Healthyregions
When Well-being Creates Economic Growth

Veneto Region

Reporting back

Nov 2010

Final Report from VENETO REGION

1) Dissemination

Questions like: What kind of dissemination activities have you organized in your region? Have you presented the project in external events on regional, national or international events?

2) Working together in the region

Questions like: How do the regional partners co-operate? Have you created co-operation with the collaborating partners? Have any new relations been created? Have you organized meetings to discuss the implementation and practical use of the project with others, e.g. politicians, regional actors etc.?

According to the regional dissemination plan that was drawn up at the beginning of the project (30 Nov 2007), our dissemination activities have been carried out according to the following objectives:

- **to involve all collaborating partners and relevant groups of stakeholders in the elaboration, discussion and dissemination of the project deliverables as well as in the implementation of the pilot projects**

  After the establishment of a regional cross-sectoral partnership of collaborating partners we have constantly worked in close collaboration with them, informing the working group about every step that was to be taken and discussing with them every document/task/deliverable that had to be achieved; the working group was established formally by means of an internal decree sent to all Director Generals of the participating local health-care trusts by the Secretary General for health care and social affairs of the Veneto Region. In this way we have acted on both levels: bottom-up by committing local decision makers (Director Generals) and top-down by committing the Secretary General of the Veneto Region to the objectives of the project. Most working documents and final deliverables have been translated or summarised in executive documents or briefs so as to keep all stakeholders informed and on track, given the objective difficulty of most stakeholders to read English. The decision making process has always been shared among the regional partnership: in particular some key partners at regional level have been asked to facilitate certain dissemination activities that involved strategic stakeholders (Regional Ministries, Secretary General, Senior executives and Heads of Regional Departments, etc..) whereas other dissemination activities at local level have been facilitated by local collaborating partners (heads of local services, Director Generals of local health-care trusts).

A preparatory meeting to the **Evaluation Seminar** involving all the collaborating partners was held in Verona in September 2009: a working document for the evaluation of their participation in the process was presented at the meeting and then shown at the Swedish Partner Meeting of the Healthy Regions project.

We evaluated their project meetings attendance, the activities related to the dissemination of information about the Healthy Regions project in their professional network, and their participation in the production of the deliverables.

More precisely, two questionnaires were administered: the first one in Dec 09 (Process Evaluation) and the second one in June 10 (Final Evaluation).

The main topics of the Questionniares were the following:

Project Meetings attendance

All the Collaborating Partners attended all the project meetings held in Verona from November 2007 to September 2009.

(In addition, contacts by mail and phone were used to spread and gather relevant information for the implementation of the project)

One C.P. (A. ULSS n.9) also took part in a Partner Meeting (UK, April 2009).

Dissemination activities

The CPs disseminated information about the Healthy Regions project:

- in their respective Local Health Care Trusts (during meetings with the Prevention Departments members, taking part in round tables, participating in multi sectoral working groups in the Health Care Services).
- in the schools (teachers).

Many health professionals were involved: community nurses, health visitors, psychologists, doctors.

Collaboration for the Deliverables

Conceptual paper (D1)

The draft of the Conceptual paper was sent to the CPs asking for their contribution and critical review. Maybe due to the short time and to the objective difficulty of most stakeholders in reading English, just one CP gave inputs to finalise the Conceptual paper.

Mapping based on the Dialogue tool (D3)

All the CPs, except one, actively participated in the mapping exercise based on the Dialogue tool.

As underlined above, this was a very fruitful occasion to start a dialogue between the collaborating partners and regional representatives in the field of health promotion, so that this partially made up for the lack of coordination and communication between local services that deal with health promotion and education and the regional level in our region.

Projects implementation (D9)

All the CPs implemented at least one pilot project in the school setting.

3 CPs implemented two pilot projects in this academic year.

All the pilot projects were concluded on **May 2010**.

Finally, on July 2010, the results of the Final evaluation Questionnaire were disseminated among the CPs.

- **to involve strategic senior executive officers of relevant Regional sectors and Departments and a selection of professionals in the mapping exercise and analysis of regional public health competencies**

  The mapping exercise and the SWOT analysis of regional public health competencies have been carried out through the involvement of our regional partnership and in particular with the inclusion of "key observers" working at strategic level within the Region in different sectors related to health. Meetings, contacts by mail and phone have been used to spread and gather information relevant for the implementation of the project. Posters, tables and other overviews summarising or explaining the project's objectives, instruments and tasks have been elaborated in Italian or translated during the meetings to facilitate the discussion and analysis of the Regional status quo among stakeholders.

- **to advocate the public health strategy proposal among regional policy makers and get their support to mainstream pilot projects' best practices**

  Unfortunately the Regional health minister changed during the implementation of the project, which has obliged us to repeat certain dissemination activities already done at the beginning of the project with the former minister. On March 2009 the current Regional minister for health visited our centre and we took this chance to talk about the Healthy Regions project's future steps. Also the Secretary General has been reminded of the next phases and tasks by our colleagues of the Brussels Office during a visit there.

Also at European level, activities have been carried out to reach these objectives:

1. to disseminate the project and its results through the European networks of regions (EUREGHA and ERRIN) of which the Veneto Region is member;
2. to liaise with the project partners' Regional Offices in Brussels.

In particular, the Veneto Region presendency of the EUREGHA network has offered a lot of chances for the dissemination of the Healthy Regions project as a best practice among the European regions and also through the EUREGHA newsletter. In addition, the Veneto Region's Brussels Office has constantly kept in touch with the Main Partner's Brussels Office and facilitated communication and exchange.
Also the Agenda of the Final Conference was distributed to the EUREGHA network.

Ways of dissemination:

We have taken advantage of all possible opportunities to disseminate information about the project through our web-site, or using press releases (i.e. holding a press conference in Verona with the former

Regional Ministry of Health and recently publishing **a second press release on the website of the Veneto Region**– March 2010) and other media at local level, such as local newspapers and broadcasting networks (i.e. communicating the start up of the project to the Press on the Regional web-site and on a local television).

Other dissemination channels and tools that have been used are: regional and local networks; formal communications between institutions, by means of decrees, letters, regional deliberations etc..; information activities (conferences and meetings) using translated summaries, power point presentations and other informative materials; mailing lists, telephone.

Recent activities:

November 2009: a regional report was spread out among stakeholders; the report describes the **results of the mapping exercise** focused on health services and best practices for children and young people. The report was presented by the regional ministry of health in a press conference held in Verona on 20th Nov 2009.

Dissemination about the Healthy Regions project (**Brochure**) was also made in occasion of the following events:

1. **November 2009:** participation in a **National Meeting** on best practices in Health Promotion (CIPES Conference) **in Sicily**.
2. **22nd and 23rd of February 2010: National Meeting in Torino** on health promotion**.**
3. **25th of February 2010 (Verona): workshop** on the regional MAPPING exercise on health services and best practices for children and young people.

Pictures of this events were published on the Regional Centre for Health Promotion website (crrps.org) on the page dedicated to the project.

Finally**, the new web forum** has been a very useful platform to exchange materials and experiences, speeding up communication between partners.

In August the Agenda of the Final Conference in Brussels was sent to all the members of the EUREGHA network.

In October 2010 a **press release** about the Final Conference of the project was published **on the website of the Veneto Region (http://www.regione.veneto.it/Notizie/Comunicati+Stampa/Ottobre+2010/1755.htm)** and on the online journal "Oggi Treviso" (http://www.oggitreviso.it/sanit%C3%A0-veneta-partner-di-un-progetto-ue-29073) reporting also the comments of the new Regional Health Minister.

In addition, 150 copies of the ***Projects Catalogue*** (properly supplied with a description of the whole project, Index and Introduction) were **printed** and **disseminated** to all Director Generals of the Local Healthcare Authorities in the region. The ***Catalogue*** was also sent to all the heads of Local Healthcare Authorities' offices for health education and health promotion or to the Local Healthcare Authorities' offices for food security and nutrition. Additional copies were sent to the Local Services which took part in the Healthy Regions Project as Collaborating Partners.

The Catalogue was also sent to some Senior executives of the Veneto Region, working in the field of Public Health.

Difficulties encountered in the dissemination activities with different stakeholders

As said before, the Regional Centre for Health Promotion has constantly kept in touch with all Collaborating Partners by e-mail updates or asking them for advice and commentaries when writing or revising documents or validating the translation of the tools.

The problems encountered with the collaborating partners have been sometimes related to the difficulty in keeping them involved and committed throughout the project implementation especially during the strategic work of the project where they were not directly involved.

A good opportunity to keep them committed has been to invite them to participate in the U.K. Partner Meeting, though the majority are not so fluent in English to be able to take actively part in a meeting, and therefore the selection has been "biased" by this factor.

In addition, supported by the staff of the RCHP, two CPs attended the last Partner Meeting (Verona Apr10) to present the projects included in the Catalogue and discuss, in plenary session, strenghts and weaknesses of the method and report the results.

Another way to raise motivation among regional collaborating partners has been to give added value to their active participation in the project, in terms of prestige and visibility at regional and European level: for example, the services involved in the pilot projects needed a formal commitment on the part of the Director General of their local health-care trust, so we planned dissemination conferences at strategic level for the directors of local health-care trusts and engaged the Regional Secretary for health and social affairs to send local Directors a formal letter communicating the interest of the Region in the Healthy Regions project and inviting them to participate in the project activities as collaborating partners.

Another example of added value offered for the participation in the project was the provision of 19 credits for the participation in the consensus conference on the project's tools and protocol: according to the regional and national health care training system, professionals must attend some training events in the form of conferences, workshops, seminars etc.. throughout the year; every event is awarded a number of credits by the national and regional health care training authority; every professional category must get a specified number of credits ranging from 100 to 150 in the course of the year. So thanks to this additional value attributed to the HR consensus meeting, we have been able to assure their full participation.

A general problem with the dissemination among policy makers, politicians and professionals has been related to the language issue: most of them are not fluent in English and therefore cannot have access to the original documents of the project, but need to be given executive summaries in Italian which are necessarily incomplete.

Another difficulty encountered with policy makers has been in getting their attention and availability for an interview because of the Summer period and their full diaries.

3) Working together with the international partners

Questions like: Have you co-operated with other partners in the project? Have you gained experiences from other partners in the project? How and what?

Working together with the international partners has been very stimulating. In particular, we have kept in touch with the German partners on the issue of healthy eating and have exchanged materials on the best practices presented by them during the P.M. in Kiel. These materials sent by our German partners have been circulated among the Services that deal with nutrition and health education across the region to raise their interest and possibly propose a replication of the German best practice. We have also held a meeting with the regional coordinator for nutrition and health education to present the German example as a possible improvement of the current methodologies and activities in the Veneto Region. The result of this dissemination activity has been quite fruitful because the nutrition experts and professionals were all very interested and willing to know more about it. Unfortunately, they were not in a position to actually start replicating the best practice in a pilot project for shortage of personnel and lack of financial resources, but they were willing to spread information about this best practice and start discussing possible ways to include it in their own routine activities. After the P.M. in Kiel, we have also been very interested in the development of the Mapping tool as presented by Prof Gulis during that meeting. We have now seen the last version of the tool and think that a great job has been done with a high scientific value. We would like to have the chance to propose this tool to the municipalities that can use it to assess competencies for the community planning process. As a follow up of the Brussels P.M., we have established a connection at strategic level between health politicians with the Swedish partner, taking advantage of the fact that a Swedish politician had planned a visit to the Veneto Region.

4) Using the tools from the project

Questions like: How have you worked with the tools from the project? What are your experiences from this work? Has the use of the tools led to any positive results / dialogue / initiatives /development in your region? Can you say anything of which level you see any effects; e.g. practical level, political level, regional level, local level etc. What kind of challenges have you met in your region in terms of the implementation; e.g. structural, political, practical?

On the front of the **mapping of health competencies and,** in general, of the **tools' implementation** during the implementation of WP5 – led by Veneto Region:

Working together with the international partners on the Dialogue tool was very fruitful as all the different perspectives and contributions were integrated in the final version of the document. However, we found some difficulties in the translation of the dialogue tool because we needed to adapt the English version to the local context in order to have a tool which could be useful for and meaningful to our target.

The elaboration of the **procedure protocol** for the administration of the dialogue tool has increased the quality and cross-validation of the mapping exercise, for each participating region could choose from this

tool box its own method to implement the mapping exercise within a framework that had been commonly agreed by partners.

Now that the mapping exercise has been almost completed in all regions, once filled with all the methodologies adopted by partners, the procedure protocol can be considered an "open resource book" of good practices for all regions to draw on.

Regional local offices for health promotion were involved to detect best practices in the different sectors of health promotion and health prevention, with a particular focus on sexual and reproductive health , healthy eating, and smoking prevention among young people;

key policy makers in the field of health at regional level were interviewed for the piloting/use of the tool among policy makers;

two regional workshops were held to use the dialogue tool and to validate the protocol with senior health professionals in charge of health promotion at local level. They took place in Verona, in September 2008, according to a specific training module that had been acknowledged as statutory training by the Regional and National Council for health professionals' training. Thanks to this added value, attendance was compulsory for our target stakeholders and so the turnout was high.

During these meetings the first session was dedicated to a general dissemination about the project's objectives and its relevance for the regional health policy.

Key decision makers in the field of health promotion at regional level were asked to analyse the Dialogue Tool in order to provide their comments on the tool structure and information about the different health themes.

The two groups filled in the Dialogue tool separately and came up with two different "spider webs", each providing evidence to support their evaluation.

From this exercise, two distinct perspectives of the future regional health status resulted and were consistently different:

1. the first group kept choosing lower levels and seemed to have less rosy expectations about the regional future development in the areas considered;

2. the second group, instead, always chose higher levels in comparison with the former, showing more confidence about the future.

This discrepancy was mainly due to the different time spans chosen: the first group chose a 3-year perspective, and therefore draw a short-term trend which could allow little change, whereas the second group considered a 30 year period which allowed them a more positive view about the future.

The results of the mapping exercise and SWOT analysis can be summarised as follows:

Main results of group 1
Present level: anchored between lev 1 and 2.

Short term perspective: less rosy prospect, things will remain unchanged or in some cases will worsen (health promotion, strategic health).
Only one exception: health education starts from level 2,5 and will reach level 3.

Main results group 2
Present level: good start between level 2 and 3.
Long term perspective: more confident prospect, in the long run things will remain unchanged or in some cases will improve (health promotion).
Two best practices from level 3 to level 3: health education, and public health competencies.

Comparing the groups
Differences
Health promotion will worsen for group 1 whereas it will reach lev 3 for group 2;
Strategic health will worsen for group 1 whereas it will stay at mid level for group 2;
Only group 2 think that though starting from lev 1 mainstreaming will reach lev 2 (for group 1 it will remain at lev 1)
Group 1 always started from lower levels except for health as economic growth (from lev 2 to lev 2).

Similarities
Both groups gave high ratings to health education, which is regarded as a best practice, and to public health competencies
Both groups gave low ratings to health and culture (the weakest area for both), and to the level of mainstreaming and to health as economic growth.
Both groups think the level of empowerment will remain the same.

On the whole, as far as health promotion and strategic health approach in the Veneto Region are concerned, both groups lamented:

- the lack of coordination, integration and communication between regional depts and policy makers:

  about this issue, let me remind you that health promotion in the Veneto Region is divided between two main health departments - health care planning and public health/disease prevention; our centre refers to the former dept. but coordinates 21 local offices for health promotion and health education that directly report to the latter dept.; what's more, nutrition and food safety along with animal health are dealt by a third department and many times the local offices for health promotion also deal with food education and nutrition.

- the lack of coordination, integration and communication between health-care services within the same local health-care trust

- the lack of a formal agreement between the National Ministry of Education and the Veneto Region – health and social affairs - for health education and health promotion in the school setting;

  similarly, within the local health-care trusts, the fragmentation between regional depts is reflected on the fragmentation between local services that deal with health promotion and health education, in particular in the school setting. For example, schools are accessed by health care services for lots of different objectives: there are services that deal with sexual health education, services that focus on nutrition, services that deal with road education and injury prevention, services that promote physical exercise etc.. All these services do not have a common framework of priorities and rules while interfacing with school authorities, but simply negotiate their offer with every single school. Interventions therefore often become "spotlike" and eventually ineffective because of the lack of an overall strategy on the part both of the health care sector and of school authorities.

- the lack of an official comprehensive document on the regional strategy for Health Promotion;

  the Regional Plan for health-care and social services is still under examination within the Regional Parliament. Health promotion has been included in the draft plan, but most health workers think that it still lacks a comprehensive strategy for health particularly focused on cultural, social and environmental determinants.

- the fact that local health care trusts do not mention health promotion among the priorities of their operational plans.

  This is almost due to the fact that, on the one hand, the Region, through the Secretary for health and social affairs, can evaluate and possibly influence the general policy of local health care trusts, by saying for example that Directors General must meet a set of objectives, among which health promotion, if they want to be positively evaluated by the regional government and consequently be confirmed in their role for another five year period – Directors General are appointed by the regional ministry and the secretary for health and social affairs every five years; yet, on the other hand, they are fully autonomous in setting their own targets and objectives. For this reason, the regional health-care system has often been compared by the media with the feudal system populated by nearly independent barons (here in the Veneto Region, the Directors General of the 21 local health care trusts) who may or may not follow the instructions of their king (the regional political government).

- the need for service provision reorientation according to a real needs assessment.

- **National Survey**

Regional local offices for health promotion were also involved in a national survey aimed at detecting best practices in the different sectors of health promotion and health prevention, with a particular focus on sexual and reproductive health and healthy dietary style among young people.

As set by national guidelines, a one day training for data collectors (health Services stakeholders) was carried out, and participants were provided with a proper manual including definitions of the questionnaire items and procedure guidelines.

Data were entered in a national web database after a six month data collection and for the future will be available for researchers and other professionals of the health care system at different levels.

The Vento Region collected data about 245 projects related to 6 different health themes:

- Sexual and reproductive health
- Addiction
- Mental health
- Physical exercise
- Nutrition
- Road injuries

As a result of this national survey, a regional report of the services and best practices for young people has been recently drawn up and will be spread out across the Region. This is an additional deliverable achieved under the umbrella and in synergy with the Healthy Regions project because we used the survey as another instrument for mapping health competences for WP4 and indeed took a lot of information from the survey data set for the identification of regional best practices and the elaboration of the project catalogue.

- **Traffic Light Matrix**

As for the use of the traffic light matrix (unabridged version) we carried out a feasibility study to understand if this tool could be used and applied to the Veneto Region's context.

As a matter of fact, our research was focused on analysing the origin of the tool to explore the possibility of adapting it to a different context like Italy, and Veneto Region in particular.

The main research question was: is the tool transferable to and meaningful for the Veneto Region's health care system?

The question brought us first carrying out a feasibility study that included:

- literature review to gather knowledge on the background of the tool
- translation and adaptation of the tool to the Italian context with a choice of meaningful/feasible sectors and criteria
- piloting of the translated version
- desk research to find out IF and WHERE relevant information and aggregated data can be drawn from the regional epidemiological system and relevant ministries

- gathering of results into a final report

The findings of our feasibility study are described below.

Findings of the feasibility study

The background

This tool originates from a British context and is strongly influenced by the local background and structure of the national health service.

It was first developed by researchers from the East Midlands region of the UK with the aim to prioritize sectors for intervention within Regional Skills Partnerships.

It was the result of a general trend that started soon after the reforms of the NHS in the 80's and was geared to evaluate and constantly monitor the quality of the NHS.

As a matter of fact, on the spur of the clinical governance approach of the late 90s, the tool was used to highlight the need for quality standards and at the same time for a

broader involvement of the NHS professionals and ultimately of patients in the evaluation of services' quality and definition of priorities for the NHS.

It consists of looking at selected sectors against a series of criteria and then rating them using a simple traffic light system and presenting it in a matrix.

One has to be aware, however, that there is a lot of evidence gathering and sector selection prior to producing the matrix, therefore a lot of preparatory research is needed.

A good example where it can be used in the UK is the Joint strategic needs assessment - introduced in the white paper (Our health, our care, our say: a new direction for community services) issued by the Dept. of health in 2006 and confirmed by the Local Government and Public Involvement in Health Act in 2007.

Since 1 April 2008, local authorities and PCTs have been under a statutory duty to produce a Joint Strategic Needs Assessment (JSNA). JSNA will inform Local Area Agreements and the Sustainable Communities Strategy as well as PCT operational plans.

The Joint strategic needs assessment is based on a core dataset which provides a rich list of indicators investigating the life conditions of local communities, taken from the National Indicator Set and Vital Signs as a good foundation which can be supplemented with local data and information.

In this case, information and data required for the evaluation process are therefore collected in a standardised way on a routine basis and with a bottom-up approach.

All this evidence brings us back to the initial **question**:

Is the tool transferable to other contexts?

The answer

The tool, as it is presented now, is too strongly rooted in its original background to be used effectively and meaningfully in a different country.

The choice of the list of sectors strongly depends on the structure of the National Health Service which is different in every partner region/country.

The list of criteria against which one is asked to rate every sector implies the possibility of getting information and single or aggregated data that are already monitored within the health care system and can be therefore systematically collected and reported.

In other words, being the national/regional health service very different in each partner region, it is extremely difficult to find an instrument that can be applied in every context.

As for the Italian context, data could not be found in the same aggregated form as indicated by the criteria used in the UK: this is because in the UK the NHS has been planned in such a way that certain indicators, such as the number of people employed in

the pharmaceutical sector and biotechnologies or the productivity of the public and private health care sectors are routinely monitored and can be easily reported.

Though recent reforms in Italy, like in the UK, have brought the issue of clinical governance on to the political agenda - which has similarly meant setting priorities, standardise procedures and health care, maintaining and improving the quality of patient care within the health system, in short, assuring the quality, accountability and proper management of health and social care organisations - still the national and regional health services lack a well structured baseline information system.

At regional level, these reforms have entirely devolved health to Regional Governments and local authorities endowing them with great autonomy to set their own regional health care models.

In the Veneto Region, local governments and local health care trusts do meet in strategic partnerships for a joint planning of local health and social services, which reminds us of the JSNA in the UK. Yet these partnerships are not based on a solid information system which remains one of Veneto Region's future challenges.

5) Results

Questions like: What are the main benefits from the project in your region up till now? What kind of learning processes have you gone through? What have you learned and how can it be put into practice?

6) How do you want to proceed

Questions like: Based on your experiences, what are your main challenges in the future of the project?

On the whole, we can say that the main benefits of the project in our region have been the following:

The mapping exercise and SWOT analysis have acted as an eye opener for the strategic level and as a confirmation for the professionals working at the practical level, who were already fully aware of the gaps existing in the health sector.
Its main benefit has been to draw attention to structural weaknesses that need to be addressed as soon as possible, namely the lack of coordination and integration among regional departments and local social and health care services. It has been important for us to use the project's framework to give legitimacy and endorsement to a well known dissatisfaction among health workers with the lack of a coherent regional strategy for health.

The fact that the Veneto Region signed a contract for a E.U. project focused on a regional strategy for health has helped us advocate the need for coordination and intergration in the health sector and speed up the process of quality improvement in the light of the project's work plan and time frame. We have also had to face the impact of a change of health minister soon after the start of the project and we have risked loosing the improvement gained up to that time with the former regional minister of health. However, under the umbrella of the Healthy Regions project and on the spur of the tasks to be carried out according to the project's work plan, we have been able to make pressure on the strategic level and thus on the new minister of health to acknowledge the existence of the project and the compelling need to carry out its tasks and achieve its objectives.

On the practical level, the participation in the project of regional collaborating partners has helped strengthening the collaboration within the network of local offices for health promotion and between these offices and other health services and stakeholders, creating synergy and integration at least at the level of local practices.

The following list of actions carried out on both levels can also be regarded as positive results of a work that is however still in progress.

Given this situation, the work that we have tried to do at strategic level can be summarized as follows:

- 13 March 09: the new regional minister of health visited our centre and we took the opportunity to present/remind him of the HR project's next steps. Similarly, a few days before, the Regional Secretary General for health had visited our Brussels Office and had been reminded of the HR project's next steps as well.

- 02 Dec 08 - 27 Jan 09 - 17 Feb 09 - 13 Mar 09 - 16 Mar 09: we had a series of important meetings/contacts with the senior executive, head of the regional department of public health (mainly based on disease prevention) to establish a common ground for collaboration on a set of key issues for the development of a regional strategy for health. As said before, one of the main weaknesses that emerged from the SWOT analysis using

the dialogue tool was indeed the lack of coordination, communication and synergy between the different regional departments that deal with health. Our centre does play an important role in linking these three areas and has therefore taken the leadership in this attempt to create the basis for an integrated regional health strategy. But though we have gone a long way, yet a lot has still to be done to create a common ground for collaboration. This is why we started a dialogue with the new head of the regional public health dept.. We have drawn a proposal and discussed it with our counterparts of the public health dept.; it has been amended and examined. It was then agreed and finalised, so that we proceeded with the following step, that is an official letter to the Secretary General stating that we have agreed to collaborate on a series of crosscutting themes that also come under the umbrella of the HR project. **Unfortunately, as a result of the new regional elections held in April 2010, there was a cabinet reshuffle at the Regional government and a new Health Minister and Secretary General were appointed. All the headway made until that moment was somehow impaired by the impact of the Regional elections, as senior officers, that had become contact persons for the HR project implementation within the Region, were changed, regional decrees and resolutions were delayed, actions and funding were frozen until the new cabinet came into force. Since June 2010 contacts have been restored with the Regional officers and policy makers in view of the final conference in Brussels. We have tried to catch up with the time lost by involving them in the preparation of the final deliverables and materials that will be presented at the final conference. Our goal is still to come up at the end of the project with a list of recommendations based on the experience gained during the HR project.**

- Another important effort - related to the collaboration above mentioned - is the hopefully forthcoming signing of the agreement between the Ministry of Education and the Regional minitries of healthcare and social policies about the implementation of health education projects at school. This is a crucial setting for health promotion in our Region, as the target population falls under the regional priority groups (for the high of prevalence of obesity and overweight, and the importance of sexual and reproductive health education at this age); thanks to this forthcoming agreement, the regional departments above mentioned and the services of the local health care trusts would have a "controlled" access to the school setting - mediated by the school authorities - prioritising and rationalising the resources according to a needs assessment that would be commonly agreed. We are sure that this act would forster best practices and enhance health promotion in the Region in line with the HR objectives.

- On the same front, in view of the UK PM, we also asked the regional public health department to identify a regional senior officer expert of public health and health promotion, that could collaborate with us in the elaboration of the project catalogue and

implementation of pilot projects. The regional public health Dept. has indicated a senior officer specialising in smoking prevention and leader of some important best practices in this field who provided us with a very well structured project on smoking prevention (namely "Let's smoke out all doubts") that was presented to the partners during the meeting.

On the front of practical work, here are our achievements:

- the mapping exercise was a very fruitful occasion to start a dialogue between the collaborating partners and regional representatives in the field of health promotion, so that this partially made up for the lack of coordination and communication between local services that deal with health promotion and education and the regional level in our region;
- we described the results of the mapping exercise focused on health services and best practices for children and young people in a regional report that was spread out among stakeholders (Nov 2009 – Jan 2010) of the Veneto Region and disseminated at two National Conference on Health Promotion.
- In order to contribute to the creation of the project catalogue, we have expanded the network of collaborating partners including new stakeholders, even among the school authorities that have been asked to suggest best practices;
- using inputs from the network of our collaborating partners and integrating this information with the dataset resulting from the mapping exercise, we have been able to identify four projects that have been studied in depth and then translated into the HR template. We needed a little more time for the choice of the fith project because we had got more options and needed to be careful to choose the right one - also in view of the collaboration with the regional public health department. The entire network of collaborating partners played a very active role in that phase of the project, giving us detailed information and being very interested in the forthcoming implementation of the pilot projects;
- in May 2009 we negotiated with the schools the introduction of pilot projects in the school curriculum of the following term (2009/2010 academic year), and we wanted to use the agreement achieved at strategic level with the school authorities**: but unfortunately we are still waiting for it to be signed**;
- we implemented our pilot projects in the school setting from Oct 2009 till May 2010, so as to be able to report results in the final PM that was held in Verona in Apr 2010
- as mentioned above, a preparatory meeting to the **Evaluation Seminar** involving all the collaborating partners was held in Verona in September 2009: a working document for the

evaluation of the collaborating partners' participation in the process and pilot projects' implementation was presented at the meeting and then shown at the Swedish Partner Meeting of the Healthy Regions project (Process evaluation Questionnaire);

- we evaluated their Project Meetings attendance, the activities related to the dissemination of information about the Healthy Regions project in their professional network, and their collaboration to the production of the deliverables;
- in May 2010 and we released the final version of the evaluation form to be compiled by the Collaborating partners (Final evaluation Questionnaire) to report back their outcomes and provide information to assess the impact of the projects in the schools.

  According to the Collaborating Partners, the main **success factors of the pilot projects** were:

- Rooted collaboration between Health Services and School which creates a trust relationship between health stakeholders and teachers

- Just little commitment requested to school's personnel, which assures better compliance

- Multi-sectoral team group and families involvement

- Peer education model – peer skills exported in other formal and informal settings

- Good mix between educational sessions and interactive games and activities (e.g. role playing).

- in October 2010 a document containing a short presentation of the project and a list of **recommendations** was released and sent to each Collaborating Partner, in order to receive feedback from them. Their comments and proposals were integrated into the final document entitled: "*Recommendations: proposte di miglioramento per le politiche di Promozione della Salute*". The document (see Annex I) was then delivered to the key decision makers in the field of Public Health.

  The Recommendations were also included as an Annex to the Project Catalogue, to increase their visibility among health stakeholders in the region. The document encloses a short description of the Healthy Regions project, its objectives on strategic and on practical level, and some proposals to improve the Health Promotion policies, as they can represent a useful tool for decision makers, being the result of the collaboration within the staff of the Regional Centre for the Health promotion and the heads of Local Health Services (Collaborating Partners in the project during 3 years).

  A translation of the *Recommendations* is reported below:

RECOMMENDATIONS: proposals to improve Health Promotion polizie

Practical Level

Proposal to improve Healthcare Services planning and organization

- Empower coordination, integration and communication between the Regional Departments an the Regional Ministries.
- Put Health Promotion among the priorities of the operational plans of the Local health care Authorities (LHA).
- Include service provision reorientation according to a real needs assessment in the LHA activities.
- Identify a Service in each LHA which is committed to coordinate Health Promotion activities at local level, working as a needs observatory, keeping a database of activities that are carried out: a sort of benchmark for all the activities linked to Health Promotion, in the region.
- Create a Regional team to manage Health Promotion activities and write an annual plan to coordinate different Operational Units involved.

Strategical Level

Proposals to improve the Health Promotion policies

- Enact an official document on the regional strategy for Health Promotion, clarifying who is supposed to implement it
- Sign the formal agreement between the National Ministry of Education and the Regional Ministries of health care and social policies about Health Promotion in schools.
- Coordination and communication between Health Care Services within the same Local Health Authorities following the guidelines of the Regional Departments, to inform stakeholders, at all levels, about actions and programmes implemented in the Region .
- The Regional Healthcare and Social Plan should include policies and actions to make the Veneto Region a real "Healthy Region".
- The local welfare plan should include a working partnership on Health Promotion.

Healthyregions
When Well-being Creates Economic Growth

ANNEX I

Healthy Regions

when well-being creates economic growth

Recommendations

proposte di miglioramento

per le politiche di Promozione della Salute

Healthy Regions: when well-being creates economic growth

Il progetto in sintesi

Nel 2007 l'Assessorato alle Politiche sanitarie della Regione Veneto ha aderito ad un progetto europeo triennale, cofinanziato all'interno del Programma dell'UE per la Salute, chiamato: "*Healthy Regions*: regioni in buona salute, quando la salute crea crescita economica", che mirava a potenziare le competenze di salute pubblica e a proporre una strategia per la promozione della salute in ogni regione partecipante. Il progetto, che si è appena concluso, è stato coordinato dal "South Denmark European Office" (SDEO) della Regione Sud della Danimarca.

Le regioni partecipanti provenivano da sei Paesi europei: **Danimarca, Svezia, Inghilterra, Belgio, Germania e Italia**.

La Regione Veneto ha affidato la **gestione del progetto** al **Programma Regionale per la Promozione della Salute di Verona** in collaborazione con il Servizio Rapporti Socio-Sanitari Internazionali della Segreteria Regionale Sanità e Sociale. La Regione ha inoltre individuato come **collaboratori locali** del progetto le **aziende ULSS** 3 di Bassano del Grappa, ULSS 7 di Pieve di Soligo, ULSS 9 di Treviso, ULSS 13 di Dolo-Mirano, ULSS 17 di Este e ULSS 21 di Legnago, che hanno collaborato alle attività del progetto attraverso i Servizi di Educazione e Promozione della Salute o i Servizi Igiene Alimentazione e Nutrizione: il lavoro dei collaboratori locali è stato fondamentale affinché il progetto potesse raggiungere capillarmente i cittadini nel territorio e si è svolto principalmente attraverso l'implementazione di progetti pilota in ambito scolastico.
Prezioso è risultato inoltre il loro contributo nella fase di elaborazione della cornice concettuale del progetto e degli strumenti di ricerca, nonché la condivisione delle proprie riflessioni per le "Proposte di miglioramento per le politiche di Promozione della Salute nel Veneto", di seguito presentate.

Obiettivo principale del progetto era quello di **collocare la salute tra le priorità nelle agende politiche dei Paesi europei, contribuendo allo sviluppo di strategie di salute innovative** per creare "regioni in buona salute" nelle quali la salute sia concepita come una risorsa, anziché esclusivamente come un costo.

Per favorire il raggiungimento degli obiettivi, il lavoro del progetto si è articolato su due livelli:

a **livello strategico**: attraverso l'elaborazione di una proposta di una strategia per la Sanità Pubblica in ogni regione partecipante.

a **livello pratico**: attraverso l'applicazione concreta dei concetti elaborati nel corso del progetto - utilizzando gli strumenti e le linee guida identificati - e l'implementazione dei progetti pilota nelle aree di interesse regionale.

Risultati e prodotti

Prodotti e risultati del progetto sono stati presentati alla **Conferenza Finale del progetto**, tenutasi a **Bruxelles**, presso il **Comitato delle Regioni** il 23 settembre 2010.

Il contenitore creato per illustrare tutti gli aspetti e le fasi di *Healthy Regions* e ispirare politiche innovative di Sanità Pubblica è il **website ufficiale del progetto** (www.healthyregions.eu).

Visitando il website è possibile accedere a tutto il materiale elaborato nel corso del progetto nei 6 Paesi partecipanti:

- Il ***Conceptual Paper***: la cornice concettuale comune predisposta dai partner come base teorica del progetto.
- Tutti gli ***strumenti*** utilizzati per mappare le competenze in ambito di Sanità Pubblica, adattati ai diversi contesti nazionali e regionali (ad es. Dialogue tool, Scenario Planning Tool, Traffic Light Matrix, Mapping tool) ed il ***Protocollo*** di procedure redatto per il loro utilizzo nelle specifiche realtà regionali.
- Il ***Catalogo*** dei progetti pilota: una selezione dei migliori progetti di prevenzione e promozione della salute destinati ai diversi target individuati all'interno di ciascuna regione, derivata dallo scambio di idee e buone pratiche tra i partner. Il Catalogo è un'ottima vetrina europea per la progettualità veneta.

L'ultimo prodotto del progetto è rappresentato dalle "***Recommendations***" una serie di **proposte di miglioramento** destinate a coloro che devono prendere decisioni nell' ambito di Sanità Pubblica.

Le proposte sono state elaborate con il prezioso apporto dei collaboratori locali del progetto *Healthy Regions* che, ancora una volta hanno messo a disposizione le preziose competenze maturate sul campo, in materia di Sanità Pubblica.

In linea con l'organizzazione del progetto, le proposte di miglioramento per le politiche di promozione della salute sono state articolate ai due livelli: pratico e strategico.

Si auspica che esse possano costituire un utile spunto di riflessione per coloro che prendono decisioni e svolgono attività di pianificazione e programmazione nell'ambito della Sanità Pubblica.

RECOMMENDATIONS: proposte di miglioramento per le politiche di promozione della salute

Livello pratico

Proposte di miglioramento per la pianificazione e il funzionamento dei Servizi socio-sanitari

- Agire per potenziare il coordinamento, l'integrazione e la comunicazione tra le Direzioni regionali e gli assessorati competenti.
- Introdurre, nei piani operativi delle ULSS, la promozione della salute tra gli obiettivi da raggiungere.
- Includere tra le attività delle ULSS il riorientamento dei Servizi, basato su una concreta valutazione dei bisogni.
- Individuare un Servizio aziendale da deputare al coordinamento delle attività di promozione della salute a livello locale, con funzioni di osservatorio dei bisogni, banca dati delle iniziative attuate, elemento di continuità delle azioni e riferimento per criteri omogenei e condivisi di intervento.
- Creare un gruppo di coordinamento regionale per la promozione della salute e definire un piano territoriale annuale per la promozione della salute, che preveda il coordinamento tra le varie Unità Operative coinvolte.

Livello strategico

Proposte di miglioramento per costruire politiche di promozione della salute

- Approvare un documento condiviso che descriva una strategia regionale integrata per la promozione della salute che stabilisca chi dovrà attuarla.
- Firmare il Protocollo d'Intesa, un accordo formale tra il Ministero della Pubblica Istruzione - Ufficio Scolastico Regionale - e la Regione - assessorato alle politiche socio sanitarie - per l'armonizzazione e il coordinamento delle politiche di prevenzione e promozione della salute nelle scuole venete.
- Favorire i rapporti intersettoriali dell'Azienda in materia di promozione della salute e facilitare la collaborazione con gli Enti Locali secondo le indicazioni della Direzione strategica, al fine di attivare e coordinare azioni rivolte a mantenere alta la consapevolezza dei programmi tra gli *stakeholder*, i partner della comunità e i decisori.
- Definire nel Piano Socio-Sanitario Regionale politiche ed azioni che siano coerenti per una "Regione Sana".
- Inserire nei Piani di Zona Territoriali (di integrazione sociale e socio-sanitaria) un tavolo di lavoro sulla promozione della salute.