

Health Intelligence

Research and Projects Supplement

Knowledge sharing for
brighter outcomes

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Knowledge Sharing for Brighter Outcomes

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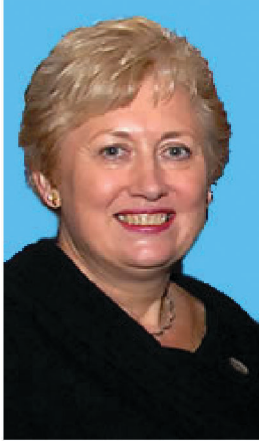
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Foreword



I am very pleased to introduce this first Health Intelligence Supplement of the National Institute of Health Sciences Bi-Annual Research Bulletin.

This supplement would not have been possible without the initiative and hard-work of my colleagues of the HSE Health Intelligence Team, our partners of the Institute, and of all those who submitted the papers – I am very grateful to them all.

Health Intelligence as a concept, a team, and an ever growing network of committed people, is nothing if not a broad church. It has been said that Health Intelligence combines evidence, experience and aspiration in planning and development, and includes:

- a wide-range of population health and health service related data and information;
- knowledge from the evidence-base of health - formal and informal; and
- the expertise and knowledge of people.

Health Intelligence encompasses then any activity aimed at enabling decision-making for policy, planning and practice development - including equipping decision-makers to apply the evidence-base of health in relation to front-line clinical services.

This supplement brings together, for the first time in Ireland, all of these strands in one document – there are over 40 papers providing a digest of knowledge generation and use right across the country.

The importance of providing this route to share this knowledge cannot be overstated – all the work to bring this supplement together is worth it because readers now and into the future will benefit as the intelligence is shared and new connections are made.

I commend the supplement to you. Further, I would be very pleased to receive your feed-back, and ideas for possible future supplements. Please contact me via info@healthintelligence.ie

Dr. Davida de la Harpe

Assistant National Director Population Health

Health Intelligence



title	Health Inequalities and Ageing in the Community: Experiences, Causes and Consequences
author	De Burca, S., Lyons, D., Humphreys, E. Health Systems Research Centre, Department of Sociology, University of Limerick

INTRODUCTION

This study is undertaken in the context of demographic trends towards an increase in the proportion of older people in the population. While still showing a younger population structure compared with the European norm, demographic projections anticipate a trend towards an ageing population in Ireland, with those aged 65 years and older expected to comprise some 15 per cent of the population by 2021 and 20 per cent by 2036. A further trend is an increase in the oldest old (aged 80 years and older). Demographic trends are linked to improved life expectancy and changes in fertility rates. The ageing of the population presents many challenges placing new demands on service provision, community, and family support structures.

RATIONALE

The rationale is rooted in the trend towards an ageing population structure in Ireland, the challenges presented by that to public policy and local communities, and as a contribution to research evidence of health inequalities linked to social status¹ (Wilkinson 1996; Marmot 2004). Recent definitions of equity in health identify it as “the absence of systematic and potentially remediable differences in one or more aspects of health between groups of people characterised socially, geographically or demographically” ² (International Society for Equity in Health) cited in Starfield (2007).

The relationships between social determinants and health outcomes are not completely understood in causal terms. Main theories proposed to explain causal relationships relevant to this research include:

- The psychosocial perspective³ (Wilkinson 1996, 2005). Increased inequality in society and worsening relative poverty affects social cohesion / social capital, leads to stress, affecting the biological pathways and producing ill-health.
- Inequalities in society and social hierarchies result in lower level of control over various aspects of one’s life for people in lower socio-economic classes⁴ (Marmot and Rose, 1981; Marmot 2004).
- Levels of social capital in society affect health outcomes, which are better where the social capital is high⁵ (Putnam 2000). The degree of income inequality in

society and contextual conditions affect the social capital^{6,7} (Kawachi and Kennedy 1997; Wilkinson 1995, 2005).

- Concentrations of affluence or poverty at neighbourhood level affect health outcomes for residents⁸ (Wilson 1987) with some evidence that poorer people benefit from sharing neighbourhoods with more affluent individuals (Hou and Myles 2005).⁹
- Access to health services can contribute to reducing inequity in health (Mackenbach 2003)¹⁰, particularly when primary care services are explicitly considered (Starfield 2007).¹¹

OBJECTIVES

The objectives are:

1. To examine the association between socio-economic status and health status amongst an older population.
2. To identify, in addition to social status, other demographic / fixed factors associated with variations in health status (e.g. gender, age).
3. To identify the relative importance of factors which moderate or mediate the relationship between socio-economic status and health status.

These include: social capital (networks of social relationships and trust), structural characteristics of neighbourhood (relative affluence / relative poverty), physical environment of neighbourhood, and quality of services. The research will aim to contribute to the research evidence on the appropriateness of existing policies to support “ageing in place” and suggest lines of action to address health inequalities for this target group.

METHODOLOGY

The methodology used in this part of the study involved a quantitative strategy based on a social survey of people aged 65 years and over. The study sites are four Limerick parishes with different structural characteristics (concentrations of high and low, and mixed socio-economic status) and profiles (traditional working class neighbourhoods, new local authority estates, newer private estates in the suburbs and affluent residential areas close to the city centre). The research also involved clinical screening of the survey participants. The social survey was based on a sample of older people in two parishes (where the elderly population is large) and total coverage in the remaining two parishes (with a smaller older population). The survey was administered based on face-to-face interviews in people’s homes. It examined the following: view of the neighbourhood including presence of key services and facilities; religiosity / practice; neighbourhood problems; quality of the area as a place to live; social capital (engagement in clubs, trust in people and trust in institutions, extent of social contact with family and friends); subjective health assessment (utilising SF36); health services utilisation and quality assessment; and socio-economic profile of respondents.

RESULTS

This paper reports the key findings of the social survey (based some 540 completed interviews and a 65% response rate) and profile of study sites based on analysis of key indicators drawn from the Small Area Population Statistics, Census of Ireland 2006.

CONCLUSIONS

The findings confirmed the relationship between social status (social class) and health status. Key findings are reported in terms of a comparative analysis of the four parishes.

Place/neighbourhood explains variations in health status (better in more affluent neighbourhoods). The findings also confirmed the association between neighbourhood and aspects of social capital including trust in people and institutions, accessibility of essential services, accessibility of community and social facilities, quality of local services, and extent of concentration of neighbourhood problems. Findings on health services utilisation suggest that apart from GPs and hospital outpatient services, rates of utilisation of services such as home help, public health nursing, day centres etc. is low amongst the older people. Uptake is concentrated amongst those who report poorer health, are older, and living in poor neighbourhoods. Quality of professional care (GP, hospital, public health nursing) however is highly rated.

REFERENCES

Available on request.

title	The Short Form 36 (SF-36) Health Survey: Utility during an Environmental Assessment Exposure Study in an Irish Rural Population
author	Garavan, C., ¹ Houghton, F. ² Department of Life Sciences, Schrödinger Building, University of Limerick ¹ Department of Humanities, Limerick Institute of Technology, Limerick ²

INTRODUCTION

The Silvermines area of North Tipperary has a long history of mining dating from the 10th century until 1994. Following the deaths of cattle in the Silvermines area from Pb toxicity in 1999, coupled with concerns of the local community regarding possible risks to human health from certain former mine sites, an inter-agency group (IAG) was formed consisting of a number of Governmental agencies and the Local Authority. Under the auspices of the IAG, a cross sectional exposure study was initiated. The human health aspect of the investigation was the responsibility of the Public Health Department of the Health Service Executive. The research project focused on the possible effects of the presence of Pb in the area on the health of the human population. This paper focuses on the utility of a general health questionnaire, the SF-36, to investigate human health in an environmental pollution incident in Ireland.

Questionnaires are an important instrument in the exposure assessment of occupational and environmental epidemiological studies. Health related quality of life (HRQOL) is related to how an individual feels and functions in their daily lives and the effects of ill health. HRQOL measurements facilitate the measurement of a population's health which cannot be measured using morbidity or mortality data.

The SF-36 instrument used in this investigation is a generic health measure derived from the longer Medical Outcome Study General Health Survey Instrument. The SF-36 has been extensively used as a generic measure of health and functional status in large population studies, as well as having been used in studies examining the health impact of environmental hazards. The SF-36 measures eight profiles of health: Physical functioning (10 items); Role limitations due to physical health (4 items); Bodily pain (2 items); General health perceptions (5 items); Vitality (4 items); Social functioning (2 items); Role limitations due to emotional problems (3 items); Mental health (5 items); General health perception (1 item).

METHODOLOGY

Data from the 1996 census was used to calculate the number of residents in the study area. This cross-sectional study was based on volunteer participation, with 278 participants aged 16-82 years old (mean age= 42.8 years, SD= 15.4) completing the SF-36 questionnaire (117 males and 161 females).

RESULTS

A set of mean scores on the eight dimensions provides a 'health profile' for the total sample. The overall mean scores obtained in each of the eight dimensions for both males and females in this rural Irish study population are presented in Table 1.

Table 1 - Overall mean scores for Males and Females on the Eight Dimensions for Study Population

SF-36 Dimension	Males (CI)	Females (CI)	Overall Mean Total Population (CI)
Physical Functioning	83.8 (78.9-88.6)	85.7 (82.3-89.1)	84.9 (82.1–87.7)
Role Limitations	84.4 (78.2-90.6)	87.1 (82.3-92.0)	86.0 (82.1–89.8)
Bodily Pain	83.3 (78.7-87.8)	82.9 (78.9-86.9)	83.0 (80.1–86.0)
General Health Perceptions	70.4 (66.0-74.8)	73.4 (69.8-77.0)	72.1 (69.3–74.9)
Vitality	67.1 (62.9-71.4)	63.9 (60.5-67.4)	65.3 (62.6–68.0)
Social Functioning	87.6 (83.2-91.9)	87.5 (84.1-90.8)	87.5 (84.8–90.1)
Role Emotional	91.6 (87.1-96.1)	90.2 (86.1-94.3)	90.8 (87.8-93.8)
Mental Health	79.3 (75.6-83.1)	77.9 (75.0-80.9)	78.5 (76.2-80.9)

Irish norms for the SF-36 are problematic. Comparison of results from the current study with published Irish population norms were not made due to the low response rate reported in the original Irish normative sample, and the possibility of conferring bias, an issue acknowledged by the authors. The results of the SF-36 from this investigation were however compared to the mean scores for the dataset obtained for the Health Interview Survey for England. Mean scores from the rural Irish male population were compared to mean scores for men obtained in Health Survey for England and were found to be similar in most domains. The rural Irish female population however, scored higher in all dimensions when compared to Health Survey for England, indicating better health.

DISCUSSION

Self reported health among residents of the former mining community, a rural Irish village, indicated that there was no evidence of harm to health from possible exposure to elevated lead levels in the area. The SF-36 item which asked respondents about the change in their health in general over the last year provided valuable information about perceived changes in health status over time. The results compared favourably to the responses in the Health Survey for England. The numbers of people who described their health as very good or good tended to decrease with age. Significant differences were found in the forty five to fifty four year age group between men and women in the four domains of Bodily Pain, Social Functioning, Vitality and Mental Health. These findings are consistent with published studies conducted elsewhere.

CONCLUSIONS

The use of the SF-36 in this study was found to be both efficient and practical in the investigation of the presence and influence of Pb in the Silvermines area of North Tipperary, providing valuable information on the self-reported health status of the population. The results observed demonstrate expected gender and age profiles which reinforce the validity of this instrument. The successful use of the SF-36 in this context is in line with the published literature where its use has previously been recommended in environmental assessment exposure studies.

REFERENCES

Available on request.

title	Urban and Rural Patterns in Adolescent Alcohol Consumption in Ireland
author	de Róiste, A., Gavin, A., Nic Gabhainn, S. Health Promotion Research Centre. NUI Galway

INTRODUCTION

Health Behaviour in School-aged Children (HBSC) is a cross-national research study conducted in collaboration with the World Health Organisation (European Office). HBSC Ireland collects data on key indicators of health, health attitudes and health behaviours, as well as the contexts of health for young people. Further information on the HBSC study can be found at www.hbsc.org.

Excessive alcohol consumption remains a substantial public health concern in Ireland. In the 2006 Irish HBSC survey, about half of students aged 15-17 reported that they were current drinkers and just over a third that they had been 'really drunk' in the last 30 days, with no gender or social class gradient. A brief analysis of the alcohol use among Irish school students aged 15-17 years across urban and rural settings is presented here.

METHODOLOGY

The HBSC study is a school-based survey with data collected from students through self-completion questionnaires in classrooms. Schools are stratified by region and randomly sampled; classrooms are subsequently randomly sampled. The methods employed comply with the International HBSC protocol and are detailed in the first national report from the 2006 survey, which can be found at www.nuigalway.ie/hbsc. The data presented here are based on the following items from the HBSC questionnaire:

- 'At what age did you first drink alcohol?'
- 'At what age did you first get drunk?'
- 'On how many occasions have you done the following things in the last 30 days:
 - 'Drank alcohol?'
 - 'Been drunk?'

Geographical location was based on adolescent self-report of whether they lived in a city, a town, a village or in the countryside. All analysis were conducted using package SPSS (12.0).

RESULTS

Overall, 75% of Irish students aged 15-17 years report ever having drunk alcohol, and 56% report ever having been really drunk. No significant gender differences were identified and the data for boys and girls are presented together here. Students who live in the countryside report being older when they have their first alcohol drink

compared to those living in the city, town or village. Those who live in the countryside are more likely to report never having had an alcoholic drink and first getting drunk at a later age compared to those living in other locations. In addition, the proportion of students who report having drunk alcohol in the last 30 days is lowest among those who live in the country. The frequency of having been drunk in the last 30 days is highest among those living in cities.

Table 1 - Students Aged 15-17 Reporting Levels of Alcohol Consumption, by Geographical Location

Alcohol consumption	City	Town	Village	Country
% first alcoholic drink at or before age 13	32	35	36	32
% first drunkenness at or before age 13	17	17	15	13
% any alcohol in the last 30 days	60	60	66	54
% alcohol 3+ times in the last 30 days	36	30	38	28
% been drunk in the last 30 days	44	49	42	32
% been drunk 3+ times in the last 30 days	20	17	18	12
<i>n</i>	<i>622</i>	<i>947</i>	<i>813</i>	<i>1451</i>

CONCLUSIONS

Although there are no gender or social class gradients in alcohol consumption among 15-17 year old students, there are significant differences in the urban and rural patterns. These differences should be considered when health promotion and public health initiatives are being developed.

FUNDING

HBSC Ireland is funded by the Department of Health and Children (the Health Promotion Policy Unit and the Office of the Minister for Children).

REFERENCES

Available on request.

PUBLISHED

This abstract is unpublished, however the substance of this abstract formed a short report, which was completed on behalf of the National Youth Council of Ireland by Aoife Gavin, Angela De Róiste and Saoirse Nic Gabhainn in 2008.

title	A Process Evaluation of the National Drug Awareness Campaign
author	Sixsmith, J., Nic Gabhainn, S., Clerkin, P., D'Eath, M., O'Higgins, S., Stevens, E., Keogh, M. Health Promotion Research Centre, National University of Ireland, Galway

INTRODUCTION

In response to the National Drugs Strategy 2001-2008 a national mass media awareness campaign was undertaken from May 2003 to December 2005 with the aim of highlighting the facts about drug misuse and increasing awareness of drugs problems. The campaign slogan was '*Drugs - there are answers*' and messages were disseminated via electronic and hard copy communication mechanisms and a community-based initiative. While the mass media have been used extensively to communicate drug misuse prevention and harm reduction messages the effect that these campaigns have on audiences has long been debated and warrants evaluation to inform future developments.

METHODOLOGY

A process evaluation was carried out to evaluate campaign development and delivery. Research objectives included: to assess the effectiveness of mass media campaigns in drugs prevention and harm reduction as reported in the literature, to make explicit the campaign development process and to determine how the aims of the campaign were interpreted and negotiated by stakeholders. A literature review was carried out and a qualitative approach to data collection undertaken with a total of 94 semi-structured interviews with key stakeholders at five points of time during campaign dissemination. Key stakeholders included representation from the National Advisory Committee on Drugs, the Drugs Strategy Unit, Health Promotion and Policy Unit, Department of Education and Science, Garda Síochána, regional drugs coordinators, HSE drugs education officers and the advertising agency involved. Documentary data was also collated and used to inform the results.

RESULTS

Criteria for campaign success identified from the literature comprised: apply and extend relevant theory, well defined target audience, message development, mix multiple media with other components, long term commitment and evaluation including formative. The National Drugs Awareness Campaign can be seen to have fallen short of these criteria that may have reduced the latent effectiveness of the campaign. The importance of planning and management emerged as paramount, with effective and timely communication mechanisms as key factors. Other areas identified by participants include the necessity for adequate funding from the outset, centrality of time-frames, time commitments, engaging with appropriate and skilled expertise and embracing the principles of participatory decision-making.

CONCLUSIONS

It would be short sighted to suggest that based on the process evaluation of this specific campaign, drug awareness mass media campaigns should not be resourced in future. Drug issues are complex and ever changing and interventions must reflect this and be founded on evidence based best practice.

SOURCE

A Process Evaluation of the National Drug Awareness Campaign, 2003-2005.
Dublin: National Advisory Committee on Drugs. 2008, 1-98.
Full report available at http://www.nacd.ie/publications/prevention_nacdevaluation.html

FUNDING

The National Advisory Committee on Drugs

REFERENCES

Available on request.

Population Health

title	Alcohol Consumption in National School Children in the Mid-West Region of Ireland, 2005
author	Houghton, F., Cowley, H., Meehan, F., Kelleher, K. Department of Public Health, Health Service Executive West, Limerick

INTRODUCTION

Studies in Ireland, the UK, and the rest of the EU, indicate levels of alcohol use among children and adolescents that are a cause of serious concern.

OBJECTIVE

In 1997, the Mid-Western Health Board undertook a baseline study to examine the prevalence of smoking, alcohol and drug use among adolescents in the region, and completed a follow-up study in 2002. In the latter study it was noted that some young people reported experimentation with these substances, while a minority of children aged 13 years and younger, reported regular use. This suggested the need for future exploration of these issues with younger children in an effort to prevent or delay initiation into these behaviours. The present study was conducted to examine the current extent of tobacco, alcohol and drug use among National School children in the Mid-West region. This paper focuses on the results concerning alcohol consumption and the availability of information about alcohol and its effects.

METHODOLOGY

Ethical approval for this study was given by the Ethics Research Committee of the Regional General Hospital, HSE-Mid Western Area. The survey instrument used in this study with children incorporated elements from previously published questionnaires. The questions concerning alcohol were drawn from the Health Behaviour in School-aged Children (HBSC) survey.

The study population was drawn from 5th and 6th class pupils attending National Schools in the Mid-West region. 50 schools were randomly selected from the 350 schools in the region. The sample was stratified into four regions, Limerick City, Limerick County, County Clare and North Tipperary, with a quarter of the schools selected from each area. 43 schools finally participated in the survey. Active parental consent was a condition of inclusion in this study. The response rate, calculated including children in the non-participating schools, was 76.2%.

1255 participants completed the confidential questionnaire. The questionnaire returned from one pupil was excluded from the analysis based on a positive response to the question on having used the fictitious drug Mexaval. Of the remaining 1254 children, 573 were males and 681 were females.

- 392 (31%) were from County Clare
- 208 (17%) were from Limerick County
- 440 (35%) were from Limerick City
- 214 (17%) were from North Tipperary

Participants ranged in age from 10-14 years of age (although only 2 were aged 14), with 47% (588) coming from 5th class and the remainder from 6th class. The mean age of the participants was 11.5 years (SD= 0.73).

RESULTS

72.8% (n=903) of pupils overall reported that they had ever tasted alcohol, even if it was only a sip. However only 10.8% (n=134) of the respondents overall reported having consumed a whole alcoholic drink. More males (64.9%, n=87) than females (35.1%, n=47) reported having ever consumed a whole alcoholic drink. Chi-square analysis revealed this gender difference in having ever consumed a whole alcoholic drink to be statistically significant ($X^2 = 21.503$, $df = 1$, $P < .0001$). Less than 1% of respondents reported weekly use of alcohol.

When asked whether they had ever had so much alcohol that they were really drunk, 94% of the children stated that they had never been drunk, with 6% overall admitting to having been drunk. Of these who reported having ever been drunk, 60% (n=45) were males and 40% (n=30) were females. Chi-square analysis revealed the gender difference in ever having been drunk to be statistically significant ($X^2 = 5.981$, $df = 1$, $P = .0145$). However, the majority 64.4% (n=57) of those children who admitted to having been drunk stated that they had only been drunk once in their lives.

Pupils were asked whether they thought their school provided them with enough information about alcohol and its effects and consequences. Overall, 27% (n=337) of the pupils thought that they were given sufficient information, 44% (n=546) felt that they needed more information (27% a little more, 17% a lot more) and nearly 17% (n=207) stated that they were given no information at all.

CONCLUSIONS

This study provided a baseline assessment of levels of alcohol use by National School children in the Mid-Western region. Although the results are encouraging and go some way to dispel anecdotal concerns, there is no room for complacency. Alcohol use and misuse is still embedded in the Irish culture and although the alcohol use rates in this survey were low, prevention or delay of initiation to alcohol use in this age group is critical. Children need to be provided with the information and decision making skills to enable them to abstain from, or delay, initiation in to alcohol use. The results from this survey should be noted by school-based health educators with regard to the mandatory inclusion of Social, Personal and Health Education (SPHE) in National Schools, particularly in relation to perceived needs for more information about alcohol use and misuse.

Two limitations of the survey should be noted. This survey focussed only on those children attending National School on the survey date and was conducted on the

basis of informed parental consent. It is possible that children from more chaotic backgrounds where alcohol misuse may be an issue were under-represented in this study. It should also be noted that “feeling drunk” is a subjective evaluation and considering the young age of the pupils in this survey, this feeling could result from a more moderate intake of alcohol than for older children. The issue was not explored in depth in this survey.

REFERENCES

Available on request.

title	"It Sort of Widens the Health Word" - Evaluation of a Health Promotion Intervention in the Youth Work Setting
author	Hodgins, M., ¹ Swinburne, L. ² Health Promotion Research Centre, NUI, Galway ¹ Department of Health Promotion, NUI Galway and National Youth Council of Ireland ²

INTRODUCTION

Defined as a place or social context in which people engage in daily activities where environmental, organisational and personal factors interact to effect health and well-being, youth organisations qualify as appropriate settings for health promotion. This study presents the results of an evaluation of the Health Quality Mark (HQM), a settings-based health promotion intervention in youth organisations facilitated by the National Youth Health Programme (NYHP).

OBJECTIVE

The aim of this study was to conduct an impact and process evaluation of the HQM focusing on impacts as perceived by stakeholders (perceived benefits and/or disadvantages of participating in the HQM) on the strengths and weaknesses of the process operated by the NYHP in implementing the HQM, and the appropriateness of the criteria in the award.

METHODOLOGY

The study sampling frame included all youth organisations that had completed the HQM either fully (16) or partially (11). Thirty seven personnel (management and Health Promotion staff) were available across 19 organisations for a semi-structured interview. Young people (9) were interviewed in a focus group setting in one organisation.

RESULTS

The perceptions of health promoters, team members and management with regard to the impact of the HQM were very positive, including both individual behaviour and organisational level changes. Those interviewed commented on the how the HQM impacted on the whole organisation, and the place of health within it. The HQM was perceived to raise awareness of health, validate and extend good practice in youth organisations and in health promotion, and to engender a sense of pride in the youth organisation. In relation to process, a number of factors emerged which contributed to the success of the HQM as a health promotion initiative. These included the structure and award-based nature of the initiative, management buy-in, the embedded training, and support from the NYHP.

CONCLUSION

The HQM is a successful settings-based health promotion intervention. The HQM initiative makes health more visible and acts as a vehicle or framework for good practice. The ideological consistency between the principles of youth work and health promotion may contribute to the success of the initiative.

FUNDING

Funded by National Youth Health Programme.



title	WHO EU Growth Surveillance Initiative - Description of Background, and Methodology
author	Heavey, P., ¹ Kelleher, C.C., ¹ McGloin, A., ¹ Hayes, C., ² O'Dwyer, U., ³ Glacken, M., ² Lynam, A., ² Reynolds, R. ⁴ University College Dublin, Belfield, Dublin 4 ¹ HSE Population Health, Dr Steeven's Hospital, Dublin 8 ² Department of Health and Children, Hawkins House, Dublin 2 ³ HSE Primary, Continuing and Community Care, Dublin Mid-Leinster ⁴

INTRODUCTION

The Nutrition and Food Security Programme of WHO/EURO is currently establishing a European childhood obesity surveillance system in some countries in the European Region in response to a recommendation from the WHO Ministerial conference on Counteracting Obesity. This has occurred in response to recognition of the need for standardized surveillance systems with a view to facilitating harmonised policy action on obesity within the European region.

OBJECTIVE

The HSE have agreed to participate in the initiative, which aims to measure routinely trends in overweight and obesity in primary school children using a standardized protocol to facilitate understanding of the progress of the epidemic in this population group and allowing inter-country comparisons within the WHO European Region. Funding has been provided for the project by the Department of Health and Children (DOHC) and Population Health HSE.

METHODOLOGY

A team of nutritionists from The National Nutrition Surveillance Centre (NNSC), at University College Dublin (UCD) are carrying out the first data collection round on behalf of the Health Service Executive (HSE). Ethical approval has been given by UCD Ethics Committee. Parents have been fully informed about the study procedures and their informed consent for the measurements obtained.

This first round commenced in April 2008 and was completed by the end of the school year. Children in one first class (aged 7-7.9 years) from a national cluster random sample of primary schools, weighted according to school size and urban / rural mix, were surveyed. Body weight, height and waist circumference were measured. Health care staff who routinely visit schools were informed of the participating schools in their areas to encourage schools to take part.

Measurements took place in 163 schools out of a recommended 180 (90.5%). Preliminary data show that 2,425 seven year olds (1,154 boys and 1,271 girls) were measured. This lies within the acceptable range of 2300-2800 recommended by WHO.

The same schools will remain the nationwide sentinel sites for the repeated measurements which will take place at two year intervals.

RESULTS

To date (26/05/2008), 148 schools have consented to participate. The principal reason for non-participation by schools is a very busy summer term schedule. The principal cause of non-participation by individuals is absenteeism from school.

Data will be analysed both at a country level with a report from the NNSC before the end of 2008 and at European level by WHO. In 2010, the first progress report on counteracting obesity will be sent to the WHO Regional Committee in which the results of the surveillance initiative will be presented.

CONCLUSIONS

The survey is in keeping with DOHC/HSE Population Health Directorates commitment to taking forward the recommendation of the National Taskforce on Obesity in setting up a national childhood database to monitor overweight and obesity.

PRESENTED

As a Paper at the *“WHO Ministerial Conference on Counteracting Obesity”* in Istanbul, Turkey from 15-17th November, 2006.

FUNDING

Funded by the Department of Health and Children, Dublin and HSE Population Health, Dublin.

title	Process Evaluation of Training in Participating Practitioners of a Motivational Interviewing (MI) Smoking Cessation Intervention in Pregnancy and Post Partum
author	Hayes, C., ¹ Gunning, M., ¹ Collins, C., ² O'Reilly, M., ² Kelleher, C.C., ³ Kearns, A., ⁴ Kelly, M.T., ⁴ Ormsby, J., ⁴ Treaner, P., ² Geary, M. ² HSE Population Health, Dr Steevens' Hospital, Dublin 8 ¹ Rotunda Hospital, Dublin 1 ² University College Dublin, Belfield, Dublin 4 ³ HSE Primary, Continuing and Community Care, HSE, Dublin North-East ⁴

INTRODUCTION

Smoking is the most important public health issue during pregnancy as it increases the risks of short term and long terms adverse pregnancy outcomes. Forty percent of women in Irish maternity hospitals smoke during pregnancy with higher rates in medical card holders. NICE guidance recommends that all smokers should be offered some form of brief intervention and advised to quit smoking.

This process evaluation of training health care professionals was carried out as part of a longitudinal study set up to determine the effectiveness of MI on smoking cessation in pregnant smoker who received the MI intervention at a number of time points during pregnancy and post-natally compared to a control group who did not receive the intervention.

METHODOLOGY

A brief postal questionnaire was drawn up for hospital-based midwives, student midwives, hospital doctors and public health nurses (PHNs) who had undergone MI training prior to implementing the intervention. A questionnaire addressing basic skills was sent to a control group of similar health professionals who did not receive the training. Pearson's χ^2 test /Fischer's exact test was used for comparative categorical variables.

RESULTS

Response rate for cases was 55% for cases (116/211) and controls (79/143). When student midwives were excluded this rose to 72% (101/141) for cases and 65% (76/117) for controls. Most practitioners undertook a condensed course rather than two full days because of shortage of time and reported learning a "moderate" amount. The trained practitioners were much more confident in the specific aspects of the programme such as being able to identify discrepancy ($\chi^2=28.5$, $df=2$, $p<0.001$). More generic skills such as reflective listening were rated comparable by cases and controls. Relatively few patients were referred to smoking cessation clinics which were located in the community and not directly accessible on the hospital site.

CONCLUSIONS

Training health professionals had a measurable effect on professional performance. Whether this translates into improved smoking cessation is awaited. The findings however illustrate the practical barriers to training in a busy maternity hospital and clinic setting, the need for future training programmes to focus on specific skills given the competing demands on practitioners' time and the need to link the training to organisational changes which facilitate the intervention.

REFERENCES

Available on request.

PRESENTED

As a poster presentation at the Faculty of Public Health Medicine, Winter Scientific Meeting in December, 2007.

As a poster presentation at the UKPHA 16th Annual Public Health Forum in Liverpool, UK in April 2008.

title	A Survey of the Prevalence, Distribution and Severity of Work-Related Musculoskeletal Symptoms in a Group of Irish Veterinary Practitioners
author	Curran, N., O'Sullivan, K. Department of Physiotherapy, University of Limerick, Limerick

INTRODUCTION

The risk of a veterinary practitioner experiencing a severe occupational accident is 9.2 times that of general practitioners. International epidemiologic studies of the profession have traditionally concentrated on acute animal-related trauma, with only a limited number including data on gradual onset or chronic work-related musculoskeletal disorders. To date there is no published information on the musculoskeletal problems (acute or chronic) of Irish veterinarians.

OBJECTIVE

The primary aim of this survey was therefore to establish baseline data on the musculoskeletal health of a sample of veterinarians employed in various settings across the country. Secondary aims were to identify whether acute or gradual onset symptoms were of most significance and to highlight potential areas for further research.

METHODOLOGY

With the cooperation of Veterinary Ireland, a self-administered questionnaire, adapted with permission from Glover *et al*, was emailed to the 926 practitioners listed on their email database (from a total of 2,376 practitioners registered within the country). The questionnaire required subjects to provide: -

1. Background personal and occupational details.
2. Information on all work-related musculoskeletal symptoms experienced over their career and in the previous 12 months.
3. More detailed information on the symptoms they considered "most significant".

In addition to simple frequency calculations, the Chi-square statistic was used to investigate the relationship between prevalence of symptoms and gender, employment setting and length of veterinary experience.

RESULTS

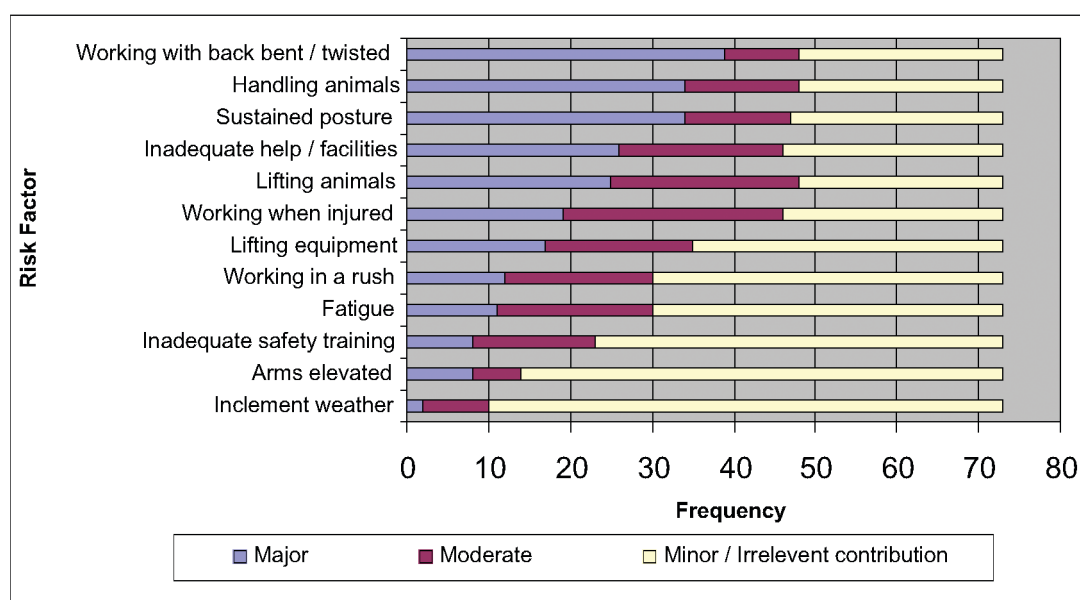
90 practitioners responded to the survey. However 1 response did not meet an acceptable level of completion, leaving 89 valid responses for analysis - a response rate of 9.6%. 59% of respondents were currently employed in private practice with the remainder in non-practice settings. Mean age of respondents was 44 years. Career and annual prevalence of work-related musculoskeletal symptoms

were 82% and 59.5% respectively. Over the course of their careers, 59.5% had sought medical care for their symptoms. 34% had taken time off and 13.5% had been hospitalised.

Low back symptoms were most prevalent (career and annual prevalence 61% and 35% respectively). 47% reported symptoms in 3 or more anatomic areas during their career. Gender or experience did not affect the likelihood of symptom report but there was a significant association between employment setting and annual symptom prevalence, with more private practice veterinarians (68%) reporting symptoms than non-practice veterinarians (44%)(Chi square with 1 degree of freedom = 4.749, $p=0.029$).

With regard to symptoms deemed most significant, gradual onset symptoms were as frequently selected (50%) as sudden onset. The most frequent age at first onset was 21-30 years (47%) and the most common area of symptoms was again the low back (56%). The occupational risk factors considered important for symptom occurrence are shown in Figure 1 below.

Figure 1 - Perceived Level of Contribution of Various Occupational Risk Factors to the Occurrence of Respondents' Most Significant Work-Related Musculoskeletal Symptoms



65% rated lifting animals as a major or moderate contributory factor to their symptoms, this figure rising to 78% of those for whom low back symptoms were most significant.

CONCLUSIONS

The prevalence of musculoskeletal work-related symptoms in this sample of veterinarians is high, but in line with that reported in farmers and dentists. Low back symptoms are most prevalent and most frequently deemed of greatest significance. The annual prevalence of low back symptoms is again similar to that reported by farmers but higher than in Irish health service workers. Unfortunately, due to small sample size, the findings of this study cannot be extrapolated to the wider Irish veterinary population. However the high prevalence of symptoms in this sample group points to the need for a larger scale study.

The frequency with which gradual onset symptoms were considered “most significant” also highlights the need for future research to adopt a broad focus by considering risk factors involved in both acute injury and gradual onset disorders. In the short term, prospective studies should target relatively inexperienced practitioners and consider a range of biomechanical, personal, psychosocial and cultural issues.

REFERENCES

Available on request.

title	Pilot Implementation of Surveillance of All-Injury Presentations to Hospital Emergency Departments
author	Meaney, S., ^{1,2} Williamson, E., ¹ Corcoran, P., ¹ Perry, I.J. ² National Suicide Research Foundation, College Road, Cork ¹ Department of Epidemiology and Public Health, University College, Cork ²

INTRODUCTION

Injury is the leading cause of death and disability in the young worldwide and in the European Union (EU). In 2007, the Council of the EU Recommendation on “Action for a safer Europe” called for a reduction of overall injury mortality in the EU of 25%, to be achieved through the implementation of National Action Plans and improved national injury surveillance.

In 2001, the Irish Department of Health and Children acknowledged injuries as a public health issue by proposing to establish a National Strategy Team to investigate the development of a National Injury Prevention Strategy.

The European All-Injury Database (IDB) is a surveillance system that monitors intentional and unintentional injuries presentations to hospital emergency departments. Funded by the European Union, it is the successor of the European Home and Leisure Accidents Surveillance System (EHLASS).

OBJECTIVE

Because of the experience gained in establishing the National Registry of Deliberate Self Harm, the National Suicide Research Foundation was invited to implement the IDB surveillance system on a pilot basis in a selection of hospitals in Ireland.

METHODOLOGY

The three Cork City hospitals with emergency departments were selected for the IDB in Ireland. The study period was from 1st of January to the 30th of June 2005. A sampling procedure was adopted whereby every eighth day during the study period was selected and data were recorded on all injury presentations to the emergency departments of the three hospitals on these days.

RESULTS

Data relating to 2,967 injury presentations were recorded. Adjusting for the sampling procedure adopted, this indicated that injury presentations accounted for 45% of all presentations to the emergency departments of the hospitals monitored. Extrapolating to the national level would indicate that 520,000 injury presentations were made to the 39 hospital emergency departments operating in Ireland in 2005.

Soft-tissue injuries (27%), fractures (20%) and open wounds (19%) were the most common types of injuries treated. Men accounted for almost two-thirds (63%) of all injury presentations whereas persons aged under 45 years accounted for three-quarters (77%) of all cases. The male rate of injury was more than double the female rate in adults aged 15-44 years. Among the over 75 year-olds, injury presentations were more common in women and this was due to the relatively high incidence of injury leading to fractures.

Accidents, assault and intentional self harm accounted for 90%, 7% and 3% of all injury presentations to hospital. In the vast majority of cases, the part of the body injured was the upper extremities (35%), the lower extremities (28%) or the head (19%).

The event leading to injury generally occurred in the person's home (21%), a sport's area (12%), a transport area (10%) or in another specified place. However, this information was not recorded for 44% of injuries. There was a similarly high level of unspecified information in relation to the activity the person was engaged in when injured (46%) and the underlying object that lead to the injury (43%).

CONCLUSIONS

Injuries constitute a major burden on emergency health services in Ireland. There is a need to proceed with the establishment of a national injury surveillance system as part of Ireland's suggested National Injury Prevention Strategy.

Information recorded in hospital in relation to injury presentations is often incomplete. This needs to be addressed through data recording guidelines and improved hospital information systems. Otherwise injury surveillance will be limited in the contribution it can make to improving injury prevention and quality of care.

PRESENTED

As a Poster Presentation at the XXIV World Congress of the International Association for Suicide Prevention, in Killarney, Co. Kerry from 28th August to 1st September, 2007.

FUNDING

This research has received funding from DG SANCO, the Directorate General for Health and Consumer Affairs of the European Commission.

title	"Shut up and Put up" - Barriers to Tackling Workplace Bullying in a Public Sector Organization
author	Hodgins, M. Health Promotion Research Centre, Department of Health Promotion, NUI Galway

INTRODUCTION

Workplace health promotion, concerned as it is with promoting the health of those in the workplace setting, has paid surprisingly little attention to the phenomenon of workplace bullying, despite its prevalence and well-documented negative impact on health. Tackling workplace bullying provides an opportunity to work coherently within the settings approach, focusing not only on what health difficulties workers report, but how the organisation and work itself contributes to these difficulties and how the organisation (as opposed to the worker) can change to reduce ill health. Such an approach assumes that how work is constructed, how the organisation is structured, work-based relations, the explicit and implicit expectations of workers all are central to improving health.

OBJECTIVE

This paper explores qualitative responses about perceived organizational responses to the problem of workplace bullying, collected as part of a larger study on workplace bullying conducted in a medium-sized public sector organization.

METHODOLOGY

Respondents replying to the open-ended questions within the instrument numbered 179, which represented 61% of the 293 respondents to the survey. The survey was emailed or posted to all staff on the payroll at that time (1,495). Comments made in the course of an on-line survey that were qualitative in nature. The basis of the process of data analysis in this study follows a general template analysis style, involving the generation of themes, patterns and interrelationships in an interpretive process.

RESULTS

Three main themes emerged in the analysis; the nature of bullying, the nature of hierarchical power and 'head-in-the-sand' culture.

Findings are discussed in the context of the need to explore the problem of workplace bullying from an organizational perspective and advocates strongly for organizational level interventions that go beyond the provision of anti-bullying policies. The need in particular to explore the organization and expression of power within work organizations is highlighted.

CONCLUSIONS

To address bullying in the workplace a whole-organisation, ecological approach is required. Ensure that Anti-Bullying policies in the workplace:

- Have visible and explicit back-up from top management
- Are proactive about informing employees
- Apply procedures that are fair, transparent, consistent and timely

PRESENTED

At the "Awareness and Perceptions of Staff of the Anti-Bullying Policy in a Public Sector Organization" 5th International Conference: Workplace Bullying- the Way Forward in June 2006, by Margaret Hodgins.

title	Implementation of the JOBS Programme in Ireland
author	Barry, M.M., Reynolds, C., Sheridan, A., Egerton, R. Health Promotion Research Centre, National University of Ireland, Galway

INTRODUCTION

This paper reports on the implementation and evaluation of the JOBS programme in Ireland. The JOBS programme is designed as a training intervention to promote re-employment and improve mental health among unemployed people. This intervention was adopted as the Winning New Jobs (WNJ) and implemented on a pilot basis in the border region of the Republic and Northern Ireland in collaboration with regional training and employment and health agencies.

METHODOLOGY

Programme participants were unemployed people recruited from local training and employment offices and health agencies. An evaluation of the process of implementation and the programme impact was conducted in order to determine the feasibility and effectiveness of the JOBS programme in an Irish context. Employing a quasi-experimental design, data were collected from 210 unemployed people in the WNJ intervention group, of which 44 were mental health service users, and from 192 unemployed people in a comparison group, prior to the training intervention and at two weeks, four months and 12 months post intervention.

RESULTS


The findings from the pilot implementation indicate that the programme was well received by both participants and trainers, and lead to improved psychological and reemployment outcomes for the intervention group, lasting up to 12 months post intervention.

CONCLUSIONS

This paper reflects on the implementation issues that arose in adapting an international evidence-based programme to the local setting and considers the implications of the evaluation findings for the roll out of the programme on a larger scale.

PRESENTATION

As a Symposium presentation by Barry, M.M. Price, R.H, Vuori, J. and Blonk, R.W.B. on Implementing the JOBS Programme in Finland, Ireland and the Netherlands, at "Work, Stress and Health 2006: Making a Difference in the Workplace", Miami Florida: 2-4th March, 2006.



As a Plenary address by Barry, M.M on Implementation essentials and evaluation in mental health promotion, at “Joining Forces Across Europe for Prevention and Promotion in Mental Health”, Barcelona: 13-15th September, 2007.

Population Health

title	Health Promotion Partnerships: An Analysis of the Factors that Contribute to Successful Partnership Functioning
author	Jones, J. Health Promotion, Health Service Executive West, Seamus Quirke Road, Galway

INTRODUCTION

Intersectoral collaborations and partnerships have been identified as a way of addressing the health challenges facing society. But are they the most effective way of solving health problems? In theory, partnerships achieve synergistic outcomes which are more than can be achieved by individual partners working on their own. It is unclear what factors create this synergy or whether it leads to extra and better outcomes.

OBJECTIVE

This study aimed to determine the key factors that influence health promotion partnership functioning and their relationship with partnership synergy and outcomes.

METHODOLOGY

A mixed methods approach was used which combined findings from a mapping study with chairs/leads of 129 health promotion partnerships, five focus groups with 36 partners, a postal survey of 337 partners in 40 partnerships and four workshops attended by 48 partners. The postal questionnaire incorporated a number of specifically designed and validated multi-dimensional scales to assess the contribution of factors that influence partnership functioning and synergy. New validated scales were developed for synergy, trust, mistrust and power. Multiple and logistic regression analysis was used to identify the significance of each factor to partnership synergy and outcomes. Outcome measures were: changes in knowledge, attitude, skill, behaviour, environment, community, and health status.

RESULTS

Trust and leadership were shown to be the most important determinants of partnership synergy. Community assets (i.e. involvement of the community in the partnership), efficiency and boundary-spanning skills were also significant predictors of synergy. Expert assets (i.e. health professionals) and mistrust had a negative relationship to partnership synergy. Although synergy was a significant predictor for outcomes investigated in the postal survey, it explained only a small percentage of the variance in outcomes. Community assets and trust were also significant predictors of many outcome categories. There was little or no relationship between synergy and outputs or outcomes reported by the chairs/leads for partner or partnership level data.

CONCLUSION

Synergy is predicated on trust and leadership. Trust-building mechanisms need to be built into the partnership forming stage and this trust needs to be sustained throughout the collaborative process. We need to develop systems where the best leaders are put forward for intersectoral partnerships. This should be consistent across all sectors and organisations. Successful partnerships need synergy if they are to achieve outcomes. Achieving synergy is not enough, however, and partnerships must also be outcome-focused if they are to be successful in tackling the health challenges facing society.

PRESENTED

Paper presented at 15th Annual Conference on Multi-Organisational Partnerships, Alliances and Networks in Boston, U.S.A. on 27th June 2008.

title	Deliberate Self Harm and Suicide: Gender Specific Trends in Eight European Regions
author	Arensman, E., Fitzgerald, A.T., Bjerke, T., Cooper, J., Corcoran, P., De Leo, D., Grad, O., Hawton, K., Hjelmeland, H., Kapur, N., Perry, I.J., Salander-Renberg, E, Van Heeringen, K. Network for International Collaboration on Evidence in Suicide Prevention (NICE-SP)

INTRODUCTION

The Network for International Collaboration on Evidence in Suicide Prevention (NICE-SP) has conducted an international comparative study to examine time trends in deliberate self harm (DSH) and suicide in eight different European regions and how rates of DSH at regional level and national suicide rates co-vary in each region.

METHODOLOGY


Across the regions, the monitoring period ranged from 6 (1998-2003) to 14 years (1989-2003). Standard registration forms were used to collect information on demographic variables and self harm characteristics. Participants were patients aged 15 years and over presenting to general hospitals following DSH in defined catchment areas. Data on suicides were obtained from national statistics offices in the individual countries.

RESULTS

The international database comprised over 44,000 DSH episodes. Trends in DSH rates over time varied considerably across the different European regions, and by gender. Based on rolling averages, DSH rates per 100,000 for females were consistently higher than for males, with the highest rates in Manchester (580.9), Oxford (416.0) and Gent (305.7), and the lowest rates in Sor-Trondelag (148.4), Umea (128.6), and Ljubljana (71.9). The two Irish regions showed intermediate DSH rates, with 266.2 in Limerick and 216.5 per 100,000 in Cork. With the exception of Ljubljana, similar trends over time were found for female and male DSH rates. Based on average annual DSH rates at regional level and average annual suicide rates at national level, a similar ranking was found for female and male DSH rates across the European regions. Looking across countries, a significant correlation (Spearman's rank correlation) was found between the rate of change in suicide rates nationally and DSH rates over time for males ($r = 0.71$, $p < 0.05$).

CONCLUSIONS

While DSH rates vary considerably between European countries, regional DSH rates and national suicide rates follow similar trends over time in both males and females.



Thus, an increase in DSH may be accompanied by an increase in suicide, in particular among males. Based on the study outcomes, it is recommended that prevention programmes target both forms of suicidal behaviour.

PRESENTED

At the XXIV World Congress of the International Association for Suicide Prevention in Killarney, Co. Kerry from 28th August - 1st September, 2007 by Dr. Ella Arensman.

title	The Incidence and Pattern of Deliberate Self Harm Presentations to Hospital in Ireland
author	Corcoran, P., ¹ Arensman, E., ¹ Perry, I.J. ² National Suicide Research Foundation, 1 Perrott Avenue, College Road, Cork ¹ Department of Epidemiology and Public Health, University College, Cork ²

INTRODUCTION

Deliberate self harm is one of the strongest risk factors for suicide and a significant public health problem in its own right. In recognition of this, the Irish government requested the establishment of the National Registry of Deliberate Self Harm.

OBJECTIVE

The primary objectives of the Registry are to establish the extent of the problem of deliberate self harm presentations to all emergency departments in Ireland, to identify demographic groups and areas with elevated rates, to describe the nature of the self-harming behaviour involved, the treatment pathways followed and the risk of subsequent repeat self harm presentations.

METHODOLOGY


Between 2002 and 2005, the Registry collected data on self harm presentations to 39 of Ireland's 40 hospital emergency departments. All data were collected by trained data registration officers working independent of the hospitals and following standard operating procedures.

RESULTS

Annually, approximately 11,000 deliberate self harm presentations were made to hospital by 8,500 persons. The majority of presentations (57%) were by women. The total annual incidence rate was approximately 200 per 100,000. The female rate (~235 per 100,000) was almost 40% higher than the male rate (~170 per 100,000). The peak female rate was among 15-19 year-olds and exceeded 600 per 100,000, double the equivalent male rate. Deliberate self harm presentations were most frequent on Sundays and Mondays and during the early hours of the morning. The vast majority of presentations involved an overdose of medication, most commonly minor tranquillisers, while self-cutting was the only other common method used.

CONCLUSIONS

In Ireland, the extent and pattern of hospital-treated deliberate self harm has been established thereby providing baseline data for Reach Out, the Irish National Strategy for Action on Suicide Prevention, which was launched in 2005. The Registry is ongoing and will continue to inform policy and service provision.



In line with Reach Out and relevant clinical guidelines, all deliberate self harm patients require an assessment of their psychosocial and mental health needs. In order to meet this requirement, there is a need to increase the availability of specialist services for self harm patients presenting to Irish emergency departments.

PRESENTED

At the XXIV World Congress of the International Association for Suicide Prevention, in Killarney, Co. Kerry from 28th August – 1st September 2007, by Dr. Paul Corcoran..

FUNDING

Health Service Executive National Office for Suicide Prevention.

FURTHER INFORMATION

National Suicide Research Foundation National Registry of Deliberate Self Harm Annual Reports, 2001-2005 (www.nsrfl.ie)

title	Indicators of Health Promoting Schools in Ireland: Towards the Participative Inclusion of Students
author	Nic Gabhainn, S., ¹ Sixsmith, J., ¹ O'Higgins, S., ¹ Delaney, E.N., ¹ Moore, M., ¹ Inchley, J. ² Health Promotion Research Centre, Department of Health Promotion, National University of Ireland, Galway ¹ Child and Adolescent Health Research Unit, University of Edinburgh, Scotland ²

INTRODUCTION

There is a political and practical need to develop appropriate indicators for health promoting schools. As key stakeholders in education, students have the right to be fully engaged in this process. This research proposed a process for engaging with students to develop school level indicators of health; a total of 164 students generated and categorised indicators and developed schematic representations of their analyses.

METHODOLOGY

In the first classroom, students answered the question “*If you moved to a new school, what would it need to have to be a healthy place?*” on individual flashcards, which were classified into groups using a variation of the card game ‘snap’ in the second classroom. In the third classroom, students discussed the relationships between the developed categories and determined how the categories should be presented. These procedures were repeated twice in three schools, resulting in six developed schemas.

RESULTS

The six sets of categories showed remarkable similarity, physical aspects of the school predominated but emotional and social health issues also emerged as potential indicators. The schema demonstrated the holistic perspectives of students. They illustrate the importance of relationships and the physical and psycho-social environment within schools.

CONCLUSIONS

These data illustrate that students can productively engage in the process of indicator development and have the potential to act as full stakeholders in health promoting schools. The methods enabled student control over the data generation, analysis and presentation phases of the research, and provided a positive, fun experience for both students and researchers.

PRESENTED

As a Paper Presentation, to the Researching Children's Worlds Conference in Galway in February, 2008 by S. O'Higgins, Dr. Saoirse Nic Gabhainn, Dr. Jane Sixsmith, Dr. Enda Delaney, M. Moore & Ms. Joanna Inchley in 2008.

As a Paper to WHO 5th Workshop on the Evaluation of the European Network of Health Promoting Schools in Sigriswil, Switzerland in June 2006, by S. O'Higgins, Dr. Saoirse Nic Gabhainn, Dr. Jane Sixsmith, Dr. Enda Delaney, M. Moore & Ms. Joanna Inchley .

As a Paper to the National Institute of Medical Research (Epidemiology and Public Health) in May 2007 in Toulouse, France by Dr. Saoirse Nic Gabhainn, Dr. Jane Sixsmith, S. O'Higgins, Dr. Enda Delaney, M. Moore. Indicators of success for health in schools: the development of schematic models by children.

PREVIOUSLY PUBLISHED AS

Health Promoting School Indicators: The Development of Schematic Models by Children. Health Education 2007;107(6): 494-510.

title	Cluster Randomisation and Design Effects in School Surveys: An Exploration of the Irish Health Behaviour in School-Aged Children Data
author	Walsh, K., ¹ Molcho, M., ¹ Dineen, B., ² Kelleher, C., ³ NicGabhainn, S. ¹ Health Promotion Research Centre, NUI, Galway ¹ Centre for Health Services Research and Development, NUI Galway ² School of Public Health and Population Science, University College Dublin ³

INTRODUCTION

School surveys are typically conducted in classrooms where children are clustered and thus each participating student is not fully independent of others. Such unavoidable cluster randomisation increases the size of standard errors, resulting in widened confidence intervals, larger probability values and therefore reduced statistical power and effective sample size. The need to address these issues is becoming more evident in the literature, with increasing impetus to publish on the effects of such sampling techniques and to consider more fully the analysis implications for complex survey data. A first step is to assess the design effects (DEFF), which is the ratio of the number of participants required to achieve precision using cluster randomisation to the number that would be required if all participants were independent.

OBJECTIVE

These analyses investigated the presence and magnitude of design effects in the Irish Health Behaviour in School-aged Children (HBSC) study.

METHODOLOGY

The Irish HBSC sample was constructed by stratifying school lists by region (n=8), randomly selecting schools within regions and then randomly selecting a class from within each school year. Therefore, classrooms served as the cluster or primary sampling unit (PSU). The sampling design was based on a 95% confidence interval of $\pm 3\%$ around a proportion of 50% and an estimated design factor of 1.2. The data were collected through self-completion questionnaires administered by teachers during a class period.

The dataset consisted of 2,365 males and 3,411 females post-primary school students. Males ranged in age from 11.2 years to 19.3 years, with a mean of 15.1 years and a SD of 1.4. Females ranged in age from 12.0 to 20.3 years, with a mean of 15.1 years and a SD of 1.4. All cases with missing data on stratification level (regions) or primary sampling unit (class) were deleted. Separate data files were created for each item. Each file was imported into Epi Info 6. The complex sample function was then used to compute the DEFF for each item, with region and class identifiers set a 'Strata' and 'PSU' variables.

RESULTS

Although the analysis was completed for all 189 survey items, only the DEFF values of those variables that were featured in the last international HBSC report are presented in Table 1.

Table 1 - DEFF values of selected HBSC survey items

Survey item	DEFF
Perceived academic achievement	1.655
Self-rated health	1.486
Body image (perception of being fat)	1.056
Level of agreement with having a good life	1.044
Life satisfaction	1.031
Level of agreement that family is well-off	2.435
Occupational status of father	1.750
Level of agreement that the local area is well-off	1.556
Frequency of going to bed or school hungry	1.098
Attempting to lose weight	1.815
Frequency of eating vegetables	1.456
Frequency of drinking 'diet' soft drinks?	1.420
Frequency of drinking whole fat milk	1.273
Frequency of eating fruit	1.190
Frequency of snacking at weekend	1.187
Frequency of eating sweets	1.006
Age of onset of menstruation (girls only)	10.986
Frequency of moderate to vigorous physical activity	1.383
Frequency of drunkenness	6.069
Frequency of drinking alcohol	5.590
Frequency of cannabis use	4.338
Frequency of smoking tobacco	3.548
Frequency of being bullied	1.869
Frequency of being injured	1.681
Teachers treating students fairly	2.911
Students enjoying being together	2.532
Liking school	2.350
Teachers encouraging students to express views	1.796
Students accepting me as I am	1.750
Frequency of e-communication with friends	3.280
Ease of talking to mother	2.135
Frequency of evenings spent with friends	1.529

CONCLUSIONS

DEFF values vary substantially across survey items. Variables that measure school context, friendship groups and risk behaviours display the largest DEFF values. These analysis serve as insight into appropriate sampling requirements for subsequent HBSC and other school based surveys.

REFERENCES

Available on request.

FUNDING

HBSC Ireland is funded by the Health Promotion Policy Unit and the Office of the Minister for Children, Department of Health and Children. These specific analyses were funded as part of a research project grant from the Health Research Board.

title	The Development of an Annotated Bibliography of Irish Infant Feeding Related Research
author	De Róiste, A., Batt, V., Nic Gabhainn, S. Health Promotion Research Centre, National University of Ireland, Galway

INTRODUCTION

In order to support the implementation of the 2005 National Breastfeeding Strategy, the Health Promotion Research Centre, National University of Ireland, Galway has produced a comprehensive and definitive bibliography of published and unpublished studies and post-graduate theses related to infant feeding in Ireland.

OBJECTIVE

The purpose of this bibliography is twofold: to provide a platform for previous research and to identify research gaps and to reduce duplication of research. The bibliography will be indexed and searchable so as to enable it to form part of an eHealth library.

METHODOLOGY

A number of methods were used to source the reports included in this bibliography. Keyword searches for relevant research were made in the library catalogues and databases. A list was compiled of key informants in the infant feeding research area who were considered to have material to contribute to the bibliography. Those informants were contacted by letter and invited to send relevant material to the Health Promotion Research Centre for inclusion in the bibliography. Follow up e-mails and calls were made as necessary. Those who are known to have conducted research into infant feeding in Ireland, as identified by library searches and personal recommendation were contacted. Some informants suggested likely sources of material for inclusion which were pursued. All those contacted were also asked to further disseminate the invitation to submit.

A request for information about infant feeding related research conducted in Ireland appeared in the February 2008 newsletter of the Association of Lactation Consultants in Ireland. This request also appeared in the newsletter of the Cuidiú-ICT Breastfeeding Counsellors and on the Cuidiú e-digest.

RESULTS

Preliminary investigations using library searches revealed a dearth of published infant feeding research and therefore the project relied on the willingness of relevant bodies and individuals to assist in obtaining copies of grey literature.

However, there are over 190 pieces of research in the bibliography, which includes: -

- Books/book chapters (n=3)
- Conference proceedings/abstracts (n=29)
- Government reports (n=10)
- Health Services reports (n= 34)
- Publications from International Organisations (n= 4)
- Non-Governmental reports (n=2)
- Non-peer-reviewed journals (n=16)
- Peer-reviewed journals (n=46)
- Reports from Research Units/ Academic Departments (n=9)
- Theses (n=39).

The dissemination format has been completed for each individual piece of research which includes the Full Citation, Publication status, Key Research Question(s), Study Design, Participant group(s), Study Conclusion(s), Key Words and Holding Status. The status of each piece of research has been documented in terms of public accessibility, length and subject matter and a hard and soft copy of each identified report has been procured where possible. The bibliography is to be indexed and searchable so as to form part of an eHealth library. The strengths of the Irish research base, and where gaps are found, will specify where there are total gaps or relative weaknesses. This work is ongoing.

CONCLUSIONS

Preliminary findings have shown a number of prominent gaps in infant feeding-related research that include the areas of breastfeeding mothers and babies being protected from discrimination in public places and mechanisms to enable hospital/community and volunteer breastfeeding support programmes to provide seamless, timely, co-ordinated, consistent, and comprehensive service to all mothers. In order to increase breastfeeding initiation and duration, further research on locally relevant approaches for improving breastfeeding promotion and support is required. This should include mother-to-mother support groups and peer counselors, especially given their documented success among disadvantaged population groups. The complete findings will be disseminated in due course. The research team would like to extend their gratitude to all that contributed and assisted in the search for infant feeding related research, both published and unpublished.

FUNDING

This project was commissioned by the National Breastfeeding Co-ordinator/National Breastfeeding Committee.

REFERENCES

Available on request.

title	Towards Understanding Food Poverty among Irish Children
author	Molcho, M., Kelly, C., Nic Gabhainn, S. Health Promotion Research Centre, NUI Galway

INTRODUCTION

Food poverty and food insufficiency are important public health issues, frequently linked to poverty and deprivation. However, research on the nature, extent, epidemiology and etiology of food poverty in childhood is scarce. Previous work has demonstrated a lack of social class gradient in Ireland and has thus questioned traditional policy responses to this problem.

OBJECTIVE

This study aimed to test the utility of a cross-national question on food poverty with Irish children. The question was originally developed in Canada as part of the protocol for the 2002 Health Behaviour in School-aged Children (HBSC) study and was originally designed to tap into extreme poverty. It is possible that children do not understand the questions we use when trying to assess food poverty, and thus their understanding is crucial to progress in this field.

METHODOLOGY

Three post-primary schools were invited to participate and consent was obtained from school management, parents and children. Data were collected from students in 7 first year groups across the 3 schools. All students first completed a short questionnaire which included socio-demographic questions and the cross-national question on food poverty:

"Some young people go to school or to bed hungry because there is not enough food at home. How often does this happen to you?" The response options were always, often, sometimes, and never.

The questionnaire also asked children to indicate if they thought they understand what the question means, and if so to explain in their own words. A class discussion was subsequently facilitated by researchers without teachers being present.

RESULTS

In total, 143 first and second year post-primary school children participated, of whom 10% reported that they had experienced 'food poverty' or hunger – with no significant difference between boys and girls. When asked, 76% reported what they think this question meant. The majority understood it as being hungry for financial reasons (68%). For example, some thought the question was asking whether you are poor (n=30), or whether there is not enough money for food or if the family has a low income (n=26). Others thought it was asking if there is a shortage of food at home (n=17). One child suggested that the question is asking whether you are homeless.

Eleven percent of children thought it referred to family disorganisation (n=12), with 10 mentioning parents who are neglecting their children and 2 suggesting that the parents are not feeding their children.

Only a few thought the question was about ever being hungry because of not eating often enough (3%), with the same number believing the question refers to skipping breakfast (3%). Fewer again suggested that it meant if you don't eat you will be hungry (2%) and the same number thought the question is about you bothering to prepare food for yourself. One child suggested that it is about children not liking the food that is being served. Six percent of children reported that they did not know what the question means (n=7) and 4% copied the question exactly as it appeared on the questionnaire (n=4).

The most striking feature of the classroom discussion was that they did not express any surprise that the question was being asked and thought it relevant to their peer group. In the classroom discussions, being poor, not having enough money to buy food or not enough food at home were what the children reported that they understood from the question. When prompted to give alternative reasons for going to bed hungry children suggested there may be no time for breakfast, parents are too lazy to prepare food, or that the children don't like the food that is given to them. Other explanations included going to bed hungry as a punishment, staying up late and thus becoming hungry, or that a child has an eating disorder, but these responses were quite rare.

CONCLUSIONS

These data indicate that children are familiar with hunger and recognise that it is a feature of Irish children's lives. The vast majority indicated that they understood the question and when probed they were clear on what the question meant. A sizeable minority suggested that hunger in children may be a consequence of family disorganisation, and this deserves further exploration. Most interestingly, very few thought that the question, as asked, was to do with not liking the food available to them or skipping meals.

FUNDING

HBSC Ireland is funded by the Department of Health and Children (the Health Promotion Policy Unit and the Office of the Minister for Children).

REFERENCES

Available on request.

title	Child Well-being: Children's, Parents' and Teachers' Perceptions
author	Sixsmith, J., ¹ Nic Gabhainn, S., ¹ Fleming, C., ² O'Higgins, S. ¹ Health Promotion Research Centre, National University of Ireland, Galway ¹ Scoil Phadraig Primary School, Westport, Co. Mayo ²

INTRODUCTION

That children's lives be better understood is a necessary contributing step to the development of child centred quality supports, services and policies and it would appear logical that actively seeking out children's voices would facilitate this endeavour. This approach is supported by the National Children's Strategy. However, traditionally adults have provided information on children's policy and service needs with parents often considered the most appropriate and primary voice of the child. Adults, such as parents and teachers, have a unique perspective and hold key insights into the lives of children which could contribute to the development of child focused policy and practice. This study undertook an exploration of parents', teachers' and children's perspectives on children's understanding of well-being with the aim of illuminating and comparing the conceptualisation of well-being from these three perspectives.

METHODOLOGY

The participatory method developed to undertake this study stems from our adaptation of the 'draw and write' technique, with children taking photographs rather than drawing and participating in data analysis. Children aged 8-12 years took 723 photographs representing well-being, while a second set of children grouped the photographs into categories. A third set organised these categories, developing and illustrating through schema the pattern of relationships between categories. This process was repeated for parent and teacher groups drawing on the photographs taken by the children.

RESULTS

Differences and similarities emerged between parents and teachers and children and adults. Teachers developed 14 categories from the photographs with their schema depicting 'home' 'family' and 'friends' as core categories for children's wellbeing. Parents provided a more detailed conceptualisation than teachers, generating 28 categories from the photographs all of which were linked in someway. Parents positioned the categories in clusters with, for example, 'family', 'home', 'support' and 'friends' grouped together. Children used 24 categories in their schema development, presenting the categories in a hierarchy with what they perceived as most important, 'family' closely followed by 'animals and pets' at the top graduating to the less important categories at the bottom. One and two way links were made between categories throughout the schema with the category 'fun' having the most connections.

CONCLUSIONS

The category 'family' can be seen in parents, teachers and children's construction of children's wellbeing as a common central feature. However, differences can also be observed. Children included pets where adults perceived school as more important in children's well-being. The identification of the differing perspectives between children and adults suggests that this approach has enabled children to illuminate their own unique perspective on well-being. It also demonstrates that children can express complex understandings of abstract concepts. The findings reinforce the need to gain children's perspectives rather than relying on adult perceptions of children's perspectives, in order to inform child centred quality service, practice and policy developments. Children's contribution to these developments must not be under-estimated and should be actively sought.

SOURCE

Health Education. 2007 107(6):511-523.

REFERENCES

Available on request.

title	Evaluating the Implementation of the Youth Led Emotional Well-being Project 'Getting it Together'
author	Meade, K., Rowel, D., Barry, M. Health Promotion Research Centre, National University of Ireland, Galway

INTRODUCTION

This study reports on the evaluation of a youth-led initiative on the promotion of emotional well-being among young people aged 16-25 years. This project was developed under the auspices of the CAWT (Co-operation and Working Together) Mental Health Sub-Group and was implemented by the National Children's Bureau. The project aimed to develop a youth friendly resource to promote emotional well-being which would be designed and delivered by young people for young people. Over a six month period, the Getting it Together project worked with a group of 12 young people from both the Republic and Northern Ireland in building their understanding of emotional well-being and developing and testing a youth friendly, needs-led resource.

METHODOLOGY

Employing a mix of research methods, including participatory methods, this evaluation documents the process of actual project development, partnership working and overall experience and impact of project participation for the young people. Following the development of the resource, its pilot implementation by the peer educators with 58 young people in the region was also evaluated.

RESULTS

The evaluation findings indicate that the key objectives of the project, were achieved i.e. a resource package was successfully developed and designed with direct input from the young people, and was assessed by their peers to be youth friendly. The project resulted in an intense, positive and productive experience for the participating young people, and enhanced their understanding of emotional well-being. The young people were successfully trained to deliver the resource to their peers, who assessed very positively both the resource and their experience of the training.

CONCLUSIONS

The project was successful in engaging the participation of a diverse group of young people in the process of project development. The process evaluation indicates that a positive partnership was established between the project leaders and the young people and that this contributed to achieving the project's aims and objectives, within a relatively short time frame. The participatory and interactive approach adopted in the project process facilitated the sustained engagement and commitment of the young people. To achieve the full potential of this peer-led initiative, the use of the

resource now needs to be tested with a wider group of young people from the region. The implications of the evaluation findings for developing and disseminating such peer-led initiatives in the context of wider strategies to promote the well-being of young people are discussed.

PRESENTED

At a parallel session on “*Joining Forces across Europe for Prevention and Promotion in Mental Health*”, at Barcelona: 13-15th September, 2007 by Rowel, D, Meade, K and Barry, M.M.

PUBLISHED

Journal of Public Mental Health (in press)

title	Family Structure and Children's Eating Patterns: Secondary Analysis of the Health Behaviour in School-Aged Children (HBSC) Study 2002
author	Kelly, C., Davin, V., Molcho, M., Nic Gabhainn, S. Health Promotion Research Centre, National University of Ireland, Galway (NUIG), Galway

INTRODUCTION

A variety of family and social factors influence children's eating behaviours such as availability of and preference for particular foods, portion size, cultural values regarding food types and preparation, parents' beliefs and practices, mealtime structure and feeding styles. With a decrease in average family size worldwide and many families consisting of one parent or two parents working outside the home, the influence of family structure on children's eating patterns is of interest.

OBJECTIVE

This paper presents data from the Health Behaviour in School-aged Children (HBSC) survey, a WHO collaborative study, illustrating the influence of family structure on children's reported food behaviour.

METHODOLOGY

This study utilised data from the 2002 Irish HBSC study, which is part of a WHO international collaborative study conducted in 35 countries in 2001/02 (www.nuigalway.ie/hbsc). The overall study aims are to gain new insight into, and increase our understanding of young people's health and well-being, health behaviours and their social context. In Ireland, a nationally representative sample of schools, stratified by region, was randomly selected and individual classrooms within these schools were subsequently randomly selected for inclusion. Data were collected via self-completion questionnaires from 8424 schoolchildren, administered by teachers in the classroom. The response rate was 83% of schoolchildren. Data entry was conducted according to the International HBSC protocol. Ethical approval was obtained from the Faculty of Public Health Medicine, Royal College of Physicians, Ireland.

Family structure was measured by students indicating who they live with, with eight response options provided: 'mother', 'father', 'stepmother', 'stepfather', 'grandmother', 'grandfather', 'I live in a foster home or children's home' and 'someone or somewhere else'. These variables were dichotomised to show if children lived with one parent or two.

Fruit and vegetable consumption was measured by a set of questions regarding the frequency of their consumption; these were dichotomised at daily consumption or more of the foodstuffs. Breakfast patterns during the week and the weekend were determined by asking children 'How often do you usually have breakfast (more than a glass of milk or fruit juice)?' with response options of 'never' to the number of days

per week and per weekend, respectively. These variables were dichotomised into those who never ate breakfast during the week and those who never ate it at the weekend. Students were asked if they were on a diet to lose weight, with response options 'yes', 'no but I should lose some weight' and 'no because my weight is fine', which was dichotomised into those on a diet and those not on a diet. Students were asked how often they snack and were provided with a seven-point Likert-type scale with the response options: 'rarely or never', 'once a day' to six or more times a day'. These variables were dichotomised into snacking twice daily or less and more than twice daily. Separate questions for weekday and weekend snacking were provided.

Associations between family structure and the likelihood of the various outcome measures (food behaviours) are expressed in odds ratios from logistic regression models in SPSS, version 12.0. Considering the reported effects of age, gender, social class and family factors such as family size and maternal employment on eating patterns, these variables were controlled for in the analyses. See table 1.

Table 1 - Associations between Family Structure and Food Behaviours

	OR (95% CI)
Breakfast consumption during the week	0.66 (0.53-.84)**
Breakfast consumption at weekends	0.92 (0.65-1.32)
Fruit consumption	1.12 (0.93-1.36)
Vegetable consumption	1.29 (1.07-1.55)**
Dieting behaviour	0.91 (0.70-1.18)
Snacking behaviour during the week	1.09 (0.91-1.31)
Snacking behaviour at weekends	1.15 (0.96-1.38)

OR: odds ratio; CI: confidence interval

*P<0.05, **P<0.01, ***P<0.001

Adjusted for age, gender, parental social class, family size and maternal employment.

RESULTS

Family structure was significantly associated with breakfast consumption during the week and with daily vegetable consumption. Children living in one parent families were more likely to miss breakfast during the week and less likely to report daily or more vegetable consumption.

CONCLUSIONS

Living in two parent families is associated with healthful dietary practices. Further work on investigating the barriers and constraints to healthy eating for one parent families is warranted. Health Professionals need to be cognisant of the influence of more recent changes in family structure in Irish society when promoting healthy eating practices.

FUNDING

HBSC Ireland is funded by the Health Promotion Policy Unit and the Office of the Minister for Children, Department of Health and Children, Government of Ireland.

REFERENCES

Available on request.

title	Family, Peer and School Relationships as Predictors of Tobacco, Alcohol and Cannabis Use in Irish Adolescents: Differences between Sustained and Experimental Substance Use Behaviour
author	Gavin, A., Molcho, M., Kelly, C. Nic Gabhainn, S. Health Promotion Research Centre, National University of Ireland, Galway

INTRODUCTION

Adolescence is a vital period in shaping behaviour patterns. Substance use is one of the most commonly studied risk behaviours among adolescents. There are three mutually exclusive levels of substance use: non-use, experimentation and current use. Understanding the social context of the experience of substance use is at the core of comprehending substance use among adolescents. Parental, peer and school influences have all been previously shown to be associated with adolescent substance use.

OBJECTIVE

This study investigates the role of relationships with parents, friends, within the school and school connectedness in predicting use of tobacco, alcohol and cannabis.

METHODOLOGY

The current study investigates the determinants of the levels of substance use examining 2 parental variables, 5 peer variables, and 3 school variables. This study is based on data collected from the 2006 Irish Health Behaviour in School-aged Children (HBSC) study (www.nuigalway.ie/hbhc). Participants for this study included 3346 students aged 15-17 years old from across the Republic of Ireland. There were 2089 males and 1842 females.

RESULTS

Sustained substance use rates were 29% for smoking, 47% for alcohol, and 11% for cannabis, with rates of experimentation at 24%, 28% and 9% respectively.

Determinants for each of the nine models were established, and all analyses were controlled for gender and parental social class. The predictive power of relationships with parents, friends and the school variables were similar across substances.

Relationships with parents were positively associated with non-substance use, and negatively with sustained use ($p < 0.05$ - $p < 0.001$). Relationships with teachers and school connectedness were also positively associated with non-substance use, and negatively with sustained use ($p < 0.05$ - $p < 0.001$).

The patterns for relationships with friends were more complex; for all substances, the relationship with opposite sex friends was most important, compared to same sex or best friend. Relationships with opposite sex friends was negatively associated with non-substance use, and positively with sustained use ($p<0.05$ - $p<0.001$).

Few of the tested variables were predictive of experimental use of any substance. None of the three models of experimentation were a good fit based on the Hosmer-Lemeshow goodness-of-fit statistics.

CONCLUSIONS

These findings demonstrate the etiological similarity of psychoactive substances, and have interesting implications for contextual models, particularly in relation to experimental substance use, and indeed for the conceptualisation of substance use itself. The data confirm within Ireland the extensive research on the importance of inter-personal relationships for health behaviour, which has been conducted on adolescent substance use in other countries. However, it also highlights the need for further investigation into the determinants of substance use. Particular attention should be given to both the parental and school variables that are important for both non-use and current use.

PRESENTED

As a Paper at the *“Psychology, Health and Medicine, Annual Conference of the Division of Health Psychology, PSI & BPS”*, in Derry, Northern Ireland during March 2008, by Aoife Gavin, Michael Molcho, Colette Kelly and Saoirse Nic Gabhainn.

FUNDING

HBSC Ireland 2006 was funded by the Health Promotion Policy Unit and the Office of the Minister for Children in the Department of Health and Children, Government of Ireland.

title	Heartbeat – Improving Heart Attack care
author	<i>Jennings, S.,¹ Bennett, K.,² Cavanagh, B.³ Department of Public Health, Dr. Steevens Hospital, Dublin 8¹ Department of Pharmacology and Therapeutics, TCD, St. James Hospital, Dublin² Health Service Executive South, Farm Centre, Cork³</i>

INTRODUCTION

In 2005, a national Steering Group, comprising HSE and Clinical Indemnity Scheme, initiated an Irish campaign (HeartBeat) to reduce mortality from acute myocardial infarction (AMI) using the American Institute for Healthcare Improvement (IHI) methodology.

OBJECTIVES

The goals of the programme were to:

- Increase the percentage of patients who receive all components of AMI care in the volunteer hospitals
- To reduce in-hospital mortality from AMI

METHODOLOGY

The programme methods were:

- Recruitment of five hospitals initially
- Establishment of data collection on the eight evidenced based components of AMI care (table 1)
- Analysis of data and regular feedback to the 5 hospitals
- Training in IHI methodology of sustainable improvement.
- 15 month review of progress

Table 1 - Heartbeat data - % Patients getting Evidence-Based Care (or contraindicated)

Indicator	15 month HeartBeat	MINAP - UK, 2006	Improving US Hospitals, 2006	Safer Now – Canada 2005
Early ASA	99.5%	NA	96.6%	NA
ASA on discharge	100%	97%	96.6%	83%
Early b blockers	98.4%	NA	93.6%	NA
B Blockers on discharge	100%	92%	96.2%	83%
ACE for LVF	96.7%	NA	86.7%	83%
Reperfusion	74.7%	83% (T'lysis)	42.5%	80% (PCI)
Smoke Cess. advice	98.9%	NA	96.6%	NA
Lipid Low. Meds	100%	96%	NA	NA

RESULTS

Analysis of the 15 month data (Oct 2006-Dec 2007) on 183 patients for the five hospitals showed:

- Seven of the eight components of care were delivered (unless contraindicated) to > 90% of patients in all hospitals
- Reperfusion within specified timeframes, was achieved in 74.9% of cases with improvement from 63.3% in the first quarter to 83.9% latterly
- In-hospital mortality was 12.5% (95% CI 8.2% - 16.8%)

CONCLUSION

In conclusion a high degree of implementation of evidenced based care is evident. Improving time to thrombolysis/PCI will require pre-hospital changes. These hospitals compare very well with US and Canadian hospitals.

PRESENTED

At the ISQSH Conference, April 14th & 15th, 2008, Radisson Hotel, Dublin Airport.

title	Helicobacter Pylori Eradication Therapy - Getting Research into Practice
author	<i>McDonnell, R., O'Morain, C., Boland, M., Culhane, A., Johnson, Z, Johnson, H., Murray, F., Doyle, D. National Population Health Directorate HSE, Health Information Unit, Dr Steeven's Hospital, Dublin 8</i>

INTRODUCTION

Helicobacter Pylori (H. Pylori) is the primary cause of duodenal ulcer (DU). Guidelines recommend that all patients with DU be considered for Helicobacter Pylori Eradication Therapy (HPET). However, the proportion of patients with DU on long term anti-ulcer medication receiving HPET is small.

OBJECTIVE

This study examined the effectiveness of the continuing medical education (CME) network of the Irish College of General Practitioners (ICGP) in promoting best practice in DU treatment among GPs in an eastern region of Ireland.

METHODOLOGY

Ninety eight GPs recruited from the CME network of the ICGP were randomised in two cohorts. Cohort 1 received an (early) intervention; GPs were asked to identify their patients with DU receiving long term anti-ulcer medication and prescribe HPET according to defined criteria. Cohort 2 received the intervention later. Prescribing of HPET was monitored using routine prescribing data.

RESULTS

Twenty per cent (286/1,422) of patients in cohort 1 and 19.2% (127/661) in cohort 2 had a DU. After exclusions, 53% (152/286) in cohort 1 and 30.7% (39/127) in cohort 2, were eligible for HPET. A significantly higher proportion of patients in cohort 1 received HPET compared with cohort 2 during the early intervention period (13.8% vs. 0.0%, $p < 0.05$). Reasons for not prescribing HPET included concurrent illness in patients, failure to comply with treatment.

CONCLUSIONS

Best practice guidelines on HPET treatment of DU can be successfully applied using CME networks. This model could be repeated in another therapeutic area where established research is not yet current practice.

PUBLISHED

Irish Medical Journal. January 2003 Volume 96 No 1, <http://www.imj.ie>

title	Adherence to Anti-Retroviral Therapy among Patients in Bangalore, India
author	<p><i>Cauldbeck, M.,¹ O'Connor, C.,² Saunders, J.A.,³ O'Connor, M.B.,⁴ Rao, B.,⁵ Mallesh, G.V.,⁵ Praveenkumar, K.N.,⁵ Mamatha, D.,⁵ McGolderick, C.,⁶ Laing, R.B.S.,⁶ Satish, K.S.⁵</i></p> <p><i>The School of Medicine, University of Aberdeen, Aberdeen, Scotland¹</i> <i>GU/STD Clinics Mid-Western Regional Hospital, Limerick²</i> <i>Department of Mathematics and Statistics, University of Limerick³</i> <i>Department of Medicine, South Infirmary - Victoria University Hospital, Cork⁴</i> <i>Department of Respiratory and HIV Medicine, Rajajinagar and Wockhardt Hospital and Heart Institute, Bangalore, India⁵</i> <i>Infection Unit, Aberdeen Royal Infirmary, Aberdeen, Scotland⁶</i></p>

INTRODUCTION

Human Immunodeficiency Virus (HIV) has an estimated prevalence of 0.9% in India (5.2 million). Anti-retroviral drugs (ART) are the treatments of choice and non-adherence is an important factor in treatment failure and development of resistance, as well as being a powerful predictor of survival. This study proposes to assess adherence to ART in HIV positive patients in Bangalore, India, a country where only 10% of those who need get therapy.

METHODOLOGY

A cross-sectional anonymous questionnaire survey of 60 HIV antibody positive patients was proposed for patients attending HIV outpatient services at The Chest and Maternity Centre, Rajajinagar and Wockhardt Hospital and Heart Institute, Cunningham Road, Bangalore. Consent was to be obtained. Translation was done by a translator and doctors. Data was to be analysed using SPSS statistical analysis.

RESULTS

Response rate: 53/60 (88%).

Mean patient age was 39.85 years, with 50% aged 30-40. 73.6% of participants were male.

60% were fully adherent. Mean family size =4.8 (1-13). 21% lived <50kms and 21% >400kms from clinic.

CONCLUSIONS

Adherence was statistically significantly linked to regular follow-up attendance (70.5%, $p=0.002$). No other results were statistically significant but trends were found.

Better adherence were seen in older patients (>40 =50%, <40= 15%), males, those from larger families, those who had AIDS (AIDS=72%, Well= 50%), those taking fewer tablets (<5 =76%, 5-9=41%) and without food restrictions (without=70%, with= 48%).

Commonest side-effects causing non-compliance were metabolic reasons (66%) and GIT symptoms (50%).

No differences were seen for education level, family income, distance travelled to clinic, time since diagnosis, or time on ART.

Regular attendance for follow up was statistically significant for adherence. Positive trends were seen in those in larger families, older, those who had AIDS, simple regimes, and without side-effects. Education income, distance travelled and length of time diagnosed or treated had no effect on adherence.

PRESENTED

List of presentations available on request.

PUBLISHED

HIV Medicine 2008 May;9 Suppl 1:42-43.

HIV Clinical Trials 2008;9 Suppl 1:29-30.

title	Audit of NCHDs Admission and In-patient Follow up Medical Entries in Nenagh General Hospital (Nov 2007)
author	<i>Sheikh, A., Ambreen, A., Yousif, A.H., Abbas, F. Cardiology Department, Mid-Western Regional Hospital, Nenagh, Co. Tipperary</i>

INTRODUCTION

Medical records serve many functions in modern healthcare environment ranging from provision of evidence of clinical decisions, good communication among different teams to availability of records for medico-legal purposes, clinical audit and research. In “Good medical practice” (GMC) has emphasized the need for doctors to keep ‘clear, accurate and contemporaneous patient records.’

The European Working Time Directive will cause a change of working patterns for NCHDS. Shifts require handovers of information and standard quality documentation of information will ensure continuity of care.

OBJECTIVES

To compare standard of admission and in-hospital follow up entries in Nenagh General Hospital compared to set standards of Royal College of Physicians UK. (RCPUK)

METHODOLOGY

40 medical admissions notes were randomly selected from month of February 2007 and August 2007. Admission entry and five in-hospital follow-up entries for each patient were reviewed making a total of 200 follow up entries.

Headings for Admission Entries:

Date, time, signature, name in bold letters against signature, legibility, Any alterations or deletions co-signed, patient name, location, senior clinician present GP details, administration details, reason for admission, presenting complaint, history of presenting illness, current diagnosis, past medical illnesses, surgeries and procedures, allergies, social history, functional status, family history, systemic review, examination findings, result of investigations, overall assessment, problem list, management plan, intended outcome, information given to patient and relatives.

Headings for In-Hospital Follow-up Entries:

Date, time, signature, name against signature, legibility, alterations/ deletions, countersigned, patient name, location and name of senior clinician presentation.

RESULTS

Most frequently documented headings:

Examination findings	100%
Management plan	100%
Senior doctor present	100% (administration notes)

Date	99%
Reason for admission	95%
Past illnesses	95%
Signature	92%
Social circumstances	80%
Medication/diet	87.5%
Overall assessment	80%

Less frequently documented: -

Patient name	67.5%
Family history	60%
Functional status	50%
Allergies	50%
Systemic review	45%
Result of investigations	45%
Time	40%

Headings not documented: -

Location of patient at admission or as in-patient
Current diagnosis
Intended outcome
Information given to patient
Problem list at admission
Authors name in bold against signature

	Documented Headings admission Notes n= 40	Follow up Entries n=200
Date	99% (39)	98.5% (197)
Time	40% (16)	5.5% (11)
Signature	92% (37)	90.5% (181)
Authors name	0%	15% (30)
Pt name	67.5% (27)	28% (56)
Location	0%	2.5% (5)
Senior doctor	100%	80.5% (161)

CONCLUSION

Comparing our record keeping standards to that of RCPUK Version 5.0, we are significantly below the recommended standard of RCP. Some of the very important headings that are helpful for clinical decisions were missing such as problem list, information given to relative /patient.

RECOMMENDATIONS

1. NCHDs should familiarize themselves with standard of good record keeping in their early training years as part of good medical practice.
2. It would bring uniformity in record keeping in all hospitals and electronic record keeping would become easy.
3. Printed proforma would be of help to save time and overcome difficulty in remembering headings.

REFERENCES

Available on Request

Health Services Research and Development

title	The Feasibility of Using Health Related Administrative Databases in Ireland to Identify Older People Living at Home to be Targeted for Preventative Healthcare Interventions
author	<i>Beaton, D. Health Service Executive - National Health Intelligence Team, Palmerstown, Dublin 20</i>

INTRODUCTION

The prospect of changing demographics and of the reduced availability of informal carers results in a pressing need to explore approaches that can target health service resources in the most effective way to both meet the expressed needs of older people to remain living at home until the end of their lives, and to avoid unnecessary expenditure.

Targeted screening, health promotion, and preventative care activities may be effective, including being associated with a reduction in admission to institutional care, however, a difficulty for health services is in accurately targeting such interventions towards those older people who can benefit most. The literature supports the premise that it is feasible to deploy a systematic method, to 'predict' people most 'at risk' or most likely to benefit from preventative interventions.

OBJECTIVE

The study sought to evaluate the organisational and technical feasibility of the use of systematic screening, using a computer-based method applied to health-related administrative data, to generate referrals of community-dwelling older people for specialist geriatric assessment and possible follow-up with interventions designed to address issues of functional decline and hence result in delay or avoidance of hospitalisation or admission to a 'long-stay' setting.

METHODOLOGY

The study was undertaken in four parts. A literature review stage was undertaken in two parts:

- The first part was aimed at making an evaluation of the current 'state of the art' with regard to systematic screening and targeting of older people at home for preventative interventions.
- The second part aimed to evaluate examples of using data from 'administrative' information systems to select individuals to be targeted for interventions.
- The third part of the study was a survey of practising Consultant Geriatricians in the Republic of Ireland by use of an anonymous self-completion questionnaire. The survey sought to establish the current position with regard to key aspects of current practice in relation to the assessment and follow-up of community dwelling older people, and the current experience, knowledge and attitudes of

the respondents in relation to methods of systematic screening and in particular a computer-based method.

- The fourth part of the study, concluded before the survey design was completed in order that the findings could inform the question design, was a review of relevant documents pertaining to the data content and population coverage of candidate health related administrative information systems in the Republic of Ireland.

RESULTS

There were thirty questionnaires returned out of forty-five issued, which represented a 66% return rate. Respondents ranged between less than 5 years to more than 20 years in practice, and were in roughly equal numbers from the four HSE administrative areas. The data contents of the PCRS (formally GMS), the HIPE scheme, and the two leading GP practice systems were reviewed - for coverage, identifier data, and data relevant to envisaged screening method.

The survey found that the 'case-mix' of older people currently referred to Consultant Geriatricians represents a good match to those that are expected to benefit most from specialist geriatric assessment and follow-up, and that the follow-up interventions used are also a good match with best practice.

However, the use of a home visit by a member of the clinical team as a usual part of the assessment or follow-up process is not common currently, and clinical teams often have a limited range of disciplines, both of which represent a mismatch with the suggested best practice approach for specialist geriatric assessment and follow-up of community dwelling older persons.

The practitioners surveyed had a limited experience of any of the three prominent methods of systematic screening about which they were asked. Overall, twenty-one out of twenty-nine of the respondents, that is 72%, had no prior experience of receiving referrals based on any of the three prominent methods of systematic screening provided as options in the survey.

On the ability of computer-based methods to correctly identify older people most likely to benefit from preventative interventions, 51.7% of respondents strongly agreed or agreed. The same proportion, 51.7%, strongly agreed or agreed that the method would be beneficial to community-dwelling older people by helping them to remain at home longer.

There was less agreement that the method would be cost justified overall, in terms of overall expenditure by the 'exchequer', with only 37.5% of those who responded strongly agreeing or agreeing with this.

The findings reveal that only around one-quarter of practitioners would give priority to referrals generated using computer-based systematic screening by displacing the lowest priority referrals from other sources, for example those from General Practitioners (G.P.s), unless there was the provision of additional resources to their clinical teams.

Finally, the survey results suggest that those willing to take such referrals in preference to lowest priority referrals from other sources were the more experienced

Consultant Geriatricians. The data essential to provide inputs to envisaged computer-based analysis are all available in the relevant type of health administration systems, with the exception of detailed data in regard to general practice consultations.

The person identifier information recorded in these systems would appear to provide for sufficient linkages of records pertaining to an individual sourced from the systems.

With respect to 'population coverage' the candidate information systems do have substantial coverage, except in relation to general practice care.

CONCLUSIONS

Resource constraints and differing practice model represents a constraint on organisational feasibility. The envisaged data-filtering approach appears technically feasible. Data quality and timeliness not tested. Data privacy issues not addressed in detail by the study. Analysis of specific indicators/ weightings for Ireland required.

REFERENCES

Available on request.

PRESENTED

As a poster presentation at the Health Policy and Management Conference in Trinity College, Dublin on Friday 13th June, 2008 by Mr. Dougie Beaton.

title	Family Meetings in Palliative Medicine
author	Kennedy, B. MICGP Registrar Palliative Medicine, Milford Hospice, Limerick

INTRODUCTION

The Family Meeting is a powerful intervention used regularly in Palliative Care Inpatient Units to facilitate communication between patients, their families and the Multidisciplinary Palliative Care team.

Relatively little has been written about them compared with physician-patient interactions. Meetings can be for information gathering where current or future fears, expectations, concerns and worries of the patient/family can be discussed. Patients and families can ask about specific details regarding disease trajectory and prognostics, treatment options and palliative care services and supports available both as an inpatient and in the community. Meetings are resource intensive, often requiring the time and presence of Doctors, Nurses, Social Workers, Dieticians, Occupational Therapists, Physiotherapists and other Health Care Professionals. Meetings can be very emotional charged for all concerned especially when bad news is broken as patients are deteriorating.

During the family meeting, patients and families can express anxieties and share feelings. Staff can explain their roles and input to date. The meeting may aid health care providers identify family and patient strengths, address possible weaknesses, and explore pragmatic discharge planning and realistic levels of care needed. When there is a large family with lots of siblings or children, a meeting can level the playing field so that all family members are privy to the same information and have equal access to the health care team.

Current general ground rules in practice:

- It is endeavoured to introduce family meetings as a concept on admission
- Meetings are organised as needed at Multidisciplinary Team meetings or as need arises on the ward if crisis occurs.
- It is aimed to schedule most meetings in the afternoon. An effort is made to facilitate a relaxed environment in a quiet room with comfortable seating, all the while remaining flexible and facilitating bedside meetings when appropriate. Phones are usually on silent mode throughout.
- A general aim is to keep the meeting to under an hour or so.
- All meetings are usually chaired/co-facilitated by either a social worker or doctor
- It is usual to have a pre-meeting talk with all health professionals who will attend, to flag the major issues to be discussed.
- Patients themselves are invited to meetings if they feel able.
- An effort is made to give family and staff adequate notice and encourage them to have questions ready. The nursing staff have been traditionally integral in facilitating this.

- It is usual to have post meeting debriefing among staff members, which serves to aid trouble shooting possible problems and to organise delegation of tasks which may have arisen from the meeting.

Evidence Base for Family Conferencing: -

- More or less non existent, there is lots of scope for further research
- Recent research on the framework of the family conference in the ICU
- Several studies on the effect of family involvement in health care outcomes

OBJECTIVES

To gather some data about family meeting process and content. i.e.:

- Roll call of Family and Staff present
- Duration/Themes of meeting
- Whether index patient present
- Family/patient/staff feed back about content and process of meeting on Likert Scale to be gathered anonymously.
- To trial “virtual inclusion” of General Practitioners by post meeting telephone communication and documenting feedback from GP and also the Hospice Doctor who phones him/her.

METHODOLOGY

- Ethical approval for project from local hospital research ethics committee was obtained
- Patient information sheet about family meetings and the purpose of the study offering inclusion into the study was provided to families and patients
- Consent was obtained from patient and family member and co-signed by Doctor present at meeting. Questionnaires given to patient/family members and health care professionals present with Likert Scale format answers. These were filled out after the meeting and placed anonymously in an envelope which was in turn placed in a sealed box until all the data was examined at the end of three month period. Questionnaires included a section for free comment i.e. what they would change about the process of the meeting, any remarks or comments etc.

RESULTS

Average family members present was 8 per meeting. Average staff present was 5.25. Average duration meeting was 42 minutes. Average time pre-meeting preparation among staff was 5 minutes. Average post meeting debriefing took 6 minutes. 37.5% of patients chose to attend the meeting themselves. All other patients were either too sick, or else decided not to attend for personal reasons. Average time to contact GP 4.8 minutes; on one occasion, the GP was uncontactable as meeting coincided with his half day. All GPs contacted were delighted with the phone contact. All strongly agreed it was worth the imposition of being interrupted. All had valuable insights to give about the patients and their families. All hospice doctors strongly agreed contacting the GP was worthwhile.

Almost all feedback from patients/families was positive.

All family members or patients themselves who filled out the questionnaires either agreed or strongly agreed that the meetings were worthwhile, questions were answered adequately and time was adequately allowed for questions to be posed. All either agreed or strongly agreed that functions of each health professional was adequately explained and they communicated well. Interesting free comments from patients who attended their own meeting included "It felt it a bit fussy"

"I went along with the idea of the meeting more to please people rather than the conviction of it being necessary". Family free comments included, "We as a family thought the meeting and the attentive care of the staff was fantastic and no words can express all the gratitude we feel toward you all for caring for our loved one", "We felt free to ask questions and were glad of replies", "It makes huge sense all who will be involved in my care get together and discuss discharge plans"

Themes discussed were primarily centred on updates in patients' health status. Updating was about improvement of patients' condition and discharge planning in 50% of cases. Updating about the deterioration in patients and issues around their end of life care was discussed in the other 50% of cases. It was felt a family meeting was necessary in 50% of cases to facilitate optimal communication as there was a large extended family involved.

CONCLUSION

This study affirms that family conferencing is indeed an excellent tool for communication and rapport building between patients their families and their health care workers. It highlights how they are used at flashpoints in caring for patients when goalposts are shifting. The dichotomy being

- a) Patient improvement and attainment of symptom control with a view to discharge to the community
- b) Patient deterioration as goalposts shift to end of life care.

It also underscores how emotionally fraught meetings can be for the patient and family. Meetings can be daunting, especially for a patient, as he/she enters a room full of loved ones and staff. One patient who opted to join the meeting halfway commented "I would have preferred to been present at the start and then left to allow family to ask questions". Interestingly, data supports "inclusion" of the GP by brief phone call after the meeting, as a potentially feasible course of action. Hopefully, this study will the pave the way for further study in this important area.

PRESENTED

At Specialist Registrar in Palliative Medicine Day, Friday 9th March 2007 in Milford Hospice, Limerick.

Health Services Research and Development

title	Researching the Implementation of Community Mental Health Promotion Programmes
author	Barry, M. M. Health Promotion Research Centre, National University of Ireland, Galway

INTRODUCTION

Understanding the process of programme implementation plays a critical role in advancing research, practice and policy in mental health promotion. This paper focuses on the implementation of community mental health promotion and considers the challenges presented in implementing and evaluating complex, multifaceted interventions carried out in the context of dynamic community settings.

METHODOLOGY

The Rural Mental Health Project¹ is used as a case study to illustrate the practical and research challenges encountered in implementing and evaluating a community mental health promotion initiative. This case study highlights the factors that contributed to the successful implementation and evaluation of a community-based intervention for rural communities on the border region in the Republic and Northern Ireland. This project entailed delivering multi-faceted interventions to diverse population groups across mixed communities in collaboration with a range of cross-border agencies and community groups. Grounded in an extensive needs assessment² the project delivered a range of interventions on awareness raising activities, community workshops, together with the adoption of structured mental health promotion programmes in schools and community settings based on international models of good practice.

A programme logic model was employed to provide a framework for evaluating project inputs, process, impacts and outcomes. The extent and quality of project implementation was monitored throughout the project, together with the degree of community participation, inter-agency and cross-border collaboration. This evaluation approach entailed using a multi-method approach, with both quantitative and qualitative data being collected from a variety of sources including project staff, steering group members, project participants, programme implementers and community members. In order to assess community level outcomes, cross-sectional surveys of the two project communities and a reference community were conducted prior to and following implementation of the project. Approximately 250 randomly selected community residents were interviewed in each of the three communities at baseline in 1997/8 and again in 2003/4 following project implementation.

RESULTS

The project embraced a partnership model of working both within and between the two local communities. Local agencies and groups were actively engaged in the planning, development and delivery of the project activities. The adoption of a structured planning model guided the implementation of the project and provided an overarching framework to steer the planning and implementation process. The project created opportunities for cross-border collaboration in developing innovative and evidence-based programmes in schools, training and employment agencies, women's groups and farming organisations. These initiatives sought to build meaningful dialogue among community members and enhance strategic cooperation between agencies across the border in promoting the mental health and quality of life of their local communities.

The findings from the community survey indicated improved awareness concerning suicide and depression in both intervention communities, with a trend towards increases in concern levels about suicide for males, and more positive attitudes towards seeking professional help³. Interviews with key players in the project were also undertaken to establish their views on the success of the project in meeting its objectives. Among the factors identified are: a partnership model of working; local coordinating structures and consultation mechanisms; use of a structured planning model to guide programme planning and implementation; mobilization of cross-community and inter-agency support; a comprehensive logic evaluation framework to assess the input, process, impact and outcomes of the project as it unfolded.

CONCLUSIONS

The Rural Mental Health Project case study illustrates the importance of a comprehensive evaluation framework when implementing complex community programmes. This project entailed extensive local, cross-border, and inter-agency collaboration. The evaluation model provided an opportunity for the research team, project staff and steering group members to work together in formulating project design, sequential planning and identification of project goals, desired outcomes and the project activities necessary to achieve them. The evaluation therefore, became integral to project planning with the results from impact and process evaluations being used to refine the setting of action plans. The evaluation also provided a solid foundation on which to build sustainable actions and ensure that a balance was struck between addressing competing local agendas and developing sustainable effective initiatives. The case study illustrates that implementation research enhances knowledge of the relationship between process and outcomes and from a research perspective increases our ability to map the critical connections between the local context, programme activities and the intended intermediate and long-term project outcomes. This information is critical to the effective adoption of programmes and the translation of research into practice.

PRESENTED

As a Paper on Bringing the evidence to life: Connecting and evidence and practice for the promotion of mental health at “*Roundtable discussion with policy makers, researchers and practitioners*” at McCaughey Centre for the Promotion of Mental Health and Community Wellbeing, School of Population Health, University of Melbourne, Australia. Melbourne: 7 March, 2007, by Barry, M.M.

As a Plenary address on Applying Evidence into practice: Lessons from a cross border rural mental health project, at “*Public mental health: the art, science and politics of creating a mentally healthy society: A four nations debate*”, Edinburgh: 26 October 2004, by Barry, M.M.

PUBLISHED

Barry, M. M. (2007). Researching the implementation of community mental health promotion programs. *Health Promotion Journal of Australia*, 18, 240-6.

Health Services Research and Development

title	Review of Research Ethics Committees & Processes in the Republic of Ireland
author	Morrissey, M., Daly, M. Corcoran, R., Hegarty, H., Warren, A., Roche, L., O'Toole, E., Hurley, M., Keenaghan, C., Smith, L., McDaid, C., Delaney, E.T., Maguire, T., Doran, J. Health Intelligence, HSE, Palmerstown, Co. Dublin Audit and Evaluation, National Quality and Risk Team, HSE, Tralee, Co. Kerry

INTRODUCTION

The first Research Ethics Committees (RECs) were introduced in the 1960s to ensure participants' rights in research. In Europe, increased attention has been paid to REC procedures since the 2001 European Clinical Trials Directive came into effect. Historically in Ireland there has been an absence of standardisation with respect to such committees resulting in variation in practices across committees. The difficulties arising from these variations are not unique to Ireland. Internationally there is a move to improve REC approved systems and processes.

RATIONALE

The REC review group of internal Health Service Executive (HSE) staff and external agencies was established in January 2007. The group was tasked with conducting a comprehensive review of RECs on behalf of the Medical Education, Training and Research Committee (METR) of the HSE. The overall review aimed to identify the current RECs and their processes of gaining research ethics approval. This review was conducted collaboratively with the Office of the Minister for Children who commissioned research in this area.

OBJECTIVES

- To quantify the number and location of RECs in Ireland
- To identify what processes they use for granting REC approval
- To collect any documented processes or Standard Operating Procedures (SOPs) that are available from the RECs
- To record their activity levels in 2006
- To identify the scope and amount of research they approve
- To identify the training needs of RECs
- To ascertain their preferred mode of training
- To ascertain REC members, researchers and participant views, attitudes and expectations for improving current RECs structures and processes

METHODOLOGY

A multi-method approach was used in the review. These were:

1. An exploration of the research ethics systems used in other countries through online searches and personal communications with experts in those countries.

2. A questionnaire sent to the Secretaries of all known RECs.
3. A consultation day with members of RECs, researchers, patients' representatives, experts and policy makers.
4. Interviews with REC chairpersons and administrators. The review at the time (August 2007) identified 50 Research Ethics Committees in the Republic of Ireland.

RESULTS

Key issues raised were:

1. The need for standardisation. Participants expressed a resounding desire for standardised processes across research ethics committees. Facets of this include the development of a single application process, the agreement of standards for turnaround times of ethics applications, and guidelines for consent with vulnerable populations, composition of membership and competencies of committees and workload.
2. The need to increase the support capacity for RECs. Such support includes dedicated administrative support, access to training, and access to specialist knowledge, IT support systems, and dedicated time for participation on RECs.
3. The need for high level leadership on issues such as governance, quality and accountability in a way that supports local structures.
4. Communication was raised as an issue at all levels of the research review process. This includes the need for improved systems at local and national levels between all stakeholders.
5. The enthusiasm of participants involved in this area and the desire to formalise a network to support the development of knowledge and expertise is clearly evident. There is a commitment to optimising the research experience to improve the health of the population while minimising the burden on RECs, researchers, and in particular, the population.

RECOMMENDATIONS

The report makes four main recommendations to address these areas of improvement to enable RECs meet their functional responsibilities.

1. A national REC resources unit should be established which would be responsible for a number of functions such as standardisation of the REC application process and procedures as well as training and advice.
2. A database/panel of individual experts should be available to steer the implementation of the recommendations of this review and as required provide expert advice on specific dilemmas for committees and the implementation of the recommendations of this review.
3. Resources should be made available to support committees locally and the national resources unit. A budget needs to be made available for this purpose.
4. Communication needs to be improved at all levels and strategy developed for its implementation.

CONCLUSIONS

Many of the recommendations of this review complement and support the recommendations of the METR strategy. The engagement of key REC stakeholders in this review provides the foundation for collaborative working to implement these recommendations in line with HSE priorities.

Appendix of full review group available on request.

Health Intelligence Initiatives

Population Health

title	An Initiative to Develop a National Inquest Support and Information System
author	Arensman, E., ¹ Corcoran, P., ¹ Williamson, E., ¹ Perry I.J., ² Kelleher, M. ¹ National Suicide Research Foundation, College Road, Cork ¹ Department of Epidemiology and Public Health, University College, Cork ²

INTRODUCTION

Ireland has made significant progress in suicide research and prevention in the past decade. Despite this, there are major gaps in our knowledge and understanding of the causes of suicide. We struggle to respond to the occurrence of suicide clusters and the bereaved are often unaware of the relevant support services that are available. Recently, a target of reducing the incidence of suicide by 10% by 2010 was set for Reach Out, the National Strategy for Action on Suicide Prevention. However, the reliability of our suicide statistics may undermine the reaching of this target.

The Health Service Executive's (HSE's) National Office for Suicide Prevention (NOSP) has commissioned the National Suicide Research Foundation (NSRF) to establish a National Inquest Support and Information System (ISIS) to be initially piloted in the Cork region.

OBJECTIVES

The main objectives of the ISIS are to:

1. Identify and better understand the causes of suicide
2. Improve provision of support to the bereaved
3. Identify and improve the response to clusters of suicide, filicide-suicide and familicide
4. Better define the incidence and pattern of suicide in Ireland

METHODOLOGY

The ISIS will operate in close collaboration with the revised Irish coroner's system which is being legislated for in 2008. The ISIS will obtain data on possible suicide deaths shortly after they occur through notification by the coroners. It will support the provision of information on suitable support services to the bereaved.

It will obtain relevant data on factors associated with the death and the deceased in an appropriately sensitive and confidential manner from sources including coroners, the family, general practitioners and mental health professionals. Elements and functions of the ISIS are in line with existing international systems, such as the National Confidential Inquiry into Suicide and Homicide, which was established in the UK in 1995 and which provides the evidence base for the development of suicide intervention and prevention programmes.

RESULTS

The ISIS will contribute significantly to the prevention of suicidal behaviour in Ireland. In particular, Ireland would be the first country in the world to establish, at a national level, the extent to which self harm patients presenting to hospital subsequently die by suicide.

CONCLUSION

There is evidence to suggest that Ireland's prevention initiatives may have stopped the rising trend in suicide. The ISIS will be central to taking the next step of reducing suicide rates.

Knowledge Management and Health Informatics

title	Health Atlas Ireland
author	Johnson, H. ¹ Cullen, C. ¹ , Boyle, E. ¹ , Doyle, D. ¹ , McDonald, B. ¹ , Kavanagh, P., Dack, P. ¹ O'Boyce, B. ¹ , Beaton, D. ² , De La Harpe, D. ² Health Intelligence, National Population Health Directorate HSE, Dr Steevens' Hospital, Dublin 8 ¹ Health Intelligence, National Population Health Directorate HSE, Stewarts Sports Centre, Palmerstown, Dublin 20 ²

INTRODUCTION

Health Atlas Ireland has been designed to integrate geographical information technologies, database and statistical techniques. It has been designed and built on an open source web enabled platform which allows access across the Irish health sector and collaborating agencies. Open source software is licence free; standards based and is used internationally.

Grant aided by the Health Research Board, Health Atlas Ireland is custom built. This HSE project is lead by Health Intelligence, Population Health, working with HPSC, in conjunction with two universities, namely UCD and NUI, Maynooth. Health Atlas Ireland has a national footprint from the outset.

The project started in 2006 and continues to be delivered on time and within budget. Health Atlas Ireland has allowed for involved liaison with stakeholders on a national and area basis. Access to Health Atlas Ireland is role based in line with good information governance.

Health Atlas Ireland supports:

- Service planning/delivery
- Health mapping
- Geospatial research
- Environmental incident management
- A public interface that will inform the general public, which is under development.

Health Atlas Ireland is being used across directorates within the HSE.

OBJECTIVES

Health Atlas Ireland was built and continues to be developed, to bring health or health related datasets, statistical tools and GIS, together in a web enabled environment for use by the HSE and its agencies and collaborators as appropriate.

The main objective of Health Atlas Ireland is to add value to existing health data by exploiting GIS and statistics.

This is the first time all three components have been made available in one place. Previously a planner or health researcher would have to gather the information and datasets before embarking on this piece of work – but through the establishment of Health Atlas Ireland, the process is easily accessible for all users.

METHODOLOGY

After securing funding for the project through a Health Research Board grant, a tender process to secure development expertise was embarked upon. This process took some time as an EU tender process was entered into. The successful vendors were identified and appointed.

The project has been structured whereby agreed functionality is delivered on a three month modular basis. This approach has allowed for flexibility in development schedules to respond to changing needs within the HSE. This project also allows for greater cross functional work within the HSE as well as with other external agencies.

Engaging with key stakeholders (both internal and external to the HSE) was embarked upon to establish buy in to the project. Many other government funded organisations continue to offer assistance and support to the project by offering access to datasets or expertise in specific fields. This project did and continues to receive senior management and user support within the HSE.

Health Atlas Ireland has allowed for collaborative work to be concluded within the HSE and with outside agencies. Some of the work concluded to date includes supporting the reconfiguration of existing services or planning of new services, to best meet the future needs of the customer, the general public.

This project has been very creative and innovative. It exploits open source technologies which mean that there are no ongoing licence issues for the HSE as the user community continues to grow. We believe that Health Atlas Ireland is the first of its kind – bringing datasets, GIS and statistics together in a web enabled environment. Many countries have done ‘bits’ of this work but Ireland is the only country to bring all three components together. Each query to the system is done on the ‘fly’ with no pre-calculated data tables used. As the product is web based, it allows users to use the system at their own desks. The architecture allows for conjoint working by users without the need for users to be in the same place. There is a tight information governance and security structure around each component of Health Atlas Ireland.

RESULTS

As this is a new initiative, the benefits are continually being achieved. For example demographic information is very important to the NHO directorate, PCCC directorate and Population Health Directorate. Prior to Health Atlas Ireland, each area would have to request the data from the Central Statistics Office and then interoperate the data in relation to their areas of interest. With the roll out of Health Atlas Ireland, this dataset is uploaded to the system where each user (after a small amount of training) can query the system from their desk, to answer demographic questions in relation to their areas of interest.

This is also true for all the datasets within Health Atlas Ireland:

- Births
- Mortality
- HIPE (Hospital Inpatient Enquiry system)
- Cancer
- Vaccine uptake
- Road collisions
- Geo Directory

This analysis allows for:

- Decisions to be made in relation to the location of services
- Provision of maps for emergency situations, such as chemical instance or bio terrorism
- Investigations of local health concerns – such as cancer cluster investigations
- Water contamination instance, such as Galway water contamination
- Reconfiguration of hospital services, taking into account travel distances, populations etc.
- Drawing exclusion zones around locations of major instance.

The system has allowed health datasets to be available for queries in one place; this is of great benefit to researchers, who previously had spent significant time in acquiring the up-to-date datasets to conduct their research on.

Health Atlas Ireland allows many queries to be answered in a more timely fashion, but it also allows for users to query the system themselves, this allows for a continued learning within the user community of the issues and complexities of the datasets involved and indeed over time may inform better ways of data collection. As users use their own data to answer questions, they may realise better data collection will lead to achieving better answers.

CONCLUSIONS

Next steps for Health Atlas Ireland are to continue to develop additional functionality to meet the changing needs of the HSE and its agencies. To continue to aid the transformation process embarked upon by the HSE.

Other datasets such as prescribing data, environmental data and international datasets will be available through Health Atlas Ireland in the future. Resource allocation models, and quality of care indicators will be developed in the coming development cycles of Health Atlas Ireland.

In addition Health Atlas Ireland has capacity to exploit Geo Directory; to geo code addresses to ED (electoral division) or XY coordinate. This proves useful when directing staff to client/patient houses for domiciliary services and for supporting important research initiatives –

HSE, HPSC, UCD, NUI(Maynooth), DCU, Trinity, Department of Health and Children, National Cancer Registry, CSO, ESRI, OSI, Geodirectory, Road Safety Authority, National Roads Authority, Siemens Ireland, Open App.

title	A Study of a Pilot Project on the Delivery of an Evidence Based Practice Radiology Course in a Practice Based Setting using Videoconferencing
author	Morrissey, M., ¹ Maher M., ² Sayers, G., ¹ Marsden, P., ³ Hegarty, H., ⁴ Allen, M., ⁵ Keenaghan, C., ⁶ Malone, D. ⁷ HSE Population Health: Health Intelligence, Palmerstown, Dublin ¹ Cork University and Mercy University Hospitals, University College Cork ² Department of Public Health, HSE Dublin Mid-Leinster, Tullamore, Co. Offaly ³ Population Health, HSE South, Wilton, Cork ⁴ Continuing Medical Education, Dalhousie University Halifax, Canada ⁵ Children and Young People's Team, Population Health, HSE West, Sligo ⁶ University College Dublin and St. Vincent's University Hospital, Dublin ⁷

INTRODUCTION

The aim of the study was to describe the experience of participating in an Evidence Based Practice (EBP) radiology course (1 hour per week for 16 weeks) delivered using videoconferencing for specialist registrars and their tutors. A multidisciplinary group was convened to evaluate the pilot project.

OBJECTIVES

1. To assess the module contents, the opportunity for discussion during the module and the use of videoconferencing technology for both the specialist registrars and their tutors.
2. To assess whether the participants would change their current practice as a result of the course.
3. To assess whether the tutors got adequate support and training to facilitate the course.
4. To pilot a questionnaire as an evaluation tool.
5. To establish if the course had any impact on research capabilities.
6. To make recommendations for next years course

METHODOLOGY

A 'Practice-Based Learning' course was delivered in 2008 as part of the Faculty of Radiologists' 'non-interpretative aspects of Radiology' programme. The course introduced motivated doctors with little prior knowledge of evidence based medicine to its principles (for example identification of problems, formulation of questions, critical appraisal, and consideration of clinical decision options). It also promoted the appropriate use of appraised evidence, especially quantitative estimates of risk, benefit, and harm. The course was delivered through the medium of videoconferencing, a novel approach for this student group. This method was chosen as it enabled delivery of training to participants throughout the country simultaneously, thereby eliminating the requirement to travel to attend tutorials.

The 16 week course was based on the model developed at the McMaster University, Hamilton, Ontario in Canada. It was developed by Professor Dermot Malone and Dr. Marie Staunton and its aim was to train trainers to lead small groups using EBP methods on local problems in Radiology training centres throughout the country. These methods are based on the 5-step McMaster University/NHS centre for Evidence Based Medicine process – Ask, Search, Appraise, Apply and Evaluate.

In the first phase, the tutorials took the form of short interactive lectures, which were hosted from St Vincent's University Hospital. The registrars learned to ASK a structured question and SEARCH for the best current evidence. They were instructed on the basics of structured critical APPRAISAL using EBP methods.

In the final phase, each registrar completed a project by applying the newly acquired learning on a pre-selected clinical problem that combined the appraisal of best current evidence with their traditionally acquired radiology expertise and local circumstances. The participants presented their results and indicated whether or not they would be advising a change in practice for the management of their selected problem locally.

There were 8 tutors (consultants in Radiology) based throughout Ireland. The sites included University College Hospital Galway, University College Hospital and the Mercy University Hospital Cork, Mater Misericordiae University Hospital, St. James's Hospital, Beaumont Hospital, AMNCH Tallaght and St. Vincent's University Hospital.

RESULTS

This current study identified what went well on the course and what needed improvement. It provided recommendations for future programmes from the perspectives of participants and tutors in relation to evidence based practice teaching. This was achieved through open ended questions using evaluation questionnaires and through a consultation discussion forum. The discussion forum was conducted with participants only. Participants were also asked to compare the video conferencing method with the traditional didactic lecture format.

CONCLUSION

This pilot study has identified an improved method of delivery of an evidence based practice course for radiologists which could be replicated in other areas of medicine.

PRESENTED

This project was presented to the Multi-Centre Group on Wednesday 28th May, 2008 in the Royal College of Physicians, Dublin.

Health Services Research and Development

title	Let's Talk Medication Safety
author	Boyce, M., Dunne, H., McDonough, C. The Irish Society for Quality & Safety in Healthcare, Blanchardstown Corporate Park, Dublin 15

INTRODUCTION

The Irish Society for Quality and Safety in Healthcare (ISQSH) developed an initial framework document called '*Let's Talk*' in 2004, which aimed to encourage healthcare service users to become actively involved in their own healthcare for better and safer practice. The document explains how and why things go wrong in healthcare and how service users can work in partnership with healthcare professionals to get the best possible care and treatment.

The success of this document highlighted the increased interest the general public have in becoming more involved in the management of their health. In addition, the 2004 ISQSH survey "The National Patient Perception of Acute Hospital In-Patient Care in Ireland" highlighted that there was a major weakness in regard to medication safety from a patients' perspective. Almost half of the patients (47.4%) were not given any information on the possible side effects of a new medication and 12.7% of patients stated that they were not given details of the purpose of the medication. The lack of provision of this basic information to patients represents the root of many medication errors. This stressed the need for a tool that encouraged patients to be more pro-active, informed and empowered, to improve medication safety on an individual basis. The publication '*Let's Talk Medication Safety*' was developed by ISQSH in response to these results, in conjunction with The Mid-Western Regional Hospital, Ennis. The research was funded by the Health Research Board.

OBJECTIVES

To examine patients' perception of medication safety and assist them in the safe consumption of their medicine through the development of a publication entitled '*Let's Talk Medication Safety*'. The project's objectives:

- Use the results from the ISQSH 2004 survey on Patient Perception of Acute Hospital In-patient Care in Ireland with particular reference to the dimensions involving safety, medication and communication.
- Investigate best practice in relation to medication safety.
- Investigate consumer attitudes to medication safety.
- Develop a series of questions to assist consumers become more involved in the safe consumption of their own medication.
- Develop a set of guidelines for medication safety.

METHODOLOGY

Firstly, further analysis of the ISQSH National Inpatient Perception survey and the HSE Emergency Department (ED) survey was necessary to discover various patterns or trends in relation to medication safety dimensions.

Qualitative methods were employed through the use of in-depth interviews (n=11) with both clinical and non-clinical key informants, and also by undertaking consumer focus groups (n=4). This ensured the views of the provider and the needs of the consumer were ascertained in relation to medication safety. The key informant interviews provided clarity and direction to the project, concentrating on key issues in the area of medication safety. The focus groups were undertaken before (n=2) and after (n=2) the development of the booklet, to ensure that the needs of the patients were met at each stage of the project, thus guaranteeing a user friendly final publication. All qualitative analysis was undertaken using the software package NVivo. The final draft was also assessed by relevant stakeholder organisations and service providers. The project was overseen at all stages by a multi-disciplinary steering group consisting of policy makers, consultants, pharmacists and patient representatives.

RESULTS

Data mining illustrated that there is a difference in patients' experiences according to age, gender and payment status across dimensions. The main emerging trend was that male and older patients recorded higher satisfaction across medication safety dimensions, in comparison to female and younger patients. The ED Survey portrayed similar patterns. All key informants and participants of the focus groups exaggerated the great necessity for this publication. However, it emerged that the content of the document needed to be simple and direct. The main areas of concern were established as: not knowing the basics of your medicine; the lack of knowledge about the interaction between over-the counter, herbal/complementary/alternative and prescribed medicines; and over and under prescribing. It became apparent that the tool should offer tips to patients providing them with the ability and support to combat these problems. From the research, it also emerged that mistakes with medication are most likely to occur at the point of handover of care, therefore the information provided should concentrate on the interface between hospital and community care, and vice versa. There was a general consensus that the target audience for the publication should be the general public as anyone can fall sick and need medical assistance. This highlighted the widespread need for the provision of accurate information and increased knowledge on medication management.

CONCLUSIONS



Medication errors are the most common single preventable cause of adverse events and are such an important public health issue. We accept that things go wrong, mistakes and accidents happen. When they do, they need to be noticed quickly before harm is

caused; therefore, it is essential that patients have the adequate knowledge to play a proactive role by being informed, vigilant and active in their own healthcare. The development of a patient involvement tool is beneficial to users and providers.

The publication 'Let's Talk Medication Safety' was launched in autumn 2008 and will be available to patients, their careers and families. If you would like more information on the project, the launch or obtaining the booklets, please contact the Irish Society for Quality and Safety in Healthcare. (www.isqsh.ie)

Knowledge Management and Health Informatics

title	National Client Index – An HSE-Wide Initiative led by Health Intelligence
author	Beaton, D. Health Intelligence (Population Health), HSE, Palmerstown, Dublin 20

INTRODUCTION

Health Intelligence is steering a project to establish a service to enable appropriate health and social care record linkage for safer, more efficient care services, and for a range of epidemiology, research, and health service planning purposes.

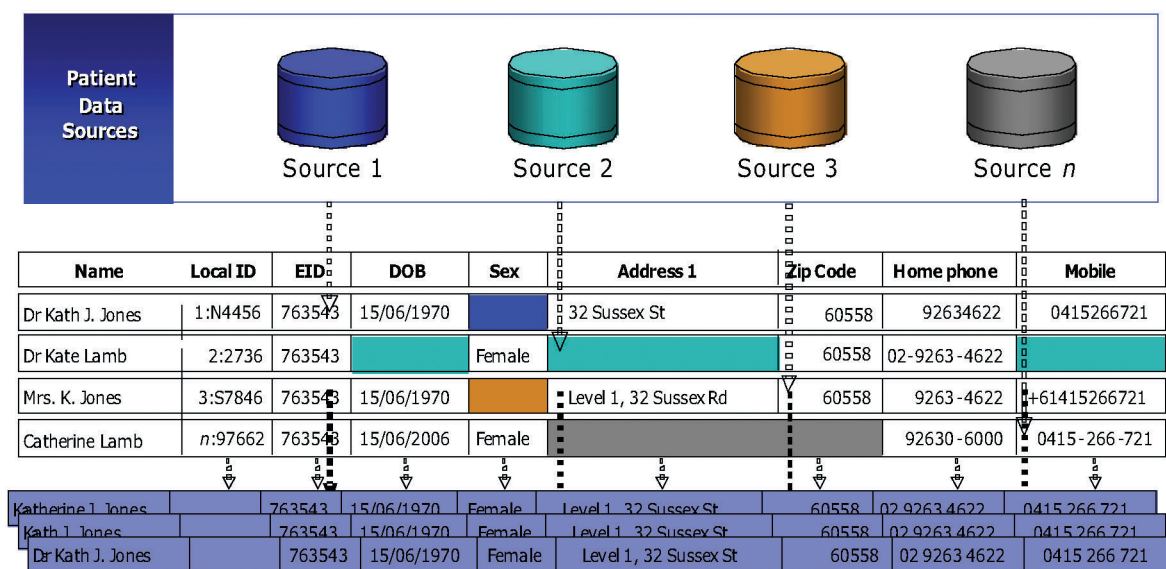
METHODOLOGY

The planned National Client Index (NCI) service will use a central 'INDEX' system that facilitates access to service user records that are stored in multiple locations and systems.

The INDEX will operate by examining existing records and linking them together using a combination of automated and manual actions, using controlled matching criteria.

RESULTS

The diagram below captures the essence of the way the INDEX will work.



CONCLUSIONS

In tandem the HSE is working closely with the HIQA and the DoH&C in a process to determine a policy decision and deployment method for a Unique Health Identifier for Ireland. When introduced, which will require legislation, a Unique Health Identifier scheme for the health and social care sector of Ireland will provide a very important step forward for efficient and effective processes of record matching.

The HSE and the HIQA are proceeding in full consultation with the Office of the Data Protection Commissioner and the NCI service will be underpinned and have as a priority the assurance of privacy and confidentiality requirements.

Knowledge Management and Health Informatics

title	The FactFile Project
author	McCarthy, S. ¹ , Cronin, J. ² , Healy, O. ² , Hegarty, H. ² Health Intelligence, HSE West, St. Camillus' Hospital, Limerick ¹ Population Health, HSE South, Wilton, Cork ²

INTRODUCTION



The HSE FactFile website aims to provide a single point of access to HSE Policy, Guidance and Activity data in an up-to-date and accessible manner to both the general public and HSE staff alike. A considerable amount of valuable HSE Policy, Guidance and Activity data is gathered from various sources within the organisation. This information is published internally in reports that inform management but may not be readily accessible to the public or many other professionals working within the organisation. HSE FactFile aims to provide an accessible location to pull these various information sources together into one electronic location and present it in a manner that is timely, accurate, intelligible and relevant to all.

OBJECTIVES

The objectives of the HSE FactFile project are to identify and utilise existing data sources and collection systems within the organisation and to provide an authoritative access point to, and location point for, accurate collated information on HSE activities and policy. The HSE FactFile website (HSEie) and Intranet site (HSEnet) is structured in an easy to use organised way which helps staff and the general public to find information on HSE activity as it relates to their respective county by use of an interactive map.

METHODOLOGY

HSE FactFile publishes information in a standardised manner with a health intelligence approach. The site was initially commissioned by the CEO's Office in October 2006. It has been available on the HSE website since April 2007 and HSE Intranet since May 2008 and is managed by the Population Health Directorate by a small team from the Health Intelligence sub directorate.

Data sources currently include:

- Performance Monitoring Report (CPCP)
- National Treatment Purchase Fund
- Performance Monitoring Units; National Hospitals Office & Primary Community and Continuing Care
- Employment Monitoring Unit
- Health Research Board
- Central Statistics Office
- LHO directories
- Capital Plan

- HSE Annual Report
- HIQA (Health Information Quality Authority)
- Research Documents and other relevant links
 - Hygiene Audit
 - Customer satisfaction

It aims to provide timely, accurate, intelligible information, which demonstrates HSE achievement towards its stated goals for a general audience, using existing data sources and collection systems: -

- To communicate agreed HSE policy
- To identify existing sources of data, collection and collation systems
- To select appropriate health information for publication
- To continually update and evaluate the website
- To make recommendations on the Health Intelligence requirements of the HSE

RESULTS

The structure of information published on FactFile by County has proven very successful and this is being mirrored in other parts of the HSE.ie and HSEnet. Publication of HSE Policy, Guidance and Activity can only help improve and enhance data quality and help strengthen the quality assurance process of HSE data collection and publication. Inaccuracies found are brought to the attention of FactFile, most often by either the relevant service provider or data collector themselves. All reported inaccuracies are investigated and amended as appropriate. This validation is an important process and has served to improve the quality of both the FactFile website and the quality of the information being provided.

CONCLUSIONS

FactFile has the potential to be a definitive source of information on HSE policy and guidance. Work currently underway in Health Intelligence is to be added to FactFile in the coming months. This will offer HSE staff and the public greater insight into the activity of the HSE and the health status of the country as a whole. The FactFile content structure allows Health Intelligence to disseminate its information effectively. In the near future, FactFile hopes to provide some commentary and interpretation of data thereby capturing and utilising knowledge to improve health outcomes for the population.

Visit FactFile

On HSE.ie www.factfile.ie

On HSEnet <http://hsenet.hse.ie/FactFile/>

Knowledge Management and Health Informatics

title	Horizon Scanning Project
author	Connolly, A.M., Murray, E., Cullen, L., Kavanagh, P., Marsden, P., McCarthy, S., Grealley, T., Johnson, H., Morrissey, M., Neeson, B., O'Toole, E. Population Health, Health Intelligence

INTRODUCTION

The Horizon Scanning service is being established within the context of the Health Intelligence Unit of the HSE to support the translation of evidence into practice through

- Appropriate extraction and synthesis of information,
- Its contextualisation into Irish setting and
- The use of influence to encourage its incorporation into national health policy and day to day practice.

OBJECTIVES

The specific objectives of the Horizon Scanning project are to:

1. Collate existing sources of evidence on specific topic questions, e.g. Diabetes, Cancer, Cardiovascular Care.
2. Publish current awareness on specific topics in a summarised briefing up to and including the most recent publications.
3. Ensure that HSE planners, directorates and departments have access to summaries of the best available evidence of what works and what may be coming down the line
4. Provide a body of summarised knowledge on a regular basis to the HSE and to other interested parties about effective health interventions.
5. Keep a watching brief/service on evidence on emerging technologies, treatments and service delivery.
6. Act as a knowledge centre/exchange on behalf of the HSE in support of evidence based planning and health care
7. Ensure Population Health skills are used in the most efficient and effective way to support evidence based health care
8. Ensure that the syntheses of evidence reach the appropriate users in the HSE and that the evidence knowledge is integrated with policy and practice

ABOUT THE INITIATIVE

This initiative builds on the previous work of the Health Intelligence Unit in developing a system and service to support Evidence Based Healthcare with its website and training support.

The focus of this project is to use existing websites containing secondary sources of evidence with systematic and structured reviews of primary evidence. This includes evidence from horizon scanning, health technology websites and websites with systematic reviews.

The horizon scanning working group consists of a range of public health staff from different backgrounds developing the products of the project.

The focus of the products will be those aspects of the HSE that are high priority and that impact on broad disease or service issues.

The initiative is currently in development and a draft template for the first priority subject, Diabetes, is near completion. A series of documents will be produced on different topic areas over time and their contents will be mirrored onto the Health Intelligence Intranet area.

RECOMMENDATIONS

The outcomes from the Horizon Scanning project will be visible in hard copy and online - summarising current best evidence on interventions in key health areas like Diabetes and Cancer. This project builds upon and enhances the Evidence Based Health Care project in Health Intelligence - offering information on the best evidence available to HSE staff, both at senior level of policy and strategy and for clinicians in the field.

FURTHER INFORMATION

www.healthintelligence.ie

Knowledge Management and Health Informatics

title	HSE Information Governance Framework – An Initiative being led by Health Intelligence
author	Beaton, D. Health Intelligence (Population Health), HSE, Palmerstown, Dublin 20

INTRODUCTION

The National Health Information Strategy states that “Information Governance refers to a strategic framework that brings coherence and transparency to information initiatives and which is responsive to the spectrum of issues and concerns of those involved” and “Information governance provides the stakeholders with a clear and practical basis for the appropriate use of health information. Issues such as information sharing, health surveillance, quality assurance, confidentiality, privacy, records management, freedom of information and data protection are included”

OBJECTIVES

In this context, and with regard to the aim to underpin a purposeful approach to integrated care, the Health Service Executive (HSE) identified in 2007, as a critical enabling project, the “Development of an information governance framework for clinical and demographic data sharing”

The specific reasons for undertaking this work are so that:

- There is greater assurance that information is being handled legally, securely, and efficiently and risks of inadvertent or deliberate disclosure are being addressed.
- All the people the health services ‘does business with’ – including patients, clients, personnel, partner agencies, and the public - will know that records will be handled appropriately, giving them greater trust in our working practices.
- The quality and safety of care will be enhanced directly and indirectly by improved linkage and sharing of information and improved accuracy of information.
- The spread of best practice and professionalism will be accelerated and duplication of effort avoided.
- The HSE and all contracted providers will be better placed to operate within the legislative and over-sight context being put in place by the Department of Health & Children (DoH&C) and the Health Information and Quality Authority (HIQA).

An Information Governance Framework approach -

- Brings together all the requirements, standards and best practice that apply to the handling of information.
- Establishes the tools to achieve and track these standards.
- Helps consistency and efficiency of practices.
- Directs training and development of employees in relation to relevant matters
- Leads to improvements in staff, service user, and public confidence.

The specific focus of the HSE project is to build on existing standards and give all health service personnel the tools and materials to help them incrementally achieve the defined requirements, and on ensuring that improvements are maintained and further improvements pursued.

The project is being pursued in the context of prevailing legislative requirements, for example currently in relation to Data Protection, & Freedom of Information.

The HSE Information Governance Framework project addresses the following closely related matters as a coherent whole:

1. Rights of Privacy, Confidentiality, Consent, and Access to Records
2. Clinical Ethics & Professional Standards / Codes of Practice
3. Guidelines and Practice on Secondary Uses – e.g. for clinical audit & research
4. Information Security - which includes but is not only a matter of IT Security
5. Records Management
6. Information Quality Assurance
7. Deployment of Data Standards and Definitions

The urgent need to pursue now a coherent approach is found in many examples of current 'dilemmas', examples of which include the requirement for greater clarity for multi-disciplinary primary care teams, and for those driving forward on integrated care across care setting and 'traditional' geographical boundaries.

CONCLUSIONS

The work will have fully succeeded in its purpose when:

- The HSE will be more assured that personal information is being handled legally, securely, and efficiently.
- Patients, clients, and personnel will know that their records will not be disclosed inappropriately which will give them greater trust in our working practices.
- The quality and safety of care will be enhanced directly and indirectly by improved linkage and sharing of information and improved accuracy of information.
- The spread of best practice and professionalism will be accelerated and duplication of effort avoided.

The HSE will be better placed to operate within the legislative and over-sight context being put in place by the DoH&C and the HIQA.

title	All Ireland electronic Health Library of Irish grey literature
author	Balanda, K., ¹ McCarthy, S., ² Bradley, L., ¹ McCune, A. ¹ Institute of Public Health in Ireland, Redmond's Hill, Dublin 2 ¹ HSE: Health Intelligence, St. Camillus' Hospital, Limerick ²

INTRODUCTION



Different types of knowledge resources in the “grey literature” - policies and strategies, reports, data (qualitative and quantitative), project details, etc - tend to be distributed across different organisations. The All-Ireland electronic Health Library (AleHL) makes it easier for people to bring together these knowledge resources in an appropriate format.

AleHL is an all-Ireland network of interoperable websites that contain knowledge resources that are relevant to health and well-being. Current members are:

- Archive of Irish Health Publications (Health Services Executive);
- Healthdata (Health Services Executive and the Irish Society for Quality and Safety in Healthcare);
- INIsPHO (On-Line) Library (Institute of Public Health in Ireland);
- National Documentation Centre on Drug Use (Health Research Board); and
- Wellnet (Investing for Health, Eastern Health and Social Services Board).

To visit the AleHL you can visit any of its member websites or visit www.aiehl.org.

OBJECTIVE

The AleHL allows you to simultaneously search over 5,300 resources that are currently held by its members as well as associated collections of other relevant resources. You can use keywords or terms taken from structured thesauri (the Public Health Language (PHL) which was recently mapped to SNOMED CT). The relevant knowledge resources of different types are presented separately together with further details of their subject, creator, etc. If you wish to view a resource you are directed to relevant member website.

For users, the AleHL provides a single search engine that allows them to simultaneously search the whole library (see Figure of new frontage). Because agreed metadata standards and well established controlled thesauri are used to tag resources, the search engine can be both sensitive and specific; returning all the relevant resources and only those that are required.

CONCLUSION

The AleHL approach offers member websites a vehicle for more widely disseminating the knowledge resources they manage while retaining “ownership” and “control” over them. All members of the AleHL benefit equally from being involved; addressing a major barrier to sharing information. In the longer term, the AleHL provides an opportunity to members to jointly develop a rational approach to the management and dissemination of the knowledge resources on their websites. With wider adaptation of metadata standards and structured thesauri, the AleHL will enable greater sharing of information to support better decision-making in health.

Footnote: The AleHL is managed, on behalf of its members, by Ireland and Northern Ireland’s Population Health Observatory (INIsPHO@IPH) within the Institute of Public Health in Ireland (IPH)

Knowledge Management and Health Informatics

title	International Summercamp - What Makes this Knowledge Network so Successful?
author	Morrissey, M.C ¹ ., O'Toole, E ¹ ., Conlon, S ² ., Somekh, D ³ ., Dunne, H ⁴ ., Buiting, M ⁵ ., Jouslin De Noray, B ⁶ . HSE Population Health - Health Intelligence, Palmerstown, Dublin ¹ Institute of Technology, Sligo ² European Society for Quality in Healthcare, UK. ³ Irish Society for Quality and Safety in Healthcare, Dublin ⁴ The Dutch Institute for Healthcare Improvement, CBO. ⁵ European Organization for Quality, EOQ, Brussels ⁶

INTRODUCTION

The change Management Summercamp concept was principally initiated by Mr. Bertrand Jouslin de Noray (former Director General of the European Organisation for Quality (EOQ)). It provides the possibility for change leaders from Business, Healthcare, Education, Industry and Academia to exchange their experiences and find new techniques and ways of facilitating change. The outcome has created a community of practice and a collective sense of responsibility about making positive changes in organizations, with the ultimate aim of having a societal impact on Europe.

The first Summercamp took place in Versailles in July 2001. Since then there have been over 28 Summercamps held in over 20 countries and more than 600 people in total have attended one or more Summercamps. The Summercamp concept is a good example of Knowledge Brokering i.e. 'Bringing together in an interactive way those who have a common interest who rarely have the opportunity to meet' (1).

The Summer Camp is a joint creation by all the participants. Summercamp uses innovative techniques and the application of psychological theory in relation to intervention with groups. Summercamp is an organic event and the creativity and enthusiasm of participants leads to unpredictable results

OBJECTIVES

As the Summercamp has been so successful and sustainable a study was conducted to determine

- The impact and benefits of being a member of the knowledge network for participants.
- How to improve Summercamp for participants.
- To identify the priorities for future Summercamps
- To learn how to effectively evaluate networks

METHODOLOGY

A survey was conducted by formal written questionnaire in August 2007 at the Summercamp in Slovenia. There were 55 attendees of whom 35 responded (response rate of 63.6%). Results were analysed using SPSS version 9. Participants included a mix of age and gender and represented over 12 different countries. The questionnaire was piloted and adjusted to accommodate the needs of participants for whom English was not their first language.

RESULTS

The following were the factors of the network which had most impact on the participants:

The impact on personal/professional knowledge, the four main areas were:

- To gain knowledge
- To access experts
- To build relationships, create a broader coalition of interest/support for your priority
- Breakthrough Management
- Management of knowledge
- Knowledge of Networks
- Effective leadership

The Impact on the respondents, organisation or community

- increased communication with other Summercamp members
- joint programmes/projects with other Summercamp members
- joint policies with other Summercamp members joint client base with other Summercamp members
- 78% said that they contacted other Summercamp members outside of Summercamp

The benefit and most valued aspects of Summercamps for the participants were

- Changed thinking
- Friendship and social networks
- Developing valuable insights
- Building a community of practice
- Identifying important questions
- the spirit of the camp
- Diversity of the Network
- Challenging current thinking
- time to reflect, renew etc

Future Considerations to improve Summercamps

- 55% referred to more opportunities for networking
- 27% simply want to continue as is
- 18% want the camps to provide more information.

The Priorities for future Summercamps were -:

- Globalisation
- Education
- Quality.

In evaluating networks in the future the researchers would suggest that if possible to have the participants identify themselves in the questionnaire. This would allow a graphical network analysis of the network and all the individual contacts and connections within it. A map was drawn for those who identified themselves and all their contacts. This gives a rich picture of the network at a given place in time.

CONCLUSIONS

Participants appreciate the opportunity that the Summercamp initiative creates. Significant numbers have attended many camps, 40% of respondents having attended five camps or more, and participating in various organisational roles at the camps with 43% of respondents financing their own attendance.

Summercamp is valued for its friendship, access to knowledge on breakthrough management and to 'experts', and challenging current thinking, developing valuable insights and identifying important questions. Lessons can be learned for those trying to establish successful networks as to the important factors what lead to their sustainability.

REFERENCES

Available on Request

title	The Development of an Information Governance Framework to Support the Development, Implementation and Operation of an on-line National Shared Infectious Disease Database
author	Brazil, J., Houlden, M., Grogan, C. Health Protection Surveillance Centre, 25-27 Middle Gardiner Street, Dublin 1

OBJECTIVE

The objective of this work was to develop and implement an information governance framework that would allow stakeholders in infectious disease management and control to efficiently and safely exchange and share highly sensitive personally-identifiable information relating to the occurrence of notifiable infectious disease across Ireland. This framework has to support the business requirements of infectious disease surveillance, and to ensure that appropriate information security management policies and procedures are developed, implemented and reviewed in conjunction with a formal risk assessment methodology. To assure users of the system and ultimately the data subjects that appropriate controls are in place and are regularly reviewed, external audit and accreditation was implemented – initially to ISO 17799 (Information Security Management) but subsequently to the updated and extended standard ISO 27001.

METHODOLOGY

An analysis of user requirements in 2000 in relation to infectious disease reporting in Ireland identified three key areas to be addressed: -

1. The need for an electronic notification system that improved the quality and timeliness of infectious disease notification and reduced the burden of multiple notifications
2. The need for efficient and effective feedback to system users in terms of infectious disease reports
3. The development of an information governance and security framework to ensure protection of privacy and confidentiality.

To enable a system to be built that could accommodate the security requirements, it was necessary to conduct a detailed business process analysis and to identify the various roles performed within the system. This allowed the identification of specific roles in relation to the system which was then used to define data access and system navigation.

The management and control of human infectious disease involves a range of stakeholders and professional disciplines that required an extensive process of communication and consultation to determine what was required in terms of privacy and confidentiality protection, whilst at the same time, ensuring the development and implementation of a solution that supported business requirements. We looked at the approach being taken in the United Kingdom by the National Health Service and noted that the NHS had identified the British Standard BS 7799 (ISO 17799) as the appropriate standard for information security management in the NHS.

Consequently it was decided that attainment of this standard would provide an objective and transparent confirmation of the development and implementation of information governance policies and procedures to ensure legislative compliance and to reassure system users and, ultimately, data subjects that their information was being appropriately and securely managed.

The first task required that the scope of the systems to be accredited needed to be identified. Initially this was limited to information handled internally within HPSC but was subsequently extended to our online national shared infectious disease database – the Computerised Infectious Disease Reporting (CIDR) system.

The second task involved a detailed mapping of the information flows both within HPSC and between HPSC and its partners in infectious surveillance and control. This allowed a consolidated view of initially differing information flows and enabled the development of the necessary information policies and procedures. Within HPSC itself this was overseen by a multidisciplinary Information Governance Committee and in relation to CIDR by a national CIDR Business Rules Committee.

RESULTS

HPSC achieved ISO 17799 accreditation in May 2004 and extended this to include CIDR in March 2005. More recently HPSC, including CIDR, has successfully achieved accreditation in February 2007 to the new updated and extended standard, ISO 27001.

One of the challenges associated with the development of an information governance framework is to ensure that all the people involved, from both the top down and from the bottom up, are aware and buy-in to this activity and to ensure that the policies and procedures developed and implemented are relevant and seen to be of value in protecting both information assets but also protecting individual members of staff when the relevant policies and procedures are followed. Another significant challenge has been the multi-agency multi-disciplinary nature of the CIDR system. Ensuring that CIDR system users remain aware of their information governance obligations in the absence of an over-arching information governance framework spanning the Health Service remains an ongoing challenge. This will be a challenge also for additional infectious disease information systems and disease registers as they are being developed.

CONCLUSION

The safe and appropriate exchange and sharing of sensitive personally-identifiable information is essential for efficient and effective infectious disease surveillance and control. Similarly the safe and appropriate exchange and sharing of sensitive personally-identifiable information for wider medical purposes is necessary to improve the delivery of health services and to enhance patient safety. Recent notable breaches of information security in Ireland and overseas, both in the private and in the public sectors, have underscored the necessity for ongoing formal externally audited information security management. This is necessary to ensure that sensitive personally-identifiable information continues to be protected and the controls necessary to ensure this are implemented and regularly reviewed.



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