Newsletter

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Health Promoting Hospitals

An International Network Initiated by the WHO Regional Office for Europe

Editorial

Dear readers,

with issue 30 of the HPH Newsletter, we welcome the new WHO-Euro focal person for HPH, Dr. Maria Haralanova, and look forward to continuing the successful cooperation with WHO with her. And we thank Oliver Gröne, former WHO focal person and now director of research and education at the Avedis Donabedian Research Institute, Barcelona, for his outstanding support of the network. On the occasion of his farewell, Oliver shares his thoughts on the current state of the Network with the Newsletter readers. Oliver, we wish you a lot of success for your future endeavours!

The section on international developments contains a report on the last HPH Governance Board Meeting and a preview on the contents to be expected at the HPH conference 2008 in lively and dynamic Berlin (May 14-16), as well as an invitation to the WHO Summer School and HPH Newcomers' Workshop 2008. The continuously updated conference program can be viewed at http://www.univie.ac.at/hph/berlin2008. A lot of exciting abstracts have already been submitted, so we expect a most interesting event and hope to see many of you in Berlin! The section on networks, task forces and member hospitals features nine contributions, spanning the globe from Taiwan, where a new network emerged in 2006, over Europe (contributions from Denmark, Northern Ireland, Poland, Switzerland, Tuscany / Italy, and the UK) to Canada. And the "thematic issues" section provides you with first thoughts of the HPH working group on patient safety, which is currently working on a position paper to be proposed to the HPH Network.

Finally, we would like to inform you that, as of issue #31, the Newsletter will change its form of appearance. Issues will be shorter, but will appear every 2 months. We are looking forward to your short contributions – please find information on how to submit at the end of this Newsletter.

With our best wishes for health and success in 2008,

Jürgen M. Pelikan, Karl Krajic, Christina Dietscher, Vienna

Introduction to the new WHO-Euro focal person for HPH Dr. Maria Borissova Haralanova

- **The new HPH contact person has a strong professional background in Public Health.**

Dr. Maria Haralanova, Regional Adviser for Public Health Services in the Division of Country Health Policies, Systems and Services in the WHO Regional Office for Europe, Copenhagen, since 2004, is the new WHO focal person for HPH. She has a strong professional background in public health issues:

Dr. Haralanova obtained a degree in Medicine (MD) at the Medical University of Sofia, Bulgaria, as well as a specialty degree in Food Safety and Nutrition and Public Health from the National Institute of Public Health of Bulgaria. Her medical specialities are Preventive Medicine and Public Health.

In her current position at WHO-Euro, and already before since 2000, she has been supporting the Stability Pact for South East Europe and the ministries of health of nine South-eastern European Member States (Albania, Bosnia and Herzegovina, Bulgaria, Croatia, Montenegro, Republic of Moldova, Romania, Serbia and The former Yugoslav Republic of Macedonia) to elaborate, implement, monitor and evaluate their public health policies and services at national level so as to improve the health system service production function in line with WHO principles.

From June 1995 to December 2000, Dr Maria Haralanova was Project Manager in the Department of

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Ludwig Boltzmann-Institute for the Sociology of Health and Medicine

WHO Collaborating Centre for Health Promotion in Hospitals and Health Care

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Environment and Health in the WHO Regional Office for Europe. In this capacity she supported the development and implementation of the National Environment and Health Action Plans in all Central and Eastern European countries and in the Newly Independent States.

Just prior to this phase, from March 1990 to June 1995, Dr. Haralanova held the position of Director-General of Public Health (and Deputy-Chief Medical Officer) at the Ministry of Health of Bulgaria. During this period she not only put forward national plans (such as the one for eradication of polio, prevention and control of iodine-deficiencies, tobacco, the introduction of a family planning programme, etc.) but also had to face the challenges of designing the reform and the future public health system of the country. During this period she was the national counter part of Bulgaria for the WHO Regional Office for Europe in areas such as environment and health, public health, food safety and nutrition.

Previously (1982-1990), she was head of the Food Safety and Nutrition Services at the Ministry of Health of Bulgaria.

The HPH network warmly welcomes Dr. Haralanova and is looking forward to good cooperation with her. A first possibility for many network members to meet her in person will be the 16th HPH Conference which will be held from May 14-16, 2008, in Berlin, Germany.

Reflections on the HPH Network by former WHO-Euro Focal Person Oliver Groene

- **On the occasion of his change of job, the Vienna WHO CC interviewed Oliver Groene (OG) about his perspectives on HPH.**

Vienna WHO-CC: If you look back on your time with the HPH Network: How did you perceive HPH when you started to get involved? And in which direction has the network developed in the meantime?

OG: My first exposure to the HPH network was in 1998 when I did an internship at WHO in Copenhagen, although it was not before early 2001 that I really got involved. At that time – I had just joined the WHO Office in Barcelona – Mila Garcia-Barbero asked me to contribute to the organisation of the coordinators' workshop that was held at the international conference in Copenhagen. One thing that I remembered from previous workshops was that for various reasons there was a long list of presentations on each network's successes and failures and it was difficult to address the real issues that were common to many networks. It also struck me that there was little involvement of the networks in shaping the agenda and little continuity between annual meetings. Since then, the network has grown and matured significantly and there are now systems in place to address these weaknesses. I think that the network is more democratic than before, has more efficient governing systems and, with the constitution, has laid the basis for further development.

Vienna WHO-CC: If you consider your own aims and goals concerning HPH: What has worked well? Where do you personally see your greatest successes? And what remains open?

OG: One of the issues that I considered very important for the HPH network was to contribute to generating evidence on health promotion strategies and to consult the existing evidence base when developing new strategies. Throughout the years I have seen many presentations on projects that reflected enormous personal involvement and vision but may have lacked methodological rigour. I think the work on the standards for health promotion initiated by the Danish network worked well to address this issue: Standards need to be based on evidence and can be used as measures of progress for projects to generate new evidence on the effectiveness of the strategy applied.

However, what I consider a real success is the development of the network to the organisational structure that it has now. When we first started to present ideas for changing the structure I felt a great deal of resistance and little by little, like a virus, everyone got a bit more involved and motivated to support the change. The discussions at the last coordinators' workshop were at a completely different level than those five years ago. Some issues are still not resolved, but the prerequisites for the successful progress exist: a constitution, clear procedures, a well-performing Governance Board and Secretariat, and economic viability. In the last two years the discussions at the Governance Board and General Assembly focused on developing the constitution and on the implications and conditions of organisational change. Since most of these issues are now solved, it will be exciting to observe the strategic directions the Governance Board will suggest for research and implementation: there is huge potential for the network to facilitate change processes and contribute to research, but that will require a common focus along a few selected thematic areas of action.

Vienna WHO-CC: In general: Where do you see the strengths and weaknesses of the network?

OG: Strengths and weaknesses are closely related. The main strength of the network in my point of view is that it unites people who feel really engaged about their work. Health promotion was never a big money business and I always enjoyed having the possibility to work with people who want to make a difference. In a way, though, I feel that the network has often been ahead of time addressing issues that did not reflect the priority concerns of health care administrators. In order to be heard by hospital management and politicians, HPH have to make a business case and focus stronger on financial and economic implications of (not) engaging in it.

A weakness of the network may be its heterogeneity that hinders the

identification of a simple action plan and limits comparability of activities and results. Part of this is due to the constitution of the network involving hospitals and health services from many countries and even continents. It is also due to lack of a clear strategic plan and marketing. There has always been a clear theme for the annual international conference and this served important marketing functions. If it were possible to adjust the networks activities, let's say biannually, to a common theme, that could greatly enhance the impact of the network. A lot of the experience in the network is also not properly published in the international, peer-reviewed literature, although there are many projects that are worth publishing.

Vienna WHO-CC: What future challenges will the network have to face?

OG: I believe the most important challenge is to ensure the financial viability of the network to support its vital functions, namely administration and secretariat, organisation of international conferences and investing in strategy work and research. It is also essential to strengthen existing and develop new strategic partnerships, including the new link with WHO, but also other partners such as the European Commission, Hospital and Health Care Associations, civil society and scientific societies. Being a WHO network meant that in the past it was almost impossible to seek partnership with the health care industry. It should be carefully assessed whether the new arrangements allow a better cooperation with industry.

Vienna WHO-CC: What would you recommend to the international / to the national and regional networks in order to support positive future development?

OG: Some of the networks are doing a tremendous work that has a real impact on hospitals and health services while others, due to economic constraints or contextual factors, struggle to achieve the same. I do not see myself in the position to give recommendations, but the basic issues that I would focus on would be the following: ensure strong leadership, raise some seed funding and establish good links with health care administration.

There are many entry points to promoting health in health services according to the principles laid out in the Ottawa Charter. I would expect network coordinators to sense which partners are most supportive in a given network and which ideas are most needed and feasible. There is a rich literature on the benefits of health promotion and many people become confused by its meaning. One thing that always struck me was that the use of language in health promotion is not always compatible with the way health professionals think: why not start with activities that have a clear link to clinical processes and broaden the focus from there? Interestingly, many clinicians and hospital managers that I talked to have a great insight into health promotion strategies and are aware of the factors that limit them, but they would never have labelled their thoughts as health promotion or settings approach! I think my suggestion would be to make a clear distinction between theory and its development (which is paramount) and implementation. But then it is always easier to say so than to do so …

Vienna WHO-CC: By developing the standards for health promotion in hospitals, you have considerably contributed to better linking HPH with quality. What needs for further development do you see in this area?

OG: It is interesting to review the ideas that Avedis Donabedian already expressed in the 1980s regarding the role of the consumer (patient) in ensuring quality in health care. He discussed three different roles of consumers and patients. The first role is to contribute through setting standards, evaluating results and informing about experiences in the process of seeking and receiving care. While many health care organisations nowadays carry out surveys on patient satisfaction or experience, this information is often not used systematically to improve services and patients aren't really involved in setting the standards of care. The second role of the patient is the one of co-producer of care, going well beyond compliance: "*No one would question that the success of health care depends, in large measure, on the consumer's intelligent participation in that care*" [1]. Avedis Donabedian was well aware of the interpersonal aspects of health care quality and encouraged to rigorously compare the effectiveness of strategies to involve consumers. The third role of patients is the one of users of health care information, empowering the user to regulate the quality of care *"by choosing what care to seek, expect and accept and from whom"*. The public-disclosure debate in the current literature reflects that there is still a long way to go, given the methodological difficulties in comparing providers based on criteria relevant to users, making data easily understood, especially by those most in need. While parts of the work of Avedis Donabedian have become common knowledge among quality managers, such as the use of monitoring systems to improve quality and the structure-process-outcome approach, other thoughts have not been taken up at the same speed, such as the roles of consumers and patients and the important factor of leadership to facilitate change.

I would hope that the health promotion field interacted more closely with the quality field as there are so many commonalities and opportunities to work towards common goals. For example, some national accreditation agencies have started to adopt and incorporate the HPH standards into their national set of hospital standards. While all agree that the HPH standards do not reflect the overall philosophy of the HPH movement, their integration into accreditation systems is a major move towards requiring hospitals to improve health promotion structures and processes, for example by making available disease specific information to patients or assessing patients for certain lifestyle factors associated with the development of ill-health. A brief

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survey that we carried out in December 2006, however, showed that only a few HPH networks have institutionalised relationships with quality agencies in their country. Moreover, we asked experienced hospital surveyors working with accreditation agencies in eight European Countries whether they were aware of the HPH standards, and only a few had ever heard of them let alone were aware of their content. At hospital level, the results of the research project "Methods of Assessing Response to Quality Improvement (MARQuIS)" suggest that health promotion has not been a focus of the hospitals' quality management system either and while, for example, policies regarding patients' rights exist, there are few policies to strengthen patient involvement. Furthermore, an audit in 113 hospitals in eight EU countries showed that half of the hospitals (48.3%) report having established responsibilities for health promotion, but only in 38% of these hospitals the person in charge was aware of the HPH standards [2]. Improving the relationships with health care regulators and accreditation agencies could probably improve awareness and implementation of the standards and the whole HPH philosophy.

I also see a great potential working with performance assessment agencies, which in many countries reflect different institutions than the accreditation bodies. In an international review of hospital performance assessment projects that we recently carried out we found that the most common indicators used for performance assessment were those addressing clinical effectiveness or patient safety [3]. Some agencies include indicators on patient satisfaction or patient experience; however, indicators that address health promotion issues are rare. There is a huge potential to work with these agencies since in many countries they begin to broaden their focus by not only addressing hospital care, but also including measures of continuity of care and community health. Some agencies also include staff-health related indicators, which is usually an issue beyond the work of accreditation agencies. I believe that the HPH networks could add very valuable experience to these agencies in developing their indicator systems. Since most of these agencies operate at national or regional level, once new measures are integrated in their systems, all hospitals or other health care providers in that nation or region will be assessed against these measures. A prerequisite to integrating health promotion measures in performance assessment is the availability of validated indicators, and here I see a responsibility of the HPH network. If the international HPH network were able in its strategic plan to identify common themes and develop and validate measures that are fit for use in clinical epidemiology and quality management then I believe that would help to facilitate research and implementation. In the end, one of the key messages of the quality improvement field is that improvement is not possible without measurement, and this applies equally to the health promotion field. Monitoring and evaluation needs to become a much stronger component in the network.

I have the fear that, if the HPH network does not position itself clearly with respect to these developments, it will miss important opportunities. The patient safety movement facilitated by the WHO World Alliance on Patient Safety has become a very strong player that is influencing research and calls published by funding agencies. The patient safety movement is also broadening and now addresses much more than topics such as ventilator-associated infections and hand hygiene. For example, the BMJ Forum on Quality and Safety has a whole track at the upcoming conference dealing with patients for patient safety, including working with patients to improve quality and safety, reviewing evidence for shared decision-making and improving care for diverse patient populations [4]. The European Society for Quality in Health Care has opened an office for patient empowerment. The Joint Commission on Health Care Accreditation has published a guide on improving health literacy. The HPH network has considerable experience regarding these topics, but the quality field does not seem to be aware of it. How is the HPH network positioned to contribute to this debate? How can the HPH network add its experience to these discussions? It will be exciting to follow these developments …

Oliver Groene, former HPH focal person at WHO-Europe, and now director of research and education at the Avedis Donabedian Research Institute in Barcelona, has tremendously contributed to the development of the HPH network: By supporting strategic and conceptual developments, by issuing publications, by improving links between the quality movements and HPH, and, most recently, by empowering the network to develop independent structures.

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[2] Methods of Assessing Response to Quality Improvement (MARQUIS). www.marquis.be

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8th HPH Governance Board Meeting

- **Internationally, HPH is finalising its constitution and further developing its relationship to WHO.**

The 8th meeting of the HPH Governance Board took place on December 3 at the WHO Collaborating Centre for Evidence-Based Health Promotion in Hospitals at Bispebjerg University Hospital, Copenhagen.

The meeting was characterised by active and fruitful discussions regarding the role and strategy of the HPH Network in the future, the

collaboration with WHO, and the identification and presentation of new working areas. The Governance Board was glad to welcome Mike Sedgley, WHO Europe, representing Maria Haralanova, the new WHO-Euro contact person for HPH.

Constitution

An important area of work in 2007 was the development of a HPH constitution. In the meantime, the draft was checked by the Legal Office of WHO, and Mike Sedgley presented the related comments. A few important issues still need clarification, and the Governance Board therefore unanimously decided to postpone the approval of the HPH Constitution until the next meeting.

New HPH members 2007

In 2007, the International HPH Network increased the number of member hospitals and health services by close to 50. The International HPH Secretariat experiences a growing interest in joining the network, which is not restricted to the continent of Europe but spread across the world. In 2008 HPH new networks are expected to emerge in Canada and Spain.

New HPH Information Brochure

At the General Assembly 2007 in Vienna it was decided to work out new information material about the HPH Network. The Governance Board took on the assignment and has over the summer worked intensely to produce an updated, high-quality information brochure with the aim of internal and external distribution and HPH advocacy. The result is the HPH brochure "Integrating health promotion into hospitals and health services", which will be printed and distributed to all HPH Networks in the start of 2008. The HPH brochure will be a WHO document, and WHO will arrange for layout and print. The brochure template will be available for translation following the model of the Manual for Self-Assessment. If interested, please contact the HPH Secretariat.

New HPH Working Groups

Several areas within the scope and field of health promotion were raised and subject for discussion at the Governance Board meeting. Priorities were put to:

1. The collaboration with the European Network of Smoke-free Hospitals (ENSH). In many countries and regions, the HPH Network is already working closely with the ENSH, which has expressed interest in joining forces with the HPH Network. Ann O'Riordan, HPH chair woman, will initialise a Working Group with the aim to present a draft for Terms of References at the next Governance Board meeting and, if agreeable, propose a HPH Task Force at the General Assembly 2008.
2. New scientific journal: Hanne Tønnesen presented an initiative and action plan for the establishment of a new Medline-indexed scientific journal for the publication of evidence-based research within the field of health promotion. The technical aspects were discussed as well as the professional and financial sustainability of the initiative. The HPH Network was asked to financially support the journal in the initial phase. A working group led by Hanne Tønnesen will work out a proposal to be presented at the General Assembly 2008.

Next meeting

The Governance Board will meet again on 10 March 2008 in Copenhagen. The report on the Governance Board Meeting in December 2007 will be available for download in early 2008 at http://www.healthpromotinghospitals.org

Majbritt Linneberg, Copenhagen

16th HPH Conference: Hospitals and Health Services in the Health Society: Quo vadis, HPH?

- **Interested in the topics of the 16th HPH Conference in Berlin (May 14-16, 2008)? Find out more in this article!**

The conference will be hosted by the German HPH Network and will take place in Berlin, Germany, from May 14-16, 2008.

Why a conference on HPH in the health society?

Health has been gaining a key role in most developed countries over the last years – a phenomenon framed as the "health society" by Ilona Kickbusch, doyenne of the health promotion movement, and others. There is mounting evidence justifying such a description: Mass media coverage and communication about health have significantly risen over the past decades, covering not only medicine and health care in general, but also prevention, positive health, fitness, wellness and health promotion, allowing for a wide access to health related information. Together with the demographic and epidemiological developments towards longevity and chronic diseases, this results in an increased relevance of maintaining and improving health in daily life – which becomes visible in lifestyle and shopping choices, in the utilisation of wellness resorts and health services. The so-called first and second health markets are booming, so that health is increasingly becoming a driving force for economic growth, by some seen as the 6th Kondratieff cycle. On a political level, these developments are mirrored by the emergence of a broader approach towards health: "Health in all policies" is high on the European agenda since the Finnish EU presidency in 2006. What consequences can be expected

for hospitals and health services? On the one hand, epidemiological and demographic developments, together with medical progress, will guarantee an increasing public and political attention for treatment and care. On the other hand, the "health society" appears ambiguous: While service providers with a strong focus on client orientation and attractive services for well-off clients may easily profit, others may find themselves left in charge of dealing with the unattractive problems of the poor, the old, the severely ill, multimorbid and dying patients. The gap between the professional doability of health and the constrained public finances is widening. Consequently, questions concerning inequalities in health and the accessibility of services are gaining new momentum, leaving health care providers in the need to further develop or even reposition themselves if they want to benefit from the health society in a socially responsible way.

How can HPH react to these developments? What alternatives for development and reorientation can the movement offer to owners, management and staff of hospitals and health services, from a health promotion perspective? How can patients, patient organisations and advocates utilise the health society to push for a patient-centred health service? How can community representatives influence health service development towards health promotion, empowerment, capacity building, cultural appropriateness and equity? Which health policy frameworks are needed to support such developments? The HPH conference 2008 will discuss these questions around four topics:

- Quo vadis, HPH: Health promotion by re-orienting core business or by expanding into new services – or by both?
- Improving patient orientation: Safety, clinical evidence, cultural appropriateness
- Improving staff orientation: The challenge of an ageing workforce
- Improving community and public health orientation: Sustainability and corporate social responsibility

Quo vadis, HPH: Health promotion by reorienting core business or by expanding into new services – or by both?

Kickbusch and others argue that health services, under conditions of the health society, may find themselves increasingly competing with other players on the health market. In order to position themselves in this new arena, they may need to orient their future developments not only at traditional drivers like medical-technological change, demographic and epidemiological trends, demands for effectiveness and efficiency, but increasingly also at patients' needs and expectations for contributions to public health. How can HPH take up the challenge – and benefit from the chances – of the health society? How can hospitals and health services understand and implement Ilona Kickbusch's recommendation of a "critical role change"?

There are two basic options: Health services can either compete by integrating health promotion principles like participation, empowerment, equity, and sustainability into their clinical core services and, by that, increase the somato-psycho-social health gain of their patients, staff, and community members. This would also include controversial issues like the reduction of unnecessary services and related risks (e.g. hospitalism). The second option is to expand into new fields, thus offering additional – and potentially lucrative – health promoting clinical, information and training services to clients. The decision on which option to take up – or how to find an adequate mix – may differ between types of health service providers, health systems, countries and regions, and will depend on expectations and demands from health policy, financiers, patients, and staff. The conference will discuss the pro's and con's of the different options from a health promotion perspective, and against the background of the different conditions in the European countries.

Improving patient orientation: Safety, clinical evidence, cultural appropriateness

(Potential) patients in the health society are becoming increasingly aware of the quality and environment of service provision. They are expecting not only clinical excellence and safety, but increasingly also empowering information provision and participative involvement in treatment-related decisions. Many clients demand for individualised services and an environment that considers their personal preferences and supports their quality of life and well-being, and they expect support also for their partners and relatives. This opens a wide range of options for health promotion interventions, many of which have been touched upon in past HPH conferences. In 2008, three issues will be highlighted exemplarily:

- Interlinks of HPH with the current WHO strategy "Strengthened health systems save more lives", especially also implications for aspects of patient and clinical safety;
- Needs and options to implement evidence based health promotion interventions in clinical core processes in order to improve clinical outcomes;
- Needs and options for providing culturally appropriate services in an increasingly globalised and diverse world.

Improving staff orientation: The challenge of an ageing workforce

In the health society, the awareness for the health impact of work is rising: Demands for fair, acceptable and healthy working conditions, including chances for a better work-life balance, are getting more prominent among the workforce. Hospitals with their predominantly high-risk working places are faced with these changing expectations at a time when they are pressured for further work acceleration and rationalisation, not at least by the increasing need for care, which is due to changes in demography and

epidemiology. At the same time, the increasing attention for the negative impacts of distress in healthcare staff on the quality of care and on patient safety are further supporting the need for workplace health promotion in health care – a need that is even stronger underpinned by the increasing shortages in healthcare staff in many countries, and by the ageing of health care staff: Already now, more than twenty percent of staff are aged 50+ in some European countries. The 2008 conference will discuss the impact of the demographic developments on the health care workforce and options for adapting workplaces in health care to the needs of older staff – which is also a precondition to be able to profit from their competence and experience and to retain qualified staff.

Improving community and public health orientation: Sustainability and Corporate Social Responsibility

Discussing the impacts of the health society draws our attention not only to health as an individual and purchasable phenomenon, but also to the health impacts of societal functioning at large and the wider health determinants. From an HPH perspective, this means to interlink health promotion with other major trends like ecology and sustainability. For health services, this brings about an increased awareness of the ecological dimensions of energy consumption, emissions, waste, traffic management, purchasing goods and supplies, and the design of buildings and gardens. The conference will focus on options for the orientation of single health care organisations and the overall health sector towards sustainability, environment-friendliness and corporate social responsibility, which may also support the survival of health care organisations in an increasingly competitive health market.

Further information

All conference topics will be discussed in keynote lectures, parallel paper and poster sessions, and in selected conference workshops. For further information about the conference and a continuously updated conference program, please visit the conference web-site: http://www.univie.ac.at/hph/berlin2008

Looking forward to meeting you in Berlin!

The team of the Vienna WHO Collaborating Centre

WHO Summer School 2008

- **Benefit from the HPH Summer School 2008 prior to the Berlin HPH conference!**

The WHO Collaborating Centre for Evidence-Based Health Promotion in Hospitals (Copenhagen WHO CC) and the German Network of Health Promoting Hospitals are proud to continue the HPH tradition of organising the HPH Summer School together. In 2008 we will work to throw light on: "How to develop Best Evidence-Based Practice for Health Promotion".

Best Evidence-Based Practice

The concept of Best Evidence-Based Practice is defined as a combination of three factors: Best Evidence, Staff Competences and Patient Preferences. Only by integrating all three factors you will achieve a scientific basis, which incorporates the human aspect of both staff and patient, for developing clinical guidelines to the benefit of all. Evidence should be the spine of research also within the field of health promotion, and at the WHO Summer School evidence-based health promotion will be our main priority: How do we work with evidence, how do we develop and implement clinical guidelines and how do we share our experience and knowledge. We will have a close look at the concept of evidence, research and research methodology, and discuss how to follow up via the HPH Standards and clinical databases.

Lecturers and target group

At the WHO Summer School we will have lectures, case studies and group work in order to facilitate close collaboration and sharing of experiences among the participants. The Summer School is aimed at health professionals who work with or are interested in health promotion. They may be members of the International HPH Network, visitors of the International HPH Conference, or come from external organisations interested in the HPH Network. In 2008 the Summer School will take place in the most beautiful surroundings of the Immanuel Hospital Berlin-Wannsee, the fascinating and historic suburbs of Berlin.

A non-profit arrangement

The Summer School is a strictly non-profit arrangement. The lecturers at the WHO Summer School are highly qualified health professionals and experts of research and implementation. They all contribute to the Summer School at no cost. The WHO Collaborating Centre and the German HPH Network equally receive no overhead, and thanks to our principle of low-cost/no cost we have managed to reduce the participant fee to Euro 100.

HPH Workshop for Newcomers

In 2008 the Copenhagen WHO CC introduces a Workshop for Newcomers within the HPH Network. The aim is to introduce new members and persons who are interested in joining the HPH Network to the concept and work of HPH: What is our background and mission, how does the network function and what can we offer to member hospitals and health services? The WHO Summer School and the HPH Workshop are open for both HPH members and others interested in health promotion. For program and

registration please visit http://www.healthpromotinghospitals.org

Majbritt Linneberg, Copenhagen

Development of the HPH Network in Taiwan

- **The network which was established in 2006 has already 24 accredited members and is growing fast.**

Background

Taiwan is located at the north of the Philippines and southwest of Japan with a population of 22.8 million. The life expectancy at birth is 80.81 years for females and 74.57 for males. The national health insurance covers more than 98 percent of the population and provides reimbursement for almost all kinds of necessary health care, including preventive services and pharmaceuticals. People are free to choose their doctors and locations for health care. There are more than 500 hospitals in Taiwan. Private not-for-profit and public hospitals account for 70 percent of hospital beds. Hospitals provide not only emergency and in-patient care, but also direct outpatient care: Not less than 30 percent of ambulatory care and 43 percent of preventive services in Taiwan took place in hospitals. One half of the health insurance payment for hospitals is paid for ambulatory care. This unique role in primary care partly explains why hospitals in Taiwan, being public or private, have a tradition of community involvement and cooperation with government policies. The first movement to implement "healthy hospitals" in Taiwan by applying five strategies defined in the Ottawa Charter emerged in Taipei City's Healthy City Initiative in 2002. The current network coordinator Dr. Shu-Ti Chiou was the commissioner of the Taipei City health department at that time. She launched an accreditation for healthy hospitals with defined standards to guide effective implementation, and all the 53 hospitals in Taipei, 30 of which passed and were publicly awarded by the mayor, were site-visited.

After the SARS outbreak in 2003 which brought about a lot of reflections on the flaws of fragmented hospital services, the national accreditation standards for hospitals were remodelled around holistic care as the heart of the health system reform. Nowadays, most teaching hospitals in Taiwan include "health" or "holistic care" in their vision statement.

In 2005, Taipei Municipal Wanfang Hospital applied to become a member of the International HPH Network and became the first WHO HPH member in Taiwan. Another two hospitals soon followed, and there were more interested to join. The Taiwan Network was thus formed in 2006 under the support of the Secretariat of the International HPH Network.

The Steering Committee

The Taiwan network decided to support hospitals not only in the organisational implementation of setting-based health promotion but also in the generation of scientific evidences for effective practice. Thus the network coordinator invited HPH scholars and government officials in addition to representatives from hospitals to participate in a steering committee and thus support the operation of the network. Regarding hospital representatives, the coordinator invited the most enthusiastic superintendents from different types of hospitals to sit in. They set good examples to attract more hospitals of their types to participate. In order to become a sustainable and legitimate organisation, Taiwan Network applied to the government and established the Taiwan Society of Health Promoting Hospitals. The directory board has twenty-seven members and the supervisory board has nine members.

Taiwanese membership application procedure

If a hospital is interested in becoming a WHO HPH member hospital, it has to become an ordinary member of the Society first. The Society staff will then provide support to help the hospital perform self-assessment, and prepare for a site visit. Two experts will be sent to the applying hospital where the superintendent shall lead their HPH committee to present the results of the self-assessment and the plan of implementation, and shall show their spaces and facilities for health promotion and health education. The experts will have a discussion with the hospital committee, answer questions, and give recommendations. After passing the site visit, an ordinary member can become a WHO network member. By the end of November 2007, there were twenty-four network member hospitals and eighteen ordinary member hospitals in the Society, and more applications are coming in.

In order to continuously allow for more scholars and experienced experts to participate, there is also membership for individual persons. Currently we have forty-three individual members.

Aims and goals

The Taiwan HPH Network and Taiwan HPH Society aim at integrating the efforts of researchers, government and the healthcare system to actively support hospitals to implement HPH projects so that holistic care can be rooted in the organisation's culture, as well as to generate evidence for effective health promotion in healthcare settings, to identify best practices in different issues and themes, and to facilitate more exchange of experiences between Taiwan and the international network.

Action areas and activities

Main activities in the first year included: education and training, hospital site visits with consultation, development of implementation and

evaluation tools in Chinese, application of self-assessment standards and international interaction.

The Network has held one and supported four HPH conferences and one workshop this year. These activities have reached more than 800 participants. International experts including Oliver Groene, Jürgen M. Pelikan, Ann O'Riordan, Cordia Chu, Hanne Tønnesen and Majbritt Linneberg were invited to Taiwan, and they gave the hospitals extraordinary inspiration. A consultation team consisting of academic, public health and clinical experts was established. They did site visits and assisted hospitals in the implementation and evaluation of HPH projects. They also participated in editing the implementation manual and the collection of international HPH cases. In 2007, nine colleagues from Taiwan attended the Vienna Summer School, and eleven attended the International HPH Conference with eight presentations. The information about the 2008 Berlin conference has been circulated to members, and the network is preparing for a bigger team to attend the coming conference.

Future development

With governmental support and strong historical background, the Taiwan HPH Network has gained very positive response from the academic and medical societies and has achieved faster progress than expected. In the future, the network will establish its official website, provide more consultations and workshop activities according to members' needs, encourage long-term care facilities and primary care clinics to join in addition to hospitals, and set up theme-oriented learning groups focusing on popular topics such as tobacco-free hospitals, health promoting workplaces, holistic diabetes care, etc. The Taiwan Network looks forward to exchanging experiences and building further collaboration with the international HPH Network.

Shu-Ti Chiou, Taipei

Workplace health promotion in Changhua Christian Hospital (CHH), Taiwan

- **CCH has found workplace health promotion a cost-beneficial intervention.**

Changhua Christian Hospital (abbreviated as CCH) is a medical centre located in the middle part of Taiwan with about 4,000 employees. We highly value the well-being of employees, because it is the most important property of the organisation. In order to ensure good health status of staff, we started to implement a "workplace health promotion project" in 2004. Different professionals, including doctors, nurses, dieticians, therapists, and employee representatives, set up a multidisciplinary task force. Our targets are: physical health management, physical fitness, healthy diet, mental health management, and tobacco control. We invest around 250,000 • per year for the project to maintain / improve the staff's health. In this article, I will briefly introduce how physical health management and mental health promotion are implemented in CCH.

For physical health management, employees working in CCH are asked to receive free yearly health examinations, including a comprehensive physical examination, blood tests, urine test, stool test, chest X-ray, ECG etc., in their birthday month. For people with high risks, such as staff older than fifty years or women older than thirty-five years, specific examinations, such as colonoscopy, mammography, are arranged according to clinical practice guidelines. All results are mailed to the examinee within two weeks. With a well-designed informative system, the health managers can catch the examinee with abnormal results easily and then call them back for continuous follow-up or refer them to specialists for further treatment. Employees with abnormal examination results have the responsibility to receive follow-up periodically. By the periodical health examination, by well-designed reminder systems and through health management skills, non-symptomatic physical problems can be detected and treated early and appropriately.

For mental health management, employees are asked to complete the Brief Symptoms Rating Scale (BSRS) to evaluate their mental status when receiving their yearly health examination. The BSRS, which can be performed and scored easily, is an effective screening instrument for the identification of mental morbidity. With BSRS, we can help staff to understand their mental status, and early detect employees who are distracted by hidden mental problems. By implementing appropriate interventions early, we may prevent severe consequences. Staff with high BRBS scores are contacted by our health managers and informed about their BSRS result. They are provided with information about available counselling resources. Following, the health managers will call staff periodically to understand if they need counselling or not. If the employees are willing to receive counselling, they are referred to experts. We cooperate with the Graduate Institute of Guidance and Counselling of National Changhua University of Education, and National Chi-Nan University to provide professional counselling for our staff. The counsellor will arrange consecutive counselling to help staff to deal with their mental problems. All information of counselling is confidential.

By both physical and mental health management, we can detect the non-symptomatic physical and mental problems earlier and implement appropriate intervention as early as possible to prevent severe consequences. The staff will benefit from less suffering, and the organisation will benefit from less loss of productivity related with poor health status of employees. "Workplace Health Promotion Project in CCH" is implemented since 2004, the job

satisfaction of employees in CCH has increased from 67 percent in 2004 to 72.2 percent in 2006, and the monthly turnover rate has decreased from 1.6 percent in 2004 to 1.1 percent in 2006. Staff health promotion is thus cost-beneficial and a win-win strategy.

Yu-Wen Yang, Changhua

Recent experiences of the Polish National Network of HPH

- **There are signs for a revival of the Polish HPH Network after a time of difficulties.**

The Polish National HPH Network, established in 1992, is one of the oldest National Networks in Europe. At present, it has 148 member hospitals, and nearly thirty of them are also members of the International HPH Network. Since 2002, five regional networks are in place within the country, covering the majority of the geographical map of Poland (i.e. the central, Southern and Eastern parts). More data concerning the Polish National Network of HPH are available on the network website:
http://www.am.edu.pl/hph
Until 2003, the organisation of the annual conferences of the Network had not created any problem. Since 2003/4 the attempts to organise consecutive national conferences met some difficulties. No member hospital was willing to organise the event. Only in 2006, the Medical University Hospital Nr 4 in Lublin undertook efforts to organise the conference (the hospital had already done so some years ago), but when the date of the conference approached, representatives of only twelve hospitals applied and were ready to attend. The conference was cancelled. Nevertheless, in the meantime one new hospital after the other applied for membership, and the network grew in numbers. At this period, two regional HPH networks organised their own conferences.
All together, one might become suspicious that dividing the national network into regional networks might result in separatist tendencies. On the other hand, it must be said, that the general situation in the Polish health system during the last years was so difficult, mainly due to financial problems, which even led to strikes of doctors and nurses in 2007, that also the member hospitals and the whole network were affected.
Nevertheless, on 10th October 2007, the Medical University Hospital Nr 4 in Lublin successfully organised the 9th National HPH Conference in Kazimierz Dolny (wonderful spot near Lublin). Very interesting issues concerning health promotion in relation to various clinical health problems were discussed by more than eighty representatives of member hospitals. The sessions were entitled as follows:
Session I: Health promotion for chronic diseases: The problem of social exclusion;
Session II: Optimisation of childbirth care;
Session III: Health promotion for arterial sclerosis and its consequences;
Session IV: Prevention of neurological diseases.
During last fall, two regional networks – Mazovian (with Warsaw in the center) and Malopolska (with Cracow in the center) – organised their regional conferences too. These developments could be signals, that the critical period for the National Network is coming to an end.

Jerzy B. Karski, Warsaw

HPH networks working Together in Ireland and Northern Ireland

- **HPH fosters North/South cooperation between Ireland and Northern Ireland.**

The 4th All Ireland HPH Conference

Six years ago the Irish Health Promoting Hospitals Network and the Northern Ireland Health Promoting Hospital Network began cooperating to develop an all-island approach. The annual All Ireland conference, now in its fourth year, is used as a platform to share experiences and learning.
This year saw the all Ireland conference coming North to Armagh City hotel on October 23rd and 24th, 2007. Mr. Colm Donaghy, Chief Executive of the Southern Health and Social Care Trust, welcomed the 104 participants to Armagh and introduced the two Chief Medical Officers Dr. Jim Kiely, Department of Health and Children, and Dr Michel McBride, Department of Health, Social Services and Public Safety. Both Chief Medical Officers were very supportive of the HPH concept, of what has been achieved to date in North and South, and of the potential for the initiative to develop further across the health services.
Dr. Blake Poland, a professor in the Department of Public Health Sciences in the University of Toronto, Canada, began with two starkly different visions of what a "hospital without walls" actually is. He then contextualised the push for healthcare without walls by unpacking some of the drivers of change in this area, examining both the stated interests on the part of hospitals, funders, and the community, as well as some of the hidden interests at play. Focusing on the issue of collaboration between hospitals and communities, he drew on research in the Canadian context to establish the prevalence and nature of hospital-community collaboration, examined

how such collaborations have been experienced and understood by stakeholders, in particular identifying issues of concern, facilitating factors and barriers.

Other keynote speakers shared their experiences of working in partnership between community and hospital on employment projects and integration of partners in chronic disease management.

The facilitated networking sessions proved to be very successful in engaging participants in identifying areas of common interest and suggestions on the way forward for North / South collaboration.

The key elements of interest at the conference were the two parallel sessions in which the platform was given over to those on the ground implementing the HPH concept. There was an overwhelming agreement from the participants that this year the quality and innovation of the initiatives and their presentations were of a very high standard both orally and in posters.

The keynote presentation will be available as sound bites on the conference website:
hphconference2007.com

Northern Ireland HPH Network

The Health Promotion Agency for Northern Ireland in their roll as regional HPH Coordinating Centre produced their first progress report (which is available on WHO website) from their member hospitals.

The health system in Northern Ireland has undergone changes and has still more developments to come. The HPH network is growing and embracing the challenges that lie ahead in the changing political environment. However, this means that the membership of the network will change with some link persons leaving and a lot of new ones coming on board as individuals' roles and responsibilities change. The membership will also be embracing the community sector as our hospitals become united with community trusts and other community organisations become interested in the settings approach.

The network is excited and looks forward to the challenges ahead as Northern Ireland moves to the development of a HPH across our health service.

Barbara Porter, Belfast

The Danish HPH network closed down at the end of 2007

- **New Danish health system structures will also need a new HPH network structure in the future.**

The Network of Health Promoting Hospitals in Denmark closed down on December 31st, 2007. The Network achieved many results, but the lack of leadership backing and financing along with new legislation and restructuring of health services nevertheless led to the closing-down of the network. The present article outlines the background and considerations that led to the decision to discontinue the Network.

Lack of leadership support

The Danish HPH Network was established in March 1999 with the majority of Danish hospitals as members. The aim of the Network was to underpin the implementation and quality control of preventive medicine, health promotion and rehabilitation in and by hospitals. In the 8½ years of existence of the Network, many concrete results have been achieved.

An external evaluation of the Network in autumn 2005 documented that the Network has successfully established a large number of interest and network groups across member hospitals and with the participation of external partners (scientific societies, health authorities, patients' associations, etc.). The work in these groups has resulted in a large number of evidence-based publications containing guidelines and recommendations in support of the implementation and quality development of concrete initiatives in the field of prevention. Several of these publications have attained regional and national visibility and impact.

Furthermore, the Network has arranged implementation seminars, thematic events, and national and international conferences that addressed the need for knowledge about prevention in hospitals and among national and international actors.

The evaluation concluded that the Network's strength was its solid clinical basis and the inter-disciplinary involvement of health personnel, and that the Network contributed to the visibility and impact of prevention in hospitals.

The evaluation showed, however, that the Network had insufficient consolidation resources. The lack of leadership support for implementation structures and financing were singled out as important causes of the Network's lack of consolidation at hospital level.

Lack of financing

The Network's economy was based on membership dues (16,500 kr. [2,212 •] annually per member hospital) and on a grant of the Ministry of Health for running the Secretariat. As of January 1st, 2008, the economic support from the Ministry of Health will be discontinued. The allocation was extended twice, and was given as temporary support for the Network's secretariat function in order to allow for clarification of the Network's future role, responsibility and organisation.

A questionnaire survey to the top management of member hospitals showed that slightly less than half of the hospitals were willing to pay an increased membership contribution.

Structural reform and a new Health Act

The introduction of a new Health Act in 2005 and a structural reform that came into force on January 1st, 2007, brought about a new distribution of tasks in the field of prevention and health promotion in Denmark. The

country was divided into five new regions, which were given responsibility for hospitals and general practices. Municipalities merged into larger units and were given a far greater responsibility for health services. Among other things they now co-finance the hospitals and are responsible for establishing preventive and health-promoting offers for the general public.

The regions, in particular hospitals and general practitioners, have an obligation to offer patient-oriented prevention in cooperation with the municipalities.

The form of cooperation is to be laid down in obligatory health agreements designed to ensure quality and coherence in the cross-sector treatment of patients.

Strategic considerations

Since 2005 the Network's executive committee has carried out a strategic development initiative with a view to reorganising and adapting the Network to the new structure. It has been the committee's view that the Network's performance of tasks could only be carried out meaningfully through close cooperation with decision-makers and key actors within the framework of the new structure.

In the course of 2006 and 2007, the Network has therefore been in close dialogue with central representatives from the regions and municipalities. The aim has been to establish future cooperation in the field of prevention and among other things to explore the possibilities for the future financing and leadership basis of the Network.

In September 2007 it became apparent that it was not possible to reach agreement with the regions concerning a model that could secure future economic viability and leadership support for the Network.

Against this background the executive committee therefore proposed the abolition of the Network at a meeting of the Network's Council in November 2007. The proposal was adopted unanimously.

The need for a future network

Prevention, health promotion and rehabilitation have received a stronger focus in Denmark. The structural reform and the new Health Act have set a new and demanding agenda for patient-oriented prevention with a changed framework for and changed requirements of the hospitals' future role and responsibilities in the field of prevention. The obligatory health agreements, which bind hospitals, general practitioners and municipalities to cooperate on patient-oriented prevention and rehabilitation, have given rise to the establishment of new networks and collaborative relations among the many municipal and regional actors.

There will be a continuous need for national coordination, knowledge-sharing and the development of models in the field of patient-oriented prevention, health promotion and rehabilitation that can ensure equal access to quality and coherence in the treatment of patients throughout the new regions in Denmark. The need to maintain and further develop the results, experience and methods that have been generated via the Network will also continue to exist. The hospitals should, however, no longer form part of a special hospital network, but find their places in this new prevention landscape. A future national network for patient-oriented prevention should be rooted in a new regional context and should be organised so as to secure leadership support and coherence with the regional strategies and tasks.

Lillian Møller, Copenhagen

Take care of your health – a health promotion program for staff in Montréal

- **Research findings show that investments into workplace health promotion are cost-effective.**

As Network coordinator, the Agence de la santé et de services sociaux de Montréal (the Montreal Agency) has been implementing a three-year comprehensive worksite health promotion program called "Take care of your health", in order to support members with the accomplishment of WHO's fourth standard for health promotion in hospitals: promoting a healthy workplace.

In April 2006, the Montreal HPH network launched the three-year comprehensive worksite health promotion intervention "Take care of your health!", a program of Acti-Menu. Acti-Menu is associated with the Centre for Preventive Medicine and Physical Activity of the *Institut de cardiologie de Montréal* (Montreal Heart Institute), a HPS member since 2005, and a national leader in health promotion. The twelve Health and Social Services Centres (HSSC) were chosen for the program in response to supporting the personnel in the many transformations the health care system is undergoing.

The mission of the Acti-Menu program is to provide tools and activities to enable people to take responsibility for their physical and mental health. This program is aimed at motivating employees to take control of their health by adopting a healthier lifestyle, and in taking care of their physical an psychological health through a personalised approach. It raises awareness and provides each participant with ongoing support.

For employers, the program aims to prevent and diminish absenteeism, to increase assiduity and productivity at work, to offer management tools to

contribute and increase employee performance, to identify stress symptoms in themselves and their employees, and finally to offer employers a turnkey program.

The program consists of six modules on the following five themes: global health, stress management, heart health, healthy eating and physical activity. Each module consists of personal health checkups for every employee and for managers, and a conference on each of the themes. Follow-up phone calls are made by the professionals of Acti-Menu to help participants to establish a personalised action plan to modify their health habits. Following each module, an executive report is made to managers, including group data and recommendations on which health actions to prioritise.

A one-day workshop is especially designed for managers to address issues such as stress management and life balance.

The program had been implemented and evaluated previously with success in the private service sector. Previous implementation of the program had shown "a significant increase in the "Global health score" according to Lise Renaud (*Renaud L, Kishchuk N, M Juneau, Nigam A, Tétrault K.: Implementation and outcomes of a comprehensive worksite health promotion program. Canadian journal of public health; article accepted: File No.:06-213A*). Previous participating organisations also benefited from the program in numerous ways: better atmosphere in the workplace, lower rates of absenteeism and concrete lifestyle changes of employees.

Moreover, several studies, according to Renaud, showed that programs conducted on the worksite in accessible locations, on company time and taking employees' schedule into account, improved employee participation and have the potential of reducing morbidity and health care cost. These results where congruent with previous studies in finding significant benefits for organisations and employees from worksite health promotion.

The positive change should be understood as resulting from a comprehensive organisational health intervention, with joint and inseparable contributions made by the health promotion program and other organisational interventions designed to increase the productivity and the retention, and to improve the organisational climate.

As of November 2007, six out of twelve HSSC where participating in the program. The participation rate of employees in the program ranges from 20 percent to 50 percent, and 80 percent of management participated on average. The expected participation rate was 70 percent.

Various issues have arisen in trying to implement the same program in HSSC and hospitals, e.g. personnel replacement, 24/7 schedules, doctors' participation and flexibility of the program. The Montreal Agency has retained the services of the Université du Québec à Montréal for their services in the evaluation of the implementation and impact of a program such as Acti-menu's "Take care of your health" on the employees of the HSSC.

We are currently looking into specific issues related to the implementation of a successful program and adapting it to a health care system environment. If you have any input or experiences on how to implement a worksite health promotion program we would be glad to hear from you, in any language, to: louis_cote@ssss.gouv.qc.ca

Louis Coté, Montreal

Health Promoting Hospitals: Gyms for health improving exercises

- **From a health promotion perspective, a HPH can be regarded as a "gym for health".**

Using a metaphor, we can compare a Health Promoting Hospital to a gym with all the possibilities to develop the skills to manage and improve one's own and others' health through practical exercise.

This exercise, which aims at facilitating the physical, psychological, relational and spiritual well-being, is carried out

- in a suitable and well-equipped environment (from a cultural and practical point of view, the hospital, as a place of care, addresses both illness and health);
- with the collaboration of properly trained 'personal trainers' (the hospital has staff and useful know-how at its disposal);
- wherever possible, together with other 'athletes' (a hospital stay allows communication and sharing of one's own experience with others).

Moreover, the exercise can be

- repeated in the everyday life setting, once it has been mastered (the knowledge and skills acquired during hospital stay will be helpful in the post-hospitalisation period, too);
- transferred to other participants, so enabling them to become real 'trainers' (the knowledge and skills acquired constitute a training background, which can be made available for the community).

Within the HPH Network of Tuscany the current main exercises are related to the possibility of

- expressing one's own dignity and rights, even in critical times, such as in case of a hospital stay;
- behaving according to the principles and habits of one's own culture;

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- improving knowledge about one's own health and the health care services' action;
- acquiring skills of management and improvement of one's own state of health;
- avoiding risks for one's own and others' health.

Fabrizio Simonelli, Florence

Annual meeting of the Swiss Network of Health Promoting and Migrant-friendly Hospitals and Health Services

- **The Swiss network focuses on reimbursement and on good health care for migrants.**

The annual Network Conference was held at the Teaching Hospital (CHUV) and at the 'Policlinique médicale universitaire' (PMU) in Lausanne. This conference was marked by a presentation of a reimbursement model for health promotion services, and a presentation of quality criteria for migrant health care. The meeting finished with a strong message in favour of good health care for migrants by Pierre-Yves Maillard, health minister of canton Vaud.

A very important paper of the day was that of Dr. Hanne Tonnesen, surgeon and director of the international HPH secretary, which described a concrete and realistic model for the identification and reimbursement of health promotion services. For Dr. Tonnesen "there is no technical barrier to the implementation of codes which would allow to refund health promotion services". Such services are essential even in surgery: Research has proven that programs of alcohol and tobacco prevention and the promotion of physical activity significantly diminish the risks of complications following surgical interventions. Therefore, the time seems to have come to persuade the partners to obtain reimbursement for those health promoting- services.

Another new challenge for the network is to offer good health care for migrants. Criteria for guaranteeing qualified linguistic assistance to migrants have been established. These criteria are based on the evaluation of needs, the education of staff in diversity management, the engagement of management in a policy which ensures access to healthcare by migrants. Those criteria are a practical example of the concept "Migration and Health 2008" of the Swiss government which aims at offering equal chances to fully realise their health potential to everybody. Dr. Patrick Bodenmann, responsible for the Department of Vulnerable Populations of the Teaching Policlinic of Lausanne, emphasised the fact that in 2006 twelve percent of the admissions at PMU, which represents over 3000 consultations, were precarious migrants, e.g. asylum-seekers. The Health Minister of canton Vaud concluded the day by recognising the impact of a restrictive health policy on migrants who find themselves in an increasingly precarious situation. He therefore welcomed PMU's community engagement.

During the business meeting of the network which preceded the conference, Ruth Humbel, Swiss parliamentarian, member of the directorate of the Swiss Health Insurance Association, as elected as the new president of the Swiss network of Health Promoting Hospitals and Migrant-friendly Hospitals and Health Services. In this function, she succeeds Pierre Boillat, who was warmly thanked for five years as president which enabled the HPH network to put issues like stress at work or even smoke-free hospitals on the agenda.

Nils Undritz, Suhr
Patrick Bodenmann, Lausanne

Acute trust contribution to Health Promotion & Inequalities Conference

- **The conference was held in Manchester, England, on 26th September 2007.**

The conference was organised in response to the recognition that there needed to be a concerted effort across Greater Manchester (GM) to address population health, life expectancy and health inequalities. Public Health is routinely seen to be the business of primary care trusts and local authorities, but many hospitals are recognising the distinct role and opportunity they have to make a significant contribution to wider improved public health.

The conference aimed to develop the public health work programme and define the contributions, standards and targets to which hospitals should aspire, thereby helping hospitals deliver the national public health policy requirements such as the Healthcare Commission Public Health Standards. Presentations were delivered on national public health policy requirements for hospitals to provide health promotion and disease prevention programmes to the whole community, public health priorities in the Northwest of England, an overview of audit work and research investigating health promotion practice in hospitals across GM which highlighted that acute trusts need to make substantial progress in screening patients for lifestyle risk factors and delivering health promotion to patients to enable them to lead healthy lifestyles, details of the successful "Manchester versus Cancer" media campaign developed by Christie Hospital, one of the leading cancer centres in Europe, which encourages early presentation to health professionals when potential signs of bowel, lung and breast cancer are observed, the need to develop informative metrics for evaluating and developing public health based

interventions in secondary care for the benefit of providers and commissioners, and a discussion on what acute trusts should expect from the public health community.

There were also parallel sessions covering smoking cessation training, health trainers, health promotion interventions for coronary heart disease patients in tertiary care, hospitals' contribution to health promotion and reducing inequalities through alcohol health promotion, and what acute trusts can do to reduce child health inequalities.

Eighty delegates from the GM acute trusts' public health community attended the conference. Feedback indicated that there is a demand for developing a public health network across the Northwest to share specific examples of successful health promotion practice / interventions and provide up-to-date information on appropriate patient and staff information and referral pathways. There was also enthusiasm for joining the WHO HPH network.

The conference was organised through the Epidemiology department at Stockport NHS Foundation Trust and supported by the Supra District Clinical Audit Programme, Bury PCT and The Association of GM PCTs.

The health promotion practice within GM hospitals audit report is available to download at http://www.burypct.nhs.uk/fileadmin/user_upload/health_promotion/test_page_2/Paul/2007_Health_Promotion_Audit_Report_2007.pdf

Charlotte L Haynes, Gary A Cook, Stockport

How is patient safety linked to HPH?

- **Striving for patient safety should be a must for any HPH. But HPH has also contribution to make to the patient safety movement.**

There is strong evidence that problems with patient safety are responsible for a high number of avoidable deaths and reduced quality of life in health care settings (see e.g. Kohn et al., 2000 [2]), and accordingly, international political players like the WHO and the European Commission, and also accreditation bodies like Joint Commission International, have put the improvement of patient safety high on their agendas. Patient safety also plays an important role in the recent WHO-Euro strategy "Strengthened Health Systems Save More Lives". Sincere there are certainly considerable interlinks and overlaps with the aims and goals HPH, a HPH working group is currently developing a position paper on interlinks between HPH and patient safety [1]. This Newsletter contribution summarises some first thoughts from the working group, and feedback from readers is very welcome.

How can HPH contribute to patient safety?

HPHs aim at better health gain for patients, staff, and community members. HPH strategies (vgl. Pelikan et al. 2006 [3]) and standards (vgl. Groene et al. 2005 [4]), designed to support the attainment of this goal, seek to systematically further develop health promoting structures and processes in health care settings, as well as health promoting cooperation with other service providers and communities, and in general to reorient health services towards health promotion principles.

Following the Hippocratic Oath in the sense of doing no harm to patients, thus making hospitals as safe as possible, is certainly a basic precondition for HPHs to meet their goals. In the meantime, the patient safety movement has developed a wealth of standards, guidelines and other tools for numerous safety issues including safe medication, hospital hygiene, avoiding wrong-side surgery, prevention of accidents in the hospital etc., and it should be a matter of course for any HPH to follow these recommendations.

But the HPH movement has more means to contribute to patient safety - firstly, by promoting a more comprehensive perspective on patient safety. This concerns at least the following aspects:

- Timeline of responsibility: As research e.g. by Tonnesen et al. (2005) [5] shows, hospitals can reduce treatment-related suffering of patients by foresighted planning of elective interventions: Tonnesen was able to demonstrate that e.g. specific lifestyle changes before surgical interventions can both reduce complications after the intervention and speed of the recovery process.
- Somato-psycho-social understanding of health: From HPH's comprehensive understanding of health follow at least two consequences for patient safety: Firstly, the mental constraint of patients that is often related with the cause of a hospital stay needs to be considered, i.e. adequate psychosocial support needs to be provided (also in order to improve compliance with physical treatment).

  Secondly, from a comprehensive view on health follows the need to avoid any unnecessary treatment – i.e. any treatment that might, although probably resolving one specific health problem, lead to a reduction of the overall health status and quality of life of a patient. This perspective is e.g. promoted in the field of acute geriatrics where the maintenance of independence and the avoidance of hospitalism, as well as the avoidance of negative interactions of the many different

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drugs a multimorbid patient usually has to take, are important goals.

- Target groups**:** Hospitals are not only unsafe places for patients but also for staff. And although the relationship between staff and patient safety may need further research, it can be presumed that staff who feel that their own safety is taken seriously will also be more motivated to take care of the safety of their patients.

HPH strategies and standards will a.o. enable hospitals to address the above mentioned issues, but they also offer many potential synergies to the wider patient safety movement:

Some of the issues addressed by HPH – e.g. patient empowerment by information, education and training; continuity and cooperation between levels of care; development of the physical and cultural setting into a safe and health promoting environment; and health promotion for staff – are also touched upon by the patient safety literature and are described as important preconditions for improving patient safety. By promoting and applying the HPH strategies and strategies and standards, a health promoting hospital or health service can therefore also support the patient safety movement.

Some potential synergies between HPH strategies and standards and patient safety are outlined in the following.

The role of an overall management policy (standard 1)

The literature on patient safety stresses the need of leadership development, clear lines of responsibility and the implementation of comprehensive documentation and risk management systems as preconditions for improving patient safety. Such an approach requires, so as also HPH, professional organisational development (OD). This is why the HPH network has developed clear recommendations in this direction, ranging from including HPH into the organisation's mission statement to the implementation of a comprehensive management structure, including goals and action plans, clear lines of responsibility in all units, a specific HPH budget, a training system, and international and external communication.

Such an approach is an important precondition for success in any area that needs strategic and comprehensive work, and adequate management structures will therefore be supportive for patient safety and HPH alike.

The role of patient health literacy, empowerment and co-production of health (core strategies PAT-2 and PAT-4, standard 3)

Research findings suggest that patient health literacy and user involvement contribute tremendously to reducing the probability of medical errors and other adverse health care events. Against this background, the Joint Commission on Accreditation of Healthcare Organisations launched the campaign "Speak Up for Patient Safety" in 2001, encouraging users to identify and advocate their own needs. This corresponds fully to the HPH perception of patients as co-producers of their health (see core strategy PAT-2, "health promoting co-production of treatment and care"), from which follows the need for patient empowerment not only with regard to lifestyles, health promoting disease management and condition-specific health literacy (see standard 3, "patient information and intervention"), but also with regard to an active participation in treatment and care.

In addition to better physical safety, the active involvement of patients as co-producers may also contribute to reducing mental harm: Although hospitals represent major risks to mental health (hospital admission usually being a stressful and sometimes critical life event), this aspect has so far hardly been touched upon in the patient safety literature, most probably because mental health problems cannot easily be attributed to single causes, do usually not directly cause death, and the related suffering cannot as easily be measured as suffering related to physical impairments. Still, avoidable suicides are listed as one type of preventable errors by Kohn et al. (2000).

The role of workplace health promotion (core strategy STA-2)

The international discussion focuses strongly on technical solutions for the improvement of patient safety. Although such solutions are in principle widely available, their implementation has so far been behind expectations according to the literature (see e.g. Leape & Berwick 2005 [6]) – one reason being that changes in routines like e.g. the implementation of error monitoring are quite touchy issues, and their success depends on numerous preconditions like e.g. the work climate and culture. Especially an organisation's aptitude towards issues of trust and confidentiality will significantly influence the readiness to report adverse events or near-misses, which in turn is an important precondition for learning from mistakes and avoiding them in the future.

It may therefore be beneficial to interlink the implementation of patient safety measures with issues of workplace health promotion like supporting staff well-being and esteem. Furthermore, staff who experience safe and acceptable working conditions themselves will also be better prepared to focus on patient safety as well. Therefore, all staff related HPH strategies, but especially HPH core strategy STA 2 ("health promoting co-production of working conditions") are of high relevance to patient safety.

The role of settings development (core strategy PAT-3)

Falls and burns are one aspect mentioned in the international patient safety discussion. These can be prevented by educating and training patients, but also by improving the physical health care settings (e.g. slip-proof floors, straps). Another aspect where the physical design can contribute to patient safety is to build

safe medication storage systems, both to avoid wrong allocation of medication and to prevent patients' access to harmful substances. The related interventions are fully in line with improving HPH core strategy PAT-3 (health promoting hospital setting for patients).

The role of continuity and cooperation (core strategy COM-2, standard 5)

Although each single health care institution can tremendously contribute to patient safety within their own sphere of influence, system-wide approaches, training and cooperation between levels of care (e.g. correct communication of patient data) are crucial for safety throughout the patient pathway. HPH very much supports continuity and cooperation (see core strategy COM-2 "health promoting co-production between levels of care" and standard 5, "continuity and cooperation") and can by that also contribute to system-wide lobbying for patient safety.

Next steps

Next steps of the working group shall be the proposition of an HPH position paper on patient safety, including recommendations to network members, and suggestions on how to

References:

[1] Members of the working group: Zora Bruchacova (Slovak HPH Network), Christina Dietscher (Austrian HPH Network, woking group coordinator), Carlo Favaretti (Italian HPH Network), Oliver Gröne (WHO), Maria Hallman-Keiskoski (Finnish HPH Network), Milena Kalvachova (Czech HPH Network), Jerzy Karski (Polish HPH Network), Margareta Kristenson (Swedish HPH Network), Jürgen Pelikan (Vienna WHO CC on Health Promotion in Hospitals and Health Services), Luigi Resegotti (Piedmont HPH Network), and James Robinson (UK-Scotland)

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Christina, Dietscher (Austria)

Health Promoting Settings Network Annual Report 2007

Sefton's (UK) Health Promoting Settings Annual Report reflects the progress in health promotion and public health achieved in each of the member settings / organisations throughout the year.

This document comprises organisational contributions and activities (e.g. strategies, action plans, terms of reference, audit tools, policies, evaluations) that are provided by each member of the Health Promoting Settings Network to share with a wider scope of organisations as examples of good practices.

To find out more about the Health Promoting Settings Network, its membership or to request the report, please contact Lina Toleikyte (Health Promoting Settings Network Co-ordinator) at Sefton Primary Care Trust (United Kingdom) by Phone: +44 (0) 151 479 6550 or email Lina.Toleikyte @seftonpct.nhs.uk

Lina Toleikyte (UK)

Call for papers for Issue no. 31 of the HPH Newsletter

- **Would you like to submit contributions for HPH Newsletter no. 31? Please follow the guide-lines below. Deadline: February 29, 08**

Especially invited are contributions about

- specific local HPH projects (either for hospital patients, for hospital staff, or for the local community population);
- comprehensive HPH approaches including the development of the whole hospital organisation;
- experiences and developments of the national / regional HPH net-works;
- conceptual and methodological is-sues;
- HPH conferences and publications;
- related subjects of interest to the HPH audience.

If you wish to submit an article for issue no. 30 of the HPH Newsletter, please send us a manuscript of no more than 750 words. Please use either Times New Roman or Arial 12, double spaced, with no extra formats, and please pro-vide references in text (no footnotes!). Please include full contact address and short information about author(s) (max. 15 words).

Please send your contribution to the Ludwig Boltzmann-Institute for the Sociology of Health and Medicine, preferably as an e-mail attachment (hph.soc-gruwi@univie.ac.at), to Christina Dietscher, WHO Collabo-rating Centre for Health Promotion in Hospitals and Health Care, Rooseveltplatz 2, A-1090 Vienna, Austria.

If you have any questions about your contribution, please contact Ms. Christina Dietscher at hph.soc-gruwi @univie.ac.at

Health Promoting Hospitals

An International Network Initiated by the WHO Regional Office for Europe

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Registering for the HPH Listserver

- **You want to be regularly informed about new HPH Newsletter issues, HPH events etc.? Then register for the listserver!**

If you want to regularly receive the International HPH Newsletter and if you are interested in receiving regular information on international HPH conferences, you can register at the listserver of the WHO-Collaborating Centre in Vienna (go to http://lists.univie.ac.at/mailman/listinfo/hph-forum, and follow the instructions). For questions, please contact Ms. Gabriele Bocek (e-mail: hph.socgruwi@univie.ac.at).

Event Announcements

16th International Conference on Health Promoting Hospitals (HPH):
"Hospitals and Health Services in the Health Society: Quo vadis, HPH?"
Date**:** May 14-16, 2008
Venue**:** Berlin, Germany
Further information:
E-Mail: bruder@dngfk.de, gabriele.bocek@univie.ac.at
Phone: +43 1 4277 48282 www.univie.ac.at/hph/berlin2008

4th Annual World Health Care Congress Europe 2008
Date: March 10-12, 2008
Venue: Berlin, Germany
Further information:
http://www.worldcongress.com/events/HR08015/

8th IUHPE European Conference on Health Promotion and Health Education
"Towards the future: new frontiers for Health Promotion"
Date: 9-13 September 2008
Deadline early registration: May 30, 2008
Venue: Turin, Italy,
Further information:
http://www.hp08torino.org/

Recommended reading

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