		p
	n	%	n	%	
Cardiovascular diseases					
Hypertension	23	28.05	60	38.71	NS
Coronary Artery Disease (acute and chronic)	14	17.07	27	17.42	NS
Congestive heart failure	6	7.32	12	7.74	NS
Arrhythmia	16	19.51	25	16.13	NS
Neurology. psychiatric & dependency disorders					
Alzheimer's disease	32	39.02	12	7.74	0.001
Other dementias	11	13.41	5	3.23	0.003
Cerebrovascular diseases	2	2.44	19	12.26	0.012
Depression	21	25.61	18	11.61	0.006
Musculoskeletal diseases					
Mono and Multiple arthritis	11	13.42	9	5.81	0.045
Broken upper limbs	2	2.44	13	8.39	NS
Broken lower limbs	7	8.54	18	11.61	NS
Ophthalmology & Ears Nose & Throat					
Deafness	6	7.32	13	8.39	NS
Blindness	2	2.44	5	3.23	NS
Glaucoma	5	6.10	2	1.29	NS
Cataract	0	0	24	15.48	0.001
Retinal detachment	0	0	2	1.29	NS
Gastro Intestinal diseases					
Peptic Ulcer	2	2.44	9	5.81	NS

The medical history of the patients is very different between the two groups. In the day-care group, the most frequent diseases are the following: Alzheimer disease and other dementia (52.43%), hypertension (28.05%) and depression (25.61%). In the inpatient group, the most frequent diseases are: hypertension (38.71%), coronary disease (17.42%) and arrhythmia (16.13%).

Concerning their dependency level we used the Activity of Daily Life scale (ADL). The ADL corresponds to 6 different items concerning :

- dressing, bathing, eating, transferring, getting to the bathroom and eliminating. Each one receives a score from 0 to 3 (3 corresponding to standard autonomy) and the sum represents the degree of autonomy.

The calculated score is significantly different between the two groups (13.22 in the day-care group versus 9.35 in the Inpatient group, $p = 0.001$). As a result, the day-care patients are less dependent on outside help.

The contact with the GP during the hospitalisation (Table 5)

Concerning the role of the GP in the care provided during the hospitalisation, it is worthwhile to remark that about 3/4 of the GPs are usual correspondents of the Vaugirard Hospital in the day-care group while only 55.48% are in contact with the hospital in the inpatient group ($p=0.005$). Furthermore, contact with the GP is more often noticed in the day-care group (69.51%) in comparison with the inpatient group (20 %) during the hospitalisation ($p = 0.001$).

Table 5: Contact with the GP

Characteristics	Day-care group		Inpatient group (IG)		p
	n	%	n	IG %	
GP as usual correspondent					
Yes	61	74.39	86	55.48	0.005
No	19	23.17	49	31.61	
Unknown	2	2.44	20	12.90	
Contact with GP during hospitalisation					
Yes	57	69.51	31	20.00	0.001
No	18	21.95	98	63.23	
Unknown	7	8.54	26	16.77	

Conclusion

The profile of the 2 groups is quite different: day-care patients live less isolated and are less dependent compared with inpatients while they more often suffer from dementias. In addition, it appears that the GPs of the day-care group patients are more often usual correspondents of the Vaugirard Hospital and they have more often contacts with the medical staff of Vaugirard Hospital during the stay of their patients. In order to present these results to the GPs of the district, an open meeting was organised in April 1997. The purpose of the meeting was not only to provide practical information and to allow GPs who participate to speak about their experience but also to inform them that the gerontology network was efficient for elderly people followed up by GPs in regular contact with the hospital.

Taking into consideration these results, the Vaugirard Hospital team decided to set up a new subproject „Hospital beyond the walls“. Its aim 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. 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 loca-

ted 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 Resource data between the professionals of the District and the Vaugirard Hospital⁴

The aim of the project was to evaluate the use of the guide and the different services created as a link between the hospital staff and the district professionals.

The objectives of the survey were to:

- measure in the 15th district the GPs' knowledge concerning the Vaugirard Hospital facilities and
- evaluate the GPs' expectations concerning a geriatric hospital.

Methods

212 GPs were listed in the 15th district. 75 of the 95 GPs contacted accepted to answer the questionnaire, which corresponds to 35% of the target population. The survey was carried out by phone from the 15th October 1995 to the 15th January 1996 and it was stipulated that the person in charge of the survey would try to contact the GP a maximum of 3 times.

It had 9 questions and an additional open question in order to obtain qualitative information about Vaugirard Hospital services. The survey described the GPs recourse to Vaugirard Hospital in the 15th district, the use of the Vaugirard Hospital guide, the referral to the geriatric outpatient service, the knowledge of the day-care hospital, the GPs' participation in the gerontology network and the GPs expectations from a geriatric hospital.

Results

The breakdown of the 74 contacts is the following: 95.9% answered by phone, 4.1% answered by mail (after a phone contact).

The place of Vaugirard Hospital in the 15th district is assessed. Most of the GPs (82%) have oriented elderly patients to Vaugirard Hospital, half of them (55%) followed up on patients discharged from Vaugirard Hospital of whom 27 % followed up on fewer than 2 patients, 37% between 2 and 5 patients and 32% more than 5 patients (not specified for 4%).

Concerning the guide, 65% are sure that they received it and 34% suppose they did not. Among the 48 GPs who received the guide, 23 (48%) use it in their practice.

49% of the GPs refer patients to the geriatric outpatient service of Vaugirard Hospital. The day-care hospital is well known (74% reply favourably). Among these doctors, 44% have used this center. Concerning the gerontology network, 59% of the GPs know about it but only 32% see it as teamwork.

⁴ With the cooperation of Yanka Stahan, Institute for Health Policy Studies- School of Medicine Broussais Hôtel-Dieu and Nicolas Nathan, MD, International Affairs Division, AP-HP

49 GPs explain their expectations of a geriatric hospital :

- 26.5% regret that their patients cannot be admitted directly to Vaugirard Hospital in an emergency situation and have to first go to an acute care hospital (Boucicaut Hospital in the 15th district which is an AP-HP hospital as well) even if the patient does not require surgery,
- 24% mention the lack of beds,
- 10% would like more hospitable relationships between staff and patients,
- 10% regret the lack of contact with the patient following hospitalisation, especially in the long term care department. They would like to receive a regular update on their patient,
- 26.5% of the GPs respond „everything is fine with the Vaugirard Hospital’s services“.

Conclusion

The results of the survey concerning the GPs’ knowledge of Vaugirard Hospital services show that these medical doctors are aware of the day-care hospital facilities and the geriatric outpatient service. Most of them have referred patients to Vaugirard Hospital. Nevertheless, it must be pointed out that only half of them use the guide regularly, thus showing that social aspects are not often taken into consideration. In addition, the care co-ordination project between the primary care system and Vaugirard Hospital is not always seen as a gerontology network. More time will be needed for the staff to become accustomed to this new approach and therefore to be able to put into practice what is written in the hospital policy.

Taking into consideration the GPs requests, Vaugirard Hospital staff members have recently created an acute care unit. This unit can admit patients directly and facilitates the hospitalisation of elderly people in a specialised environment. The Vaugirard Hospital staff continuously tries to find means to improve the relationships between Vaugirard Hospital and the health and social professionals of the 15th district of Paris. Taking into account the results of the GPs survey, the guide will be revised in 1998.

The programme to improve the staff working conditions⁵

Working in geriatrics requires very specific training for the staff. However in France, there is no geriatric specialty for nursing staff, social, technical and administrative personnel. For medical doctors, there is a 2-year residency programme in geriatrics and gerontology is just beginning to be taught at the university. In the past few years, professionals have begun to express the need to develop specific training for health care workers. As a result, a survey was conducted in Vaugirard Hospital in 1997, in order to know what training and experience they have had in geriatric care and to identify the needs for continuing education in this field in the near future.

⁵ With the cooperation of Matthieu de Stampa, MD, International Affairs Division, AP-HP

Methods

This survey consisted of a questionnaire, made up of 10 questions and one additional open question to obtain qualitative information concerning the motivation of the staff to work in geriatrics. The questionnaire was filled in by the staff. 160 out of 320 staff members were randomly chosen from the hospital personnel file. It was decided to take half of the people in each professional category: medical doctors, nursing staff, social personnel, technical personnel and administrative personnel.

Results

148 out of 160 answered the questionnaire (92.5%). The distribution for each professional category was the following:

- nursing and medical staff represented 58.8% of the replies;
- social, technical and administrative personnel made up 41.2% of the replies.

The first question concerned specific training in geriatrics beyond the initial schooling. 79% of all the staff was not trained in geriatrics. Taking into consideration each professional category, the percentages of trained people are the following :

- social activities manager (100%);
- chief nurses (50%);
- physiotherapists (43%);
- medical doctors (33%);
- nurses (33%);
- auxiliary nurses (32%).

The second question explored the need to be trained in geriatrics among the staff who had not been trained previously. 69.5% of all the staff is willing to take part in training sessions.

The most frequent request concerns care for the terminally ill (59% of all professionals). Auxiliary nurses have asked for theoretical training (24%). 10% of the replies concerns the need for training in psychology to work with elderly people. Finally, 7% of the staff is interested in technical care. Concerning care for the terminally ill, we can observe that a large percentage of the persons directly in charge of elderly patients would like to attend specific sessions: auxiliary nurses (80%), medical doctors (80%), nurses (66%) and physiotherapists (50%).

The third question referred to the professional experience in geriatrics before working in Vaugirard. It appears that only 61.5% of the staff has this experience, thus explaining the request for continuing education in this field. Among the total 57 replies, the results for each category are the following :

67% of the chief nurses, 59% of the auxiliary nurses, 55% of the medical doctors, 50% of the psychologists, 42% of the physiotherapists, 38% of the nurses, 35% of the catering team members, 12.5% of the administrative board members and the social activities manager who was hired at the beginning of the hospital project. These results show that there is a lack of preparation of the staff to deal with all of the aspects involved in geriatric care.

In addition, the staff was asked about their everyday work insisting on difficulties and satisfactions when working with elderly people. One of these difficulties concerns the behaviour troubles which are pointed out by 17% of the auxiliary nurses, 16% of the nurses, 14% of the physiotherapists, 12% of the technical workers and 5% of the catering team members. The main problem the staff has to face in this context is dealing with the difficulty with death and dying. It concerns 23.5% of the auxiliary nurses and 22 % of the nurses.

The satisfactions at work focus firstly on the help they are able to give to elderly people. This point is very important for auxiliary nurses (42.5%) while it appears less fundamental for administrative staff (25%), nurses (16%), chief nurses (16%), medical doctors (11%) and catering members (10%). On the other hand, the improvement of the health conditions of the patient is the most positive point for medical doctors (44%), nurses (33%), physiotherapists (28%) and auxiliary nurses (17%).

Participants were asked about whether or not they chose to work in geriatrics. 59% of the nursing and medical staff have chosen to work in geriatrics (100% of M.Ds, 100% of chief nurses, 77% of nurses, 57% of auxiliary nurses and 55% of physiotherapists). Finally, 68.3% of the Vaugirard Hospital employees consider that they have a very challenging job.

Conclusion

Taking into consideration these results, it appears that there is a lack of trained people due to the lack of recognition of the geriatric speciality in France and that the staff is confronted with difficulties. The initial training is insufficient in France. Since the nineties, the nursing schools have included in their curriculum a specific programme in geriatrics. But our results clearly demonstrate that there is a specific need for training concerning care for the terminally ill. Our results clearly demonstrate that the staff is willing to improve its knowledge. It must be added that for the most part, health care professionals have willingly chosen to work in geriatrics especially for M.Ds. and nursing staff. These results will help the decision makers to organise the training programme of the staff because the final goal of Vaugirard Hospital board managers is to have the staff trained in geriatric care to help them adapt their attitudes, broaden their knowledge while improving their working conditions.

A partnership between the volunteer associations and the Vaugirard Hospital staff⁶

Since the Vaugirard Hospital opened its doors, the board managers have encouraged volunteer associations' participation in the everyday life of the hospital in order to improve the living conditions of elderly people. The aim is to reduce the phenomenon of isolation by bringing people from outside the hospital into their environment, thus improving their morale. In addition, the presence of volunteers alleviates the pressure on the staff. The idea of volunteer work is not very developed in the French health sector. Nine million people do volunteer work, 7.2% of whom in the health care system. More than 11 associations have been involved in the Vaugirard Hospital

⁶ With the cooperation of Thérèse Flageul, International Affairs Division, AP-HP

programme since 1992. These associations range from the traditional associations often religious in origin to cultural groups doing activities such as arts and crafts, reading and trips.

Methods

The survey was carried out in February and March 1997. It consisted of interviews of the 11 associations, each association being interviewed as a group. The survey was descriptive, giving information on the associations with the help of a questionnaire: welcome upon arrival at the hospital, training of the volunteers, the relations between hospital staff and volunteers, families and volunteers as well as motivations of associations' members. Secondly, the survey included questions about volunteers such as their demographic characteristics, their professional background and the time devoted to volunteer work.

Results

Concerning the associations, 45% takes part at the hospital's request. Before beginning activities, 82% of the associations' chair persons was screened by a Vaugirard Hospital board manager. Orientation sessions took place between volunteers and staff for 65% of the associations while meetings are organised between volunteers and staff in 55% of the cases. 91% per cent of the associations stated that the staff takes into consideration their opinion. There were little contact between volunteers and patients' families, 18%.

The motivations of the associations as a whole were the following :

- 45% were assigned to work with elderly people;
- 55% were motivated by their interest in working with elderly people.

Vaugirard Hospital was designated mainly for its location (63% of the associations). Concerning the volunteers, the average age is 58. They are predominantly women (82%). Half of the volunteers have no present professional activities: 62% are retired and 33% are homemakers. 73% practice their religion. They devote an average of 11 hours and a half to volunteer work a week of which 5 hours devoted to Vaugirard Hospital. 45% of them have received training in geriatrics mainly through their associations (66%). 82% of these volunteers are active in other associations or clubs not related to hospitals.

Conclusion

Volunteer associations participate in improving the living conditions of elderly people in Vaugirard Hospital by providing cultural activities and entertainment, religious services and a presence of people willing to listen, talk, comfort... The associations' role is now recognised as having an important place in Vaugirard Hospital. As a result, volunteers participate actively in the everyday life of the hospital. It must be pointed out that they need to be trained in geriatrics and more integrated in the hospital team. Systematic interviews should be scheduled before associations start and regular meetings organised between the staff and the volunteers. Concerning the visibility of these results, a poster at the entrance of the hospital describes the activities of the volunteers. A new subproject „Hospital beyond the walls“ is being set up

to involve the volunteers in the every day tasks of a specific flat where very dependent elderly people will live. Volunteers will perform tasks such as accompanying elderly people to the market, a park etc.

The patients' satisfaction surveys

As soon as it opened its doors in 1991, the Vaugirard Hospital team decided to conduct an annual survey concerning quality of services in order to modify facilities and medical activities organisation if necessary. These satisfaction surveys go along to HPH principles of improving the health of the patients by taking into consideration all the aspects of hospitalisation.

Methods

A questionnaire was drafted and presented to the staff for approval. This questionnaire is sent to all the elderly persons' families every year as the vast majority of the patients is not able to fill in such a form (people with Alzheimer's diseases and other dementia...). This questionnaire concerns patients hospitalised in long term care units. For the patients who were discharged from Vaugirard Hospital or died during their stay, their families receive the same questionnaire. In France, a questionnaire is systematically given to the discharged patient concerning the quality of their stay. Due to the low response rate in previous years and the need to assess hospital quality, hospital managers will have to provide this information to the funding authorities.

The families fill in a grid, listing the following points with 4 possibilities of response, very good, good, average, insufficient and a space to specify things to improve: the welcome upon arrival, admission procedure, medical care, nursing care, health aid care (bathing, changing, eating, mobility), physiotherapy care, meals, hair dressing, modern conveniences, cleanliness, room furniture, daily routine and schedule, entertainment, information and availability of professionals.

The second part of the questionnaire gives the responders more latitude in expressing their opinion concerning Vaugirard Hospital: strong points, weak points, whether or not they would like to find another hospital or retirement home for their relative, suggestions, questions to be discussed at the annual meeting with families. Although the questionnaire is sent by name, each family has the right to return the questionnaire anonymously.

Results

The results are collected for each division and are presented to the staff. An annual meeting allows the families to voice their opinion and meet the different professionals and the board managers. In addition, quarterly meetings are held with the different units' teams. The concrete measures which were decided as a result of the survey include: the welcome upon arrival which is now part of a training programme; the information given to the families which is now published in a quarterly newsletter; systematic procedures have been implemented concerning cleanliness controls, temperature controls...; modification of the schedule to allow elderly people to have supper a little later (8.30 p.m.) and breakfast until 10 am.; opening of a restaurant and a cafeteria for patients and visitors; an afternoon dance scheduled monthly.

Conclusion

The results of the annual surveys allow the board managers to propose new means to improve the everyday life of elderly people and discuss the patients' needs with their families.

General Conclusion

The evaluations of the original 5 subprojects gave rise either to new subprojects such as „Hospital beyond the walls“, „Quality assurance programme“ and „Staff exchange programme“ or to new ideas for example „Prescription guidelines“.

Additional Subprojects within the 1993–1996 HPH programme

These new subprojects illustrate the fact that a health promotion culture is being developed in Vaugirard Hospital. New ideas come in order to pursue the programme 1993–96. The new subprojects which are being implemented in Vaugirard Hospital are the following:

Prescription guidelines for the elderly

Prescription guidelines for the residents (young doctors doing internships) who were not taught pharmacology for the elderly during their medical studies have been published. This quality of care programme was implemented by the Vaugirard Hospital pharmacist. Each new group of residents is tested when they join the staff in order to evaluate their prescription capabilities. Then, training sessions are organised by the pharmacist for all the residents. The main topics concern antibiotics, pain relievers, antidepressants, hypnotic drugs, anti-inflammatory drugs and especially the interaction between medication.

Staff exchange programme

After years of trying to implement a gerontology network, the board managers have gone a step further in the implementation of their gerontology network by setting up a staff exchange programme for the nurses. The nurses of the 15th district involved in home health care work in Vaugirard Hospital while their counterparts visit patients at home. This programme makes it possible for the staff and the nurses of the district to become aware of the working conditions of each other while re-enforcing the coordination between the Vaugirard Hospital staff and the health care professionals of the district.

Vaugirard Hospital beyond its walls

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. Taking into consideration the increasing needs, Vaugirard Hospital board managers have decided to provide services outside the hospital. A ground floor apartment will be leased to accommodate a group of very dependent elderly people in order to allow them to stay in their district while being followed up by the hospital team. This project is planned for 1998. It will be interesting to know if this kind of mini nursing homes correspond to future long term units.

Quality assurance programmes

A quality assurance manager was hired in Vaugirard Hospital to set up, implement and evaluate quality programmes. These programmes concern for example the flexitime organisation while enforcing actual work time, the quality services of the catering team, the efficiency of managers and others more.

Conclusion

The Vaugirard programme is a completely new approach to promote the health and well-being of elderly people in a hospital. It gives a major role to the professionals of the district. This programme 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 health 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 will be under the authority of a regional agency on hospitalisation whereas the ambulatory system will be 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 Social Security system will finance health networks' experiments in order to promote care co-ordination. The main consequence of this evolution is the transformation of a liberal system into a new organisation where MDs would be salaried employees rather than liberal professionals. They are not ready to accept this modification even if the demographic situation of MDs limits the setting up of new medical practices.

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.

References

- Béresniak A., Duru G. *Economie de la santé*, Paris: Masson, 1995
- Bertrand D. *La protection sociale*, Paris : Que sais-je ?, 1988
- Bocognano A., Raffy-Phan N. (1995): *L'emploi dans le secteur santé : évolution 1982-92*. Paris: CreDES
- Clément J.-M. (1985): *Les réformes hospitalières 1981-84*. Paris: Berger-Levrault
- Clément J.-M. (1990): *Les pouvoirs à l'hôpital*. Paris: Berger-Levrault
- Coca E. (1995): *Les inégalités entre hôpitaux*. Paris: Berger-Levrault

- Couty E. and Tabuteau D. (1993): Hôpitaux et cliniques : les réformes hospitalières. Paris: Berger-Levrault
- Dupeyroux J. J., Pretot X. (1996): Le droit de la Sécurité Sociale. Paris: Dalloz
- Dupeyroux J. J., Prétot X. (1996): Sécurité Sociale. Paris: 9e édition: Sirey
- Durieux P., Matillon Y. (1994): (under the direction) L'évaluation médicale: du concept à la pratique. Paris: Médecine Sciences Flammarion
- Health and Welfare Canada, Ministry for Supplies and Services (1990)
- Health and Welfare Canada: A guide for Health Promotion by health care Facilities. Health Services and Promotion Branch
- Henrard J. C., Ankri J. (1996): Systèmes et politiques de santé. Paris: éditions ENSP
- Jolly D. (1988.): L'hôpital au XXIème siècle. Paris: Economica
- Jolly D. Durand-Zaleski I. (1997): (under the direction). Politiques de santé en France: quelle légitimité pour quels décideurs ? Paris: Médecine Sciences Flammarion
- La santé des français (1995): Rapport général. Paris: la Documentation Française
- La santé des français (1995): Travaux des groupes thématiques, Paris la Documentation Française
- Le Faou A.-L. (1997): l'Economie de la santé en questions. Paris: Ellipses
- Lequet-Slama D., Duriez M. (1997): Les réformes des systèmes de santé : spécificités et convergences. In: Actualité et dossier en santé publique, n° 18, mars 1997, p. I-XXXII.
- Ministère du Travail et des Affaires Sociales (1997): Annuaire des statistiques sanitaires et sociales. Paris
- Moreau Yannick. Les dépenses de santé: un regard international, Paris: La Documentation française, 1992
- Moreau Y. (1993): Les dépenses de santé: un regard international. Paris: La Documentation Française.
- Murard N. (1993): La protection sociale, Collection Repères. Paris: Editions La Découverte
- Official Journal of the French Republic (1997): Agreement of the contract between „Sécurité Sociale“ and representative medical unions. Paris
- Peretti J.-M. (1991): Fonction personnel et management des ressources humaines. Paris: Vuibert
- Tanti-Hardouin N. (1994): Economie de la santé. Paris: Armand Colin éditeur
- US department of Health, Education and Welfare (1978): Disease prevention and Health Promotion. Washington DC
- US department of Health, Education and Welfare (1979): Healthy people. Washington DC
- US department of Health, Education and Welfare (1979): Promoting Health/ Preventing Disease: Objectives for the Nation. Washington DC
- WHO (1986a): A discussion document on the concept and principles of Health Promotion. Health Promotion 1 (1)73-76
- WHO (1986b): Ottawa Charter for Health Promotion. World Health Organisation & Health and Welfare, Ontario, Canada
- WHO (1991): Budapest Declaration of Health Promoting Hospitals – an International Network. World Health Organisation, Health Promoting Hospitals, Budapest, Hungary

Areteion Health Promoting Hospital A Southern European Hospital in Transition

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Hospital Owner:	University of Athens
Hospital Ownership:	Public
Specialisation:	Surgery Hospital
Beds:	250
Staff:	Medical Staff: 120, Nursing Staff: 142, Other Staff: 232 (other professional staff: 55, admission, Technical Services: 177), Total Number of Staff: 494
Utilization:	Average Utilization of Beds/Year: 68 %, Average Stay in the Hospital/Day: 8–10 days
Patients:	Number of Inpatients/Year: 4.247, Number of Outpatients/Year: 10.301
Number of Departments:	8 (5 dep. equipped with beds; 3 without beds)
Location of Hospital:	Inner city
Catchment Area:	Regional, Number of Population: Athens: 4.000.000 (Greece: 10.000.000)
Other Functions than Medical Care:	
Teaching:	Medical Students, Postgraduate, Nursing Education, Other Health Professions: Midwives
Research:	Clinical Research, Other Health Research: Research on liver transplantation
Subprojects:	<ol style="list-style-type: none">1. Study of Patient Satisfaction2. Study of Health Level in the Hospital Community3. Total Quality Management in the Nephrology Department4. Development of a Quality Control Program in the Surgical Department5. Early Diagnosis of Neonatal Hearing Loss and Prevention of Mutism6. Health Education Program for the Training of Young Mothers on Issues of Perinatal Care and Breastfeeding7. Control of Hospital Acquired Infections8. Hygiene and Safety in the Hospital9. Rational Use of Antibiotics through the Link to a National Database

The National Health Care System in Greece

Introduction

Health care in Greece is provided by the National Health System (NHS), the public and private insurance organizations, and the private sector. The Greek NHS was established in 1983 and consists of primary, secondary and tertiary care. The most important principles of the law for the Greek NHS are:

- a) health is a social benefit and does not obey the laws of profit;
- b) all citizens, regardless of their social and economic position or place of residence, have the same right to equally high levels of treatment and social care;
- c) health protection is the exclusive responsibility of the state and is exercised through a unified, decentralized and democratic health system.

The main sources of financing of health services in Greece are the government and the social insurance organizations (about 370 organizations), which are mostly financed by the contributions of the employers and the employees (Abel-Smith, Caltorp, Dixon, et al. 1994; Ferrera 1993; Iatridis 1987; Mamas, Karokis, Polysos, et al. 1994; Skalkidis 1991). Private insurance programs cover only a small part of the population, and concern mainly hospital services. The percentage of population covered by private programs has markedly increased during the last years. According to international comparisons, Greece is presenting a relatively low percentage of health expenditures. Data from the Organization for Economic Collaboration and Development (OECD) suggest that the total health expenditure in Greece is 8% of the Gross Domestic Product (GDP) (Health Data 1993). Greece presents a high percentage of private expenditure (30% of the total; 1991 data), that have significantly increased, even after the establishment of NHS. The majority of these private expenditures are distributed to primary health care services (Androutsopoulos, Kyriopoulos, Georgoussi 1993).

Greece presents one of the highest rates of physicians per residents (1:260) among the OECD countries. Contrary to the high number of physicians there is a relative lack of trained nurses, the ratio of nurse to physicians being two to three. The majority of Greek physicians are specialized, and half of them work in the private sector and the primary health care.

Primary Health Care

Primary care in rural areas is provided by a network of 170 Health Centers (HC) in combination with 1,311 Health Stations (HS), by the outpatient departments of the public hospitals and by the polyclinics of insurance organizations and local authorities (i. e. municipalities). The staff of HC consists of general practitioners, specialized doctors, nurses, health visitors, midwives etc. All of them are full time civil servants and their salary is paid by the state. The number of physicians in each HC depends on the population of the area of coverage. Some of the HC develop activities in the field of Health Promotion and Health Education (Iatridis 1987; Skalkidis 1991).

Secondary and Tertiary Care

Secondary care is provided by the general hospitals located in almost every one of the 52 prefectures of Greece. These hospitals have all the basic medical specialties. Tertiary care is provided by the University Hospitals of the seven medical schools of the country, as well as by the regional hospitals. Most of the tertiary care is concentrated in the greater Athens area. The majority of the employees in public hospitals are full-time civil servants. The inpatient-care services are provided by 414 hospitals of an overall capacity of 53,388 beds. Within the NHS, there are 128 hospitals (119 General, 9 Psychiatric). There are 37 public hospitals outside the NHS, while in the private sector, there are 249 hospitals (200 General, 49 Psychiatric).

On average, there are 5.2 hospital beds and 12.6 hospital admissions per 1,000 residents per year. Hospitalization per person is 1.1 days, and the overall mean duration of hospitalization is 9.8 days.

It has to be noted that there are great geographical variations in the availability of hospital services, as well as variation between the public and the private sector. More than 60% of the hospital beds and health personnel are in the greater Athens area (Abel-Smith, Caltorp, Dixon, et al. 1994; Iatridis 1987; Skalkidis 1991;).

Other Services

Long stay inpatient services for physically and mentally handicapped: These categories of services are provided mainly by the private sector. Within the public sector, there is a National Rehabilitation Center for the physically handicapped, and a few nursing houses for the aged. A greater number of institutes for the aged are offered from the private sector.

Social services: Open Care Centers for the elderly have been established in many municipalities. These centers have proven very popular and successful.

Services for specific groups: Greece has only recently started to host ethnic minorities from the former eastern European countries and other Asian countries. No special initiatives for these minorities have been established yet.

Comments

Thirteen years after the establishment of the Greek NHS, important problems remain in the health sector and some of the fundamental provisions of the Greek NHS law had not been fully implemented (Tountas, Stefenson, Frissiras 1995). Manpower shortages and lack of functional links between primary and secondary care, are two of the major problems of the Greek health system.

The number of hospital beds has decreased, as many small private clinics have closed down while the number of private diagnostic centers and the number of doctors have increased significantly. This has resulted in an increase in the use of primary care services and an increase in the diagnostic tests carried out. The mean number of medical visits per person per year is greater than six. The consumption of pharmaceuticals has increased. From 1987 to 1992 the pharmaceutical market increased 320% (40% per year). The expenditure for pharmaceuticals represents almost 15% of the expenditure of hospitalization. There has also been an increase in the number

of the patients who travel abroad for advanced hospital care. The latter is a result of the recently adopted policy of most of the insurance organizations to cover the cost of services that cannot be provided in Greece.

In relation to the overall public expenditures, there has been an increase in the public expenditure for hospital care. This may be attributed to the increased cost of hospital care, while the fees for hospital care paid by the insurance organizations remained stable.

The overall condition of public hospitals in Greece remains poor. Main problems are: under-financing and staff shortage problems, poor managerial support, wasteful utilization of hospital beds and under-utilization of operating rooms, poor maintenance of patient records and lack of computerized services. There is also a serious shortage of long-term care hospital beds; this may lead to serious problems in the future due to the aging population. Finally, there is an overall lack of motivation among hospital employees, who largely function, in a resigned fashion as permanent civil servants, well aware that neither reward nor punishment will be forthcoming in case of superior or inferior performance. A low level of professional satisfaction has been recorded among doctors working in public hospitals in Greece, and is undoubtedly related to the existing situation.

In 1994, the Minister of Health called upon experts from around the world to form a committee to investigate the situation of the Greek NHS and propose reforms. Based on this report, the Minister of Health has proposed a number of reforms to the Greek NHS. The most important of them are:

- a) Creation of a new institution which will be responsible for the financing of the health services of the Greek NHS and the management of their resources.
- b) Development of a public health network, with public health officers, public health committees and public health laboratories in every region of the country.
- c) Establishment of family practitioners who will be responsible for the total Greek population. All citizens will have the right to choose the family practitioner of their preference, who will provide primary care and who will serve as a „gate-keeper“ for secondary and tertiary services.
- d) Introduction of administrative changes in the hospital system, like the creation of positions for general managers of the hospital, the possibility for outpatient and laboratory services during afternoon and evening hours, and the modification of the employment of physicians with more flexible and pluralistic options.
- e) Restructuring of the central management of the Greek NHS with the introduction of a more powerful executive committee and appointment of a director general.

Policy and Structure of Health Promotion in Greece

Health Promotion has not yet been fully developed in Greece. National institutions for Health Promotion or Health Education do not exist. Initiatives are taken by certain private non-profit scientific organizations such as the Institute of Child Health, the Greek Heart Foundation, the Research Foundation on Child Health, the Greek Cancer Society, the Society for Health Promotion and Health Education, the Society of Social Pediatrics, the Anti-Smoking Society, the Institute of Social and Preventive Medicine, etc.

In the Ministry of Health, there is a Department of Health Education, which undertakes rather traditional prevention activities such as the protection of child and maternal health. Since 1992, the Committee of Health Education Planning supports this Department.

There is also a National School of Public Health, which is supervised by the Ministry of Health. This School offers postgraduate training in Public Health and carries out several programs on health education.

The University Departments of Social Medicine in the seven medical schools of the country are active in the broader field of Social Medicine. The Department of Hygiene & Epidemiology of the University of Athens, the University Mental Health Community, and the Institute of Child Health carry out more specific Health Promotion activities.

A governmental organization which is active in the field of AIDS education / health promotion is the Center for the Control of Specific Diseases (KEEL). The establishment of a National Center for Health Promotion and Health Education has been suggested by an expert committee and proposals for the Center's aims, responsibilities and organizational logistics have been submitted to the Ministry of Health. However, a final decision is still pending.

In general, several Health Promotion and Health Education activities are undertaken in Greece, but they are fragmented, as the lack of national organization results in a lack of co-ordination. The various above mentioned bodies which are active in the field of health promotion and health education produce purpose-made health promotion material for their activities. However, in the Ministry of Health, the Department of Health Education is also responsible for the production and distribution of health education material.

Health education in schools is undertaken by specific organizations and is usually supported by the Ministry of Health (Department of Health Education), the Ministry of Education, as well as by the Local Authorities. A School Health Education Department has been established within the Ministry of Education, which has appointed recently a Health Education Officer in every educational district.

The Development of the Health Promoting Hospital Project at Areteion Hospital

Getting Started

Areteion Hospital opened in 1896 at a nice suburban location, being at the time a state of the art facility, serving the greater Athens area that had a population of no more than 500,000. Currently, Areteion is an inner city, teaching hospital, owned by the University of Athens. The population of Athens is now more than 4,000,000 and the surroundings of Areteion are far from the picturesque suburb of the early 1900s. Since its first days, Areteion enjoyed an excellent reputation and developed a strong academic tradition. Thousands of Greek physicians completed part of their undergraduate and postgraduate training in Areteion. Famous professors, who shaped the Greek medical establishment served in the staff of the hospital and several important innovations (e. g. open-heart surgery, liver transplants) were introduced in Greece through Areteion. Despite the construction of several bigger hospitals in the same

area, Areteion maintained its high profile among Greek patients; high demand for the services of Areteion often leads to long waiting lists.

During the past decade, Areteion underwent some major renovation; new departments opened (day surgery unit, angiography unit, outpatient department, experimental surgery laboratory) and existing departments were remodeled to better serve the changing needs of both patients and hospital staff (Papadimitriou, Tsiftsis, Pralialias, Papadimitriou 1997). However several problems remained, the most important being the financial restrictions which were connected to the financial crisis of the Greek health system overall. Those restrictions caused staff shortage and impaired the ability of the hospital to expand its activities and services. Currently Areteion has a staff of 494 and a total of 250 beds of which 105 are assigned to the University Department of Surgery and 95 to the University Department of Obstetrics and Gynecology. Finally Areteion hosts smaller specialized units (nephrology, neonatology, radiotherapy, pain management, etc.) and various supporting laboratories and newly constructed research facilities.

Areteion has three major functions:

- a) tertiary care center for general surgery and gynecology patients;
- b) teaching hospital for under- and post-graduate medical education as well as training center for nurses, midwives and radiology technicians and
- c) research center with clinical research activities.

Despite its scientific and academic achievements, Areteion had a very weak background in health promotion. Before 1993, the only health promotion activities in the Hospital were two long-running programs on secondary prevention of breast cancer and cervical cancer which were successfully implemented by the Department of Surgery and the Department of Obstetrics and Gynecology respectively. A smaller program promoting hepatitis B vaccination among hospital staff was intermittently run by the Blood Bank and Hematology Laboratory. Otherwise, health promotion in the Hospital was empirically approached by the staff physicians in often enthusiastic but uncoordinated personal attempts to provide better health services to their patients. In addition, a substantial part of the patient population of Areteion was that of a tertiary care, referral center; elderly, multi-hospitalized, gravely ill patients who were not responsive to health promotion activities.

In early 1993, following a suggestion by Dr Yiannis Tountas, the Board of Trustees took quick action and decided to join the European Pilot Project of Health Promoting Hospitals (HPH) and develop the Areteion HPH Project in collaboration with the Institute of Social and Preventive Medicine (ISPM).

ISPM would provide assistance in all aspects of project coordination, planning, implementation, evaluation and transfer of experience.

Several reasons for joining the HPH project, could be identified among the various groups in the hospital community:

- a) *HPH Project as a marketing tool*: Despite the existence of some health promotion projects, the overall idea of health promotion was not developed in Areteion as it was thought to be more of a primary care activity while Areteion had always been a well developed tertiary care center. However, the administration of

Areteion realized that adding the novel concept of health promotion in the hospital's functions could benefit the patients and the staff. In addition, joining a prestigious WHO-sponsored European project could improve the Hospital's image and increase the opportunities of funding at both a national and a European level as well as offer access to the valuable experience of other Hospitals on issues of health promotion and hospital administration in general.

- b) *HPH Project as a work-environment improvement tool:* The hospital staff envisioned improvements in the work environment being introduced through the channels of the HPH Project.
- c) *HPH Project as a research tool:* The University of Athens community immediately recognized the research opportunities that would be provided by the Project as well as the potential for improvement in the University's international relations. Therefore, members of the academic community were involved in the Project development since its very first days and had a major contribution to the implementation of the HPH idea in Areteion. Given that the Hospital is owned by the University of Athens, we believe that early development of strong links to the academic community were of paramount importance for the Project's success.

Following the official launching of the HPH Project a Steering Committee was appointed by the Hospital Board. The eight-member committee included representatives from the hospital administration and employees as well as health promotion

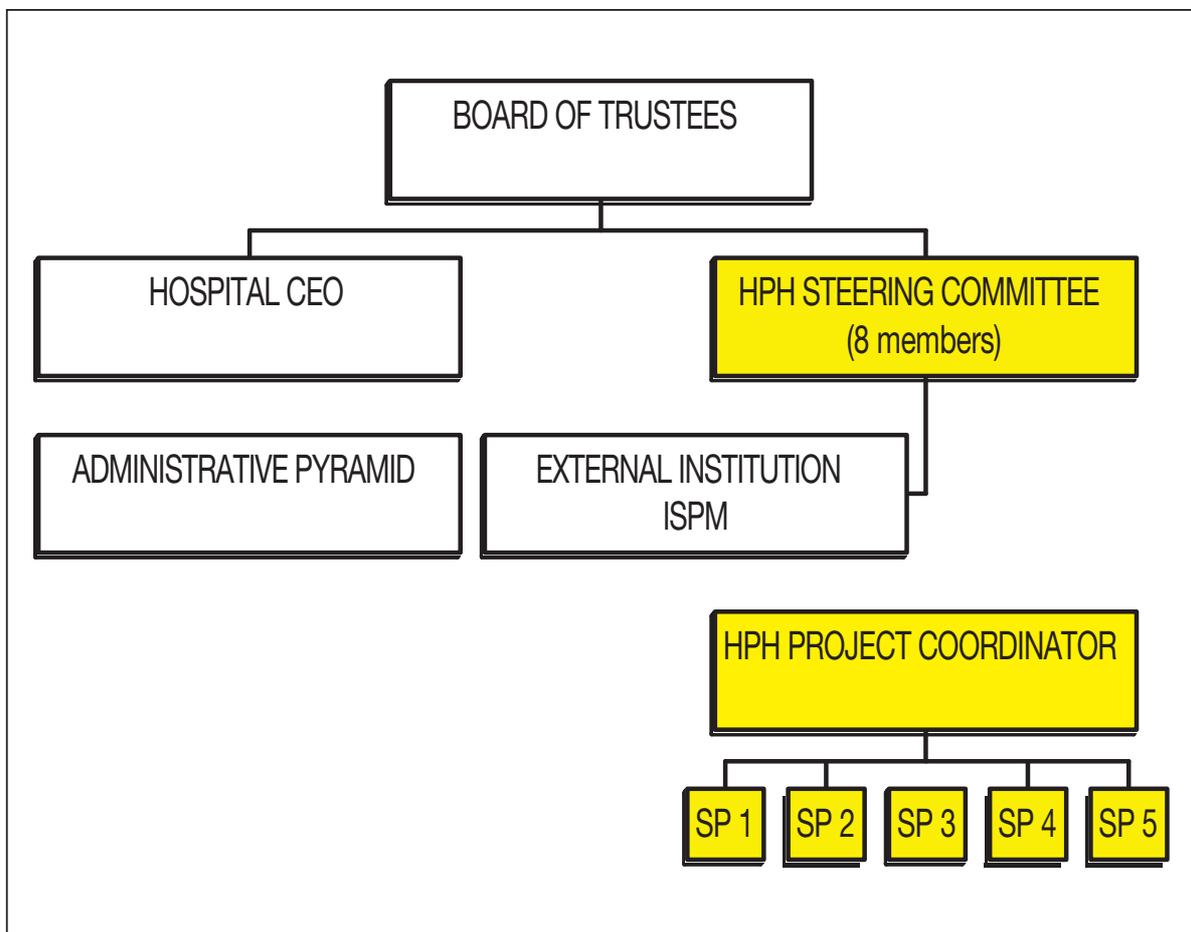


Figure 1: Organizational structure of the HPH Project at Areteion Hospital

specialists from ISPM. The employee union was also represented in this Committee. After initial discussions, it was determined that the Project goal would be the broadening of the hospital's health care philosophy through introduction of health promotion in the daily hospital functions. It was also determined that the existing administrative structure and priorities would not allow for the flexibility that was necessary in order to implement the entirely new concept of health promotion in the Hospital functions. Therefore, it was decided that at least for the first two years, the organizational structure of the HPH Project would be kept separate from the existing administrative pyramid (Figure 1).

In practical terms, this would mean that the Project Steering Committee would have a significant degree of autonomy in pursuing its goal of integrating health promotion in the Hospital's culture. Although the Committee would have to collaborate with the Hospital administration, direct links to the Hospital's Board of Trustees would ensure that the Committee's work would not be delayed even in the case of different administration priorities. During the first meeting of the Steering Committee, the strategy for development of the Areteion HPH Project was agreed upon and a Project coordinator was appointed. During the next two meetings, the subproject groups were formed and the main decisions regarding the Project development were finalized. All major organizational structures of the Project were in place by the end of 1993. Although regular monthly meetings of the Committee were held throughout the Project, most management decisions were based on the continuous interaction of the Project coordinator with the subproject groups.

Subprojects as a tool for change

Since the first steps of the European HPH Project, it became clear that specific, focused subprojects would be the main tool for the desired transformation of hospitals. In Areteion, we decided that all subprojects should have the same basic structure, which would include the following stages:

- a) benchmark study to evaluate pre-existing conditions in the area of the subproject;
- b) implementation phase;
- c) evaluation phase;
- d) transfer phase during which a subproject would be incorporated into the daily hospital function.

Subprojects were chosen based on suggestions by members of the Steering Committee. Selected subprojects had to be of interest to all parts involved in the HPH Project (staff, patients and the University) and meet the Committee's requirements for applicability and low cost. Availability of expertise in the subproject's field was another important consideration during the selection process. In the following paragraphs, we will give a brief overview of the subprojects that were successfully developed within the Areteion HPH Project.

In each case, a Subproject Committee was formed. The Committee included experts from ISPM, the Hospital staff and administration as well as medical students; this group was responsible for the daily management of the subproject functions.

Hygiene and safety in the hospital environment

Many structures and activities in the complex environment of a modern hospital can expose hospital staff in professional risks. Areteion has always tried to comply with the existing state regulations on safety in the work environment issues. However, because a comprehensive professional investigation had never been undertaken, data on the hygiene and safety status of the hospital were incomplete. The lack of sufficient documentation of the existing hygiene and safety conditions made any intervention in this field very difficult. Many people who were involved with the HPH project at the time felt that limiting occupational hazards in the Hospital should be one of the top priorities of a health promotion project. Areteion HPH Project seemed to provide a first-class opportunity to study the issue of hygiene and safety in a systematic way that would:

- a) re-introduce the concept of safety in the work place to the hospital community and increase the awareness of both the hospital staff and administration and
- b) facilitate the design of interventions to improve the working conditions in the hospital and promote well being of the hospital staff.

With the aid of ISPM, a team of experts was brought together. The team included two work safety specialists, the hospital's safety officer, one hospital employee representing the workers' union, one representative of the hospital administration and one medical student. The subproject team determined that the primary subproject objective should be the identification of occupational risks in the hospital and the registration of the delays in the application of Greek and European Union legislation, concerning hygiene and safety in the hospital. The long-term objective would be the implementation of a wide intervention program to solve the identified problems in the area of hygiene and safety and to create a periodic-preventive program for the surveillance of staff health. To serve the subproject objectives the following phases of development were designed:

- a) completion of a comprehensive review of the existing national and European legislation on hygiene and safety in hospitals;
- b) systematic registration of all hospital activities in order to identify potential occupational hazards;
- c) completion of a questionnaire based survey of the employees' knowledge of and attitude towards occupational hazards;
- d) design of interventions in high risk areas;
- e) development of a health promotion program for the staff;
- f) incorporation of the subproject in the daily hospital routine.

In the first year of the subproject implementation (1993-1994) all existing Greek and European laws and regulations were thoroughly reviewed by one of the work safety specialists with the aid of a medical student. During the first year of subproject implementation, hospital plans were also reviewed and the second phase of the subproject was designed.

In the two years to follow (1994–1996) the second and third phase of the subproject were realized. Two members of the subproject team carried out an extensive on-site

investigation across the hospital premises. The randomly selected sites were: department of surgery (wards, operating rooms and intensive care unit), pathology laboratory, endocrinology laboratory, nephrology unit, hematology laboratory, blood bank, microbiology laboratory, computerized tomography and magnetic resonance tomography units, kitchen and employee cafeteria, linen and washing services, outpatient clinic and experimental surgery laboratory. The investigation process included an unannounced visit and detailed physical inspection of premises together with staff interviews. Finally the head of the unit was contacted and asked for remarks and suggestions. Results of the second phase were analyzed and presented to the hospital administration and employees' union and the process of phase three and four was initiated. Despite of the project still being incomplete, several data have already accumulated and important preliminary observations have been made. Many areas of increased occupational risk have been identified and carefully planned interventions are under way. In addition, based on the findings of the initial study, a staff vaccination program as well as an anti-smoking campaign are being planned.

Training of young mothers on neonatal care and breast-feeding

The Department of Obstetrics and Gynecology is the second biggest department in Areteion and one of the biggest in Greece. Programs for health education of young mothers on neonatal care and promotion of breast-feeding had been initiated a few times in the past only to be abandoned after the first practical difficulties were encountered. In 1993, when the AHPH project started, no program for the training of young mothers in their new role as care providers for their babies, was in place. This gap was occasionally filled by family physicians or pediatricians after discharge from the Hospital; however, many young mothers – especially those with a lower socioeconomic background – had limited access to those resources.

In May 1993, aided by ISPM, the Areteion HPH Project Steering Committee decided to pursue the development of a health education program targeting women in the Hospital's maternity ward. A subproject team was formed, consisting of one pediatrician, one gynecologist, one specialist in social medicine, one social worker, two nurses and one medical student. First, a benchmark study was carried out, in order to evaluate existing knowledge and attitudes towards issues of neonatal care and breast-feeding. One hundred and eighteen women, who delivered in Areteion during a period of four months, were included in the sample. Data were collected through personal interviews based on a standard questionnaire. Analysis of the women's responses showed that 85% of them had no contact with a specialist on perinatal care. 73% reported that they were able to take care of their newborn after returning home. 91% intended to breast-feed their newborn even though only 20% had discussed this with a specialist about breast-feeding. In addition, 88% of the women surveyed believed that breast-feeding was beneficial for the mother while 99% believed this practice to be beneficial for the child. Based on the above data, an intervention program was designed and was incorporated in the daily activities of the ward during a two-year period (1995-1996). This program included carefully standardized talks to small groups of mothers as well as „hands-on“ demonstrations on the practical aspects of neonatal care and breast-feeding, followed by a session where women were en-

couraged to discuss all their questions and concerns with the subproject team. Following the intervention, an evaluation was carried out based on completion of the same questionnaire as before the intervention (Table 1).

Table 1: Results of the evaluation survey of the subproject „training of young mothers on neonatal care and breast-feeding“

	Before	After	P
Feel capable to take care of their baby, after re-entering home	85%	82%	0.001
Have the intention to breast-feed their baby	93%	90%	0.001
Know the care of breasts during breast-feeding	50%	82%	0.001
Know the handling of the baby during breast-feeding	74%	84%	0.001
Know what nutritional habits the mother should follow during breast-feeding	65%	73%	0.001
Believe that breast-feeding makes good to child's health	100%	98%	NS

The results of the post-intervention survey demonstrate a significant improvement of knowledge on practical aspects of the newborn's care. However, issues related to the attitudes of young mothers (e. g. intention to breast feed) remained unaffected. It is possible that psycho-social factors emerging after birth are more important than improved scientific knowledge in determining the choices of the mothers. The subproject is currently under evaluation and a different intervention with a behavioral change component is being designed (Tsamandouraki, Giannaki, Xanthi, Arkadopoulos 1996).

Early diagnosis of neonatal hearing loss and prevention of mutism

As mentioned above, the maternity ward in Areteion Hospital, despite providing excellent clinical services, never extended its traditional clinical activities into preventive medical and social action. In 1995, following a suggestion by Dr Th. Papastavrou, the Areteion HPH Project Steering Committee decided to introduce a subproject aiming at the secondary prevention of neonatal hearing loss through a generalised, screening programme in the maternity ward. Early detection is generally believed to lead to early speech rehabilitation and prevention of mutism. The timing for testing has been placed at the neonatal aged because the whole neonatal population can be captured in maternity hospitals.

The screening technique used was the detection of Evoked Otoacoustic Emissions (OAEs). This relatively new technique presents several advantages over the alternative Brain Evoked Response Audiometry (BERA), including higher sensitivity, low cost and ease of use. Neonates with questionable or abnormal responses were subsequently tested with BERA because of its higher specificity.

The subproject committee determined that a pilot phase should precede development of the full program since it was the first time that such an extensive program of

specialized secondary prevention would be introduced in the maternity ward and un-anticipated difficulties might arise.

In the initial pilot phase 187 neonates were tested and 34 of them (18%) were found to have questionable OAEs and were referred to a specialized neuro-otologic unit for re-testing first with OAEs and then with BERA. Neonates with definitive positive findings were eventually referred to the appropriate specialist for treatment.

The pilot phase of the subproject helped the subproject team accumulate important experience on how to set up and carry out a complex-high technology prevention program in the maternity ward. Several practical difficulties were encountered, most notably the high background noise of the ward and the sub-optimal coordination between the research team and the ward staff in preparing the babies for the examination (feeding time, moving babies, etc). It is believed that those technical problems are responsible for the unduly higher than expected incidence of positive test (18% observed vs. 10% expected).

Currently, the program is being re-designed in order to overcome the practical problems identified during the pilot phase. It is expected that the newly designed program will fit better the characteristics of the maternity ward in Areteion and will be incorporated in the normal ward functions (Papastavrou, Giannaki, Malamitsi 1996).

Control of hospital acquired infections

The aim of this subproject was to develop a structure for the continuous control of hospital acquired infections. Although similar programs had been initiated in the past, none had been established as a standard system of studying nosocomial infections occurring in Areteion. The HPH Project Steering Committee considered this a high priority subproject with a big potential for improving patient outcomes, decreasing length of hospitalization and cutting costs.

The subproject group included four microbiologists, one research nurse, one epidemiologist and two medical students. A questionnaire-based benchmark study of all surgical patients was completed in October 1993. The questionnaire registered a variety of parameters including all known risk factors for the development of nosocomial infections. Data from 193 operations were analyzed. These data included 72 general surgery patients and 121 obstetrics-gynecology patients. Thirty-three patients were men and 160 were women. Twenty operations were characterized as „emergencies“ while 173 were „elective operations“. According to the official classification of surgical procedures, 31 operations were „clean“, 141 were „clean-contaminated“, 18 were „contaminated“ and three were „dirty“. The following risk factors were studied: a) presence of urinary catheter, b) presence of intravenous catheter, c) length of preoperative hospitalization, d) time of shaving before the operation, e) duration of the operation and f) type and dosage of antibiotic prophylaxis. Multiple regression analysis revealed that the decision for the type of antibiotic prophylaxis was independently associated with the classification of the operation as „emergency“ or „elective“ and the presence of risk factors such as diabetes, cancer, etc. The nosocomial infections identified (3.6%) were found to be independently associated with the duration of antibiotic prophylaxis and the presence of intravenous catheters. Several useful conclusions were derived from that benchmark study:

- a) Although the nosocomial infection rate in Areteion Hospital was relatively low, several risk factors were identified.
- b) Shaving on the previous day, scheme of antibiotic prophylaxis and length of preoperative hospitalization were identified as the main areas with room for improvements (Figure 2).

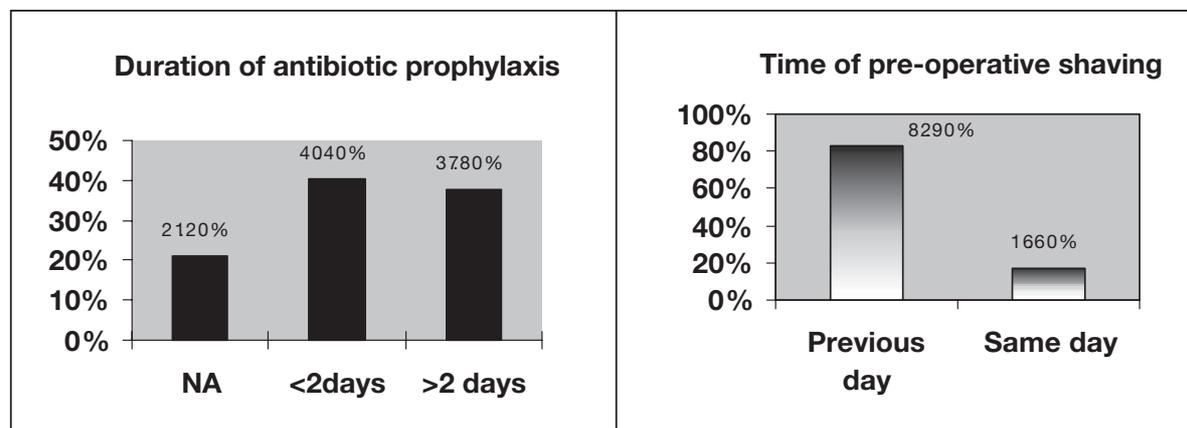


Figure 2: Identified risk factors for nosocomial infections

Despite the intervention phase still being incomplete, the subproject on hospital acquired infections is widely thought to be responsible for extensive improvements in the understanding of the epidemiology of nosocomial infections and for the re-activation of the Hospital's Nosocomial Infection Committee, which is currently using the accumulated data and expertise, in order to incorporate active infection prevention in the daily functions of the wards.

Study of patient satisfaction

The patient satisfaction subproject was launched in Areteion in order to identify patients' opinions about how health care is delivered in the Hospital. Following analysis of weak areas in patient satisfaction, appropriate measures would be designed and implemented in order to address the specific problems identified.

All aspects of hospital services were scrutinized by having the patients fill in questionnaires anonymously. When participants were asked about the extent of their involvement in decisions about their medical care, they indicated that their participation in decision making was very good in 60% of the cases. The amount of time dedicated by doctors and nurses to patients was deemed by most of the patients adequate. Some differences appeared to exist between nurses and doctors in the way of building up an effective relationship with their patients. Most of the patients reported that it was very easy or somewhat easy to find someone from hospital staff to talk about their personal concerns and most of the times this person was their physician. Most of the patients stated that they always trusted their doctors and most of the times their nurses too. One third of the patients felt that their opinion about practical aspects of their treatment was not taken under consideration by the Hospital staff. Additional problems were revealed in the areas of ward furniture, cleanness, noise and quality of food. Furthermore, 25% of the patients reported the appearance of sleep problems

during their hospitalization. Finally, three quarters of the patients stated that the overall quality of care and the quality of services in Areteion were excellent, while one fourth stated that it was very good or good. Analysis of these very interesting findings is still in progress. Interventions are currently being piloted in three areas of high priority namely: ward cleanness, patients' sleep problems and patients' involvement in decision making. In addition, a survey of patient satisfaction as a standard part of the patient's discharge process, is currently being designed.

Quality assurance of the surgical services

The aim of this subproject was to develop an electronic medical file and a hospital information system for the improvement of surgical services. The subproject group included several hospital informatics specialists as well as staff physicians and medical students. The schedule of the subproject development included design of an electronic medical file, implementation, evaluation and finally modification of the pilot scheme, using the remarks of the involved hospital departments. The ultimate goal of the subproject would be to use the electronic records in order to develop techniques for quality control of the surgical services.

Computerization of medical record in Areteion Hospital has proved to be a major task. The main reasons for this, were

- a) lack of experience in this field throughout the country;
- b) lack of flexibility in the organizational structure with subsequent difficulty to accommodate major changes;
- c) health professionals' attitudes, who show for various reasons a remarkable reluctance to adopt those changes.

Nevertheless, the major effort, which was made in Areteion University Hospital, to proceed, despite constrains and cultural obstacles, has resulted to a significant change in our initial plans. The type of Electronic Medical Record (EMR), which was chosen in the beginning, could not meet, from the technical point of view, the hospital needs as a whole. Thus, the initial plans had to be revised. The subproject team had to redesign not only the structure of EMR but especially its links with all other departments and units of the hospital. By doing so, the primary, long-term aim to improve the quality of medical care and the efficiency of services would be facilitated in the best way possible. Redesigning and finalizing the type of EMR for each clinical department was a long process, which did not involve many users. However, at the end, everyone's comments were taken into account. The most important underlying principle was to build a system from which the user could easily extract clinical information and combine them with demographic data of the patient along with organizational data of the hospital. Until now, a wealth of statistical indicators related to clinical care has already been developed. These indicators can easily identify inefficiencies in the quality of clinical services, as well as managerial problems of the hospital.

Although this subproject is still in progress, a first assessment from clinical departments indicate that clinicians are much more thoughtful and careful in their clinical practice, knowing that all activities are recorded and can be used for research purposes.

Failures and successes in the long road to a Health Promoting Hospital

Despite an initial acceptance of the HPH idea by the Hospital community, the Project started in Areteion under unfavorable conditions. Limited resources and lack of previous health promotion experience and training made the future look uncertain. In addition, the already mentioned characteristics of the patient population in Areteion made patient-oriented health promotion look like an impossible task. Finally, many members of the Hospital community feared that health promotion activities would be distracting to the traditional clinical functions of the Hospital that was focused on offering high-tech specialized care to a seriously ill patient population.

Absence of health promotion background proved to be a limiting factor during the initial stages of the Project development, when the innovative concept of health promotion had to be introduced to the Hospital community. However, this gap of knowledge was quickly filled by the expertise of ISPM consultants and did not affect the Project development beyond the first difficult year. On the contrary, two other issues would become the major sources of problems during the development of the Project.

Financial resources

Financial problems of the Greek Health System did not allow for sufficient financial support of the HPH Project in Areteion. Contributions by a corporate sponsor (ERGO S.A) during the second of the Project provided a temporary relief but did not reach the funding level required to keep the Project development on schedule. In view of the severe budget limitations, offer of a significant amount of voluntary work by the Hospital staff and medical students (average total = 3.777 hours of voluntary work offered per year) proved critical for the Project survival.

Staff shortage

Directly related to the financial problems, understaffing of hospitals is a major problem throughout the Greek health system. In particular, nurses and specialized technical personnel are in short supply. Since the first steps of the AHPH Project, it became evident that any addition of extra activities to the existing workload of the wards would compromise patient care functions and impose extreme stress on the personnel. Two strategies proved successful in overcoming staff shortage problems:

- a) extensive utilization of any external sources of assistance- mainly ISPM and medical students and
- b) mobilization of staff physicians with the use of HPH-related research opportunities as an incentive.

Medical students proved to be a major resource for the Project. Strong links between Areteion and the University community allowed for students to participate in almost every subproject, under the guidance of members of the University faculty. This collaboration proved extremely fruitful. Medical students gained valuable experience in all aspects of planning and development of health promotion projects in a hospital; they also became familiar with innovative concepts in hospital care and had the opportunity to participate in health promotion related research. On the other hand, the

Project benefited not only from the extra manpower but also from the enthusiasm and energy invested by medical students as well as by their critical thinking and creative suggestions.

Development of motivation strategies for staff physicians was a major challenge since their attitudes towards the HPH concept were widely variable ranging from complete disapproval to enthusiastic acceptance. For the less motivated physicians, offer of opportunities for research and publications through participation in the HPH Project, proved to be a strong motive. Finally, Hospital doctors turned out to be one of the most active groups and had a major contribution in the Project's accomplishments.

Unfortunately, despite the imaginative efforts of the Steering Committee, the two major problems of funding restrictions and staff shortage persisted through the Project duration and compromised its development by causing serious delays and deviations from the initial planning. Three subprojects had to be cancelled:

- a) Rational use of antibiotics with the use of a national database
- b) Total quality management in the nephrology department
- c) Study of the quality of life in the Hospital community with the use of the SF36 questionnaire.

In addition, exciting new subprojects (e. g. health promoting employee cafeteria) never made it beyond the stage of planning.

Due to the already mentioned delays, all subprojects are still under progress with some of them being close to completion. A large study aimed at evaluating the overall HPH Project in Areteion is currently under way. Although the impact of the Project cannot be fully appreciated before final data from the evaluation studies are scrutinized, there are several preliminary observations on „successes“ of the HPH experiment that merit further analysis.

Organizational changes

In our view, the most important gains from the HPH Project in Areteion were the novel organizational experiences associated with the Project development. First, the value of teamwork was exemplified by the success of the subproject groups. The development of every single subproject was a lesson in collaboration across organizational boundaries for the sake of effective outcomes. Putting the team's objectives ahead of one's own and commitment to quality outcomes were two of the important values that were experienced in subproject teams and had a cultural impact on the hospital community. Furthermore, on an administrative level, important experiences in planning, approaching problems through expert teams and translating a long-range strategy into meaningful actions were acquired during the Project evolution.

Sharing of the experiences was greatly favored by the small size of Areteion; moreover, this factor greatly enhanced flexibility and speed in decision making and facilitated the testing of innovative ideas during the Project development.

Effective staff motivation was another important organizational accomplishment within the HPH Project. This was achieved through applying three strategies:

- a) development of subprojects that aimed at promoting safety in the workplace and staff well-being;
- b) development of internal communication of the project (e. g. staff meetings, newsletters, etc.) and
- c) introduction of specific incentives for the different groups in the Hospital community (e. g. research opportunities for the physicians, internal advertisement for the nurses, etc).

On average, nine percent of the Hospital staff actively participated in project groups, while another 30% got involved at some point of the subprojects' evolution. Significant annual increases of both the rate of staff involvement and the amount of voluntary work offered were among the major successes of the project (Figures 3 and 4) (Arkadopoulou, Tsamandouraki, Tountas, Papadimitriou 1997).

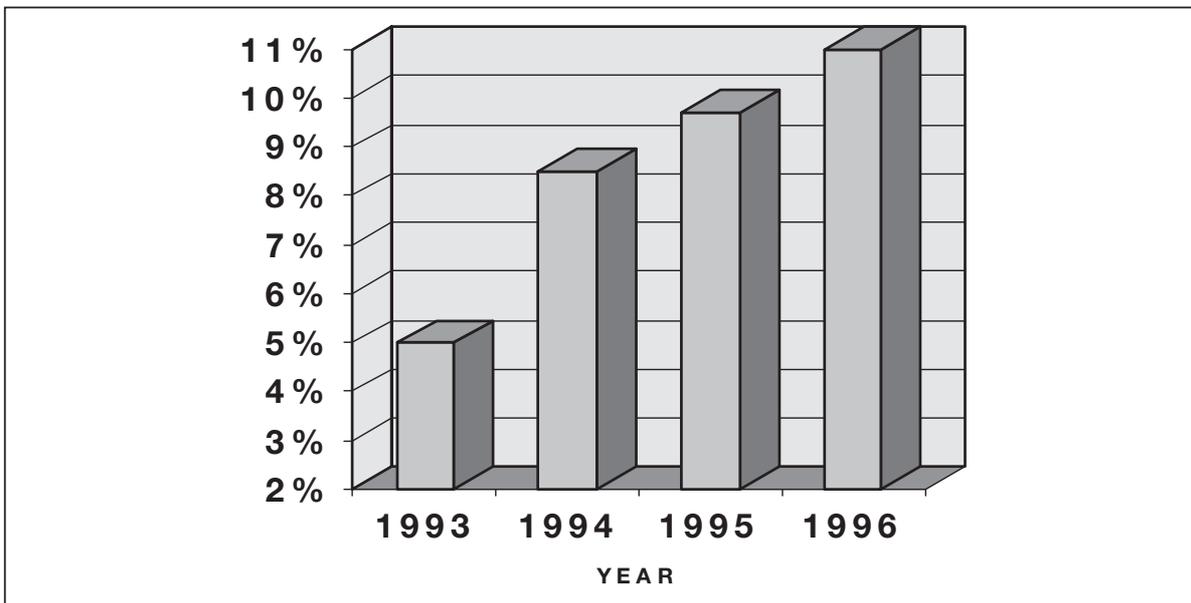


Figure 3: Staff involvement in subprojects (percent of total hospital staff)

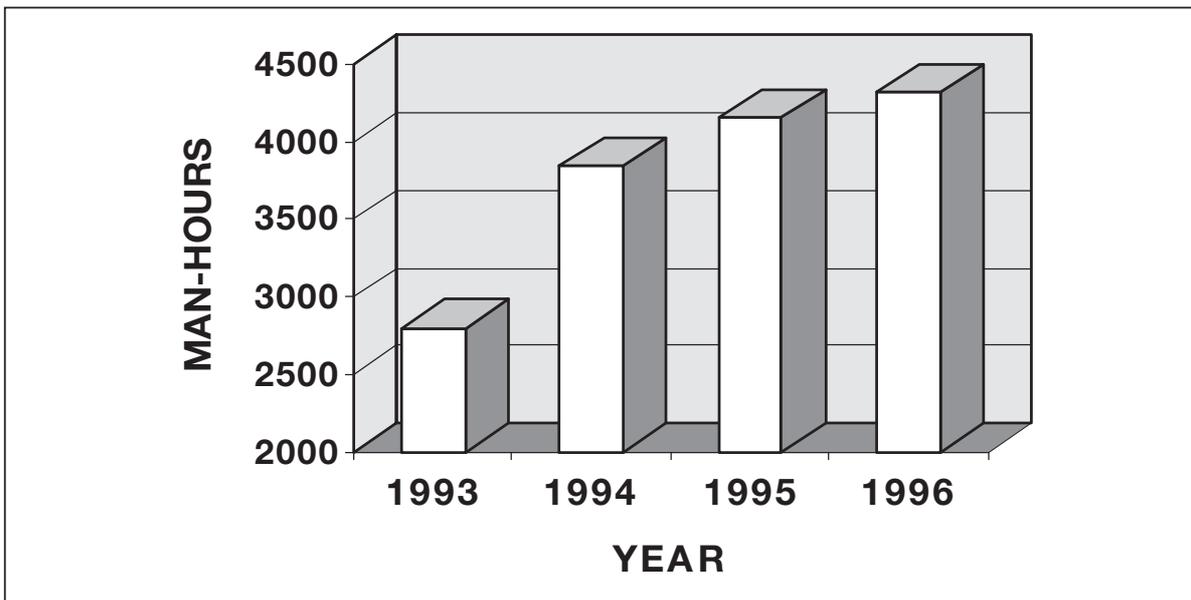


Figure 4: Voluntary work offered for the Areteion HPH Project

In conclusion, as in the case of successful staff motivation techniques, the HPH Project offered a wealth of examples for the effective utilization of hospital resources; however, these valuable experiences cannot be translated into managerial practices before the ongoing evaluation studies are completed and their results carefully analyzed.

Specific changes related to specific subprojects

The introduction of various health promotion practices in the daily hospital was another important outcome of the project. For example, adoption of measures related to the prevention of nosocomial infections, increase in occupational hazard awareness and improvement in understanding of the patients' sleeping problems are direct results of the Project implementation. Gains from individual subprojects are expected to increase with time as existing health promoting activities expand in the Hospital and new subprojects are being added.

National transfer of experience

Based on the experience of Areteion, development of a national network of health promoting hospitals has already been initiated (Tountas, Tsamandouraki, Pavi, Arkadopoulos 1997). By the end of 1997 five hospitals had already joined the new network and Areteion is expected to play an essential role in the expansion of the HPH idea in the Greek health system. However, more work is needed on a political level, in order to design meaningful interventions in the Greek health system based on the experience gained from the Areteion HPH Project.

The true impact of the HPH project both on Areteion and on the Greek health system in general, cannot be fully appreciated before all evaluation studies are completed and analyzed (Pavi, Tsamandouraki, Arkadopoulos 1997). However, during the past four years, we have witnessed a significant change in Areteion Hospital; the integration – to a varying degree – of the health promotion idea in the values of the Hospital staff and administration. Awareness on health promotion issues greatly increased among the Hospital community and a health promotion culture started to develop in people with no relevant background in before. Areteion started to move beyond its traditional clinical care activities towards a new image of a „healthy hospital“ i.e. an institution that promotes health for its patients, staff and the local community. Southern European problems such as lack of financial resources and poor tradition in health promotion were effectively balanced by the enthusiasm of people involved in the Project.

Finally, for hospitals with similar size, structure, background and resources as Areteion, four years worth of HPH wisdom, can be summarized in four recommendations:

1. Staff health and well-being has to be the primary consideration of any HPH Project.
2. Communication and motivation strategies are the most important tools for the implementation of the HPH idea.

3. Collaborations at both national and international levels (e. g. participation in networks) are of paramount importance for the Project survival.
4. Transition to a Health Promoting Hospital can be a long and painful procedure that requires major investments of resources and enthusiasm. However, at the end of the road, progress prevails over the strongest tradition.

References

- Abel-Smith B., Caltorp J., Dixon M., et al. (1994): Report on the Greek Health Services. Farmetrica, Athens
- Androutopoulos D., Kyriopoulos J., Georgoussi E. (1993): An attempt of measuring the private health care expenditure in Greece (1970–1990). *Archives of Hellenic Medicine*; 10:204–209
- Arkadopoulos N., Tsamandouraki K., Tountas Y., Papadimitriou J. (1997): Areteion Health Promoting Hospital (AHPH) Project: Overview of a four-year experience. 5th International Conference on Health Promoting Hospitals. Vienna, Austria
- Ferrera M. E. C. (1993): Citizens and social protection: main results from a Eurobarometer Survey Committee of the European Community. Brussels
- Iatridis S. G. (1987): Health care system in Greece. *Lancet*, 792–794
- Mamas Th., Karokis A., Polysos N., et al. (1994): Study for the planning and organisation of health services: analysis and structure of the system. Ministry of Health, Athens
- OECD (1993): Health Data 1993. Paris
- Papadimitriou J., Tsiftsis A., Prahalias A., Papadimitriou K. (1997): Surgery in Greece. *Archives of Surgery* 1997; 132: 224–231
- Papastavrou Th., Giannaki G., Malamitsi A. (1996): Early detection of perinatal hearing loss for the prevention of mutism. 4th International Conference on Health Promoting Hospitals. Londonderry, N. Ireland
- Pavi E., Tsamandouraki K., Arkadopoulos N. (1997): Overall assessment of the pilot HPH project of Areteion Hospital. 5th International Conference on Health Promoting Hospitals. Vienna, Austria
- Skalkidis Y. (1991): Greece: health systems in the 12 member states. In: Leadbeater N. (Ed), *European Health Services Handbook*. London: European Health Services and Management Association; 81–84
- Tountas Y., Stefanson H., Frissiras S. (1995): Health reform in Greece: planning and implementation of a National Health System. *International Journal of Health Planning and Management*; 10: 283–304
- Tountas Y., Tsamandouraki K., Pavi E., Arkadopoulos N. (1997): The Greek HPH Network. 5th International Conference on Health Promoting Hospitals. Vienna, Austria
- Tsamandouraki K., Giannaki G., Xanthi S., Arkadopoulos N. (1996): Knowledge of and attitudes towards perinatal care and breast feeding issues of young mothers in Areteion Hospital. 4th International Conference on Health Promoting Hospitals. Londonderry, N. Ireland

The Korányi Institute in Budapest as Hungarian Health Promoting Pilot Hospital

László Kautzky, Tamás Halmos



Korányi Institute, Budapest

Project Coordinator(s):	László Kautzky
Contact:	Országos Korányi tbc és Pulmonológiai Intézet Pihenő ut 1 H-1529 Budapest XII Tel. and Fax: +36/1/2002-879
Hospital Owner:	Ministry of Welfare
Hospital Ownership:	Public
Specialisation:	Pulmonology, Internal Medicine, Cardiology
Beds:	759
Staff:	Medical Staff: 114, Nursing Staff: 274, Other Staff: 622, Total Number of Staff: 1010
Utilization:	Average Utilization of Beds/Year: 95.6 %, Average Duration of Stay in the Hospital/Day: 16
Patients:	Number of Inpatients/Year: 14 500, Number of Outpatients/Year: 15 300
Number of Departments:	21
Location of Hospital:	Suburbs/rural
Catchment Area:	National and regional, Number of Population: 500 000, in special cases from all over the country
Other Functions than Medical Care:	
Teaching:	Medical Students, Postgraduate Students, Nursing Education, Other Health Professions: Social-worker training
Research:	Clinical Research, Basic Scientific Research Professional Supervising of National Pulmonary Network:
Subprojects:	1. Patient Education Programme 2. Healthy Nutrition 3. Postgraduate Training of Nurses 4. Individual Health Protection of Staff 5. General Hygienic Programme

The National Background of the Koranyi Institute Health Promoting Hospital Project

The National WHO Health Promotion Strategy in Hungary

Hungary has been cooperating successfully with WHO for several decades, mainly in developing the new health policy. WHO started assisting the elaboration of the health promotion programmes in 1988. Thus a serious step was taken toward prevention and health protection, instead of giving priority only to curative medicine.

After the radical political and economic changes in Eastern Central Europe the European Regional Committee created the EUROHEALTH programme in 1991, aimed at assisting the development of health care in the European countries including the Eastern ones. The programme consists of short, medium and long-duration subprogrammes. At least 20 countries have Regional Offices led by a liaison officers. The main aim of the programme is the amelioration of the health situation of the whole population and the decrease of differences between the health services of the countries involved.

In Hungary a new policy called “Health of the Nation” was introduced in 1989. The Chief Medical Officer and his co-workers elaborated a directive which was debated nationwide. WHO experts helped the health-policy makers in the implementation of the new paradigm and in evaluating and monitoring the present health situation. The Ministry of Welfare was supported by WHO-EURO and other agencies with considerable advice for this programme of modernization.

The World Bank and PHARE programmes are assisting the project through financial aid in cooperation with other highly developed countries.

The Eastern-European countries are in special need of a new health policy, owing to the very bad circumstances they are in. Behind the unhealthy and harmful lifestyle of their inhabitants there are many socio-economic causes. These lead to a degree of stress which is nearly unbearable for the people living in our countries.

Among the big “killers” are smoking, unhealthy nutrition, alcoholism, drug-abuse, crime and other deviancies. Behind these are social factors like unemployment, a general uncertainty as to living conditions, and no perspective for the future.

Becoming aware of the fact that these deviancies could completely destroy and terminate the life of a nation, Hungary reoriented its health policy along WHO’s Health for All Project. At present most of WHO-Euro’s health promotion programmes are represented in Hungary:

- *Healthy Cities*: since 1986. In 1992 a National Foundation became the project owner. 13 cities are currently involved in the project.
- *Health Promoting Schools*: It started its work in 1990 and comprises 10 schools today. The main aim is to integrate the principles of health into school curriculums and to involve teachers and parents in the healthy lifestyles movements.
- *Health Promoting Workplaces*: was initiated by the National Institute of Occupational Work some years ago with two subprojects (i. e. non-smoking and noise-reduction at the workplace).

- *Healthy Villages*: was started in 1994 by the Hungarian Red Cross in close co-operation with the Healthy Cities Project.
- *Health Promoting Hospitals*: was initiated in 1991, shortly after the Budapest Business Meeting where the first “Declaration” of this International Network was set down. *The Korányi Institute* acted as the Hungarian Pilot Hospital, and is now also co-ordinator of the National Network of Health Promoting Hospitals founded in 1994.

Beside the Ministry of Welfare, an independent organisation co-ordinates the Health Promotion efforts. It works as a WHO Co-ordinating Centre, and organises and supervises the activities.

A Short Overview of the Hungarian Health Services

The basic questions for the health services are: Where does health arise and where does it get lost. As we know now, this is not only a concern of the health-care system. No one can trust in the health-care services to keep everybody alive forever and in a healthy state, whatever people do. Accordingly, the health-care system alone cannot be blamed for the decline in health and the increased morbidity in our country (Table 1).

Table 1: Health statistics in Hungary

Number of population	10 210 000
Active	4 470 000
Pensioner	2 983 000
Live birth / 1000	11,0
Mortality rate / 1000	14,2
Number of doctors	42 635
Hospital doctors	13 640
Paramedical doctors	129 000
Panel doctors	5 011
Patient-doctor visits x 1000	101 693
Hospital beds	82 867
Average utilisation of beds %	71
Average duration of hospital stays/days	10,8
Life expectancy male	65,3
female	74,5
Health expenditure (% of GDP)	5
Health expenditure / capita (USD)	220

It is so far evident that the social, economic, cultural and political background serves as the main determinant of the health situation of a nation. This is not a matter of an individual alone, but the problem of the whole society. The right and appropriate health policy together with a more comprehensive national policy can create proper conditions for healthy life, as it is not possible to conduct the efforts to improve health in a political vacuum. It is indispensable to deal with governments' health promoting actions and cultural attitudes towards health as a whole.

Now, there is an increasing difference regarding technically possible, medically needed and economically feasible services. The population is decreasing, the birth-rate is lower and the number of elderly people is growing. Resources are getting lower and lower. The GDP has reached the level of twenty years ago.

However the main characteristics are:

- not enough medical and paramedical personnel;
- the state of infrastructure, buildings, equipment is not up-to-date;
- the availability of services is generally good but unevenly distributed, great regional differences can be found;
- life expectancy is low (69 years on average);
- a high mid-age-group mortality, morbidity;
- a high rate of suicide, alcoholism, deviant behaviour, environmental hazards, etc.;
- prevention is underdeveloped;
- personnel is underpaid;
- the annual health expenditure is 270 USD/capita.

Very closely correlated, additional determining components of the present day health hazards are:

- a lack of positive life models;
- a lack of health education and underdeveloped abilities for self-care and self-help;
- an enormously increased self-exploitation, etc.

These factors deeply influence people's health attitude and pose a great challenge for the health services.

The Structure of Health Care

The health services organisation functions on three levels. The basic level consists of the general practitioners /GP/, who take care of the greater part of the patient, but only in simple, not serious cases, which can easily be treated by them. There are a total number of about 5000 panel doctors in our country and 1500-2000 citizens „belong“ to each of them. But the patient/doctor (GP) visits are approx. 130 000 000 per year! However, they have too few facilities and possibilities for their curative work.

They have a lot to do, many tasks and responsibilities, and owing to this, they are overburdened. In the first place they have the role of a dispatcher.

The second level is the outpatient-specialist consultation offices where the patients are sent by the GPs, where much better equipped laboratories and examination facilities are available to help doctors to find diagnosis.

The third one is the hospital level in which our institution is also involved. This layer represents the top level in our health-care system today .

The above mentioned levels are at different levels of development. During the last 30-40 years the hospital level was developed extensively. Many hospital beds were created, many hospitals were built, as this symbolised the socialist way of people’s public health. Now it became clear to everybody that hospitals are the most expensive form of health-care. The two other levels were kept underdeveloped and so became insufficient for their main task: to protect the citizen’s health. The whole structure can be seen as a pyramid, turned upside down. (Figures 1 and 2)

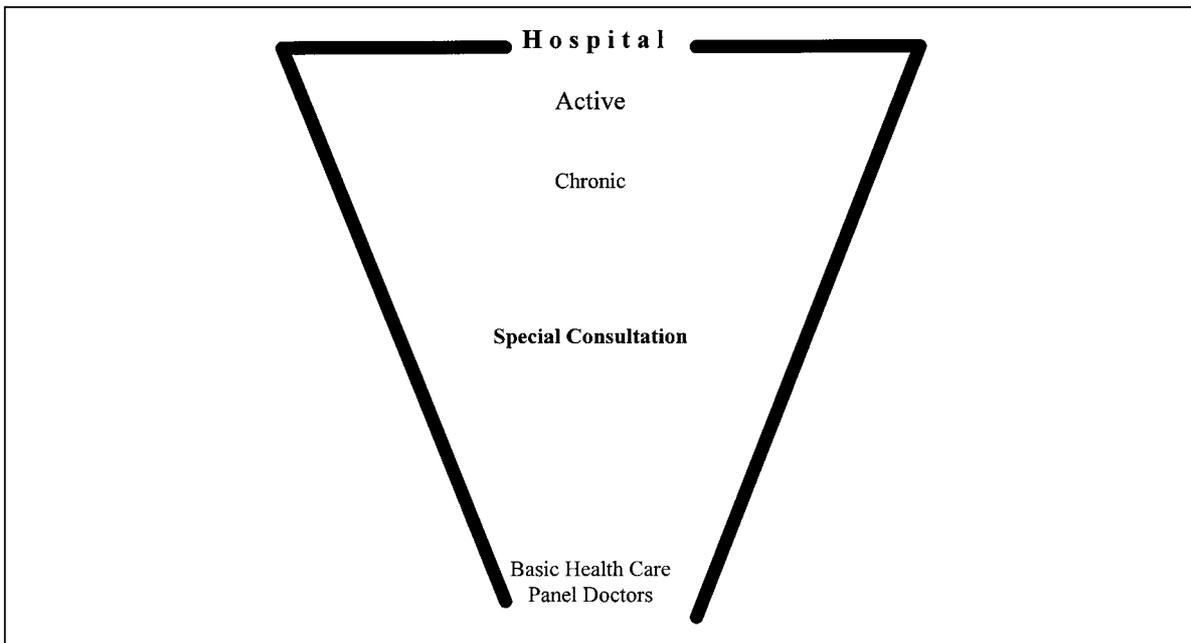


Figure 1: Present status

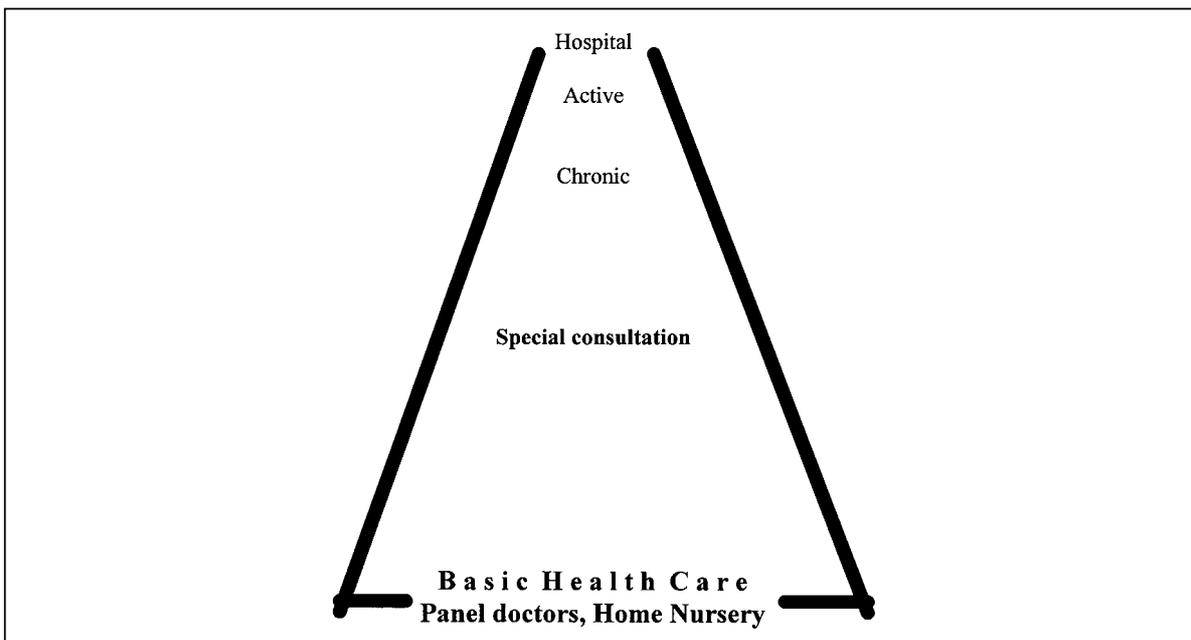


Figure 2: The planned reform status

Forthcoming Changes in the Health Care Sector

The main problem in our country concerning health services is their inappropriate and disproportional structure compared to the needs of the population.

In the new health policy the decision-makers are planning to make radical changes. Hospital-centred medical care is not maintained any longer, and the biggest role is passed onto the basic care level, the outpatient-services, perhaps even in hospitals as well. The main targets of this new paradigm are:

- strengthening the role of public health;
- primacy of prevention over cure;
- elaboration of health-supporting state policy by all sectors of the governmental fields (agriculture, industry, marketing culture, etc.);
- the elaboration of a compulsory insurance system to guarantee basic health-services for all;
- decentralisation of the structure of health care management;
- involving private sector in health services;
- improving availability, abolishing inequality in the capacity of health care; and
- economic use of resources.

One step will be to reduce the number of hospital beds radically by the beginning of 1997 (from nearly 100 000 to 80 000). This will cause a lot of trouble, because the plan was created only from a monetary point of view and does not take medical interests into consideration. There is a Health Bill, which was already accepted by Parliament several months ago, supporting the legislation of these abrupt changes, which seem to be reasonable financially only and do not take care of human and medical consequences which can be foreseen well in advance, as the “background” health service resources will not be able to bear this overwhelming „weight“ yet. It is plausible that many sacrifices will be made at the beginning of this new reform, because the health services are not prepared to accept and perform the necessary steps so suddenly. This method of implementing reform principles is in contradiction to the health status of the whole country. The resulting health parameters can be expected to become worse soon, – the first sorrowful consequences are already visible now, as the GDP has fallen under the level of 1978–80. Although the medical profession is also aware of the need for reform, the way it is done now is being seriously criticised. The number of contagious (tbc) and non-contagious (cardiovascular, cancer) diseases are increasing, the morbidity parameters are rising. The serious reduction in the number of beds at the hospital level called „reorganisation“ by decision makers is called restriction by health service people. (Table 2)

One of the consequences that can be expected, is a changing role of hospitals in health promotion and health education work. The accent will be moved towards basic health care. Some aspects of the duty and tasks of hospitals will change.

Education will play an enormous role in everyday life because the layman level of patients’ care is to be developed too. This is a brand new conception which was unknown in Hungary until now (Table 3).

Table 2: Present problems of the health service reform

<ul style="list-style-type: none">● restrictive financial support● reduction of hospital beds and expenditures● liquidation of several hospitals● lack of improved basic health care● unemployment● unsolved health insurance system● misuse of redistributed allotments● shortage of adequate interests● shortages of long term strategies

Table 3: Objectives of the health policy reform

<ul style="list-style-type: none">● improve the health status of all● improve the efficiency of services● improve the availability● abolish differences● surveyable● controllable● create better social, economic conditions● priority of prevention● multisectoral● source founding● developed basic health service● advanced special out-patient consultation● reduced hospitalisation
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New Horizons for Family Doctors

From now on, panel doctors will have additional competences and tasks to fulfil. They will be the guardians of the population in their care, having to look after them in every medical aspect of life, including health education and the prevention of illness and accidents. We know that health education is a necessary if not sufficient precondition for maintaining and promoting health.

It is necessary, because without appropriate knowledge, conviction and behaviour people can have no health promoting attitude, even given top level conditions. Without a health culture even in the case of other necessary preconditions there can be no healthy lifestyle.

Health education is not a sufficient precondition for health defence either, as in addition the necessary resources and financial-material background (flat, food, clothing, workplaces, political security, etc.) has to be organised by the Government.

The general practitioners will have to regard the somato-psycho-social factors in the generation of diseases. They have to interact closely with all family members using a holistic approach. They have to put fragmented patients together again, whose pieces have been mended by specialists. The family doctors have to know everything from the environment of the patients and the whole community. Their educational work will have to cover all spheres of life.

The GPs have to keep in close contact with hospitals from where they get back the patient after being discharged. They will have to continue the health work started in the hospital. Theirs should be a special supportive, emphatic, open-hearted, conflict-tolerant attitude towards clients. Health education and promotion never ends at the gates of the hospital.

Health Promoting Hospital and Co-operation with General Practitioners

- As the duty of a Health Promoting Hospital changes from that of a normal hospital, so the duty of a panel doctor will have to change as well. They have to work together and not independently of each other. As they will have to involve each other in health promotion work, it will be indispensable for a Health Promoting Hospital to get in contact not only with the surrounding community, but also with the family doctors of that very region. The main aims of this closer co-ordination are:
 - to create citizen-centred/insured preventive health care;
 - to use resources effectively and efficiently;
 - to supply uniformly accessible medical care;
 - to stop misuse and lack of facilities;
 - to reach a balance between demands, possibilities and necessities;
 - to organise, support and supervise lower level, laymen self-care management in the communities.

In the given situation, the above mentioned factors are dreams, plans only. Hungary is now at the beginning of this reform. Nobody knows what the close future will bring. The purely bureaucratic, economic, financial approach of the welfare system, lacking the professional, humanistic, medical aspects seems to be difficult to realise, because this procedure is not at all cheap and is not without serious human sacrifice. The amelioration of the harmful long-term consequences of hurriedly undertaken measures (worsening morbidity) will cost a lot of money later. People's trust and faith in social welfare has been lost, dissatisfaction is growing, the whole atmosphere has become pessimistic. There are great differences in income. The middle class, which is the most important class for a country's economy, culture and democracy, is disappearing.

The GDP is lower than ever, the welfare budget is over 8 %, but this amount is little in absolute value. Under such circumstances what we need is a revolutionary change.

Anybody can imagine how difficult it will be to realise the Health for All WHO principles.

In this country there are some well organised programmes: EPI, CINDI, Stroke, Diabetes Care, Maternity Care and so on. Many of them work in co-operation with some Health Promoting Hospitals, the number of which is increasing since a National Network came alive some years ago.

How the Korányi Institute Got Involved with WHO's European Pilot Project on Health Promoting Hospitals

In 1990 WHO's, Regional Office for Europe (The Healthy Cities Project in co-operation with the Hospitals Programme) and the Ludwig Boltzmann Institute for the Sociology of Health and Medicine organised a meeting on "Hospitals and Health" where representatives from our hospital participated as invited observers. Returning home from this meeting, we discussed the possibilities of joining this movement with our management and stakeholder. In concordance with our authorities and decision-makers of the City of Budapest (and Korányi Institute), we served as host for the forthcoming Business Meeting of Health Promoting Hospitals. At this meeting one of the most important documents, the so-called *Budapest Declaration*, was set down. This declaration is based on the principles of the *Ottawa Charter for Health Promotion* of 1986. At this meeting there was concordance in accepting both the Ottawa and the Budapest documents as strategic framework for the partners involved in the International Network of Health Promoting Hospitals and more specifically the European Pilot Hospital Project. The Korányi Institute applied for membership, which was confirmed soon after.

Before joining the EPHP Project officially, we had to inform the *owner* of the Institution (Ministry of Welfare) in detail, and subsequently also the staff-members of our hospital. The management supported us strongly from the very beginning, but staff members, especially many medical doctors, were uninterested. It took a certain time until the majority of medical and paramedical staff could be convinced to join to this movement. People were uninterested initially, because they didn't know much about health promotion in a hospital setting.

After the staff had agreed, we created a board to decide which project should be involved in the Korány's HPH programme. Board members were as follows: chairman, co-ordinator, economic manager of the Institute, head nurse, hygienist, and chief dietician.

We focused on those projects, which could supply better working conditions for staff and patients and also concentrated on those projects, which could serve as a model not only for patients and relatives, but also for the community.

After long lasting negotiations, five subprojects were selected which seemed to fulfil the above mentioned criteria. Each project was headed by a co-ordinator, who was fully responsible for the implementation of the targeted goals.

The subproject co-ordinators formed the final "Project board". As chairman of this board, Tamás Halmos MD – at that time scientific director of the Korány Institute – was assigned. László Kautzky MD was appointed co-ordinator of the entire project

and fully responsible for it. This board has regular meetings every three months and continuously evaluates the results of each subproject.

At the very beginning of the project the board devised a detailed information leaflet in which we explained the reasons and the necessity of joining the HPH movement.

The Korányi Institute's Subprojects

In the following chapter we will provide an overview on our five subprojects, drawing the background of each of them, characterising successes as well as pitfalls. We describe objectives, aims, methods, results and conclusions of all subprojects.

We applied for a health promotion grant and received some money from the Ministry of Welfare. This was a one-time grant. The money has partly covered the expenses of our subprojects as a fund-raising action. The project work was covered by the hospital budget. The health promoting work itself was done voluntarily without any salary.

The Patient Education Programme

Objectives

Chronic, non-contagious diseases are in the focus of public health. Morbidity and mortality rates in our country are among the worst in Europe and they are getting worse each year. The reason for this, as already briefly discussed, is the critical economic and financial situation. The worsening life-standard leads to a lot of deviant behaviours like unhealthy life-style, smoking, alcoholism, drug-abuse, suicide, destruction of the environment, etc. To overcome and prevent the high morbidity of these chronic diseases, it was of utmost importance to develop and enrich the knowledge of patients, concerning health.

Aims

For three wide-spread chronic diseases, diabetes, asthma and chronic bronchitis and alcoholism, special patient education groups were created. In all of these three groups our aim was to promote a better knowledge of the patients for their respective disease.

Methods

For all chronic diseases three methods were used to reach the above mentioned aims:

- *Individual training.* This seems to be the most effective way, however, it is relatively expensive and time-consuming.
- *Small-group training.* This form is effective, the cost/benefit ratio is better, but it is still relatively expensive.
- *Club-organisation.* This form of education might be less effective, but it has many advantages which the two above mentioned forms lack.

The social characteristic of the club meetings are one of the most important factors. People getting together, suffering from (almost!) the same problems, can open their heart to each other. In exchanging experiences, questions and answers, mutual aid is provided to help accept the handicapped life associated with these diseases.

Usually physicians, dieticians and other experts *present* short *lectures* on related problems at these club-evenings. Different clubs have *different events*, like the presentation of health-foods, respiratory gymnastic, psychological training, etc. There are possibilities to buy healthy food products, supporting pharmaceutical companies present new drugs, etc. The topics of the forthcoming events are discussed and decided upon by the audience. Although the efficacy of the club movement is debated, our personal experiences are rather positive. The colourful picture of the questions and remarks and the active discussions in the clubs are superior to individual or small group educational forms in many respects.

Results

The evaluation of this project is rather difficult. In the “asthma club” for instance, one parameter for evaluation seems to be the reduction of hospitalisation. Avoiding intercurrent infections, refraining from smoking and regular, intensive respiratory exercise are effective methods in achieving these results. The increasing number of abstinent people is a result of effective social work in „alcohol-clubs“. Avoiding acute and chronic complications typical for diabetic patients is a good parameter for the educational work done in „diabetic-clubs“.

As a long-term goal, in accordance with the *St. Vincent Declaration*, (a meeting held in San Vincente-Italy in 1989, dedicated to a better diabetic care in Europe), unnecessary amputations, diabetic blindness and end-stage renal disease should be reduced significantly. Club movements are effectively contributing to this.

To evaluate our work, a survey was carried out among the members of the diabetic-club. The questionnaire included information about patients’ knowledge of different problems concerning diabetes which had been touched upon at club events. The results were pretty variable, but can be regarded as promising. Elderly people usually gave less precise answers than younger patients, but even their replies were in many aspects encouraging, for they gave correct answers in 73 % of the questions in comparison with 45 % participants who didn’t attend regularly.

For diabetes especially, widespread educational programmes already exist, so club movements cannot totally replace these forms. But, as an additive contributinal teaching-system, it seems to be helpful.

Another advantage of club movements is, that among the participants there are always individuals who are not ill themselves, but are relatives of the patients, or friends, etc. In this way the whole community becomes involved. Sometimes we also invite speakers on these topics (experts, well-known professors, even from abroad!) or we invite representatives of the Media, etc.

Conclusion

All three of our clubs are successful, due to the popularity of the events they offer. *Pitfalls are:* the efficacy is still not satisfactory and financial resources are sometimes missing, bringing about difficulties in the organisation of meetings. We have to find different firms to support these events every time.

We have taken the final decision to continue these efforts in attaining better health conditions for these three main disease-forms.

Healthy Nutrition

Objective

As it is well known in Europe, that traditional Hungarian cooking uses a lot of animal fat, pork, salami, sausages, bacon, etc. It also contains much refined sugar and high quantities of animal protein. This overcalorization, which involves more than 50 % of the population, leads to obesity, and increases metabolic disturbances and cardiovascular morbidity and mortality.

Unfortunately the present economic situation supports this unhealthy nutrition, because these kinds of foodstuffs are much cheaper than healthier ones. As unhealthy nutrition seems to be a strong risk factor for the above mentioned diseases both quantitatively and qualitatively, the introduction of a healthier diet was unavoidable in our health promotion activities.

Aims

To introduce a new „reform nutrition programme“ instead of traditional fare, which retains the main characteristics of Hungarian cooking. By this healthy nutrition we hope to reduce metabolic and cardiovascular and maybe also cardiovascular diseases in the future.

Methods

This subproject is based on two pillars. The *first pillar* is linked directly to the patient education programme. In the club meetings – especially in those on diabetic events – we started to advertise a healthier nutrition. During the past decades regular dietetic lectures were held by trained experts, and at the end of the meeting, after a question-answer forum, the participants could taste selected healthy foods as little snacks, and on many occasions there was the possibility to buy these healthy products at a reasonable price.

The *second pillar* was concentrated on the hospital and aimed at improving the situation for staff-member and patients. The main aim of this subproject was to widen the assortment of foods on the menu. The dieticians' work group elaborated a computer-based menu list, regarding the nutritive value of foods, whilst preserving the traditional Hungarian taste of foods.

Conclusion

This subproject is of long duration. Therefore targeted aims like the reduction of metabolic and cardiovascular chronic diseases can be expected only after a longer period of time. The direct effect however, can be evaluated immediately, by the satisfaction of patients and staff.

In comparison with other hospitals, our diet assortment seems to be more varied and tasty. We have managed to implement this reform type nutrition in spite of financial difficulties, regrouping the hospital budget to some extent. Our achievements are mostly the work of our highly qualified dieticians.

For staff-members we supply „normal“, light-mixed, diabetic, low-calorie, and ovo-lacto-vegetarian menus. The majority of the staff choose the vegetarian or low-calorie diet. For the patients we serve 33 different kinds of menus. We can also fulfil in-

dividual demands which can be important in treating metabolic and cardiovascular diseases.

The most significant results of the new catering are: a decreased amount of total fat and cholesterol. The “normal” diet contains 84 g fat/day, one year ago it was 89 g. The Hungarian average fat intake is about 140 g/day! Eggs are used only in the preparation of foods except of course in the vegetarian menu. To supply an appropriate amount of vitamins, minerals and dietetic fibres we serve fresh vegetables, greens and fruit. We prefer deep-frozen products to canned food. As for animal protein, we usually serve low-fat sliced chicken, ham and other poultry. Regarding cereals, we prefer brown bread, rye and bran products.

Many years ago the daily carbohydrate intake for diabetics was prescribed in so called roll units (one Hungarian roll is equal to 30 g), because it contains highly purified white flour with a high absorption rate. Products with high bran content are more advantageous for diabetic and obese people. During the modernisation of catering, where transport and delivery allowed, we introduced individual bed side dish supply beside dining-room service. We also purchased isolated dish containers to keep food hot.

Postgraduate Training of Nurses

Objectives

The nursing staff plays an important role in health promotion. If we regard the quality management of nursing care, the spirit of the *Ottawa Charter* aims at achieving optimal service. Until now the usual nursing care dealt with the ill person only.

Aims

The usual nursing care, traditional disease-oriented work, should be replaced by health-oriented educational activity. This means that nurses should be more active in health promotion and prevention. The main aim of this subproject was to increase nurses' knowledge, professional skills and ability.

Methods

At our Institute there is a special nursing school which offers a special first grade certificate.

In 1996 50 students got their first grade diploma. As side effect of this type of postgraduate training, a total of more than 13 000 working hours had to be substituted by the rest of the staff. Practical training takes place in the different departments, and theoretical training takes the form of plenary lectures. After 10 months of postgraduate training, nurses have to undergo practical and theoretical examinations. Beyond general nursing skills and knowledge, these courses provide the participants with special professional updated data on an advanced level to increase capability, with an emphasis on holistic medical views of different specialisation. The tutors are highly qualified doctors, psychologists, and chief nurses.

As the human and emphatic side of nursing care tends to be neglected, we pay special attention to psychological and mental aspects of nursing behaviour and attitude. To evaluate the level of our nursing care, we elaborated a detailed questionnaire,

which is supplied to each patient at the time of admittance, and which is collected before the patient is discharged.

Results

Our trained nurses are integrated in complex, holistic, integrated patient-care models for patients dying of severe illnesses. We have good contacts with different churches, which assist the medical staff in the spiritual care of patients. As a result we provide the opportunity at national level for special training of paramedical staff working in basic health care (GP's level). We also offer practical training for students training as social workers.

Four years ago a course was begun in Hungary to train higher qualified, so called *diploma nurses*. These students do their practical course and their practical and theoretical examinations at the Korányi Institute.

Last year we started a special course for diabetes nurses. Our Institution and especially the diabetics department serves as host for the practical training and the examinations at a practical and theoretical level.

Conclusion

Our experiences, in concordance with feedback from the patients, present a picture of general satisfaction. The nurses' greater knowledge and professional skills, mirrored in their everyday work, was expressed by the patient satisfaction questionnaires as a quality management device.

Nevertheless there is a severe shortage of much important equipment. The professional and humanitarian side of nursing care is appreciated in the opinion of our patients, in comparison with other metropolitan hospitals. These good results seem to prove the efficacy of intensive and lively postgraduate training of nurses and medical assistants.

Individual Health Protection and General Hygienic Programme for Hospital Staff

Objective

Hospitals are in general dangerous workplaces, regarding bacterial, viral and other kind of infections, because of the risk of contamination with infectious material. There are many chemical materials, widely used in a hospital, which can have toxic effect. There are also a lot of manipulations and procedures which can damage the environment and can cause diseases among patients and staff members.

Aims

Our goal was to avoid the above mentioned harmful and toxic effects of these materials. In accordance with our wider goals, our main target was to effectively eliminate those substances without damaging the environment. For the protection of personnel, we targeted to introduce equipment which is highly *protective*.

Methods

Due to the general elimination process, we reconstructed the old waste annihilator furnace. The new equipment meets all the requirements of the European standard of air pollution. The central heating system was also totally reconstructed.

In the past there had been problems with the quality of drinking water, owing to the very old water-pipe system. During the past years, the old system has been renewed, and now our drinking water is of high quality. Because our Institution consists of many separate buildings (pavilion system), the transportation of food containers creates many problems. Now we have purchased modern properly locked, heat-isolated containers, in which the dish can preserve its fresh taste and temperature.

Regarding individual health protection, we introduced closed blood collecting test tubes, plastic gloves, caps, face masques, disposable isolating towels, surgical gowns, etc. We purchased disinfectant, skin protective fragrant materials as well as paper towels. Regarding sterilisation, we use non-toxic formaldehyde gas instead of toxic aethylenoxide.

The cleaning of the entire hospital is carried out by a professional external cleaning brigade, which is supplied with up-to-date equipment. Where necessary we can perform special test for HIV. We have introduced active vaccination against hepatitis B infection for all those dealing with blood, sputum, urine and other infectious human excrement. For clearing icy slippery roads we now use less harmful MgCl, mixed with sand.

Results

The infection rate of hepatitis B has been reduced significantly, nosocomial infections disappeared among the staff and were considerably reduced among patients. Regarding postoperative and intensive-care patients, there have been no significant epidemiological outbreaks during the last years.

Some HIV positive patients were diagnosed and transferred to the Central Hospital for Infectious Diseases. We created an Antibiotics Committee, which supervises the application of antibiotics, in order to secure effective antibiotic treatment and avoid the unnecessary and misused administering of these drugs. We also introduced oncotherapeutic vacuum boxes for cytostatic therapy.

Because of our high capacity to liquidate harmful substances, we undertake the elimination of waste products for some neighbouring hospitals.

Conclusion

As the Korányi Institute is situated on a hill-side, in the middle of an oak-and pine-forest, it is of paramount significance to preserve nature, its beauty and fresh air. We are convinced that by achieving these goals, our institution provides a more human and friendly environment and atmosphere for staff, patients and visitors.

We believe we are headed the right way in preserving the environment and supplying better and safer working conditions for staff.

The role of Korányi Institute in Setting up the HPH Network

Once one accepts the importance of the concept of health promotion, it seems to be reasonable to try and dissipate the theory. So we started to organise and build up the National Network of Health Promoting Hospitals. The Korányi Institute now works as a co-ordinating and organising centre. We called representatives from the Hunga-

rian hospital associations together for business meetings. Step by step, more and more hospitals were interested and became willing to join the principles of the Ottawa Charter and Budapest Declaration. We presented the results and experiences of our specific subprojects and the experiences gained and learned from the international Pilot Hospital Network. We have learned a lot from the above mentioned events and activities and projects. We were able to realize the great achievements 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 enlist and recruit more members, some 26 hospitals have declared their intention to join the network. Altogether these 26 hospitals run 86 health promoting programmes, which cover 12 different topics:

- Healthy nutrition
- Anti-smoking activities
- Postgraduate courses for nurses
- Hospital hygiene
- Protection of the environment
- Club activities
- Mental-hygiene
- Healthy life-style, sport
- Baby-friendly hospital
- Staff health care
- Co-operation with GP's
- Patient information

We created a Foundation for Health Promoting Hospitals in 1996. We then applied for monetary support from the Ministry of Welfare and gained some monetary aid and dispensed this amount among the hospitals applying for support. The member hospitals insist on continuing the projects, in spite of financial and organisational difficulties. We are continuously working to disseminate the concept of HPH and to raise general awareness about health, by carrying information to the countryside and by holding regular meetings.

Final Conclusion

We are convinced, that all five subprojects are successful, in spite of having to face financial and other difficulties. We want to repeat again, that in our opinion the originally formulated aims of the Health Promoting Hospital Project are changing and should be changed during the ongoing Health Care Reform, which dramatically affected the role of health promoting services in the health care system.

The original concept was to provide better working conditions for patients and staff *in the hospital* (intramuros). In evaluation, three of our own subprojects meet these criteria. The *Club movement* subprojects opened the doors of the hospital, the events take place "*extra muros*". The dietetic subproject started originally **in** the hospital, but now it serves as a model for healthy nutrition for the community, especially when presenting health food products at the Diabetic Club evenings.

We think that our Health Promoting Hospital should *break down the walls* of the hospital, and should enrol family doctors, social workers, different churches, as well as the entire community. Our dietetic and club movement programmes are *bridges* between “intra and extra muros” activities.

Because the Health Promoting Hospital Project is an “offspring” of the Healthy Cities Project, we think, that after a successful pilot period the Health Promoting Hospital Project might turn back on a higher level to its initiator! Of course, the original concept, supplying better working conditions for staff and patients, must be preserved.

A general conception of Health Promotion is already evident. However, the implementation into everyday health care seems to be very difficult, owing to old, traditional habits and conservative aspects. There is no more important goal for the country to achieve than an advanced level of health. We are coping with the difficulties of old paradigms of medicine, i.e. curative actions only. Unfortunately today’s health policy is still disease-centred instead of being health-oriented. The attitude towards hospitals, and in general the view of health services, has to be changed radically and accepted by health care providers and staff. Partly due to the above-mentioned facts and partly to the low level of the national economy it seems to overburden the welfare budget. Prevention and health-protection is not cheap.

Every preventive or health-protective action will achieve results only after 10-15 years. We strongly believe however, that the expenses for health promotion are not in vain. Because of the restrictive health budget, the situation for all hospitals in Hungary is worsening, health promoting activities for Health Promoting Hospitals are becoming more problematic.

In spite of this, the Korányi Institute is going to continue the health promoting programmes by striving for a better allocation of resources, by obtaining financial supports and applying for grants for different projects (Health-risk donations, “Soros” foundation, National Health Insurance Company grants, etc.).

References

- Baric L. (1995): Health Promotion and Health Education Module I. Barns Publ.
- Halmos T., Kautzky L. (1997): Health Promoting Hospital Screening Project Involving Family Doctors. Abstract for HPH IC 1997. Vienna
- Jenei I. (1994): Népegészségügy és etika. Népegészségügy 75, 71-73
- Jolly D., Gerbaud I.: The Hospital for Tomorrow WHO/SCH/92.1. Paper No5
- Kautzky L. (1996): Report of the Hungarian Health Promoting Hospital. (Report for Ministry of Welfare)
- Kautzky L. (1995): The Role of Family Doctors in the HPH Projects In: Health Gain Measurements as a Tool for Hospital Management and Health Policy. Proc. of 3rd International Conference on Health Promoting Hospitals. Linköping
- Kautzky L., Halmos T. (1997): Worsening Financial Situation, Uncertain Future of HPH Projects. Abstract at the 5th International Conference on Health Promoting Hospitals, Vienna
- Kautzky L., Halmos T. (1996): Hungarian Pathway toward the Health Promoting Hospital. Report for WHO/EURO
- Kopátsy S. (1995): A népjóléti politika alapjai . Kórház II 44–45

- Lerberghe W., Lafort Y.: The Role of Hospital in the District WHO/SHS/CC/90. 2, Paper No 2
- Makara P., Kolláth Gy. (1995): Tájékoztató az Országos Népegészségügyi Bizottság részére NEVI
- Nemzeti Egészségvédelmi Intézet (1993): Ki őrzi az Egészségét
OEP Statistical Yearbook (1995)
- Ökény M. (1995): Egészségpolitikánk és fő dilemmája: a magyar lakosság egészségi állapota. Kórház II 2–4
- Sándor L. (1995): A kórházügy aktualis kérdései. Kórház II 6–9
- Szabó Gy. (1997): A kórházügy aktualis kérdései. Kórház II 2–5

The Health Care System in Italy

Carlo Favaretti

Introduction

The present Italian Health Care System has been drawn by two laws, promulgated in 1992 and 1993, and has been implemented since January 1995¹. These laws reformed a previous one, approved in December 1978, which established a National Health Service (NHS), implemented since January 1980². The institution of the NHS in 1978 was achieved after two decades of political debate with the main task to unify at local levels the provision of health care services previously run by different administrative bodies. In 1945, at the beginning of the political debate about the Constitution of the Italian Republic, a working group of eminent professors of the University of Padova prepared a Report (Fanno et al 1945) addressed to the Comitato di Liberazione Nazionale del Veneto (National Liberation Committee, Veneto), focusing on the opportunity to unify at local levels the provision of health care services, which were fragmented and separated. The Constitution, in article 32, stated that health is a right for all the Italian citizens and health protection is a primary benefit not only for the individual but also for the society, and a prerequisite for the development of social progress and common welfare. Before the NHS, classic public health (control of infectious diseases and environmental health) was strongly centralized at national level which had Medical Officers at provincial and communal level; primary medical care was run by Communes for poor people and by several National Sickness Funds for employees (Communes and Sickness Funds also reimbursed hospital care for the enrolees); psychiatric care was run by Provinces; hospitals were public charities based on Communes. In the 70's, with a first reform, hospitals were transformed into independent organizations, regulated by the regional planning, and they also took the responsibility of psychiatric care³.

The National Health Service

The NHS, instituted in 1978, was organized into national, regional and local levels (Hospital Committee of the European Community 1993). At national level, Parliament and Government were responsible for setting principles and objectives, planning and coordinating the policy decision making, financing. At regional level, Regional Councils and Governments were responsible for regional planning, including levels

¹ Testo aggiornato del decreto legislativo 30 dicembre 1992, n. 502, recante: „Riordino della disciplina in materia sanitaria, a norma dell'articolo 1 della legge 23 ottobre 1992, n. 421“, Gazzetta Ufficiale della Repubblica Italiana, Supplemento Ordinario n. 4 del 7 gennaio 1994.

² Legge 23 dicembre 1978, n. 833 „Istituzione del Servizio Sanitario Nazionale“, Gazzetta Ufficiale della Repubblica Italiana, 28 dicembre 1978, n. 360.

³ Legge 12 febbraio 1968, n. 132 „Enti ospedalieri ed assistenza ospedaliera“, Gazzetta Ufficiale della Repubblica Italiana, 12 febbraio 1968, n. 68.

Legge 13 maggio 1978, n. 180 „accertamenti e trattamenti sanitari obbligatori“, Gazzetta Ufficiale della Repubblica Italiana, 16 maggio 1978, n. 133.

and standards of health care, and distribution of funds to the local level by capitation. The great innovation was introduced at local level where, by means of regional laws, about 600 Unit = E0 Sanitarie Locali (Local Health Units) were established. Each Local Health Unit (LHU) was an association of Communes: the City Councils elected their representatives in the Assembly of Communes which appointed a Comitato di Gestione (management committee). This political body administered the LHU within the regional planning.

According to the national law, the Regions and the LHU's were responsible for physical and mental health (with reference to WHO definition of health) even if several Regions, particularly in the north of the country, promulgated a legislation to give the LHU's a delegated responsibility in several social care services (i.e.: elderly, handicap, drug addiction). Several principles inspired the institution of LHU's:

- the principle of a single organization delivering all health care services
- the principle of universal health care coverage
- the principle of comprehensive health care service, including prevention, treatment, care and rehabilitation
- the principle of uniform levels of health care across the country.

The participation and empowerment of citizens, through health education, and the continuing education and training of health care professionals were also included among the relevant objectives of the NHS. According to the principle of a single organization delivering all health care services, hospitals were included within the responsibility of LHU's, with the exception of institutions with relevant research activity (Istituti di Ricovero e Ricerca a Carattere Scientifico, IRRCs), private profit and no-profit hospitals with special agreement with the NHS, and Military Hospitals.

The Reform of the National Health Service

The epidemiological and demographic transition, the unresolved inequalities of health care provision across the country, the technological development, the decrease of public financial resources and an unsatisfied public opinion can be considered key elements in the crisis of the NHS. In particular, an unclear financial accountability among the three levels of the NHS, a too centralized and bureaucratic planning approach, an excess of political influence in the administration and a management based on consensus have been relevant factors which did not allow the NHS to tackle the above mentioned key elements. These factors plus the political debate about a new welfare state, the process of convergence towards the criteria of the European treaty and the influence of health care reforms in other European countries produced the present reform of the NHS. The main characteristics of the reform can be summarized as follows (Taroni 1996):

- role of the central government focused on control of the overall public expense and on equity of access to uniform levels of care (national health care package)
- decentralization of the responsibility of system management to the regional governments with the obligation to cut financial losses or the possibility to fund, with their own revenues, higher levels of care (regional health care packages)

- institutional local level of a regional system of LHM's and Hospitals with the status of public companies, administered by Directors General appointed by the Region
- financing system based on both capitation (from central to regional level and from regional to LHM's level) and prospective payment of health care services (from LHM's to Hospitals)
- tendency to separate functions between purchasers (LHM's) and providers (i.e.:hospitals)
- introduction of some competition tools between providers (public vs. public; public vs. private).

The expected short term effect of the reform was the increase of system efficiency, but the medium term objective should be linked to an increased effectiveness, appropriateness and quality of health care. It is probably too early to evaluate the reform, because the regionalization has different timing in implementation and also different approaches. For example some Regions (i.e. Lombardia) recently choose a definite purchaser/provider split, while some others (i.e. Veneto) have only a few hospitals with the status of independent public company. The reason for these different approaches could be related to the starting points of the regional systems in terms of financial balance, capacity of response to the above mentioned key elements of crisis, customer satisfaction or pressure to change, etc. However, the introduction of a directive management, instead of that based on consensus, and the regionalization have had some positive effects in terms of accountability, even though the present political debate claim a new commitment from the Communes, which have had an historical role in public health, substantially lost in the present reform. As a consequence of this debate the Minister of Health presented to the Parliament a proposal to correct some structural aspects of the reform. On the other hand, some experiences, such as the Healthy Cities program (Paccagnella 1990), the Health Promoting Hospitals Networks initiative (De Piero, Favaretti 1997) or the TRiPSS project (Network Cochrane Italiano 1997), involving 20 LHM and Hospital Companies to transfer research into practice of health care services, are priming both a political and technical debate on a new public health, based on health promotion, and on effectiveness and appropriateness of health care services. It is impossible to say if these experiences will have wide impact on the present and future health care system, but they seem to be relevant and of high potential.

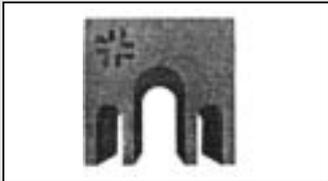
References

- Fanno M., Giovanardi A., Graziani A., Loria A., Meneghetti E. (1945): Progetto di riforma dell'ordinamento sanitario italiano, in Atti della Consulta Veneta di Sanita', Comitato di Liberazione Nazionale, Regionale Veneto, Padova, 1, 2
- Hospital Committee of the European Community (1993): Hospital services in the E.U., Leuven, n.512
- Taroni F. (1996): DRG/ROD e nuovo sistema di finanziamento degli ospedali, Il Pensiero Scientifico Editore, Roma, n. 332

- Paccagnella B. (1990): Il concetto di città sana: promozione di ambienti e á stili di vita, in Righetto G. (Ed.): Città sana: ambiente, stile di vita e tecnologia, Centro di Ecologia Umana dell'Università di Padova, Padova, n.41–47
- De Pieri P., Favaretti C. (1997): La rete veneta degli ospedali per la promozione della salute, in La promozione della salute nel Veneto, Padova, n. 45–50
- Network Cochrane Italiano (1997): Trasferire i risultati della ricerca nella pratica dei servizi sanitari: il progetto TRiPSS, ASI, 7, n. 34–37

Towards a Regional Network: The Vittore Buzzi Hospital as an example of good Health Promoting Hospital practice in Milan

Francesco Ceratti, Marines Axerio



Vittore Buzzi Hospital, Milan

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Hospital Owner:	Local Health Unit No 41
Hospital Ownership:	Public
Specialisation:	General Hospital (mother-infant oriented)
Beds:	239 (ordinary 190 + 37 cots; day-hospital 12)
Staff:	Medical Staff: 94, Nursing Staff: 216, Other Staff: 63, Total Number of Staff: 373
Utilization:	Average Utilisation of Beds/Year: 63,7 %, Average Duration of Stay in the Hospital/Day: 5,16
Patients:	Number of Inpatients/Year: 13 452 (ordinary: 10 232, day-hospital: 3220)
Number of Departments:	19 (7 Divisions, 3 Day hospitals, 9 Services and Pharmacy)
Location of Hospital:	Inner city
Catchment Area:	Regional and local, Number of Population: Regional: 8 800 000 for certain specialities, Local: 1,4 Mio for primary care
Other Functions than Medical Care:	
Teaching:	Nursing Education (until 1995)
Subprojects:	1. Surveillance of Operating Theatre Staff 2. Post-Menopausal Osteoporosis 3. Family Risk of Premature Arteriosclerosis 4. Psychological Impact of Hospitalisation on Children 5. Early Discharge of Puerpera and New Born 6. Survey on Relationships in the Hospital

The Vittore Buzzi Hospital in Milan was established towards the end of the last century as a children's hospital. The hospital building was extended substantially at the beginning of the current century and then again in later periods as a result of private donations from many citizens of Milan. Throughout these structural changes the hospital was always dedicated to the field of children's medical care.

In 1972 a large new pavilion with wards for obstetrics, new-born babies and neonatological pathology was open. Later on, as a consequence of Lombardy's regional laws, a general surgery as well as general medical wards for adults were opened.

Although the V. Buzzi Hospital is mainly a paediatric hospital, other activities in general medicine and surgery also take place. The obstetric-paediatric unit includes obstetrics, neonatology and paediatrics with an intensive care unit, surgery and day care facilities. There is also an audiophonology centre for children.

Additionally, multispecialist centres for home care of terminally ill patients, for arteriosclerosis, osteoporosis, menopause and breast cancer have been set up.

Since July 1992, the hospital was taken up by the Milan Local Health Unit Nr 75/VI and thus linked to other territorial services such as the general practitioners and paediatricians, family and paediatric consultant centres. Since then, it has been possible to develop integrated projects together with other health care services.

The way to the Health Promoting Hospital Project

The idea of joining the European Health Promoting Hospital Project (HPH) resulted directly from the collaboration of V. Buzzi Hospital with the Healthy Cities Project of Milan. In this respect it was seen, that the hospital, due to its traditional paediatric vocation, could represent a focal point for pilot projects and initiatives in the field of health promotion.

The Subprojects

After a discussion of the options for joining the HPH project between the managing staff of the hospital (General Manager, Medical Director, Chiefs of Department, Chief of Nursing Services) and the co-ordinator of the Healthy City Project of Milan, 10 subprojects were originally planned. After their presentation at the 3rd Business Meeting of the Health Promoting Hospitals, held in Milan in April 1992, and after a careful verification of the conditions for their implementation, the subprojects were reduced to 6, where concrete initiatives have been developed, aims and targets set and concrete project work carried out. The six subprojects are as follows:

“Survey on relationships in the hospital”

Overall objectives:

to humanise care in the hospital by improving communication and the relationship between the care providers in the various departments respectively, and between these and the patients, and their respective families.

Specific objectives:

- survey of the existing relationships and the communication structures in the hospital, aimed at identifying areas for improvement;

- developing organisational models and communication behaviour within the hospital in order to improve communication and information flow between the different actors.

“Psychological impact of hospitalisation on children”

Overall objective:

to limit the psychological impact of hospitalisation on children and their families.

Specific objectives:

- to understand and limit the emotional impact of hospitalisation on children and their families;
- to establish relationships based on confidence between the patients’ relatives and the medical and nursing staff;
- to direct medical and nursing staff towards an integrated assistance of the children and their families.

„Early discharge of puerpera and new-born from hospital“

Overall objective:

to improve the relationship and psycho-affective development between mother and new-born, while at the same time supporting protected labour pains / travail, delivery and childbirth.

Specific objective:

to reduce the duration of stay in hospital to a minimum and to guarantee appropriate home care.

Side-objectives:

- to reduce social and economic costs by hospitalisation of healthy patients;
- to try out an organisational model and its applicability for other parts of the health care sector.

„Family risk of premature arteriosclerosis“

Overall objective:

to reduce the level of risk factors in teenagers and young adults with a high risk of coronary artery disease.

Specific objective:

to promote healthy lifestyles, such as

- better nutrition habits;
- reduced smoking;
- more physical exercise.

„Postmenopausal osteoporosis“

Overall objective:

to promote awareness and knowledge about osteoporosis, its related complications, and the importance of prevention and early therapy to reduce fractures in elderly women.

Specific objectives:

- to promote healthy life styles that may reduce the risk of fractures;
- to increase the level of acceptance and compliance with hormone treatment among women in recent and/or early menopause where indicated.

“Surveillance of operation theatre staff“

Overall objective:

to improve the hygienic environment and the working conditions of hospital staff in the various operation theatres of the hospital.

Specific objectives:

- to implement a health supervision protocol;
- to define and implement a maintenance protocol;
- to develop behavioural models for operators.

As the results of this subproject are especially promising, we shall describe it in more detail in the following chapter.

An example of a subproject: surveillance of operation theatre staff during occupational exposure to anaesthetic gas¹

The contribution of the following description is to demonstrate how the experience of health surveillance for operating theatre workers, which was started in our hospital in 1991, has now become routine through periodical checks and well established protocols.

It is worthwhile to mention here that in our country health surveillance procedures had to be practically implemented by 17. 11. 1995 in compliance with the Community Recommendations concerning the improvement of workers` health and security at the working site².

However, we want to point out that we took action on this specific issue given the impulse of the Healthy Hospital Network and well in advance of the law recommendations.

Biological monitoring

By biological monitoring we mean the monitoring of a parameter during a period of time, using one or more biologic fluids (urine, blood, exhaled air) that may indicate statistically the exposure in terms of absorbed dosage of anaesthetic gas and/or possible early health effects. Biological monitoring provides a good possibility of assessing the exposure level in connection with anaesthetic gas.

It is worthwhile to mention here that for a correct assessment of exposure, and therefore of the potential risk to health, biological monitoring must be performed in the context of environmental monitoring, or by measuring the polluting agent, in our case the anaesthetic gas, at the level of environmental air in the operating theatre.

¹ By M. Ronchin, A. Fumagalli, C. Caretti, Local Health Unit 41, Milan, Italy. Vittore Buzzi Hospital.

² (EEC Directives 89/391/EEC, 89/654/EEC, 89/655/EEC, 89/656/EEC, 90/269/EEC, 90/270/EEC, 90/394/EEC, 90/679/EEC) and with the Italian Law 19. 9. 94 Nr. 626.

All the measurements of environmental monitoring have to be interpreted especially in relation to their temporal progress during the operating session, with the surgery performed and with the anaesthetic methods used. The individual values of biological monitoring must be interpreted in relation to the various tasks performed by the staff in the operating theatre.

It must be noted that biological monitoring has been only recently adopted in Italy. References on this subject, particularly at an international level, show how the dosage of azote protoxide and of haloid in urine has a good sensitivity as indicator of interior dosage. Elimination of gas through urine is very quick (a few minutes) and in constant balance with arterial blood and alveolar gas. The fluctuation of environmental azote protoxide and haloid concentration shows immediately in the urinary system. The vesica acts as a container and therefore the anaesthetic gas concentration at urinary level is a weighted value, representative of an „average“ level of exposure for the period of urine collection in the vesica.

Results from those publications available, indicate a precise correlation between the azote protoxide values present at environmental level and at urinary level. The trend of the above mentioned correlation is shown in Table 1:

Table 1: Concentration of azote protoxide

Azote protoxide present at level	
environment	urinary
25 P. P. M. -----	13 mcg/l
50 P. P. M. -----	27 mcg/l
100 P. P. M. -----	55 mcg/l

The environmental concentrations of azote protoxide shown in Table 2 (25, 50, 100 P.P.M.) correspond respectively to the limits suggested by NIOSH, by ACGIH and by the Swedish National Board.

In Italy, recommendations about the limit of values for exposure were the subject of a Ministry of Health and Lombardy Region Circular of 1993; they set the limit at 50 p.p.m. for newly built operating theatres and at 100 p.p.m. for existing ones.

However, it is worthwhile to point out that fundamental prevention consists in the correct design and management of the operating theatre, with particular attention paid to the air conditioning installations, scheduled maintenance of the anaesthesia equipment and the awareness of the anaesthetists to adopt measures/behaviours to limit anaesthetic dispersion in the environment.

Results

Results presented are related to the same staff monitored in two subsequent situations. Between the first and the second monitoring the existing old anaesthetic equipment had been substituted or overhauled, with specific attention to the sealing requirements. This intervention allowed a significant drop of anaesthetic gas concentration in the environment of the operating theatre.

It must be pointed out that the exposure level before the preventive intervention was not so high as to cause any alarm about possibly significant health hazards. However, it was decided to act along a logic of containment of exposure, taking into account the non-exhaustive conclusions from publications on the effects of exposure to anaesthetic gas and in order to protect hypersensitive subjects.

During the first round of tests, 176 subjects were involved in different tasks. Table 2 summarises the exposure profile in relation to the above mentioned limits.

Table 2: Exposure profile of anaesthetic gases – pre-tests

Limit Value		Lowest Value		Highest Value		Total	
biologic mcg/l	envirn. ppm	Nr.	%	Nr.	%	Nr.	%
13	25	83	47,2	93	52,8	176	100
27	50	124	70,5	52	29,5	176	100
55	100	155	88,1	21	11,9	176	100

As we may see from Table 2, only 21 subjects (equivalent to 11.9 %) showed azote protoxide urinary values above 55 mcg/l. Tasks performed by these 21 subjects were as follows:

- on 17 occasions surgeon or anaesthetist
- on 2 occasions person appointed to handle surgical instruments
- on 1 occasion head nurse
- on 1 occasion nurse

The most frequently represented (surgeon and anaesthetist) tasks are those of the workers in the most unfavourable „micro-environmental“ conditions since they work in close proximity to the operating table and to the anaesthetic equipment. Consequently the absorption of anaesthetic gas is much more significant because of their tasks.

The analysis of these 21 cases allowed us to make very interesting observations and to conclude that the actual occupational exposure was lower than first supposed on the basis of the data available.

In fact, in four out of the twenty-one cases, urine collection was performed during a day when, due to technical problems, air conditioning of the operating theatres was not working: Practically no ventilation of the theatres with consequent sharp rise of the anaesthetic gas concentration in the environment.

Indirectly, this proved the importance of a correct performance of the air conditioning installation as a key element in preventing pollution.

In three of the twenty-one subjects an azote protoxide urinary value, equal or higher than 1000 mcg/l was reported: however, this could not be compared with the data available from environmental monitoring, with the observations during the work performance (presence in the theatre but at a certain distance from the operating ta-

ble) and led to quite different results from the values reported of other exposed subjects in the same situation.

Going deeper into the problem, we could draw the following conclusions:

- in the first case, urine collection took place in the proximity of the operating theatres, therefore in an environment itself polluted by anaesthetic gas. This proves the importance of carefully selecting the room where the urine collection is performed;
- in the second case, subsequent tests gave negative results and, in order to explain the first data collected, we assumed a fortuitous non-acidification of the test tube used for urine collection;
- in the third case, the subject examined presented an asymptomatic infection from *Escherichia Coli* treated as per antibiogram. It must be mentioned that a negative result of the urine cultural test corresponded to a normalisation of the azote pro- xide urinary values.

During the second round of tests, 148 urine samples from the same number of operating theatre staff were analysed, after having carried out the environmental improvements as described above. At this stage, acceptance of tests slightly diminished (28 subjects less than in the previous session). The results of the analysis are set out below utilising the same scheme as before.

Table 3: Exposure profile of anaesthetic gases – post-tests

Limit Value		Lowest Value		Highest Value		Total	
biologic mcg/l	envirn. ppm	Nr.	%	Nr.	%	Nr.	%
13	25	93	62,8	55	37,2	148	100
27	50	124	83,8	24	16,2	148	100
55	100	143	96,6	5	3,4	148	100

The trend shown in Table 3 is different from the previous one; in relation to the different limit- values utilised (13-27-55 mcg/l) and mentioned earlier, the following modifications may be observed:

- subjects with values above 13 mcg/l changed from 52.8 % to 37.2 %;
- subjects with values above 27 mcg/changed from 29.5 % to 16.2 %;
- subjects with values above 55 mcg/l changed from 11.9 % to 3.4 %.

In this situation, as in the previous one, subjects (five in this case) showing values above 55 mcg/l were submitted to a new test. The following observations were made:

- two female subjects presented an asymptomatic infection of the urinary system, a factor that may determine false positivity, a hypothesis proved also at literature level; after appropriate therapy, subsequent tests gave negative results;
- a subject showed standard values at subsequent tests.

Once these three cases had been set apart, it may be stated that subjects with values above 55 mcg/l are a negligible number.

We must also consider the total number of persons examined during the first and second rounds of tests (176 as against 148). At this point it may be reasonably assumed that the 148 cases examined were more significantly exposed, in as much as they were more frequently present in the operating theatres, in relation to the task performed, and therefore more available for urine collection. The subjects not included were also performing other tasks, either in emergency units or intensive care units, and did not work in the operating theatre during the whole working week.

Taking this hypothesis as valid, we may conclude that the results of these tests are even more encouraging. The environmental situation undoubtedly improved in respect to the first round of tests through maintenance interventions on the anaesthesia equipment.

In order to maintain this important result it is necessary to elaborate a program of equipment maintenance, taking into account its normal wear and tear.

The recommendation of carrying out an environmental and biological monitoring once a year in the above described situation and an adequate program of health surveillance of the exposed persons is however valid.

Expectations concerning the involvement in the Health Promoting Hospitals Project

Besides the specific aims and objectives set for each subproject, the initial expectations also included more general cultural and behavioural changes in V. Buzzi Hospital. Health promotion was to become a central element in all professional decisions and activities. These changes were also expected to improve the management of everyday clinical work and to reduce the specific professional risks faced by all health professionals in the hospital.

To ensure the impact of the project on the overall activity of the hospital, an HPH office was to be established, dedicated to the development of the project and additional resources were allocated to the project.

From 1992 to date, V. Buzzi Hospital was subject to three major institutional changes as a consequence of the general hospital reform in Italy and in the region. Each of these changes went hand in hand with the substitution of the general director and partly also of other directors. As a consequence, the continuity of the project was not given and had to be negotiated several times anew in order to obtain the necessary institutional support, political approval and financial funding. Additionally each new director made some changes in the objectives of the project, giving more or less emphasis to the overall project objectives or to the specific objectives of the single subprojects and consequently changing budget allocations.

The story of the project development

The recommendations given in the Budapest Declaration on Health Promoting Hospitals provided an important basis for the project design. On the overall level a struc-

ture for the project organisation was set up, a Steering Committee was implemented which included the General Manager of the Hospital and representatives from Milan Municipality. A project co-ordinator was established and co-operation with an external institution for evaluation and organisational consultancy was started.

Nevertheless the project organisation could not be carried out continuously because of changes in the political and structural environment which seriously affected the project. The Steering Committee especially, only convened a few times, because the members changed continuously. On the other hand the project co-ordinator (though he was assigned to the management staff of another hospital), as well as the external institution represented by a private company (SOGESS), remained in charge, both supporting continuous project development.

The already mentioned HPH office, dedicated to supporting the project's practical implementation, was realized only partially and for a short time, mainly because it was not sufficiently possible to dedicate institutional working time for running the project to the staff members involved. As a consequence, the circulation of information amongst the hospital staff, the visibility of the project and the general involvement of staff members remained rather slow.

On the level of the subprojects, project leaders and vice-project leaders were established, objectives were defined and – where necessary – resources were allocated. In general it can be seen, that positive results were achieved only in those cases, where objectives were set precisely and dependable funding had been realized. On the other hand, subprojects without these prerequisites, faced difficulties in the involvement of team members, the continuity of activities and in achieving positive results.

Funding of the project

The overall structure of the HPH project was funded directly by the hospital owner. Funding included:

- working time of the staff involved in the overall project and/or in subprojects;
- fees for the external institution for consultation and evaluation (only till June 1996)
- expenses incurred for the required international activities such as participation at Business Meetings, International Conferences and additionally the organisation of the Business Meeting in Milan in 1992.

The funding of the subproject work was covered by different sources:

- Regional Health Authorities' funds for special innovative research projects;
- funds from work contracts and by the Regional Health Authorities dedicated to the training of personnel;
- funds made available by pharmaceutical industries for subprojects with objectives and impact of a clinical nature.

What was achieved at V. Buzzi Hospital?

At its last meeting the Steering Committee, aiming to do an evaluation of the project, indicated the following results on the level of the overall project for the four years work period of V. Buzzi as a Health Promoting Hospital:

1. A cultural change in relation to health promotion issues as well as clinical work in the direction of health gain orientation. The issue of health is now more strongly referred to in daily decision making processes as well as in the clinical field. However these changes occurred only partially, and only individual health professionals are following these new directions – especially the project leaders, the project team members and others actively involved in the development of the sub-projects. No indication was found so far that a more general involvement of staff members and a more general change of organisational structures and routines have been achieved.
2. The experiences of project work helped the managing staff and the project leaders to acquire skills in project management, which until then had been rather scarce and unusual in a hospital setting. These management qualities also led to additional efforts for funding procedures.
3. Those who have been actively involved in the project work, experienced that health care institutions must co-ordinate their activities more efficiently in order to achieve better health for people and to put the resources available to a better use. As hospitals often carry out their activities autonomously, disregarding the necessity of the continuity of care and the collaboration with the other health care providers, this result is especially important.
4. Those subprojects which have developed well defined objectives and were supported by continuous funding have achieved the best results and have finally become part of the hospital's routine. Especially the subprojects „Early discharge of puerpera and new-born“ and the „Surveillance of operating theatre staff“ were successful. The transfer of these projects to other hospitals of the city of Milan was also organised, where they became standard procedures.
5. Additional transfer also took place through the active role V. Buzzi Hospital had in initiating a network of hospitals in the city of Milan dedicated to specific initiatives in the fields of health promotion.

In 1997, on the basis of the city networking experience, it was decided to promote the involvement of other public and private hospitals in the Lombardy Region in order to set up a Regional Network on Health Promoting Hospitals.

Health Promoting Hospital Our Experience in a Frontier Project

*Giorgia Marcato, Massimo Castoro, Adriano Marcolongo, Carlo Favaretti,
Adriano Cestroni, Margherita Boschetto, Patricia Burga, Michela Franchin*



Padova Teaching Hospital

Project Coordinator(s):	Adriano Marcolongo, Giorgia Marcato, Massimo Castoro
Contact:	Azienda Ospedaliera di Padova Direzione Sanitaria – Medical Directorate via Giustiniani 1 35128 Padova – Italy Tel: ++39 49 8212489; Fax: ++39 49 8213395 e-mail: pad06921@pd.nettuno.it
Hospital Ownership:	Public
Specialisation:	General Hospital and University Center
Beds:	2,454
Staff:	Medical staff: 918, Nursing staff: 2384, Other staff: 800, Total
Number of health personnel:	4102
Utilization:	Average Stay in the Hospital/Day: 7.2
Number of Departments:	75
Subprojects:	1. A Smoke Free Hospital 2. Occupational Risk for Health Workers 3. Changing Demand of an Ageing Population 4. Quality Improvement of Birth 5. Nutrition and Health

Providing hospital care, basic and continuing education and research constitutes the mission of the institution.

In the Padova Hospital and University Medical Centre (Azienda Ospedaliera di Padova) there are 2454 beds, 60 wards (of which 24 are for surgery, 28 for medicine and 8 for maternal and child health). There are also 118 out-patient facilities and 5 Emergency Care units, one of which is a medical and surgical unit and the other 4 are specialised (Obstetrics-Gynaecology/Ob-Gyn; Paediatrics; Ear Nose and Throat/ENT; Ophthalmology).

The infrastructure consists of 16 buildings, located in an area of 180,000 square metres.

The organisation delivers complex services such as organ transplantation (including heart, lungs, liver, pancreas, kidneys, corneas and bone marrow), Percutaneous Transluminal Angioplasty (PTCA), intensive care and radiotherapy.

Several high technology apparatus are available including Magnetic Resonance Imaging (MRI, 2 equipments), Computerized Tomography (CT scan, 4 machines) and Single Photon Emission Computed Tomography (SPECT).

There were 90,961 admissions in 1996, with a total of days of stay of 655,638.

At present we offer 55 Day Hospital services.

Staff includes 918 doctors, of whom 546 are hospital employees and 372 are university physicians, 2384 nurses, 448 ancillary personnel and 352 technicians.

The implementation of the Health Promoting Hospital pilot scheme

The Hospital of Padova joined the European Pilot Hospital project for two reasons: first, because the town of Padova is involved in the Healthy Cities Programme which represents the first effort towards a new public health model; second, the Hospital of Padova has been co-operating with the WHO/EURO Hospital Program since 1987.

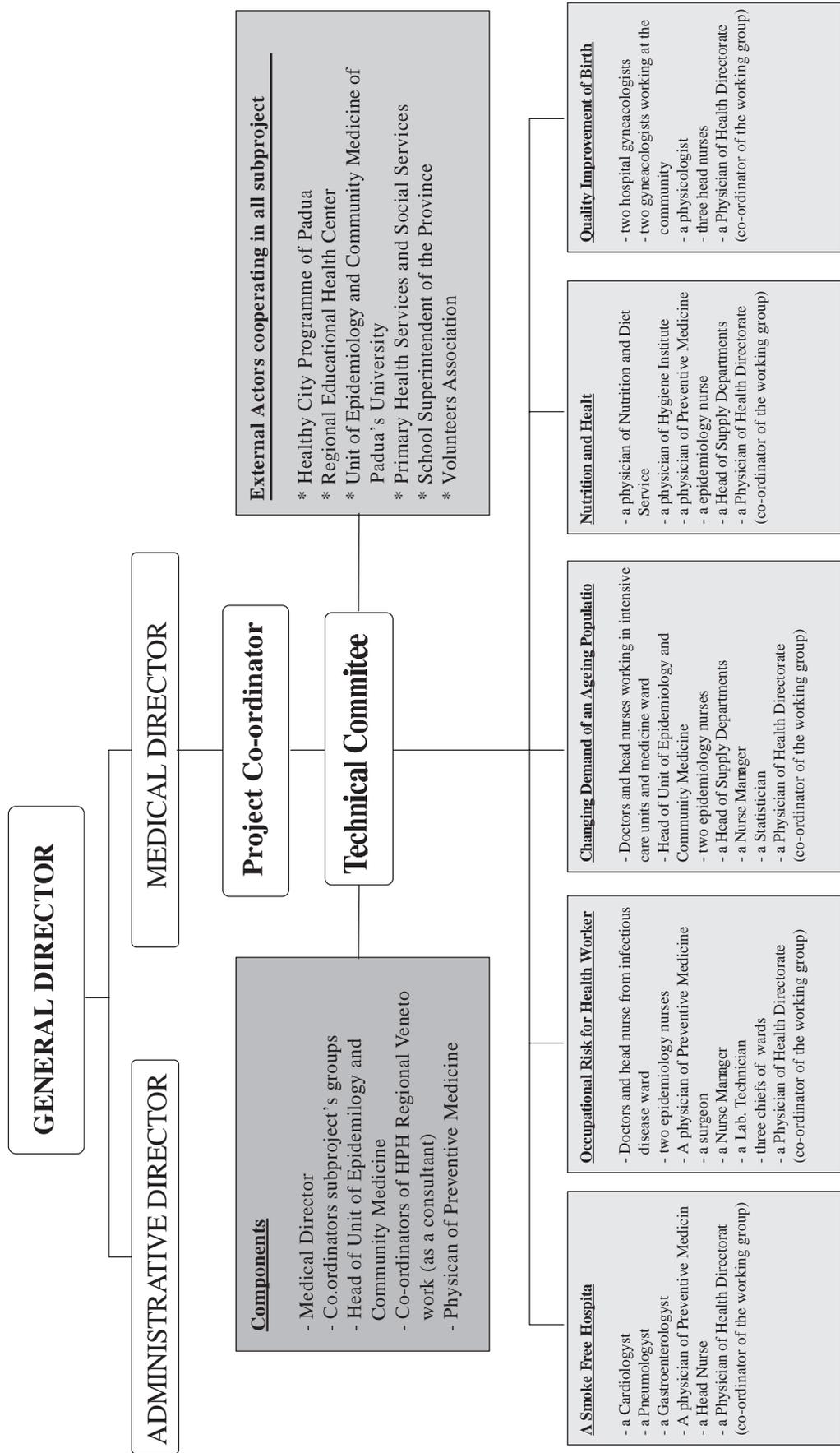
Following the resolution of 1992, when Padova hospital joined the HPH Pilot project, the technical committee was nominated. The Pilot Project organisation was founded after the 1995 health care system reform (represented in Scheme A).

Several groups working on the project supervise and support the project's progress. Every six months co-ordinators attend the technical committee meetings in order to point out both progress and/or difficulties.

Since May 1992 the Project Committee of the hospital of Padova has planned and implemented 5 new sub-projects in order to apply the criteria of the Pilot HPH Programme. The following topics were selected:

1. *A Smoke Free Hospital*
2. *Occupational Risk for Health Workers*
3. *Changing Demand of an Ageing Population*
4. *Quality Improvement of Birth*
5. *Nutrition and Health*

Scheme A - Organisation of the HPH Projekt at Padua Hospital



Several obstacles have slowed down the implementation of sub-projects, especially after a new National Health Service was introduced in 1995. Because of this reform a number of job positions had to be changed. The Hospital was subdivided into two entities: the Padova Hospital Trust (formerly Hospital and University Medical Centre) and the Local Health Unit Trust (LHU n. 16 – formerly made up of community services and three smaller hospitals).

Because of these changes, it was sometimes difficult to control the project, as the political influences slowed down the process of the project. The subprojects were also slowed down because of the rapid turn-over of the Project co-ordinators (three different persons took this responsibility within three years) and the members of the Technical Committee. Our work had to focus on showing the HPH project to the new authorities in order to reinforce their commitment towards the HPH Pilot Project.

We used local newspapers and TV, internal newsletters, and meetings within the Veneto region to spread information about the project that we are running.

The first co-ordinator of the HPH programme in Padova Hospital changed his job position in 1995. He became General Director of the LHU n.19 in Adria and focused his interest on the Veneto Region Network of the HPH, which was the first regional HPH Network in Italy. He was also chosen by the Italian Minister of Health as the national co-ordinator of a National Network of Health Promoting Hospitals yet to be established. The second Regional Network was launched in the Piemonte Region in June 1997.

A Smoke Free Hospital

As we know, smoking represents one of the major causes of illness and premature death in Europe and the rest of the world. Scientific evidence of smoke-related illness due to passive smoking make this problem a priority in the health politics. For this reason we decided to launch this project in 1991.

The purpose of this project is to promote the principles of the Ottawa Charter. Health promotion is the means of enabling people to increase control over relevant health determinants, and improve their health in order to achieve a complete physical, mental and social well-being.

This project is not only a hospital program, but also an important step towards a more global intersectoral action, in which the hospital, the L.U.H. services and the Healthy City Project of the City of Padova work together. Schools and other social organisations are involved in influencing Community Health. This project significantly focuses on the following problems which are thought to be of great importance :

1. Smoking habits are the first cause of avoidable cardiovascular and pulmonary diseases;
2. The high prevalence of smokers within the hospital personnel;
3. A poor involvement in the non-smoking law within the hospital.

Aims:

- to promote healthy life styles within the Hospital;
- to safeguard patients' rights;

- to become a model for the Community;
- to have all health workers involved in the project;
- to reduce smoking habits;
- to have smoke free areas;

We believe the multisectoral work strategy is the only way to get more people involved in this project. The people and institutions co-operating in the realisation of this project are:

- the Health Promoting Hospital;
- the „Healthy City Programme“ of Padova;
- the Regional Educational Health Centre;
- the Unit of Epidemiology and Community Medicine of the University of Padova;
- the Primary Health Services and Social Services;
- the School Superintendent of the Province ;
- some Volunteers Associations (red cross, hospital volunteers, leagues against tumours, etc.)

This project is the only one that addresses three different levels at the same time: The Community, the Staff, and the Patients. At each particular level we had implemented the following initiatives:

Activities towards the community

- a) The introduction of new non smoking signs (Figure 1):



Figure 1: No-Smoking Sign

- Adoption of new regulations in accordance with the national legislation in order to have the whole hospital area free of smoke: 189 signs with the above logo and the slogan proposed by WHO, „A smoke free hospital, it can be done“, were installed.
- Assessment of effectiveness of signs (two surveys were conducted; the second survey showed that the new signs were noticed by 90% of the visitors, compared to only 57% in the first survey; in the second survey, 89% of the people were observed to respect the non smoking signs, compared to 36% from the first survey (see Figure 2); 85% of the people interviewed agree with the initiative).

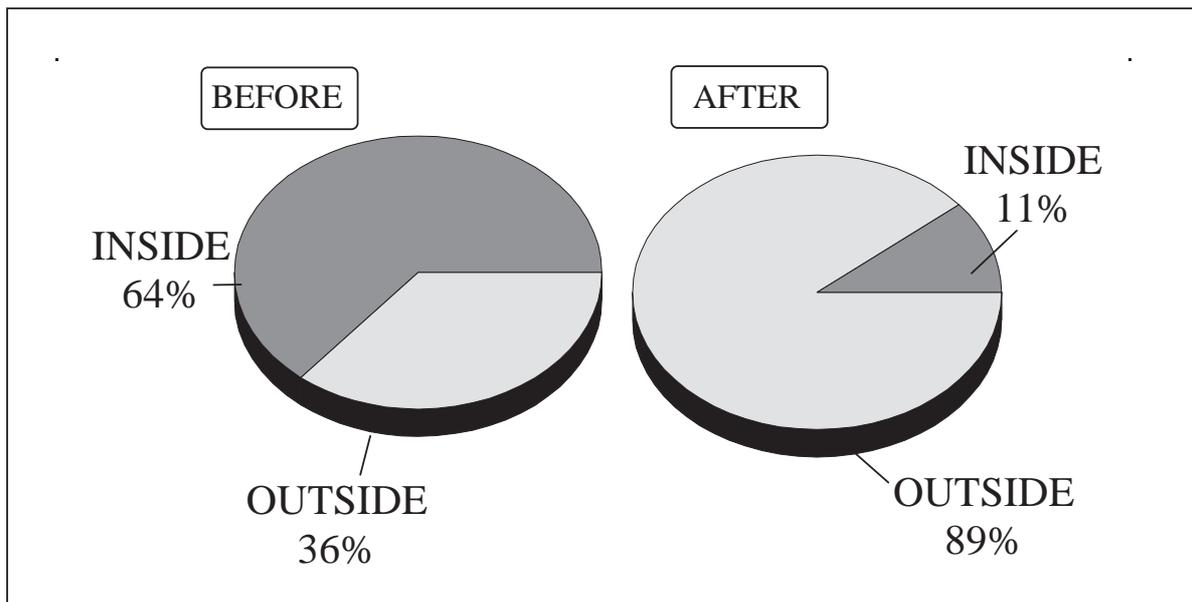


Figure 2: Percentage of interviewed smokers that smoked inside the hospital buildings before and after new signs installation

A new anti-smoking act came into force in December 1995. In Italy the law establishes that smoking is forbidden in all public buildings and therefore in all hospitals. All signs must include the statement „No smoking“ and the name of the person responsible for the implementation of the norm. Consequently, signs concerning no smoking strategies have been updated.

Hospital regulations were assigned on the basis of the new law. Smoking is now prohibited in all areas, including modes of transportation. No space is available or provided for smokers inside the Hospital. The Heads of wards are responsible for the implementation of the norm.

b) Visibility

- Celebration of World Day against Smoking: May 31st from 1993 to 1997;
- The European Chart was given to Health Personnel;
- Several public talks;
- Production and distribution of an internal HPH newsletter which was addressed to all employees.

Activities towards patients

- a) Counselling of patients conducted by nurses: A booklet guide, titled „How to help your patients to stop smoking“, was designed.

Training of Pneumology and Cardiology nurses and physicians who will introduce counselling in their practice. Counselling activities will begin in three wards, i.e. Cardiology, Pneumology and Pneumotisiology after the end of the nurses' training. The activity will be organised on the basis of the approach recommended in the guide presented at the HPH International Conferences. The Hospital Directorate (consisting of a General Director, a Medical Director and an Administrative Director) has adopted a new strategy following the recommendation based on the new national labour contract for nurses. The principal character of such a strategy is called „project-Aims“, and aims to link individual assessments and financial incentives with strategic goals (health care, efficiency, counselling activities etc.). This approach has helped to create a positive attitude towards the various projects, the aims, the negotiation, and achievement of the results. Hopefully this will contribute to a reorientation of the hospital aimed at total quality improvement.

All this is congruent to the philosophy of health promotion and to the strategies which will make the project real. In the near future, anti-smoking counselling might become a project-aim.

- b) Activities already achieved

Design of a booklet for General Practitioners: „How to help your patients to stop smoking“, completed and presented at various meetings in 1994.

Counselling by General Practitioners towards their smoking patients. This activity has been realised and is still running. It has been co-ordinated by the Health Education Centre within the LHU n.16.

Actions towards personnel

- a) In order to get a real evaluation on the smoking habits among personnel, a prevalence study was conducted on a 10% sample of health employees (around 350) in 1993. The first results show that 27,9% of the employees declared to be smokers. Although sex is not statistically relevant, we have noticed how the sex distribution changes according to the professional roles and the job distribution (Figure 3–4).
- b) During the spring of 1997 a training course was held for the Physicians and nurses of the Preventive Medicine concerning the counselling activities for smoking personnel. By the end of 1997 the counselling activities will be addressed to all the hospital workers.
- c) An assessment of the effectiveness of counselling and a follow up on the prevalence survey after one year of systematic counselling activities will be done at the end of 1998.
- d) Involvement of other hospitals in the initiative „A smoke free hospital“. Between 1994–95 a national survey was promoted in Italian Hospitals (around 2000 hospitals were involved) in order to check those hospitals which had already adopted a non-smoking policy and those which were interested in being involved in the

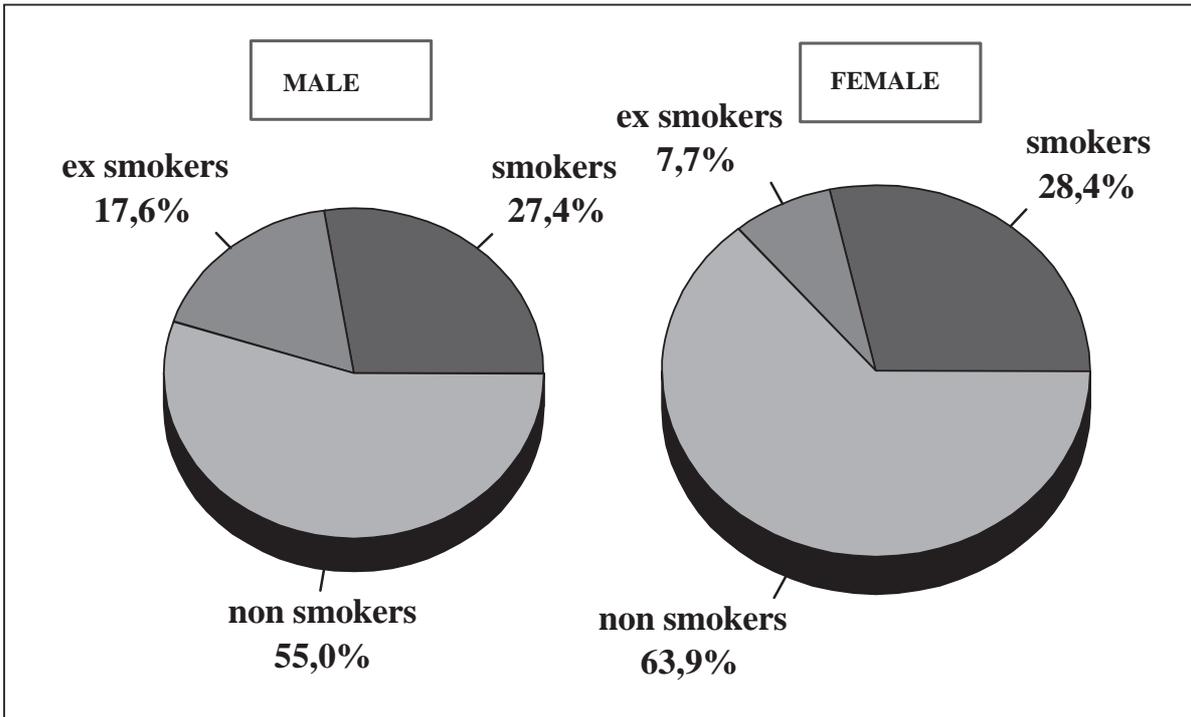


Figure 3: Smoking habits among health personnel

MEDICINE AREAS				SURGICAL AREAS			
	male	female	total		male	female	total
physicians	26,1%	25,0%	25,8%	physicians	27,0%	37,5%	28,9%
others	32,3%	32,9%	32,6%	others	30,3%	19,4%	23,0%
total	28,6%	31,5%	30,1%	total	28,6%	21,3%	24,8%

Figure 4: Smokers prevalence

smoke free hospital project. After the Veneto Regional Network of HPH (which includes almost the entire LHU) was constituted in 1996, almost all the participating hospitals showed an interest in the non-smoking project. A booklet containing all the information about how to apply aims, strategies, and how to start the project was published in order to inform any other hospital wishing to adhere to the project.

Conclusions: We found many obstacles in developing this project. The national health reform and the subsequent changes in personnel previously involved in the project slowed down the entire process. We also had to deal with daily work schedules. Nevertheless we are encouraged in carrying on with the project because we have seen the results; for example the impact of signs against smoking, the involvement of physicians and nurses in counselling activities, the organisation of several public discussions, and the involvement of visitors and the community at large in the support of the project.

Occupational Risk for Health Workers

In recent years the problem of hospital staff exposed to risks of infections when on duty has become increasingly serious because of new infectious diseases, the occurrence of old infectious diseases and of the lack of effective therapies for diseases such as AIDS and hepatitis C. Following the national legislation, priority should be given to staff health. Thus strategies and rules to prevent staff from being infected while on duty became an important issue in the Padova Health Promoting Hospital project.

Infections can be transmitted by needle pricks, accidental cuts and by handling biological fluids. The sub project focused on risks that the staff is exposed to and aims at improving safety measures as well as risk control. The hospital is the best place to control risks and prevent infections. In the hospital it is possible to control the health of the staff more closely and to promote strategies focused on improving their operational standards. Promoting staff health means also to enhance their working efficiency in a safe, physically and socially healthy environment.

At present the project group consists of a head of department, two nurses assigned to infections control, a physician and one head of ward from the Infectious Diseases Ward, a surgeon, a nurse manager, a laboratory technician and three head nurses.

The *general aim* is to reduce risks and the number of cases among staff exposed to infections. More *specific aims* are:

- to provide knowledge on the epidemiology of work related infections of staff members;
- to make staff more aware of the risks in order to promote risk minimizing behaviour;
- to develop effective strategies in order to prevent infections.

Sub Project Activities

a) The Health head and the Infectious Diseases Ward launched a project in 1987, aimed at controlling risk when staff is on duty. The Infectious Diseases Ward prepared a claim form in order to check accident reports that occurred on duty. The claim form includes staff personal data, their qualification, the date of accident occurrence, how staff was exposed to risk, the cause of the accident, patients' serological status when the accident occurred, and the follow-ups 1, 3, 6 and 12 months afterwards. Preventive strategies were based on the analysis of the results.

The Infectious Diseases emergency ward is in charge of monitoring this accident program.

- b) The best strategy to prevent work related accidents on duty is to inform and educate staff. Newsletters containing specific guidelines on prevention were given to the staff. Signs warning against needle re-encapsulation were shown on various working sites. Formative activities were promoted in order to educate staff members and to help them to adopt preventive methods against infections. Heads of wards, nurses and physicians were the primary target groups involved in the formative courses. An interactive method between teachers and students was used, since students as members of staff also experienced risk exposure every day. Slides and audio-visual materials prepared by the epidemiology and prevention of infectious diseases departments were used. They illustrated risky behaviours and habits.
- c) Following the results of the cognitive analysis, preventive records were spotted. Accidents on duty occur most frequently because of needle-pricks (especially by blood sample taking=58%). In order to prevent those accidents a vacuum blood sample taking system was developed. This system avoids transferring blood into test-tubes; and it is therefore more hygienic and practical. Furthermore it prevents test-tubes from being spotted with blood, thus avoiding invisible exposure to infection risks. The new system was launched in 1995 by the directorate. As a first step, the head nurses and nurses were given information on how to apply the new technique, and on its safety and hygienic measures. In addition they received a manual.

Staff members on the wards were given several protective instruments, such as masks to protect nose, eyes and mouth. Information meetings were organised and information leaflets were handed out. Furthermore, analysis was made containing a more general need assessment on infection control. In detail the following questions were asked:

- analysis and evaluation of those risks which could not be avoided;
- exposure to occurrences;
- place of work characteristics;
- protective measures and characteristics of instruments;
- evaluation of the possibly available protective measures compared to those already used.

Informative meetings were organised, and information leaflets were handed out in 1995.

Evaluation

Monitoring of accidental exposures among personnel has become a routine activity during the last ten years. Data show a substantial reduction in the frequency of exposures followed by a steady incidence during the last three years. In fact, accident occurrence diminished, remaining constant from 1994–96 (Fig. 5).

Preventive measures have been applied especially regarding needle-sticks which represented the most important type of accidents. A device allowing blood collection

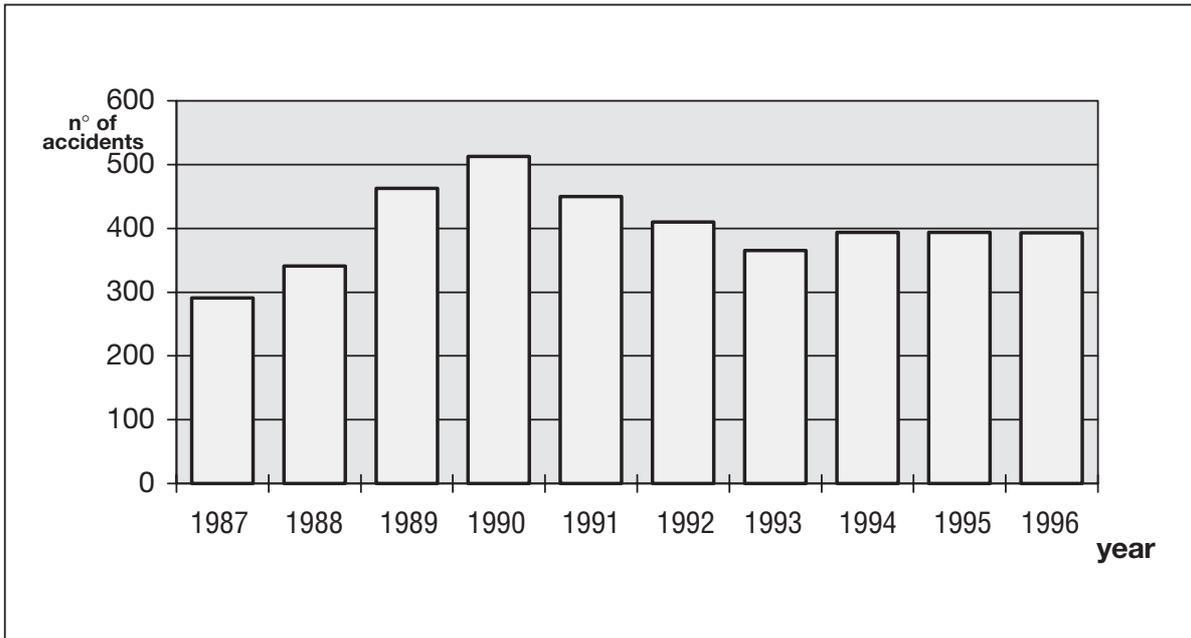


Figure 5: Accidents by year at Padua Teaching Hospital (1987–1996)

under vacuum directly into test tubes, therefore avoiding the use of syringes, has been adopted by all services in 1994. A mid-term evaluation has shown a decrease of this kind of accidents by 11.5% in 1995 and 16% in 1996, relatively to 1994. During the last three years, such reduction has occurred particularly in patient's rooms, whereas an increase was observed in operating theatres (Fig. 6–7).

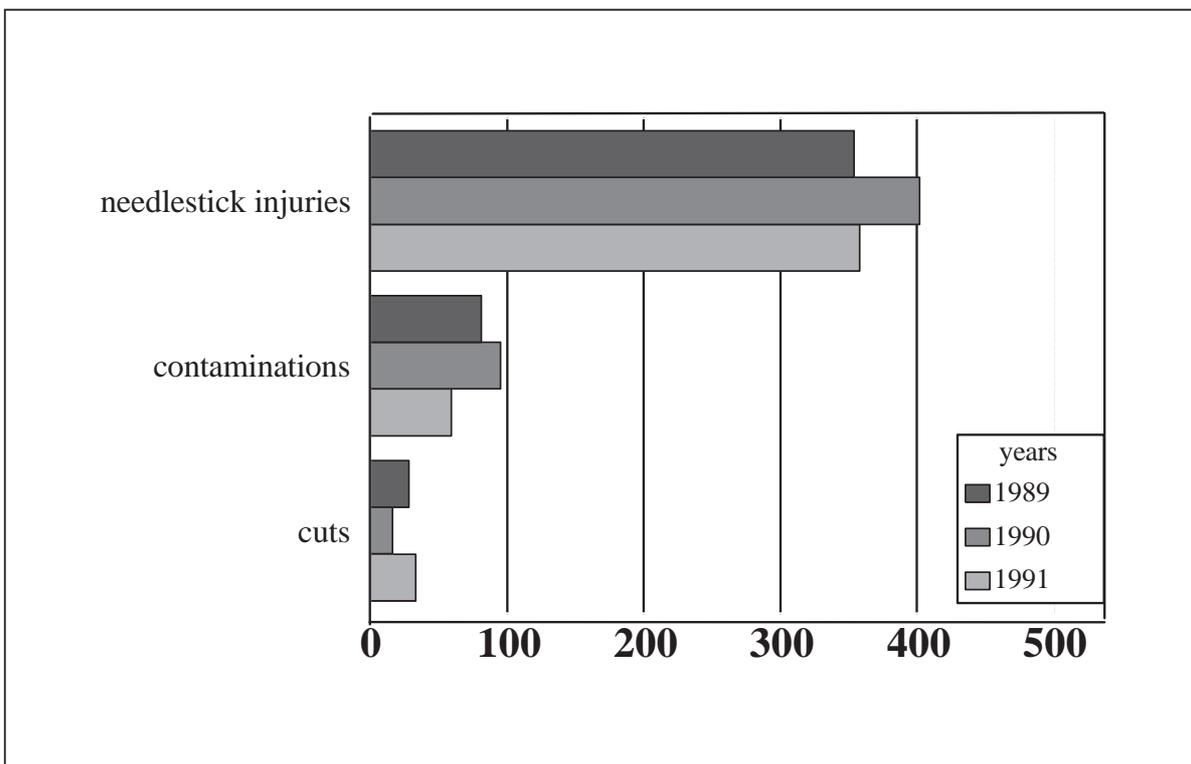


Figure 6: Type of accidents (1989–1991)

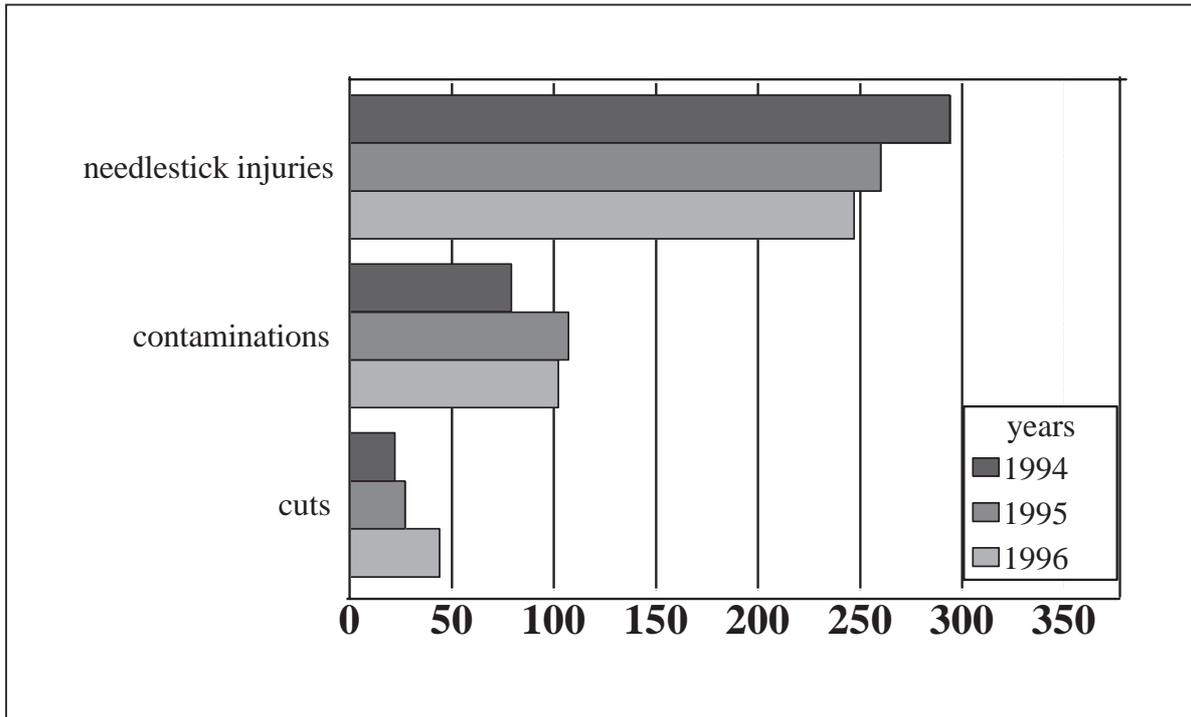


Figure 7: Type of accidents (1994–1996)

The effectiveness of the preventive measure described above and the staff compliance were evaluated by analysing information on routine accidents.

Nurses are more exposed to infection risk (51%) than physicians (12%). Accident reports made by nursing trainees diminished from 15% to 1,5% (because the vocational regional school closed down), whereas accident reports made by specialised doctors increased from 11% to 22%.

Further training courses are now about to be completed at the end of 1998; and detailed evaluation will be conducted soon.

The data collection sheet about accidents is now being reviewed and will also include the time of exposure so that more detailed knowledge can be provided in the future.

The promising experiences of the sub-project on risk prevention of infectious diseases together with the recently set up new legislation provide the background for the future plans to widen the scope of the project and also include planning other professional risks such as anaesthetic gases, antitubercular drugs, heavy use of computers, and carrying of weights.

Changing Demand of an Ageing Population

Unfortunately, after the health reform of 1995, the Geriatric Hospital has been separated from the Teaching Hospital and, consequently, the project concerning elderly patients had to be started again in the latter structure. Our hospital has no geriatric ward, with the exception of a surgical unit; nevertheless there is a high proportion of older patients. Therefore a program aiming at safeguarding elderly peoples' health in the Hospital of Padova was launched in 1996.

It focuses on in-patient injuries caused by falls, and on bedsores, as those are considered as indices for the quality of services. The project has been extended to all in-patients.

Preventing Bedsores

In Padova Main Hospital there are several wards where patients are significantly exposed to the risk of bedsores.

This problem has been taken very serious because of the increasing number of elderly patients and of chronic-degenerative diseases:

- the patients' health and the time they stay in hospital are affected by it;
- social and sanitary costs are affected by it;
- because of the relationship between risk and damage, this is a serious and urgent problem to deal with;
- according to the AISLeC (Italian Nursing Association for bedsores) research, bedsores are very common and the number of patients affected is increasing.

Moreover, one should not forget that patient-oriented care following set standards of quality will ensure the best treatment to our patients and minimise bedsores.

However, bedsores problems involve several organisational areas:

- resources areas, with a subsequent rise in expenditure and consumption;
- productive process areas which involve working methods;
- goods (quality and quantity);
- results in achieving patients' well-being and satisfaction.

Needs regarding the above problem are:

- information about how serious and urgent the problem is;
- information in order to make people aware of the problem;
- staff training;
- effective monitoring of the problem.

The working group was formed by doctors and head nurses working in intensive care units and internal medicine, the head of the Epidemiology and the Community Medicine Unit, a statistician and epidemiology nurses.

The *general aim* is to achieve a standard level in preventing bedsores.

The *specific aims and activities* were set:

1. to investigate bedsores occurrence; to analyse the preventing and curing methods in the various wards;
2. to prepare information leaflets and nursing service records on how to prevent and treat bedsores; to highlight the needs and characteristics of prevention and treatment departments;
3. to raise staff awareness on how serious the problem is and on its role in preventing and treating bedsores;

4. to edit and implement guidelines about pressure sore prevention and treatment through multidisciplinary working groups;
5. to check service quality standards and its relation to the general nursing rules.

Sub-project activities

Regarding aim n° 1: to investigate bedsore recurrence. The group involved in the project chose the wards where the bedsore study was carried out. A risk-evaluation system and a questionnaire was prepared for the staff and patients.

1. Head nurses were involved in meetings (between June and October 1996) in order to be informed about the project aims and what kind of products should be used to prevent and treat bedsores. Moreover the project focuses on a constant contact with head nurses and on informing and counselling both staff and patients.
2. Interdisciplinary groups were set up in order to:
 - a) prepare records using the Norton Scale to classify exposed-to-risk patients, and the Shea scale classification system to evaluate bedsores;
 - b) to define the technical characteristics of the nursing services in order to classify risks and sores by Shea scale system.
3. Formative meetings were held in 1996 and information leaflets were handed out in order to illustrate results and to make staff aware of the bedsore problem and of the project aims.
4. To apply records and to check service quality standards and, when required, to provide the more apt materials (as apt matters) to the single patient. In 1997 an apposite committee composed by two anaesthetists, one physician from health directorate, eight head nurses, one nurse manager and two epidemiology nurses, published a questionnaire in order to check the risk rate of patients (measured by Norton Scale) and/or bedsores seriousness (measured by Shea scale). This allows physicians to choose the correct materials. This committee tested several kinds of mattresses, that were provided by the different firms involved in this project during 4 months. The most apt mattresses will be bought or rented by 1998.

Results

Prevalence of bedsores during the end of 1996: 1459 patients were involved. Bedsores occurrence rate was 3,5% (51/1459); exposed-to-risk patients were 21,1% (51/241). The rates were compared between various specific wards; the wards exposed to a larger risk-rate were the intensive care units and post surgery intensive care units (t.i.p.o.) (31% = 15/49). Although in intensive care units patients are more exposed to the risk of bedsores, in medicine wards the number of patients exposed to serious or medium bedsore risk is bigger (Figure 8):

Bedsores occur frequently on sacrum (60%=36/65 ;i.e. on total bedsores reported), on toes and malleous (30,7% = 9/65), peritrocanteric zone (6,1% = 4/65), head and knees (3,2% = 1/65).

The Shea system classifies bedsores seriousness: 53,8% sores (35/65) are 1st class, 20% (13/65) are 2nd class, 23% (15/65) are 3rd class and 3,2% (2/65) are 4th class. 54% sores occurred in the wards where the study was carried out.

	Total	Patient exposed to risk (*)	%	Number of patients with bedsores	Sores prevalence in patients exposed to risk	Sores prevalence in total population
Intensive Care Units	62	49	79%	15	31%	24%
Surgical Areas	714	84	12%	15	18%	2%
Medicine Areas	683	108	16%	21	19%	3%
Total	1459	241	17%	51	21%	3%

(*) Norton Scale: patient with low, medium and high risk

Figure 8: Risk exposure and prevalence of bedsores

The analysis of the preventive and treatment measures adopted by different wards showed that only 6,1% wards had complete nursing service reports, 49% (24/49) wards adopted only general preventive and first aid measures, 44,9% wards did not give enough information about their methods. There is a wide range of products used to prevent and treat bedsores (more than 20 products are used, ranging from alcoholic solutions to disinfectants to antibiotics).

Only 51,1% (25/49) of the head nurses claimed to have enough products to prevent and treat bedsores as a consequence.

A board was set up in order to define the technical requirements about products used to treat bedsores according to exposed-to-risk groups. Members of the board are the health head of department, the epidemiology and prevention of infections wards, the supply departments, physicians and head nurses working in intensive care units and in internal medicine wards.

Currently the board is analysing patient data in order to evaluate the service quality standards of preventive and treatment wards, the sores occurrence risk, and the degree of seriousness of the sores as well. A questionnaire was introduced in seven wards in order to make staff aware about conditions which favour bedsores occurrence and in order to adopt common preventive and treatment standard measures. For the spring of 1998 work-groups will be organised in order to work out nursing services records and to print information leaflets to be handed out to patients.

Ongoing studies will be carried out to monitor the bed sore problem and to check compliance to the nursing services records.

Evaluation

The results of our study showed that bedsores cases occurred less frequently than average (3,5%) in our hospital, whereas the exposed-to-risk patient rate corresponded to average (21,1%).

53,8% bedsores were 1st class according to the Shea scale; 46% (23/51) sores occurred before patients entered the hospital. Preventive and treatment measures adopted for the same kind of sores differed widely throughout the wards. In the near future it will be necessary to evaluate risk rates and to work out scientifically oriented preventive and treatment measures. Both staff and patients relatives should get mo-

re involved in the project in order to guarantee patients a constant adequate treatment inside and outside the hospital.

Falls during hospital stay

In-patient falls involve not only the elderly but the entire hospital population; they increase morbidity and hospitalisation rates.

The project group working on this sub-project consists of a physician from the head of the health department, four physicians, one head nurse, two nurses and one statistician.

The *general aim* is to analyse the phenomenon in order to develop effective prevention strategies in those wards where falls occurs more frequently.

The *specific aims* are:

1. to define characteristics by analysing the injuries reports sent to Health Head Department this last two years;
2. to analyse information used to monitor falls and to check nursing service quality standards effectively;
3. to inform staff about the results of this study;
4. to analyse crucial factors and to define sound strategies in order to improve staff organisation and specifically the nursing services towards patients (especially towards the elderly population).

Sub-project activities

Regarding the aim n° 1 all the reports concerning injuries caused by falls from 1.1.1995 to 31.12.1996 were studied. Attention was focused on patients' age, the time of fall, the ward and place where falls occurred, the kind of injuries reported and how and where they occurred.

In order to assess how efficient information is in our hospital, the number of correct answers given to the injury reporting questionnaire were analysed. The Morse J. M. and Morse R. M. system were used to classify injuries and to check staff's compliance in reporting all the accidents occurred. All the data will be revised by the end of 1998. The health records regarding all the patients will be taken into account, in order to check if any clinical, pathological or pharmacological conditions could be related to the accidents.

Activities concerning aims n° 3 and 4 are still in progress. They focus on raising staff awareness on the problem through information sheets on the study's results and active information meetings at the wards. However, on those wards where accidents are observed more frequently, all the staff members are involved in the project.

Results

727 falls were reported (385 males and 342 females) between January 1995 to December 1996. The age average is 65 (+/-19,7): 63% patients are aged 65 or older.

Accidents occurred more frequently in internal Medicine and Infectious Diseases wards. Usually they occurred two to three days after the patients entered the hospital

(less frequently falls occurred the first day after hospitalisation). Falls occurred more frequently at night between 1 a.m. and 6 a.m. The time of falls was analysed in comparison with staff shifts. High-pitched fall rates were registered at midnight, at 2 a. m. and 6 a.m. Falls occurred less frequently between 1-8 p.m. (Figure 9–10)

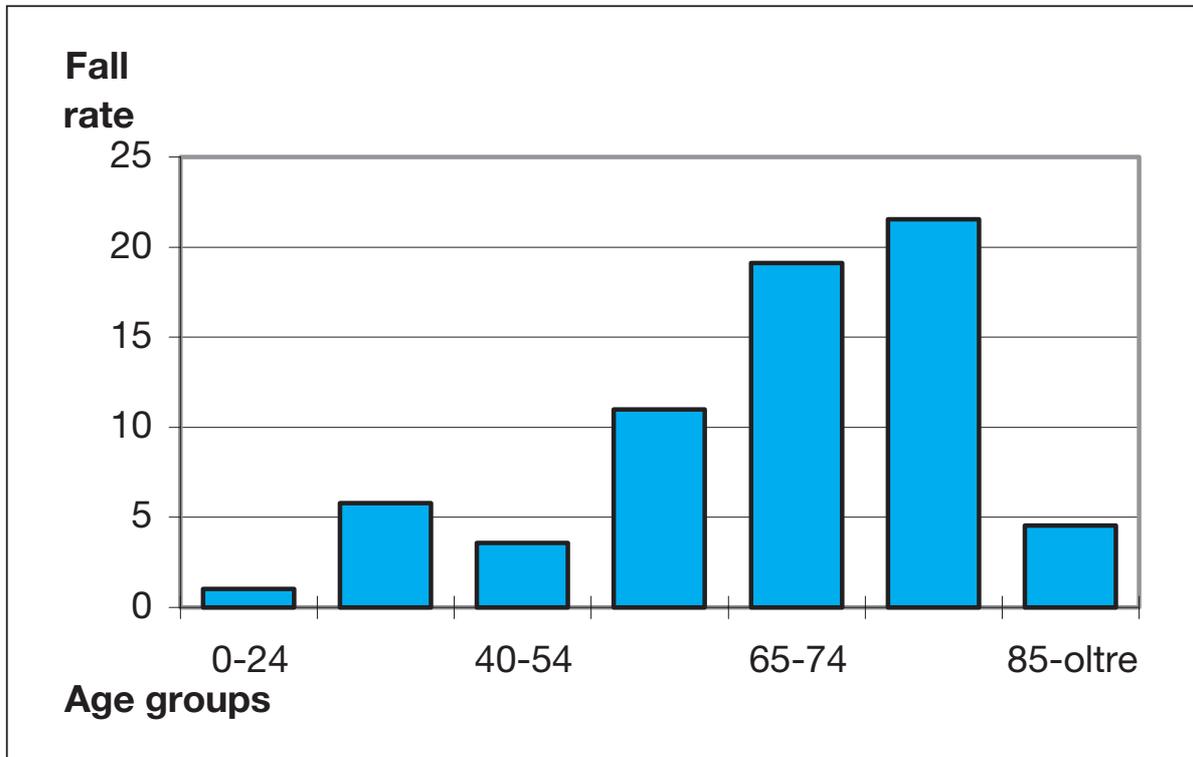


Figure 9: Falls distribution by age

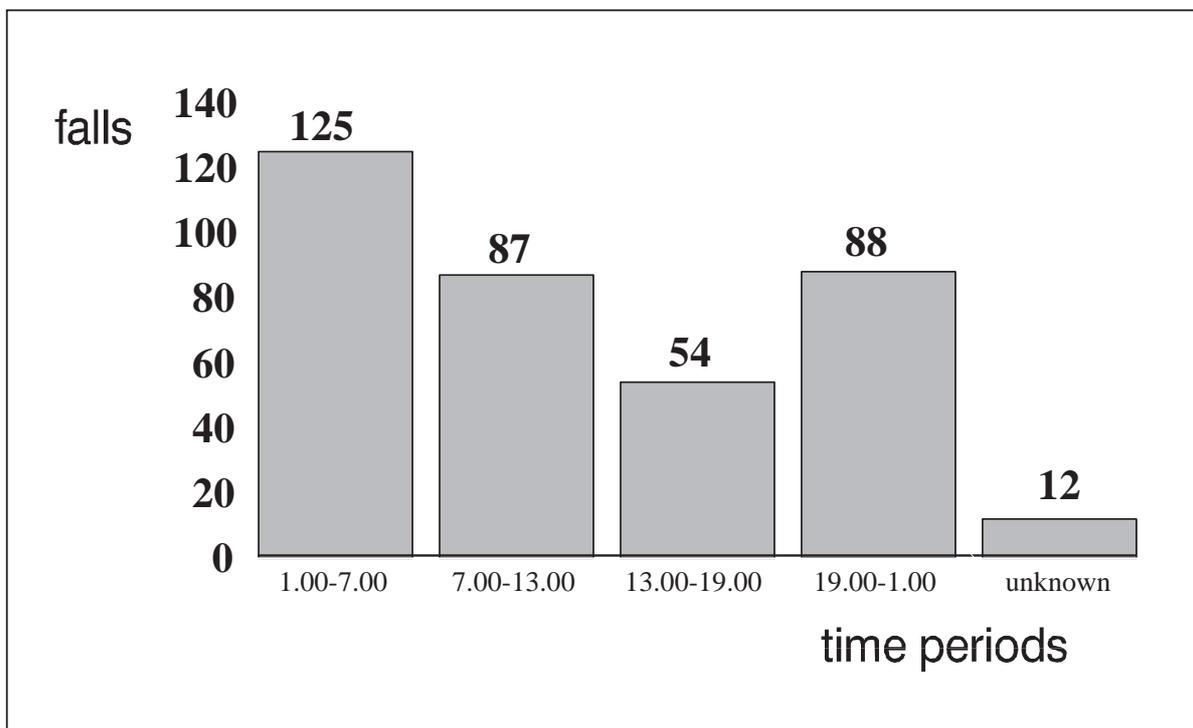


Figure 10: Falls by time periods (1996)

The following fall rates were reported: total = 0,5 per 1000 days in hospital; exposed-to-risk patient rate = 4,1 per 1000 in-patients; bed falls = 0,14.

Regarding information strategies, the number of reports regarding the kind of injuries caused by falls was computed (in 97% cases the kind of injury was specified).

The seriousness of the injuries was classified as follows: no injury (20,4%), minor injuries (56%), medium sized injuries (20,9%), serious injuries (2,1%).

Evaluation

The observed fall rates in our hospital are lower than average. Falls occurred more frequently at night. At the moment we are not able to explain why this happens (it might depend on the decrease of staff, on patients' diminished watchfulness and on psychotropic drugs assumption). These factors are going to be analysed in 1998.

It is important to remember that the study focused on the whole in-patient population. It is therefore necessary to evaluate what kind of nursing services are offered in our hospital, and to distinguish between strategies according to patients' age.

Finally we are planning to set up a project group whose task it is to increase the awareness and understanding among personnel about their role in surveying and carefully applying safety measures especially towards elderly patients during night shifts.

Nutrition and Health

This project has also been slowed down as a consequence of the National Health Service reform, because the appointed people left their positions, and those who remained did not commit themselves to the project sufficiently because of their limited ownership in the project. Nevertheless a new team was founded in 1996, with a new collaboration with Preventive medicine, the Nutrition and Diet Service and the Hygiene Institute (belonging to the University). Besides, other LHU were involved by the HPH Veneto Regional network.

The 'Nutrition and Health' sub-project is a wide-ranged initiative targeting (a) in-patients and hospital health workers, and (b) the population, especially school-age children, mothers and new-borns.

General aim

To maintain and/or enhance patients' well-being by a healthy and balanced diet which takes into account the health conditions and the individual activities, in order to reduce those pathologies caused by bad food habits.

Target groups

1. Patients affected by pathologies or exposed to risk factors, and age groups (such as children, mothers, new-borns and elderly people);
2. nurses and staff involved in the preparation and/or distribution of food in the hospital;
3. the surrounding social community, such as students, parents, teachers and restaurant-operators;
4. those who use the basic hospital services.

Aims

1. to assure a qualitatively and quantitatively balanced diet for patients according to age groups (adults, elderly people and children);
2. to prevent that patients who are affected by chronic disease get worse, by modifying their food habits;
3. to guarantee a wide range of choice in the menu according to patients' personal taste;
4. to improve patients' satisfaction;
5. to teach patients, personnel, students and families how to choose a correct diet;
6. to prevent epidemics originating from food;
7. to insure correct preparation and preservation of food;
8. to counsel patients to be discharged and those using hospital services concerning correct food habits;
9. to involve extra-hospital health services in the planning and the realisation of programs addressed to specific groups;
10. to start a counselling activity for patients and doctors.

Activities towards patients

1. Patients were offered a choice from a menu according to their specific diseases; (there are patients whose diet demands a low-protein, a low-salt, a low-fat, a low triglyceridis, a low residue, regime or various types of unseasoned food);
2. A food surveillance system was established;
3. An appropriate preparation and conservation of food (system HACCP- Hazard Analysis of Critical Control Point) was established;
4. A food counselling service for patients and family members was developed;
5. Leaflets concerning diet in order to uniform working schemes between wards and ambulatories were designed and distributed.

Activities toward staff

1. Mediterranean menus are given to about 1000 employees in the hospital restaurant. It is possible to choose between 4 courses;
2. A food counselling service for staff will be implemented by the Service of Dietology and Preventive Medicine in 1998.

Results

This project about food involves schools, families, voluntary associations, small communities and trade activities. All together they should help hospitals to convey constantly co-ordinated coherent messages aimed at transforming the social economical health system.

In order to guarantee safe and hygienic food, a microbiological control program was launched. This survey system was started in 1993 and is still in progress periodically.

Food samples are taken from the different kitchens of the hospital. The microbiological quality is evaluated according to a quality scale: excellent, good, fair and poor. These interventions are always done in the absence of any manifestation of food poisoning. The results are shown in Figure 11.

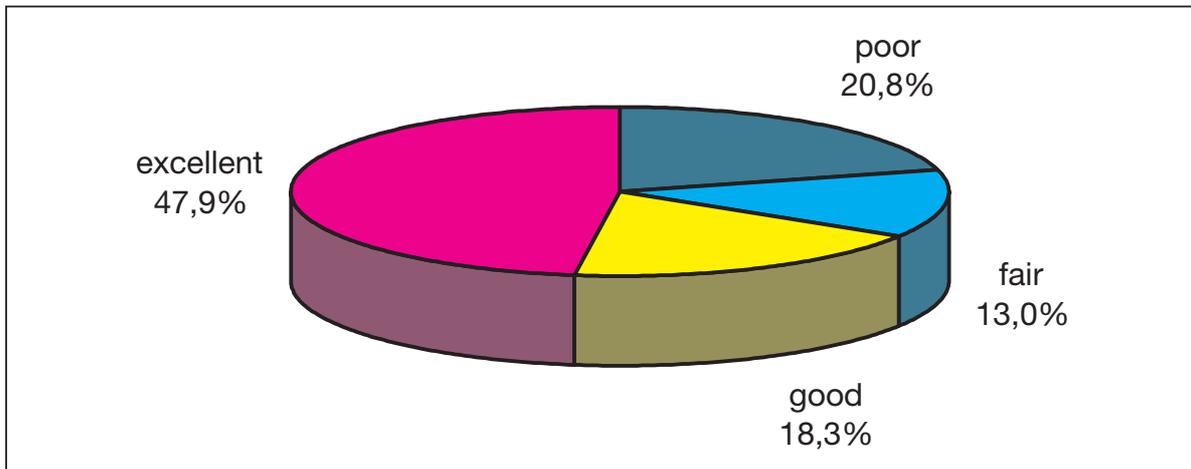


Figure 11: Food Quality

Padova main hospital focuses on food quality monitoring, on counselling and on staff health.

In detail, the following measures were put into practice:

- at present, information leaflets are given to pregnant women and lying-in patients (aim 6); later on, they will also be distributed at the ambulatory services;
- courses promoting breast-feeding (which has risen from 48% to 90%) (aim 7) were organised;
- ward kitchens and dining rooms were renovated;
- wards were given small electric household facilities;
- some products such as fruit and vegetables were promoted in paediatrics ward;
- menus were personalised in summer of 1997 (aim 1);
- diet counselling for diabetics and their relatives was established;
- meals were considered a social and therapeutic activity for staff, paediatrics and psychiatry wards.

Quality Improvement of Birth

During the last few years there has been a progressive change in the birth and delivery procedures. This change has been supported by the medical point of view that tends to industrialise birth. Delivery has been transformed from a natural experience to a surgical event, and in the majority of cases delivery is seen primarily as a physiological event.

However pregnant women ask for a more personal approach and possibilities for an active participation in giving birth, since they experience this event as an important

event in their life. Thus health care institutions should be ready to keep up with the new expectations and to use the human resources and technology for adequately providing a good quality of care and at the same time satisfying the needs of the clients. As the real actors in this important event are the women, their partners, and the newborn, we believe strongly that they need intimacy, privacy and silence, moments which can be provided by the hospital. This project has not been successful to the full extent as we had planned and the development was slowed, because of many external reasons, such as:

- In 1993–94 the working group decided to promote a survey on in-patients puerperas in the hospital in order to check the rate of satisfaction about the assistance given during recovery. The purpose was to collect enough information in order to direct future activities; the results of the survey nevertheless were not useful because the answers turned out to be too positive, the comments were not sufficient and there were also many evasive answers. The information given by the health personnel working in the OB.GYN wards and the results of the patient survey did not correspond.
- Later on, the working group cancelled its activities before the health reform and it was not constituted again until the end of 1996, also because of quick turn-over of the chiefs of the three OB.GYN wards.

In order to realise this project a multidisciplinary technical committee has been set up again and the experiences of those involved in the maternal care were taken into account. It is hoped that they will try to work out new ideas and to co-operate with each other in improving the quality of birth. The professionals involved are: gynaecologists working at the hospital and in the community, psychologists, head nurses, and physicians of the health directorate.

The *general aim* of this sub project is to evaluate the procedures and the quality of care and to reorient the services according to the health promotion approach considering pregnancy and delivery as an important moment in the woman's life and as first step in maternity and paternity.

The scheme developed by the project group distinguished three important moments *pregnancy, delivery, discharge/first care-new born assistance*. For each of these aspects specific goals were defined trying to follow WHO recommendations in order to assure a good quality assistance during the delivery. The most important goals are:

- The mother's psychological well-being must be guaranteed, not only by allowing free access to a family member of her choice during childbirth, but also by favouring the possibility that she can receive visits during the post-natal period; in addition, the therapeutic team must provide emotional support both in the presence and in the absence of the person who accompanies the woman and who does not belong to the institution.
- A healthy new born must remain with its mother as long as the conditions of both permit it; no check up of the new born health justifies its separation from the mother.
- Breast-feeding must be promoted immediately, even before the mother leave the delivery room.

- There is no proof that after a previous low transverse caesarean section, a subsequent pregnancy will require another caesarean delivery. After a caesarean section, vaginal childbirth should be encouraged, a well equipped room with an emergency service for possible surgical intervention should be prepared
- The woman should be encouraged to walk during labour, and every woman may choose freely the position she prefers to adopt during childbirth.
- Protection of perineum must be evaluated and enacted with alternative measures; systematic episiotomy is not justified;
- The routine administration of analgesics or anaesthetics should be avoided unless these are specifically required in order to correct or prevent complications during the birth process.

Specific aims concerning pregnancy

1. to give more equal care, both in terms of information and assistance to the pregnant woman;
2. to unify information and working procedures within the three OB.GYN wards and services;
3. to match the intersectoral activities within the health community services;
4. to decrease the number of unnecessary recoveries especially during the last weeks of pregnancy;
5. to guarantee the mother the possibility of being accompanied during all the procedures.

Sub-projects activities

- Information and education meetings about the best conditions to receive the new born are to be held with the parents in order to provide information and assistance within the 4th month of pregnancy. Information regarding the delivery moment should be started at 7th month in order to teach the techniques of assertive training (aim 1);
- Meetings within the intersectoral groups of the three OB.GYN wards should be held in order to improve co-operation among them, promote common activities and goals and to make common diagnostic and therapeutic protocols (aims 2, 4, 5);
- the different professionals in the community health services should be involved in the initiatives mentioned above (aim3).

Specific aims concerning the delivery

1. to guarantee the presence of a close relative during the labour in order to guarantee the mother emotional support during this phase;
2. to let the pregnant woman choose the better position during the delivery whenever this is compatible with the obstetric situation and after a serious professional evaluation;
3. to decrease the use of amniorexi in order to allow delivery to start spontaneously;
4. to avoid drug somministration as a routine practice (Es. ossitocine, analgesics and anaesthetics) unless it is requested by the woman;

5. to decrease the use of episiotomy as a routine practice;
6. to promote breast-feeding and the natural physical contact between mother and child;

The activities concentrated on:

- psycho-social support during the delivery;
- protocols that have been set up to promote the physiological delivery;
- to let the new born stay with its mother immediately after the delivery.

Specific aims concerning puerperio/first cures in the postnatal period

1. to promote manual skills of the new mother (eg. changing nappies, bathing the new-born);
2. to develop the ability of understanding the newborns signs (to understand when the child cries because it is hungry, when it has the colic because of gas, when it is thirsty etc.);
3. to promote breast feeding;
4. to improve nursing staff knowledge on how to give a highly qualified help and support to the puerpera and the new born;
5. to guarantee co-ordination between all hospital and extramural services in order to give a continuous support;
6. to identify those puerpera who are exposed to risk of post-natal depression;
7. to promote the autonomy and the intimacy of the puerpera;
8. to promote the physical contact of the new-born with the mother;
9. to guarantee the patient the right to communicate with and contact their relatives respecting their privacy; activities at peak-hours and access to the ward should be decided.

Activities

- Organising meetings within two days after the recovery of the puerperas in order to talk and exchange experiences and knowledge about common topics such as: breast feeding, crying, vaccines, hygiene, as well as about contraceptive methods, loss of weight (aims 1, 2, 3, 8);
- training for nurses are held in order to improve their capacity of supporting the mother and child (aim 4);
- according to the new national laws the childbirth can be registered by the hospital and therefore bureaucratic procedures can be avoided by the parents, we have already fully implemented this kind of service (aim 5);
- regular meetings between hospital staff and the extramural services should be held every six months in order to draw guidelines addressed to those women who are finishing the pregnancy;
- organising discussions before the discharge about psychological and emotional changes during the post natal periods (aim 6)

- information leaflets containing advice about: personal hygiene, sexual health and nutrition are given in the post natal period (aim 7);
- setting up organisational rules to be applied in the internal ward, such as visiting hours, meeting points with relatives etc. (aim 9);

Concerning the three phases of giving birth (pregnancy, delivery, post natal period and new-born assistance) the working group is now planning the aims and the activity phases that will start in early 1998.

Conclusions

In order to fully achieve the aims of the five subprojects, the Padova hospital applied at the final Business Meeting of the European Pilot Hospital project in Vienna (April 1997) to renew the contract as a HPH Pilot Hospital for another two years. Finally our hospital has been introduced in internet, providing general information on the hospital, our service chart, description of Padova's Hospital experience as a HPH Pilot Hospital and news about the recently established health promoting Hospitals Veneto Region network (<http://www.padovanet.it>).

Altogether, we summarise our experiences by giving the following weakness and strengths:

Weaknesses

- Substantial changes of persons acting as decision makers with the 1995 Health Care Reform;
- Quick turnover of the project's local co-ordinators (3 co-ordinators in three years from 1995 to-1997);
- An atmosphere of uncertainty, clinical personnel have not yet understood completely the implications of the new position of the hospital in the Regional Health Care System, which sometimes causes difficulties in communication and crises but, the worst of all, is
- the delay in the implementation of several sub-projects.
- Scarce co-ordination with community services because these are now under the authority of another LHU and therefore cooperation became more difficult. This situation limits the possibility to be coherent with the health needs of the target population and consequently to adopt strategic plans.

Strengths

- The recent national labour contracts for physicians and nurses consider an important amount of income as a premium if results are obtained. It is become stimulating to personally involve work activities and services based on projects aims and results.
- The team of the hospital directors (General Director I, Medical Director and Administrative Director) has adopted a new strategy following the approval of the new national labour contract of nurses. Such strategy is called „project-aims“ and its main orientation is linking aims with individual assessment and financial in-

centives. In order to obtain better results different trainings are prepared for improving project management skills of the hospital employees. A booklet was edited and distributed. This approach helps creating a positive attitude towards projects, their aims and the achievement of good results. Hopefully this will contribute more strongly to reorient the hospital towards total quality improvement.

All these experiences seem to be in congruence with the philosophy of health promotion which sets the bases and the strategy but which must be translated into concrete activities. Given the points, our General Director decided to continue Padova hospital's participation in the Health Promoting Hospital network.

References

- Borroni, P. Di Giulio (1984): „Indagine sulle lesioni da decubito: la costruzione di un protocollo,, Rivista dell'Infermiere, 2/84, 89–97
- Briani, G. Marcato, C. Favaretti et al. (1996): „L'ospedale di Padova per la promozione della salute Progetti per la qualità dell'assistenza al parto e ai pazienti anziani ricoverati“, Ambiente risorse e salute, giugno, 53–56
- Brunner-Suddarth-Smelter-B.G. Bare (1995): „Nursing medico chirurgico“, Vol 1, Ambrosiana; Milano, 249
- Diana L, Favaretti C et al (1992): „Ospedale e Promozione della Salute – Progetto Padova“ Health Superintendent, LHU n.21, Padova
- Favaretti C. and the Project Committee (1994): „Experiences of the Hospital and University Medical Center of Padova as a Pilot Hospital of Health Promoting Hospitals“ Proceedings of 2nd International Conference on Health Promoting Hospitals; April 15–16, Padova, Italy
- Favaretti C, Marcato G, De Pieri P, et al (1994): „Un Ospedale Senza Fumo: valutazione di impatto di una nuova segnaletica“ L'Ospedale, n.7–8, July/August
- Gruppo infermieristico per lo studio delle lesioni cutanee: ricerca sulla mobilitazione e la profilassi delle lesioni da decubito, Professioni infermieristiche, 2,94, 49–50
- Marcato G, Briani M, Zeni L, Favaretti C et al.(1996): „La rete internazionale degli Ospedali per la Promozione della Salute“ Ambiente Risorse Salute, February, 54–57
- Marcato G, Favaretti C, et al (1996): „L'Ospedale di padova per la Promozione della Salute: il progetto Ospedale senza Fumo,, Ambiente Risorse Salute, September 1996, 49–53
- Mariotto, M.G. Bonavina, C. Favaretti (1992):„Le cadute dei pazienti durante il ricovero in ospedale: un indicatore della qualità dell'assistenza“, l'Ospedale, 10:180–4
- Marcolongo A, Briani M, Favaretti C, Selle V, Mariotto A. (1997): „Incidenti occupazionali nel personale sanitario del presidio ospedaliero di Padova: analisi del fenomeno negli anni 1990/91“ L'Igiene Moderna; 107, 143–161
- Veneto region Network of HPH & Health Educational Regional Center (1996) „Ospedale e Servizi Sanitari senza Fumo – Linee guida per un progetto di promozione della salute“ November

Developing a Health Promotion Culture: The JCM Hospital Story

Ann O'Riordan, Tom Gorey, Anna Clarke



**EASTERN
HEALTH
BOARD**

James Connolly Memorial Hospital, Dublin

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Hospital Owner:	Eastern Health Board
Hospital Ownership:	Public
Specialisation:	General Hospital
Beds:	377
Staff:	Medical Staff: 78, Nursing Staff: 372, Other Staff: 315, Total Number of Staff: 765
Utilization:	Average Utilization of Beds/Year: 98 %, Average Stay in the Hospital/Day: Medical 7 days, Surgical 5.5 days
Patients:	Number of Inpatients/Year: 10,441, Number of Outpatients/ Year: 51.463
Location of Hospital:	Suburbs/rural
Catchment Area:	Regional, Number of Population: 150.000
Other Functions than Medical Care:	
Teaching:	Medical Students, Postgraduate, Nursing Education, Other Health Professions: Physiotherapy, Pharmacy
Research:	Clinical Research
Subprojects:	<ol style="list-style-type: none">1. Back Care Project - Ergonomic Approach to the Reduction of the Physical Load of some Nurses (Care of the Elderly)2. Waste Management Project3. CPR Project - Basic Life Support (BLS) Training Project4. Smoke Awareness Project - Smoke-Free Hospital Policy and Stop Smoking Support services development5. Stress Management Project6. Cardiac Rehabilitation Link Programme7. Continence Promotion in the Care of the Elderly Project

Background

Since the foundation of the Irish State in 1922, responsibility for ensuring a high standard of health and medical service for the whole population has increasingly been seen as an obligation of the State. Rapid developments within medical science have greatly influenced the quality of medical care available to the population as a whole, resulting in the gradual widening of the eligibility for health services in Ireland. This, accompanied with a growing demand for services, has contributed to the sharp rise in the cost of providing these services.

In recent times, Irish health care services have gone through a period of consolidation with respect to existing services and expansion into new services, adapting to the changing practices in treatment and care and to meet changing needs. This period was also marked by a drive to achieve maximum efficiency, while maintaining the volume and quality of patient services at the highest level possible. It was within this climate that James Connolly Memorial hospital became a participant in the European Pilot Hospital Project. Irish hospitals are currently required to develop service plans, on which their funding will be agreed. This has created a climate, where hospital managers are actively involved in implementing new methods and processes that will assist them in this activity. This, to some extent, has led to the introduction of radical changes both in organizational practices and design.

The present political climate in Ireland both supports and complements the development of organizational change in hospitals along the lines of the Health Promoting Hospitals concept. The general trend towards rationalisation of hospital services based on quality and cost-effectiveness has certainly contributed greatly to the interest and involvement of hospitals in the Health Promoting Hospitals initiative. In addition, the National Health Strategy launched by the Government in 1994, and supported by the Health Promotion Strategy in 1995, clearly outlines the significance of health promotion in the hospital setting. Health promotion provides the obvious starting point for any re-focusing of the health services towards improving health status and the quality of life. While good progress has generally been made, there is still room for improvement, particularly within the hospital care service. The basic thrust of the health promoting hospital is the creation of organizational change while simultaneously developing the hospital as a health promoting “setting”.

The Health Promoting Hospitals concept and philosophy can assist all hospitals in Ireland in this change process. Through networking and project management, hospitals are assisted in a process of development that allows them to draw up more realistic service plans. Service plans that will be based on measurement and explicit outcomes. In this way, the Health Promoting Hospitals concept can play a major role in the re-orientation process of hospitals towards health and community participation.

Introduction

The HPH concept, originally a multi city action plan of the WHO-Healthy Cities Project, was introduced formally to Ireland in 1992 by the Dublin Healthy Cities Project. One of the main partners of the Dublin Healthy Cities Project and owner of the James Connolly Memorial Hospital (JCM) is the Eastern Health Board. It was lo-

gical, therefore, for JCM Hospital to be among the first hospitals targeted for participation in the HPH Network.

JCM Hospital, a large general hospital, servicing the north/western region of Dublin City, has a staff of over 800 and a bed complement of 380. During the past four years the hospital has worked hard to bring about the desired organizational change through the implementation of the requirements of the European Pilot Project, based on the Ottawa Charter (1986) and the Budapest Declaration (1991). The hospital's aim, through participation in the European HPH Pilot Project, was to broaden the range of its services, by developing an organizational focus that would go beyond the provision of high quality curative services. It sought to introduce health promotion into every decision making process within the organization and to further influence service development through the creation of demonstrable health outcome indicators.

To realise this aim, it was acknowledged that a number of factors needed to be addressed and new strategies devised and implemented. The implementation of the HPH concept necessitated the adoption of an approach that actively sought participation and ownership of the project, at an organizational and a local level. Furthermore, in order to move the project forward, from awareness to conviction and action, the concept needed to be made real. In order to attain this aim the hospital set about achieving the following objectives:

- Raising general awareness of the importance of the hospital's health promotional role.
- Motivating staff to identify, develop and evaluate the effectiveness of their health promotional activities.
- Development of a cultural change within the organization
- Improving communication and collaboration with existing social and health services in the local community.
- Encouraging the exchange of information and;
- Introducing the health promoting hospital concept to other Irish hospitals.

The following account attempts to look at, under a number of headings, the approaches adopted by JCM Hospital towards the attainment of these objectives. It outlines the successes and difficulties encountered through the implementation of these approaches and strategies.

Creating general awareness and a shared vision

A hospital, like any community, is populated by a variety of different people; people with different social, economic and intellectual backgrounds. Unlike many communities, the hospital community is engaged in a single purpose - Health Service. For this community to prosper and develop, it needs to have an agreed agenda and to conform to common ideals and values. The traditional purpose of the hospital has been the cure and treatment of illness and disease. The implementation of the health promoting hospital concept calls for a widespread attitudinal shift and a fundamental change in the agreed purpose of the hospital. Difficulties can occur with this change process if

people are either unaware of or do not sufficiently understand the new vision. To be successful, it is imperative that an awareness and understanding of this new concept is achieved at all levels. Therefore, the project's primary objective was to create an awareness of the health promoting hospitals concept among staff, thereby, generating a shared vision of purpose within the hospital.

The first point of entry for the HPH concept into JCM Hospital was through the hospital's senior management team. Senior management support proved to be vital. Here, it was readily adopted as an innovative and progressive approach towards the introduction of organizational development. However, universal acceptance and understanding of the concept was considered essential for the successful attainment of the desired organizational change. To this end, the hospital set about generating awareness of and obtaining general acceptance for the project. In this matter, the hospital was assisted by the need to implement the various requirements for participation in the European Pilot Project. These requirements are outlined in the Table 1 below.

Table 1: European HPH Pilot structures

<ul style="list-style-type: none">● Attainment of general staff approval for participation● Establishment of a Joint Project Committee/Steering Committee● Nomination of a Project Manager/ Coordinator● Involvement of an evaluation expert through linkage with an External Organization● Development of an internal newsletter● Selection of at least five innovative health promoting subprojects
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The two initial approaches pursued were:

- Public consultation of the hospital workforce (including representatives of unions, working council).
- Introduction of an internal Newsletter for the discussion of health promotion issues and possible health promotion activities within the hospital.

The achievement and implementation of these and other structures and strategies, such as the establishment of a Project Steering Committee, the appointment of a project coordinator and the identification and development of five health promoting subprojects, constituted a new approach and a move away from more traditional practices.

Public consultation

At the outset, a general hospital meeting was held, to which all staff was invited during working hours. All sections of the hospital staff were invited and all heads of department were requested to facilitate as many staff as possible to attend. The meeting was well attended with a cross section of staff represented. A short presentation was given by the Chief Executive Officer of the Eastern Health Board, in which the main

aims and objectives of the HPH concept were outlined. In addition, the principles set out in the Ottawa Charter (1986) and the Budapest Declaration (1991), were discussed and subsequently endorsed by the hospital as a whole. The importance of multidisciplinary involvement and participation in the project was stressed. As a consequence of this meeting, general approval for participation was formally cemented through the signing of the WHO/Agreement Document by the Hospital Manager, a requirement for participation in the European Pilot Hospital Project.

Internal Newsletter

To enhance awareness and encourage ownership with active involvement, a formal communication tool was considered necessary. An internal newsletter was the tool recommended by the European Pilot Project. Although, originally intended as a quarterly publication, it was successfully produced as a bi-annual publication, entitled *Pro-Health*. The internal newsletter was seen as another effective method of maintaining staff awareness and interest in the project. It set out primarily to maintain staff awareness in the development of the HPH Project, but also aimed to raise health promotion issues generally. Each issue carried updates, results and recommendations on the initial five subprojects, together with articles dealing with wider health promotional topics and new project initiatives.

Figure 1 shows the changing content of the newsletter over the project period. It reflects project outlook development and the hospital's collaboration in national health promotion campaigns. To encourage uptake and readership of the newsletter, a Personal and Social column was added, along with a lead article from the Hospital Manager. The lead article updated staff on the hospital's general development plan and outlined future development strategies. These additional columns provided staff with general information that went some way towards improving staff communication generally.

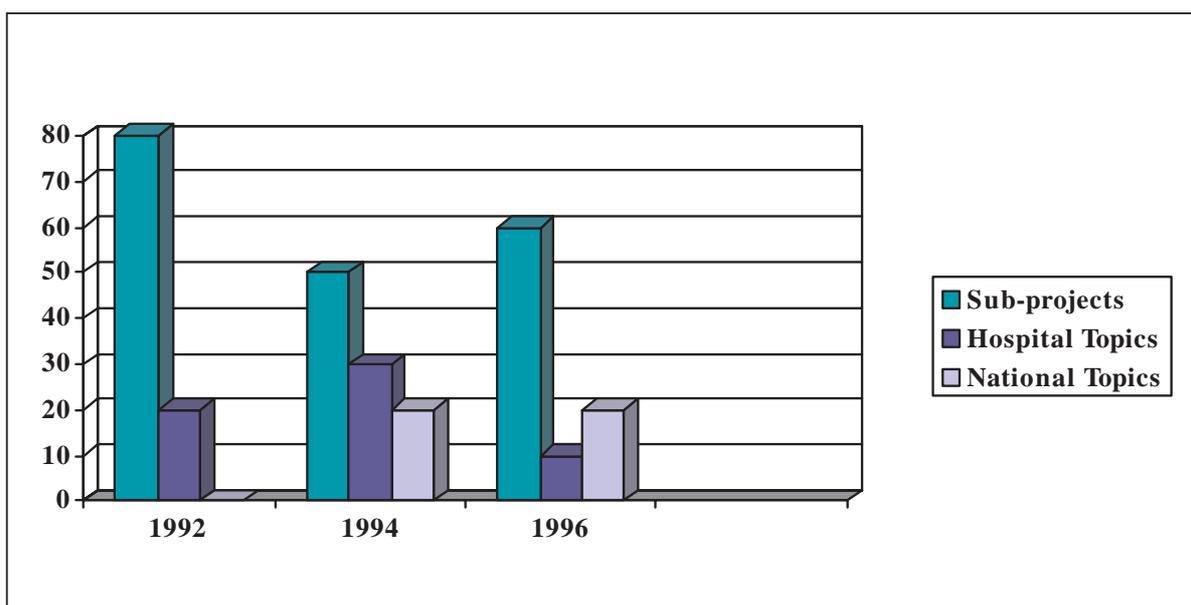


Figure 1: The percentage of space allocated to the topics covered by Newsletter „Pro-Health“.

As a communication tool, it has proved to be an effective method but its ability to impact on project ownership has yet to be determined. Although ownership was initially achieved, it became apparent with time that many staff differed in their understanding of the concept and purpose of the HPH Project. In hindsight, more attention should have been given at the outset to this issue. However, a balance needed to be struck between attention to detail and the need to maintain existing momentum and enthusiasm.

Project Coordinator

The Project Coordinator, another requirement of the European Pilot Project, was appointed to manage and develop the project in 1992. Originally established as a part-time position, its worth and value was recognised at an early stage by the Project Steering Committee. It became a full time position in 1993. As a full-time position the Project Coordinator had the time and opportunity to conduct informal discussions with staff. This process increased the profile of the project, while enabling many organizational concerns and practices to be identified. This was particularly pertinent with respect to the Smoke Awareness Project and the development of the Smoke-Free Hospital Policy.

The Project Coordinator role was pivotal to the development of the project. It enabled support to be given to the subproject groups, cohesion to the development of the overall project and visibility to the project as a whole within the hospital. The coordinator had a key responsibility for maintaining management and staff commitment to the development and implementation of the HPH Project. In relation to the subprojects, the full time coordinator role provided subproject leaders with practical assistance and support in areas such as motivation, resource allocation, documentation and the undertaking of evaluation processes.

External Consultant

Evaluation is an essential component of any project, to examine whether the stated aims have been achieved and in the long term whether outcomes have been met. The provision of feedback is also a fundamental element in the creation of awareness and ownership. Feedback is particularly powerful, when the content of the feedback is technically sound and professionally presented. Expertise in both these areas was considered vital. In the JCM Hospital project, an external consultant was engaged on a voluntary basis to provide this expertise. By involving the external consultant at the planning stage of each new project, technical expertise was available right from the beginning. This ensured the credibility of the outcomes and the subsequent feedback. The role of the external consultant covered the following areas:

- Input during the planning phase of all subprojects
- Expert advise on methodology and project design
- Assistance with subproject data analysis
- Full involvement in areas of overall project evaluation (i.e. questionnaires, surveys, data analysis, evaluation reports etc.)
- Assistance with documentation.

Project Focus

To maintain staff interest, it was considered that the issues addressed should be relevant and of interest to the organization generally. At the commencement of the project, a staff health survey was carried out with the assistance of the External Consultant. A questionnaire was sent to a random selection of staff. The aim was to assess lifestyle behaviours and obtain views on various topics. The questionnaire elicited information on staff smoking, alcohol, and exercise behaviours, participation in health screening programmes, views on perceived stress levels, hospital catering service and interest in back care, cardiopulmonary resuscitation and stress management training programmes.

The questionnaire worked well, as it provided important information on lifestyle issues and suggested ways to move the project forward. This gave direction to the overall project. The survey repeated three years later demonstrated many of the positive effects of the project on staff lifestyle behaviours and views. For example, Figure 2 shows the general increase in the uptake of stress management and relaxation courses, along with the utilisation of relaxation techniques as an effective stress management tool. Further evidence is demonstrated in Figure 3, where the positive influence of the project can be seen in relation to exercise; here more staff reported that they took moderate exercise on a regular basis as part of their lifestyle. Questionnaire response rate 77% (166) in 1993 and 52% (115) in 1996.

Therefore, in many respects JCM Hospital has been successful in attaining its primary objectives, of creating general awareness and generating a common vision based on the HPH philosophy. However, more time is required before total ownership of the HPH concept can be demonstrated at an individual level.

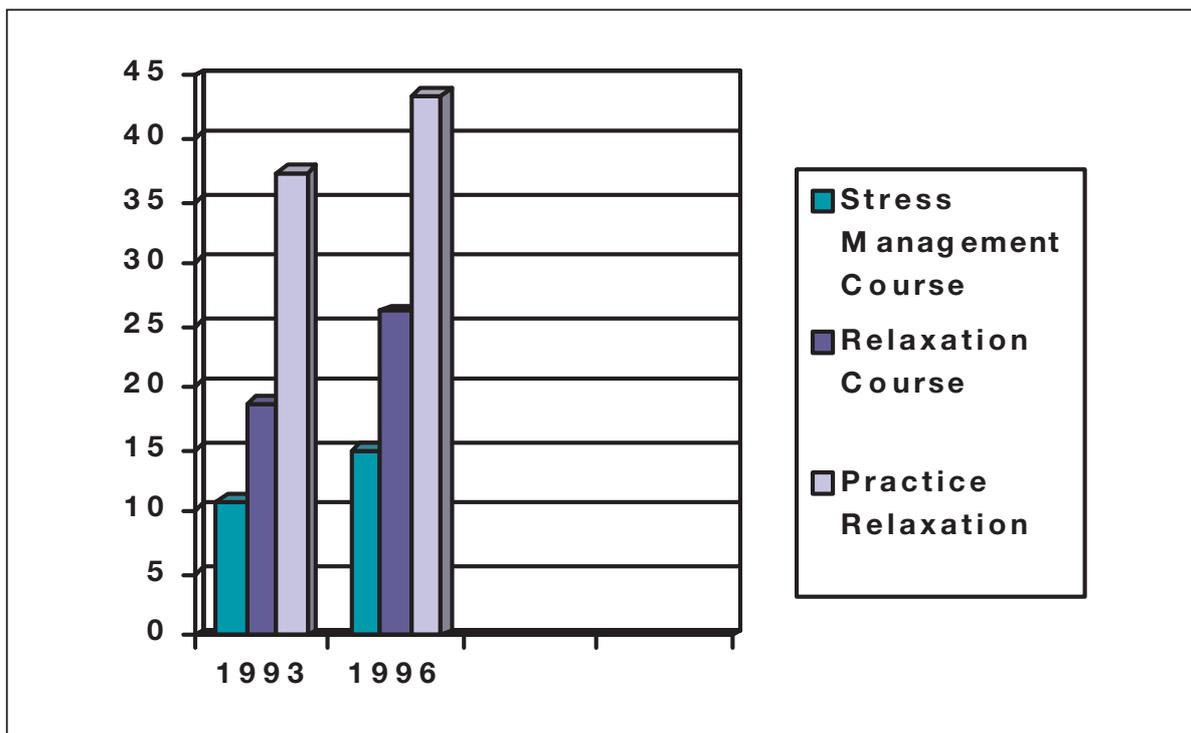


Figure 2: Demonstrates increased staff uptake of stress management/relaxation courses and practices.

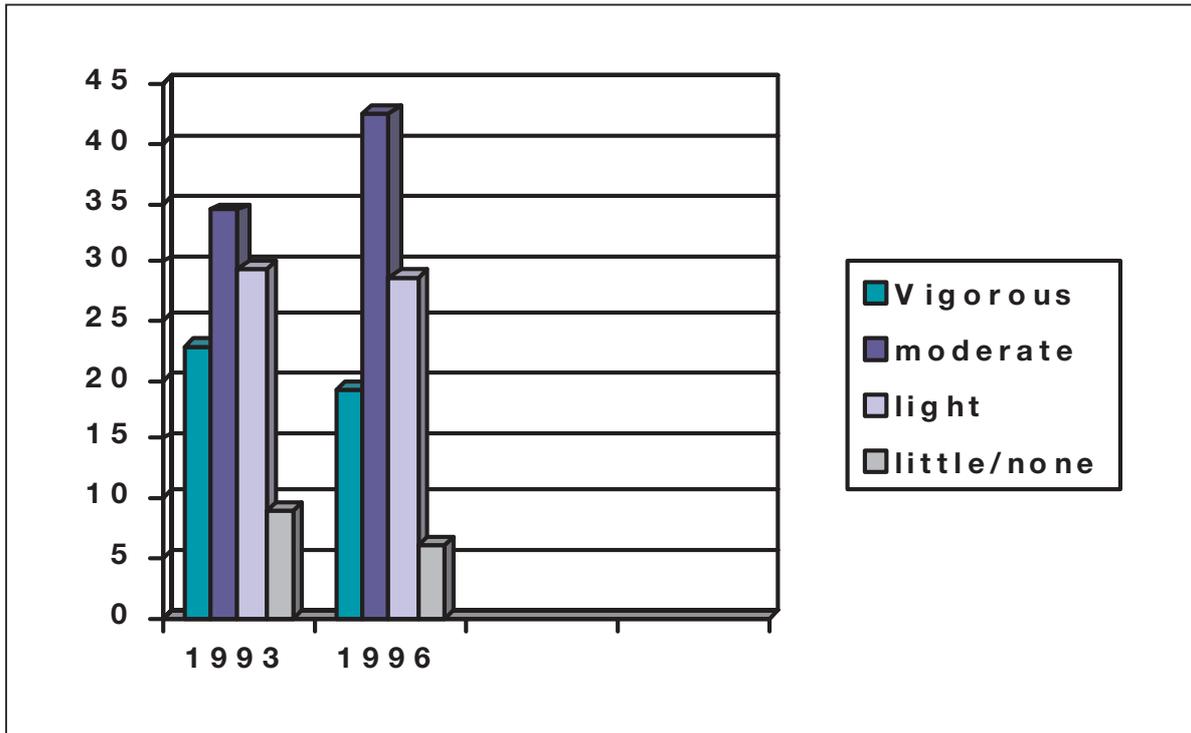


Figure 3: Positive influence of the project on staff exercise levels during the project period.

Generate active multidisciplinary involvement and participation

The generation of sustained active multidisciplinary participation is fundamental to the long-term development of the HPH concept. Having achieved an initial awareness and general acceptance, it was considered vital that the momentum be maintained. As previously stated, the project needed to focus on issues of common interest and relevance to the organization. The main strategy adopted to attain this objective was the establishment of a Project Steering Committee and the selection, development and implementation of the subprojects.

Project Steering Committee

The Project Steering Committee, originally a somewhat management dominated body, was quickly widened in 1993 to include subproject leaders and later still to include staff representatives. Initially, the key members were the representatives of Dublin Healthy Cities Project, Eastern Health Board, External Evaluator, Hospital Management Team AND Project Coordinator, as illustrated in Table 2. In 1995, to encourage wider participation and commitment within the hospital, the committee was widened to include representatives from many of the major staff groupings within the hospital (e.g. nursing, paramedical, and ancillary staff). This constituted a somewhat radical change from the established traditional structures and proved to be extremely successful in establishing a multidisciplinary profile for the HPH Project. Widening of the Steering Committee membership was a significant step towards maintenance of staff involvement and ownership of the project, a major project objective.

Table 2: Steering Committee (1992)

- Medical Administrator (chairman)
- Health Board Representative
- Healthy Cities Representative
- Hospital Matron
- Hospital Manager
- External Consultant
- Project Coordinator

The additional members were initially co-opted on to the committee for a period of six months; this was later extended to two years. The committee found that the longer period was required to achieve the active commitment and participation of all committee members. All staff was invited to send in nominations to the committee, an approach that proved to be unsatisfactory, as the majority of applicants came from the same staff grouping. A more successful approach was one of direct canvassing by the Project Coordinator. The result was a larger committee that reflected a cross mix of the hospital staff. However, this increase in membership to fourteen members, necessitated the setting up of an organizational sub-group. The sub-group was responsible for reviewing issues in-depth and making recommendations to the Steering Committee.

Initially, committee meetings were held on an ad hoc basis, but later were regularised to quarterly meetings to provide greater support and structure for the developing project. The Steering Committee proved to be a valuable method of maintaining project momentum, multidisciplinary participation and in keeping the HPH Project on

Table 3: Steering Committee (1997)

- Medical Administrator (chairman)
- External Consultant
- Hospital Manager
- Project Coordinator
- Nursing Administration (2)
- Medical Representative
- Patient Services Officer
- Paramedical Staff Representative
- Ancillary Staff Representative
- Health & Safety Representative
- Cardiac Rehabilitation Nurse
- Maintenance Staff Representative

the hospital management team's agenda. The steering committee now as outlined in Table 3 consists of seven-core members, reflecting senior management's commitment to the project and six elected members representing the active involvement of staff generally in the development of the project.

Sub-project Development

As a participant in the European Pilot Hospital Project, the hospital was required to instigate, manage and evaluate at least five innovative subprojects. These subprojects were viewed as the means through which the HPH concept could best be introduced and developed within the hospital. It was imperative therefore, that the subprojects chosen should contain certain characteristics; they needed to reflect the needs of the organization, be feasible to achieve within a short period of time and have as wide an appeal within the organization as possible. In this respect the following six sub-projects were chosen:

- Smoke Awareness
- Cardiopulmonary Resuscitation
- Stress Management
- Waste Management
- Back Care
- Promotion of healthy lifestyles

The subprojects gave visibility and status to the overall HPH Project. Each sub-project sought to incorporate the spirit of the HPH concept by establishing a multidisciplinary team and by bringing about change based on demonstrable outcomes.

To identify the subprojects, apart from the health status questionnaire mentioned previously, all staff was canvassed for their suggestions through normal hospital communication channels. This helped to ensure that the subprojects selected were relevant to the organization, while also identifying potential subproject leaders and possible members for the multidisciplinary subproject groups. Enthusiastic or committed staff submitted the initial subprojects. These people automatically became the subproject leaders. In hindsight, this may not always have been the best approach, as some project leaders ended up being the only active member of the project group.

In an attempt to demonstrate some of the successes and difficulties experienced by the subprojects, the following account will focus on two of the original subprojects: the Smoke Awareness and Cardiopulmonary Resuscitation Training Projects. These two have been selected as they highlighted some of the general difficulties associated with change and how we dealt with them.

Smoke Awareness Project

Initially, involvement in the subproject groups was based mainly on voluntary participation. This, at times, made commitment difficult as project work was undertaken in addition to normal workload. Limited time release for the project leader at least, was successfully negotiated in most cases. In fact, time release was successfully extended in some cases, following the publication of evaluation data demonstrating the effectiveness of the subproject interventions.

Table 4: Smoke-free hospital policy – development & implementation outline

● Review of existing policy & practice	a) Staff questionnaire b) Random site observation survey c) Semi-structured interviews with selected managers
● Workforce consultation	a) Open meeting – all staff invited b) Informal discussions conducted at dept. level
● Formation of a Working Party	a) Multidisciplinary and Union participation b) Mixture of smokers and non-smokers
● Designation of Smoke-free and smoking areas	
● Management Consultation	
● Public implementation of agreed policy	
● Evaluation two years later	a) Staff questionnaire repeated b) Random observational survey repeated c) Informal discussions at dept. level

In the case of the Smoke Awareness Project, the project leader, a ward manager, was released initially for six hours a week, later extended to eight hours. This subproject had two distinct parts; firstly, the development and implementation of a Smoke-free Policy as outlined in Table 4 and secondly, the provision of services aimed at bring about a reduction in smoking levels as described in Table 5.

Table 5: Stop Smoking Support Programme – Objectives & interventions.

Objectives:	To provide regular stop smoking group support sessions To encourage and facilitate more staff to give up smoking To motivate and assist nursing and medical staff to develop a more positive approach to smoking cessation within the client relationship To provide on-going support for patients through improved hospital/community links
Interventions:	Development of three (eight week) Stop Smoking Group Support sessions annually Introduction of a formal in-patient counselling and referral service Provision of low cost nicotine reduction therapies for staff Establishment of a link staff programme Involvement with community awareness and education programmes
Evaluation:	Telephone follow up – one and two years post counselling Review of referral documentation Uptake and long term effectiveness of nicotine therapies for staff Informal interviews with link staff

In relation to time release, further extension was given to the subproject leader, on the publication of the results achieved by the stop smoking support interventions during the first year (see Fig. 4). In all 79 people attended for counselling, of which 34 (43%) made serious attempts to stop smoking and of these 13 (38%) were still non-smokers one year later.

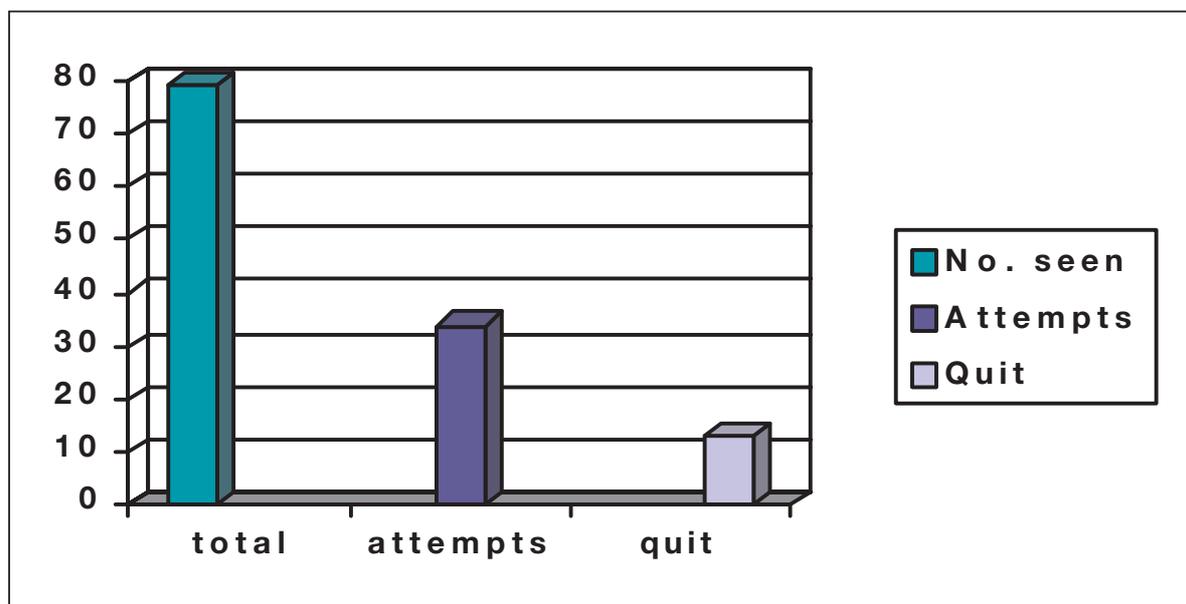


Figure 4: Results achieved by stop smoking interventions during 1994–1995 among the 79 people who attended for counselling during this period.

The service had a wide focus and was availed of by staff, patients and local community members (see Fig.5). The positive outcomes attained during the subproject phase resulted in the continuation and further development of these services as part of the routine hospital service.

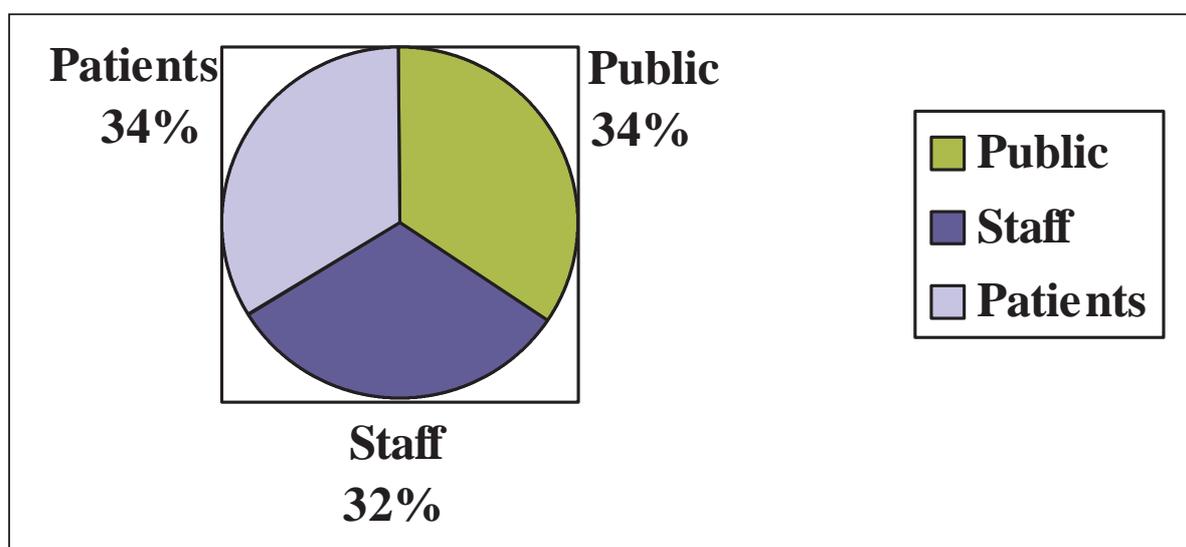


Figure 5: Percentage of those attending the stop smoking services during 1994–95, 27 members of the public, 27 registered patients and 25 staff members.

Cardiopulmonary Resuscitation (CPR) Training Project

All the subprojects were developed using the principles of project management and attempts were made to involve multidisciplinary participation and co-operation in the project groups. All subprojects developed well, although, continuous multidisciplinary involvement was not always maintained. Certain project groups worked better than others. These in general were found to be project groups, where a common interest in the issue previously existed. An example of this was the Cardiopulmonary Resuscitation project group, the composition of which is outlined in Table 6 below.

Table 6: CPR Sub-Project Group

<ul style="list-style-type: none"> ● Consultant in Accident & Emergency ● Consultant Cardiologist ● Consultant Anaesthetist ● Nursing Tutor ● Resuscitation Training Officer ● HPH Project External Consultant
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Table 7: Cardiopulmonary Resuscitation (CPR) Training Project

Objectives:	<p>To recruit a Resuscitation Training Officer (RTO)</p> <p>To secure the provision of equipment and facilities essential to the training programme</p> <p>To develop a standardised basic life support (BLS) training course, to include skill proficiency & information on heart disease and associated risk factors</p> <p>To observe/audit the composition and performance of the Cardiac Arrest Team</p> <p>To monitor the results of resuscitation attempts and evaluate survival rates from Cardiac Arrests</p> <p>Evaluate the effectiveness of the BLS training programme at the end of two years</p>
BLS Course Content:	<p>Course Introduction x 5 minutes</p> <p>Discussion on Heart Disease and associated risk factors x 5 minutes</p> <p>Emergency Response System in the hospital x 5 minutes</p> <p>1-Rescuer CPR: Slides, Demonstration + Practice x 30 minutes</p> <p>2-Rescuer CPR: Airway equipment, Demonstration + Practice x 20 minutes</p> <p>Foreign Body Airway Obstruction: Video + Practice x 30 minutes</p> <p>Special CPR situations/infant + child CPR: Demonstration x 20 minutes</p> <p>Principles of Advanced CPR: equipment, team roles, drugs + documentation x 30 minutes</p> <p>Evaluation: Assessment of Practical Skills/Multiple Choice questionnaire x 30 minutes</p>
Programme evaluation:	<p>Review of individual risk factors and lifestyles</p> <p>Practical Skills assessment</p> <p>Knowledge assessment – repeat multiple choice questionnaire</p>

Here the group members had an established and vested interest in the development of the subproject. Moreover, the group was supported by the appointment of a full-time Resuscitation Training Officer, responsible for the coordination of the project. As a result this group has continued to work together and be active in the development of the project, even after the initial subproject phase. The CPR Project set out initially to train and enhance efficiency of basic CPR skills amongst hospital staff and in the community. Further developments have led to the development of an Advanced Cardiac Life Support Training Course, both Basic and Advanced Instructor training programmes and to the hospital being recognised as a centre of excellence for cardiac life support training in Ireland. A brief overview of the initial CPR subproject can be seen in Table 7.

Other difficulties to emerge, with regard to multidisciplinary involvement, related directly to an imbalance that resulted from the reliance on voluntary participation. Some groups had a predominance of one discipline and lack of or poor participation of another. Canvassing, in some cases, was essential when a particular expertise was required. Other groups experienced a variety of difficulties around ownership and leadership styles. In one case, strong leadership led to a perception of sole ownership, while in another, weak leadership led to the disintegration of the project group. To a certain extent, these difficulties were later overcome when new projects were being set up as individual roles, goals and targets were clearly defined and made explicit at the beginning. Most of the initial subprojects have been successfully absorbed into the routine of the hospital service.

Contribution of subprojects to the overall HPH project

The key results of the subprojects contributed greatly to the growth of the HPH Project, in that a wide range of staff became directly involved and gave substantial personal commitment to the development of the project. Through their efforts very positive results have been achieved in the improvement of the quality of many of the hospital's services. Patient empowerment has occurred, particularly in the areas of Cardiac Rehabilitation, Stress Management, Smoking Cessation and others, where better patient facilitation actively encourages definite action towards a healthier lifestyle. Furthermore, staff participation and the presentation of subprojects at HPH Business Meetings, national and international conferences has highlighted the achievements, status and credibility of the HPH Project within the hospital. (Roban, 1994, Boland, 1995, Duggan, 1995, Smyth, 1996, Lawlor, 1996, Bellew 1997).

Community education programmes have been developed whereby the knowledge and expertise of hospital specialists are being disseminated into the community. Later development and motivation were gained through the hospital's obligation, under the European Pilot Project contract, to facilitate the establishment of a National Health Promoting Hospitals Network. This gave recognition to the work already achieved, while stimulating new areas for expansion and development. This further increased the visibility and prestige of the hospital, not only in the local community but also throughout the health service. The successful outcomes of the subprojects are viewed as the pebbles that will create the ripples of change, essential for the achievement of the ultimate aim of organizational change.

Development of a Health Promotion Culture within the hospital.

To create and sustain change requires the development of a supportive environment. The approach adopted to achieve this objective was the development of strategies that would heighten awareness and positively encourage attitudinal change. It was considered important that the HPH Project should raise and maintain visibility for the determinants of health. The hospital attempted to do this through its participation in a number of national health promotion campaigns. These were:

- Clean Up the World Campaign,
- National Healthy Eating Week
- World No Tobacco Day
- Irish Heart Week
- Cancer Awareness Week
- European Safety Week
- National Hospital Challenge Day
- Mental Health Awareness Day

Active participation in these campaigns raised awareness and highlighted a need for change. This process was stimulated using questionnaires, quizzes, and free assessment and testing. Prize draws were used to encourage feedback and obtain evaluation data. A central strategy to this approach was the ability of each member of the overall project team to contribute by highlighting health promotion principles in key areas within the hospital.

To aid communication of the HPH concept into the community, the hospital became and remains an active participant in a local community health forum. The forum promotes health awareness through a range of activities that enable people to make healthier choices. Furthermore, through the successful development of a number of the subprojects, recognition for the HPH concept has been gained on a national level. In an effort to facilitate the exchange of information, experiences and outcomes, JCM Hospital was responsible for initiating the first national HPH conference in April 1995. From this conference the Irish National HPH Network emerged, sponsored by the JCM Hospital Project. In addition to this, regular feedback on the development and implementation of subproject interventions promoted the growth of a health promotion culture and the development of a supportive environment for healthier lifestyle choices.

These interventions included some of the following:

- implementation and on-going monitoring of a Smoke-Free Hospital policy;
- introduction of ergonomic changes to reduce back strain in the care of the elderly;
- reduction of hospital waste through the introduction of recycling facilities;
- provision of regular cardiopulmonary resuscitation training for staff, with a focus on the risk factors associated with heart disease;
- measures that assist in the reduction of stress caused by hospitalisation;
- service delivery measures that promote continence among the elderly;

Change, once realised, can subsequently influence the culture within the hospital. These initiatives have created and realised a need within the organization for change that has subsequently influenced the culture within the hospital. While, the HPH Project has tried to involve the community as much as possible, this is one area that needs to be expanded. Talks on healthy living, lifestyle and CPR have been given at various venues in the community and community attendance for smoking cessation counselling is greatly encouraged. However, no community subproject has yet been developed and it is hoped to concentrate on this area in the future.

Conclusions drawn at the close of the project.

In many respects, JCM Hospital has been successful in attaining the objectives set by the European Pilot Project. However, it must be acknowledged that more time is required, before the level of ownership essential for the maintenance and development of the HPH concept, can truly be realised. Many difficulties and problems have been encountered during the period of the European Pilot Project; many of which have been resolved successfully, although some still require on-going attention.

Difficulties/ Problems encountered:

- Communicating an intangible concept
- Establishing individual and collective staff ownership of the HPH Project
- Generating active multidisciplinary involvement
- Budget and resource deficiencies
- Development of on-going effective communication strategies.

So, what has been achieved? What changes have resulted from the hospital's participation in the European HPH Pilot Project? Quantifying the results in itself is a difficult task and it is realise that we still have some way to go to achieve this. Notwithstanding this, our achievements can be separated into two different categories: tangible aspects (Table 8) and intangible aspects (Table 9).

Table 8: Tangible Aspects

<ul style="list-style-type: none"> ● Sub-projects ● Staff Participation and Development ● Patient Empowerment ● Community Education

Table 9: Intangible Aspects

<ul style="list-style-type: none"> ● Staff/Management Awareness ● Heightened Public Profile ● Multidisciplinary Approach ● Staff Empowerment
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Identifiable achievements at the end of the project

- The establishment of a multidisciplinary HPH Steering Committee.
- Renewal of the Health Promotion Coordinator role within the hospital.
- Regular publication of the “*Pro-Health*” Newsletter.
- Continued support for the development of new sub-projects and the funding of new initiatives with a health promotional focus.
- A general move within the organization towards decision-making that is based on health gain orientated outcomes.
- Improved image and prestige within the local community health service generally.

The identification of these achievements and the drawing up of the subsequent conclusions and recommendations for future action were arrived at following the initiation of various evaluation processes. These were:

- a review by senior management of all organizational changes that occurred during the project period and the identification of changes that directly resulted from the hospital’s participation in the European Pilot Project,
- critical review of the Project Coordinators role by the Steering Committee,
- staff views and lifestyle changes gained from the staff health questionnaire data,
- a review of the minutes from all Steering Committee meetings,
- open discussions with Steering Committee members, Project Coordinator and Senior Management Personnel and;
- acknowledgment of the interest generated by the project within the National Health Service.

Despite the many difficulties, enthusiasm remains high and greater effort is now being placed on the development of new subprojects, the encouragement of wider multidisciplinary co-operation and the provision of adequate feedback to all grades of staff on the development of change. In addition, our future plans are to improve not only hospital-community participation but also community involvement in the development of hospital services and the creation of a healthier community environment.

Recommendations for Future Action

Future plans include greater emphasis being placed on the following points:

- Increasing multidisciplinary involvement
- Provision of adequate and frequent feedback to staff on developmental progress
- Motivation and support for new and existing subproject developments
- Introduction of models of best practice gained from other HPH hospitals
- Fostering and encouraging community links
- Continuing to be a key participant in the development of the Irish National HPH Network

Recommendations for Other Hospitals

The story of the Health Promoting Hospital development initiative in James Connolly Memorial Hospital is one of growing success. Lessons can be learned from our experiences and outcomes. The subsequent list of recommendations was drawn up following a critical review of the project and sub-projects by the Project Steering Committee. These recommendations aim to provide other interested hospitals with some guidelines on ways to develop or extend a health promotion infrastructure within the hospital setting.

Recommendation and Possible Action

1. Place health promotion squarely on the agenda of senior management. Obtain agreement to develop a new mission statement for the hospital, one that will incorporate health promotion as a core activity.
2. Develop a variety of effective communication strategies, to ensure that all staff understand and can become directly involved in the HPH process.
3. Establish the credibility and status of the HPH initiative by forming a Steering Committee, capable of developing and implementing the HPH strategy. It should be a multidisciplinary team that comprises all staff groups.
4. Identify someone in the organization to lead the health promotion initiative. Someone who, given the position and authority, will maintain momentum and drive the initiative forward. A job description, with relevant reporting mechanisms outlined, along with the provision of administrative and technical support are essential requirements for success in this position.
5. Establish organizational health promotion targets. Define long and short term objectives, make them explicit and generate general agreement on their achievement.
6. Survey and assess current health promotion initiatives/programmes/ support within the organization and community - Develop a health promotion database. Identify potential areas of development and also potential barriers to health promotion.
7. Subprojects should be selected on the basis of feasibility, relevance to the organization and be achievable within a specified time-frame.
8. Attention should be given to project structure, both in terms of the overall project and the subprojects. Aims and objectives should be clearly stated. Evaluation processes should be incorporated during the planning phase and linked into the project objectives. Evaluation procedures should encompass the gathering of appropriate information.
9. Develop links with an external academic institution for the purpose of evaluation expertise. Measurement, an essential element of the HPH concept, is the basis on which future development can be planned. Knowledge and skills in this area are critical to the credibility of the HPH outcomes. Where possible formal agreement should be obtained. Alternative links would be with specialists in Public Health.

10. Establish a financial commitment to health promotion within the hospital. It is recommended that a percentage of the hospital budget should be allocated to cover the staffing, training and development costs of the HPH initiative. However, other costs incurred are in the nature of development costs and are best met from within existing budget arrangements.
11. Facilitate community involvement and inter sectoral action for health promotion. Develop networks with social, voluntary, charitable, business and government bodies.

References

- Bellew, Catherine, (1997), *Cardiac Link Programme*, Paper presented at the Irish National HPH Symposium „Creating the Links“. Dublin, Ireland
- Boland, Margaret, (1995), *Stress Management for Hospital In-patients*, Poster presentation at the 3rd International Conference on Health Promoting Hospitals, Linkoping, Sweden
- Dept. of Health, (1994), *Shaping a healthier future; a strategy for effective healthcare in the 1990s*, Government Stationery Office, Dublin, Ireland
- Dept. of Health, (1995), *A Health Promotion Strategy; making the healthier choice the easier choice*, Government Stationery Office, Dublin, Ireland
- Duggan, Eilis, (1995), *An ergonomic approach to reducing the physical load on the health care worker in a long stay geriatric unit*. Paper presented at a HPH Seminar „Health Promoting Hospitals in Practice“ Hildesheim, Germany
- Lawlor, Billie, (1996), *If you are going to do it, do it right - Cardio Pulmonary Resuscitation Training*, Paper presented at the 4th International Conference on Health Promoting Hospitals, Londonderry, Northern Ireland
- Roban, William, (1994), *Waste Management Project*, Paper presented at the Conferenza Internazionale „La Promozione Della Salute E Del Benessere Degli Operatori E Degli Utenti Nell`Ospedale, Milan, Italy
- Smyth, Mary, (1996), *Create and Support Changing Environments - a Smokefree Hospital Policy*, Paper presented at the 4th International Conference on Health Promoting Hospitals, Londonderry, Northern Ireland

The National Health Service System in Poland

Jerzy B. Karski

The political and economic changes that have been taking place over the last few years in Poland have not encompassed the whole sphere of social security which includes health care; this is mainly financed from the state budget. The reform of the national economy directed at capital market mechanisms and ownership transformation was not accompanied by changes in the organization and financing of health and social services.

People's health is deteriorating, while financing, with regard to the needs and opportunities of the medical sector, is being reduced relatively. Structural transformations in Poland in the public health service system should as a requisite introduce changes as an obligation to the sector and adjust the health service to the new political and economic conditions, which have emerged in our state. The directions of such changes are specified in the „Strategy for Health“ program based on the government program „Strategy for Poland“. Transformation of the primary health care system is one of the important elements of this strategy.

The main strategic objectives of the „Strategy for Health“ include: (i) improvement of the health of the population, (ii) ensuring universal access to health care services and maintaining equal rights to the range and quality for all those entitled, (iii) increasing the effectiveness and quality of health care services, and (iv) ensuring stable sources of funding and control of expenditure.

The current system of organization and financing of Polish health care still remaining under the influence of the previous socio-economic order is to be changed over the next few years. The crucial planned changes are as follows:

- a) Health services will be financed through health insurance, and they will be provided by health care institutions and individual health professionals who have appropriate qualifications and accreditation, which will be regulated elsewhere. Health insurance institutions will make contracts with the health care institutions and professionals for services defined within the act on guaranteed services. The contracts will be based on a free choice of provider irrespective of the ownership status. Within the terms of the contracts free choice of health care institution or professional will be available to the insurance member. The health insurance system is expected to guarantee appropriate quality of services which will be regulated separately.
- b) The system will be characterized by solidarity as in the case of social insurance. This means that there will be risk sharing in relation to disease and disability and for the bearing of costs. The financing of health insurance will be through subscription, and health insurance funds will be able to generate income which will also be subject to separate regulations. In the initial phase of the functioning of the system a significant contribution from the central budget must be anticipated.
- c) In view of the planned regionalization of health services the principle applied should be one of local use of funds gathered locally for local health needs. How-

ever, a proportion of the funds gathered will be diverted to the central level to be used to alleviate disproportions between regions. Agreements between the universal and alternative health insurance institutions will provide for reciprocal care of patients based on accounting. Supplementary insurance may be purchased to cover co-payment for guaranteed services, for drugs and appliances, for non-standard services and for those excluded from this range within the universal and alternative health insurance systems. The system may provide full or partial refunds for costs borne depending on individual agreements between subscribers and the health insurance institution.

- d) During the next two years of transformation the legal basis for the functioning of health care and health insurance institutions must be established. These institutions will make contracts based on cost-accounting and a uniform price list for services. The principles of the functioning of health care institutions and professional teams at the primary level must be defined. The team will include: a general practitioner or family doctor and pediatrician (also as group practices), community nurse and midwife, dental technician and hygienist. Contracts will also include specialist referrals for: internal medicine, surgery, pediatrics, gynecology and obstetrics, neurology, oncology, dermatology, ophthalmology, ENT, tuberculosis and respiratory disease, and occupational health. The remainder of activities at the primary level will be provided in the district general hospital and in life-threatening cases by the emergency services. Referral to specialist and for diagnostic tests at secondary and tertiary levels should also be based on contracts.

The transfer to health insurance should be gradual and the territorial character of service provision based on contracts with various providers will favor the establishment of the health insurance system. Cost-accounting within the provider institutions will enable the development of a national price list of services based on a points system for medical procedures.

In the near future the *powiat* (a reintroduced district level; between *voivodship* and *gmina*) will include primary care and the specialist diagnostic, therapeutic, rehabilitation services mentioned above, including in-patient services financed from funds available from the health insurance system and from their own self-government financial sources at the district level. Regulations will be drawn up concerning the principles of the functioning of provincial and academic hospitals in accordance with regionalization of health services and the provision of secondary and tertiary specialist diagnosis, treatment and hospitalization, particularly with regard to narrow specialties and tests. The financing of academic hospitals and research institutes will continue to be funded from the central budget. Afterwards (in-coming), all health care services should be paid by the insurance system fund.

Resources for health care at the district level should come from the insurance system and provincial governor's budget and the self-government local authority. The value of the registration fee should be established uniformly throughout the country and should be tax deductible. The provincial governor's budget should ensure funds for health services, maintenance and investment, which are necessary to meet the health needs of the given district.

Transformation of the present hospitals into hospitals well-adapted to current and expected health demands of the population, is part of a long-term process of hospital planning, which concerns the period of the next 5-7 years. The outline of the Polish hospitals restructuring is to prepare conditions for faster transformation of in-patient care and later for the best distribution of hospitals in voivodships, regions and the whole country (the country hospitals network). This should be achieved by making gradual changes in the existing traditional structures of hospitals by dividing them into: short-term care hospitals, day hospitals, long-term hospitals, nursing homes and palliative treatment centers.

The health care system with elements of market economy, such as buying of hospital services by the voivodship health authorities or by the family doctors, paves the way to optimal restructuring of hospitals and adjusting the structure of in-patient care to the needs of the population. The main reason for speeding up the process of restructuring hospitals in Poland is due to current unsatisfactory utilization of hospital beds in comparison with EU countries.

Among the changes, a new trend in the hospital's function is expected to be created. Since 1992, *the Polish National Network of Health Promoting Hospitals* has been developed, and now consists of more than 40 hospitals within the country (i.e. about 6.2% of the total number of hospitals in the country). 18 of the hospitals are also members of the European Network of Health Promoting Hospitals.

The profiles (structure) of the Polish Network of Health Promoting Hospitals are as follows:

- a) the main group consists of general hospitals, including university medical school teaching hospitals and one central (nationwide cover) hospital. Other hospitals of the group are mainly local, district or regional 200-300 bed hospitals;
- b) another group of hospitals are children's hospitals, mainly with their full name being „mother and child hospital“, and they are 200-600 bed hospitals in size;
- c) the last group of hospitals of the Network are specialist hospitals; psychiatry, rehabilitation, cardiology, oncology, neurology, rheumatology, etc.

Amongst the personnel of the Network Member Hospitals, about 14% (range: 3 – 78%) of physicians and 16% (range: 1–80%) of nurses and midwives have been engaged in health promotion activities. The average percentage of other „white“ personnel of the hospitals engaged in health promotion activities has been assessed to be about 34% (as from 1 to 100%), i.e. therapists, psychologists, dieticians, etc.

Development of the Polish National Network of HPHs can be characterized by the following milestones:

- 1992 – Establishment of the Polish National Network of Health Promoting Hospitals;
- 1993 – The First International (European) Conference of Health Promoting Hospitals in Warsaw – in the Memorial Hospital – The Child Health Centre;
- 1994 – The First National Conference of Health Promoting Hospitals (with foreign guests' participation) in Ustron (Upper-Silesia Cardiac Rehabilitation Centre);
- 1995 – The Second National Conference of Health Promoting Hospitals in Warsaw -Miedzylesie (The Rail Central Hospital-Warsaw);

1996 – The Third National Conference of Health Promoting Hospitals in Kalisz held on October 5-6th¹;

1997 – The Fourth National Conference of the Polish HPHs in Lublin/ Kazimierz Dolny held on October 16-18th; and

1998 – The Fifth National Conference will be held in Kraków/Cracow.

The leading role in the organization of a health promoting hospital, is played by the will of hospital staff to be actively involved in health promotion activities. The majority of the member hospitals have established their own permanent health promotion team (with, e. g. Program Council, the HPHs Project Board, Health Promotion Team, etc.). The leader of the team was previously a physician or a nurse. The team is responsible among other things for the working out of, implementation and co-ordination of compulsory projects² and their own original health promotion projects, as well as for collaboration with remaining hospital personnel, hospital management staff and with representatives of the local community.

Apart from the Network Statute published already in the Vienna HPHs European Coordinating Center Newsletter No 5, pp. 8–10 (May 1995), the Network has its own self-evaluation system for its member hospitals health promotion programs assessment.

Each National Conference of Health Promoting Hospitals resulted in an increase of new hospitals' applications for the Network membership. Another observation has also been made; there is some relationship between the number of hospitals which are Network Members and the environmental health-related hazards and density of population in the region. The more health environmental risks there are and the higher the density of population in the region, the higher the number of hospitals which joined the Health Promoting Hospitals Network. This would mean, that people realized the higher health promotion needs in these regions of the country.

During the five years that the Polish Network of HPHs has been functioning, in spite of many difficulties, the hospitals have been undertaking many health promotion activities, gaining both positive and negative experiences. The number of hospitals joining the Network is constantly rising. More and more people are committed to health promotion. The increase of interest is connected with hospital staff raising health awareness, with acknowledgment of benefits and positive changes resulting from the health promotion programs and improvement of health care service quality, which is fulfilling patients' expectations more and more. It is also connected with the increase in job satisfaction and professional prestige. Simultaneously however, some people withdraw from health promotion activities, because of lack of time and funding, i. e. because of the lack of additional wages for personnel dealing with health promotion as an additional job alongside their basic medical responsibilities.

¹ Since the Conference in Kalisz, there is a leading topic of the Conference; e. g. Kalisz – “Health of digestive and nutrition”; Lublin – “Stress at hospital”; Kraków – “Cooperation with local community”.

² Members of the Polish Network of HPHs are obliged to deal with 5 compulsory projects connected with health promotion. There are the following: 1. Incorporation of health promoting into the hospital structure, 2. Health education, 3. Healthy food and healthy nutrition management in the hospital, 4. Anti-tobacco activity and alcohol and drugs constraints, 5. Cooperation with local community and administration.

Incorporation of health promotion within a hospital structure is favorable for positive changes in the hospital's function (although this is not the same for all hospitals). Positive changes have been observed in the interpersonal communication and collaboration among various professional hospital groups, the diminishing of job-related stress, changes relating to interpersonal relationship and hospital management style. These changes attract the hospital staff to health promotion activities and are conducive to integration not only within the hospital, but also outside the hospital environment.

Work of the interdisciplinary health promotion team has helped not only with mutual support and empowerment, but has also helped in establishing respect, involvement and equal treatment of all professions represented at the hospital, changes in the style of management and personal commitment of the hospital management personnel. In addition, activities were directed at improving communication and cooperation in structure, as well as in interpersonal relations, and measures were taken to improve social and general work conditions.

All present and planned changes will lead to the rationalization of the financial decision making process and will increase the interest of local self-governments in taking over health care services. Up to the present, 1,752 health care institutions have been taken over by local self-governments (among them 1,423 primary health care institutions).

Progressive implementation of the National Health Program being one of the major elements of the Strategy for Health and development of current and intended health promotion activities will support the planned organizational and financial changes to improve the health status of the Polish population.

It may be expected, that international cooperation and support in the process towards a United Europe will accelerate Polish efforts to bring the health care system norms and standards into accordance with the European Union patterns.

The Upper-Silesian Rehabilitation Centre „Repty“ in Ustroń as a Pilot Health Promoting Hospital

Zbigniew Eysymontt, Zbigniew Bączek, Alina Marzec



Silesian Rehabilitation Centre Repty, Ustroń

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Hospital Owner:	Upper-Silesian Rehabilitation Centre in Tarnowskie Góry
Hospital Ownership:	Public
Specialisation:	Rehabilitation Hospital
Beds:	120
Staff:	Medical Staff: 54, Nursing Staff: 24, Other Staff: 35, Total Number of Staff: 113
Utilization:	Average Utilization of Beds/Year: 98.4 %, Average Stay in the Hospital/Day: 25
Patients:	Number of Inpatients/Year: 1575, Number of Outpatients/Year: 176
Number of Departments:	3 (2 Cardiac Rehabilitation Deps.; 1 Orthopaedic Rehabilitation Dep.)
Location of Hospital:	Suburbs/rural
Catchment Area:	Regional, Number of Population: mainly Upper Silesian Region: 2 Mio
Other Functions than Medical Care:	
Teaching:	Postgraduate, Other Health Professions: Physiotherapists, Rehabilitants
Research:	Clinical Research, Basic Scientific Research
Subprojects:	<ol style="list-style-type: none">1. Ergonomic and Aesthetic Workplace2. Promotion of Culture and Coping with Stress3. Healthy Food4. Personnel Health Check Up6. Health School7. Minimizing Epidemiological Dangers8. Hospital as a Smoke Free Zone9. Separation and Utilization of Waste10. Influence of Climate on Rehabilitation Programmes

The project's start

The Upper-Silesian Rehabilitation Centre „Repty” in Ustroń was established in 1989 as an annex to the main centre in Tarnowskie Góry. The early stages of cardiac rehabilitation are managed in two cardiac rehabilitation departments which admit patients who have had heart attacks, open-heart surgery or coronary bypass surgery. The Ward for Orthopaedic Rehabilitation simultaneously treats patients after orthopaedic surgery, injuries and other orthopaedic diseases. We treat around 1900 patients annually in our hospital, and up to the present time around 2000 patients have been admitted for cardiac rehabilitation a month after a heart attack or after having cardiac surgery. 53 % of patients of the Orthopaedic Department are being treated after trauma or immediately after undergoing surgery.

The main focus of our institution – i.e. working with patients immediately after cardiac or orthopaedic operations – created the need to broaden the current rehabilitation programme and to include psychotherapy and health education, the value of both of which had previously not been appreciated in health centres of this type.

The initial plans for the implementation of a comprehensive programme of health promotion in the hospital appeared midway through 1992. From the very beginning the father of the idea and main promoter was the head doctor of the Rehabilitation Centre „Repty” in Ustroń Dr. Zbigniew Eysymontt. Of vital importance for an effective initiation of the plan was the full support from the hospital authorities, represented by the director of the Rehabilitation Centre „Repty” in Tarnowskie Góry, Dr. Krystian Oleszczyk.

The initial preparations for the health promoting hospital project were met with a cautious reception by the hospital staff and even with a certain antipathy. This was mainly due to a fear of the unknown, since the subject of preventive medicine is little understood by society at large and only little better by the health care professionals.

The cautious reception among staff furthermore also resulted from a dislike of organisational change, and the fear of being given extra duties with no chance of additional financial rewards. This attitude of the personnel toward the implementation of the project has changed gradually.

The importance of the “pro-health campaign” run by the mass media must be mentioned as well. This campaign has helped for a further understanding of health promotion issues by the whole staff. In the beginning possible advantages were better understood by the hospital management.

However, even today after a five year period of work, a group of malcontents remains within our ranks who can see no point in the changes that have been implemented and who only contribute to health promotion through their criticism, which is not always constructive, needless to say.

The Ustron Health Promoting Hospital Project – from motivation to implementation

At the beginning three activities were set. First, the Joint Committee was set up. Next, contact was made with independent external institutions who could support

our work on health promotion projects and thirdly, a list was drawn up of subprojects to be implemented in our hospital.

In the first phase 9 subprojects were put into action:

1. Hospital as a smoke-free zone
2. Segregation of waste
3. Minimising the epidemiological dangers
4. Healthy food
5. Health School
6. Coping with stress
7. Ergonomic and aesthetic work place
8. Activities for the staff and the local residents
9. The hospital as a place for the promotion of culture

Each of the subprojects had its own team-leader and a small project team, differing in size (3–9 members) who collaboratively developed an action plan, whose implementation would rely on the efforts of the members of the team and more widely also on the efforts of a wider group of volunteers drawn from the hospital staff.

After our application as Pilot Hospital had been accepted by WHO and the first public presentation of the hospital and the project during the 1st International Conference of the European Network of Health Promoting Hospitals in Warsaw (May 1993), the first phase of practical implementation of our aims was begun.

Early on, in the first few months, problems appeared which hampered the implementation of the project and which, as it turned out, apparently still affect us today. The first is the financial shortage which hinders the successful implementation of subprojects. Another issue is the lack of support from the local authorities and political representatives which is all the more incomprehensible since numerous activities are aimed at the local community. Another serious problem is the lack of suitable training and experience in the areas of carrying out planning, documentation and evaluation, and assessment of projects, which implies an absence of knowledge in the field of project management.

Many of our efforts are based on intuitive behaviour and amount to a stating of the obvious. It should also be mentioned that shortly after starting the subproject on encouraging increased physical activity among the staff, this had to be cancelled because of a lack of interest in the project by the hospital's staff members.

Two new subprojects have nonetheless appeared:

- The influence of climate on the rehabilitation programme (1995)
- Personnel health check-up (1996)

At the present, we are in the process of implementing 10 subprojects at varying stages of development, determined by the problems mentioned above, of which the constant lack of funds is the most significant.

The subprojects which are the furthest toward being completed are at present:

1. Health school

2. The hospital as a place for the promotion of culture
3. Healthy food
4. Hospital as a smoke-free zone
5. Segregation of waste

In spite of minor set-backs which are almost inevitable, given the conditions in which we have to work, this time has not been wasted. Many of the newly-established working procedures have been completely adopted into the daily routine of the hospital, as have the subprojects we have implemented. The lectures organised as part of 'The Health School' have become an integral part of the medical rehabilitation programme. A similar situation applies to the cultural events which take place in our hospital. Conscious of the soothing effects of music we also hope for its positive influence on the process of rehabilitation. However, our plan to promote culture in the hospital does not limit itself to the organisation of concerts. We also host exhibitions of paintings, meetings with artists, and poetry evenings. Patients have become accustomed to a comprehensive range of dietary advice, often linked to practical teaching about the preparation of healthy meals, and to sampling the results. As part of the programme on 'coping with nicotine addiction' patients are invited to take part in seminars and film-showings devoted to this issue. Patients also have the chance to overcome nicotine addiction with the help of acupuncture and laserpuncture. Staff responsible for the maintenance of cleanliness in the hospital and its grounds are offered regular training in the sorting and disposal of waste and pollutants. A similar campaign with the help of leaflets also includes the patients.

During the course of this whole campaign there has also been increased activity *outside* the hospital's walls, aimed particularly at the local community. Announcements on lectures by the 'School of health' cycle or cultural events taking place in the hospital appear in the local press. Members of the fire brigade, police and municipal police have received training in first aid and basic resuscitation as part of the programme of health promotion. The health promotion campaign has also extended to the youngest members of the local community through the help of art competitions on the subject of health promotion in schools.

We have also managed to spread the idea of health promotion among a wider audience as a consequence of meetings organised in the hospital on the subject of 'rehabilitation and health promotion'. Our health promotion project was widely discussed during the 35th anniversary of the Upper-Silesian Rehabilitation Centre „Repty” in Tarnowskie Góry which was celebrated in April 1997.

Another opportunity for presenting our Health Promoting Hospital Project was at a presentation during the Regional Self-Government Forum ¹ in Katowice, the capital of Upper Silesia Region.

These are only a few examples of our project's efforts to involve the community during the past year. Thanks to the hard work, enthusiasm and commitment of the personnel of the Upper-Silesian Rehabilitation Centre „Repty” in Ustroń over the last four years, we can be justly proud of what we have achieved.

¹ This is an annual interdisciplinary conference on the different ways of health promotion (hospitals, schools, local government).

1. Annual presentations and presentations during the conferences took place regularly
2. Staff was informed by „Piramidka” (internal bulletin) and meetings twice a year
3. Decisions were taken by the leaders of the subprojects and project co-ordinator with acceptance of the hospital board

The realisation of the subprojects

In the following chapter we present our experiences of the implementation of the five most advanced and documented subprojects, we have been working on, since joining the European Pilot Hospital Project. The successes achieved by the particular teams result, among other things, from the exceptional commitment of the staff in putting the projects into action, and also the conviction as to their positive influence on the patients' rehabilitation process as a whole and of the necessity of introducing health promotion into everyday hospital practice. The small financial input needed for the successful realisation of the subprojects described below is of real significance.

The Health School

First plans involving the introduction of health education appeared well before the hospital joined the international project. The need to broaden the programme of cardiological and orthopaedic rehabilitation by including education about health, was seen as essential for achieving success in the rehabilitation programme. In the beginning all attention was focused on patients who had suffered heart attacks or who had undergone cardiac surgery. The first meetings had a fairly informal character, involving groups of patients burdened with the greatest risk of another heart attack or post-operative restenosis of the coronary vessels.

In December 1992 the initiative took on a more formal character by drawing up a plan for the realisation of this project which was presented in our application. In this plan the aims and methods of implementation were outlined, a leader and responsible individuals were chosen, a temporary plan of action was drawn up, divided into spring and autumn sessions with a holiday break, and the means to evaluate the project were provisionally outlined.

The cycle of meetings in the initial stage consisted of monthly lectures.

Within the framework of the project, courses dealing with basic resuscitation, intended for the hospital staff as well as for members of the police and the municipal police, were organised. A certificate was awarded at the successful completion of the course.

From February 1994 the team implementing the project underwent a change. Dr Jerzy Klimczak, head of the Orthopaedic Rehabilitation Department, and Sister Danuta Borecka, ward sister in charge of the Orthopaedic Rehabilitation Department, became project leaders. With the change in leadership the implementation of the subproject gained new impetus.

From then on meetings took place with increased frequency: up to 7–8 times per month. The topics of the meetings, apart from information about preventing diseases

of the circulatory system, were extended to include new information on orthopaedics, on ways of coping with stress, healthy nutrition, fighting nicotine addiction and information about diabetes. This breadth in the range of subject matter demanded the participation of an increased number of experts in the programme, representing various medical fields, i.e. medical doctors, a graduate psychologist, a dietician and nurses. An information campaign, implemented on a wide scale both in the hospital and in the neighbouring tourist hotels and the town of Ustroń, also contributed to the increase in the number of lecturers. Unfortunately, although information was provided in the form of posters printed free of charge by a friendly printer and announcements in the press, the number of people attending the meetings from outside the hospital has not increased. As a consolation it is worth adding that pupils from local primary schools have attended the lectures several times.

An increased number of lectures and a growing interest in the subject matter shown by the patients (around 250 participants monthly) was achieved among other things, by making the lectures more attractive through the introduction of interesting teaching aids such as slides, an overhead projector, video films, and practical demonstrations on ways of preparing healthy meals.

Among the Health School Subproject team's plans for the near future, the problem of attracting a greater number of participants from the local community to the lectures was given priority. Great emphasis is placed on the constant development of the lectures' attractiveness and on broadening their subject matter to include issues concerning AIDS, information about women's health and family health in future.

One of the aims is the purchase of audio-visual aids and the production of new slides. They also plan to extend the methods of evaluating the lectures by asking participants to give ratings to particular speakers and by beginning to test the audience on what it has learned.

The subproject „School of Health” has become an essential part of the patients' total rehabilitation programme and is now part of the hospital's daily practice. This is confirmed by the certificate of attendance of lectures which is written in the patients' case notes and in the patients' discharge notes. Nevertheless attendance in the 'School of Health' lectures is completely voluntary and depends entirely on the patients' own motivation.

Sorting of waste

This subproject has been implemented since the beginning of 1993 by a three-person team led by Mrs Ewa Drobik, the hospital's chief administrator. As was the case in the other subprojects, the work began with the creation of a plan of action, including a description of the aims and measures, a schedule of realisation and the means of evaluation. The development of effective procedures for the sorting and disposal of medical and non-medical waste, was identified as the main goal. Training of the staff responsible for the maintenance of cleanliness in the hospital was an intermediate stage in the overall aim.

The first stage to realisation consisted of running several training sessions for a month, during which staff members were informed about the aims of organising the sorting of waste and the effectiveness of the methods of its introduction. At the same

time an information campaign among the patients was started. Leaflets written in an accessible style and giving information about the methods of waste sorting in the hospital were distributed around the wards.

In addition, practical action was also taken and waste bins were bought, which, after having been labelled appropriately, were placed at prepared points around the hospital. Full implementation of the project was only possible after the acquisition of three containers, placed outside the building for the final sorting of waste products before transportation to the rubbish dump.

At present glass, metal waste, plastic and paper waste are sorted. Leaflets distributed to the wards every three months and regular training of the staff responsible for the maintenance of cleanliness in the hospital serve as a reminder about the need to sort waste. It should be noted that the success of this subproject was due, in no small measure, to the active involvement of the project leader in looking for sponsors, prepared to finance purchases essential for the project. The subsidy of \$1200 US from the Fund for the Protection of the Environment and Water Management, Bielsko-Bia3a, was earmarked for the purchase of external bins, from which the waste is removed free of charge by another sponsor. Another valuable initiative is the free supplying of plastic binliners to the hospital by their manufacturer.

The programme of sorting waste met with considerable interest from other health promoting hospitals in Poland with whom co-operation was begun with the aim of sharing experience within the Polish network. Co-operation is based on mutual visits and presentations at the National Network and other conferences.

In October 1994 representatives from our hospital presented the subproject at a training seminar at the Polish Academy of Science Centre in Poznań.

The hospital as a place for the promotion of culture – the school of stress management

As early as the first few months of the hospital's existence it became clear that physical rehabilitation based solely on physical exercises would not be enough to satisfy the patients' most essential requirements. In accordance with this conviction, continuing the tradition of the Polish model of comprehensive rehabilitation and exploiting the experience of the parent Rehabilitation Centre in Tarnowskie Góry, we started to broaden our programme by introducing psychotherapy, music therapy and so-called concert therapy. The resident psychologist started to run psycho-educational sessions and autogenous training with elements of music therapy, supplementing the programme where necessary with individual counselling.

Taking advantage of friendly contacts with opera artists, the Head Doctor took the decision to organise charity concerts in the so-called 'Winter Garden'. This is a kind of small orangery with a great number of plants and a pool with a fountain and ornamental fish, which had not been used for this purpose before. This activity, sporadic at first, became organised once GCR Repty in Ustroń had joined the Polish, and then the European, Health Promoting Hospitals Network. Thus, in 1992, teams responsible for the promotion of culture and the dissemination of methods of coping with stress were created. After some time, owing to the similarity of the aims, the two

teams were amalgamated. A plan containing a detailed schedule, a description of the method, and the means of monitoring the results, was drawn up.

Activities involving psycho-education and psychotherapy

At the very beginning of the team's formation, the psychologist introduced some suggestions for the staff. Meetings which highlighted the most common errors made by the medical staff when dealing with patients were held. Music therapy methods were developed, through a broadening of the range of musical styles and also by adding elements of visualisation, set against a background of nature sounds. In addition sponsors provided the means to equip our music therapy rooms with ergonomic couches. One of the firms which supports us, introduced a system where music is played to the patients over headphones, while a relaxing text is read by the person running the session. The hospital's record and cassette library was also enlarged.

Finally, in co-operation with the 2nd Cardiological Clinic in Katowice, a programme was prepared for the assessment of rehabilitation patients' quality of life after cardio-surgical operations. Patients were given a comprehensive questionnaire in the periods before and after their operations, thus supplying information on the long term results and the effect of rehabilitation from the patient's – and not just the doctor's – perspective. The consequences of an operation which affects not only physical abilities, but also emotional, familial, social and occupational functioning, are both interesting and important. We hope that the results of this work will permit us to find an answer to the question, what effects cardio-surgical intervention and rehabilitation have on the patients' quality of life.

The programme described here will require increased involvement and commitment from the hospital's psychologist. For that reason in the very near future a qualified professional will be employed who will take on the running of music therapy, the organisation of therapeutic concerts and will be responsible for increasing the activities offered to patients in their free time during their stay in the hospital. It will also enable us to restart training for the staff, which has been interrupted.

Promotion of culture in the hospital

The main aim and mission of this subproject is health promotion through the promotion of culture. The staff of our hospital believe that art is healing. They also believe that art is essential; not only to those people who know what can be gained from it and do so in their everyday lives, but also to those people who are exposed to different forms of music or art for the first time. We are convinced that sensitivity to the beauty of art can be aroused during a stay in our hospital. Then, the desire for regular contact with beauty that listening to beautiful music or admiring works of art gives, can enrich the life of an ill person and help him or her to overcome the difficult moments associated with the illness itself and with daily life problems.

Our proposals do not only extend to patients of the „Repty” Centre, but include health resort visitors to Ustroń, hospital staff and members of the local community.

As mentioned earlier, the first charity concerts were performances by opera singers. We always endeavoured to make sure that well-known artists performed so that the encounters with art were of a high standard. Gradually, the team assembled a wider

range of attractions with the aim of promoting health through promoting culture. A number of more or less formal agreements were drawn up with, among others, the directors of the Academy of Music in Katowice, and the University of Silesia Affiliate in Cieszyn, the directors of several music schools and the leaders of music groups. As a result of these agreements, regular concerts, recitals and individual performances by artists, lecturers, university students and music school students were begun.

The acknowledgement of our activity by the local authorities was a very significant – and symbolic – step, as was the subsidising of some concerts by Ustroń Town Council's Department of Culture.

All concerts forming part of the series of 'Music For The Heart' (of which there have been 57 by autumn 1997) were organised according to the following principles.

They are charity concerts or financed by sponsors. The concerts are free of charge for patients, but during the concert voluntary contributions are collected which are allocated for the programme's further development. Artists who have had to travel a long way receive travel expenses and free board and accommodation in local guest houses.

Art and photography exhibitions – and vernissages, of which there have been several – are organised in a similar way. All the events forming part of the promotion of culture are documented in a special album with comments, autographs and photographs of the artists and performers.

We greatly appreciate the participation of residents of the rehabilitation centre at our concerts and events. In general, however, the participation of town residents at our concerts is still modest, and currently we are planning a more extensive popularisation of the health promotion activities within the local community.

The healthy food project

Its implementation is based on two main principles:

- Carrying out an educational programme within the „Health School”;
- Putting principles of healthy nutrition into practice during the preparation of meals in the hospital kitchen.

The educational input is based on regular lectures for patients which take place at least once a month. During the meeting, current research findings on the relationship between the occurrence of diseases of civilisation and eating habits are presented. Particular emphasis is placed on the demonstration of the above relationship in the case of cardiovascular diseases, which have become a serious threat to the Polish population, taking into consideration the constantly growing morbidity rate and death rate as a result of these diseases. For our patients, it is often the first time they receive relevant information concerning the increased risk of developing arteriosclerosis as a result of a diet rich in fat and cholesterol, as well as getting information about the amount of cholesterol in particular foods.

This information has specific significance for Polish society, which for centuries has advocated lavish, high-calorie meals washed down with alcohol. Hence our forefathers considered individuals significantly exceeding the accepted norms of the Body Mass Index as representing the model of an ideal figure. Such attitudes have carried

on to today, making Poland one of the most obese nations in Europe, and threatening us with a greater incidence of diseases of civilisation, linked in their aetiology to this lifestyle. Another important factor which induced us to carry out an educational programme in the area of nutrition is the character of the hospital. We rehabilitate patients who have had heart attacks or surgical treatment of cardiovascular disease. As research shows, prognoses linked to the development of the above conditions depend, to a great extent, on lifestyle, where diet plays an important role. The constantly growing number of people coming to attend these meetings attests to the felicitous choice of this type of session. In 1995 300 people took part in such meetings and in 1996 there were 700 attendants. Another way of teaching the fundamentals of healthy nutrition is through individual consultation with the dietician. Patients may arrange appointments themselves or their doctor may recommend that they attend.

The meetings are attended by people with specific dietary problems such as serious obesity or insufficient knowledge of how to apply a diet as part of the treatment of diabetes, for example.

At the beginning of 1996 the attractiveness of these meetings for patients was increased considerably through the introduction of practical demonstrations on how to prepare healthy meals followed by their sampling. This style of teaching the rudiments of healthy cooking met with the particular interest from our patients.

Articles on the subject of the culinary arts, aimed at the hospital staff and the residents of the town were periodically placed in the hospital bulletin „Piramidka” and in the local newspaper, and also serve to introduce the essentials of healthy nutrition. Patients can take advantage of the many leaflets and other literature available in our hospital. The collaboration with the Institute of Hygiene and Nutrition in Warsaw and the Council for the Promotion of Healthy Nutrition with headquarters in Warsaw played an important role in the creation of such materials. They provided information and descriptions of models of good practice (booklets, video tapes). Our dietician participated in courses organised by the above institution.

The other direction of our work within the framework of ‘Fundamentals of Healthy Nutrition’, is the practical implementation of the essentials of healthy nutrition in the preparation of meals in the hospital kitchen. In accordance with these principles, the consumption of fatty pork was limited to a minimum while the quantity of beef, poultry and fish was increased. The amount of cooked meats were reduced and often replaced by fresh salads. The consumption of dairy products, mainly low-fat, was increased considerably. The use of saturated fats was reduced to a minimum and they were replaced by mono- and polyunsaturated vegetable fats, while vegetable fat margarine took the place of butter on the menu. Wholemeal bread was introduced to the daily diet. The use of sugar and salt in preparing meals was significantly reduced, table salt being replaced by salt enriched with minerals. Hot spices e. g. pepper and paprika were replaced by aromatic herbs. Onions and garlic are included in the diet as often as possible.

The next success was to introduce healthy food products in the hospital shop and café. These include: bran, corn-flakes, fruit and vegetable salads, natural fruit juice and products free of preservatives.

The subproject „Healthy food”, running since 1992, has become a permanent part of day to day hospital practice, supplementing the patients’ rehabilitation programme with essential knowledge from the field of healthy nutrition. Unfortunately the obstacle to complete practical implementation of the principles of healthy eating in the hospital kitchen is the lack of funds with which our centre has to contend. For this reason we hope that our patients make full use of the culinary knowledge they have gained from us in their own kitchens.

The Hospital as a Smoke-Free Zone

The plan to implement this subproject came about long before the hospital joined the Health Promoting Hospitals Network. The reason for the implementation of this project was that certain members of staff considered it unacceptable that smoking should be permitted in such places as the duty physicians’ and nurses’ rooms or other rooms exclusively used by the personnel. Therefore the project, in its initial stage, was directed primarily at the hospital staff, particularly at those individuals ‘in the grip of the addiction’. In the first few months of its implementation the project met with serious opposition from those members of the hospital staff, who for many years, had been accustomed, to being allowed to smoke in public places, hospitals included. This resistance was met, however, with strong disapproval from the ‘non-smoking’ part of the staff, who began, more and more openly, to demand their right to a workplace free of smoke. This view was expressed several times in petitions calling for a total ban on smoking in the hospital.

The medical staffs ambiguous moral attitude had considerable significance of course. As in the old joke, they warned sick patients about the harmful effects of tobacco and ordered them to give up smoking completely, ‘with a cigarette in their own mouth’. After a good deal of disagreement the issue was resolved, by setting aside an area outside the building for smokers, although staff representative found it difficult to come to terms with this solution at first. Smokers fought with the ban on smoking in the first few months, by keeping to the rules in the morning and succumbing to the temptation of their habit in the afternoon when, in the absence of their superiors, they could smoke freely in the staffroom. As time went on however, the air in the consulting rooms has become cleaner and cleaner. The recent wide-spread campaign in the mass media to fight nicotine addiction, often with the participation of well-known personalities from culture and science, had its effects too. The low average age of employees in the hospital also had an influence on the success of the scheme, owing to the relatively shorter length of their smoking habit and their greater openness to change.

Next we started helping our patients to give up smoking. This task appeared much more difficult, as in this case we were dealing with patients who had been smoking cigarettes for many years with a firm belief in their beneficial effect e. g. in relieving stress. A significant difficulty is also the limited possibility of taking any action against patients who smoke, particularly in places where smoking is permitted.

To implement the project, the following methods were applied:

- Leaflets acquainting patients with the harmful effects smoking has on their health were produced.

- Within ‘the School of health’, regular lectures (a minimum of once a month) were begun, discussing issues linked to cigarette smoking.
- The opportunity to have individual counselling with trained nurses to help cope with nicotine addiction was arranged.
- Practical help in giving up smoking through laserpuncture and acupuncture was made available to patients who expressed an interest.
- The annual celebration of „World Non-Smoking Day“ was begun.

In addition to this, the principles of the non-smoking campaign were spread among young people by organising art competitions in local primary schools on an anti-smoking theme. With time we managed to establish contact with other organisations and foundations also promoting principles of healthy lifestyle. The co-operation with The Polish Health Promotion Foundation – which is led by Professor Witold Zatoński, an authority in the area of preventive medicine – has proved to be particularly fruitful. We have got helpful leaflets and video tapes from this Foundation.

The result of that partnership is that a video film showing the negative effects of smoking on the human body and many interesting anti-smoking leaflets and books, which have proved to be great allies in the fight against the addiction, have been added to our teaching resources. This project belongs to those few whose implementation does not demand great expenditure and whose success depends to a great extent on engaging people’s imagination and intellect.

The effect of the Health Promoting Hospital Project in “Repty” – a cautious analysis of the impact

A change in the way of thinking

A positive way of thinking among the staff has evolved over the period of several years during which the Health Promotion Programme has been put into practice in our hospital. Before the centre joined the European Pilot Hospital Project the majority of the hospital staff treated the hospital merely as a source of income (a cash dispenser paying out money at intervals). This situation was linked more than anything else to the fact that staff members hardly identified themselves with their workplace at all. This phenomenon is based on a view, nurtured over decades, of the means of production being state-owned or having no owner, which was carefully maintained by the Communist authorities. Unfortunately the lack of identification by the staff with their work and the low judgement of it by the authorities – reflected in the poor level of pay – resulted in a conviction of the work’s overall lack of purpose.

In such a situation the staff’s introduction to the idea of health promotion proved to be especially productive. The aim of the programme was quickly and clearly outlined and concrete action plans were set up.

Patients were to be in the centre of attention, and the staff’s task was to make full use of the patients’ stay in hospital in order to improve their state of health, both physical and psychological. Numerous publications about factors leading to diseases of civilisation and the need to avoid them, helped to identify the aims and objectives. At that

time a great deal was being said about the growing epidemic of circulatory system illnesses in Poland.

In the face of these facts, the need to change our views in relation to the workplace where we spend the majority of our active life, became obvious to many health professionals.

Clearly formulated criteria on the idea of health promotion made it possible to redirect significant, and previously untapped, energies in the staff towards activity, aimed at the well-being of the patients above all. The first signs of a change in the way of thinking about work became evident. A considerable number of staff members realised that their place of work, the hospital, is a 'second home'. This was also reflected in those realised subprojects which had activities directed at the hospital's employees health as their priority. Among these subprojects are:

- An ergonomic and pleasant place of work
- The hospital as a smoke-free zone
- Improving the staff's state of health

The invitation of GCR „Repty“ in Ustroń to the European Pilot Project on Health Promoting Hospitals initiated the birth of a new way of thinking about the hospital as a place of work. A result of this change in the way of thinking was a greater identification of staff members with their workplace. To a certain extent this also fostered a sense of pride derived from working in an 'elite' hospital, which at the present time significantly eases the solving of everyday problems.

This is a general strong impression – difficult to measure up to now.

Benefits for the rehabilitation process

As a next significant effect of the implementation of the health promotion project in our hospital, we must mention its influence on the patients' rehabilitation programme. Before beginning work on the health promotion programme, earlier post-hospital rehabilitation was based mainly on the principles of the 'Polish School of Rehabilitation' created by Professor Askanas and modified by Professor Rudnicki.

As the principles of health promotion in our hospital became disseminated a gradual modification of the rehabilitation programme took place. The aim of these changes was to create the best conditions possible to carry out full physical and psychological rehabilitation of our patients.

The varied cross-section of patients thus demands very individual treatment in relation to the programme of rehabilitation, which involves considering the needs of specific patients and how they can benefit from rehabilitation. The rehabilitation programme was modified to include psychotherapy sessions as part of a daily routine. The creation of the 'Coping With Stress' subproject was very helpful in this respect. Psychotherapeutic activity has taken on a multifaceted character in our hospital.

Individual counselling organised by a psychologist was initiated, with the aim of identifying the patients' specific problems and then finding ways of coping with them more successfully. In addition, from time to time the psychologist organises group sessions with all the patients within the 'School of Health'. During these ses-

sions the psychologist teaches general principles of coping with stress. Another form of psychotherapy which now has a permanent place in our rehabilitation programme is music therapy, which has been particularly warmly received by the patients.

Educating the patients became the next element to which we turned our attention. It would be difficult to imagine a one-dimensional rehabilitation programme for patients, focusing only on an attempt to improve their physical capabilities without giving them any information about the causes of their basic illness. The main focus of our hospital (The Cardiac Rehabilitation Departments and the Orthopaedic Rehabilitation Department) demanded close attention from the medical staff to the factors leading to the illnesses with which our patients contend. Within the 'School of Health', regular lectures concerning the orthopaedic and circulatory system illnesses were begun, especially taking into account the risk factors that contributed to their occurrence. Our patients have the additional chance to gain information about other diseases of civilisation e. g. diabetes, obesity etc. Lectures are also presented on the subject of the fundamentals of healthy nutrition. In our hospital, we treat the 'School of Health' project as a very important aspect of the rehabilitation process, which is why it is considered necessary to note the patients' attendance at lectures in their case notes.

Benefits for the local community

The local community also benefits directly from the presence of a health promoting hospital in the locality. Our activity in the field of propagating the fundamentals of health promotion gives the town's residents the opportunity to take part in lectures of the „Health School”. Information about the topics of the current lectures appears regularly in the local press. Town residents, as well as tourists staying in local hotels and hostels, can take inspiration from the subproject 'The hospital as a place for the promotion of culture', by attending a wide variety of cultural events such as concerts, poetry evenings, photographic and painting exhibitions. Our work does not only focus on adult members of the local community. We have experience in working with school children as well. For example a painting competition was organised in connection with the project 'Coping with nicotine addiction'.

Dietary advice and recipes prepared by our dietary specialists responsible for the project 'Healthy eating' regularly appear in the local press.

The town of Ustroń, within whose boundaries the hospital lies, recently joined the Association of Healthy Towns, part of the WHO project „Healthy Cities”, the activity of our hospital as a health promotion centre having contributed to this, as the town's authorities acknowledged in an article published in the local newspaper.

Benefits for the natural environment

The natural environment in which we live and work also benefits from our project. It is well known that a hospital is the source of a great deal of waste products, particularly difficult to dispose of. The 'green' way of thinking, which was new to many of us, greatly influenced the subproject 'Sorting and making use of waste', set up on the principle of transforming the hospital into an environmentally-friendly place. This

aim was realized through the system of sorting hospital waste, which is maintained by a constant process of training the staff responsible for maintaining cleanliness in the hospital and by awareness-raising actions among the patients. The remaining waste which cannot be disposed, is dealt with according to official health and safety regulations.

Organisational benefits as the hospital becomes self-dependent

The majority of activities carried out within the framework of the health promoting hospital programme have a close relationship with the ongoing changes in the national health protection system taking place in Poland at the present time.

This situation puts our hospital in a favourable position in relation to the process of health-care institutions becoming self-dependent. In this respect it is most helpful that we have already gained considerable experience in organisational change, specifically in working groups making use of project management cycles (plan of implementation – documentation – monitoring). This was especially supported by applying training groups of lecturers to teach the principles of business.

Furthermore we could perfect the rehabilitation process by:

- Development of health education, psychotherapy and promotion of culture.
- Putting into practice a programme for improving the quality of service.
- Evaluating patient's satisfaction with the service and research on the influence of rehabilitation on the patients' quality of life.

Children's Memorial Health Institute – Pioneering the health promoting hospital concept in Poland

Pawel Januszewicz, Jerzy Socha, Anna Stolarczyk¹



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Hospital Owner:	Ministry of Health and Welfare
Hospital Ownership:	Public
Specialisation:	Paediatrics
Beds:	573
Staff:	Medical Staff: 350, Nursing Staff: 631, Other Staff: 1.407, Total Number of Staff: 2.388
Utilization:	Average Utilization of Beds/Year: 70 %, Average Stay in the Hospital/Day: 7,6
Patients:	Number of Inpatients/Year: 19.077, Number of Outpatients/Year: 162.723
Number of Departments:	22
Location of Hospital:	Suburbs/rural
Catchment Area:	National, Number of Population: about 10 millions (all children up 18 years old)
Other Functions than Medical Care:	
Teaching:	Medical Students, Postgraduate, Nursing Education, Other Health Professions: Rehabilitation, Dietetic, Psychology, Pharmacy
Research:	Clinical Research, Basic Science Research
Subprojects:	<ol style="list-style-type: none">1. Oral Health in Chronically ill Children2. Promotion of Psycho-Social Wellbeing of Hospitalised Children3. The Hospital: One of the Sources of Health Education4. The Child Health Centre - A Nonsmoking Environment5. Nutrition and Health6. Prevention of Hepatitis B among High Risk Hospital Staff Groups in CHC

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Introduction

The Children's Memorial Health Institute also known as the Child Health Centre (CHC) is a multi-specialty hospital which serves children nation-wide with the most modern diagnostic techniques and therapies.

The history of the hospital started officially in 1968, but it has its roots in the time of the World War II, when 13 million children and young people perished. In that time more than 6 million Polish citizens died, 2,200,000 of whom were children.

Such painful experiences have been commemorated by the Polish people with monuments at the places of heroic combat and martyrdom, but it was felt that a special, separate commemoration of the children was needed. Various suggestions for monuments and a museum to honour the youngest war victims were proposed. However, in 1968, the concept of building the Memorial Hospital to the memory of the child-martyrs, child-soldiers and underground fighters gained general support and tremendous popularity among Polish community.

It was the ambition of the initiators of that fine idea to carry it out using only public donations. Polish society; a number of governments; Polish people living abroad; large international concerns; businesses and factories – and almost the whole world responded to the appeal of the Social Committee for the Construction of the Child Health Centre. Many countries formed their own Social Committees. They not only gathered donations, but above all promoted the ideas that were the guiding principle for the construction. In addition to considerable donations for the construction, unique, precious medical and technical equipment was developed and donated also.

The contest for the architectural design of the Centre attracted 39 entries, even though there were no prizes offered. On June 3, 1973 the foundation stone of the Memorial Hospital was laid in Miedzylesie – a suburb of Warsaw. On October 15, 1977 the Child Health Centre admitted its first patients – children from all over Poland.

The Child Health Centre is now well-known both in Poland and abroad for its unique equipment; high quality of service and its position as a reference centre for all medical schools in Poland. Its conception as a memorial hospital has influenced its ethos, and it has a very special place in the hearts of the Polish nation.

It is also a teaching centre for postgraduate medical education (physicians, nurses, and all medicine-related professions). The CHC is a reference centre for Eastern European countries and admits patients from Latvia, Estonia, Russia etc. It is considered an unusual hospital, with a special outlook focusing not only treatment at the highest level and providing unique conditions for hospitalisation of children, but also on the social condition of their families. Even the name of the hospital – “Child Health Centre” – has an optimistic, hopeful tone, and suggests a place for cure rather than for disease. In 1994 the Polish Committee of Child Rights held a country-wide contest which, because of children's opinions expressed in questionnaires, resulted in the hospital being awarded the title of ‘Child Friendly Hospital.’

However, as the CHC shares the same economic conditions as other hospitals in Poland it therefore also faces difficult times at present. Changes in the health service system in Poland have created new problems and tasks for all hospitals, and especi-

ally for a hospital which provides a specialised service with rare, but expensive, procedures.

The great political and economic changes occurring after 1989 made more visible the inequality in health resulting from poverty; unemployment; and low education etc. accumulated in the lower classes of our society. This currently creates considerable challenges for health promotion and disease prevention.

In 1996 the CHC acquired the status of a Scientific Research Institute and is now one of the most important institutions in the paediatric health care sector in Poland. In addition the importance of health promotion in our society has also been influenced by our hospital.

How the Child Health Centre started the project

Information about the health promotion movement came to Poland in the late 1980s, initially as the result of the WHO declaration 'Health for all by the year 2000' and then through European projects such as: 'Healthy Cities' and 'Health Promoting Schools'. The new idea of a 'health promoting hospital' became known to the health service in Poland through publications in foreign journals; contacts; and visits of scientific workers to a number of hospitals in Europe, where the idea was already accepted.

It is difficult to establish the exact moment of its introduction into our hospital. We had recognised, that in some Western hospitals health promotion programmes had been used to overcome problems similar to those which we faced. Main areas of interest were similar – hospital nutrition, cigarette smoking, and creating a healthy workplace. It seemed, therefore, that our extensive contacts with Western hospitals would create excellent opportunities to transfer the concept of the health promoting hospital into the CHC, together with some projects which they had already undertaken. Projects already implemented in other hospitals seemed clear and easy to pursue.

In 1990–91 the Ministry of Health and Welfare took responsibility for the organisation of the Polish Network of Health Promoting Hospitals and officially introducing the idea of health promoting hospital into the health care system in Poland.

The first 'official' contact of hospital staff with the idea took place at a Conference in February 1991 organised in the CHC in co-operation with the Ministry of Health and Welfare, and open to all staff. The Conference put forward the idea of the hospital as a place for health promotion and as a lead institution responsible for developing activities aimed at improving the health of patients, hospital staff and the community. The Conference was initiated by Dr Jerzy Karski – who subsequently became the coordinator of the Polish Network of Health Promoting Hospitals. The background, objectives and goals of health promoting hospital concept were presented, together with the experiences of Western hospitals. The event was very well received by the staff and this gave us the encouragement to join the international project. After this first event, discussions were then held by all professional groups.

A new and modern approach to the problems of disease and health; a new concept of the hospital; and the promised co-operation with WHO within the European Net-

work of Health Promoting Hospitals focused attention on the problems, which could be resolved through health promotion.

In 1991, the Child Health Centre became the first member of the Polish Network of Health Promoting Hospitals. In 1993 the CHC hosted the 1st International Conference of Health Promoting Hospitals (28 April – 2 May) and became one of the 20 hospitals in the WHO European Pilot Health Promoting Hospitals Project.

The 1st International Conference hosted representatives of 78 hospitals from 14 countries and was of great importance in influencing the attitude of all staff members to accept and adopt the idea of health promotion. It also prepared the ground for the implementation of the projects.

From the very beginning, the idea of health promotion through a hospital seemed very attractive as a new concept for the health care system in Poland (and for the way forward for the CHC). A new concept of health, resulting from WHO Pilot Hospitals Project, was accepted and the concept of services for healthy as well as ill people very clearly expressed the feelings and emotions already existing in many people's consciousness. Within the CHC organisational structure, health promotion was the name for the provision of extra services, additional to the treatment of our patients and in very short time gained new enthusiastic supporters.

The concept of HPH found extensive commitment among the hospital staff. Participation in the WHO Project, and co-operation with other European hospitals within the Twenty European Pilot Hospitals Project, created awareness of the prestigious character of the hospital. Participation in the project became a new challenge for both management and staff.

All staff involved in the project have shown interest and motivation, which greatly influenced the process of realisation. The main problem has been the lack of sufficient funds needed for successful activities. Available resources were very limited and all staff were involved, therefore, on a voluntary basis. The benefit for those actively contributing was the satisfaction resulting from the new experiences, which also was of importance for professional knowledge and identity.

From vision to projects: How the Health Promoting Hospitals approach was realised

We were aware from the outset that the concept of Health Promoting Hospitals would fit very well our experience and with the challenges that the CHC faced when the project work started. As a first step, 6 sub-projects were developed according to the Budapest Declaration and a project committee was set up. The goals, objectives, methods of documentation and evaluation for each sub-project were defined. The Project committee consisted of the General Director (1); Medical Director (1); Head Nurse (1); and leaders of each sub-project (6). A Project co-ordinator was appointed. From time to time representatives of technical or administrative staff were invited to the meetings – according to problems which were to be discussed. The task was to prove that Polish hospitals are suitable for health promotion.

The project co-ordinator was responsible for reports; co-operation with other Pilot Hospitals and hospitals of the Polish Network; and attendance at all the Business

meetings of the Pilot Hospitals. The aim of these meetings was to exchange information; to report progress; problems; external activities; and to discuss the next stages of activities within the sub-projects. Official meetings were organised every 3 months and chaired by the Medical Director (as according to the management structure, health promotion belongs to his area of responsibility). The internal weekly newsletter 'Informator Tygodniowy' – with a special column headed 'Health Promotion' – was the main tool of communication with hospital staff. It was open for anyone involved in the programme to contribute to this column. Information concerning activities within sub-project were announced and also reprints of articles concerning healthy life styles; mental health; healthy work places etc.

Despite the initial motivation of the project committee and staff members, the project realisation suffered from many problems, such as financial resources and methodological problems. Lack of experts in public health and in health promotion in Poland with the relative little experiences in activities which would meet our local circumstances – together with limited reference material- resulted in decreased enthusiasm within the sub-project teams.

Although the aims, targets and activities within the sub-projects were generally accepted, all additional tasks deriving from the project – such as documentation, evaluation, analysis etc. – were a considerable burden for the sub-project leaders.

Lack of synonymous expressions for health promotion in the Polish language – and sometimes insufficient fluency in English – were also problems and contributed to a feeling of inadequacy. The initial enthusiasm of the sub-project leaders was outweighed by piles of documentation; regular obligatory reports (in English); and a depressing amount of extra work. It became clear that health promotion needs professionals, who can lead projects on a full-time basis. Two "jobs" for sub-project leaders make it difficult to balance needs and possibilities, resulting in a loss of interest and motivation.

The Sub-projects of the Child Health Centre Pilot Hospital

The main areas of interest identified were related to patients, their families, and hospital staff. Because of the country-wide catchment area, the influence of the hospital on the local community was of marginal importance. Our contribution to the promotion of a healthy lifestyle within the wider community was possible through our close contacts with the mass media.

Six sub-projects were drawn up as a result of identified problems and the area in which action was possible. Besides improvement of quality of services, activities focused on creating awareness and self-responsibility for health, and also on the provision of services in line with the idea of health promotion (i. e. – hospital as a healthy environment for patients and visitors, and a healthy work place).

To date all sub-projects have been carried out successfully, according to the aims initially agreed as part of the pilot project. The next range of activities are now being developed to meet new demands which we have identified. The sub-projects are described briefly below.

Nutrition and Health

The main problems addressed with this programme were hospital nutrition for children and nutritional education for patients, their families and hospital staff.

The aims of the first part of the sub-project were to improve the quality of hospital meals, to improve the organisation of the dietetic department and to improve its co-operation with hospital wards. Hospital menus and meal times were reviewed and the list of hospital diets was agreed. Seven hundred people (34% of hospital staff) were surveyed with questionnaire concerning smoking, nutritional habits, physical activity, body mass and nutrition-related diseases in the family. An educational programme concerning healthy life style and healthy nutrition for hospital staff and patients was developed. „Healthy food“ presentations; lectures; meetings with nutritionists; and a dietetic education programme are run on the basis of regular meetings. Ward dieticians are involved in staff education about healthy eating. Informal contacts with experts from The National Food and Nutrition Institute have been arranged for the programme leaders and the dieticians involved in the sub-project, to discuss how to encourage staff to eat a more healthy diet.

Co-operation with the Physiotherapy Department produced a programme to promote fitness and physical activity in combination with nutritional programme. It is available for all staff, but mainly for those with obesity problems. Sessions for obese or overweight women were conducted over a 3 month period. Mean weight loss was 5 kg, but the best participant lost 15 kg. All participants agreed that a combination of exercise and diet under a specialist's supervision was very useful form of nutritional education and rehabilitation. The programme is continuing and the list of interested staff awaiting the next session is increasing. In addition, leaflets and sample menus have been prepared for distribution among patients and staff.

Smoke-free Hospital

More than 30% of the hospital staff smoke cigarettes. Since January 1994 smoking has not been allowed on the hospital premises, and cigarettes are not available for sale at the hospital. An area has been reserved for outside the hospital for smokers. Stop smoking courses, counselling, and a support programme is available for smokers who want to give up. An exhibition of patients' anti-smoking posters is held every year during the international „No smoking” day (November 19). New health workers are informed of the policy in their contracts. The number of smokers among hospital staff has decreased. The CHC is a member of the organising committee of the annual stop-smoking action day in Poland, when people who have given up smoking can win an attractive prize (e. g. foreign trip) or other valuable gifts. Our activities have expanded to include a number of patients (children !) smoking cigarettes.

Prevention of Type B Hepatitis in children and hospital staff

The purpose of this programme was to eliminate cases of type B hepatitis among high-risk hospitalised children, and hospital staff most vulnerable to this infection. In 1988, there were 32 persons suffering from HBV (Hepatitis B Virus) and these were recognised as cases of occupational illness at CHC. In 1989 a vaccination pro-

gramme against infection among the high risk staff group was started using „Engerix- B“ vaccine. Between 1989 and 1994 the HBV infection incidence decreased rapidly each year, and since 1994 we have not recorded any new cases of HBV infections among hospital staff.

A significant decrease in HBV incidence among hospital staff was realised by regular training; meetings about basic hygienic rules in the workplace; distribution of educational films for medical staff; routine sterilisation of multiple – use equipment; introduction of disposable equipment; and biological and chemical sterilisation control of supplies. Although the vaccination programme for hospital staff started in 1989, the Pilot HPH project provided a new impetus to expand the programme to include patients from high risk groups; to reinforce realised activities; to develop adequate documentation and a sub-project structure. The Health Promoting Hospital concept was useful in creating a vaccination policy programme for chronically ill paediatric patients. In addition, a Hospital Infection Control Team was created to examine all cases of hospital infection, and to provide constant education for employees and visitors about hospital hygiene rules. New forms of education for personnel have also been introduced.

Promotion of Psycho-Social Well-Being of Hospitalised Children

To fulfill the psycho-social needs of hospitalised children and their parents and to reduce the psychological stress due to hospitalisation, this project aimed to create an atmosphere of warmth, trust and security for patients; to continue an open-door policy; and to provide printed information to families about the hospital and the way its various services work, and about patient's rights.

The sub-project framework reflected earlier results, indicating that in the process of treatment paediatric, patients need not only professional medical service, but also presence and care of their parents. In addition, parents need clear and comprehensive information.

Evaluation was based on a questionnaire concerning availability and usefulness of leaflets about the hospital and its rules regarding patient-parents-staff co-operation; frequency of visits; and parents' proposals concerning increased efficiency in hospital functions aimed at improving patients' comfort. A date was chosen to gather information and a questionnaire was completed on that date and time in most hospital wards. Parents were present during the survey, which was undertaken with every second patient. 97% parents who were questioned visited their child everyday, and 92% visited it for the whole day or longer . Nearly 80% of parents knew of the leaflets with information about hospital and patient's rights. The first contact with the information had taken place at the Admitting Room.

Nearly 90% of parents confirmed the usefulness of the leaflets. Qualifying comments concerned matters such as insufficient information about public transport facilities (between hospital and city center; reservation for patient's families etc.). About 60% of those questioned had proposals for how to improve conditions at hospitalisation and patient comfort. Some of these ideas have already been introduced into hospital practice.

The Hospital – one of the Sources of Health Education

This programme has been implemented by the Department of Education of the Child Health Centre and is addressed to our patients and their families, as well as to teachers and other staff of the department. A healthy life-style is popularised through games, play, contests, manual training, occupational therapy and fine art sessions. Verbal, visual and active participation methods are used.

Involvement of Department of Paediatric Dentistry in the Health Promoting Programme

The objective of the project is to extend prophylactic and therapeutic oral cavity care to all CHC patients and also to provide a consultation service for the oral care of children in other hospitals and institutions country-wide.

Among chronically ill or handicapped children, we often find a very poor oral health condition due to the fact that those who take care of these children don't see the problem as very important compared to serious diseases or impairment. Health promoting activities are also often not available to these children or their carers.

During hospitalisation children's perception and knowledge of their own health is significantly improved, as is the interest of parents in health care. Knowledge of the individual health condition of the child, given to parents at the right time, may effectively avoid many problems arising from inadequate prophylactic. The HPH can influence their behavioural re-orientation.

To be effective, the strategy for health promotion should be based on the individual needs of children. Nine main 'needs-groups' have been identified for which standards have been developed. The groups are – physical impairment only; mental disease only; congenital heart failure; cerebral palsy; haemopathies; endocrinopathies; metabolic diseases; awaiting organ transplantation or chemotherapy; and other bed-ridden states, procedures and rehabilitation measures.

Other activities

The health promoting hospital programme stimulates new activities (some of which have yet to be formalised as Pilot Hospital projects) and co-operation between different departments. For example, besides routine rehabilitation activities, the Physiotherapy Department introduced games and amusements – based on competition – into the rehabilitation process to make it more attractive for patients.

Courts for baseball, badminton, volleyball, and tennis have been prepared within the hospital area and are available for hospital staff, patients, visitors and the local community. A swimming pool, sauna, and gymnasium are available at a reduced rate for hospital staff. Mini Olympic games for hospitalised children have been organised, including the 'Olympic Torch' and 'Olympic Oath'.

Two new interdisciplinary targets for our Health Promoting Hospital Programme are patient satisfaction and the nursing process. The Project committee proposed undertaking a cost-effectiveness assessment of health promoting activities within the hospital. The planning of this assessment project is now at the preliminary stage.

Presentations on the background, organisation, results and conclusions of all sub-projects have been presented during meetings or at the conference of the Polish Network of HPH. In addition, our experiences and data are available for all interested hospitals in Poland.

Through its early involvement in the European Pilot Project, the CHC acts as the leading hospital in the Polish National Network of Health Promoting Hospitals. In 1994 the CHC published a book entitled 'manual of health promotion in the hospital', which was of great importance to all interested hospitals and other institutions in Poland. Publication was sponsored by a pharmaceutical company.

The book contained information about health promotion and the health promoting hospital background; history; and key data on the Polish Network organisation. It also described the programmes of the 20 European pilot hospitals and hospitals of the Polish network, together with preliminary results and experiences of the CHC as a pilot hospital. It was distributed to all Polish hospitals (nearly 700) and also to other institutions whose position seemed crucial for the development of the concept. The book has provided an important starting point for most hospitals currently participating in the national network. As the CHC acts an important institution in the paediatric health care sector, the importance of health promotion in our society is also influenced by our hospital.

Project committee members and sub-project leaders are very active in their areas, and share experiences within the medical environment. There are invited workshops and educational meetings for all groups of medical professionals. They give lectures on topics related to their activities and also about their experience on health promotion action inside and, mainly, outside the hospital. Many papers have been published in both specialised journals and popular magazines for health professionals. The expression 'promocja zdrowia' (health promotion) has become a catch phrase in the mass media such as the press, radio and TV. It is obvious that the popularisation of a healthy lifestyle, and the increasing interest in health promotion in the general population in Poland, has its roots also in the health promotion activities undertaken within the health care system.

What did we achieve- and what advice can we give to other hospitals?

One of the main criteria for the success of the overall project was to introduce health promotion into the culture of the hospital. According to the basic assumption, each sub-project team had to find its own way to achieve this goal.

The project committee wished to avoid a 'race to success' between the sub-projects. So the overall project committee decided to focus on systematic evaluation, clear documentation, and realistic planning instead of intensive but disorganized activities with short-term results. Despite the fact, that political changes and health service system reforms in Poland created a positive background for the concept of health promoting hospital, the real circumstances for activity in this area seemed disadvantageous and needed to be adjusted to local conditions. Co-operation with Western European hospitals within the same WHO project was 'stress generating', but – on the other hand – motivated us to look for new approaches. Regular contacts with more experienced project leaders were of great importance for the project.

Now health promotion exists in the everyday work of the hospital and the project seems to be successful and worthwhile to undertake.

Evaluation of the process indicated that in-depth changes were necessary in each sub-project to adjust it to actual circumstances. However, the need to continue the activities was obvious. As a result of organisational and structural changes health promotion became an integrated element of all medical, educational and other activities within the CHC. A new approach to patients and their hospitalisation; rehabilitation; information and education, became a regular element of the staff's work and was shown to come up to patients' and their parents expectations. Health promotion proved to be a useful tool in creating a holistic, people-centred approach in line with modern health concepts.

The most visible and well documented achievements of the project are a reduction in the number of smokers among hospital staff; a diminished problem with hospital infections; and improved nutrition for patients. Both patients and staff reported satisfaction with the changes. The attention focused on the new concept of health is seen as the most important result of the project.

Recommendations for hospitals interested to become a Health Promoting Hospital

- *Establish a health promotion team* (to manage the overall project; to motivate, support and supervise activities; to inspire new initiatives)
- *Create a guide for health promotion* (include a glossary of terms; practical guidance on evaluation; and guidance on the documentation required to record the project's progress and make it easier to undertake evaluation).
- *Develop a Health Promotion Project Plan* (detailed plan based on clear identification of the main areas of interest, goals, aims, methods and short term objectives. Goals should be very realistic, and should closely match agreed local needs. It is also crucially important to agree a timetable and to allocate financial resources (a separate budget) to the project).
- *Close co-operation with hospital management* (keep the hospital management committee informed about activities, plans and needs, successes and problems. Involve hospital management members in the health promotion team meetings).
- *Ensure support and consult specialists from the whole hospital staff* (with reference to both on-going or planned activities within sub-projects. The interdisciplinary nature of the sub-projects helps to create interest in wider staff groups and assists the spread of information).
- *Publish short but systematic notes about the activities in the sub-projects given in the hospital newsletter* (report on the development of each of the sub-projects; keep everyone in the hospital informed and maintain staff awareness about continuity of the process of health promotion).
- *Develop networks with hospitals country-wide that are involved in health promotion.* (Disseminate your experiences as soon as possible to co-operating hospitals. Create a 'partner relationship' – an atmosphere of friendship and mutual inspiration – and avoid a climate of rivalry or competition. Involve the mass media to inform the community about activities, experiences and successes, and to motivate hospital staff).

- *Evaluate the sub-projects and the overall project* (review aims, targets and strategies within every project group and progress to date, measured against what you set out to achieve).

Patience is the extra condition for health promotion. Don't expect miracles and an immediate improvement in the health state of the community. Making people conscious of self-responsibility for their own health and trying to do something for themselves is the first step for success.

Conclusion

Becoming a Health Promoting Hospital is an innovative, modern approach to achieving the targets of a health service system. It is a model for activities which hospitals should offer to patients, staff and the community.

As an initiative, the Pilot Hospital was also of great importance for the primary health care system as it focused attention on the role of the hospital in:

- creating a new approach to health care and the role of hospital staff,
- co-operating with local communities in promoting a healthy life style,
- providing leadership and
- creating change even when faced with difficult circumstances.

The experiences of the CHC indicates that the role of a central hospital is:

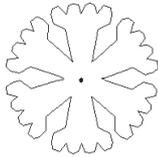
- be the leader for wider the community, communicated through mass media
- be a "model of good practice"
- create confidence to start activities in your own way, according to local circumstances.
- suggest possible activities and motivate hospital staff to improve the quality of life for themselves (at the out-set) and for their families.

References

- Gniazdowski, A. (1994): Promocja zdrowia w miejscu pracy – teoria i zagadnienia praktyczne. IMP
- Grossmann, R., Scala, K. (1993): Health Promotion and Organizational Development. Vienna
- Hauke, E. et al (1995): Poradnik dla zapewnienia jakości w szpitalu. COiEOZ. Warszawa
- Hawkins, J. D., Nederhood, B. (1994): Podręcznik ewaluacji programów profilaktycznych. Instytut Psychiatrii i Neurologii, Warszawa
- Januszewicz, P., Socha, J., Stolarczyk, A. (1994): Szpital Promuj 1cy Zdrowie. Centrum Zdrowia Dziecka, Warszawa
- Karski, J. (1994): Organizacja ośrodka promocji zdrowia – poradnik, COiEOZ, Warszawa

The University Hospital in Linköping, a Pilot Health Promoting Hospital. A Story of 5 Years

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Hospital Owner:	Östergötland County Council
Hospital Ownership:	Public
Specialisation:	General Hospital
Beds:	776
Staff:	Medical Staff: 510, Nursing Staff: 2.580 (registered nurses: 1.379; other nursing staff: 1.201), Other Staff: 1.424, Total Number of Staff: 4.514
Utilization:	Average Utilization of Beds/Year: 90 %, Average Stay in the Hospital/Day: 4.9
Patients:	Number of Inpatients/Year: 36.258, Number of Outpatients/Year: 430.451
Location of Hospital:	Inner city
Catchment Area:	Regional, Number of Population: approx. 1 mio
Other Functions than Medical Care:	
Teaching:	Medical Students, Postgraduate, Nursing Education
Research:	Clinical Research, Basic Science Research
Subprojects:	<ol style="list-style-type: none">1. Management towards a Decentralised and Outcome Oriented Responsibility2. The Total Quality Care Project3. Tobacco. The Smoke-Free Hospital4. Nutrition. Shopping for a Better Life5. Caring for Patients with Alcohol Problems Identified at the Emergency Ward6. Hospital Accident Analysis in the Prevention of Accidents7. Psychological and Social Support to Patients, Relatives and Staff Suffering from Crisis8. Swedish Health Care Meeting with Refugees9. The Östergötland Osteoporosis Prevention Project10. Environmental Protection and Pollution Control11. Early Active Rehabilitation for University Hospital Personnel

The Hospital and Its Environment

History

The Swedish Health Care System has, just like in other countries, double roots. These are found, on the one hand, in an idealistic perspective where the role of health care has been to help the sick and suffering. However, these roots have on the other hand also been found in a Public Health perspective, where the role of the earliest hospitals was to protect society, by isolating the mentally ill or people with contagious diseases from the public in general.

By 1930 the medical knowledge had developed to such an extent that the positive effects of hospital care had passed the risks of hospital treatment. The „scientific“ health care started to grow, and the role of hospitals in the treatment of patients grew and also changed its character. Together with a rising medical knowledge followed an increasing specialisation and also rising costs. This development occurred at the same time as the development of the „welfare state“. In Scandinavia the development of the welfare state and the development of scientific medicine were in continuous close interaction.

However the development in the Nordic countries and in Great Britain took a different route than in Central and Southern European countries. In the Northern European welfare-states, this development was largely based on the thought of a strong state which stood right behind the citizen and intervened when needed. In the Central and Southern European countries, this development was dominated by the Subsidiary Principle, or the „lowest level of care“ formulated by the Pope Pius XI. The Northern European models were based on the thoughts of Beveridge and Bevan, Steincke and P.A. Hansson from the second part of the 1920s, the Southern European on Pius XI's „Quadrogesimo Anno“ from 1931.

In the beginning, the State, as the owner of hospitals and primary health care, played a dominating role in Sweden. Health Care was organised in geographical districts. The private share of health services has for a substantial time (since 1850's) been less than 10%. As opposed to the situation in Great Britain, the Nordic countries, (except for Finland, which for many years was under Russian rule) had strong regional political governing bodies, Counties, with their own taxation rights. With time, it was therefore natural that these Counties took over also the responsibility for the hospitals from the State.

With the increasing specialisation of hospitals and the fragmentation of health care and the sparse populations the counties were not able to deal with highly specialised health care alone. They therefore had to co-operate within regions, often in rather loose alliances.

The hospitals were hierarchically divided in three groups according to the degree of specialisation. With the development of transportation and primary care in recent years, hospital division has been reduced to only two groups, corresponding to secondary and tertiary hospital care. Tertiary care hospitals, regional hospitals, of which Sweden has eight, are most often also University Hospitals. The other hospitals have a varying degree of specialisation and co-operate, when needed, with their regional hospital.

Hospitals are the Counties largest economical undertaking. The Counties are politically governed with locally elected parliamentarians. They have a secretariat with advisers and executive administrative functions at their disposal. In recent years the hospitals have, more and more, tried to bring together the medical and economic responsibilities at level of the clinic by having physicians-managers with responsibility for the budget. Larger hospitals are often split into divisions, in recent years with a tendency toward network-like organisations.

The Health Insurance

The Health Care is paid by local taxes, which are collected through proportional taxation, directed from a political (County) level. In contrast, the Health Insurance, which remunerates the patient for loss of income due to disease, and which remunerates some costs for medication and medical equipment, is directed by the State. It was originally financed by a progressive state taxation. Thus we have two separate financiers, whose interests can come into conflict.

Nowadays the Health Insurance is financed by the individual and by the employer, through a proportional taxation of work. The contribution from the State is zero, or in reality negative, because the Health Insurance has a surplus of 22 billion SEK. The State, which still has this money at its disposal, draws on these funds and uses them for other social purposes such as Parental Insurance or Unemployment Benefits. Therefore, there are four different principals for the economy: the County, the State, the employer and the patient himself, each with an agenda of its own, with the problems which this entails.

During recent years, even more costs have been transferred to the patient. This has been seen as a dismantling of the welfare state.

The Development of the Primary Health Care

In 1970 the Counties also took over responsibly for the Primary Health Care (PHC) from the State. There were several reasons for this. The hospitals had developed an extensive polyclinic services which led rather to mechanistic care of the patients than to an holistic view which was supposed to dominate every day Health Care. Also a medicalisation of social problems developed.

There was also a wish to change the financing system from performance payment, which was considered as cost driving, to a principle of total salary. But most of all there was an idea that, with one principal, Health Care would become more coherent, and this would lead to a marked rise in the quality of care.

New PHC centres were built, which were organised within the Counties given their responsibility for first line care. One problem related to this was, that the body of family physicians developed slower than planned. Until 1980 only 3-4% of all physicians in the country were family physicians. At that time a specialist Degree in Family Medicine was introduced and considerable investments were made in the development of PHC. Thereby the number of appointments for family physicians were multiplied and „complete“ Primary Health Care centres with family physicians, district nurses, district physiotherapists and district occupational therapists were established all over the country.

The basic idea was that the PHC would have a total responsibility for the population for a given geographical area. PHC-Centers were supposed to offer Primary Health Care, easily available and of high quality, in line with the idea of „lowest effective level of care“. The responsibility should also include both preventive measures and terminal care. The long tradition for a geographically oriented perspective of Health Care in Sweden, led to expectations also for the PHCs to develop community diagnoses and programmes for primary prevention at a population level.

Rising demands to ease the burdens of the hospitals were ceaselessly given to the PHC. In recent years this was enhanced by the hospitals shorter care times, „short stay“ surgery and polyclinic treatments, in situations which earlier had demanded long stays in hospital.

Demographic Development

Sweden was earlier than most other countries affected by „the greying society“. The care for the elderly and for the *diseases* of ageing has had a central place in Swedish Health Care for many years. Traditionally, the local community is responsible for the „healthy“ old people, and the County has the responsibility for the ill old people. It has not always been easy to create agreement on what is illness and what is ageing. The patients in Swedish hospitals have a high average age. A broadening of the responsibility held by the local community has been seen in recent years. This has placed heavy burdens on the budgets of local communities and also risen the demands of *health care* competence of their Officers, a competence which it takes time to reach.

The Later Development of Hospitals

During the strong rationalisation of industries in the 1970s and 1980s, the job opportunities in trade and industry were reduced. To avoid a rising level of unemployment, the public sector was expanded, especially the health care sector, where the capacities in hospitals and in Primary Health Care were developed in parallel. The reform of Primary Health Care in 1970 had been very costly, but had enhanced the perceived quality of health care.

However, after 1973 the national income could no more cover the cost of the public sector and the welfare state could only be maintained by transactions from abroad. When, with time, the failing economy of the Swedish state became obvious, it became necessary to reduce the expenses of the public sector. Within the health care sector, the focus was first on the hospitals, which had had substantial increasing costs. They were given extensive demands for cost reductions and for making services more effective. A common solution for hospitals was to transfer more patients to Primary Care, to reduce the number of hospital beds and hospital personnel, with thereby following higher demands on other societal sectors.

There were several difficulties in changing the services in a well accepted way. At administrative level, maybe the most important fact was that nobody had any experience in how to manage this new situation because, until then, everybody had lived their lives in an expanding economy. Most importantly, however, *was the general public's* sensitivity towards experiments on social insurance or care.

It was therefore difficult, or even impossible, to receive the political climate necessary for a reduction of the level of service or to make a change at all.

The Demands to Achieve a More Effective Health Care

When health care is at its best, it gives value both for the individual and for the society. When pressed clinic managers tried to claim the societal benefit of their work, the problems given by two different financiers of health care became apparent. In Sweden *the state owned* common health insurance has the role to pay sickness benefit when an illness leads to an inability to work. A clinic whose work leads to less days of sick insurance thereby saves money for the State, *but not for its employer*, the County.

Queues and inhumanly early discharge creates problems for the State and for local communities, but saves money for *the county*. The basic problem was that the bottom line for Health Care never can be money, but should always be health gain for individuals or society. Health gain can only be measured in money from a health insurance perspective. *But sickness benefits are not relevant for elderly*, for children or for the weak in society i.e. for those who are the most common customers of Health Care. *These groups are not payed any insurance money as they have no jobs.*

The Clinical Decision

The basis for prioritisation within Health Care is, and has been, related only to the meeting between physician and the patient. The physicians norm of quality is „science and experience“ whereas the latter is often delusive and applied science has a short life span. „Science“ often implies that methods are applied which are the results of what clinical researchers have achieved during optimal circumstances, i.e. efficacy.

There is today no routine control of how well these methods work within daily routines *that is the effectiveness* (Vang 1997).

The work on quality control is an answer to this deficiency (Nelson et al 1996; Palmberg et al 1996; Lungmedicinska kliniken 1996). Thus, at the University Hospital in Linköping, medical outcome measures for about 50% of diagnoses are today recorded and included in the yearly reports.

In addition, sporadic trials are ongoing in order to study, and incorporate into decisionmaking, patients perspectives on health outcomes. The view of patients has earlier mostly been restricted to questions regarding service (Kristensen et al 1997; Long 1996a+b; Ware et al 1993, Warner 1996).

New Trends in Development

In all organisations a clear definition of the goals is critical for the well being of personnel and for the efficacy of the organisation. Within the public health care sector, during the last decades, the goals for the organisation have seldom been discussed. For physicians and nurses the goal is often self evident; the duty-ethical imperative to cure or to relieve, to help. The dilemma comes in the choice whether one should try to cure or only give relief, and in the choice of method. For the organisation as a

whole, there is often a utilitarian demand: maximizing services to as many people as possible.

„Keeping the budget“ becomes a goal in itself, independent of the effects on the working situation for personnel, or its effects on patients. These two goals are not always, but often, in conflict. They can probably never become totally congruent, but a larger congruence would be reached if the common goal was oriented towards results, i.e. health gain, for the individual patient, the personnel as well as for the society.

Criteria for prioritisation have, in Sweden, earlier mainly been discussed in relation to the value of the individual and to treatments with a documented effect. The latter discussion builds on controlled clinical trials. In an investigation of priorities, made by the State, there was no discussion of the value or the possibility of routine measurements of outcomes (SOU 1993).

Built on the results of outcome measurements, priorities could instead be made according to experiences of those activities which added value to the patient. Instead of the discussion on whether an 80 year old woman or a 50 year old businessman should have an operation, the issue would be in which case the operation would give a health gain. If, after the operation, the old woman can live a normal life, live at home with little help, then the operation has given value, both to the patient and to the society, and a value in both human and monetary terms. Thus, priorities can be made more pragmatically than philosophically if results are measured as health gains.

In addition, to be able to evaluate the own organisation, every health care supplier needs to develop a feed-back system. This is necessary in order to progress towards the „lowest effective level of care“, which is not necessarily the „lowest level“. The development of an outcome managed organisation builds on the integration of outcome measures into the hospitals accounts. Using these reports is a way towards the „learning organisation“ and the empowerment of personnel (Kristensen et al 1997; Long 1996a+b; Ware et al 1993, Warner 1996).

The Personnel

Swedish Health Care has a well educated work force, and education in health care occupations has always been attractive. In spite of relatively low salaries, nurses, physiotherapists and occupational therapists have expressed pride in their occupations and pleasure in their work. That kind of pleasure and creativity is found among people who find their work meaningful.

The savings during recent years has led to rising demands on time effectiveness and process quality without requests for outcomes or patients satisfaction. This has added to an increasing frustration among personnel, often enhanced by a feeling of fewer opportunities to influence their working situation. There is now an intention to address this by creating clear goals for the organisation and by actively involving all personnel in the process of organisational change of the health services.

The Reasons Why the University Hospital in Linköping Became a Pilot Health Promoting Hospital.

In 1992 the University Hospital (US) in Linköping was accepted as one of 20 pilot hospitals within the European Pilot Project of Health Promoting Hospitals (HPH). The hospital management's interests in this work was based on

- a new medical curriculum,
- a new Health Policy Programme for the County and
- the need to develop the management of the hospital and make the hospital more effective.

As described below, the two first factors made it clear that the health services needed a change towards a more explicit health orientation. The need for managerial change in the hospital came at the same time. Therefore, the idea of The Health Promoting Hospital; i.e. a vision where the goal was orientation towards health, was very relevant for all three areas;

The New Medical Curriculum

The medical faculty in Linköping was radically changed in 1986, when the Faculty of Health Sciences was introduced. The Faculty became a member of the Network of Community Oriented Faculties for Health Sciences. This network has the goal to develop health professionals with „knowledge and skills relevant for the society they are to serve“¹.

This goal had not been very clear in earlier medical curricula. Often these have had the same structure since the beginning of the century and professional interests, rather than their relevance for the society, had characterised their content. Also the pedagogical model was renewed, both for medical and for the intermediate health education. In a time with an accelerating growth of knowledge, it is not enough to have a knowledge of facts. It is also necessary to train people to learn actively, to read critically and to prioritise. Therefore the method of Problem Based Learning was chosen as the pedagogical model.

To give a better understanding of the role of Health Care within the society, elements of community orientation were introduced. This included more education in prevention and epidemiology, study visits at industries and social organisations and also a rearrangement so that more basic clinical training was accomplished in Primary Health Care. These changes were not easily achieved as many participants in the Health Care organisation still had a disease oriented, rather than a health oriented, view.

One central theme in the new curriculum was to get stronger mutual respect and understanding between different health professionals/occupations i.e. between physi-

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Faculty of Health Sciences, Linköping University <http://www.liu.se/hu/en>

cians and nurses, nurses and occupational therapists etc. This was achieved by integrating educational groups. The first half of the first term is thus spent in integrated study-groups where the students study the subject „Man and Society“ with the goal to achieve a common frame of reference including a holistic view. This is followed up at the end of the training where students, on a „students ward“ co-operate in care teams, each one in their newly gained professional roles.

The Health Policy Programme

It was taken in 1987. The goals embraced four areas: lifestyle related disease, prevention of accidents, diseases in the locomotion system and better health of the elderly. This programme showed the clear political intent to strengthen the public health perspective within Health Care. The strategy was to integrate this perspective within the ordinary Health Care system. This showed itself to be difficult because the traditions, the culture and the structures of Health Care did not support the strategy.

Developing the Management and Making the Hospital More Effective

This demanded a more clear and visible goal which could be embraced by everybody. It also demanded a change from process- to outcome orientation, a quality orientation, not only from a professional perspective but also from a patient and societal perspective.

It demanded a functional, holistic health orientation rather than a mechanistic disease orientation. Still, this desired reorientation could not be allowed to lead to losses of professional knowledge, technical skills or „frontline“ orientation. Reductions of hospital stay time and new technology had made the hospital too large, and it was obvious that further reductions were possible and that some reorientation of the services was needed.

The commitment of the hospital management in the development towards a more effective hospital increased in the late 1980s. Problems like hierarchies and territorial thinking were identified as restraining renewal and effectiveness. Several parallel processes were started to activate, engage, and change views. Methods applied were analysis of caring chains, total quality management and training programmes for managers.

Also a large change in organisational structure was performed, whereby the clinics were organised together in Centres defined by specific symptom groups. One example of these methods was a strengthened „orientation towards the market“. This happened during a period in which hospitals through contracts were to „compete for the customers“, both for individual patients but also, as the US is a highly specialised hospital, compete for payees from other hospitals. The period was characterised by increasing economical problems, with a simultaneous development of more complex economical managerial systems.

It was difficult to make the different developmental programmes strengthen, and not compete with, one another. This led to the need for a common vision and goal for the hospital. This goal could not be monetary as the overriding goal for health care is health and not profit. The ideology of health promotion was regarded as a possible

vehicle for the change process and as a useful frame of reference both for the internal development of the intellectual and human characteristics of Health Care, and also for the hospitals image and external relations.

In 1992 the University Hospital of Linköping was accepted as a Pilot Health Promoting Hospital. The Goal of the Hospital was discussed in different groups, especially in the Strategy-group for HPH. This group was, with the Hospital Director as Chairman, composed by the Heads of the hospitals Centres and by professors from the Faculty of Health Sciences. The representation from the faculty was based on a mutual interest that the hospital and the faculty should strengthen their interaction, as both parts were dependent on a parallel and successful development of the other. Just as representatives of the Faculty of Health, during their first years, met criticism and fear that the word „Health“ could be regarded as something less serious, this concern was also evident when the word Health Promotion was to be applied to the highly specialised hospital. Still, the need for a common goal was obvious and a more relevant goal than „satisfied customers“ was difficult to find.

The mission statement of the hospital was then defined as “*Health Gain for Patients, Effectiveness and Client Satisfaction*”.

As a pilot Health Promoting Hospital, one task was to define and carry out a number of sub-projects. Those chosen by the University Hospital of Linköping were all already ongoing or planned projects, which were brought into focus to illustrate the concept of a health promoting hospital.

The overall umbrella project regarded management towards an outcome oriented decentralised organisation, which was the overriding goal and strategy for the hospital. This included a project on Total Quality Management (TQM). This can be seen in the analogy with Problem Based Learning within education. By consciously applying a problem solving approach it was possible to create an empowering and learning process in the organisation.

Still the problems remained in that TQM is developed for the industry. Results are easy to measure in industry when money is the bottom line. The outcome of health service interventions are not measured routinely, and particularly not from the patients point of view. And money is not the bottomline. Therefore it is necessary to develop outcome measures relevant for health care.

The sub-projects can be related to three main areas;

- *Health Gain for Patients:*

- Swedish Health Care Meeting with Refugees.

- Psychological and Social Support of Patients, Relatives and Staff Suffering from Crisis. Caring for Patients with Alcohol Problems Identified at the Emergency Ward.

- The Smokefree Hospital

- *Health Gain for Personnel:*

- Early Active Rehabilitation for University Hospital Personnel.

- *Health Gain for Society:*

- Hospital Accident Analyses in the Prevention of Accidents.
- Healthy Food for the Family.
- The Östergötland Osteoporosis Prevention Project.
- Environmental Protection and Pollution Control.

Management Towards a Decentralised Organisation

The Process

The decision to apply for a pilot hospital status was taken by the Hospital Management, but the application was also signed by the owner, i.e. by the designated politician in the County, and by the representatives of all unions. Information about HPH was given to the personnel in the Hospital Newsletter, LINUS, where recurring articles illustrated the ideas and goals to the personnel.

There was, however, no other large scale information. This was a conscious decision, because it was felt important, in this very large organisation, to try to give the process time and to work with a combined „top down“ and „bottom up“ strategy.

The overall or umbrella project, concentrating on management, was the top down approach, while the sub-projects represented the bottom up strategy. The latter gave examples of what a HPH is, or can be like, and from these interest and understanding could grow among the personnel. The resources given were very small. The project should be able to build on existing resources within the ordinary budget.

The leader is an important person, especially in times of change and development. Therefore the development of the University Hospital as a pilot HPH was substantially influenced by changes of the position as Hospital Director came in January 1995. After discussions in the new Hospital Management Group, the new goal for the hospital was defined as *Health Care and Research for Health Gain*.

The TQM method was emphasised more strongly than before as the instrument by which the process of development would be performed at the clinics. Over time, the economical pressure on the organization had increased. For the first time in the hospitals history it was necessary to discharge personnel, and from this period until 1997 the hospital personnel was reduced from 6,500 to 4,500 employees.

The situation made substantial adjustments necessary. It became more and more obvious, that to be able to prioritise, Managers and Department Heads needed a clearer understanding of the results of the activities of their services. This led to discussions on the need measure outcomes in medical practice, not only from the professional perspective but also from the perspective of the patient. A series of seminars were held together with leading politicians, managers and physicians on the possibility to measure Health Gain. This was defined as the combination of the professionally defined medical outcome and the self-rated health gain as reported by patients.

Today TQM is introduced all over the hospital (see below). At the same time outcome measures are being developed. For the year 1996 every clinic has, in addition to the traditional statement of economic accounts, also delivered a statement of quality account with results of medical outcomes for four diagnoses per clinic. A num-

ber of project which measure patient perspectives on outcomes, are ongoing. The aim is to develop „Quality-accounts“ which include both service-questions, medical outcome judged by professionals and patients self-reported health gain.

Even though changes in leadership can give problems, it may also open opportunities. When the previous Hospital Director was made Managing Director of the Östergötland County Council Administration, the concept of Health Promoting Hospitals followed with him. In 1995 the County Council declared, that it was no more a disease oriented, but a health oriented County Council. When the Swedish Network for HPH had its first meeting in 1996 with representatives from 15 hospitals, the County Council of Östergötland was represented by all the four hospitals of the County Council.

Conclusions

Our experience has been that the concept of Health Promoting Hospitals is relatively easy to accept, for personnel, patients and politicians. However, this concept is difficult to pursue if the managerial system is process- and not outcome-oriented, or if the economical rewards are productivity-oriented and not outcome focused. However, we believe that three levels are important.

- *Health Gain for Patients*

This means adjusting the focus of the hospital towards relevance and outcome of the activities. The TQM method has been very effective in this respect. However, this approach needs to aim at health gains as a goal for the activities and therefore demand regular measuring and reporting of health outcomes. Without this the development process is blind. With a routine measurement of outcomes, the personnel can rearrange services after outcomes and the management may focus on activities and processes which are efficient.

- *Health Gain for Personnel*

Making the mission of the hospital clear, setting goals for the activities and making them visible and explicit creates a confident and assured personnel. Empowerment of the personnel is also of equal importance in order to create a healthy workplace. This has been shown clearly, both from the experiences of TQM and from the project of Early Active Rehabilitation of Personnel. To this can be added, that as a part of the new „Quality-Account Statement“, the Department Heads must now report how large a proportion of the personnel was involved in the process of change in the department.

- *Health Gain for Society*

The hospitals knowledge of and information about the state of health in the catchment area, as well as the concentration of medical knowledge at the hospital, makes it possible to initiate preventive programmes in the local community from the hospital level. An example in Linköping is the Accident Programme, which now is a joint venture with the local community. The immediate accessibility of the 1% of the total population, which works at the hospital, makes the hospital an excellent setting

for health promotion and life style development, not only in the hospital, but also reaching out in the society.

Important problems in the processes of change are the lack of time and the fear of bureaucracy. To minimise this, it is vital that all ongoing developmental projects are clearly inter-linked. Thus, health orientation, health gain measurements, quality assurance and leadership programmes need to clearly be parts of the same process of change, with a shared goal: the mission of the hospital, i.e. health gain for the people served.

Below follows a summary of the sub-projects which were identified in The Pilot Health Promoting Hospital, the University Hospital of Linköping.

The University of Linköping Pilot Hospitals Sub-projects

Management Towards a Decentralised Organisation

As this is the umbrella project described in the concluding discussion above, it tries to combine a clear, visible goal for the organisation, with decentralisation of decision-making whereby personnel can develop and their knowledge and potential be brought to use.

The Total Quality Care Project

(by Marianne Bergstedt, Personnel Department, Linköping University Hospital)

The quality process started at the University Hospital of Linköping 1992. The concept chosen was the Swedish Distinction for Quality. This has been developed by the Swedish Institute for Quality Development (SIQ), based on the international concept of Total Quality Management (TQM). (Morgan, Murgtroyd 1994)

The steps in the process are:

- Information and discussions with responsible Heads of Clinics. Goal setting.
- Education of examiners within the frame of the TQM-concept.
- Descriptions of the services and evaluation.
- Education of internal tutors.
- Quality education of all personnel.
- Plan of action.
- Development activities.

The process started with only a few clinics. The first enthusiastic clinics followed the planned route, while it became increasingly difficult to get other clinics to start their process. The main reason for this was that the process had been started at the clinic level, i.e. Division Managers for the ten divisions or centers of the hospital, had not been involved, which affected their commitment to the project. After a down period, the quality process re-started in autumn of 1995. The Executive Management of the hospital made it very clear that the quality work should continue, and that this should be done at a faster speed than before. The goal set was that every clinic in the hospital should have done their „description of activities“ by the autumn of 1996. Today all clinics have started their quality process.

The goal for 1997 is that the quality process embraces all work places in the hospital and should be seen as an instrument for the development of services. Sub-goals:

- All clinics should have written their „activity description“ by December 1996.
- The Executive Management group of the hospital should write a description of the services of the hospital by December 1996.
- Every clinic shall one month after training have started at least three development projects.
- The clinics shall after one year report outcome measures for the three most important diagnosis groups/services.
- The quality work shall be an integrated part in the hospitals personnel policy
- The quality work shall be marketed in such a way, that the hospital should be recognised as a quality conscious hospital.
- Quality-accounts shall be reported

As central vision we want to develop a strategy of change which is well integrated in the daily routines and which gives structure to, and co-ordinates activities which lead the hospital towards the goal of being a Health Promoting Hospital.

Tobacco

Smoke Free Hospital

(by Birgitta Elwing; Centre for Public Health Sciences)

Aim: The Hospital Management decided in 1991 that from 1st of January 1992 the University Hospital should be a Smoke-Free Hospital.

Method: Information to personnel, education to those in charge of the work, and a simple competition about knowledge of tobacco. Personnel who wanted help to quit smoking were offered help from the companies health care. The major part of the indoor smoking rooms were closed. A limited number of outdoor smoking areas, with roofs, were built.

Results: The hospital became smoke-free as decided. Less complaints than expected were noted. One problem was that smokers stood outside the entrances and smoked, which created an unintended negative impression and caused litter around the entrance. This changed after smoke areas had been built outside the entrances. Smoking is allowed for patients who stay at the hospital. Patients who are too ill to leave their rooms, and who want to smoke, can, from the physician or nurse get permission to smoke in their room, if they have a single room.

Sustainability: The responsibility for the work to achieve a sustainable smoke free hospital has since 1994 been held by the Hospitals Group for working environment. From 1996 it is no longer possible to buy any tobacco in the shop/cafe at the hospital.

Smoke-Free Pregnancy

(by Birgitta Elwing; Centre for Public Health Sciences)

All midwives at the University Hospitals have passed the course „Smoke free pregnancy“ developed by the Swedish National Institute for Health. This was done in or-

der to support them in their work to help women to abstain from smoking during pregnancy.

Unit for Less Tobacco Use

(by Susanne Wärjestam, The Anti-Smoking clinic at the University Hospital)

In 1995 an Anti-Smoking clinic started at the Cardiologic clinic at the University Hospital. In addition to their support to patients who want to quit smoking, they also serve as a Centre of competence on anti-smoking issues for the hospital as a whole, and in the longer term for the whole County. The clinic is served by three persons, one physician, one nurse and one psychologist.

Nutrition

(by Birgitta Elwing, Centre for Public Health Sciences)

Dietitians at the University Hospital:

The hospital has dietitians, who work both with individual and with groups of patients. Within diabetic care, patients and relatives are taught how to choose and cook healthy food in the hospital's training kitchen. Within children's health care, the dietitian has contacts with children, their parents, and also those who cook the meals in schools and in day care, and school health care personnel. The food served to patients is composed following the standards made up by the National Committee for Hospital Diets. Also food served in the personnel's restaurant is nutritionally balanced.

Healthy Food for the Family

Aim: By education to young parents achieve healthier food habits.

Method: Dietitians in primary health care teach people, who have recently become parents, how to choose and cook healthy food for themselves and for their children. Parents met three times in cooking classes and had both theoretical and practical training.

Evaluation: By interviews.

Results: The parents are very interested in the subject and ask for education where also fathers take an active part. As the parents feel unsure, both theory and practical training were considered to be important. Home cooked food was considered to have less nutritional value before the education.

Shops for a Better Life

Aim: To make healthy choices easy choices, for customers when they buy food.

Method: By education about healthy food to all staff in the three largest supermarkets in the county. This was done in co-operation between the shops, the County Council, and the Agricultural Society in Östergötland.

Evaluation: Questionnaires were given to customers and personnel before and after the intervention. In addition interviews were performed with key individuals of the staff.

Results: The education given to the personnel had increased their competence on food, on health and on the connections between them. This should increase the pos-

sibility that the personnel, by a better display and fixing of the prices, would help customers to choose healthy food.

Sustainability: The project time is over and now work is ongoing, aiming to achieve a sustainable development of „Shops for a Better Life“ and make it possible to offer the idea to as many supermarkets as possible in the County of Östergötland. (Elwing et al 1996)

Caring for Patients with Alcohol Problems Identified at the Emergency Ward

(by Margareta Kristenson, Centre for Public Health Sciences)

The project is cancelled.

Background: Experiences from personnel working with alcoholic patients show that these patients often have long case histories and have, before the alcohol problem is diagnosed, payed many visits to the emergency ward for different reasons. The patients themselves often wish that someone would have taken more active part in their problems earlier than has been done. They often feel sure that the personnel have seen their alcohol problem, and are disappointed that nobody cares earlier. It is well known that about 30% of patients at an emergency ward have an alcohol problem as their main problem.

Aim: An early intervention should help to avoid secondary socio-economic problems from alcohol abuse, such as loosing job or family.

Method: Using the emergency ward as the arena, the personnel was educated on alcohol problems. The training concentrated on identification of early signs of alcohol abuse, on how to ask about alcohol without offending patients, and learning where to refer those who are interested in receiving help.

Results: The personnel were informed at several meetings about the aim of the project. There was an initial fear of the difficulties in asking about alcohol. Would the patients be offended? However, the project was seen as important as these patients were a part of every day routines.

Short before the project was started, it was reported to the Justice Ombudsman. The question was if it was not professional misconduct to ask patients about alcohol, if they did not explicitly ask for help on this subject.

When contacted, the Justice Ombudsman by telephone gave reassuring information that they found the project important, without juridical problems but it took one and a half years before this information was given by a formal letter. Until the arrival of that letter staff members were not willing to work in the project. At the time of the formal conclusion of this matter, other activities had taken over the agenda. We now have to await another opportunity to embark on the project.

Hospital Accident Analysis in the Prevention of Accidents

(by Anne Hallberg, Emergency Ward, Linköping University Hospital)

Background: In Sweden accidents are the major cause of death among people 0-40 years old. The costs for accidents are 4% of the National Income or in 1990 7.289SEK/inhabitant. These costs include expenses for health care, health insurance,

employers costs, justice, police and loss on income from taxes. The major cost for the individual is pain and suffering. It is well known that accident prevention programmes can reduce accidents by 15-30%. This leads to less costs and less suffering.

Objective: Piloting a new model using an „accident co-ordinator“, who co-ordinates contacts between the hospital and the relevant instance in the society, and analysis of accidents to gain information relevant for designing preventive measures.

Method: The project was accepted by the personnel. Previous results from other hospital's work were used as arguments. Staff members at the emergency wards were asked to give information on the date, place, accident type and the type of injury. They were also asked to give signals if the case was a basis for important/possible preventive actions. The preventive work has two phases:

Step one is an immediate contact with a relevant person, with authority to take action, if direct action is considered possible or important. This is done by the „accident co-ordinator“, who collects and controls the accident information on a daily routine. She also receives information on „accident traps“ directly from the public. In this work one important contact is the local communities office for „traffic and streets“.

Step two is a continuous registration of all accidents. The information in aggregated data is the basis for preventive programmes. These are developed within the framework of preventive networks; A network for the prevention of children's accidents, including members from different authorities in the local community, was started in 1994. A network for the prevention of accidents among the elderly was started in 1995.

Results: The model with an „accident co-ordinator“ has made it possible to use „fresh“ accident information for direct actions. During the latest three years 250 actions have been taken. The established networks made large preventive programmes possible.

Sustainability: After a project period of three years, payed by external funds, the project is from 1 January 1996 an ordinary activity at the emergency ward. The routines of collecting information on accidents was simplified through integration in the ordinary admittance routines and by using computer programmes. Other hospitals in the County are also involved in the development of the accident prevention programme. This gives a larger population base for the registration, and reduces the development cost for each hospital. The local authority has shown a large interest in this work. A part-time nurse (50%) has been hired to support the network for the prevention of accidents for the Elderly.

Psychological and Social Support to Patients, Relatives and Staff Suffering from Crisis

(by Anita Linders, department of Childrens Pshychiatry, Linköping University Hospital)

Background: Some people may develop long term psychologic and psychiatric problems if not supported in coping with crisis reactions, such as after a disaster.

Objective: To prevent later psychological problems after disasters:

- to build a flexible organisation, with well educated personnel, which can be at hand for psychological or psychiatric support, when needed;
- to judge and handle acute psychotraumatic stress reactions and
- to identify people, who need more psychological support after the initial care.

Method: Early crisis intervention for individuals or groups and debriefing (psychological detraumatization) for personnel in health care or rescue services. There is a continuous development of the method by a co-operation with Senter for Krisepsykologi in Bergen, Norway.

Target groups: Patients, relatives and health care personnel. Also personnel from the rescue service and the Police, who have been involved in accidents of disaster.

Results: A crisis intervention group was started at the University Hospital initiated by staff members. They were supported by the management, and the project has its organisational address at the Clinic of Childrens Psychiatry. The members of the group work at different departments at the hospital. They have different backgrounds, such as physicians, nurses, psychologists, welfare officers and clergymen and receive a continuous training in crisis intervention. A network in the local community has been established, with the aim to expand competence and capacity.

Partners: Networks, involving colleagues from the local community, primary health care centres, schools, police, church, and other hospitals in the County.

Time frame: Started on 19th May 1989. Now a part of the hospitals ordinary activities.

Economy: 10% of the working time for the project leader, who is a psychologist. Those who are on the emergency list get an extra 500 SEK/month (approx. 50£).

Evaluation: An evaluation was performed in 1991. It showed that the managers found the project important as it had increased the involvement in these issues amongst the personnel at the clinics. Also, it had broadened the personnels competence and given a better image to the clinics. The co-operation with other services was seen as very important. Problems, such as the time taken from ordinary work, had been marginal and less than expected.

Sustainability: The project has for several years been a part of the hospitals ordinary services. Educational and developmental activities are ongoing, within the hospital, in co-operation with other hospitals in the County (Motala and Norrköping) and also across the country.

Swedish Health Care Meeting with Refugees

(by Ann Charlotte Hermansson, Dep. of Health and Environment, Faculty of Health Sciences)

Background: With its 8,8 million population, Sweden now has the world's highest ratio of re-settled refugees of the total population (1:47). A great number of these refugees came to Sweden in the 1980's and early 1990's.

Aim: In order to satisfy the increasing need of medical care for newly arrived asylum seekers and refugees, a specialised somatic ward was established in 1986 at the University Hospital in Linköping. This marked the starting point for the Medical Centre

for Refugees, which has expanded in the following years to include also a psychiatric ward and three psychiatric out-patient units as well as health care units at refugee reception centres in Sweden.

Results: Due to the reduced refugee migration in the last few years, and the lack of financial support, the somatic ward was closed in 1994 and the psychiatric ward was closed in 1996. The three out-patient psychiatric units are now primarily concerned with psychiatric treatment of patients and families with war traumas and adjustment problems in the Swedish society. Furthermore, in co-operation with the various highly specialised medical and surgical clinics at the University Hospital of Linköping, the Medical Centre for Refugees are presently evacuating patients from Bosnia-Herzegovina who cannot receive adequate treatment within the country. This is performed in close co-operation with IOM (International Organisation for Migration) and the Swedish Immigration Board.

It has been widely recognised that the variety of needs of the refugees in Sweden are not yet met adequately in the ordinary medical system. The knowledge and experiences which have come out from the activities at the Medical Centre for Refugees have been spread through publications and educational activities, as well as national and international conferences.

Ongoing research: The following research projects are now going on in co-operation with the Department of Community Medicine. A quantitative analysis of data concerning premorbidity and sociodemographic factors of asylum seekers which has been continuously collected at the refugee reception centres health care units. A qualitative study of Kosovo-Albanian asylum seekers and their meeting with Swedish health care. A follow-up study of 180 concentration camp prisoners from Bosnia-Herzegovina who arrived in Sweden as quota refugees in 1992. A four year follow up of eleven Bosnian families. They arrived in Sweden in November 1992 and the men were among the very first Bosnian concentration camp prisoners who came to Sweden. The results from a two year follow-up of a culturally heterogeneous group of war-wounded refugees were presented in a thesis in 1996. Further follow-up is planned in 1997, when the group has spent 10 years in Sweden. (Hermansson 1996; Sandstadt et al 1992.)

The Östergötland Osteoporosis Prevention Project

(by Owe Löfman, Centre for Public Health Sciences).

Background: A considerable increment in the incidence of fractures related to osteoporosis has been recorded for several decades. Besides the increase caused by a growing number of elderly people, there is also a substantial contribution coming from the age-specific incidence of fractures. This is especially obvious in hip fractures, which also cause the highest morbidity, disability, mortality and have a major economic impact in the society. Osteoporosis and its related fractures can be regarded as a large health problem where strategies for prevention are extremely important.

Aims: To reduce the incidence of hip fractures and other fragility fractures which relate to osteoporosis. Furthermore, to reduce the prevalence of osteoporosis and to reduce the risk factors leading to osteoporosis and traumatic falls.

Methods: The Osteoporosis Unit was established in 1989 as a resource centre for the development of preventive strategies, by co-operation between the departments of Community Medicine and Environmental Epidemiology, Internal Medicine/Endocrinology and Clinical Chemistry at the University Hospital. The monitoring of fracture incidence and the distribution of osteoporosis related risk factors in the population were assessed by register studies, questionnaires and the screening for bone mineral density of large random samples from the general population.

In the catchment area of one Primary Health Care Center (PHC), a special project, mainly for primary prevention, was launched using a cross-disciplinary approach and in close co-operation with various parts of the society (organisations, work-places, schools, etc). The preventive measures were mainly focused at: (1) increased calcium intake, (2) improved physical activity, (3) reduced smoking, (4) improved status of vitamin-D among the elderly and (5) reduction of the risks of traumatic falls, especially in the homes of elderly people. Furthermore we developed strategies to find high-risk individuals and to offer them optimal secondary prevention, pharmacotherapy included.

Education of health professionals, as well as of the general population, was also offered with regard to risk markers for osteoporosis, and new possibilities to diagnose it, and how to initiate secondary preventive measures against the disease.

Development of a programme for the management of osteoporosis including various aspects and several medical disciplines like the clinics for internal medicine, endocrinology, orthopaedics, gynecology, geriatrics, rheumatology and primary health care were initiated. This programme is under evaluation by a group of PHC's, using a mobile densitometer for the assessment of bone mineral density (BMD).

Duration: The programme was started in 1988 beginning with a baseline assessment of risk factors, and measurement of BMD in the population. The PHC project was started in 1990 and will be evaluated after the last round of follow-ups in 1999. The programme for the management of osteoporosis was started in 1996 and is to be evaluated three years from now.

Evaluation: The distribution of risk factors and BMD have been assessed in about 4,000 randomly selected subjects, using the same standardised questionnaire. BMD measurements have been performed by Dual-Energy-X-ray-Absorptiometry (DXA) in the spine and hip sites, and Single-Photon-Absorptiometry (SPA) in the forearm. Intermediary measures like BMD, changes in attitudes, knowledge about osteoporosis, risk factor patterns etc., are followed regularly, although the fracture outcome is the most relevant measure (incidence studies). Treated high risk individuals are followed by various other clinics, the osteoporosis unit included, where the results are monitored in a programme for quality assessment.

Results: Basic knowledge about the occurrence of osteoporosis and distribution of risk factors have been collected. During the project, the importance of life style factors has become more obvious in the population, and the attitudes have shifted in favour of preventive measures. Normal values of BMD have been established for the local population and new methods to analyse and follow biochemical markers of bone turnover developed. The last will help to judge if a single subject responds to prevention or pharmacological treatment, since BMD measurement is not a sensitive

method for monitoring changes in the short term. According to the WHO-guidelines for definition of osteoporosis in women (a BMD value -2.5 SD below the mean value in young healthy adult females) (Lofmann et al 1997, Waller et al 1997)

Our investigations show that 60-70% of women over 70 years of age have osteoporosis, although they have not necessarily suffered from a fracture. The results of the ongoing study of hip fracture incidence will end later this year and reveal if the increase in incidence has been stopped according to one of our goals. The last end-point, planned to be evaluated in the year 2005, is to confirm that a decrement in the hip fracture incidence has been attained.

Environmental Protection and Pollution Control

(by Anne- Marie Gabrielsson, Security Officer, Linköping University Hospital)

Organisation: The organisation with special personnel responsible for the chemicals at each laboratory, is functioning well and makes staff at the laboratories take responsibility for the safety of chemicals. It is also a good channel for information. The chief managers now take more responsibilities for their equipment and thereby also for outlets to waste water. The system of „KEM-risk“ (the name refers to chemical risks, in Swedish chemical is „kemisk“) where laboratories report their chemicals directly via the KEM-risk satellite, is working well. The laboratories collect their information in their own computers. The information is thereafter transferred to the main system.

Activities and outcomes: During 1995-1996 CFC (completely halogenated chlorine-fluorine-carbon) as chilling media was exchanged to gasoline, which is non-toxic to the environment. There are only small local chill aggregates left which are run by HCFC (incompletely halogenated chlorine-fluorine-carbon). These will also be exchanged.

Today 93% of the rinsing water from the hospital's X-ray department passes an ion-change. As a result the amount of silver let out with the rinsing water has gone down substantially from 12 kg/year to 0.5 kg/year.

Mercury has been taken away from the hospitals processes. Fever thermometers were exchanged for non-mercury devices in 1990. Within dentistry equipment for detachment of amalgam and water locks have been installed.

Due to economical problems, the waste end-station for management of waste, which was planned to start in 1993, has still not been built. Now it is again planned and shall be built during 1998. In parallel local waste stations shall be built in the different buildings at the hospital area. An information campaign will be performed in order to start a more developed source-separation which will come into service end 1998.

Waste of food from the hospitals restaurants and kitchen is from 1996 sent as pigs food. All meat is separated for special treatment. In October 1997 the hospital kitchen was rebuilt and the waste-mills in the hospitals kitchen were exchanged. Work is ongoing to find other routines which will be safer for the personnel.

A „mercury dog“, i.e. a dog that can smell and detect mercury to a level of 0.6 mg Hg has controlled 1065 drain traps and 60 draining gutters. 5 markings have been cleaned and the hospital is now regarded to be free from mercury.

Policy and planning. In 1997 a new environmental policy programme has been taken by the County Council. This policy is planned to be transferred to a policy document for the hospital adherent to the European Union's Eco-Management and Audit Scheme.

Also, during 1997 an environmental audit has been performed at the University Hospital. 150 persons have been designated „ombudsmän for the environment protection“, i.e. with a certain responsibility for this and all personnel shall be offered 4 hours education on environment protection during 1998.

Early Active Rehabilitation for University Hospital Personnel; The Prehab-Team

(by Birgitta Öberg, Physiotherapist, Dr med vet., Linköping University Hospital)

Background: A high ratio of ill health with large expenses for sick-leave is existing within the health care personnel. The employees are a risk-group for problems with movement and illness related to the locomotion system due to the large amount of females and an age-profile with many in the older age-groups. Models for successful rehabilitation are founded on an early co-ordinated effort with competence within medicine as well as behavioural science.

Aim: To develop the knowledge and readiness for rehabilitation and prevention in both the individual and at the workplace, through early efforts, even before the problem lead to absence due to illness.

Means: A rehabilitation resource team consisting of four people for a period of two years was set up. Areas of competence: rehabilitation, management and behavioural science.

Methods: To deal with individual cases on request from, and together with, the management and staff members at the workplace.

To develop schemes for early physical training, to support the development of networks for rehabilitation measures as well as to support the development of the workplaces own rehabilitation strategies. The workplace-managers role is central in this work, and has been developed through attending specific courses for managers.

Evaluation: Methods are interviews with managers and long-term sick-listed and evaluation of the effects of physical exercise during working hours. The development of sick-listing patterns over a two year period could not be evaluated due to changes in the rules for sick-listing.

Results: Approximately 100 employees have contacted the team during 2 years time. The main reason for contact was physical problems. 90% were concerned with problems in the locomotion system and a wish to receive help from a physiotherapist. After review there was referral to physiotherapist (40%), physician (20%), company health care (10%) and workplace review (30%).

Conclusions:

A successful rehabilitation can be pursued through increasing the competence of managers and staff at the workplaces, to identify and to deal with ill-health at an early stage whereas feedback of experiences is an important part of the learning process. A rehabilitation team should consist of medical competence, management compe-

tence and a good knowledge about hospital work as well as competence within the behavioural sciences. A resource, close to the workplace, which offers physical exercise at the same time as a possibility to health information, can prevent the development of ill-health and problems in the loco-motor system. However the resources to, at an early stage, deal with ill-health caused by psycho-somatic reasons are insufficient and have not been solved by this model.

Has the project led to changes within the hospital?

A decrease in resources caused that exercise opportunities close to the workplace remained scarce. However the experiences of the project have been passed on to the company health care. Also, the cooperation with the social insurance officers has developed further.

Today, contacts with the workplace managers are taken at an early stage to plan return to work. Some workplaces have been chosen for work-training, as part of the rehabilitation, for people with long-term problems.

References

- Elwing B, Gladh K, Angbratt M. A., Glad E. (1996): Rapport 96:1, Butik för livet. Folkhälsovetenskapligt Centrum 58151 Linköping (In Swedish)
- Hermansson A.-C. (1996): War-wounded refugees. A prospective study of well-being and social integration. Medical dissertation. Linlöping University
- Kristenson M., Sullivan M., Wärnberg Gerdin E., Vang J. (1997): Measuring health gain. In: Vang J, Kristenson M, eds. Outcome measures make sence, do they also make a difference? Stockholm: SPRI and Centre for Public Health Sciences, (In press)
- Lofman O., Larsson L. Ross I., Toss G. Berglund K. (1997): Bone mineral density in normal Swedish women. *Bone* 1997, 20:167–174
- Long A. (1996a): The need for a broader perspective. The health outcomes in Europe. The bulletin of the European clearing houses on health outcomes. 4:1
- Long A. (1996b): The user's perspective in outcome measurement: an overview of the issues. *Outcomes briefing*, 8: 4–8
- Lungmedicinska kliniken (1996): Kvalitetsarbetet vid Universitetssjukhuset i Linköping, (In Swedish)
- Morgan C., Murgtroyd S. (1994): Total Quality Management in the Public Sector. Buckingham, Open University Press
- Nelson E. G., Mohr J. J., Batalden P.B., Plume S.K. (1996): Improving health care, part 1: The clinical value compass. *Journal of quality improvement*, 22 (4): 243–258
- Palmberg M. (1996): QUL. Ett verktyg för verksamhetsutveckling i Hälsa och Sjukvården. *Överläkaren*, 3: 6–12 (In Swedish)
- Sandstedt A.-C., Carlsson V.A., Hörnqvist J.O., Thyberg M. (1992): War-wounded refugees, Quality of life after 2-3 years in Sweden. *Scandinavian Journal of Social Medicine*; 20 (3): 173–178
- SOU (1993). Vårdens svåra val. Rapport från utredningen om prioriteringar inom hälso och sjukvården, 93
- Vang J. (1997): Health gain measurements-an approach to outcome governed health services management. In: Long AF, Bitzer E, ed. Health outcomes and evaluation: context, concepts and successful applications. Leeds: University of Leeds, European Clearing Houses on Health Outcomes, Nuffield Institute for Health

- Waller J., Angbratt M., Blomberg C., Kronhed A.-C., Larson L, Lofman O. Moller M., Toss G., Trell E. (1997): Logics and Logistics of Community Intervention against Osteoporosis: An Evidence Basis. *Journal of Medical Systems*, 21: 33–47
- Ware J.E., Snow K.K., M. K, Gandek B. (1993): SF-36. Health Survey Manual and Interpretation Guide. Boston: New England Medical Center, The Health Institute
- Warner M. (1996): Focusing on health gain. A good way to herd cats toward a total health promoting hospital. In: Vang J, Kristenson M, ed.: 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, 13–31

The British National Healthcare System

Dominic Harrison

The budget for the NHS in Britain is approximately £42. billion pounds in 1996/7 representing about 7% of the nations Gross Domestic Product . The service is funded through a mixture of national insurance and general taxation and administered by the Department of Health, through the NHS Management Executive. The NHS Management Executive has a national office in Leeds in the north of England, and functions in England through eight regional offices . The NHS in Scotland, Wales and Northern Ireland is managed through their respective government offices (the Welsh Office, the Scottish Office etc.).

The NHS provides primary care through family doctors (GPs), opticians, dentists and other healthcare professionals; secondary care through hospitals and ambulance services and tertiary care through specialist hospitals treating particular types of illness such as cancer. At the same time the NHS works with local Social Services Departments to provide community care.

Mission and Principles

The NHS defines its mission as „to secure through the resources available the greatest possible improvement in the physical and mental health of the people of England by promoting health, preventing ill health, diagnosing and treating injury and disease and caring for those with long term illness and disability who require the services of the NHS“. The principles on which the NHS was founded in 1948 were :

- The NHS provides comprehensive care for the promotion of health prevention of illness and treatment of disease.
- Everyone in the UK has the right to use it
- Care is provided according to peoples clinical need – not their ability to pay.

Structures

Finance and priority setting is highly centralised though some attempts have been made in recent reforms to pass accountability for decision making to local Health Authority and General Practice / primary health care teams.

Each year financial allocations and ‘priority and planning guidance’ is sent through the government controlled Regional NHS Executive Offices. They then define regionally focused Corporate Contracts for Health Authorities who in turn translate these priorities into contracts with local Hospital , Community Service or Ambulance Trusts as well as those for General Practices (primary health care teams).

At a local level of approximately 500,000 population, Health Authorities are purchasers of services and Trusts and General Practices (primary health care teams) are providers.

Use of Services

Nine out of ten people who use the NHS are seen in the community – usually through

their GP. In 1993 there were 26,000 GPs in England, most working in group practices and supported by a healthcare team of practice nurses and other support staff. Typically a GP has a 'list' of 1,900 patients, though in areas of poverty lists are often much larger.

Some 280 major district hospitals in England provide a range of services from accident and emergency to maternity to care of elderly people. Hospitals range in size from large institutions to smaller community hospitals. Bed numbers are falling dramatically as a result of technological and practice changes driven by cost containment measures and efforts to improve outcomes.

Between 1982 and 1992 for example, the number of beds available for all clinical specialisms fell from 348,000 to 231,000 while the number of patients treated rose by more than a third. Central to changes in practice is the move towards multidisciplinary teams, and a wider understanding of the concept of clinical authority. All hospital staff – doctors nurses and other support staff now work increasingly together to provide a continuum of care.

Leeds is a typical metropolitan area with a population of 724,000. NHS services provided to this community are: 406 GPs in 133 practices, 29 of whom train new GPs, 294 dentists in 158 surgeries, 153 pharmacies, 171 opticians, 6 general hospitals employing 841 medical and dental staff, 3791 nurses and 691 other medical professionals, 4 psychiatric hospitals and over 60 community health centres and clinics.

Health Promotion Infrastructure

The cornerstone of local health Promotion work is the Specialist Health Promotion Services. These employ postgraduate trained health promotion specialists who facilitate health education and health promotion programmes and organisational development for health both within and outside the healthcare sector.

Whilst health education and promotion remain a small but growing part of total NHS business, financial allocation for specialist health promotion services make up less than 1% of the NHS total budget. In 1996 explicitly allocated NHS resources for health promotion and education was accounted for by: £3m for a Health Of the Nation Unit in the Department of Health (DoH), £42M for the English Health Education Authority and national other national programmes, £90m Specialist Health Promotion Units in Health Authorities and Trusts, and £76 M payments for general practice based primary health care health promotion functions.

Health Care Reform

Since the election of the New Labour government in the UK in the spring of 1997 a rapid programme of structural and policy reform has taken place. These reforms will radically change the value base and direction of national health policy.

New Structures

The reformed National Health Service will keep the existing structure of a Department of Health managed by the civil service through a National Health Service Executive. This will retain national offices and keep the eight Regional Offices in each

health region of England. Scotland and Wales and Northern Ireland will manage their own health services through their respective offices with Scotland and Wales soon able to review their own service structures through arrangements for limited political devolution.

Below Regional levels there will continue to be Health Authorities (commissioners of health services) and NHS Trusts though their numbers will be gradually reduced in order to provide management / overhead costs efficiencies.

Fundholding general practitioners and primary health care teams will be abolished in favor of a four tier Primary care system of 'Primary Care Groups'. A Primary Care Group will comprise community nurses, paramedics and general practitioners in a geographical area taking responsibility for commissioning services for their local community in close collaboration with social services. The four tiers of Primary Care Groups offer differing levels of autonomy and financial control including the opportunity to become a Primary Care Trust which may take over responsibility for community hospitals and other health services. None of the options affect the independent contractor status of general practitioners.

Health Services will become more public health focussed with all relevant agencies including Local Authorities being required to collaborate in the development of a local 'Health Improvement Programme'.

A new Minister of Public Health has been appointed within the Department of Health with responsibility for co-ordinating the non NHS sector response to population health development.

Health Strategy

A revised national health strategy has been published replacing the DoH (1992) 'Health of the Nation' document. The new strategy DoH (1998) 'Our Healthier Nation' will keep a number of disease prevention targets but will focus more on the determinants of those diseases from a social and environmental perspective (rather than from that of individual behavior change). The strategy will also focus on:

- Developing partnerships for health.
- Developing a public health focussed NHS.
- Reducing inequalities in health.
- Developing health promoting communities, workplaces, schools and health care systems.
- Responsibilities of individuals for their own health.

NHS Performance Indicators

A consultation document on revised NHS Performance Indicators was issued in January 1998. This focussed on outcomes and effectiveness rather than those indicators previously used which focussed on activity and inputs. Key indicators will include:

- Population Health Improvement.
- Fair access.

- Effective delivery of appropriate healthcare.
- Efficiency.
- Patient / carer experience.
- Health outcomes of NHS Care.

About 35% of the proposed indicators will require a new measurement tools and infrastructure as they are not routinely collected within existing data systems. Particular deficiencies are noted in relation to outcome assessment and patient perspectives.

Public Health

The DoH Chief Medical Officer is undertaking a major review of Public Health in the UK, which will report in the summer of 1998. This review is expected to recommend a major expansion in training and education of NHS and other staff in public health skills and to suggest a broadening of Public Health away from the narrower Public Health Medicine base. The development of a multi-disciplinary public health approach to population health development is likely to be recommended.

Patients Charter

There is to be a reformed Patients Charter which will include rights for patients in respect of information, treatment, access to GPs, participation in decisions and confidentiality. The new rights are to be set in the context of patient responsibilities such as keeping appointments, not knowingly withholding information relevant to diagnosis or treatment, taking good care of own well-being and not making gratuitous demands on the service. This responds to a growing scepticism among health service staff that the Patient's Charter standards did not reflect the true quality of the service and ignored the social responsibilities of the ordinary citizen in accessing health care.

New National Health Institutions

In order to facilitate the changes the government has developed plans for a range of new national institutions. These will include:

- A new *Food Standards Agency* to separate responsibility for food standards and nutritional public health away from the interests of food producers. Currently one department (Ministry of Agriculture Fisheries and Food) represents both interests and this is widely credited as a key contributory factor in the UK BSE (Mad Cow) debacle.
- *NHS Direct* will be established as a new 24 hour direct line health advice service staffed by nurses.
- A new *National Institute for Clinical Excellence* will be established to promote high quality national guidelines for treatment based on the most up-to-date scientific evidence.
- A new *Commission for Health Improvement* will make sure that all parts of the NHS learn from and are brought up to, the standards of the very best.

Further to these changes, the new government have made clear their commitment to international collaboration as a valued strategy for health development.

Prevention and Cure Collaborate at Altnagelvin

Raymond McCartney, Carrie Jain, Margaret Doherty



Altnagelvin Area Hospital, Londonderry

Project Coordinator(s):	Margaret Doherty/Carrie Jain/Eilish McCloskey
Contact:	Altnagelvin Area Hospital Glenshane Road UK-Londonderry, N Ireland BT47 6SB Tel: +44/1504/345171-3539, Fax: +44/1504/611222
Hospital Owner:	Altnagelvin Hospitals Health and Social Services Trust
Hospital Ownership:	Public
Specialisation:	General Hospital
Beds:	462
Staff:	Medical Staff: 179, Nursing Staff: 887, Other Staff: 569 Total Number of Staff: 1635
Utilization:	Average Utilisation of Beds/Year: 75% Average Stay in the Hospital/Day: 5
Patients:	Number of Inpatients/Year: 26,700 Number of Outpatients/Year: 110,000
Location of Hospital:	Suburbs/rural
Catchment Area:	Regional Number of Population: approx 160,000
Other Functions than Medical Care:	
Teaching:	Medical Students, Postgraduate, Nursing Education
Research:	Basic Science Research, Other Health Research: Biomed
Subprojects:	1. Alcohol Project 2. Breast Feeding Promotion 3. Accident at Work 4. Children's Education Programme 5. Cardio-Pulmonary Resuscitation Training Programme 6. Smoking and Health Policy 7. Promoting Health through Nutrition

Altnagelvin Hospital – A Major Care and Treatment Provider in Northern Ireland

Altnagelvin Group of Hospitals primarily serves its local population of approximately 160,000 stretching from Limavady to Strabane and incorporating Northern Ireland's second city, Londonderry. The Group of Hospitals also serves a wider population within Northern Ireland and beyond Northern Ireland.

The Northern Ireland populations on 30 June 1995 (Department of Health and Social Services (DHSS) 1996)¹ was estimated to be 1,649,000. Population projections indicate for N Ireland that the number of elderly people will continue to increase for the foreseeable future. By the year 2000 the number of people over 75 years is predicted to increase by 10% and the number over 85 years by 24%. At the same time the number of children under 15 years is forecast to fall by 4%.

Increases in life expectancy (see Figure 1) are the main reason for the increasing number of elderly people. While these increases are significant, compared to 25 years ago, life expectancy in Northern Ireland is less than that of the European Union average and the UK.

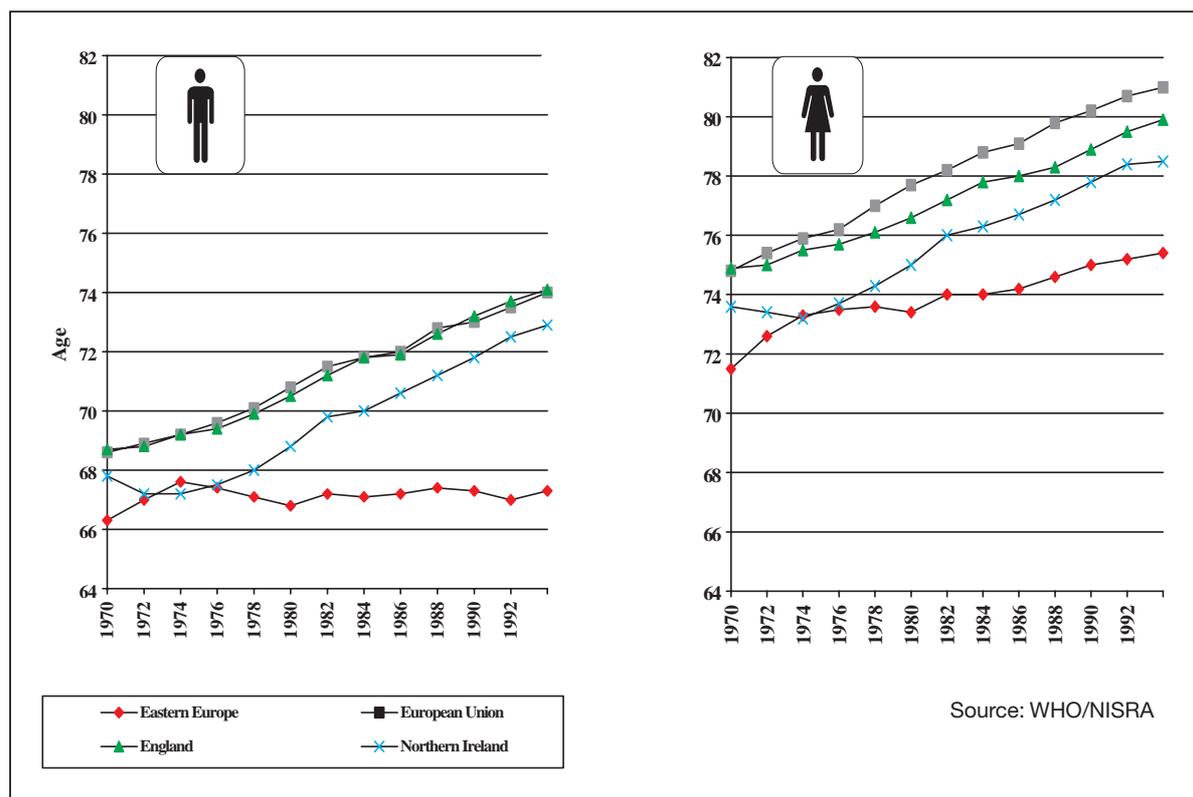


Figure 1: Life Expectancy at Birth in Europe

This pattern of demography recurs throughout Northern Ireland, however, there are a number of important characteristics which differentiates the local population served by Altnagelvin Hospital from other areas in Northern Ireland.

The District Council areas of Strabane, Limavady and Derry exhibit indicators of social and economic disadvantage which are among the worst in N Ireland (Table 1).

Table 1: Indicators of Social and Economic Disadvantage (WHSSB 1997; Dept of Environment NI 1997)

	N Ireland %	Londonderry %	Strabane %	Limavady %
% of Population > 65 years	13	9	11	9
% of Population < 14 years	24	29	27	27
% Without Car	35.5	45.4	36.7	Not Available
% of Owner Occupied Homes	62.3	50.6	54.4	56.2
% of Children in receipt of Free School Meals	27.4	41.8	39.7	32.3
Unemployment %	8	12.5	15	Not Available
Level of Deprivation using Robson Index ¹		3	1	11

¹ Comparison of deprivation across the 26 District Council areas of N Ireland.
1 = Most Deprived 26 = Least Deprived

The areas served by Altnagelvin have above average unemployment levels and below average incomes with a fast growing and youthful population alongside a high rate of net emigration. They are the areas determined as most disadvantaged when measured on the Robson Index (WHSSB 1997). There is an established valid and reliable relationship between the health and social care needs of a population and its social and economic status.

The Northern Ireland Health Care System is part of the United Kingdom National Health Service (NHS). There is one major difference in that the service in Northern Ireland combines Health Services and Social Services and these integrated services are funded, commissioned and provided within a single administrative system (Fig. 2).

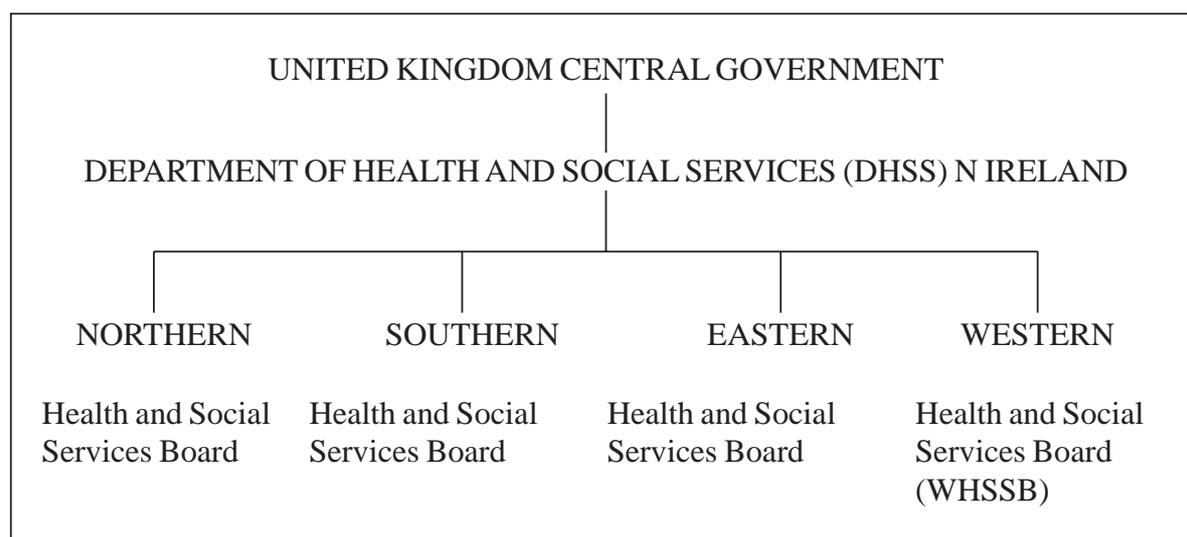


Figure 2: The Northern Ireland Health Care System

A key feature of the Northern Ireland Health Care System is its division into four administrative areas known as Health and Social Services Boards. Each Board is responsible for the commissioning of health services and personal social services for its resident population. Each Board has a responsibility for the assessment of Health and Social Care needs within its area and for the agreement with Health and Social Services Trusts (Providers) on the provision of services to meet the assessed need.

Altnagelvin Hospital is the main provider of Acute Hospital services within the Western Health and Social Services Board area. Some 80% of Altnagelvin's income is derived from agreements with the Western Health and Social Services Board to treat its residents.

The Hospital provides the most comprehensive and coherent range of diagnostic and treatment services to be found outside the major regional teaching hospitals. The provision of Accident and Emergency, Coronary Care, Trauma and Orthopaedics, Otorhinolaryngology, Oral Surgery, Ophthalmology, Paediatrics, Computed Tomography Screening and Intensive Care facilities, alongside the traditional general specialties ensure an infrastructure of comprehensive and excellent services.

The staff at Altnagelvin have shown themselves to be outstanding in their respective fields and in recent years have earned respect through their capacity to work closely in multidisciplinary teams in innovative and flexible ways which have improved patient care.

Situated in the north west corner of Northern Ireland on the periphery of the rest of Europe, Altnagelvin Group of Hospitals has developed collaborative networks with Regional Centres in Belfast, the University of Ulster, Queens University Belfast, peer organisations in the Republic of Ireland, and with international networks through the World Health Organisation and the European Community. These communication and collaborative networks are vital to the continuing professional development of all staff in the Hospital. Altnagelvin Hospital is committed to ensuring that all staff have optimum access to education and training and to energetically linking this to an ongoing pursuit for excellence in the management and provision of health care.

Can Acute Hospitals Contribute to Health Gain? – Altnagelvin Tests the Water

It is the clear responsibility of Altnagelvin Hospital's management to progress their hospital capability to serve the community. The hospital exists to treat and care for patients and to do so in a way which gives the community a service that is as good as or better than they could get anywhere in the world. As a major health care provider within the community, Altnagelvin increasingly saw a need to also develop its wider role and capability in the area of health and well-being.

A number of factors combined around 1992 which caused Altnagelvin Hospital to examine how it might ensure its continued and increasing effectiveness as a health care provider. Two key factors were:

1. Altnagelvin was about to become an independently managed unit; a National Health Service Hospital Trust.
2. The new Northern Ireland Health care strategy was giving increasing emphasis to health promotion issues and health promotion processes (DHSS 1991).

Altnagelvin's imminent independence provided all the necessary incentive for a major review and relaunch of its organisational development programme. A major programme of change was embarked upon which included a revision of organisational structures, a redrawing and restating of the Hospital's mission statement and, most importantly, organisational development activities were agreed and actioned as the main vehicles to carry forward the principles, values and processes of the newly emerging organisation at Altnagelvin. The Health Promoting Hospital Project (HPH) became a key organisational development activity at this critical change point allowing a number of important development issues to be addressed.

The project would allow issues of health gain and clinical effectiveness to be explored and disseminated. It would permit hospital staff to become more closely attuned to wider health and well-being issues affecting their community. Above all, the project was concerned with providing staff from all disciplines with opportunities to become involved in relevant and appealing health developments.

At the same time the new health care strategy was seeking to address major health promotion challenges such as:

- establishing integrated public policies which contribute to health gain
- strengthening community participation and action, and encouraging a re-orientation of health services towards health promotion and disease prevention.

This strategy, building on the previous one, retained Health Promotion as one of the main themes of health care policy and stipulated that all health care premises should have appropriate health promotion policies on smoking, diet, alcohol and occupational hazards. All contracts for services were to include a health promotion element. The two incentives of major imminent organisational change and a regional health care strategy which was emphasising health promotion allowed Altnagelvin to turn its attention more vigorously to giving health promotion policies a greater role at Altnagelvin.

Introducing Changes – A Project Management Approach

In Altnagelvin, the change from a curative approach to healthcare to that of a settings approach was built upon the strong foundations of the alliance between the Hospital, the Health Promotion Department and the Department of Public Health Medicine.

In developing a structure for Altnagelvin's pilot project, these three key players adopted a project management approach (Figure 3).

A strong and highly visible lead for the project was provided by the Chief Executive who assumed overall ownership and responsibility.

The steering committee, management team and project group comprised staff from a range of specialities/disciplines/professions, with a senior nurse manager and a health promotion officer contributing to both the management team and the project group. This contributed to effective information flow throughout all levels of the structure.

A preliminary audit of health promotion work ongoing within the hospital revealed a number of initiatives which, on assessment, appeared particularly appropriate for

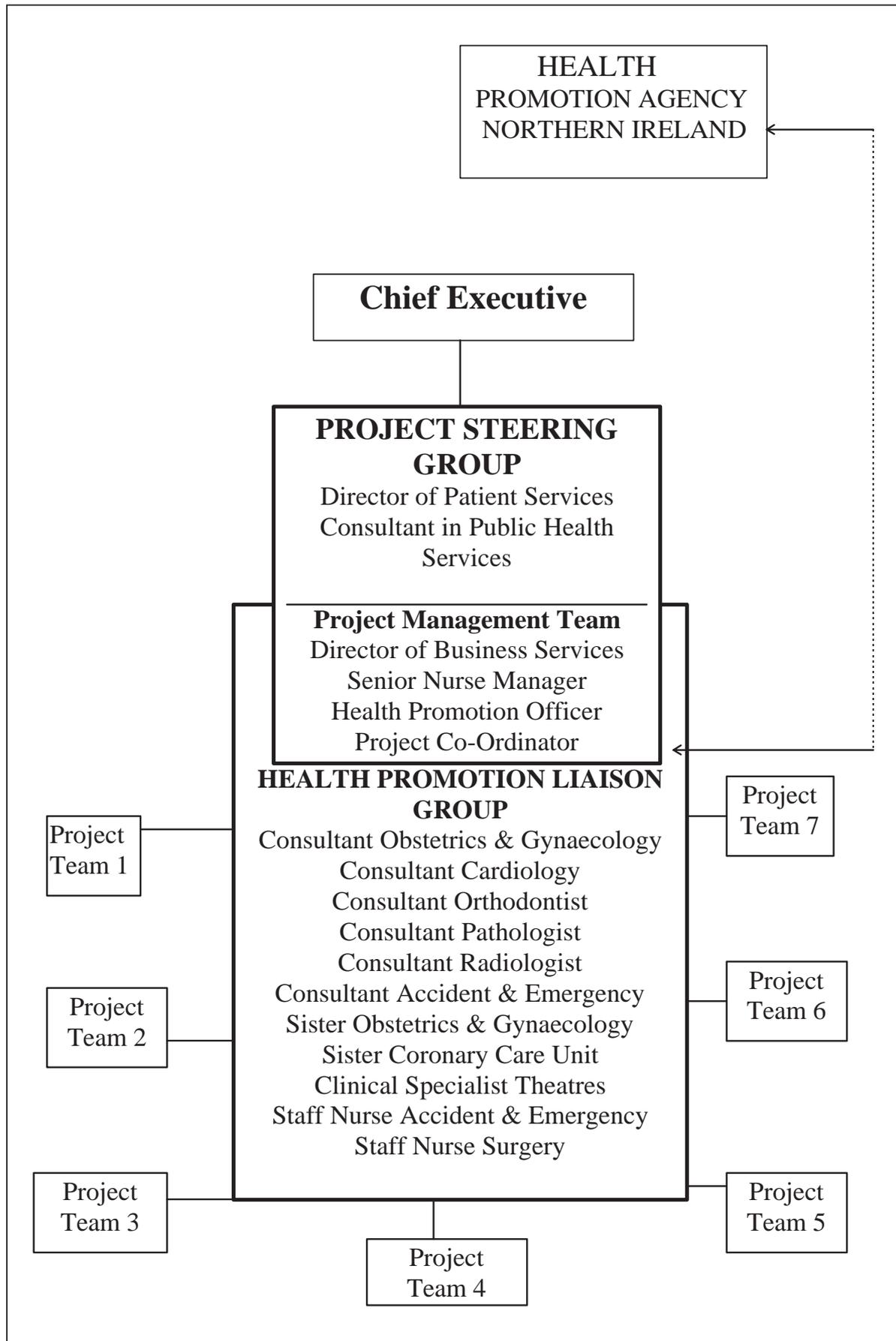


Figure 3: Structure of The Health Promoting Hospital Pilot Hospital Project at Altnagelvin

inclusion in the pilot project. The next step was to identify additional key personnel who expressed interest in the work of these initiatives. Multidisciplinary teams were then developed to take forward the work of the seven sub projects. Senior representatives from each of these groups formed the project group – the operational level of the structure. An outline of the seven sub projects along with project structures were submitted with our application to join the European Health Promoting Hospital pilot project (WHSSB 1993).

Identifying a range of staff from across areas/disciplines/specialities was the first step towards promoting the pilot project and the sub projects as widely as possible throughout the organisation. Staff from the management team and the project group were encouraged to inform their colleagues about the project and to explain the concept on an opportunistic basis. However, a more planned approach to both internal and external promotion of the project was required and a strategy was therefore developed to achieve maximum awareness throughout Altnagelvin and beyond to the population it services.

In order to achieve maximum awareness, one of the earliest measures chosen was to run a series of awareness sessions for all staff. The senior nurse manager and the health promotion officer (the project co-ordinator) invited all staff to attend seminars explaining what the project was to mean for staff, patients and the care provided by the hospital. These were advertised extensively throughout the hospital and attracted a significant number of the merely curious and the truly enthusiastic.

A leaflet was produced explaining the Health Promoting Hospital (HPH) concept and the pilot project and this was attached to payslips of every staff member.

Prominent photographic displays of the sub project teams and graphic information about the sub projects were sited in the main foyer of the hospital, while posters illustrating the work of the sub projects were mounted on each floor of the hospital tower block.

Articles were published in Altnagelvin's in-house magazine and in the Health Promotion Department's quarterly publication "Health Matters". Both have a large distribution network within the hospital, the primary care sector and the hospital's wider environment.

The hospital radio station broadcast news of the project to patients and the local media showed a keen interest in the project and carried a number of articles during the initial phase. This relationship with the local media has continued throughout the project, with the Press, local radio and TV carrying reports on the range of activities carried out in support of the sub projects.

Throughout the life of the pilot project, a small team from the Health Promotion Department and Altnagelvin Hospital responded to requests to make presentations on the work of the pilot hospital to a number of other hospitals within the Western Health and Social Services Board areas and beyond these boundaries to hospitals in other parts of Northern Ireland.

One year after the launch of the pilot project a conference entitled 'Care, Cure and Prevention' was held with the aim of further exploring the potential of the Health Promoting Hospital. The conference organised jointly by Altnagelvin and the Health

Promotion Department brought together delegates from local government departments throughout Northern Ireland, from hospitals regionally and nationally, from universities and from Altnagelvin itself.

The conference highlighted the conceptive challenge of the Health Promoting Hospital and outlined the potential benefits in terms of organisational development, health gain and the provision and delivery of care. With such a wide audience, the conference was of great benefit in highlighting how the Health Promoting hospital can fit into many different agendas – the public health view of health as an interaction of social and environmental issues alongside a medical focus, the health economists search for maximum measurable health gain at minimum cost and the politicians need to find a constructive alternative to the spiralling costs incurred by high tech medicine.

The conference was opened by the Secretary of State for Northern Ireland and the background to the Health Promotion Hospital movement was provided by representatives from the World Health Organisation and Ludwig Boltzmann-Institute. Examples of models of good practice were also presented, as were clinical view points. The focus broadened with a presentation on the Western Health and Social Services Board's 'Health and Lifestyle' survey (WHSSB/ University of Ulster 1993) which provides the background on which much health promotion work is based. The conference also heard details of an innovative accident prevention programme, 'Street-smart', which used a multi-agency approach to promoting accident prevention, targeting young school children.

Altnagelvin staff were involved throughout the planning of the conference and evaluation indicated that the presentations on the seven sub projects provided a high point for many delegates. For staff involved in the presentations, this was a most rewarding, if nerve wracking, experience. The opportunity to share their efforts and achievements with a prestigious audience gave the sub project teams recognition and acknowledgement for their hard work and commitment and provided added impetus for those working on the sub projects.

April 1996 saw Derry as the venue for the Health Promoting Hospitals 4th International Conference. This was a particularly busy and exciting time for staff in Altnagelvin and the Health Promotion Department.

The theme for the conference was 'A Vision for Development in Times of Change' which provided delegates with the opportunity to further develop basic concepts, to find out about examples of good practice and critically question the Health Promoting Hospital as a visionary concept for hospital development.

With staff empowerment a major focus of the Health Promoting Hospital project and the conference, involvement and participation of the sub-project groups was of major importance.

Representatives from the sub project groups served on the steering committee, working throughout the planning stage, assuming a range of responsibilities and ultimately contributing to the conference itself. The reception held for business delegates was a social high point and gave many staff from the sub projects the opportunity to meet people from across the United Kingdom and Europe and to find out informally about the work going on in other pilot hospitals.

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 (Jain, McCartney 1997).

- 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.

Altnagelvin Hospital in common with many hospitals finds itself being pulled along at a frenetic pace by the relentless demands to provide more services and better services. Emergency admissions increase, waiting lists continue to get longer, resources are never sufficient to adequately meet the demand. In such settings it is easy to see that the urgent can easily dominate the important.

In this environment obtaining a clear focus on and commitment to a health promoting hospital project requires a determined pursuit. At Altnagelvin this determination and focus was provided by the Chief Executive's commitment and by delegation of the project manager role to the Deputy Chief Executive/Director of Business Services. A project co-ordinator and secretarial support were appointed to the project at an annual cost of US \$54,000. In addition each sub-project was allocated a small budget of \$3,000 to cover costs of materials used in the project and travel costs in support of their research work. While the overall project structures provide a secure framework within which to plan, organise, direct and control the project it is our experience that two key components of the structure were vital for its success.

Firstly, the project had an energy source which was tenacious in its approach and provided a continuous source of vitality to the overall project. Within the Altnagelvin project structure this energy source was provided by the Project Management Team who met monthly. This group was made up of the Deputy Chief Executive, Senior Nurse Manager, the Hospital Health Promotion Manager and the Project Co-ordinator. This group made it its business to stay very close to the working of the sub projects and to find creative ways to motivate and support this sub project work.

The second and most important components were the sub-projects. From an early stage it was recognised that the project ownership rested with sub-project participants and all efforts were channelled to ensuring their continued empowerment.

The Projects Gain Some Ground

Over the life of the pilot project from 1993 to 1997 important gains were achieved by all the sub-projects:

- Breast feeding levels at discharge from hospital increased from 24% to 31%.
- Patient and staff menus now include 'healthy options' each day.
- Over one thousand children have attended the children's education programme which is designed to minimise the negative perceptions that children have of hospitals.
- Input from the Accident and Emergency staff has been requested by some of the major employers in terms of accommodation improvement and monitoring of their safety standards.
- Forty hospital managers have received training in the early recognition of alcohol related problems.

Two of our most successful projects, the Cardiopulmonary Resuscitation Training Programme and The Implementation of the Smoking and Health Policy, were to some degree motivated by the very high incidence of ischaemic heart disease in the catchment area of Altnagelvin Hospital – 221 male deaths per one hundred thousand of population (DHSS 1996).

The Smoking and Health Policy was relaunched in 1993 in an attempt to reduce cigarette smoking which is a modifiable risk factor in ischaemic heart disease. As a Health Promoting Hospital we also wanted to challenge the dichotomy of preaching one thing and practising another. The Smoking and Health Policy set the very ambi-

tious target of making 'No Smoking' the norm within Altnagelvin Hospital. This target was to be pursued through a two pronged attack of increasing public awareness and increasing the availability of support for those wishing to stop smoking.

Three public awareness campaign days were held during each year of the pilot project. The campaign days in March and May were planned to coincide with the UK National No Smoking Day and the International No Tobacco Day respectively. The third campaign day held in November provided an opportunity for a more localised campaign and ensured that our no smoking campaign was never allowed to drift away from public attention. In preparing the campaigns the Smoking and Health Policy Sub-Group involved inpatient and outpatient children in constructing hospital exhibitions to support and publicise the campaign. Children were involved, often with their parents, in preparing and putting up posters or in designing and constructing exhibits which supported the campaign. Children and their families were also involved in radio and press coverage of the campaign days. In one year the entire campaign was directed at expectant mothers. Posters and exhibitions were designed to highlight the risks to unborn babies from tobacco use by expectant mothers. Smoking and Health lectures and presentations were included in ante-natal classes. Information leaflets were designed to provide information on the risks associated with smoking and were sent with other pre-admission information to all patients before coming into hospital. Information leaflets were also provided in all public reception and waiting areas throughout the hospital.

The sub-project team members were all involved in preparing and giving presentations to groups of staff throughout the hospital and to groups of staff in neighbouring workplaces.

All new staff joining Altnagelvin Hospital, whether permanent or temporary, are required to attend an induction programme. Shortly after joining Altnagelvin, as part of their programme, new staff spend a full day in a classroom setting receiving information to help them become effective new employees. All new staff now receive instruction and information about the Smoking and Health Policy at Altnagelvin during the induction programme. Altnagelvin's Smoking and Health Policy is now stated on all advertisements of job vacancies at Altnagelvin and on job descriptions and contracts of employment.

In order to provide support for those wishing to stop smoking, Altnagelvin Hospital embarked on a programme of training hospital staff as stop smoking counsellors. Course participants receive training in skills to enable them to assist individual smokers to give up and to run stop smoking groups. The hospital has now trained forty stop smoking counsellors. Stop smoking support classes are held regularly and on an opportunistic basis for patients. All patients are asked on admission if they smoke and if they indicate a wish to give up they are offered the help of a trained counsellor.

In 1997, Altnagelvin was given the Smoke Free Award. This award was presented after a visit from the Department of Environment's Environmental Health Office during which a high level of compliance with the hospital's no smoking policy was confirmed.

During 1997 a survey was conducted to seek the views of staff working at Altnagelvin Hospital towards its Smoking and Health Policy (Doherty 1997). Overall the survey found a high level of awareness about the Smoking and Health Policy (98%) and strong support for and commitment to the continuation of the policy (90%). Over half of the respondents felt that the policy had led to some positive improvements in making Altnagelvin smoke free. Some 66% of respondents felt that Altnagelvin should continue to strive to be smoke free. Almost two thirds of smokers in the survey sample indicated that they had cut down on their smoking since the introduction of the policy. This finding is in keeping with other studies including a recent American study which found that workplace smoking restrictions markedly altered smoking patterns (Brigham 1994).

Prior to the introduction of the Smoking and Health Policy, smoking throughout the hospital was accepted as the norm. Cigarettes were sold by the hospital shop and were even delivered to immobile patients in wards. Relatives provided cigarettes for patients and joined them when smoking. The survey confirms that significant gains have been made towards establishing a smoke free environment. In the absence of established UK legal precedent, pushing on to a totally smoke free hospital will remain very difficult. A recent review of smoking policies in the NHS in Scotland (Walker, Millhouse, Batten 1995) found that many hospitals claiming to be smoke free were not. In Northern Ireland guidance states that Health and Social Services premises should provide a virtually smoke free environment for staff, patients, residents and visitors (DHSS 1993). This has been interpreted by most hospitals which have a smoking policy that the environment should be smoke free apart from the limited provision of designated smoking areas. This situation is in contrast to the US situation where there is a strong public lobby for a smoke free environment generally, and the law is clearer in its support for the rights of non-smokers. Smoking policies in US health settings appear to be much more stringent and successful. Some 80% of US hospitals which are in compliance with the Joint Commission Accreditation of Healthcare Organisation's (JCAHO) national smoke free policy initiative have more successful smoking policies. A recent national survey (Longo 1995) showed 96% of these hospitals have met the new JCAHO smoking ban standard (no smoking permitted for staff, patients or visitors in the hospital buildings) just two years after implementation.

The expressed aim of the Cardio-Pulmonary Resuscitation (CPR) team was to improve standards of resuscitation by providing appropriate training in Basic Life Support for all disciplines within the hospital. Since more often than not it is the nurse who is the first on the scene of cardiac arrest, the team made a conscious decision to target the nursing staff in the first instance. The training programme was designed in accordance with the Resuscitation Council UK, in conjunction with the European Resuscitation Council guidelines. Initially the team held monthly classes in the College of Nursing which is situated approximately 400 metres from our main hospital building. This did not enhance attendance at the classes as staff had to be away for a considerable time from the wards. The CPR Sub-Project Group obtained agreement from hospital management to establish a designated training room within the hospital, convenient for all staff. With the \$3000 provided to each Sub-Project of the Health Promoting Hospital Pilot Project essential training equipment was purchased

including an overhead projector, flip chart/easel, manikin wipes and a filing cabinet. With a generous donation from the British Heart Foundation a manikin with monitor and simulator were purchased. Classes were held monthly and approximately ten to twelve staff were expected to attend. As the numbers initially were small the Director of Nursing was approached and, as a result, CPR training became mandatory for all trained nurses throughout the hospital. This did make an impact on attendance at the classes. Studies show that people do not retain their skills and so regular updating was also necessary. To facilitate this CPR facilitators were appointed on each ward and department in the hospital. Guidelines were drawn up for them to follow and a specific role for them was agreed. CPR Sub-Project team members met regularly with the CPR facilitators to offer them support and keep them up to date on new developments within the training programme. CPR facilitators were charged with the responsibility to ensure that all staff attend training and reattend every three to six months for reassessment of their skills and knowledge.

The success of the Sub-Project Group's work was critical in persuading the hospital management of the benefits potential in having available a full time Resuscitation Training Officer. A full time training officer has now been appointed with funding assistance from the British Heart Foundation. This officer is required to:

- Develop and co-ordinate all levels of resuscitation training.
- Audit training performance.
- Conduct research and development in resuscitation practices.
- Develop training strategy policy and CPR practice standards.

By the end of 1997, basic and intermediate life support training has been provided for 800 staff (50% of staff) over 300 of whom are nursing staff. A further 70 staff have been trained in Advanced Life Support. Thirty five CPR facilitators have been trained and 60 patients and their relatives have received training. The table below shows the training achievements in 1997/98 and the continuing ambitious targets for

Table 2: Cardio-Pulmonary Resuscitation (CPR) Training Targets

Objective	1997/98	1998/99	1999/2000
Training in CPR organised for all staff	60% of staff trained	90% of staff trained 2 nd Training Officer needed	90% of staff trained
CPR training offered to local workplaces	10 Workplaces	10 Workplaces	10 Workplaces
First Aid Training to be offered to local workplaces	60 employees	60 employees	60 employees
First Aid at Work Refresher course to be offered	30 employees	30 employees	30 employees

the next two years which reflect the success the programme has experienced (Table 2).

After the Pilot – Consolidating the Achievements in Altnagelvin.

The “Artscare” project described earlier 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 (Jain, McCartney, 1997), 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 (see Figure 4.) 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 (see Figure 4) 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 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 (Dudley 1995). 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 key to the 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.

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 ArtsCare 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. 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). 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.

Altnagelvin Hospital, through its involvement in the EPHP, has secured within its thinking and actions a stronger role for health promotion. With the more enlightened visions being set out in the health care strategies, such as 'Well Into 2000', Altnagelvin feels it is well placed to accelerate the development of the health promotion role

within its own hospital and to become a powerful influence on other hospitals getting involved.

References

- Brigham, J. et al (1994): Effects of a restricted work-site smoking policy on employees who smoke. *American Journal of Public Health*, 84 (5) pp.773–8
- Department of Health and Social Services (1991): Health and Personal Social Services Regional Strategic Framework for Northern Ireland.
- Department of Health and Social Services (NI) (1993): DHSS Circular Letter HSS (OP1) 2/93. 10 March 1993
- Department of Health and Social Services (1996): The Health of the Public in Northern Ireland.
- Department of Health and Social Services, (1997): Well Into 2000. A Positive Agenda for Health and Wellbeing
- Department of the Environment for Northern Ireland (1997): Shaping our Future.
- Doherty M. (1997): On the Horizon. A Report of the Smoking and Health Survey at Altnagelvin.
- Dudley C. (1995): Health Promotion Link Nurses – A Concept in Networking. Proceedings of 3rd International Conference on Health Promoting Hospitals, Sweden
- Jain C., McCartney R. (1997): A Vision of the Health Promoting Hospital: Art for Health's Sake. Proceedings of 5th International Conference on Health Promoting Hospitals, Vienna, Austria
- Longo DR., et al (1995): Smoking Bans in US Hospitals. Results of a national survey. *JAHA* 274 (6), pp. 488–91. August 1995
- Walker S., Millhouse A., Batten L. (1995): Monitoring Smoking Policies in the NHS in Scotland. ASM Scotland, August 1995
- Western Health and Social Services Board (1993a): Application for Membership of the International Network of Health Promoting Hospitals.
- Western Health and Social Services Board (1993b): Health and Lifestyle in the Western Board Area.
- Western Health and Social Services Board (1997): Social Care Review 1996–1997.

The Health Promoting Hospital Project at Prince Philip Hospital

John Price, Brenda Stephens



Prince Philip Hospital, Llanelli

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Hospital Owner:	Llanelli Dinefwr NHS Trust
Hospital Ownership:	Public
Specialisation:	General Hospital
Beds:	209
Staff:	Medical Staff : 113, Nursing Staff: 665, Other Staff: 611, Total number of staff : 1,389
Utilization:	Average utilisation of beds/year: 88%, Average stay in hospital/patient: 8 days
Patients:	Number of Inpatients/year: 10,041 Number of Outpatients/year: 76,525
Location of Hospital:	Suburban/rural
Catchment Area:	Regional, Number of Population: 100,000
Other Functions than Medical Care:	
Teaching:	Postgraduate, Nursing Education
Research :	Clinical Research
Subprojects:	1. Exercise and Stress Management on Prescription 2. Early Minimal Intervention and Drinking Behaviour 3. Llanelli Manual Handling Project 4. Healthy Choice Eating on a Low Income 5. Diabetes Education

Prince Philip Hospital and its Environment

No hospital can conduct its business in a policy vacuum. It must take account of prevailing government policy and the agendas of other decision makers.

Therefore, it was important that we analysed the external and internal environments to determine what factors would influence our capacity to develop a health promoting culture, and move Prince Philip Hospital forward in a health promoting direction. It became clear from this analysis that the re-orientation of the hospital would be occurring against a background of continual change. The salient issues included:

- commitment to the broad aims of the WHO's '*Health For All by the Year 2000*' strategy;
- our national health promotion strategy '*Strategic Intent and Direction for the NHS in Wales*';

as shaped by

- reorganisation of the NHS in Wales;
- changes in funding arrangements;
- implementation of new management structures in all hospitals.

The Health Promoting Hospital Project at Prince Philip Hospital

The World Health Organisation defines a Health Promoting Hospital as one which develops a corporate identity that embraces the aims of health promotion and demonstrates a health promoting structure and culture within the hospital.

The fundamental purpose of the European Pilot Hospital Project was to demonstrate if, and how, health promotion had become an integral part of our hospital. In order to substantiate evidence of change in the organisation's structure and culture, an in depth analysis was required. This looked at the process that we undertook in attempting to move forward and develop Prince Philip Hospital as a health promoting organisation. This analysis included the way in which our hospital had:

- *generated shared ownership of the overall project and subprojects;*
- *generated a shared vision at the outset of the project;*
- *maximised consultation and participation during the formulation and implementation of the overall project/subprojects*
- *identified potential resistance and barriers to developing a health promoting culture;*
- *selected appropriate change strategies and;*
- *identified the political approaches necessary to influence the decision making process in the organisation.*

This six point plan was a crucial element to the process of implementing successful action at a local level and in determining, with a fair degree of accuracy, how far the hospital had moved toward a health promoting ethos.

Through 'The Story of Success' and 'The Story of Realisation', the following account looks at a response to these issues and their effects on developing an intrinsic

health promotion culture. It concludes by offering some recommendations for other hospitals wishing to tread the health promoting path.

The Story of Success

Generating a Shared Ownership at the Outset

In order to move the concept of a health promoting hospital toward a reality it was necessary for us to determine, in some detail, where we wanted to go and how we aimed to get there. In part, this process was assisted by the objectives of the European Pilot Project which were:

- *to broaden the focus of hospital management and structures of health care (beyond solely treatment and cure); and develop the necessary infrastructure to achieve these goals;*
- *to introduce health promotion into the culture of the hospital;*
- *to develop documented and evaluated examples of good practice for use by other institutions;*
- *to identify areas of common interest, develop programmes and evaluation procedures.*

Our project team viewed the Health Promoting Hospital Project as 'a product'. If the objectives above were to be achieved then:

- *the 'product' had to satisfy the needs of our target audience i. e. staff, patient, community, and*
- *the 'product' must be integrated within the organisation's objectives.*

So, from the very beginning there was a need for a marketing approach; one where new and innovative ways to address health problems could be used. By working with and influencing the target audience i.e. the hospital management board, senior managers, staff, patients and the wider community, we hoped to generate a shared ownership of the overall project.

To these ends our health promoting hospital project started well. The hospital's Senior Management and Executive Board examined the principles set out in the Ottawa Charter and formally accepted them. The agreement between WHO and Prince Philip Hospital was signed by the Chief Executive of our hospital.

A publicity launch followed in March 1993 announcing that Prince Philip Hospital was embarking upon a project in conjunction with 19 other hospitals across Europe. The launch was well attended by many people from different areas of the health service as well as people from different sectors. Staff throughout the hospital were informed of the purpose of the launch by the use of a leaflet issued to everyone. The media at that time played an important part in disseminating information to the general public.

The news that Prince Philip Hospital was involved in an international project developed by the World Health Organisation made the front page headlines of most local papers. Six well designed posters were sited in the main foyer of the hospital explaining to patients, relatives and visitors the part Prince Philip Hospital was to play in the European Project.

An Overall Project Team was created. Led by the Overall Project Manager the team consisted of the leaders of the five subprojects who represented their subproject groups. The purpose of the Overall Project Team was to work toward the objectives of the European Project by ensuring that:

- *the marketing plan was being implemented as designed;*
- *the local project was continually reaching its target audience;*
- *the subprojects maintained momentum and were being supported;*
- *detailed documentation was kept.*

Generating a Shared Vision

To generate a shared vision the philosophy of the Health Promoting Hospital movement required good communication and diffusion throughout the organisation. The main aims of our marketing plan were therefore:

- *to create an understanding of the 'product' (or vision);*
- *to identify the characteristics of specific target audiences which make up the larger audience;*
- *to carry out some formative research prior to the implementation of the overall project to determine any strengths, weaknesses, opportunities and even any threats there may be.*

At first, the 'product' or vision was not easily recognisable by the staff, patients and wider community, for after all, „What hospital isn't health promoting?“, was the usual reply. From this typical response it was clear to the Overall Project Team that the problem which confronted it was encouraging the hospital to exchange the intangible for the intangible, i.e. accepting a new philosophy of actively promoting positive health and disregarding, to some extent, the old philosophy that hospitals purely exist for treatment and curative purposes.

The plan was first to ensure that the Overall Project Team knew about the concepts, principles and aims of the Health Promoting Hospital. A half day workshop was held in 1993 for leaders and members of each subgroup in order for them to grasp the purpose. These people from both inside and outside the organisation could then be recognised as 'change agents' whose role was to use every opportunity possible to explain the aims of the Health Promoting Hospital. This was followed shortly after by another half day workshop when the subproject groups presented the structure of their subprojects to each other as well as to a hospital audience.

Information about the European Project was communicated to hospital staff through 'Team Briefing' (a monthly process of briefing all hospital staff on important hospital issues) and through 'Pulse' (a hospital newsletter). Other means of constantly communicating the 'product' to the target audience included a four tier structure of health promotion education within the hospital:

- *an induction session for all new staff joining the hospital;*
- *a health promotion mini foundation course (a six day study course);*
- *a health promotion practitioners course (planned for the summer of 1996), and*
- *specialist education (attendance of health promotion staff on a masters degree course in Health Promotion).*

Furthermore, a dedicated newsletter for health promotion called „The Best of Health“ has been another tool used to communicate the European Project news.

In April 1996, as part of the integrated development of health promotion in the hospital, a health information 'shop', called 'Health Matters', was funded to the sum of £ 45,000. Situated in the main entrance of the hospital, the 'shop' provides a high profile for all health promotion issues in the hospital and community. It also provides an ideal opportunity to promote the European Health Promoting Hospital Project.

Our marketing plan took into account that the hospital is made up of many different people, skilled and non skilled staff, with varying occupational status, roles, responsibilities and needs. Also our patients, visitors and relatives belong to various social groups who have differing needs. If the Health Promoting Hospital project was to have an impact on the attitudes and behaviours of the hospital population and wider audience it had to approach this task by selecting and targeting these various sub-groups which make up the whole hospital population. This provided a systematic approach to communicating the right type of message to the right audience rather than relying on an approach which used one standard message for all audiences. Further, by understanding the roles, responsibilities and needs of the different staff and patients, the messages and product could be developed to meet their needs.

To support the development of our shared vision we undertook research into four areas:

- *to carry out an external audit of the environment to determine the political, economic, societal and technological influences on the organisation;*
- *to carry out an internal audit of the organisation in order to determine the strengths, weaknesses, opportunities and threats to implementing a health promoting culture;*
- *to identify the needs of different staff, patients and visitors;*
- *to test the concepts and messages to determine their acceptability.*

The results were used to shape our methods for implementing the overall project.

Maximising Consultation and Participation

In order to ensure the successful implementation of the local project across the whole organisation it was necessary to understand the communication and distribution systems as they relate to the discrete subgroups in the hospital. These two systems were seen as a critical part of the local project.

In marketing terms, maximising consultation and participation required a careful 'Channel Analysis' to:

- *identify and understand the 'media' habits of the target groups in the hospital;*
- *make sure the philosophy reached a significantly large proportion of the hospital population in order to meet the European Project objectives;*
- *determine the variety of communication channels available;*
- *determine the complexity of the communication channels;*
- *determine the reach and frequency of the channels.*

Fortunately for the Overall Project Team the hospital Communication Steering Group was developing an internal and external communication strategy at the same time as the channel analysis was being undertaken. Equally fortunate was the fact that both the Overall Project Manager and the Health Promotion Manager were on the Communications Steering Group.

In order to maximise the consultation and participation process it was eventually deemed necessary (and obvious) to create a network of teams with thematic terms of reference. Most of these teams developed in 1995 and have already produced detailed plans based on local evidence together with some quite impressive short term results.

As previously stated, the Overall Project Team was responsible for tracking the progress of the overall project and subprojects. This was considered integral to the marketing approach if consultation and participation was to be maximised.

Identifying Potential Resistance and Barriers to Developing a Health Promotion Culture/Selecting Appropriate Change Strategies

If Prince Philip Hospital was to succeed in two of the major objectives of the European Project, - i.e. to introduce health promotion into the culture of the hospital and, to broaden the focus of hospital management and structures of health care, not just curative care- then consideration had to be given to the ways and means of facilitating this change, both at an individual and at an organisational level. Conducting a 'Forcefield Analysis' that identified the driving and restraining forces to the change was considered an essential element in the management of the overall project.

Using the results of this analysis (and the strengths, weaknesses, opportunities and threats analysis), certain strategic choices were made in terms of speed of the effort of implementation, the amount of pre planning and the involvement of others in the change process. It was also important that those who were trying to initiate the new culture recognised the different approaches that could be used to bring about the change.

The different approaches were thought of as existing on a continuum. At one end of the continuum the change process called for a very rapid implementation, a clear plan of action and little involvement of others. Clearly this was not the desired approach. At the other end, and more relevant to the project objectives, the process required a much slower change, a less clear plan with the participation of many people. This approach was designed to reduce resistance to a minimum. The tools of education, communication, participation and support were used to bring about the desired effect. Central to this approach was the 'change agent' role of each member of the overall project team. They aimed to influence individual decisions about the philosophy of the Health Promoting Hospital in the desired direction. In this way it was possible to influence change in the covert aspects of the organisation, such as individual knowledge, beliefs, perceptions and attitudes, over a moderately short period of time.

However, bringing about change at an organisational level was a far slower process and required determination, good leadership and involvement of key stakeholders within the hospital. Subtle changes 'here and there' were the only indicators of initi-

al success. Nevertheless, changes at this level, however small, in terms of organisational goals, structure, utilisation of financial resources, policies and procedures accumulated over time moving the hospital forward in a health promoting direction.

Political Approaches Necessary to Influence The Decision Making Process in the Organisation

Successfully turning the Health Promoting Hospital from a concept to a reality relied heavily on the key individuals in the organisation negotiating the internal and external environments, generating a shared vision and ownership, facilitating change and maximising consultation together with participation. However, it was naive to assume that the overall project could exist with little or no attention to preparation or lobbying of key 'gatekeepers' in the hospital.

So to raise what was considered to be a final implementation barrier to the health promoting hospital culture, we carried out an 'administrative diagnosis'. This attempted to identify where the power of decision making lay and what approaches were necessary to influence the decision making process.

The 'gatekeepers' (or opinion leaders) were those officials within our hospital who had powerful interests and could potentially have an obstructive or 'watering down' effect on the objectives of the local project. It was essential that these individuals became the early adopters of the philosophy of the Health Promoting Hospital concept. It was this small group of people who could eventually influence the more sceptical of the hospital population. Regular reviews indicated that an administrative diagnosis was a crucial and ongoing requirement, a fact which became painfully obvious during the mid term of the project.

Even at this stage it was borne in mind that acceptance of the philosophy of the Health Promoting Hospital by the gatekeepers did not necessarily mean implementation. Therefore we took some time in the early stages of the overall project to consider why some projects flounder, so that any future problems are pre-empted.

Conclusion to the 'Story of Success'

By providing an outline of the six key issues which have guided Prince Philip Hospital toward achieving the objectives of the European Project, we have attempted to demonstrate some sound reasons for adopting a rational planning approach to implementing the project.

Understanding the macro (international/national) and micro(local) power structures whilst utilising existing planning and management skills provided the strategic and practical tools with which our Health Promoting Hospital Project might achieve success. Lack of such understanding and skills could have rendered the local project ineffective so it was incumbent upon the Overall Project Team and others who became involved to ensure that the two were applied appropriately and wisely.

The following section, 'The Story of Realisation', examines the degree to which the six guiding principles assisted the integration of a health promoting culture in our hospital. More importantly perhaps, it offers a critique of what could have been done to improve the integrative process.

The Story of Realisation

As a pilot hospital our overall project was ‘*to develop Prince Philip Hospital as a health promoting organisation through a process of organisational change*’. Our sub-projects are a demonstration of this process and the story of realisation set out below addresses both the overall project and subprojects.

Subprojects which aimed to bring about change were:

1. *The Staff Health and Physical Exercise Studio*. This aimed to provide comfortable and accessible fitness equipment for staff through the development of a hospital based facility.
2. *Exercise and Stress Management on Prescription*. This involved an alliance between local General Practitioners, Health Visitors, Hospital Staff, Independent Trainers, Leisure Centre Management and Staff. The project aimed to:
 - Encourage and develop mechanisms by which advice from G.P. to patients about taking more exercise and relaxation could be put into practice by using existing community resources;
 - Foster increased awareness of the benefits of exercise and enhanced coping skills in the population of Llanelli Dinefwr;
 - Assist in identifying factors which were critical to the success of a more permanent service to be offered to G.P throughout Llanelli Dinefwr.
3. *Early Minimal Intervention for Patients with Alcohol Related Problems on a Medical Ward Setting*. The project was managed by a Training Officer and Development Worker of a local Alcohol Agency (known as PRISM), hospital ward managers and nursing staff together with the hospital Social Work team. It also included input from the Medical Directorate within the hospital. The aim was to test the value and practicalities of a standard screening and intervention process for alcohol related problems in a medical ward setting in Prince Philip Hospital.
4. *Manual Handling*. The three aims were:
 - To introduce a safe lifting policy into the hospital which provided initial and ongoing training and advice in the principles and practices of safe lifting;
 - To provide every member of staff with training appropriate to their job task;
 - To move the environmental culture of the hospital toward one which exhibits a minimal lifting ethos.
5. *Healthy Choice Eating on a Low Income*. The project involved joint working between the Community Education Department of the local authorities and staff of the hospital. The three aims were:
 - To inform individuals within a specific target group, enabling them to make healthy choices in their eating habits;
 - To enable individuals in the target group to make choices for their families appropriate to their health needs and economic circumstances;
 - To evaluate the impact of information given on the attitudes and/or practices of the individuals.

Subprojects which aimed to extend the boundary of services delivered were:

1. *Development of The Health Promotion Manual.* This aimed to provide a point of reference for all health promoting activity within Llanelli Dinefwr NHS Trust.
2. *Diabetic Education.* Hospital staff worked in conjunction with the local branch of the British Diabetic Association together with school teachers and youth leaders. The project aimed to promote effective monitoring of improved education to selected groups of diabetics.

The implementation of these subprojects were phased throughout the overall project period. Each subproject leader was a member of the Overall Project Team which was in turn led by the Overall Project Manager. Many of the subproject groups included staff from the hospital, community health staff and people beyond the health sector.

Realisation of the Overall Project

Generating a Shared Ownership at the Outset

To generate ownership of the project with the target audiences the overall project team used a marketing approach.

As the overall project progressed, four main flaws emerged:

- *the target audiences were treated rather passively initially, encouraging little direct input from them and only at specific points in the process. This was particularly so with the senior management of the hospital as direct input was sought only when funding was required for business and conferences or when reports had to be submitted to the co-ordinating institute for the European Pilot Hospital Project*
- *not all the key target audiences were identified at the outset because they were either overlooked or because it was naively accepted that there was organisational consensus in support of the Health Promoting Hospital Project;*
- *we had underestimated the need to continually define clearly the mission and objectives of the local project. It was difficult to convey adequately the importance of the European Project in a way that was meaningful to the subproject leaders. This resulted in some loss of motivation;*
- *rapid reorganisation involved major cultural change. These pressures continually placed political, territorial and professional objectives before those of the European Project. Such changes could not have been envisaged at the beginning of the project and the speed of change meant it was almost impossible to be pro active in devising contingency plans. As a result, two of the original subprojects (The Health Promotion Manual and the Staff Health And Physical Exercise Studio) lost momentum and were replaced by subprojects which fitted better into the current climate of change (The new subprojects are Exercise and Stress Management on Prescription and Early Minimal Intervention for Patients with Alcohol Related Problems in a Medical Ward Setting).*

However, these difficulties were systematically addressed and became less significant as the project progressed as a result of:

- *the use of the media at every opportunity and,*
- *the increased involvement of senior management:*
- *joint working with other organisations outside the health sector;*
- *ensuring that the benefits gained were shared by all;*
- *improving our quality standards;*
- *developing better skills in project management;*
- *ensuring a strong foothold for health promotion training in the Staff Development Programme.*

These were a few of the important outcomes of the local project.

Generating a Shared Vision

The ultimate purpose of generating a shared vision, direction and values was to maximise short and long term benefits and to communicate them in ways which were clearly understood by all. Hence, to succeed in developing a Health Promoting Hospital 'product' there was a need for the hospital to allow and encourage a multidisciplinary approach. Unfortunately many health care organisations tend to lend themselves to unitarist structures because of the number of professional groups. It was recognised that this type of design may give priority to health professional aims and objectives rather than to the four objectives of the European Project.

So, in response, continual emphasis was placed with those directly engaged in the five subprojects on the Concepts and Principles of Health Promotion (WHO 1984) and to the aims of the Health Promoting Hospital. Particularly relevant was the continuous consultation, dialogue and exchange of ideas between individuals and professional groups even though this was considered rather weak in retrospect.

At the same time care was taken not to exclude other professionals and lay people from this process. This was achieved principally through the use of our dedicated newsletter. The goal was to move away from viewing health in traditional segments by cutting across the existing hospital structure, working toward adopting a holistic view of health and expanding this ethos.

It was perceived in the early stages of the local project that subproject group members were becoming involved as partners in the decision making and management process of the overall project. On the downside, it was becoming increasingly obvious that this early success was eventually overshadowed by a new wave of change in the NHS which saw some participants 'retreat' into their professional segments once again. This was particularly so during 1994-96 in light of the severe financial restrictions, escalating demands upon all services and decreased morale generally in the organisation. In spite of these problems, the profile of health promotion in our hospital during 1995/96 was extremely high.

At the same time as attempting to maintain the uphill task of multidisciplinary consultation, the process of implementing a marketing orientation for the local project clearly needed to start at the top of the organisation. This was addressed with the development of the Prince Philip Hospital five year Health Promotion Strategy.

Based on a local interpretation of the national strategic influences in Wales, the Health Promotion Strategy for Prince Philip Hospital was accepted by the hospital's Management Board in September 1992. It included the aims, objectives and plan of work to be undertaken in the European Pilot Hospital Project over the period 1992-97, together with details of the five original subprojects.

Whilst serving several purposes, the Health Promotion Strategy was principally devised as a visible tool to establish the concept and meaning of health promotion at the very top of the organisation. Furthermore, it was a vehicle which encouraged political commitment for health promotion to be expressed at the highest level. From the development of the Health Promotion Strategy, there followed the production of yearly business plans for health promotion which were incorporated into the overall corporate business plan of the hospital. These plans served as internal planning and monitoring tools. Through this process health promotion was becoming an integral part of working practice.

With many lessons learned on the way, a critical analysis of our original five year strategy was undertaken during 1995. As a result, a redirected and fresh approach was accepted by the Trust Board and the Executive Group. A huge amount of work has since gone into developing 'The Framework Document – a New Look at Health Promotion in Llanelli Dinefwr 1995/99'. Together with our increased profile in the Welsh Network of Health Promoting Hospitals the Framework Document has been a key influence in maintaining the vision with key personnel inside the organisation.

A crucial element when developing the Health Promotion Strategy (and the recently revised strategy) was the research activity or market analysis to determine position, i.e. the external and internal environmental audits which would assist in creating the vision of where we wanted to be as a Health Promoting Hospital. The results of the external environmental audit (political, economic, societal and technical) and the internal audit (strengths, weaknesses, opportunities and threats for Prince Philip Hospital as a Health Promoting Hospital) were presented at the Padova Business Meeting and Conference. If the ultimate goal of developing a health promoting culture which was integral to the organisation was to be achieved, then the Overall Project Team had to focus on a positive response to the external and internal factors which directly or indirectly affect health promotion within the hospital.

In terms of the internal audit, any weaknesses identified in moving the local project forward toward its objectives had to be changed into strengths. Similarly, any recognised threats should be changed into opportunities. For example, the analysis identified that the Overall Project Team was not skilled in the field of research. So, to assist project management, Health Promotion Wales (the National Co-ordinating Centre) organised workshops on research and evaluation techniques. Later, individual members of staff from the Research Department at Health Promotion Wales were assigned as mentors to each subproject. Changes in organisational structure at Health Promotion Wales, however, meant withdrawal of this valuable resource.

Throughout the overall project period the principles of Total Quality Management provided significant steps to implementing a health promotion culture by:

- *meeting the needs and expectations of staff, patients and visitors*

- *being consumer centred particularly with the development of the Health Matters' shop'*
- *valuing people as individuals*

These actions helped to integrate health promotion activities across the organisation, allowing them to be endorsed by senior management and therefore aligning the aims and objectives of the organisation into supporting a health promoting culture.

Patient and visitor needs were continually assessed through patient satisfaction surveys which were part of a pro active public relations strategy and positive complaints management. A major staff survey, technically known as 'diagonal slicing' was conducted in 1993 to determine staff attitudes. Even though the response rates to several of these surveys were quite poor a commitment to an ongoing market research programme was vital if a health promoting culture was to be cultivated.

Maximising Consultation and Participation

Because target audiences (and subproject groups for that matter) were treated somewhat passively in the process, the principle of participation in some aspects of the planning, delivery and evaluation of the project was sacrificed to a certain degree.

People participation in the early stages of the overall project should have laid the foundation for ownership of effort and assisted the later stages of the project. But instead, this approach meant that support needed to sustain the overall project during the mid term was difficult. Once again lessons were learned, and the management of the later stages of the project improved.

In retrospect, there may have been several reasons why consultation and participation was not fully maximised:

- *although the emphasis at the very beginning of the project was a decentralisation of authority and accountability to facilitate health promotion across the organisation, the reality was that rapid culture change which was sweeping the NHS in Wales. This, together with centralisation of the power base within our hospital rendered the emphasis on decentralisation ineffective to a large extent;*
- *the agendas of senior management were changing rapidly;*
- *there were pressures that placed political and professional objectives above the project objectives;*
- *the sense of urgency which often accompanied the requirement of six monthly documented evidence of subproject progress often led to short cuts in the consultation process, excluding some participants in decision making;*
- *the original Overall Project Manager left the organisation. This reduced the lines of communication between the Overall Project group and the hospital Management Board.*

As a combined result of all these factors, maintaining the momentum of the project in its later stages required continual review and adaptation, together with better problem solving skills. Ultimately the positive aspects of these times of uncertainty has meant:

- *the opportunities to clarify the meaning of health promotion at many levels of planning are now far greater;*
- *health promoting networks and support in – and out of – the hospital are better structured and more visible;*
- *health professionals are now more aware of their role in nurturing and enabling health promotion.*

Identifying Potential Resistance and Barriers to Developing a Health Promotion Culture/Selecting Appropriate Change Strategies

The 'Forcefield Analysis' referred to earlier in the 'Story of Success' outlined the means of identifying the driving and restraining forces for and against the Health Promoting Hospital ethos. It should be stressed that such an analysis did not occur at one point in time, but was a continuous evaluation at an organisational and individual level. It was a project management skill that improved as our overall project progressed.

From the analysis, six major organisational barriers to implementing a health promoting culture were recognised:

- *there was a traditional vertical hierarchy with strict reporting and delegation relationships;*
- *there was evidence of long standing battles, conflict and issues of responsibility;*
- *health care workers had a limited scope for practice to a lack of education in health promotion;*
- *health care staff demonstrated strong allegiances to their professions rather than to organisational goals,*
- *there was a focus on achievement of skills of the individual, rather than overall team performance;*
- *complicated channels for communication existed which hindered the distribution of the Health Promoting Hospital concept.*

Even though this analysis demonstrated a rigid system of health care, changes in our organisational development was encouraging a more flexible structure which was far better suited to a health promoting culture.

Driving and restraining forces at an individual level were obvious. The health care process is based on knowledge and experience of individual doctors, nurses and allied health care workers. These individuals demonstrated two dimensions of mode of health intervention. One dimension demonstrated there was the expert led, top down type of intervention which reinforced the authority of the medical professionals. With the other dimension there were health professionals who appeared far more receptive to the broader social model of health, recognising health promotion to be process orientated.

On the face of it, these health professionals exhibited a greater tolerance for change in health care delivery. Therefore several new thematic teams were created, enlisting many people to act as 'change agents'.

Consequently, both at an organisational and individual level, these differing health care approaches created a number of limitations for implementing a successful health promotion culture.

In response, appropriate strategies for overcoming resistance at an individual level were very time consuming, but reasonably successful with certain target audiences. This was particularly so with the development of a structured education programme; improved communications; and the creation of thematic teams. Encouraging participation and involvement of the medical staff in the overall project and sub-projects was an emphasised change strategy. This was based on the dual understanding that those who participate will be committed to implementing change and that those people who do not participate have considerable power to resist the effort. This change strategy was only partially successful.

The reason for its partial success may have been the result of change occurring in a disjointed way and not part of a clearly considered change strategy. This was re-addressed during 1995 and the outlook became far more optimistic. In retrospect other methods of dealing with, and overcoming, resistance should have been considered in more detail rather than using only one approach.

Realisation of the Sub-projects – A Summary

The summary of the sub-projects is a brief appraisal of what happened, findings, impact on the organisation and future intentions relating to each project.

The Staff Health and Physical Exercise Studio

Due to high funding implications the development of a staff health suite could not continue. Alternative arrangements were made, and nearly 18% of staff have become members of a discounted corporate membership scheme at the local leisure centre.

Exercise and Stress Management on Prescription

- The project management group included General Practitioners, Health Visitors, Independent Trainers, hospital workers, leisure centre management and staff. Its purpose was to define goals, objectives and evaluation questions, and also to constantly monitor progress of the sub-project;
- The level of evaluation examined both the process and the outcome;
- The project was launched in February 1996 supported by high profile media and press coverage;
- Eight 'Lifestyle Courses' were organised during 1996/97. Each course ran for six weeks. Patients were referred to the course by their G.P. Fifteen patients attended each course;
- Patients completed pre-course, post-course and six month post-course questionnaires in order to examine change in attitude and behaviour as a result of the 'Lifestyles Course';
- Patient attitudes became far more positive toward participating in exercise and managing personal stress;

- The provision of the 'Lifestyles Courses' have created a huge demand from many local G.Ps in the area
- A Project Report will be produced with the aim of encouraging the prescription scheme to run on a permanent basis. Funding for this is to be sought from the Health Authority Commissioners;

A further development is the possible creation of a community cardiac rehabilitation programme at the leisure centre, as a follow up for patients discharged from the hospital cardiac programme.

Early Minimal Intervention for Patients with Alcohol Related Problems on a Medical Ward Setting.

- A project group was formed between the local alcohol agency, hospital and social work staff;
- 23 medical ward nursing staff were trained in brief intervention techniques;
- A 'Problem Drinking Indicator Questionnaire' was designed and used as a major screening tool. The scoring system identified possible problem drinkers and those who required input from the specialist alcohol agency;
- A patient information booklet was produced by the alcohol agency to assist the project;
- The project was launched in April 1997;
- Reaction from the nursing staff and patients has been positive. Nurses reported that:
 - they now identify patients with high levels of drinking who would not have otherwise been identified
 - the specific questions asked provide an objective, non-judgemental approach to raising the drinking issue with patients;
 - patients are not generally aware of alcohol facts and the links between drinking and medical problems;
 - patients are generally positive about discussing their drinking.

The intention is to expand the project during 1998 to all wards in the hospital as well as to the Accident and Emergency Department.

Llanelli Manual Handling Project

- A two year Manual Handling Strategy was developed and passed by the Hospital Executive Management Group;
- A Manual Handling Task Group, Sub Group and Workplace Trainer Support Group was set up to oversee the strategy implementation;
- A 'Cascade System of Training' for all hospital and community staff commenced in January 1997 and is ongoing;
- During 1997, seventeen courses, each of a four day duration, were organised in order to train 164 Manual Handling Workplace Trainers in the theory and practice of minimal manual handling techniques;

- Following a survey to determine needs, major funding was obtained to replace and update manual handling equipment;
- Record books were issued to each member of staff to demonstrate their participation in the training;
- It will be some time before a clear picture emerges of the impact the programme has had on staff accident and injury statistics;
- A strong network of workplace trainers has developed to provide support and regular updating;

Refresher courses for workplace trainers are planned for the future together with two day induction courses for all new staff.

Healthy Choice Eating on a Low Income

- The subproject consisted of a pilot course run at a local community centre with participants invited from the surrounding area. The course was facilitated by dieticians and local community support workers;
- The main objective was to influence maternal and child health through improved nutrition. This was reflected in the individuals participating in the pilot course, who were all parents with young families;
- Subjective feedback from both the participants and support workers was positive. A formal evaluation showed 100% of participants describing the course as both “very useful” and “very interesting”. 84% stated that they had made actual changes to their own – or their family’s – eating habits as a result of attending the course;
- The direct impact on the organisation has been limited so far. However, the apparent effectiveness of the pilot course should influence the future health promotion strategies of the organisation;

Future additional resources are being sought through the health service contract process to enable development and expansion of the programme, so that future courses may be facilitated in a number of locations.

The Health Promotion Manual

The required high levels of staff input required – together with difficulties in monitoring standards whilst continuously updating the manual – made this project difficult to maintain over the long term. The project was therefore discontinued.

Diabetic Education

- This subproject targeted women of child bearing age and school children who were insulin dependent;
- The aims were to;
 - improve education and prevent long term complications whilst allowing children to lead a normal active life;
 - to improve education with pre-pregnancy counselling and
 - to enable mothers to have uncomplicated pregnancies and deliver healthy babies of normal birth weight;

- the intervention methods used included group teaching sessions with partners, family, children, friends, schoolteachers, youth groups and school nurses. There were also organised events such as swimming, camping activities and discos.
- The process evaluation questions focused on:
 - the need for good glycaemic control to help prevent long term complication;
 - achieving full understanding the educational needs of diabetics and the need to respond to emergency situations;
 - the number of classes run per year;
 - the number of participants in each group;
 - the number of friends/relatives contacted;
- Outcome factors used to demonstrate success of the intervention included:
 - birth of live baby with normal weight;
 - a healthy, trouble free pregnancy for mother and
 - schoolchildren able to lead a normal active life whilst maintaining glycaemic control;

Conclusion to the 'Story of Realisation'

Implementing a health promotion culture into Prince Philip Hospital and broadening the focus of hospital management and structures has had a strong marketing orientation. This approach has required a great deal of time and research, which included turning the organisation 'inside out' to assess needs.

Any hospital wishing to adopt a similar approach may consider the six point plan detailed in this study. From our experience turning a marketing strategy into action requires several essential elements in combination, i.e. political will; the need to set agreed agendas; generating shared objectives and ownership; and top management backing all the way. These can only be secured through unceasing determination; permission of the hospital management; involvement of the 'gatekeepers'; good leadership; and clearly determined shared benefits for the individual and the organisation.

As with other hospitals, financial restrictions will impose never ending pressures against moves to integrate health promotion in our hospital. The six point plan we adopted has given Prince Philip Hospital a great deal of hope for the future.

Recommendations for other Hospitals

The following list of recommendations offer some suggestions on ways to develop or extend a health promotion infrastructure within a health care setting.

1. Establish credibility for Health Promotion Policies – include in the Organisation's Business Plans; Corporate Goals and Objectives; and Local Health Strategies.
2. Identify someone in the organisation who will give leadership to the health promotion commitment – Appoint a Health Promotion Manager, or Senior Manager or Director, or Board Member.

3. Establish a financial commitment to health promotion in the organisation – Develop a budget for health promotion as a percentage of the overall hospital budget. Redirect resources from health care services.
4. Make specific management recommendations to Senior Managers, Directors, Board level, in terms of objectives for health promotion – Develop a Health Promotion Strategy/Business Plan. Incorporate long and short term objectives.
5. Establish an inter-disciplinary committee for developing and implementing the Health Promotion Strategy. Members should be well known to the workforce – Health Promotion Team/Committee with members from all levels within the organisation. Include planners, managers, medical staff, nursing staff, health care professionals and other staff members.
6. Survey and assess current health promotion initiatives/programmes/support within the organisation and community – Develop a directory or manual of health promotion activities. Identify potential areas of development and also potential barriers to health promotion.
7. Assess and develop communication channels for distribution and dissemination of the health promoting hospital concept – Ensure both 'Top Down' and 'Bottom Up' channels are available. Develop a Quality Strategy and Communication Strategy to facilitate this.
8. Facilitate community involvement and intersectoral action for health promotion – Develop networks with social, voluntary, charitable, business and government bodies.
9. Create accountability in health promotion plans, goals and objectives – Determine specific targets within the Health Promotion Strategy and Business Plan. Link to local, district, regional and national health gain targets.
10. Review and evaluate health promotion programmes and initiatives – Develop a series of indicators to allow evaluation and review of progress against specified targets. Develop an evaluation strategy.
11. Establish a continuing health promotion function within the organisation to create a vision for health and health gain – Update and review activities continually in relation to both internal and external factors e. g. National Strategies and Policies/Purchasing and Procurement Contracts.
12. Develop a training and education strategy for health promotion to include management and staff from health and other sectors.

Appendix: Key facts about Prince Philip Hospital

Table 1: Setting the Local Project into Context

Key Facts: Wales		Key Facts: Prince Philip Hospital	
Population	3,000,000	Population served	100,000
Number of Hospitals	141		
Hospital Staff (WTE)	53,000	Number of Staff	1,376
1995/96 patient Throughput:		1995/96 Patient Throughput:	
Inpatients	531,400	Inpatients	10,041
Outpatients	2,695,600	Outpatients	76,525
Day Cases	263,200	Day cases	10,078
Casualty	200,000	Casualty	40,034

Table 2: Health Status Issues in Wales

Mortality and Morbidity
<ul style="list-style-type: none"> ● 32% of deaths are caused by heart disease and 25% by cancer; ● Respiratory diseases and strokes account for over 50% of deaths from other causes; ● 4.2% of the population in Wales has diabetes
Quality of Life
<ul style="list-style-type: none"> ● 48% of the population are classed as overweight (50% men, 48% women); ● Only 26% of adults exercise regularly (36% men, 16% women); ● Smoking prevalence amongst adults has declined steadily and is now 30% (31% men, 25% women); ● Drinking alcohol above the recommended sensible limits has decreased to a reported 25% of men and 12% of women

Table 3: Local Health Status Issues: Prince Philip Hospital

Mortality:
● High incidence of heart disease, cancers and strokes
Quality of Life:
● Poor nutrition and obesity ● Extremely high rates of dental decay ● Low levels of participation in exercise ● Each year 1100 people die from smoking related illnesses ● 35% of adults exceed the recommended limits of alcohol

Preston Acute Hospitals NHS Trust

A Pilot Health Promoting Hospital in the WHO European Network

Pauline Fielding, Dominic Harrison. Marion Woan



The Royal Preston Hospital

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Hospital Owner:	Secretary of State, Department of Health
Hospital Ownership:	Public
Specialisation:	General Hospital
Beds:	816
Staff:	Medical Staff: 362, Nursing Staff: 1826, Other Staff: 1,698, Total Number of Staff: 3,886
Utilization:	Average Utilization of Beds/Year: 75.5 %, Average Stay in the Hospital/Day: 4.08
Patients:	Number of Inpatients/Year: 45,708, Number of Outpatients/Year: 213,332
Number of Departments:	32
Location of Hospital:	Suburban/semi-rural
Catchment Area:	Regional, number of population: local: 120,000, regional: 1,2 Mio
Other Functions than Medical Care:	
Teaching:	Medical students, postgraduate, nursing education, other health professions: professions allied to medicine
Research:	Clinical research, other health research: Child development, distribution of disease, digital image processing, toxicology
Subprojects:	<ol style="list-style-type: none">1. Food and Health2. Health at Work3. Health Promoting Hospital in the Community4. The Storage, Collection, Transport and Disposal of Domestic and Clinical Waste5. Management of Post-Coronary Patients6. Prevention of Accidents through Self Care7. 'Talkwize' – A Young People's Information Service

The Hospital and its environment

As structures and developments of the British National Health Care System are already outlined in more detail in this book (Harrison 1998), we can focus the following description on the regional environment of the Royal Preston Hospital in the North West Region of England.

The concentration of the population in the two major conurbations (Liverpool and Manchester) and the towns of Lancashire and Cheshire, gives the North West Region its urban character. The concentration of people in declining urban areas ensures that the Region has higher than the national average levels of deprivation and health needs. One in six children lives in a lone parent household, the highest proportion of any British Region, and the proportion of low birth weight babies is seven percent above the National average. Low birth weight is associated with a greater need for health care support. The North West along with the Northern Region of Scotland, has some of the highest death rates in Europe from circulatory diseases, (NWRHA 1994). Preston in particular has a high proportion of black and ethnic minority groups concentrated in the three most deprived areas of the town.

Table 1: Characteristics of Preston (Preston Borough Council 1994)

<p>Preston, between 1992/3, ranked nationally in: The worst six per cent of areas for deaths from stroke The worst thirteen per cent of areas for deaths from heart disease The worst nineteen per cent of areas for deaths from lung cancer The worst fourteen per cent of areas for deaths from road traffic accidents The worst twelve per cent of areas for deaths for suicides The worst eight per cent of areas for deaths of all causes The worst twenty per cent of areas for deaths of babies around the time of birth.</p>
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Preston is the administrative centre for the county of Lancashire and it also has important road and rail junctions. This has had an impact on the development of hospital services in this part of the Region.

From concept to reality

In 1991, Preston Acute Hospitals NHS Trust, (formerly Preston Health Authority) was approached by Professor Leo Baric (WHO Consultant) and Denise Richardson (senior lecturer at the University of Central Lancashire) when the opportunity arose to become the pilot hospital for England. Meetings with the managers from both the hospital and North West Lancashire Health Promotion Unit resulted in a successful submission to the Health Promoting Hospital (HPH) Business Meeting in Dublin in September 1992.

As a response to the growing enthusiasm for the HPH concept in England, in 1993 the NHS Executive set up a National Reference Group, representing a wide range of interests to explore how the commitment in the Health of the Nation might best be fulfilled. They undertook to assess the interest in the NHS by questionnaires, surveys

and consultative workshops. Based on the results of this work, a framework for development of the concept was identified. Using the National Reference Group's criteria, a Health Promoting Hospital:

- demonstrates formal and open commitment at the highest levels of management to protect and promote the health of staff, patients and visitors within the context of the Health of the Nation Strategy;
- creates a culture for health gain within the organisation and enters alliances to promote health and prevent disease in the community outside the hospital;
- seeks the views and active participation of staff, patients and visitors in the planning of HPH activities;
- undertakes monitoring and evaluation of the process and outcomes of all interventions; and
- has the ability and willingness to network and share experience and good practice.

These very broad criteria set out the fundamental characteristics and allowed for a wide range of local interpretation and variations in response to local need, preference and priorities.

The project partners and the project committee

At Royal Preston/Sharoe Green Hospital the principles of project management were used to establish an appropriate organisational structure and process to realise the aims of the HPH. Building on an existing association, a tripartite partnership developed between the hospital, North West Lancashire Health Promotion Service and the University of Central Lancashire. A multiprofessional project committee was established to oversee the work of the five subprojects (later to become seven), and a project manager was appointed. The roles and responsibilities of the project partners and members of the project committee were defined.

Project partner Preston Acute Hospitals NHS Trust – Co-project manager and project committee chairperson

Executive Director with lead responsibility for all health promoting activity within PAH. Responsible for the overall management of the local HPH pilot project in collaboration with NW Lancashire Health Promotion Service and the University of Central Lancashire.

- chair the project management meetings
- line manage the project coordinator
- joint representative of PAH in the European network of HPH pilot hospitals
- At Executive level liaise and support other hospitals and Trusts considering the HPH initiative for their organisations

Project partner – North West Lancashire Health Promotion Service, Co-project manager.

Responsible for the overall management of the local HPH pilot project in collaboration with Preston Acute Hospital NHS Trust and the University of Central Lancashire.

- negotiate a contract between parties involved, i.e. Preston Acute Hospitals NHS Trust (PAH), North West Lancashire Health Promotion Unit and the University of Central Lancashire
- plan, propose and implement project management targets
- control the scope of the project
- ensure that all participants understand and are committed to the overall project goals
- adopt a clear HPH management team reporting structure
- ensure that the project's systems and documents are understood by all
- assure project compliance with commitment and assess project progress at major milestones
- propose/initiate appropriate education and training, e. g. strategic importance of the HPH project, project management techniques, conference planning
- manage the HPH budget
- health promotion specialist advisor
- line manage the project administrative support person
- media spokesperson and publicity advisor
- joint representative of PAH in the European network of HPH pilot hospitals
- liaison with the Health Education Authority, NHS Executive and WHO
- resource person with regard to national networking/international dissemination

Project partner University of Central Lancashire – Project evaluator

Responsible for evaluating the HPH project in Preston

- liaise between the University of Central Lancashire and the HPH project
- specify research protocols and documentation
- develop monitoring and evaluation systems with the subproject managers
- produce reports, disseminate and publish findings
- Network with facilitators in Eire, Northern Ireland, Scotland and Wales regarding the HPH evaluation process/training initiatives

Administrative support to the project

Responsible for providing administrative support to the overall project and one of the project's co-managers

- organise HPH resources and information
- liaise with the NHS Executive and the European coordinating centre in Vienna
- provide HPH information to local and national inquirers as required

Project coordinator (from September 1995)

Responsible for the coordination of the HPH subprojects in Preston and initiation of further HPH projects in collaboration with PAH staff

- ensure that the project objectives and targets are met

- provide information and advocacy to the subproject managers and other project leaders within PAH
- offer supportive advice and consultancy to other hospitals within the North West Lancashire Health Authority area.
- national facilitator network member
- liaise closely with the overall HPH project managers and evaluator to develop and publicise the Preston HPH project

Subproject managers (originally 5 but later 7)

Individual responsibility for management of their subprojects within the Preston HPH pilot project:

- liaise with the overall project managers, coordinator and evaluator to produce a flexible, but robust subproject plan
- manage the structured programme of work by delegating responsibility
- define the scope of the subproject in context with their other work responsibilities
- manage budget control of any devolved HPH funds
- identify individual training and development needs and those of the subproject team members, e. g. project management techniques, health promotion
- liaise with other work colleagues to disseminate the objectives and progress of the project

Project aims

The aims of the project in Preston were based on the WHO and NHS National Reference Group's criteria:

- plan, implement and evaluate the development of a model HPH in England over a five year period from 1993 – 1997
- reorientate acute hospital based services towards the prevention of morbidity and mortality within the community
- develop and evaluate a wide range of hospital based health promotion interventions aimed at achieving health targets identified within the Health of the Nation
- provide a networking centre for the development of health promoting hospitals throughout England and to represent England in the European HPH Network.

Intervention studies

Five subprojects were chosen to become intervention studies:

- A healthy environment in a health promoting hospital, now renamed Health At Work
- A review of the storage, collection, transport and disposal of clinical waste
- The health promoting hospital in the community
- The management of post-coronary patients
- Prevention of accidents through self care.

Two other subprojects had been developed as intervention studies by 1995/96:

- A food and health strategy
- The provision of a young people's information centre.

The purpose of formalising the research proposals into intervention studies was mainly concerned with the hospital staff acquiring the necessary knowledge and skills in health promotion and health education. It was thought that this strategy would enable them to find out for themselves the best ways of fulfilling the principles on which a health promoting institution is based, i.e.: creating a healthy work environment, integrating health promotion into daily activities and initiating and/or enabling creation of networks and alliances within the community. All subprojects at one time or another have utilised the expertise of health professionals, educationists, voluntary workers and others from within as well as external to the hospital.

Project Committee meetings

Initial meetings were held by the original seven member project committee to ensure that they fully understood the HPH concept and that the aims of project were clear. This was important for the next stage of communicating the principles and the philosophy of the HPH to the wider organisation and the communities served by the hospital. Subsequent committee meetings gave opportunities for the subproject managers to relate progress, discuss barriers and potential ways of overcoming them. The meetings also provided the project managers with opportunities to update the rest of the team of HPH developments locally, nationally and internationally. These meetings were always well attended and valued by the individual committee members. Since April 1997 the meetings have become far less formal and open to any member of hospital staff. Wider staff involvement is seen as crucial to the continuing development of a 'healthy hospital'.

The project committee was also given the responsibility of ensuring that the project had full publicity both within the hospital and the wider community. In order to explore issues identified by the general public and hospital managers in relation to the development of a health promoting hospital, two consultation conferences were held in September 1993. The aim of the subsequent report was to inform local and national developments in relation to HPHs. In addition, the report was circulated to all hospital managers asking them to integrate its findings into their business plans and service developments. In December 1994 the hospital managers were asked to complete a proforma audit form to identify what action they had taken in response to the staff and public consultation findings. The response rate was low, however those responses received were of a very high quality showing considerable commitment by some key departments. A great deal of the current service development agenda in a range of departments can be adapted to respond to staff and consumer demand without the application of considerable additional resources. Some departments who might be considered as 'support staff' rather than dealing directly with patient care can often contribute more than expected e. g. Information Technology.

Project Progress

Preston's HPH Project saw a number of developments during 1994/5. As well as the audit of the public and staff consultation exercise, there was healthy alliance development and an increase in resource commitment, for example:

- The University of Central Lancashire funded (from within its own resources) a project evaluator and a Health Promoting University Coordinator who links into the Preston HPH project in the development of settings based health promotion work. The role of the project evaluator, a post doctoral research fellow, is primarily concerned with the overall local project evaluation but has been available to offer expertise and guidance to subproject managers when requested.
- North West Lancashire Health Promotion Unit and Preston Acute Hospitals NHS Trust agreed two years funding support for the Preston project. This consolidated and extended existing project support which now consists of an HPH project coordinator – whose role is to support and extend new and existing health promotion projects within the hospital; a project administrator – whose role is to facilitate the internal project with administrative support and to assist with meeting external enquiries and requests for training, education and resources from other UK and European hospitals currently developing HPH status.
- Preston Acute Hospitals NHS Trust made available internal resources for four of the initial five subprojects who each received a small operational budget for a two year period. The fifth project was resourced by the provision of staff time from the University of Central Lancashire.

There were also changes to the subproject intervention studies. The original research proposals were designed to incorporate evaluation at all stages of the project. This was to be achieved by conducting base line studies prior to any intervention. In some of the projects these base line studies were not undertaken. Whilst some evaluation techniques can be applied retrospectively, others cannot. Also, many of the original objectives were not pursued, and the level of evaluation required was difficult to assess. The subproject managers rewrote their subproject objectives. Additionally, each subproject needed to be formally documented. Whilst this may be a familiar technique to professional researchers most of the subproject managers had not had this training and they required detailed guidance from the project coordinator to complete this activity effectively.

The concept of a health promoting hospital was initially difficult to grasp for managers. However organisational development is encouraging a structure that is more adaptable to health promotion. This process is slow and the outcomes of this cultural change are likely to be seen over the coming years. Health promotion was first incorporated into the Trust's business plan 1995/96. The hospital has a wide range of health promoting personnel, health and safety and employment policies in place designed to promote a healthy hospital. These include a smoking policy, drug and alcohol use policy, and a health and safety policy. There is evidence that health promotion is being incorporated into the every day work of the hospital by the use of specific target setting in strategy documents, e. g. health promotion audit within the nursing and midwifery strategy.

Communicating about the work of the local project and its national and international context is offered to all staff during induction and orientation to the organisation by the project coordinator. At ward and department level, practitioners are heavily involved in health promoting activity. It was only during 1995/96 that this activity was recognised and recorded and consequently retrospective evaluation is proving difficult. Although hospital practitioners acknowledge their important role in health promotion, it was clear that training in one to one interventions was not available to them. This need is now being addressed with suitable research based health promotion training. A growing number of nurses in particular are attracted to health promotion modules on the undergraduate and postgraduate programmes at the University of Central Lancashire. They are using these programmes to develop health promotion interventions in their work setting. This has enabled practical work to be evaluated academically. Many students have been given limited time to participate in the study programmes by their managers.

The HPH project has received continued national impact in health journals and conferences, as well as contributing for instance, to all the annual English national conferences on Health Promoting Hospitals since 1993. At least eleven papers have been published in professional health journals nationally, for example: NHS Executive (1994), Hobbs (1994), Harrison (1995), Hutton (1996), and local television, radio and newspapers have been used to publicise and disseminate the project.

The english national HPH network

At the Hildesheim Business Meeting of the European Pilot Hospital Project in October 1995, most of the pilot HPHs in Europe including Preston Acute Hospitals were formally asked by WHO to develop and coordinate National/Regional Networks and thus become part of the European HPH Network. At a meeting in Oxford in November 1995, a number of interested parties from across England discussed how best to pursue the national development of the project. There was agreement that Regions in England that were already working on local aspects of HPH development would continue their work. It was also agreed that Preston Acute Hospitals in partnership with the NW Lancashire Health Promotion Service and the University of Central Lancashire, would pursue its aim to pick up the networking function previously briefly undertaken by the English NHS Executive.

A National HPH network centre based in the North West Lancashire Health Promotion Unit is now operational. This has been funded to date with resources from inside the partner organisations, but membership subscription to the National HPH Network from 1998 and beyond will help to offset costs. The centre works closely with Regional Network Coordinators and undertakes a number of functions to provide a wide range of health promotion support to English hospitals as well as fulfilling its role in the European WHO/EU Network.

The management of domestic and clinical waste at the Royal Preston Hospital

Introduction

One of the seven subprojects has been chosen as an example of how the theory of a Health Promoting Hospital can be translated into practice. This subproject has been

chosen because it was the one that had recorded its successes, failures and pitfalls most thoroughly for the duration of the pilot study.

The Directorate of Estate and Facilities employs a total of 430 staff, covering three main areas; capital, property and support services, hotel services and estate operations and maintenance. Waste management activities are controlled by the operations and maintenance section of the directorate, whose other functions include; engineering, telecommunications, energy management, building services, traffic management and medical engineering.

The section also provides several work placement schemes each year, for school and college students as well as undergraduates and postgraduates. Within the field of waste management, the hospital has had three groups of MSc students, from the University of Central Lancashire, completing various projects, one of which involved work for this study.

Royal Preston has its own incinerator on site, in which, around 800 tonnes of clinical waste per annum is burnt. This figure excludes additional contracts for clinical waste disposal from external organisations such as clinics, dental surgeries and private homes. Approximately 600 tonnes of domestic waste is also produced, which is compacted in the hospital's compactor equipment and then land filled. On occasions when there is an excess of clinical waste, as a result of either repairs or maintenance of the incinerator, the services of an external waste contractor are employed.

For both clinical and domestic waste disposal the hospital is obliged, under the Duty of Care Regulations, to ensure that whilst the waste remains on site it does not escape from its' control. The hospital is further required to make certain that any waste leaving the site is passed onto a registered waste carrier and is accompanied by a written description. These regulations mean that the responsibility for the safe disposal of waste cannot be discharged once the waste is passed to the carrier, instead the hospital becomes part of the chain of responsibility for the waste it has produced.

In addition to complying with the Duty of Care Regulations, the hospital is also regulated by the Environment Agency regarding its waste management activities and emissions from the incinerator stack. This involves monitoring of discharges to the air by the hospital engineering staff and Agency representatives at regular intervals and satisfying other various conditions.

The waste management area of operations and maintenance has been working closely with clinical supplies company Vernon Carus. An investigation was carried out with the company into the minimisation of packaging waste from items such as dressings packs, used in the theatres. Vernon Carus and the hospital are hoping to

Table 2: A review of the storage, collection, transport and disposal of clinical waste: Project Core Team

Barry McEwan – Deputy Director of Estate and Facilities Management
Howard Jackson – Assistant Director of Estate and Facilities Management
Christine Green – Personal Assistant
Sian Fisher – Waste Minimisation Officer

reduce the amount of clean paper and plastic packaging which is currently disposed of as clinical waste. This is likely to be through either minimising the materials used or making them more easily recyclable.

Case Study

Initially the project team consisted of three individuals only, (core team) but this latter grew to four when the waste minimisation officer was appointed in 1996. They were self selected and jointly maintained overall responsibility for the project. The core team co-opted other individuals onto the team as and when appropriate, for example when the hospital was investigating the reduction of packaging, the general sales manager of Vernon Carus, a local clinical supplies company worked with them. Also students from the University of Central Lancashire were part of the team when they were working on the project. All funding for the project had to be found from within existing resources or had to be bid for using existing hospital funding mechanisms.

The primary aim of this project was to improve the present methods of storing, collecting, transporting and disposing of clinical and domestic waste at Royal Preston Hospital. A review of the waste management system was deemed necessary as a result of the introduction of legislation, such as the Environmental Protection Act, (Department of the Environment 1990), governing waste related activities and also, the ever increasing costs of waste disposal.

In the initial stages however, the project was delayed as a result of lack of finances. For the waste management system in the hospital to be improved, a number of capital outlays were necessary, e. g. purchase of clinical waste containers, bin lifting and cleaning equipment and the appointment of a dedicated waste minimisation officer. Obtaining funding for these items proved difficult and was a lengthy process, which attributed to the delay in completing many of the aims and objectives of the intervention study. However by mid 1996, all the structures were in place and the interventions were operational.

At the beginning of the main study, a number of investigations and observations were carried out to assess the current waste management system and identify those areas where improvements could be made. From these, it was discovered that Royal Preston Hospital was not fully conforming with waste legislation, particularly in the areas of storage and collection and that the methods being used at the time posed a health risk to hospital staff, patients and visitors. It was also found that fairly large amounts of domestic waste were being disposed of as clinical waste. This costs the hospital more money, as clinical waste is at least five times more (per tonne) to dispose of than domestic waste.

Two staff questionnaire surveys were carried out. The first was commissioned by the project team to a post graduate student on placement from the University of Central Lancashire. Following further analysis and synthesis of the initial questionnaire by the Health Promoting Hospital project coordinator and external evaluator, a series of other questions were raised. These were addressed in a questionnaire formatted by the hospital Clinical Audit Department on behalf of the Waste Minimisation Officer.

Informal discussions also took place with various hospital staff, regarding their waste management knowledge and related practices. It was determined that many staff were unclear of exactly what was clinical and non-clinical waste and some were unsure of the correct procedures for handling and disposing of the different waste streams.

In addition to talking to staff, observations were made to assess the procedures for handling, storing, collecting and disposing of both clinical and domestic waste. From this exercise it was discovered that a number of these activities did not comply with waste legislation and the hospital waste disposal policy. For example clinical and domestic waste was being stored and transported together, domestic waste was being disposed of as clinical waste and clinical waste bags and sharps containers were being thrown up into the incinerator hopper.

As a result of the surveys and observations it became apparent that inappropriate waste management was occurring mainly due to lack of training and awareness of staff and the absence of facilities, to enable employees to correctly deal with the waste. It was therefore clear that if waste management at Royal Preston Hospital was to improve, a comprehensive staff training programme was required and additional equipment needed. Following careful analysis of the investigations, it was possible to see the extent of the training and extra facilities required and also identify where promotional material could be used as a learning aid for staff.

Training material

When planning for and designing the training material, it was realised that there were several different groups wanting training, each with different educational backgrounds and varied training requirements. The five groups were identified as nursing staff, domestic staff, porters, incinerator operatives and patients and visitors.

The nursing staff were classed as producers and handlers of waste, as they not only create both clinical and domestic waste, but may also have to empty waste containers and put the bags out for collection. The domestic staff were defined as waste handlers, as part of their job is to empty the bins and put the waste out for collection. The porters were classed as handlers and disposers, as they collect the waste from the wards/departments, transport it to the yard and then dispose of the domestic waste by placing it in the compactor. The incinerator operatives were also identified as handlers and disposers, as they deal with the clinical waste once it reaches the yard, which also includes disposing of it in the incinerator. Finally, the patients and visitors were categorised as waste producers, as they create waste from items brought into and used in the hospital.

It was realised that each of the identified groups, would require slightly different training methods and material. The present waste disposal policy for the hospital, covered all aspects of the waste management system, from production, to transport, to disposal. As not all of these areas were applicable to every group, it seemed pointless to train each employee in the waste management system as a whole. It appeared to be more effective to prepare separate policies for production, storage, handling, collection, transport and disposal procedures and train each group only in the areas relevant to their jobs. This would then mean that staff only received training and information

related to their daily activities and were not confused by procedures which they would never have to use. For example it would have been pointless to train nursing staff in the transport and disposal procedures, when they do not carry these activities out. It was also thought that by limiting the scope of each groups training, there should be less confusing and irrelevant information for staff to learn.

The training of the nurses and domestic staff groups was carried out in the form of a series of basic, short, introductory seminars, which all staff were invited to attend.

A 'link' person or waste management contact was appointed for each ward and department and any further training and subsequent updates are given to these people, who are expected to relay the information to staff in their area. The porters and incinerator operatives were trained on a one-to-one basis as smaller numbers of staff were involved.

For the patients and visitors, it was not feasible or practical to actually train people. Instead, each ward or department is supplied with leaflets, which patients and their visitors are encouraged to read. The leaflets provide information on the waste management system in use and outline why it is necessary and important.

Provision of facilities

As a result of the observations carried out in several wards, it was noticed that facilities for properly dealing with waste were not provided. In particular there were insufficient domestic waste bins, therefore large amounts of domestic waste was being disposed of into clinical waste bins. Waste containers were not labelled to identify the types of waste that could be disposed of in them, which meant that if the colour of the bag could not be seen, the lid of the bin had to be lifted to determine this. Few posters were visible to assist staff in recognising what was and was not clinical waste. A very small number of staff had actually read the waste disposal policy, usually because only one copy was held in each area and the policy was quite lengthy and confusing. No designated storage areas or containers were provided for waste awaiting collection, which led to it being stored in inappropriate locations and clinical and domestic waste stored together. No containers were provided for the transportation of clinical and domestic waste, separately, to the yard, which meant that they were transported together in the same collection trolley.

In response to these findings it was decided that waste segregation, storage and transport needed improving. To assist in waste segregation it was planned to label all waste containers with either yellow 'clinical waste only' or black 'domestic waste only' labels, to correspond with the bag colours for these waste types.

For the improvement of waste storage and transport, a number of yellow wheeled bins were purchased. The bins would be used for clinical waste only, to make the storage of this waste safer and to separate it from domestic waste. The yellow wheeled bins would serve the purpose of improving waste handling as waste would have to be handled less, therefore making it safer. Following the purchase of these bins, bin washing and lifting equipment was bought. If the containers were to be used in wards and departments they would need to be cleaned regularly and machinery for carrying this out automatically was more practical. The lifting equipment would mean that

yellow bags and sharps containers from within the hospital would not have to be physically placed in the incinerator hopper by the operatives or porters, as the bins would be emptied into the hopper. The use of the yellow wheeled bins would also mean that the collection trolleys could be used for domestic waste only, therefore reducing the risk of contamination.

In addition, each ward or department has a waste storage area designated, for the location of the yellow wheeled bins and domestic waste bags. This prevents the accumulation of waste in areas such as corridors and by the service lifts, where general access and fire escape routes were previously obstructed.

All different staff groups received waste management handbooks with details of the procedures (relevant to their jobs) to be used as reference sources. Promotional material such as posters, are also on display to assist staff, for example in recognising clinical and domestic waste.

Implementation of new system

The new waste management system was commenced on a trial basis in a pilot ward. This allowed any problems with the system and training to be identified and solved, prior to wide scale introduction. Considerable changes were made to the waste collection procedures. Prior to the study waste was collected at regular intervals during the day and night, in the same collection trolley. The introduction of the yellow wheeled bins, meant that clinical waste only had to be removed once or twice in a 24 hour period. This is because the waste is contained and stored in an appropriate area, it is also more effective in terms of time management, for the bins only need to be removed when they are full. However, although the clinical waste requires removing less frequently, when it does have to be taken away, a clean bin needs to be provided. This means that each time the porters go to a ward to remove a bin for emptying, they have take an empty bin with them as a replacement. This process makes clinical waste collection and transportation a more time consuming procedure than previously. In addition to this the domestic waste still has to be collected, although this is carried out using the previous system of the waste collection trolley. It is worth noting that due to successful segregation, the amounts of clinical waste have decreased and domestic waste increased. Previously, as a result of a shortage of domestic waste bins and information, fairly large amounts of domestic waste was being disposed of as clinical waste.

In the early stages of the introduction of the new waste management system, two systems were in operation and this was confusing for the porters and incinerator operatives in particular and any nursing and domestic staff who moved to wards where a different system was in use. Care was taken to ensure that the changeover was made as easy as possible for all staff.

Evaluation of the waste management subproject

Following the introduction of the new system and the staff training programme on the pilot ward, careful monitoring and evaluation took place. Staff were asked to complete evaluation forms at the end of their training. Observation of waste man-

agement practices and procedures of all parties and all waste related activities were closely monitored. The monitoring and evaluation is continuing now that the system is being implemented on a wider scale. Regular meetings continue to take place between the waste minimisation officer, waste management contacts, porters, incinerator operatives and domestic services managers.

Results

Developed satisfactory rapport with statutory authorities

Necessary capital funds obtained

Overcame initial staff resistance to change

Obtained academic assistance from the University

Policy produced

Appointment of a Waste Minimisation Officer

Increased staff, patient and visitor awareness regarding waste management

Improved health, safety and waste management procedures

Increased waste segregation, hospital policy and legislation compliance and environmental benefits

Reduced waste disposal costs and physical risks

External organisation interest in the project.

Unexpected benefits

Heightened awareness to environmental issues

Dialogue with a range of external organisations and other project groups within the European Health Promoting Hospital Network

Dissemination of experiences to interested organisations

Problems experienced over project life

Funding, capital and revenue

Several groups of students used to assist, inconsistency experienced

Who should manage/control the waste collectors

Training medical staff

Nursing staff attitudes – ‘Not another student/trainer,’ ‘When are we going to see results?’

Compliance with legislation

Culture of the organisation

Printing of handbooks

Location of yellow wheeled bins, (fire regulations)

Training domestic staff, (High turn over)

Changing waste collection round

Training staff on pilot ward

Monitoring and auditing – plays a large part in the process

*Table 3: Total approximate amounts of clinical waste produced by the trust:
April 1996 – March 1997*

Month	Outgoing Waste	Incoming Waste	Incinerator Disposal	Tonnage Produced
April 1996	55.828	20.06	51.94	87.708
May	29.374	23.79	75.96	81.544
June	34.56	19.94	71.57	86.19
July	29.391	21.14	41.16	49.411
August	95.448	19.18	71.57	147.838
September	76.886	19.66	19.54	76.766
October	98.0	20.75	–	77.25
November	110.48	22.27	–	88.21
December	102.924	20.86	–	82.064
January 1997	74.046	23.97	–	50.076
February	22.412	20.9	58.37	59.882
March	55.465	19.76	66.14	101.845
Average	65.4	21.02	57.03	82.399
TOTAL	784.814	252.28	456.25	988.784

*Table 4: Total approximate amounts of clinical waste produced by the trust:
April 1997 – August 1997*

Month	Outgoing Waste	Incoming Waste	Incinerator Disposal	Tonnage Produced
April 1997	57.902	21.73	30.96	67.132
May	27.721	21.93	87.14	92.931
June	23.888	21.54	73.09	75.438
July	24.966	22.55	62.09	64.506
August	40.89	19.926	21.88	42.844
Average	35.073	21.535	55.032	68.57
Total	134.469	87.75	253.28	342.851

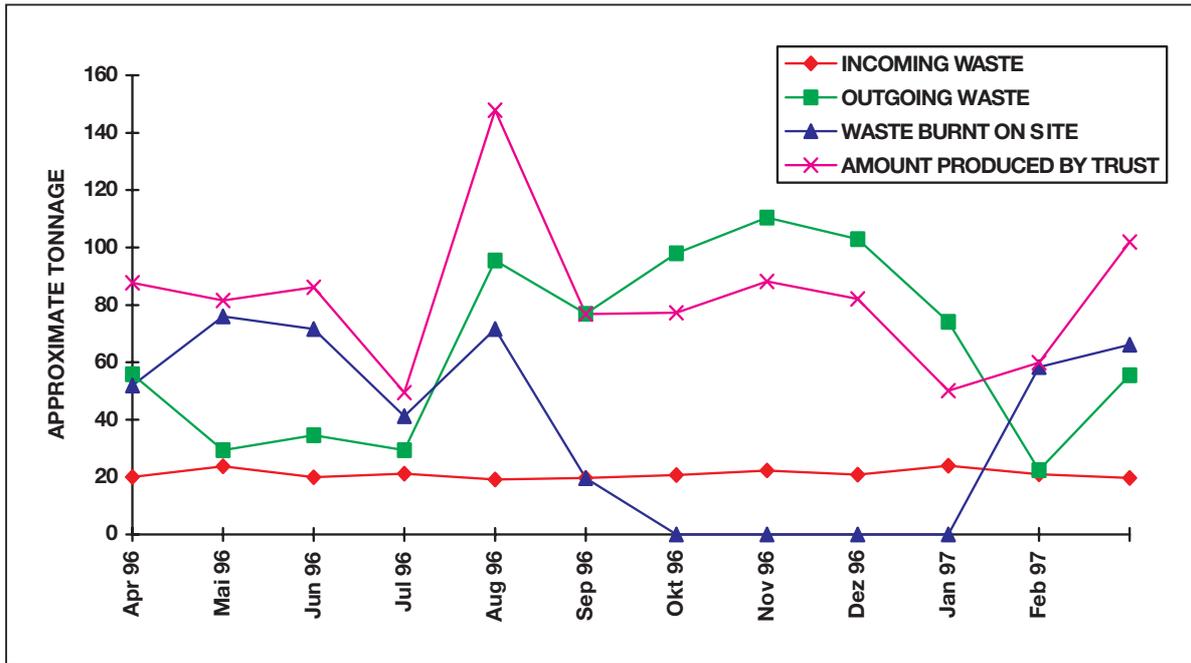


Figure 1: Clinical waste handled and disposed of April 1996 – March 1997

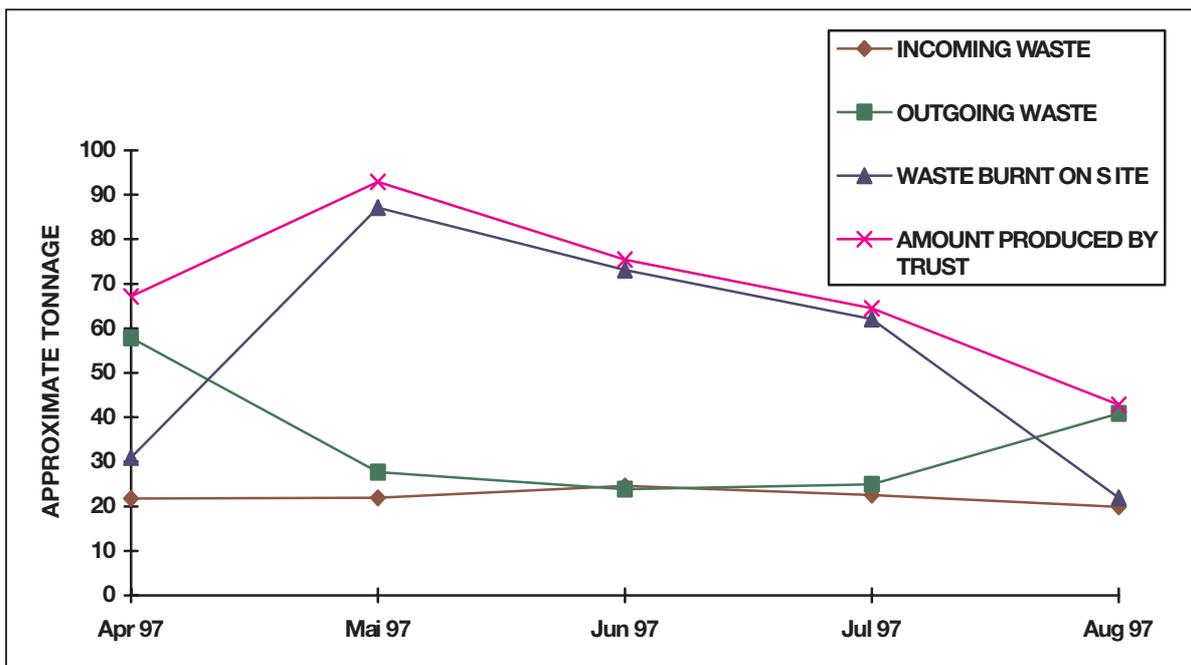


Figure 2: Clinical waste handled and disposed of April 1997 – August 1997

Overall evaluation of the preston project

Measuring the effectiveness of the interventions within the seven subprojects, although difficult, was not impossible. What probably made it most difficult was the fact that the sub project managers did not have project management, health promotion or research methodology training prior to the start of the project. Many of the intervention approaches used in the subprojects had already been shown to be effective both nationally and internationally and they are well represented in the literature, for example, cardiac rehabilitation and accident prevention.

Seeking health gain outcomes has made increasing demands on evaluation methodologies to demonstrate the effectiveness of different programmes. In contrast to the measurement of biomedical interventions in clinical care, a range of social, cultural, political and organisational issues presented the greatest challenge in terms of identifying and measuring organisational change for the duration of the project in Preston.

The Evaluation Approach

The method used to evaluate the local Preston Pilot HPH project was the Labonte technique, (Labonte and Feather, 1996). Ron Labonte, a Canadian health promotion academic, along with others developed a 'structured dialogue' approach to story telling in order to provide a relevant and reliable qualitative research tool. Sharing stories with colleagues is an important and valuable approach to problem solving, critical reflection and skill development. However, the structured dialogue approach is different from discussions or conversations. Discussions often ramble around topics in an informal way and just 'telling a story' may not be very revealing. What makes the story telling an effective learning device is the way the story is constructed and the way it is examined to reveal its helpful lessons.

Series of evaluation workshops were facilitated by Preston's external HPH evaluator, a post doctoral research fellow at the University of Central Lancashire. The aim of using this evaluation technique was to extrapolate what was learnt by the hospital from the pilot study, in order to share these insights with other organisations considering a similar approach to organisational development.

The subproject managers, and all other members of Preston's HPH Project Committee were invited by the HPH evaluator to participate in the workshops. All HPH Project Committee members attended at least one workshop including the Chief Executive from the hospital. They were fully involved in the story dialogue method but none of them had previous experience of using the Labonte technique. Those who participated in the workshops were guided through the process by instructions at the start of the workshops and at milestones in between the different activities. With permission from the people involved, all sessions were either audio or video recorded.

During the structured dialogue activity, explanations were offered for what and why things happened for the duration of the project. The key lessons were synthesized from the story using 'so what' questions and new actions were planned using the 'now what' questions. Each insight was written down with enough detail that could be understandable to others not part of the story group.

The Results

The following insights represent particular lessons, questions, tensions or challenges that remain from the project. (In no particular order).

- The HPH Project gave work (that needed doing) within the hospital focus and drive.
- It helped to create, stimulate, sustain and develop the need for change within the organisation.

- It challenged people's perceptions of the function of the hospital into a health promoting organisation that is not totally focused on disease and illness.
- The process of setting up dialogue within the organisation is very important for the organisation to learn...this is gradually getting easier but it takes a long time.
- The process of generative project based problem solving is the best strategy for health promotion intervention/development.
- Links to population epidemiology are necessary.
- We have harmonised the HPH initiative with other work on the need to change the role of hospitals in general and Royal Preston/Sharoe Green Hospitals in particular.
- Change is a slow process. This has been the case for change in the culture required for the HPH projects to be successful in Preston. The message is *DON'T GIVE UP*.
- Regular reporting of progress using popular staff communication channels are important to keep people informed and encourage other to get involved.
- There is heightened awareness of health promotion through a range of external organisations and other project groups within the National and International HPH network.
- We have learnt from the experience and we are linking to other settings, e. g. schools, communities.
- Introducing diversity into people's work is not necessarily health promoting – change can have a detrimental effect on health.
- Empowerment of nurses is a constant issue – we recognise that they can initiate change.
- We are still a learning organisation in terms of putting the HPH concept into practice.
- Common features need to be included in job specifications when recruiting staff. (Empowering management styles).
- Celebrate successes.

The way forward

This evaluation was completed over the Summer of 1997. Following the formal end of the pilot study, the co-project manager and project committee chairperson used the results of the evaluation to ask Preston Acute Hospitals Trust Board several questions:

- How do we sustain the pilot projects and ensure that the necessary transformation of the work into everyday business takes place?
- How do we support new projects?
- How do we develop new areas of work e. g. the accreditation of healthy wards?
- How do we support the English network?

- and most important of all, how can we translate the organisational learning during the pilot project into a health strategy for the Trust?

It was clear that there were many links from the pilot project to other areas of activity within the Trust e. g. clinical audit, effectiveness research and development, amongst others. The forum and process for the work to be continued was, therefore, problematic. Whilst the facilitation and support of projects could continue as before, there clearly needed to be a wider understanding of the nature of a health promoting organisation and a broad based commitment to incorporating the principles into everyday business and strategic development.

It was agreed by the Trust Board and project committee, based on the evaluation results and with wider discussion with hospital staff, that a Healthy Hospital Forum be established instead of the relatively small project committee. This has the potential of supporting existing areas of work, developing new ones and engage not only existing players but create new alliances both inside and outside the Trust. Support for this approach is derived from Ferlie and Pettigrew (1996) who have documented the development of network based organisations within the National Health Service in Britain and have concluded that, in contrast to traditional hierarchical vehicles for change, they have much to offer.

The Trust's role in supporting the English National Network of Health Promoting Hospitals is two fold:

- The Trust continues to facilitate the North West Regional Network via the HPH project coordinator.
- The Trust remains in partnership with the University of Central Lancashire and the North West Lancashire Health Promotion Unit in running the National HPH Network.

To date the Healthy Hospital Forum meetings have attracted a different set of players. People from all levels of the hospital with fresh enthusiasm are keen to contribute their knowledge and different skills to the health promoting hospital work, whilst others come to listen about the wide range of health promoting activity being generated and sustained across the organisation. The Trust Organisational Strategy currently being redrafted by a small multiprofessional team makes explicit reference to the effective utilisation and empowerment of staff. The main themes of 1998/9 Trust and individual directorate business plans will focus on improvements in health and the development of quality services.

The pilot project has helped the organisation learn how to decide on priorities and how to articulate these principles into practice. We have really only scratched the surface, so much more needs to be done. However, the positive start made by this organisation because of the opportune involvement in the HPH pilot project has ensured that it will keep moving in the right direction.

Recommendations for other hospitals

Based on our learning at the Royal Preston/Sharoe Green Hospital and following the evaluation of the pilot project, the recommended framework for a systematic approach to Health Promoting Hospitals requires an understanding of:

- the cultural, health, behavioural and demographic characteristics of those who work, receive treatment, or otherwise spend time in a hospital environment;
- the built environment of the hospital, and how this environment can be modified and optimally managed from the perspective of environmental and personal health;
- how the organisational values, and culture of the hospital affects the health of those subjected to it;
- the specific health issues raised by hospitals as settings;
- the external relations of the hospital to the community and as a force for health and health leadership in its community.

References

- Department of Health (1992): Health of the Nation. Department of Health. London
- Department of the Environment (1990): The Environmental Protection Act. HMSO. London
- Ferlie E., Pettigrew A. (1996): Managing Through Networks: Some Issues and Implications for the NHS. *British Journal of Management*. Vol. 7. Special issue, 581–599 (March 1996)
- Harrison D. in Riley C. et al (Eds) (1995): Releasing Resources to Achieve Health Gain. Radcliffe Medical Press. London
- Harrison D. (1998): The British National Healthcare System. In: Pelikan J.M. et al (Eds): Pathways to the Health Promoting Hospital. Gamburg: Health Promotion Publications, Conrad
- Hobbs A. (1994): Warding off ill health. *Healthlines*. December 1993/January 1994. 17–19
- Hutton J. (1996): Hospitals for Health. *Health Director*. March 1996 12–13
- Ilfie S. and Gould M.M. (1995): Hospital at Home, A Substitution Technology that Nobody Wants? *British Journal of Health Care Management*. Vol.1, No. 13, pp. 663–665
- Labonte R., Feather J. (1996): Handbook on Using Stories in Health Promotion Practice. Prairie Region Health Promotion Research Centre. University of Saskatchewan. Canada
- NHS Executive (1994): Health Promoting Hospitals. Department of Health. London
- NWRHA (1994): Patterns of Health: Improving Health in the North West. NRWHA. Warrington, England
- Preston Borough Council (1994): Local People, Local Voice. Preston Borough Council
- Smee C. (1995): Releasing Resources Overview. In Riley et al (Eds.) Releasing Resources to Achieve Health Gain : Radcliffe Medical Press. 1995

Stobhill NHS Trust – A Pilot Health Promoting Hospital

Anne Kaskonas



Stobhill General Hospital, Glasgow

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Hospital Owner:	Stobhill NHS Trust
Hospital Ownership:	Public
Specialisation:	General Hospital
Beds:	700
Staff:	Medical Staff: 230, Nursing Staff: 855 FTE (1.049 Head Count), Other Staff: 2.000, Total Number of Staff: 3.085
Patients:	Number of Inpatients/Year: 34.000 (including Day Surgery), Number of Outpatients/Year: 350.000
Number of Departments:	50
Location of Hospital:	Suburbs/rural
Catchment Area:	Regional, Number of Population: 220.000
Other Functions than Medical Care:	
Teaching:	Medical Students, Postgraduate, Nursing Education, Other Health Professions: Paramedical, Dieticians etc.
Research:	Clinical Research, Basic Science Research, Other Health Re- search: Clinical Audit
Subprojects:	1. Minimal Intervention 2. Cardiac Rehabilitation 3. Food & Health 4. Smoking Cessation 5. Health Promotion Co-ordinator

Health Promoting Hospital Project 1994–1998

Introduction

The National Health Service

The National Health Service (NHS) was established in 1948 its purpose, to improve and promote health and remove the burden of anxiety about illness and disease which so affected previous generations in the United Kingdom (UK). The NHS is a public service aimed at promoting health and offering high quality health care to everyone on the basis of need regardless of the ability to pay

The aim of the NHS is to secure continuing improvement in the health of the people by:

- Adding years to life – an increase in the life expectancy and reduction in premature death, and
- Adding life to years – increasing years lived free from ill health, reducing or minimising the adverse effects of illness and disability and promoting healthy lifestyles.

Scotland is at, or close to the bottom of, the international health league table in the key areas of coronary heart disease and cancer, and people in other European nations enjoy a significantly longer life expectancy than the people of Scotland.

The Scottish NHS, which costs around £4.5 billion annually, is committed to meeting the needs of individual patients and to the development of healthcare services and is designed to be:

- universal in its reach, available to everyone wherever they live
- high quality, applying the highest professional standards and employing techniques based on the latest knowledge
- available on the basis of clinical need, regardless of the ability to pay, and
- patient-centred through its increasing focus on the experiences and needs of individual patients.

The National Health Service in Scotland

The NHSIS in Scotland employs over 130,000 people working in hospitals, health centres and patients' homes. It is one of the largest employers in Scotland, with a workforce in which over 70% are women.

Over recent years, there have been many changes to the Scottish health care system. The direct management of health care services has largely passed from the fifteen Health Boards in Scotland to the forty seven NHS Trusts that have been developed. An internal market for health services was established as the means by which standards would be improved and services made more responsive to patients' wishes.

Through the internal market, or contracting process, the health boards directed money to follow patients through the healthcare system by contracting for services identified as required through population health needs assessment. By assessing population needs, health boards would contract for services responsive to the requirements of the local population and not simply give funding to Trusts on an annual basis as had previously happened.

In March 1996, the Shields Report set out the Roles and Responsibilities of Health Boards and described the key role they now play as commissioners of health care, working in close co-operation with general practitioners including GP fundholders, to give strategic direction to local health services. GP fundholders were set up to allow GP's to purchase a limited amount of services for their patients from the provider of their choosing to ensure the best quality of care for the patients.

The creation of Trusts and GP fundholders devolved decision-making about patient care to those in closest contact with patients to give them a proper say in the way services are organised and delivered.

New Proposals for the National Health Service in Scotland

A change of Government again brings with it a commitment to the original principle of the NHS, that if you are ill or injured there will be a national health service there to help, with access based on need and need alone, not on your ability to pay, or who your GP happens to be, or on where you live.

This is to be achieved through the development of a patient-centred health service and the development of new technologies to improve the and effectiveness of patient care. A commitment is being made to clinical effectiveness to ensure that patients will receive the highest quality of care. This new approach to care is to develop a seamless service to provide continuity of care from the point of contact with the GP through the hospital and into rehabilitation.

The White Paper "Designed to Care" sets out the system which will replace the internal market in healthcare. Health Improvement Programmes, designed to promote an overview of the health needs of the communities are proposed as a collaborative approach to create a common agenda for co-operation amongst all those concerned with health care.

This White Paper states that the new internal market of only five years ago has caused '...fragmentation, a burgeoning of bureaucracy and the potential development of a two-tier service'.

It is proposed however that hospital Trusts developed will remain, fewer in number but will retain their autonomy over day-to-day operational activity. The Trusts will be re-focused to give clinicians and patients a bigger say in their management.

The White Paper commits NHS employers to develop specific proposals to enhance the health, safety and security of staff and that staff be given access to health promoting activities in the workplace, consistent with the aim of improving the health of Scotland.

The Vision for the Future

The vision is of an NHS for the people of Scotland that offers them the treatment they need, where they want it and at the right time and designed to put patients first. The proposal is to provide an NHS that aims to improve health, reduce inequalities and not just treat illness.

A Problem with the internal market is that it has focused on the short term, with too much emphasis on an annual contracting system and that in reality it is now recognised that service developments require longer to develop and longer to evaluate.

Health Improvement Programmes are designed to promote a longer-term perspective on health and the elimination of the bureaucracy associated with contracting. The proposals are that;

- *Health Boards* will retain their existing responsibilities in relation to public health protection, health improvement, needs assessment, service strategy and performance management, and will be given a small number of new powers to ensure that local strategies can be implemented.
- *NHS Trusts* will be retained, re-focused on improving the quality of service to patients by giving clinicians who work in the hospitals, along with those who use their services, a bigger say in their management. The number of Trusts operating within the NHS in Scotland will be reduced. There will be two main types of Trust: Acute Hospital Trusts and Primary Care Trusts.
- *Primary care* will be given strong organisational form through the creation of Primary Care Trusts. They will be responsible for all primary health care and will typically comprise community hospitals and mental health services as well as networks of general practices in Local Health Care Co-operatives. These Co-operatives will replace the standard GP fundholding system, which will be brought to an end. Joint Investment Funds (JIF) will be established to encourage co-ordination of services at the interface between primary and secondary care. Primary Care Trusts will also need to work closely with those responsible for social work services and housing.

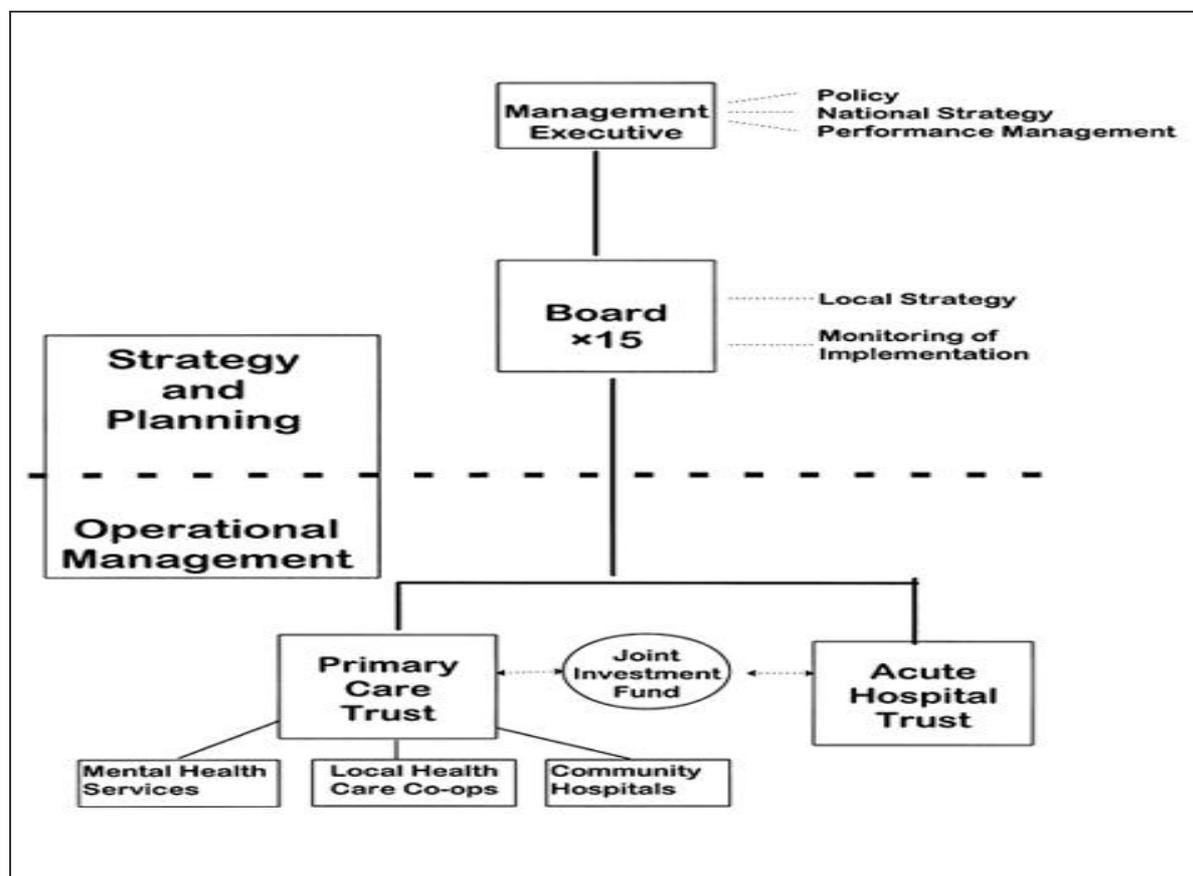


Figure 1: The Proposed Structure of the NHS in Scotland (Designed to Care 1997)

Health Improvement Programmes (HIPs)

To help deliver the most effective care to patients, Health Boards, NHS Trusts, primary care practitioners and others will work together to develop effective care, delivered efficiently, and to put patients interests first. This will be achieved through the development of the Health Improvement Programmes (HIP's) for the people of each Health Board area. HIP's will focus on health gain and improved health for the population.

It is proposed that Health Improvement Programmes should:

- build on existing Health Board service and financial plans and Trust plans;
- cover a period of 5 years;
- include firm plans for the forthcoming year 1998/99 and provisional plans for later years which should nevertheless be as firm as possible; and
- be open to public scrutiny, recognising the role of the Local Health Council.

Each Health Improvement Programme should set out:

- proposals to protect the public health, including emergency planning;
- proposals to promote health;
- proposals to analyse and tackle health inequalities;
- service changes and developments, including those involving primary care;
- a rolling programme for the implementation of evidence-based clinical guidelines and clinically effective practice, to be monitored through clinical audit;
- resource assumptions including locally generated efficiencies;
- human resource strategies;
- how efficiency in the use of existing assets will be maximised; proposed capital investments; and changes in the National Health Service's estate; and
- Information Management and Technology strategies.

Stobhill NHS Trust Health Promoting Hospital Project

Why Health Promotion in Stobhill?

When we think about promoters or advocates of health, we often think about doctors, nurses and hospitals. Nowadays we are more aware of the broader factors that can affect our health such as lifestyle and the social and physical environment.

Health is relatively poor in Greater Glasgow compared with Scotland as a whole. Social factors in the city, such as poor housing, unemployment and the detrimental effects of previous generations of poor parental health, have given rise to health related behaviours, smoking and excess alcohol intake, poor diet and infrequent exercise, which have contributed to poor health.

Stobhill Hospital is an NHS Trust providing health care to the population of approximately 200,000 residents in the North of Glasgow and surrounding areas. The Trust employs about 2,500 staff and our operating budget is about £70 million.

Each year the hospital sees 250,000 outpatients, 30,000 inpatients and 10,000 day surgery cases. The Trust provides a comprehensive range of health care services

from Cardiology, a comprehensive Renal Service to Medicine for the Elderly and people with disabilities. The Trust gives particular priority to Health Promotion.

As a Pilot Hospital within the European Network of Health Promoting Hospitals, Stobhill NHS Trust considers very seriously promoting the health of its patients, staff and visitors. The hospital provides many opportunities to raise awareness of health promotion issues.

Occupation Health and Personnel developments for staff include around the areas of health promotion and support staff through policy development leading to a healthy environment and encouraging a healthy lifestyle. The development of a Trust communication strategy and the delivery of training initiatives co-ordinated by the Stobhill Training and Personnel Department to cover issues around staff educational and training needs identification and the development and delivery of programmes tailored to fit the needs contribute to the health and well-being of staff.

By taking the initiative and joining the European Network of Health Promoting Hospitals, Stobhill Hospital made a unique contribution to health promotion in Scotland. This is an expression of our commitment to “Framework for Action” and “Scotland’s Health A Challenge to us All” which set out the strategy and targets for health within Scotland.

The Health Promoting Hospital initiative offers to take health promotion and disease prevention to the heart of its health services, with an emphasis on health gain, and provides an opportunity for Stobhill NHS Trust to participate in and contribute to the improvement of the health of the Scottish.

Health Promotion and the Prevention of Ill Health

The Stobhill Pilot project for health promotion in the hospital setting is directed towards the intentions of the Health Service set out in the policy statement ‘Scotland’s Health – A Challenge to us All’ and summarised in the ‘Patient’s Charter’ and ‘Framework for Action’ is:

- *to promote good health*
- *to diagnose and treat those who are ill; and*
- *to provide health care for those with continuing needs*

irrespective of the individual’s need to pay, in partnership with people and other organisations, and within the resources that the country makes available.

Scotland’s National Health Priorities 1996–1999

Scotland’s national health priorities:

- Mental Health
- Cardiac and cerebro vascular disease
- Cancer

There are many reasons why these three areas are priorities for the NHS in seeking to improve the health of the Scottish population. They are all major health problems in terms of the number of people who are affected. The severity and enduring nature

of the associated illnesses means that together the above conditions account for major disability and morbidity. The importance of these national health priorities lies in the need to improve health, not simply treat illness or disease.

Mental Health

A Scottish Needs Assessment Programme, report estimated that 30% of adult population of Scotland suffer from a mental health problem at some point in their lives and that around 10% of the population in a year will be diagnosed by their General Practitioner as having a mental health problem.

The intention is that preventive strategies are put in place. In considering preventive strategies, it is important to understand the relationship between mental health and stress.

We know that demands and pressures affect different people in different ways. They play an important part in our everyday lives by stimulating and motivating us. However if the demands and pressures become too great or last too long, people experience a variety of physical and mental reactions commonly known as stress. Long term exposure to stress can damage physical and mental health.

Cardiac and cerebro vascular Disease

Each year in Scotland, coronary heart disease, stroke and peripheral vascular disease together account for almost half of all deaths, over 100,000 hospital admissions and a massive burden of chronic illness.

Much of this is potentially preventable and much can be done to improve the quality of life of people with established disease and reduce complications. There is an increasing knowledge base about risk factors and effective interventions ranging from prevention, to treatment and rehabilitation to which health care organisations need to respond.

Cancer

Each year there are around 28,000 new cases of cancer in Scotland. One in 3 Scots will get the disease and one in 4 will die from it. The multiplicity of tumour sites, the different stages at which they present, the complications of the disease and the complexity of treatment present a major challenge to the NHS.

The Trust operates a Tobacco Policy that is designed to promote smoking cessation or reduction and to go some way to addressing the local and national targets to reduce tobacco consumption through education and awareness raising and supportive strategies for smoking cessation.

Becoming a Health Promoting Hospital?

There are several conditions that Stobhill was required to agree to in assuming this status. One of the stipulations was that we seek to develop links with the community we serve, with similar institutions around the country and promote the formation of a national network. We have links with the community: with some schools, through the cardiac rehabilitation club, through tackling smoking in an area where smoking has a high prevalence. And not least through the connections of the large number of staff who live locally.

We have also promoted the development of a network of health promoting hospitals around Scotland. We have held four national conferences on health promoting hospitals with the fifth planned to coincide with the celebrations of fifty years of the National Health Service, July 1998. We have also been host to the 4th Business Meeting of the International Network. We have several expressions of interest and support.

The unique position of Stobhill as a Pilot Hospital within the International Network has helped make the change from rhetoric to action in health promotion in the hospital. Health promotion is being incorporated into the everyday life and work of the hospital.

Health promotion in the hospital setting

Hospitals offer excellent opportunities for patient oriented health promotion, where awareness of health and changes in lifestyle become more likely within the day to day environment. This message is extended to relatives and visitors. The hospital setting also offers an important health promotion message for its work force and by developing an environmental policy as part of the health promoting hospital initiative, the hospital intends to become a good example for responsible environmental behaviour.

Health promotion is being implemented in four fields:

1. Adding new health promoting programmes to the current range of services
2. Enhancing the quality of the medical services by incorporating attention to the social dimension of patient well-being.
3. A sustained and systematic effort to incorporate health promotion principles into all aspects of the life and work of the hospital – patients, workforce, workplace, environment.
4. To develop and strengthen the image of the Trust hospital as a promoter of health in the community as well as provider of services for the ill.

By offering specific health promotion services and improving the quality and comprehensives of services already offered within Stobhill the hospital hopes to influence patients, staff, visitors and the wider community.

As a health promoting hospital Stobhill NHS Trust, in addition to treating illness aims to offer a more comprehensive, holistic philosophy in its approach to health promotion. The hospital demonstrates a willingness to change management structures to improve health, and involves patient and staff participation. As a member of the European Network of Pilot Health Promoting Hospitals launched in 1990 Stobhill NHS Trust agreed to meet certain conditions:

1. An agreement to support the “Ottawa Charter” and the 1991 “Budapest Declaration” on Health Promoting Hospitals.
2. Staff support for the process of organisational change.
3. Linking with an independent academic research institution for monitoring and evaluation.
4. The development of at least five sub projects or intervention studies which can mean new initiatives or an extension of existing work to run for at least five years.
5. To develop links with other hospitals in similar institutions around the country.

The health promoting hospital initiative intends to build on the existing skills, strengths and commitments of the senior management and staff enthusiasm for the concept of health promotion as a way of achieving the targets set down in “Scotland’s Health, a Challenge to us All.”

There has been considerable interest in the five sub-projects operating within Stobhill NHS Trust and the Trust has won awards for innovation and commitment to Health Promoting Programmes.

Five Health Promotion Projects at Stobhill

Clinical Care & Smoking Cessation

The national targets set out in “Scotland’s Health A Challenge to Us All” are to achieve a 30% reduction in the number of smokers age 12 to 24 by the year 1986 to 2000 and a 20% reduction in the number of smokers age 25 to 64 by the year 2000.

The hospital setting offers opportunities to reach populations of tobacco users with personalised cessation approaches. Stobhill offers smoking cessation advice and opportunities to patients and staff.

The hospital operates a Tobacco Policy since it believes that health personnel have a professional duty to discourage tobacco use since it causes ill-health and impairs recovery. It is well known that smoking is the major public health challenge facing Scotland today. Its impact affects us all in some way, whether in terms of loss of years of life, illness and suffering in individuals and their families, or the economic cost to the nation. In Scotland it has been calculated that 10 617 people die each year as a result of smoking.

A stay in hospital is a life event and can offer the opportunity for medical and nursing staff to help smokers, who can be particularly receptive to stop-smoking advice at this time.

Also, by being in a smoke-free environment can help motivate and support smokers who are trying to stop.

The policy states that patients will be discouraged from smoking at all times. All patients are asked at admission about their smoking status and this is recorded. Patients are asked to abstain from smoking during their stay. Information and advice on smoking cessation is provided and the patients motivation to ‘quit’ is recorded. Guidelines on nursing helping smokers to stop are in use. It is accepted that some in-patients will insist on smoking. These patients are permitted to smoke only the designated patient smoking area available for their ward and at the agreed restricted times.

The Trust has a legal responsibility to protect staff from the effects of passive smoking. The Tobacco Policy recognises that everyone has the right to breathe smoke-free air and no-one should be subjected to tobacco smoke against their desire. The policy also recognises that smokers have the right to exercise an informed, free choice to smoke, except when the exercise of that right affects the right of others to smoke-free air.

Existing staff who smoke are encouraged to seek advice and support on quitting which is available on the hospital site and during working hours. Opportunities to ac-

cess such support is clearly publicised to all staff and the numbers of staff stopping smoking is being monitored. This Trust policy has secured second place in the Tom Hurst European Hospitals Award 'Towards Smoke Free Hospitals' Tobacco won a National award (1997).

The objective of the Clinical Care & Smoking Cessation Project is to encourage patients coming through the hospital out patients and day surgery departments to consider their smoking status. The aim is to reduce the prevalence of smoking.

All patients being admitted for day surgery intervention receive a one to one pre-anesthetic assessment counselling session during which their smoking status is discussed and willingness to stop smoking identified and acted upon. The patient is followed up through the day surgery experience and three months after discharge. Additional encouragement is given to their GP to reinforce smoking cessation in the patient during this time.

The project targets developed are to ensure that all qualified permanent members of staff are trained in smoking cessation skills and to develop a quality programme of aims and objectives creating a smoking cessation approach applicable to nursing and medical staff within the hospital. This project has won a National award from Action on Smoking and Health (ASH) for innovation (1995).

Minimal Intervention Alcohol Project

Most people in Britain drink alcohol at some time. Its very familiarity can make it hard for us to think of drinking alcohol as a health concern. However, excessive alcohol consumption is associated with raised morbidity and mortality and the overall risk of alcohol related problems increases continuously with rising consumption.

The cost of sickness / absence associated with alcohol consumption has been calculated at 779 million pounds in Britain in 1996 alone, and the cost of treatment to the NHS is estimated in excess of 140 million pounds. There are over 1000 deaths each year from chronic liver disease, cirrhosis and other direct causes of alcohol poisoning in England and Wales, if this trend continues it will increase to over 3000 deaths per year by 1998.

The National Health Service in Scotland has been set the target of reducing the proportion of people drinking beyond the safe limits of alcohol by 20% by the year 2000 in order to achieve this target the Stobhill NHS Trust has developed and implemented a strategy to train its staff in an intervention known as minimal intervention.

The population served by Stobhill NHS Trust includes many who consume alcohol to excess. When they are admitted to hospital, the level of enquiry and intervention is variable, but has been generally low.

1. The Minimal Intervention Alcohol Project is aimed at raising staff awareness of patients excessive alcohol intake.
2. To recognise the early signs and symptoms of alcohol withdrawal in order to prevent patients developing the delirium tremens.
3. To reduce the patients level of alcohol intake and to reduce the level of re-admission.

A simple valid screening instrument is used in the early detection of problem drinkers. This model uses brief counselling by nursing and allied professionals to enhance medical advice. The brief, low density approach intervention has shown to be successful in reducing self reported reduction in alcohol consumption.

The population served by Stobhill NHS Trust includes many who consume alcohol to excess. When they are admitted to Hospital, the level of inquiry and intervention is variable, but has been generally low.

A great deal of time and money is spent on the 5% of the population who are dependant drinkers, whilst the bulk of the cost and potential harm occurs in the moderate and heavy drinker. Minimal intervention is a pro-active technique aimed at detecting harmful consumption before it leads to dependence and serious harm and is the approach taken by the Stobhill NHS trust towards the prevention detection and management of alcohol related problems.

It was recognised that the greatest barriers to identifying and responding to alcohol related problems in the moderate to heavy drinkers are a belief on the part of the nursing and medical staff that they do not possess the skills necessary to respond effectively and a pessimism about the effectiveness of any advice that they may give. Around 20% of adult patients admitted to general hospitals may be classified as harmful or hazardous drinkers, and are unlikely to be detected unless specifically screened.

Staff training in Minimal Intervention aims to increase the health professionals awareness of alcohol as a health issue and as a major cause of morbidity and mortality. The Minimal Intervention itself consists of an assessment of alcohol intake and information on harmful and hazardous drinking, followed by clear, straightforward information and advice on how the patient can change their behaviour. The patient is then followed up after discharge to detect a reduction in drinking levels and to determine the success of the Minimal Intervention.

A simple valid screening instrument is a necessary part of early detection of problem drinkers. The screening instrument questionnaire chosen at Stobhill NHS Trust is the Alcohol Use Disorders Identification Test (AUDIT). This instrument is a development of the provisional 'core' screening instrument used in the World Health Organisation collaborative study based in six countries and developed by Saunders and Aasland in 1987.

The questionnaire consists of 10 items enquiring about alcohol consumption, drinking behaviour and alcohol related problems. The responses are scored between 0-4 giving a maximum score of 40. In the Saunders et al trial, those diagnosed as having a harmful or hazardous alcohol use, 92% (sensitivity) had an AUDIT score of 8 or more, and 94% (specificity) of those with non hazardous consumption had a score of less than 8.

This technique of using brief interventions has been shown by many to be effective in reducing alcohol consumption by over 20% in the individual.

The basis of this project is a three day on site training programme for trained staff delivered by an experienced counsellor specialising in addictions. To date one fifth of the trust staff have been trained in Minimal Intervention and further training is planned.

There is a great deal of interest in this project from Trusts Scotland wide. A standard and guidelines for the project have been developed by the project manager in order to maintain and deliver a comprehensive approach to this initiative.

The Food and Health Project

Glasgow has an unenviable record in diet related diseases, in particular coronary heart diseases and some types of cancer. Although the links between diet and these diseases are frequently the subject of media debate, over the last ten years there has emerged a consensus of international scientific opinion as to the changes which should be made in this country to achieve a healthier diet.

These are enshrined in the NACME (National Committee on Medical Education) report 1993, the COMA (Committee on medical aspects of food policy) report 1994 and the report dietary reference values for food and energy nutrients for the United Kingdom 1991. The hospital has a responsibility to set a clear example on endorsing these reports in support of it's Health Promotion activities.

The aim is to increase awareness of the relationship between food and health and to promote the adoption of eating habits conducive to health. The Chief Dietician gives advice on aspects of training required for catering staff and for all other staff involved in food service. While nutrition and patient education form an important part of basic nurse education there are training implications for developing the role of all ward staff and advising patients of the availability of healthy options and encouraging their uptake.

Evaluation includes internal audit of the implementation of the policy including recording one to one interviews with patients, their experiences and beliefs, their knowledge of the policy and one to one interviews with nursing staff to determine process evaluation of the programme. One to one patient and staff interviews. Staff training in Food and Health Policy. Descriptive analysis of observed Policy implementation to determine the process aspects of the project. Quantitative targets include determining the number of nursing staff who had participated in the training and seen the food and health training video and implemented the food and health policy within their ward determining the numbers of catering staff familiar with the policy.

Critical success factors include displaying at the point of interim evaluation an improvement on the previous evaluation showing that all patients coming into hospital are made aware of the food and health policy and given assistance to make an informed healthy food choice. Regular evaluation throws forward any indication of not achieving this success and is rapidly picked up with more training and assessment carried out.

There is growing evidence that the scope for dietary intervention in the hospital setting is substantial. The three most prevalent conditions for which physicians give dietary advice are hypertension, functional digestive disorders, and ischemic heart disease.

As well as clinical diseases, risk factors such as raised plasma cholesterol concentrations also provide opportunities for dietary intervention. Research studies in general practice show that small changes in plasma cholesterol concentrations can be

achieved by dietary interventions. Intensive intervention can also influence salt intake to a small extent. However, the most important, potentially cost-effective roles for the nurse in health promotion are the legitimisation and reinforcement of public health information by brief advice and the distribution of written material. Secondary and tertiary prevention is a priority in the hospital setting and may entail use of drugs, but drugs are not a desirable solution for the unhealthy diets of healthy people.

Cardiac Rehabilitation

It is widely recognised that rehabilitation should be a part of the medical management of post myocardial infarction patients. To be effective it should start in the acute phase of hospital admission and continue through the convalescent phase at home for a period of at least two months.

Rehabilitation around the country, and even within hospitals ranges from occasional outpatient visits to (rarely), residential courses, and structured programmes that are arranged for the individual to follow at home. Where formal rehabilitation classes do exist, they typically consist of exercise sessions with counselling on such matters as diet, smoking, and lifestyle.

At Stobhill NHS Trust the Cardiac rehabilitation programme consists of exercise, psychosocial support and education. Its purpose is to facilitate readapting to normal life through the achievement of maximal functional capability and to reduce heart disease risk factors. This rehabilitation is a comprehensive process of continuing care which takes place at different levels. Hoffman (1992) described Cardiac Rehabilitation as achieving an overall reduction in cardiac mortality by 20%, a slowing down of disease progression, an improvement in physical work capacity and improved psychosocial adjustment. Pashkow (1993), stated that meta-analysis of studies of the effectiveness of cardiac rehabilitation programmes have also shown that this type of intervention reduces cardiovascular deaths by 20%, and sudden death by 37% in the year after suffering a MI, and that cardiac rehabilitation has demonstrated a reversal of atherosclerosis in these patients.

A Policy Approach to Health Promotion

The approach used to promote health at Stobhill is based very much on policy development. This type of approach to health promotion and disease prevention has been shown to have great effect. However when a policy lacks a systematic framework for implementation and evaluation benefit will be lost. A staged framework for the consultation, development, implementation and evaluation of health promotion policies is required

- identification of risks and options for intervention;
- consultation of identified intervention;
- engaging as many professions as possible in development of the policy;
- approval and support by the Trust board;
- policy implementation;
- evaluation.

A strong focus requires to be placed on the evaluation within this policy approach to health promotion.

It can be difficult to make a balanced appraisal of the effectiveness of a health promotion intervention however there is growing evidence that learning principles such as rewards and feedback increase effectiveness. The Health Promotion Co-ordinator at Stobhill is applying these principles to current health promoting initiatives.

The development of the health promotion link nurse scheme increased the systematic use and uptake of health promotion initiatives. The Health Promotion Manager is now expanding and developing this initiative to formalise and structure teaching of public health, health promotion and the use of media campaigns.

Appendices

The sub-projects of the European Pilot Hospital Project – Overall documentation

In the following we have listed all documented sub-projects from the 19 hospitals participating in the European Pilot Hospital Project from 1993–1997 according to the scheme of HPH: interventions addressing the health of patients, staff, the community and the organisation. As many sub-projects address health not only in one area but in a multiple way, some sub-projects are assigned to more than one area. A more detailed description of most of the sub-projects documented in this overview can be found in the respective chapters of the Pilot Hospitals Case Studies in this book.

1. Projects related to the health of patients

Title of sub-project	<i>Hospital</i>	<i>Status</i>	other areas addressed
Care	<i>Alten Eichen Hospital, Hamburg</i>	<i>Finished and evaluated</i>	Staff, Organization
Health Promotion for Patients	<i>Alten Eichen Hospital, Hamburg</i>	<i>Finished and evaluated</i>	No
Health Promotion for Staff and Patients	<i>Alten Eichen Hospital, Hamburg</i>	<i>Finished and evaluated</i>	Staff
Nutrition	<i>Alten Eichen Hospital, Hamburg</i>	<i>Finished and evaluated</i>	Staff
Accident at Work	<i>Altnagelvin Area Hospital, Londonderry</i>	<i>Ongoing and evaluated</i>	Staff, Community
Alcohol Project	<i>Altnagelvin Area Hospital, Londonderry</i>	<i>Ongoing and evaluated</i>	Staff, Community
Breast Feeding Promotion	<i>Altnagelvin Area Hospital, Londonderry</i>	<i>Ongoing and evaluated</i>	Community
Cardio-Pulmonary Resuscitation Training Programme	<i>Altnagelvin Area Hospital, Londonderry</i>	<i>Ongoing and evaluated</i>	Community
Promoting Health through Nutrition	<i>Altnagelvin Area Hospital, Londonderry</i>	<i>Ongoing and evaluated</i>	Staff, Community
Smoking and Health Policy	<i>Altnagelvin Area Hospital, Londonderry</i>	<i>Ongoing and evaluated</i>	Staff, Community
Control of Hospital Acquired Infections	<i>Areteion Hospital, Athens</i>	<i>Ongoing</i>	Staff, Community
Early Diagnosis of Neonatal Hearing Loss and Prevention of Mutism	<i>Areteion Hospital, Athens</i>	<i>Ongoing</i>	Community

Title of sub-project	<i>Hospital</i>	<i>Status</i>	other areas addressed
Health Education Program for the Training of Young Mothers on Issues of Perinatal Care and Breastfeeding	<i>Areteion Hospital, Athens</i>	<i>Ongoing</i>	Community
Hygiene and Safety in the Hospital	<i>Areteion Hospital, Athens</i>	<i>Ongoing</i>	Staff, Community
Rational Use of Antibiotics through the Link to a National Database	<i>Areteion Hospital, Athens</i>	Cancelled	Community
Study of Patient Satisfaction	<i>Areteion Hospital, Athens</i>	Ongoing	No
Total Quality Management in the Nephrology Department	<i>Areteion Hospital, Athens</i>	Cancelled	No
Nutrition and Health	<i>Child Health Centre, Warsaw</i>	Finished and evaluated	Staff, Community
Oral Health in Chronically Ill Children	<i>Child Health Centre, Warsaw</i>	Ongoing	Community, Organization
Prevention of Hepatitis B among High Risk Hospital Staff Groups in CHC	<i>Child Health Centre, Warsaw</i>	<i>Finished and evaluated</i>	Staff
Promotion of Psycho-Social Wellbeing of Hospitalised Children	<i>Child Health Centre, Warsaw</i>	<i>Finished and evaluated</i>	No
The Child Health Centre, Warsaw – A Non-Smoking Environment	<i>Child Health Centre, Warsaw</i>	<i>Finished and evaluated</i>	Staff, Community
The Hospital: One of the Sources of Health Education	<i>Child Health Centre, Warsaw</i>	<i>Finished</i>	<i>No</i>
Conceptual Framework for Establishing a Complex Quality Management Concept	<i>Hospital of the City of Chemnitz</i>		Staff
Introduction of an Effective Patient Information and Conselling System	<i>Hospital of the City of Chemnitz</i>		<i>No</i>
Ways and Means for Putting Care in the Chemnitz Municipal Hospital on a Professional Basis	<i>Hospital of the City of Chemnitz</i>		Organization
Cardiac Rehabilitation Link Programme	<i>James Connolly Memorial Hospital, Dublin</i>	<i>Ongoing and evaluated</i>	Organization
Continance Standard Implementation Project	<i>James Connolly Memorial Hospital, Dublin</i>	<i>Ongoing and evaluated</i>	Organization
Reduction of Hospitalization as a Patient Stressor	<i>James Connolly Memorial Hospital, Dublin</i>	<i>Finished and evaluated</i>	Organization
Smoke-Free Hospital Policy Project	<i>James Connolly Memorial Hospital, Dublin</i>	<i>Ongoing and evaluated</i>	Staff, Community, Organization
Staff Basic Life Support (BLS) Training Project	<i>James Connolly Memorial Hospital, Dublin</i>	<i>Ongoing and evaluated</i>	Staff, Organization

Title of sub-project	<i>Hospital</i>	<i>Status</i>	other areas addressed
Stop Smoking Support Project	<i>James Connolly Memorial Hospital, Dublin</i>	<i>Ongoing and evaluated</i>	Staff, Organization
General Hygienic Program	<i>Koranyi Institute, Budapest</i>	<i>Ongoing and evaluated</i>	Staff, Community
Healthy Nutrition	<i>Koranyi Institute, Budapest</i>	<i>Ongoing and evaluated</i>	Staff
Individual Health Protection of Staff	<i>Koranyi Institute, Budapest</i>	<i>Ongoing and evaluated</i>	Staff
Patient Education Program	<i>Koranyi Institute, Budapest</i>	<i>Ongoing and evaluated</i>	Community
Postgraduate Training of Nurses	<i>Koranyi Institute, Budapest</i>	<i>Ongoing and evaluated</i>	Organization
A Smoke Free Hospital	<i>Padova Teaching Hospital</i>		Staff, Organization
Changing Demand of an Ageing Population	<i>Padova Teaching Hospital</i>		Community
Quality Improvement of Birth	<i>Padova Teaching Hospital</i>		No
Nutrition and Health	<i>Padova Teaching Hospital</i>		Staff, Organization
Medical Emergency Service Cooperating with the Hospital	<i>Philipps Hospital, Riedstadt</i>	<i>Ongoing</i>	Community, Organization
Networking of a Hospital Ward with Out-Patient Services	<i>Philipps Hospital, Riedstadt</i>	<i>Finished and evaluated</i>	Organization
Psychoeducational Groups for Patients Suffering from Adiction	<i>Philipps Hospital, Riedstadt</i>	<i>Cancelled</i>	No
Psychoeducational Groups for Psychotic Patients and their Relatives	<i>Philipps Hospital, Riedstadt</i>	<i>Ongoing and evaluated</i>	Organization
Staff-Training to Create a Low Expressed Emotion Atmosphere within the Wards	<i>Philipps Hospital, Riedstadt</i>	<i>Cancelled</i>	Staff
Theatrework in Psychiatric Health Care	<i>Philipps Hospital, Riedstadt</i>	<i>Ongoing</i>	Staff
Diabetic Education	<i>Prince Philipp Hospital Llanelli</i>	<i>Ongoing and evaluated</i>	Community
Early Minimal Intervention and Drinking Behaviour	<i>Prince Philipp Hospital, Llanelli</i>	<i>Ongoing and evaluated</i>	No
Llanelli Manual Handling Project	<i>Prince Philipp Hospital, Llanelli</i>	<i>Ongoing and evaluated</i>	Staff, Organization
'Talkwize' - A Young People's Information Service	<i>Royal Preston Hospital</i>	<i>Ongoing</i>	Community, Organization

Title of sub-project	<i>Hospital</i>	<i>Status</i>	other areas addressed
Food and Health	<i>Royal Preston Hospital</i>	<i>Ongoing</i>	Staff, Organization
Health Promoting Hospital in the Community	<i>Royal Preston Hospital</i>	<i>Ongoing</i>	Staff, Community, Organization
Management of Post-Coronary Patients	<i>Royal Preston Hospital</i>	<i>Ongoing</i>	Community, Organization
Prevention of Accidents through Self Care	<i>Royal Preston Hospital</i>	<i>Ongoing</i>	Community, Organization
The Storage, Collection, Transport and Disposal of Domestic and Clinic Waste	<i>Royal Preston Hospital</i>	<i>Ongoing</i>	Staff, Community, Organization
Cooperation between Central and Clinical Departments	<i>Rudolfsstiftung Hospital, Vienna</i>	<i>Ongoing and evaluated</i>	Organization
Healthy Food in the Hospital	<i>Rudolfsstiftung Hospital, Vienna</i>	<i>Finished and evaluated</i>	Staff
Nursing	<i>Rudolfsstiftung Hospital, Vienna</i>	<i>Finished and evaluated</i>	Staff, Organization
Organization of Hospital Hygiene	<i>Rudolfsstiftung Hospital, Vienna</i>	<i>Finished and evaluated</i>	Organization
Patient-oriented Team Nursing	<i>Rudolfsstiftung Hospital, Vienna</i>	<i>Ongoing and evaluated</i>	Staff, Organization
Reorganization of a Ward	<i>Rudolfsstiftung Hospital, Vienna</i>	<i>Finished and evaluated</i>	Staff, Organization
The Out-Patient Clinic as Interface between In- and Out-Patient Care	<i>Rudolfsstiftung Hospital, Vienna</i>	<i>Finished and evaluated</i>	Community, Organization
Training of Diabetics	<i>Rudolfsstiftung Hospital, Vienna</i>	<i>Finished and evaluated</i>	Community
Volunteer Patient Service	<i>Rudolfsstiftung Hospital, Vienna</i>	<i>Finished and evaluated</i>	No
Health School	<i>Silesian Rehabilitation Centre Repty, Ustron</i>	<i>Ongoing and evaluated</i>	Community, Organization
Healthy Food	<i>Silesian Rehabilitation Centre Repty, Ustron</i>	<i>Ongoing and evaluated</i>	Staff, Community
Hospital as a Smoke Free Zone	<i>Silesian Rehabilitation Centre Repty, Ustron</i>	<i>Ongoing and evaluated</i>	Staff
Influence of Climate on Rehabilitation Programme	<i>Silesian Rehabilitation Centre Repty, Ustron</i>	<i>Ongoing</i>	No
Minimizing Epidemiological Dangers	<i>Silesian Rehabilitation Centre Repty, Ustron</i>	<i>Ongoing and evaluated</i>	Staff
Promotion of Culture and Coping with Stress	<i>Silesian Rehabilitation Centre Repty, Ustron</i>	<i>Ongoing and evaluated</i>	Staff, Community, Organization

Title of sub-project	<i>Hospital</i>	<i>Status</i>	other areas addressed
Admission Unit – Reception of Patients in the Hospital	<i>St. Bernward Hospital, Hildesheim</i>	<i>Finished and evaluated</i>	Staff, Organization
Health Consulting – Promoting Health by Information, Consultation and Environmental Changes	<i>St. Bernward Hospital, Hildesheim</i>	<i>Ongoing and evaluated</i>	Staff, Community
Health-Oriented Quality Management in the Operating Theatre	<i>St. Bernward Hospital, Hildesheim</i>	<i>Ongoing and evaluated</i>	Staff, Organization
Doctor-patient-Seminars and Seminars for patients and Other Persons	<i>St. Irmingard Hospital, Prien/Chiemsee</i>	<i>Ongoing</i>	Community
Early Integration of Cancer Patients	<i>St. Irmingard Hospital, Prien/Chiemsee</i>	<i>Ongoing and evaluated</i>	Community
Effective Communication Strategies for the Patient-Doctor-Relationship	<i>St. Irmingard Hospital, Prien/Chiemsee</i>	<i>Cancelled</i>	Community, Organization
Energy Pollution Commission	<i>St. Irmingard Hospital, Prien/Chiemsee</i>	<i>Ongoing</i>	Staff, Organization
Improvement of Healthy Food and Prudent Diet for Patients and Staff Members	<i>St. Irmingard Hospital, Prien/Chiemsee</i>	<i>Finished</i>	Staff
Initiative to Improve Public Acceptance of Psychosomatic Disorders	<i>St. Irmingard Hospital, Prien/Chiemsee</i>	<i>Ongoing</i>	No
More Colours and Flowers in the Hospital	<i>St. Irmingard Hospital, Prien/Chiemsee</i>	<i>Finished</i>	Staff
Self-Management Training for Patients with Hypertensive or Metabolic Disorder	<i>St. Irmingard Hospital, Prien/Chiemsee</i>	<i>Ongoing</i>	Community
Self-Measurement of Blood-Clotting-Time	<i>St. Irmingard Hospital, Prien/Chiemsee</i>	<i>Ongoing and evaluated</i>	Community
Seminars for Trainers for Out-Patients with Cardiovascular Diseases	<i>St. Irmingard Hospital, Prien/Chiemsee</i>	<i>Ongoing</i>	Community
Cardiac Rehabilitation	<i>Stobhill General Hospital, Glasgow</i>	<i>Ongoing and evaluated</i>	Community
Food & Health	<i>Stobhill General Hospital, Glasgow</i>	<i>Ongoing and evaluated</i>	Staff, Community
Health Promotion Co-ordinator	<i>Stobhill General Hospital, Glasgow</i>	<i>Finished and evaluated</i>	Staff, Organization
Minimal Intervention	<i>Stobhill General Hospital, Glasgow</i>	<i>Ongoing and evaluated</i>	Organization
Smoking Cessation	<i>Stobhill General Hospital, Glasgow</i>	<i>Ongoing and evaluated</i>	Staff, Community
A Total Quality Care Project	<i>University Hospital, Linköping</i>	<i>Ongoing and evaluated</i>	Staff, Organization

Title of sub-project	<i>Hospital</i>	<i>Status</i>	other areas addressed
Care for Patients with Alcohol Problems Identified in Emergency Ward	<i>University Hospital, Linköping</i>	<i>Cancelled</i>	No
Hospital Accident Analysis in the Prevention of Accidents	<i>University Hospital, Linköping</i>	<i>Ongoing and evaluated</i>	Community
Swedish Health Care and the Meeting with Refugees	<i>University Hospital, Linköping</i>	<i>Ongoing</i>	No
Tobacco and the Smoke-Free Hospital	<i>University Hospital, Linköping</i>	<i>Finished</i>	Staff, Community
Improving the Life Conditions of Elderly People at Vaugirard Hospital, Paris	<i>Vaugirard Hospital, Paris,</i>	<i>Finished and evaluated</i>	No
Prescription Guidelines for the Residents	<i>Vaugirard Hospital, Paris</i>	<i>Ongoing</i>	Organization
Prevention of Hospital Related Diseases	<i>Vaugirard Hospital, Paris</i>	<i>Ongoing</i>	Organization
Promotion of Geriatric Care for Nurses	<i>Vaugirard Hospital, Paris</i>	<i>Ongoing</i>	Organization
Early Discharge of Puerpera and New Born	<i>Vittore Buzzi Hospital, Milan</i>	<i>Finished and evaluated</i>	Organization
Family Risk of Premature Atherosclerosis	<i>Vittore Buzzi Hospital, Milan</i>	<i>Cancelled</i>	No
Post-Menopausal Osteoporosis	<i>Vittore Buzzi Hospital, Milan</i>	<i>Finished and evaluated</i>	No
Psychological Impact of Hospitalization on Children	<i>Vittore Buzzi Hospital, Milan</i>	<i>Ongoing and evaluated</i>	Organization

2. Projects addressing the health of staff

Title of sub-project	<i>Hospital</i>	<i>Status</i>	other areas addressed
Care	<i>Alten Eichen Hospital, Hamburg</i>	<i>Finished and evaluated</i>	Patients, Organization
Environmental and Health Protection	<i>Alten Eichen Hospital, Hamburg</i>	<i>Finished and evaluated</i>	No
Health Promotion for Staff and Patients	<i>Alten Eichen Hospital, Hamburg</i>	<i>Finished and evaluated</i>	Patients
Improvement of Working Conditions	<i>Alten Eichen Hospital, Hamburg</i>	<i>Finished and evaluated</i>	Organization
Nutrition	<i>Alten Eichen Hospital, Hamburg</i>	<i>Finished and evaluated</i>	Patients

Title of sub-project	<i>Hospital</i>	<i>Status</i>	other areas addressed
Accident at Work	<i>Altnagelvin Area Hospital, Londonderry</i>	<i>Ongoing and evaluated</i>	Patients, Community
Alcohol Project	<i>Altnagelvin Area Hospital, Londonderry</i>	<i>Ongoing and evaluated</i>	Patients, Community
Promoting Health through Nutrition	<i>Altnagelvin Area Hospital, Londonderry</i>	<i>Ongoing and evaluated</i>	Patients, Community
Smoking and Health Policy	<i>Altnagelvin Area Hospital, Londonderry</i>	<i>Ongoing and evaluated</i>	Patients, Community
Control of Hospital Acquired Infections	<i>Areteion Hospital, Athens</i>	<i>Ongoing</i>	Patients, Community
Hygiene and Safety in the Hospital	<i>Areteion Hospital, Athens</i>	<i>Ongoing</i>	Patients, Community
Study of Health Level in the Hospital Community	<i>Areteion Hospital, Athens</i>	<i>Cancelled</i>	No
Nutrition and Health	<i>Child Health Centre, Warsaw</i>	<i>Finished and evaluated</i>	Patients, Community
Prevention of Hepatitis B among High Risk Hospital Staff Groups in CHC	<i>Child Health Centre, Warsaw</i>	<i>Finished and evaluated</i>	Patients
The Child Health Centre, Warsaw – A Non-Smoking Environment	<i>Child Health Centre, Warsaw</i>	<i>Finished and evaluated</i>	Patients, Community
Conceptual Framework for Establishing a Complex Quality Management Concept	<i>Hospital of the City of Chemnitz</i>		Patients
Health Promotion for Staff on Workplace	<i>Hospital of the City of Chemnitz</i>		Organization
Ergonomic Approach to the Reduction of the Physical Load of some Nurses (Care of the Elderly)	<i>James Connolly Memorial Hospital, Dublin</i>	<i>Finished and evaluated</i>	Organization
Smoke-Free Hospital Policy Project	<i>James Connolly Memorial Hospital, Dublin</i>	<i>Ongoing and evaluated</i>	Patients, Community, Organization
Staff Basic Life Support (BLS) Training Project	<i>James Connolly Memorial Hospital, Dublin</i>	<i>Ongoing and evaluated</i>	Patients, Organization
Stop Smoking Support Project	<i>James Connolly Memorial Hospital, Dublin</i>	<i>Ongoing and evaluated</i>	Patients, Organization
Waste Disposal and Human Health Project	<i>James Connolly Memorial Hospital, Dublin</i>	<i>Ongoing and evaluated</i>	Community, Organization
General Hygienic Program	<i>Koranyi Institute, Budapest</i>	<i>Ongoing and evaluated</i>	Patients, Community
Healthy Nutrition	<i>Koranyi Institute, Budapest</i>	<i>Ongoing and evaluated</i>	Patients

Title of sub-project	<i>Hospital</i>	<i>Status</i>	other areas addressed
Individual Health Protection of Staff	<i>Koranyi Institute, Budapest</i>	<i>Ongoing and evaluated</i>	Patients
A Smoke Free Hospital	<i>Padova Teaching Hospital</i>		Patients, Organization
Nutrition and Health	<i>Padova Teaching Hospital</i>		Patients, Organisation
Occupational Risk for Health Workers	<i>Padova Teaching Hospital</i>		Organization
Ergonomic Realisation of Computer Workplaces	<i>Philipps Hospital, Riedstadt</i>	<i>Finished and evaluated</i>	Organization
Family Centered Working Hours for Employees with Families	<i>Philipps Hospital, Riedstadt</i>	<i>Cancelled</i>	Organization
Socialwork Counselling of the Staff	<i>Philipps Hospital, Riedstadt</i>	<i>Finished and evaluated</i>	No
Staff-Training to Create a Low Expressed Emotion Atmosphere within the Wards	<i>Philipps Hospital, Riedstadt</i>	<i>Cancelled</i>	Patients
Team Supervision	<i>Philipps Hospital, Riedstadt</i>	<i>Ongoing and evaluated</i>	Organization
Theatrework in Psychiatric Health Care	<i>Philipps Hospital, Riedstadt</i>	<i>Ongoing</i>	Patients
Llanelli Manual Handling Project	<i>Prince Philipp Hospital, Llanelli</i>	<i>Ongoing and evaluated</i>	Patients, Organization
Food and Health	<i>Royal Preston Hospital</i>	<i>Ongoing</i>	Patients, Organization
Health at Work	<i>Royal Preston Hospital</i>	<i>Ongoing</i>	Community, Organization
Health Promoting Hospital in the Community	<i>Royal Preston Hospital</i>	<i>Ongoing</i>	Patients, Community, Organization
The Storage, Collection, Transport and Disposal of Domestic and Clinic Waste	<i>Royal Preston Hospital</i>	<i>Ongoing</i>	Patients, Community, Organization
Health at the Workplace	<i>Rudolfsstiftung Hospital, Vienna</i>	<i>Finished and evaluated</i>	No
Healthy Food in the Hospital	<i>Rudolfsstiftung Hospital, Vienna</i>	<i>Finished and evaluated</i>	Patients
Nursing	<i>Rudolfsstiftung Hospital, Vienna</i>	<i>Finished and evaluated</i>	Patients, Organization
Patient-oriented Team Nursing	<i>Rudolfsstiftung Hospital, Vienna</i>	<i>Ongoing and evaluated</i>	Patients, Organization

Title of sub-project	<i>Hospital</i>	<i>Status</i>	other areas addressed
Reorganization of a Ward	<i>Rudolfsstiftung Hospital, Vienna</i>	<i>Finished and evaluated</i>	Patients, Organization
Activities for the Staff	<i>Silesian Rehabilitation Centre Repty, Ustron</i>	<i>Cancelled</i>	No
Ergonomic and Aesthetic Workplace	<i>Silesian Rehabilitation Centre Repty, Ustron</i>	<i>Ongoing and evaluated</i>	Organization
Healthy Food	<i>Silesian Rehabilitation Centre Repty, Ustron</i>	<i>Ongoing and evaluated</i>	Patients, Community
Hospital as a Smoke Free Zone	<i>Silesian Rehabilitation Centre Repty, Ustron</i>	<i>Ongoing and evaluated</i>	Patients
Minimizing Epidemiological Dangers	<i>Silesian Rehabilitation Centre Repty, Ustron</i>	<i>Ongoing and evaluated</i>	Patients
Personnel Health Check Up	<i>Silesian Rehabilitation Centre Repty, Ustron</i>	<i>Ongoing</i>	No
Promotion of Culture and Coping with Stress	<i>Silesian Rehabilitation Centre Repty, Ustron</i>	<i>Ongoing and evaluated</i>	Patients, Community, Organization
Separation and Utilization of Waste	<i>Silesian Rehabilitation Centre Repty, Ustron</i>	<i>Ongoing</i>	Community, Organization
Admission Unit – Reception of Patients in the Hospital	<i>St. Bernward Hospital, Hildesheim</i>	<i>Finished and evaluated</i>	Patients, Organization
Development of a Health-Promoting EDP-Infrastructure	<i>St. Bernward Hospital, Hildesheim</i>	<i>Ongoing and evaluated</i>	Organization
Health Consulting – Promoting Health by Information, Consultation and Environmental Changes	<i>St. Bernward Hospital, Hildesheim</i>	<i>Ongoing and evaluated</i>	Patients, Community
Health-Oriented Quality Management in the Operating Theatre	<i>St. Bernward Hospital, Hildesheim</i>	<i>Ongoing and evaluated</i>	Patients, Organization
Energy Pollution Commission	<i>St. Irmingard Hospital, Prien/Chiemsee</i>	<i>Ongoing</i>	Patients, Organization
Improvement of Healthy Food and Prudent Diet for Patients and Staff Members	<i>St. Irmingard Hospital, Prien/Chiemsee</i>	<i>Finished</i>	Patients
More Colours and Flowers in the Hospital	<i>St. Irmingard Hospital, Prien/Chiemsee</i>	<i>Finished</i>	Patients
Food & Health	<i>Stobhill General Hospital, Glasgow</i>	<i>Ongoing and evaluated</i>	Patients, Community
Health Promotion Co-ordinator	<i>Stobhill General Hospital, Glasgow</i>	<i>Finished and evaluated</i>	Patients, Organization
Smoking Cessation	<i>Stobhill General Hospital, Glasgow</i>	<i>Ongoing and evaluated</i>	Patients, Community

Title of sub-project	<i>Hospital</i>	<i>Status</i>	other areas addressed
A Total Quality Care Project	<i>University Hospital, Linköping</i>	<i>Ongoing and evaluated</i>	Patients, Organization
Early Active Rehabilitation in the University Hospital, Linköping Personnel	<i>University Hospital, Linköping</i>	<i>Finished and evaluated</i>	No
Psychological and Social Support to Patients, Relatives and Staff Suffering from Crisis	<i>University Hospital, Linköping</i>	<i>Ongoing</i>	Community
Tobacco and the Smoke-Free Hospital	<i>University Hospital, Linköping</i>	<i>Finished</i>	Patients, Community
Improving the Work Conditions of the Staff in this Geriatric Hospital through Training Sessions	<i>Vaugirard Hospital, Paris</i>	<i>Ongoing</i>	Organization
Prevention of Burns in the Hospital Kitchen	<i>Vaugirard Hospital, Paris</i>	<i>Ongoing and evaluated</i>	No
Surveillance of Operating Theatre Staff	<i>Vittore Buzzi Hospital, Milan</i>	<i>Finished and evaluated</i>	No
Survey on Relationships in Hospital	<i>Vittore Buzzi Hospital, Milan</i>	<i>Ongoing and evaluated</i>	Organization

3. Projects addressing the health of the community

Title of sub-project	<i>Hospital</i>	<i>Status</i>	other areas addressed
Accident at Work	<i>Altnagelvin Area Hospital, Londonderry</i>	<i>Ongoing and evaluated</i>	Patients, Staff
Alcohol Project	<i>Altnagelvin Area Hospital, Londonderry</i>	<i>Ongoing and evaluated</i>	Patients, Staff
Breast Feeding Promotion	<i>Altnagelvin Area Hospital, Londonderry</i>	<i>Ongoing and evaluated</i>	Patients
Cardio-Pulmonary Resuscitation Training Programme	<i>Altnagelvin Area Hospital, Londonderry</i>	<i>Ongoing and evaluated</i>	Patients
Childrens Education Programme	<i>Altnagelvin Area Hospital, Londonderry</i>	<i>Ongoing</i>	No
Promoting Health through Nutrition	<i>Altnagelvin Area Hospital, Londonderry</i>	<i>Ongoing and evaluated</i>	Patients, Staff
Smoking and Health Policy	<i>Altnagelvin Area Hospital, Londonderry</i>	<i>Ongoing and evaluated</i>	Patients, Staff
Control of Hospital Acquired Infections	<i>Areteion Hospital, Athens</i>	<i>Ongoing</i>	Patients, Staff

Title of sub-project	<i>Hospital</i>	<i>Status</i>	other areas addressed
Early Diagnosis of Neonatal Hearing Loss and Prevention of Mutism	<i>Areteion Hospital, Athens</i>	<i>Ongoing</i>	Patients
Health Education Program for the Training of Young Mothers on Issues of Perinatal Care and Breastfeeding	<i>Areteion Hospital, Athens</i>	<i>Ongoing</i>	Patients
Hygiene and Safety in the Hospital	<i>Areteion Hospital, Athens</i>	<i>Ongoing</i>	Patients, Staff
Rational Use of Antibiotics through the Link to a National Database	<i>Areteion Hospital, Athens</i>	<i>Cancelled</i>	Patients
Nutrition and Health	<i>Child Health Centre, Warsaw</i>	<i>Finished and evaluated</i>	Patients, Staff
Oral Health in Chronically Ill Children	<i>Child Health Centre, Warsaw</i>	<i>Ongoing</i>	Patients, Organization
The Child Health Centre, Warsaw – A Nonsmoking Environment	<i>Child Health Centre, Warsaw</i>	<i>Finished and evaluated</i>	Patients, Staff
Efforts Directed at Ensuring that Hospital Will Enjoy an Ever Greater Acceptance among the Children and Youth of the Catchment Area	<i>Hospital of the City of Chemnitz</i>		Organization
Public Relations Work for Health Education	<i>Hospital of the City of Chemnitz</i>		No
Smoke-Free Hospital Policy Project	<i>James Connolly Memorial Hospital, Dublin</i>	<i>Ongoing and evaluated</i>	Patients, Staff, Organization
Waste Disposal and Human Health Project	<i>James Connolly Memorial Hospital, Dublin</i>	<i>Ongoing and evaluated</i>	Staff, Organization
General Hygienic Program	<i>Koranyi Institute, Budapest</i>	<i>Ongoing and evaluated</i>	Patients, Staff
Patient Education Program	<i>Koranyi Institute, Budapest</i>	<i>Ongoing and evaluated</i>	Patients
Changing Demand of an Ageing Population	<i>Padova Teaching Hospital</i>		Patients
Active Health Behaviour/Health Promotion at the Workplace	<i>Philipps Hospital, Riedstadt</i>	<i>Ongoing and evaluated</i>	Staff
Medical Emergency Service Cooperating with the Hospital	<i>Philipps Hospital, Riedstadt</i>	<i>Ongoing</i>	Patients, Organization
Diabetic Education	<i>Prince Philipp Hospital, Llanelli</i>	<i>Ongoing and evaluated</i>	Patients
Exercise and Stress Management on Prescription	<i>Prince Philipp Hospital, Llanelli</i>	<i>Ongoing and evaluated</i>	No
Healthy Choice Eating on a Low Income	<i>Prince Philipp Hospital, Llanelli</i>	<i>Ongoing and evaluated</i>	No

Title of sub-project	<i>Hospital</i>	<i>Status</i>	other areas addressed
'Talkwize' – A Young People's Information Service	<i>Royal Preston Hospital</i>	<i>Ongoing</i>	Patients, Organization
Health at Work	<i>Royal Preston Hospital</i>	<i>Ongoing</i>	Staff, Organization
Health Promoting Hospital in the Community	<i>Royal Preston Hospital</i>	<i>Ongoing</i>	Patients, Staff, Organization
Management of Post-Coronary Patients	<i>Royal Preston Hospital</i>	<i>Ongoing</i>	Patients, Organization
Prevention of Accidents through Self Care	<i>Royal Preston Hospital</i>	<i>Ongoing</i>	Patients, Organization
The Storage, Collection, Transport and Disposal of Domestic and Clinic Waste	<i>Royal Preston Hospital</i>	<i>Ongoing</i>	Patients, Staff, Organization
The Out-Patient Clinic as Interface between In- and Outpatient Care	<i>Rudolfsstiftung Hospital, Vienna</i>	<i>Finished and evaluated</i>	Patients, Organization
Health School	<i>Silesian Rehabilitation Centre Repty, Ustron</i>	<i>Ongoing and evaluated</i>	Patients, Organization
Healthy Food	<i>Silesian Rehabilitation Centre Repty, Ustron</i>	<i>Ongoing and evaluated</i>	Patients, Staff
Promotion of Culture and Coping with Stress	<i>Silesian Rehabilitation Centre Repty, Ustron</i>	<i>Ongoing and evaluated</i>	Patients, Staff, Organization
Separation and Utilization of Waste	<i>Silesian Rehabilitation Centre Repty, Ustron</i>	<i>Ongoing</i>	Staff, Organization
Health Consulting – Promoting Health by Information, Consultation and Environmental Changes	<i>St. Bernward Hospital, Hildesheim</i>	<i>Ongoing and evaluated</i>	Patients, Staff
Doctor-patient-Seminars and Seminars for patients and Other Persons	<i>St. Irmingard Hospital, Prien/Chiemsee</i>	<i>Ongoing</i>	Patients
Early Integration of Cancer Patients	<i>St. Irmingard Hospital, Prien/Chiemsee</i>	<i>Ongoing and evaluated</i>	Patients
Effective Communication Strategies for the Patient-Doctor-Relationship	<i>St. Irmingard Hospital, Prien/Chiemsee</i>	<i>Cancelled</i>	Patients, Organization
Self-Management Training for Patients with Hypertensive or Metabolic Disorder	<i>St. Irmingard Hospital, Prien/Chiemsee</i>	<i>Ongoing</i>	Patients
Self-Measurment of Blood-Clotting-Time	<i>St. Irmingard Hospital, Prien/Chiemsee</i>	<i>Ongoing and evaluated</i>	Patients
Seminars for Trainers for Out-Patients with Cardiovascular Diseases	<i>St. Irmingard Hospital, Prien/Chiemsee</i>	<i>Ongoing</i>	Patients
Cardiac Rehabilitation	<i>Stobhill General Hospital, Glasgow</i>	<i>Ongoing and evaluated</i>	Patients

Title of sub-project	<i>Hospital</i>	<i>Status</i>	other areas addressed
Food & Health	<i>Stobhill General Hospital, Glasgow</i>	<i>Ongoing and evaluated</i>	Patients, Staff
Smoking Cessation	<i>Stobhill General Hospital, Glasgow</i>	<i>Ongoing and evaluated</i>	Patients, Staff
Environment Protection and Pollution Control	<i>University Hospital, Linköping</i>	<i>Ongoing and evaluated</i>	No
Hospital Accident Analysis in the Prevention of Accidents	<i>University Hospital, Linköping</i>	<i>Ongoing and evaluated</i>	Patients
Nutrition. Shopping for a Better Life	<i>University Hospital, Linköping</i>	<i>Finished and evaluated</i>	No
Psychological and Social Support to Patients, Relatives and Staff Suffering from Crisis	<i>University Hospital, Linköping</i>	<i>Ongoing</i>	Staff
The Östergölland Osteoporosis Prevention Project	<i>University Hospital, Linköping</i>	<i>Ongoing and evaluated</i>	No
Tobacco and the Smoke-Free Hospital	<i>University Hospital, Linköping</i>	<i>Finished</i>	Patients, Staff
The Gerontology Network between Vaugirard Hospital, Paris and the 15th District of Paris	<i>Vaugirard Hospital, Paris</i>	<i>Finished and evaluated</i>	Organization

4. Projects addressing the health of the organisation (in a metaphorical sense)

Title of sub-project	<i>Hospital</i>	<i>Status</i>	other areas addressed
Care	<i>Alten Eichen Hospital, Hamburg</i>	<i>Finished and evaluated</i>	Patients, Staff
Improvement of Working Conditions	<i>Alten Eichen Hospital, Hamburg</i>	<i>Finished and evaluated</i>	Staff
Development of a Quality Control Program in the Surgical Department	<i>Areteion Hospital, Athens</i>	<i>Ongoing</i>	No
Oral Health in Chronically Ill Children	<i>Child Health Centre, Warsaw</i>	<i>Ongoing</i>	Patients, Community
Efforts Directed at Ensuring that Hospital Will Enjoy an Ever Greater Acceptance among the Children and Youth of the Catchment Area	<i>Hospital of the City of Chemnitz</i>		Community
Health Promotion for Staff at the Workplace	<i>Hospital of the City of Chemnitz</i>		Staff

Title of sub-project	<i>Hospital</i>	<i>Status</i>	other areas addressed
Ways and Means for Putting Care in the Chemnitz Municipal Hospital on a Professional Basis	<i>Hospital of the City of Chemnitz</i>		Patients
Cardiac Rehabilitation Link Programme	<i>James Connolly Memorial Hospital, Dublin</i>	<i>Ongoing and evaluated</i>	Patients
Continenence Standard Implementation Project	<i>James Connolly Memorial Hospital, Dublin</i>	<i>Ongoing and evaluated</i>	Patients
Ergonomic Approach to the Reduction of the Physical Load of some Nurses (Care of the Elderly)	<i>James Connolly Memorial Hospital, Dublin</i>	<i>Finished and evaluated</i>	Staff
Reduction of Hospitalization as a Patient Stressor	<i>James Connolly Memorial Hospital, Dublin</i>	<i>Finished and evaluated</i>	Patients
Smoke-Free Hospital Policy Project	<i>James Connolly Memorial Hospital, Dublin</i>	<i>Ongoing and evaluated</i>	Patients, Staff, Community
Staff Basic Life Support (BLS) Training Project	<i>James Connolly Memorial Hospital, Dublin</i>	<i>Ongoing and evaluated</i>	Patients, Staff
Stop Smoking Support Project	<i>James Connolly Memorial Hospital, Dublin</i>	<i>Ongoing and evaluated</i>	Patients, Staff
Waste Disposal and Human Health Project	<i>James Connolly Memorial Hospital, Dublin</i>	<i>Ongoing and evaluated</i>	Staff, Community
Postgraduate Training of Nurses	<i>Koranyi Institute, Budapest</i>	<i>Ongoing and evaluated</i>	Patients
A Smoke Free Hospital	<i>Padova Teaching Hospital</i>		Patients, Staff
Nutrition and Health	<i>Padova Teaching Hospital</i>		Patients, Staff
Occupational Risk for Health Workers	<i>Padova Teaching Hospital</i>		Staff
Counselling Centre for Patients who are Foreign Citizens	<i>Philipps Hospital, Riedstadt</i>	<i>Ongoing and evaluated</i>	Patients
Environmental Movement in the Hospital	<i>Philipps Hospital, Riedstadt</i>	<i>Cancelled</i>	No
Ergonomic Realisation of Computer Workplaces	<i>Philipps Hospital, Riedstadt</i>	<i>Finished and evaluated</i>	Staff
Family Centered Working Hours for Employees with Families	<i>Philipps Hospital, Riedstadt</i>	<i>Cancelled</i>	Staff
Implementation of an Intensive Rehabilitation Unit	<i>Philipps Hospital, Riedstadt</i>	<i>Cancelled</i>	Patients
Medical Emergency Service Cooperating with the Hospital	<i>Philipps Hospital, Riedstadt</i>	<i>Ongoing</i>	Patients, Community
Networking of a Hospital Ward with Out-Patient Services	<i>Philipps Hospital, Riedstadt</i>	<i>Finished and evaluated</i>	Patients

Title of sub-project	<i>Hospital</i>	<i>Status</i>	other areas addressed
Psychoeducational Groups for Psychotic Patients and their Relatives	<i>Philipps Hospital, Riedstadt</i>	<i>Ongoing and evaluated</i>	Patients
Team Supervision	<i>Philipps Hospital, Riedstadt</i>	<i>Ongoing and evaluated</i>	Staff
Llanelli Manual Handling Project	<i>Prince Philipp Hospital, Llanelli</i>	<i>Ongoing and evaluated</i>	Patients, Staff
'Talkwize' – A Young People's Information Service	<i>Royal Preston Hospital</i>	<i>Ongoing</i>	Patients, Community
Food and Health	<i>Royal Preston Hospital</i>	<i>Ongoing</i>	Patients, Staff
Health at Work	<i>Royal Preston Hospital</i>	<i>Ongoing</i>	Staff, Community
Health Promoting Hospital in the Community	<i>Royal Preston Hospital</i>	<i>Ongoing</i>	Patients, Staff, Community
Management of Post-Coronary Patients	<i>Royal Preston Hospital</i>	<i>Ongoing</i>	Patients, Community
Prevention of Accidents through Self Care	<i>Royal Preston Hospital</i>	<i>Ongoing</i>	Patients, Community
The Storage, Collection, Transport and Disposal of Domestic and Clinic Waste	<i>Royal Preston Hospital</i>	<i>Ongoing</i>	Patients, Staff, Community
Cooperation between Central and Clinical Departments	<i>Rudolfsstiftung Hospital, Vienna</i>	<i>Ongoing and evaluated</i>	Patients
Mission Statement Rudolfstiftung	<i>Rudolfsstiftung Hospital, Vienna</i>	<i>Ongoing</i>	No
Nursing	<i>Rudolfsstiftung Hospital, Vienna</i>	<i>Finished and evaluated</i>	Patients, Staff
Organization of Hospital Hygiene	<i>Rudolfsstiftung Hospital, Vienna</i>	<i>Finished and evaluated</i>	Patients
Patient-oriented Team Nursing	<i>Rudolfsstiftung Hospital, Vienna</i>	<i>Ongoing and evaluated</i>	Patients, Staff
Reorganization of a Ward	<i>Rudolfsstiftung Hospital, Vienna</i>	<i>Finished and evaluated</i>	Patients, Staff
The Out-Patient Clinic as Interface between In- and Out-Patient Care	<i>Rudolfsstiftung Hospital, Vienna</i>	<i>Finished and evaluated</i>	Patients, Community
Ergonomic and Aesthetic Workplace	<i>Silesian Rehabilitation Centre Repty, Ustron</i>	<i>Ongoing and evaluated</i>	Staff
Health School	<i>Silesian Rehabilitation Centre Repty, Ustron</i>	<i>Ongoing and evaluated</i>	Patients, Community
Promotion of Culture and Coping with Stress	<i>Silesian Rehabilitation Centre Repty, Ustron</i>	<i>Ongoing and evaluated</i>	Patients, Staff, Community

Title of sub-project	<i>Hospital</i>	<i>Status</i>	other areas addressed
Separation and Utilization of Waste	<i>Silesian Rehabilitation Centre Repty, Ustron</i>	<i>Ongoing</i>	Staff, Community
Admission Unit – Reception of Patients in the Hospital	<i>St. Bernward Hospital, Hildesheim</i>	<i>Finished and evaluated</i>	Patients, Staff
Development of a Health-Promoting EDP-Infrastructure	<i>St. Bernward Hospital, Hildesheim</i>	<i>Ongoing and evaluated</i>	Staff
Health-Oriented Quality Management in the Operating Theatre	<i>St. Bernward Hospital, Hildesheim</i>	<i>Ongoing and evaluated</i>	Patients, Staff
Interdisciplinary Co-operation within and among Wards and Departements	<i>St. Bernward Hospital, Hildesheim</i>	<i>Ongoing and evaluated</i>	No
The St. Bernward Hospital, Hildesheim as ‘Learning Organization’ (Planned Nov. 96)	<i>St. Bernward Hospital, Hildesheim</i>		No
Effective Communication Strategies for the Patient-Doctor-Relationship	<i>St. Irmingard Hospital, Prien/Chiemsee</i>	<i>Cancelled</i>	Patients, Community
Energy Pollution Commission	<i>St. Irmingard Hospital, Prien/Chiemsee</i>	<i>Ongoing</i>	Patients, Staff
TQM – Total Quality Management	<i>St. Irmingard Hospital, Prien/Chiemsee</i>	<i>Ongoing and evaluated</i>	No
Health Promotion Co-ordinator	<i>Stobhill General Hospital, Glasgow</i>	<i>Finished and evaluated</i>	Patients, Staff
Minimal Intervention	<i>Stobhill General Hospital, Glasgow</i>	<i>Ongoing and evaluated</i>	Patients
A Total Quality Care Project	<i>University Hospital, Linköping</i>	<i>Ongoing and evaluated</i>	Patients, Staff
Management towards a Decentralised and Outcome Oriented Responsibility	<i>University Hospital, Linköping</i>	<i>Ongoing</i>	No
Improving the Work Conditions of the Staff in this Geriatric Hospital through Training Sessions	<i>Vaugirard Hospital, Paris</i>	<i>Ongoing</i>	Staff
Information of the Professionals of the District	<i>Vaugirard Hospital, Paris</i>	<i>Finished and evaluated</i>	No
Prescription Guidelines for the Residents	<i>Vaugirard Hospital, Paris</i>	<i>Ongoing</i>	Patients
Prevention of Hospital Related Diseases	<i>Vaugirard Hospital, Paris</i>	<i>Ongoing</i>	Patients
Promote the Role of Volunteers’ Associations in Vaugirard Hospital, Paris	<i>Vaugirard Hospital, Paris</i>	<i>Ongoing and evaluated</i>	No
Promotion of Geriatric Care for Nurses	<i>Vaugirard Hospital, Paris</i>	<i>Ongoing</i>	Patients

Title of sub-project	<i>Hospital</i>	<i>Status</i>	other areas addressed
The Gerontology Network between Vaugirard Hospital, Paris and the 15th District of Paris	<i>Vaugirard Hospital, Paris</i>	<i>Finished and evaluated</i>	Community
Early Discharge of Puerpera and New Born	<i>Vittore Buzzi Hospital, Milan</i>	<i>Finished and evaluated</i>	Patients
Psychological Impact of Hospitalization on Children	<i>Vittore Buzzi Hospital, Milan</i>	<i>Ongoing and evaluated</i>	Patients
Survey on Relationships in Hospital	<i>Vittore Buzzi Hospital, Milan</i>	<i>Ongoing and evaluated</i>	Staff

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European Pilot Hospital Project

October 1993

"Aims and Strategies,
Functions and
Responsibilities of the
Partners of the European
Pilot Hospital Project"

Agreement

Coordinating
Centre and
Secretariate:



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1. Aims and Strategies

The European Pilot Hospital Project is an international Project designated to support the development of Pilot Hospitals for Health Promoting Hospitals as Models of Good Practice, following the concepts for Health Promoting Hospitals developed in the «Budapest Declaration on Health Promoting Hospitals».

The European Pilot Hospital Project will assist the participating Pilot Hospitals in developing towards Health Promoting Organizations for patients, personell and the community.

2. Partners of the Project:

The Partners named below agree to collaborate in the »European Pilot Hospital Project« of »Health Promoting Hospitals - an International Network« and to run this project for a first period between 1993 and 1996.

1.1 Pilot Hospitals of Health Promoting Hospitals (PHOs)

- Alten Eichen Diakonie Hospital, Hamburg, Germany
- Altnagelvin Area Hospital, Londonderry, Northern Ireland, United Kingdom
- Areteion Hospital, Athens, Greece
- Vittore Buzzi Hospital, Milano, Italy
- Chemnitz Municipal Hospital, Chemnitz/Saxony, Germany
- Child's Health Centre, Warsaw, Poland
- James Connolly Memorial Hospital, Dublin, Republic of Ireland
- Emergency Care Hospital, Praha, Czech Republic
- Koranyi Institute, Budapest, Hungary
- Linköping University Hospital, Linköping, Sweden
- Padova University Hospital, Padova, Italy
- Philippshospital, Riedstadt/Hessen, Germany
- Prince Philip Hospital, Llanelli, Wales, Great Britain

- «Repty» - Silesian Rehabilitation Centre Annex Ustron, Ustron, Poland
- Royal Preston & Sharoe Green Hospital, Preston, England, Great Britain
- Rudolfstiftung Hospital of the City of Vienna, Vienna, Austria
- St. Bernward Hospital, Hildesheim, Germany
- St. Irmingard Hospital, Prien/Chiemsee, Germany
- Stobhill General Hospital, Glasgow, Scotland, Great Britain
- Hôpital Vaugirard, Paris, France

1.2 WHO Regional Office for Europe (WHO-EURO)

- Department Health Services
- Department Lifestyles and Health

1.3 Coordinating Centre: Ludwig Boltzmann Institute for the Sociology of Health and Medicine, Vienna (CC)

3. Responsibilities of the Partners in the European Pilot Hospital Project

To reach the aims of this joint project, the partners agree to fulfill the following functions and take the following responsibilities.

3.1 Functions and Responsibilities of the Pilot Hospitals participating in the European Pilot Hospital Project

Following the document «Criteria for participating as a Pilot Hospital in Health Promoting Hospitals» of the «Budapest Declaration on Health Promoting Hospitals», the Pilot Hospitals declare

- to develop a Local «Health Promoting Hospital Project»
- to support the European Pilot Hospital Project
- to support the Wider Network of Health Promoting Hospitals (HPH-Network) in the ways specified below.

A. Responsibilities concerning the development of Local «Health Promoting Hospitals» Projects (this is referred to as «Local Project» in the following formulations).

3.1.1 The Pilot Hospitals accept the principles declared in the «Ottawa Charter on Health Promotion» and the specifications of the document «Content and Aims for Health Promoting Hospitals» of the «Budapest Declaration on Health Promoting Hospitals» as basis of their Local Project.

3.1.2 The Pilot Hospital declare, that their Local Project and their participation in the European Pilot Hospital Project is approved by the owner, management and personnel of the hospital.

3.1.3 The Pilot hospitals declare that they are cooperating with a specific independent institution named to WHO-EURO and the Coordinating Centre in relation to planning, consultation, documentation, monitoring and evaluation of their Local Project, or that such a cooperation is at least initiated.

Changes of the external institution will have to be agreed with WHO and the Coordinating Centre and made known to the partners of the European Pilot Hospital Project.

3.1.4 The Pilot Hospitals declare that an appropriate organizational structure and process for their Local Project has been established or is in the process of being established, using the techniques of project management to realise the aims of the Health Promoting Hospital.

3.1.5 The Pilot Hospitals declare that a Joint Project Committee (with representatives from the Pilot Hospital itself and institutions of research and/or consultation) for their Local Project has been established and a project manager been nominated.

3.1.6 The Pilot Hospitals declare that the necessary personnel and financial resources for their Local Project

and for the participation in the European Pilot Hospital Project will be provided or the provision of these resources has been initiated.

3.1.7 The Pilot Hospitals declare that at least five innovative health promoting projects related to the hospital, the people who work within it, and the population served have been started and will be further developed in their Local Project. To run less than five projects will have to be agreed with WHO and the Coordinating Centre and made known to the Partners of the European Pilot Hospital Project.

3.1.8 The Pilot Hospitals declare that public discussion of health promotion issues and possible health promoting activities within the hospital will be encouraged by the internal newsletter of the Local Project (the hospital may use also any other appropriate means) and by regular public presentations within the hospital.

3.1.9 The Pilot Hospitals declare that the necessary steps for an annual evaluation of their Local Project have been taken, in order to guide further action and to be able to act as a model for other European Hospitals.

3.1.10 The Pilot Hospitals declare that evaluation information on their Local Project will be regularly available to the Joint Project Committee, the management and the personell in the Hospital. Evaluation Information will also regularly be given to the hospital owners, to those organizations which provide the funding of the HPH-project, and to the wider public. Evaluation information will also be communicated to WHO-EURO and the Coordinating Centre. The Pilot Hospitals will also be ready to welcome referees for an annual (peer) review of the project as means for mutual learning (possibly in conjunction with the annual public presentation of the Local Project).

3.1.11. The Pilot Hospitals declare their willingness to link their Health Promoting Hospital projects with congruent local health promotion pro-

grammes, especially those within the Healthy Cities Network.

3.1.12 The Pilot Hospitals declare that they intend to conduct their HPH-Projects for a period of at least 5 years.

B. Responsibilities towards the European Pilot Hospital Project and the HPH-Network

3.1.13 The Pilot Hospitals also declare their willingness to support the European Pilot Hospital Project and the HPH-Network by reporting on their Local Project in the following forms:

- a. Send two delegates to each of the 8 Business Meetings planned for 1993 - 1996.
- b. Send at least one delegate to the annual International Health Promoting Hospitals Conference, taking place in conjunction with one of the two annual Business Meetings of the Pilot Hospital Project.
- c. Write short reports/ prepare posters and handouts for each Business Meeting.
- d. Report on important developments of their Local Project at the Business Meetings or in the Circular Letter of the European Pilot Hospital Project (twice a year).
- e. Regularly forward evaluation information to WHO-EURO and the Coordinating Centre and welcome referees for an annual (peer) review of the project (cf. 3.1.10).
- f. Write a contribution for the HPH-Newsletter on the aims and the design of their Local Project and give short information on important steps in the newsletter.
- g. Prepare the text of a detailed description of their project for the publication series «Working Papers of Health Promoting Hospitals - Pilot Hospitals».
- h. Prepare a case presentation (Goals, Strategies, Steps, Results) for a review book on the European Pilot Hospital Project to be published in the end of 1996 .

3.1.14 The Pilot Hospitals declare their willingness to support the European Pilot Hospital Project by making

the following contributions:

- a. Support the organization of one of the eight Business Meeting of the European Pilot Hospital Project planned till 1996 by acting as Local Host or offering organizational and financial support to Pilot Hospitals acting as Local Host. The suggestions for Local Hosts are specified in the guidelines issued by WHO-EURO and the Coordinating Centre. Offering free accomodation and board to the Participants of the Business Meeting will be very welcome.
 - b. Support the organization of one of the four International Conferences of Health Promoting Hospitals planned till 1996 (organized in conjunction with one of the two Business Meetings of the European Pilot Hospital Project) by acting as Local Host or offering organizational and financial support to Pilot Hospitals acting as Local Host. The suggestions for Local Hosts are specified in the guidelines issued by WHO-EURO and the Coordinating Centre.
 - c. Assist the Coordinating Centre in the fundraising for the coordination of the European Pilot Hospital Project (Secretariate, HPH-Newsletter, HPH-Publications, organization of Business Meetings; travel expenses for peer reviews).
 - d. Be prepared to share necessary functions at the business meetings (chairing, reporting, ...) and support the Coordinating Centre by editing single issues of the Circular Letter of the European Pilot Hospital Project.
 - e. Receive visitors from other Pilot Hospitals and present their HPH-Project (excluding responsibility for costs of travel or accomodation).
 - f. Support other Pilot Hospitals: This support will depend on the resources available and can range from advice in areas of expertise to models of continuous support (e.g. «twinning»).
- 3.1.15 The Pilot Hospitals declare their willingness to support Health Promoting Hospitals by also receiving visitors from the wider Network (excluding responsibility for costs of travel or accomodation).

3.1.16 The Pilot Hospitals declare

European Pilot Hospitals

- Diakonie Hospital Alten Eichen, Hamburg, Germany
- Altnagelvin Area Hospital, Londonderry, Northern Ireland, United Kingdom
- Areteion Hospital, Athens, Greece
- Vittore Buzzi Hospital, Milano, Italy
- Hospital of the City of Chemnitz, Chemnitz/Sachsen, Germany
- Child Health Centre, Warszawa, Poland
- James Connolly Memorial Hospital, Dublin, Republic of Ireland
- Emergency Care Hospital, Praha, Czech Republic
- Koranyi Institute, Budapest, Hungary
- University Hospital Linköping, Linköping, Sweden
- University Hospital Padova, Padova, Italy
- Psychiatric hospital Philippsospital, Riedstadt/Hessen, Germany
- Prince Philip Hospital, Llanelli, Wales, United Kingdom
- Silesian Rehabilitation Centre "Repty", Annex Ustron, Ustron, Poland
- Royal Preston Hospital, Preston, England, United Kingdom
- Rudolfstiftung Hospital of the City of Vienna, Wien, Austria
- St.Bernward Hospital, Hildesheim, Germany
- St.Irmingard Hospital, Prien/Chiemsee, Germany
- Stobhill General Hospital, Glasgow, Scotland, United Kingdom
- Hospital Vaugirard, Paris, France

their willingness to support National Networks of Health Promoting Hospitals.

3.1.17 The Pilot Hospitals declare their willingness to act as partners in the European Pilot Hospital Project of Health Promoting Hospitals for the initial period from 1993 to 1996. If extraordinary circumstances appear which make a further collaboration in the Pilot Hospital Project impossible, the Pilot Hospital will formally notify its partners in the project, explaining the reasons and asking to be formally released from the obligations of this agreement.

3.2 Functions and responsibilities of WHO/EURO

3.2.1 Provide political and strategic leadership and technical support for the European Pilot Hospital Project

3.2.2 Coordinate the Project jointly with the Coordinating Centre.

3.2.3 Organize in collaboration with the Coordinating Centre and the local host two Business Meetings of the European Pilot Hospital Project per year (until October 1996). One of these should take place at the same time as the Annual International Conference on Health Promoting Hospitals.

3.2.4 Organize in collaboration with the Coordinating Centre and the local host the Annual International Conferences on Health Promoting Hospitals, planned until 1996.

3.2.5 WHO/EURO will monitor progress and organize in collaboration with the Coordinating Centre regular evaluations of project development.

3.3 Functions and Responsibilities of the Coordinating Centre

3.3.1 Advise on strategies and provide technical support by coordinating the project jointly with WHO/EURO.

3.3.2 Give administrative support by being responsible for the secretariate

and a documentation centre for the European Pilot Hospital Project.

3.3.3 Raise funds for the coordination and administration of the European Pilot Hospital Project.

3.3.4 Issue an internal circular letter of the European Pilot Hospital Project in collaboration with WHO/EURO and the Pilot Hospitals.

3.3.5 Organize in collaboration with WHO/EURO and the local host two Business Meetings of the European Pilot Hospital Project per year (until October 1996). One of these should take place at the same time as the Annual International Conference on Health Promoting Hospitals.

3.3.6 Organize in collaboration with WHO and the local host the Annual International Conferences of Health Promoting Hospitals, planned until 1996.

3.3.7 Issue a series of Working Papers of Health Promoting Hospitals.

3.3.8 Prepare together with WHO/EURO by the end of 1996 a publication on the first phase of the European Pilot Hospital Project.

Signature

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„The Budapest Declaration on Health Promoting Hospitals, May 1991“

Part 1

Content and Aims for Hospitals participating in Health Promoting Hospitals – an International Network

Beyond the assurance of good quality medical services and health care, a Health Promoting Hospital should:

1. Provide opportunities throughout the hospital to develop health-orientated perspectives, objectives and structures.
2. Develop a common corporate identity within the hospital which embraces the aims of the Health Promoting Hospital.
3. Raise awareness of the impact of the environment of the hospital on the health of patients, staff and community. The physical environment of hospital buildings should support, maintain and improve the healing process.
4. Encourage an active and participatory role for patients according to their specific health potentials.
5. Encourage participatory, health-gain orientated procedures throughout the hospital.
6. Create healthy working conditions for all hospital staff.
7. Strive to make the Health Promoting Hospital a model for healthy services and workplaces.
8. Maintain and promote collaboration between community based health promotion initiatives and local governments.
9. Improve communication and collaboration with existing social and health services in the community.
10. Improve the range of support given to patients and their relatives by the hospital through community based social and health services and/or volunteer-groups and organisations.
11. Identify and acknowledge specific target groups (e.g. age, duration of illness etc.) within the hospital and their specific health needs.
12. Acknowledge differences in value sets, needs and cultural conditions for individuals and different population groups.
13. Create supportive, humane and stimulating living environments within the hospital especially for long-term and chronic patients.
14. Improve the health promoting quality and the variety of food services in hospitals for patients and personnel.
15. Enhance the provision and quality of information, communication and educational programmes and skill training for patients and relatives.
16. Enhance the provision and quality of educational programmes and skill training for staff.
17. Develop an epidemiological data base in the hospital specially related to the prevention of illness and injury and communicate this information to public policy makers and to other institutions in the community.

Part 2

Criteria for Hospitals – an International Network

Basic Recommendations

1. Acceptance of the principles declared in the «Ottawa Charter on Health Promotion».
2. Acceptance of the document «Content and Aims for Health Promoting Hospitals»

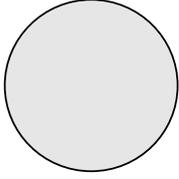
Specific Recommendations

Acceptance of the criteria of the European «Healthy Cities» project as they relate to the hospital:

1. Approval to become a Health Promoting Hospital to be sought from the owner, management and personnel of the hospital (including representatives of unions, working council). A written submission will be required.
2. Willingness to cooperate and ensure the funding of programmes with an independent institution in relation to planning, consultation, documentation, monitoring and evaluation.
3. Evaluation to be undertaken annually in order to guide future action.
4. Willingness to develop an appropriate organizational structure and process, supported by project management to realise the aims of the Health Promoting Hospital.
5. Establishment of a Joint Project Committee (with representatives from the Pilot Hospital and institutions of research and/or consultation).
6. Nomination of a project manager by the hospital, who is accountable to the Joint Project Committee.
7. Provision of necessary personnel and financial resources as agreed by the Joint Project Committee.
8. Readiness to develop at least five innovative health promoting projects related to the hospital, the people who work within it, and the population served, with goals, objectives and targets for each project. Projects should be complementary to health promotion initiatives in primary health care.
9. Public discussion of health promotion issues and possible health promoting activities within the hospital by
 - Internal Newsletter
 - Public presentations within the hospital.
10. Provision of evaluation information at least annually to
 - the Joint Project Committee
 - the management
 - the staff
 - the public and to those who provide funding
 - other organisations, both local, national and international including WHO and the Co-ordinating Centre for the Network.
11. Exchange experience by networking with:
12. – other hospitals
13. – Health Promoting Hospitals – an International Network (participation in Business Meetings etc.)

14. – National Network (group of nominated observers from different institutions with an interest in health).
15. Link the Health Promoting Hospital projects with congruent local health promotion programmes, especially those within the Healthy Cities Network.
16. Prospective running period of the model: 5 years.

This declaration has been issued at the 1st Business Meeting of the International Network of Health Promoting Hospitals.



Health Promoting Hospitals *Working for Health*



The Vienna Recommendations on Health Promoting Hospitals*)

Introduction

The new developments in the health promoting hospital (HPH) project, the changes in health policy and the health care reforms in Europe created a need to review the framework in which the project is based. The shift from the HPH pilot project (based on the framework defined in the Budapest Declaration on Health Promoting Hospitals) to a broader network supported mainly by national and regional networks and the Ljubljana Charter on Reforming Health Care provide the background for the new phase of the HPH project. The Ljubljana Charter was issued in June 1996 with the approval of the health ministers, or their representatives, of the Member States of the WHO European Region. The Charter addresses health care reforms in the specific context of Europe and is centred on the principle that health care should first and foremost lead to better health and quality of life for people.

Hospitals play a central role in the health care system. As centres that practice modern medicine, conduct research and education, and accumulate knowledge and experience, they can influence professional practice in other institutions and social groups.

Hospitals are institutions through which a large number of people pass; they can reach a large sector of the population. In some countries, up to 20% of the population come into contact with hospitals as patients every year, with an even larger number of visitors. In some cities the hospital is the largest employer; 30 000 hospitals in Europe employ 3% of the total workforce.

Hospitals can be hazardous workplaces. Hazards to health include not only exposure to various toxic or infectious chemical or physical agents but also stress arising from pressures related to the nature of the work and responsibilities involved.

Hospitals are producers of large amount of waste. They can contribute to the reduction of environmental pollution and, as consumers of large amounts of products, they can favour healthy products and environmental safety.

Traditionally, hospitals have offered a wide range of diagnostic and therapeutic services, including medical and surgical interventions, in response to acute or chronic

* The Vienna Recommendations were adopted at the 3rd Workshop of National/Regional Health Promoting Hospitals Network Coordinators, Vienna, 16. April 1997.

diseases. As a result, hospitals focus mainly on illness and curative care, not health. Today, hospitals show a growing concern for patients' lives before and after their hospital stays; they show an increasing awareness of their relationships to other parts of the health field and to the community as a whole. Although hospitals have been only marginally concerned with health promotion and disease prevention, they have an enormous potential in these fields. Realizing this potential could optimize their use of resources, directing them not only to curative care but to health in its broader sense.

The growing need and new possibilities for treatment and care on the one hand and tight public budgets on the other hand create a situation in which health care providers and hospitals in particular have to increase their efficiency in using their resources. At the same time, the development of medical and information technology opens innovative options for health care services. As a consequence, substantial changes in the hospital as an organization are on the way, as are shifts in hospitals' responsibilities within the health care sector. A clear orientation towards health gain should contribute to services that better meet the needs of clients and consumers and to the rational use of resources.

The Vienna recommendations take account of the needs of health care reforms and the need for hospitals to be more concerned with health.

The recommendations are divided into three parts:

1. fundamental principles
2. strategies for implementation
3. appendix: participation in the HPH network.

Fundamental principles

Within the framework of the health for all strategy, the Ottawa Charter for Health Promotion, the Ljubljana Charter for Reforming Health Care and the Budapest Declaration on Health Promoting Hospitals, a health promoting hospital should:

1. promote human dignity, equity and solidarity, and professional ethics, acknowledging differences in the needs, values and cultures of different population groups;
2. be oriented towards quality improvement, the wellbeing of patients, relatives and staff, protection of the environment and realization of the potential to become learning organizations;
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 to patients and their relatives, to facilitate the healing process and contribute to the empowerment of patients;
5. use resources efficiently and cost-effectively, and allocate resources on the basis of contribution to health improvement; and
6. form as close links as possible with other levels of the health care system and the community.

Principles for the creation of Health Promoting Hospitals

The HPH project provides opportunities throughout the hospital to develop health-oriented perspectives, objectives and structures. This means in particular:

1. fostering participation and creating commitment by:
 - encouraging participatory, health-gain-oriented procedures throughout the hospital, including the active involvement of all professional groups and building alliances with other professionals outside the hospital;
 - encouraging an active and participatory role for patients according to their specific health potential, fostering patients' rights, improving patients' wellbeing and creating health promoting hospital environments for patients and relatives;
 - creating healthy working conditions for all hospital staff, including the reduction of hospital hazards, as well as psychosocial risk factors;
 - enhancing the commitment of hospital management to health gain, including the principles of health in the daily decision-making processes;
2. improving communication, information and education by:
 - improving communication within and the culture of the hospital so that they contribute to the quality of life for hospital staff (communication styles used by hospital staff should encourage interprofessional cooperation and mutual acceptance);
 - improving the communication between the hospital staff and the patients so that it is guided by respect and humane values;
 - enhancing the provision and quality of information, communication and educational programmes and skill training for patients and their relatives;
 - integrating the principles of the health promoting hospital into the hospital's routine through developing a common corporate identity within the hospital;
 - improving the hospital's communication and cooperation with social and health services in the community, community-based health promotion initiatives and volunteer groups and organizations, and thus helping to optimize the links between different providers and actors in the health care sector;
 - developing information systems that measure outcomes as well as serving administrative purposes;
3. using methods and techniques from organizational development and project management:
 - to change and reorient existing hospital routines to make the hospital a learning organization;
 - to train and educate personnel in areas relevant for health promotion, such as education, communication, psychosocial skills and management;
 - to train project leaders in project management and communication skills;
4. learning from experience:
 - exchanges of experience with implementing health promoting hospitals projects at the national and international should be promoted so that participating hospitals can learn from different approaches to problem solving;
 - health promoting hospitals should commit themselves to regional, national and international exchange and communication.

Participation in the WHO Health Promoting Hospitals Network

Hospitals that want to belong to the WHO Health Promoting Hospitals Network:

1. should endorse the fundamental principles and strategies for implementation of the Vienna recommendations;
2. should belong to the national/regional network in the countries where such a network exists (hospitals in countries without such networks should apply directly to the international coordinating institution);
3. should comply with the rules and regulations established at the international and national/regional levels by the members of the international network, the World Health Organization and the international coordinating institution.

There will be three types of membership:

- members of the national/regional networks
- individual members from countries where no national/regional network exists
- members of thematic networks.



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