Healthyregions
When Well being Creates Economic Growth

WP 5

Procedure Protocol

Introduction

The *Healthy Regions* project is an "action research" project, and is therefore highly process oriented and pragmatic in its approach. The main objective of the project is to develop different practical tools, within an overall concept for "Healthy Regions". The tools will be tested within the participating regions, in order to gain practical experiences. The documentation of the practical experiences that each region has gained through the testing of the tools, and the implementation of the project, is a very important part of the project results, as the documentation will be used to illustrate the degree and the scope of usefulness of the tools. As such, the documentation of the practical experiences is an important input to the final conceptualisation, in the form of recommendations, guidelines and good practice examples, that other regions can get inspired from.

The protocol is a living document throughout the rest of the project and will be the result of the work in progress that each region has carried out, based on its specific situation and needs. At the end of the project, the protocol will stand out as individual result of the project and will include a set of guidelines on how to use the tools in the different regions arisen from the practical activities implemented in the regions.

Its aim is also to give inspiration, recommendations and clarifications on how to use the tools to solicit fruitful discussion between social actors involved in the decision making process about health so as to make a region an "Healthy Region" that has the best foundations to reach the goals of the Lisbon Strategy.

Instructions to the partners to complete the Protocol:

Each partner completes the box/boxes corresponding to the tools used in the Region.

- Methods: when describing methods, please be concise and provide an answer to these questions:
  - Why did you choose that tool?
  - At which stage/starting point was your Region? Under which conditions was the tool used in you region? E.g. was the tool used within a bigger regional development process?
    - Please give reasons for the choice of a specific tool: e.g. 1) advantages/disadvantages, 2) structural, political and financial reasons, 3)
  - Who was the tool meant for? Did you use it mainly on a political level, practical level or both?
  - Which actions were carried out, according to which time frame?
  - How did you use it? (Techniques and procedures followed: i.e. use of focus groups or in-depth interviews or Delphi method; use of a glossary, definitions etc…)
- Target: description of the specific target group for the tools and the reasons for this choice.
- Results and effect: summary of results based on the information and evidences gathered by using the tools.
  - What are your concrete experiences from this work?
  - What kind of challenges have you met in your region in terms of the implementation - e.g. structural, political, practical?
  - What kind of difference has it made to your region to use the tools, if any?
    - In relation to e.g. awareness raising, new regional collaboration activities, strategies and / or practical activities / intervention
    - Can you say anything of which level you see any effects; e.g. practical level, political level, regional level, local level etc.
- Guidelines to the use of the tool: description of the best way to proceed when using the tool in the Region, taking into consideration YOUR specific structural, political and financial situation.

Region: VENETO

Dialogue Tool

Methods:

Health Promotion in the Veneto Region is divided between two main health Departments: Health care planning and public health.
Our regional Centre refers to the department of health care planning, but coordinates 21 Local Offices for health education and health promotion that directly report to the department of public health.
Similarly the fragmentation between regional departments is reflected on the fragmentation between local services that deal with health education and health promotion, in particular in the school setting.
In addition, our Region is still lacking an official comprehensive document on the regional strategy for Health Promotion and Local Health Care Trusts do not mention health promotion among the priorities for their operational plans.
Improving the integration and kicking off a dialogue between the different sectors affecting citizens' health should/must become a priority for the Veneto Region.
On this basis, the DT was chosen as it could be useful because it started up the dialogue between local Offices for health education and health promotion belonging to the different Local Health-Care Trusts of our Region (Collaborating Partners in the HR project) so as to fill the gap of communication and promote integration between the Local Health Care Trusts involved in the project.

The tool was implemented at both political and practical level: policy makers working in the field of health were interviewed to test the tool and give their own opinion about the health themes mentioned in the DT.

At a second stage, the DT was used to stimulate the dialogue between the Collaborating Partners, by organizing a meeting involving Senior professionals working at practical level.

After policy makers 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 Committee for health professionals' training. Thanks to this added value, attendance was compulsory for our target stakeholders and so the turnout was high.

We chose to try the tool with 2 groups because we wanted to gather two different points of view and to discover if the tool could be employed in different ways. The 2 groups were composed by people having the same status, because we tried to avoid hierarchy's effects and stimulate discussion. In addition, we set two small groups because we estimated that it would be the best condition to promote a really active participation.

Targets/Stakeholders:

Key policy makers in the field of health at regional level were interviewed for the piloting of the tool; Senior health professionals working in the Local Offices for health education and health promotion took part in two regional workshops.

Results:

The two groups filled in the Dialogue tool separately and came up with two different "spider webs", each providing evidence to support their evaluation.
The spider web is a figure representing three levels, which is very useful for an immediate visualization of

the different evaluations of the subjects listed in the Dialogue Tool.
From this exercise, two distinct perspectives of the future regional health status resulted and were consistently different[1]:

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 (3 years and 30 years).
Differences:
Health promotion was expected to worsen in the short term for group 1, whereas for group 2 it was expected to reach level 3 in the long run; in the same way strategic health was expected to worsen for group 1, whereas for group 2 it was expected to stay at mid level.
Only group 2 expected mainstreaming to reach level 2 (for group 1 it was expected to remain at level 1)
On the whole, group 1 always started from lower levels except for health as economic growth .
Similarities between the two groups: both groups gave high ratings to health education, which was 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 thought the level of empowerment would not improve.

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 input from this exercise was fundamental, because the dialogue arisen will lay the foundations to write down the recommendations for the policy makers in the Healthy Regions project.

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, it's relevant to clarify that health promotion in the Veneto Region is divided between two main health departments - health care planning and public health/disease prevention; the Regional Centre refers to the former dept. but coordinates 21 local offices for health promotion and health education that directly report to the latter dept

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

- 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;

- 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

[1] See Annex I, pages 12 and 13

workers think that it still lacks a comprehensive strategy for health particularly focused on cultural, social and environmental determinants.

Finally, both the groups highlighted the fact that local health care trusts do not mention health promotion among the priorities of their operational plans and the need for service provision reorientation according to a real needs assessment.

Guidelines to the use of the tool:

The tool can be a fruitful device to start up a dialogue between health agencies and stakeholders involved in Health Promotion at regional level: on one hand it stimulates a dialogue, and on the other hand it reports the participants' point of view on specific health topics.
We encountered some difficulties in the translation of the items: this is why it is important to plan a pre-meeting session to present and clarify all the issues listed in the Dialogue Tool, making sure that participants have understood the definitions before starting the discussion.
Another recommendation is about the time span: we warmly suggest to choose the same time span when more than one group is working and thinking about the future (5 year could be a good time span); if the groups choose different time spans, it will be difficult to compare results.
Senior health professionals (working in the Local Offices for health education and health promotion) were a good target as they were involved both at practical and political level, being decision makers in their Services, and constituted a sort of liaison between the two levels.
It's fundamental to use the tool to interview policy makers to get their perspective about the regional process.

Region: Veneto

Traffic Light Matrix

Our research has been 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?

Methods:

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 the project interim report.

Results:

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 – which came from the Social Care Green Paper 'Independence, wellbeing and choice.' and was reinforced 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.

Question: is the tool usable in the Veneto Region context?

Answer

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, 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.

Region: VENETO

Verona Benchmark

Rationale

The Verona Benchmark has been included in the tool box of the Healthy Regions project.

It has also been included in the protocol of our Region because we consider it very useful on the practical level to solicit fruitful dialogue and create solid partnerships between different social actors involved in the field of health promotion.

Creating partnerships and promoting cross sectoral collaborations in the field of Public Health are core objectives of the H.R. project

In addition, the approach to Health Promotion behind this tool is consistent with the ecological model adopted and illustrated in the Framework Paper of the project, which constitutes the theoretical basis of all the work done in the course of the H.R. project.

The Verona Benchmark is the result of a past WHO initiative that took place in Veneto with the collaboration of the Regional Government and was used in a local exercise funded by the Regional Government and carried out in Veneto.

During the implementation of the Healthy Regions project, the Veneto Region chose to pilot new tools, but we wanted to include its description in this protocol to take advantage of the precious knowledge acquired on a practical level about this tool.

In short, we have reported our experience of the use of the tool <u>because:</u>

- the objectives of the VR Benchmark are consistent with the objectives of the Healthy Regions project
- working with this tool laid the foundations for the participation of the Veneto Region in the Healthy Regions project
- reporting the experience acquired could be useful for the other partners of the project that have chosen to use this tool in the time frame of the H.R. project (see UK experience)

Methods

The Verona Benchmark is a package of practical management tools that was tested in 15 sites across Europe.
It is based on a recognition that investment for health should be understood as an approach to health development that finds ways in which the different interests involved in economic and social development can achieve their prime objectives in a way that improves people's health.
It is the result of the work from three international Arena Meetings of the Verona Initiative undertaken by the World Health Organization Regional Office for Europe in the Veneto Region held between 1998 and 2000.The three meetings focused respectively on helping countries, regions and communities to carry out a needs assessment before Investment for Health can happen, analyse the characteristics of decision and policy making process and, finally, assuring that the learning about Investment for Health produced by the Verona Initiative could be used to influence policy makers everywhere.

As a result of the collaboration between WHO and the Veneto Region on The Verona Initiative, a new WHO European Centre for Health Promotion and Investment for Health has become operational in Venice, Italy,

since 2003. In the light of the "Investment for health approach" that was at the basis of the Verona Initiative and guided the collaboration between WHO and Veneto Region, the Benchmark was designed to be used by multi-sectoral partnerships working at local and regional level to improve the quality of partnership work and to help them focus on delivering sustainable and integrated health, social and economic development.

A related benchmarking tool is the Verona Benchmark Self Assessment Tool which aims to provide both guidance and interpretation of the levels that partnership working may reach.

The Healthy Regions project, when considering this tool, has also taken advantage of the lessons learned from the pilot studies that originated from the Arena Meetings and from other similar local experiences.

In Italy, there was not a real piloting of the Benchmark, as it was originally conceived during the Arena Meetings. Only Bologna initially took part into the research, but no final results were produced from the local pilot project.The Veneto Region had been evaluating the possibility of piloting the Benchmark for a while, when it took some preliminary steps on this front some years after the last Arena Meeting, between 2002 and 2003.

The first step undertaken was a feasibility study about the real possibility of implementing the Benchmark piloting within the local *Piano di Zona*, that stands for local government's statutory strategic partnership or community planning and involves local strategic partnerships between municipalities, health care trusts, non profit and voluntary sector.The Veneto Region's local example of community planning – *Piano di Zona* – was reviewed and analysed in detail, as it was found to be the most similar partnership working example to the British community planning.

The study included:

seminars, in depth interviews with strategic participants, focus groups, and desk research (critical literature review, collection and analysis of laws and regulations at national and regional level, study of some recent documents containing the community planning strategy for the years 2002-2004).

Finally, the Verona Benchmark tool was used in a local exercise funded by the Regional Government and carried out in Veneto.

Targets/Stakeholders: policy makers, health professionals working in the local strategic partnerships including local health care trusts, local government and community-based organisations, non profit and voluntary sector.

Results

The lessons learned from this feasibility study carried out in the Veneto Region showed that the main weaknesses of the local strategic partnerships were related to: a) their narrow focus on health, merely seen in terms of disease prevention; b) their narrow scope of action, only based on the regional healthcare and social system, without locally addressing, for example, the intertwined key issues of crime, health, housing, education, jobs, economic growth, and physical environment; c) their consequent lack of inclusiveness, as they did not actively involve all the local key players, including the public, private, community and voluntary sectors to the benefit of the local community's social, economic and environmental regeneration and wellbeing.

Guidelines to the use of the tool

The following guidelines are based on the protocol procedures and work plan that were preliminarily drawn in the Veneto Region for the assessment of the VR Benchmark tool. They are complete and take into account all possible steps and developments of the benchmarking exercise according to the indications and instructions gathered from the relevant literature. The use of the future tense reflects the perspective taken at that time before starting the actions. The actual exercise in the Veneto Region did not follow all the steps outlined here below, but was partially modified after the implementation of the feasibility study. Yet we think that this outline should be still taken into consideration as a good example of protocol procedures for a possible use of the benchmark tool at regional level.

PRELIMINARY ACTIONS

1. TRANSLATION OF THE REVISED VR-BENCHMARK

The first issue to address is the following: how does the present implementation of the Benchmark piloting at the level of community planning relate to the Verona Initiative follow up in general and to the Verona Benchmark in particular?

The answer to the previous question will lead us to a preliminary study of the results achieved by the pilot sites involved in the first implementation of the Verona Benchmark.

Indeed, before deciding what our best use of the Benchmark can be, it is necessary to acquire a thorough understanding of the tools as they have been conceived in the previous Verona Benchmark piloting.

The first action to carry out is thus to translate the revised version of the Verona Benchmark. The translation process demands, on the one hand, a thorough knowledge of the source, cultural background and business excellence model that have resulted in the revised Verona Benchmark and, on the other hand, a similarly deep understanding of the target institutional setting, aims and functions in order to come up with a useful and effective tool that can be really meaningful to its users.

The first step to be taken in the field of translation is the “work on the source language”; the following step is the analysis of the target institutional framework in which the translated tool has to be used. This preliminary work includes the identification of the pilot areas and of the local multisectoral partnership that will be assessed using the pilot benchmark tool, and the analysis and elaboration of a “locally oriented” benchmark tool designed to assess the strengths and the areas of improvement of the identified local partnership.

2. BENCHMARKING EXERCISE

These steps will have to be taken:

- Appointment of the benchmarking team.
- Appointment of a team of facilitators.
- Administration of the questionnaire.

- Collation, analysis and feedback of the assessment information.
- Benchmarking workshop to enhance the learning and improvement process.

In preparation for the workshop, working from the completed audit template, the facilitator should work out a mean score (0-5) for each sub-element – i.e. vision, technology. From this, the sub-elements should be divided into 2 groups: areas of strength (mean score between 4 and 5); and areas for improvement (mean score between 0 and 3).

Question: is it legitimate or methodologically correct to apply metrical techniques to non-metrical variables? In other words, if we work out the mean score from an ordinal scale, are we doing right?

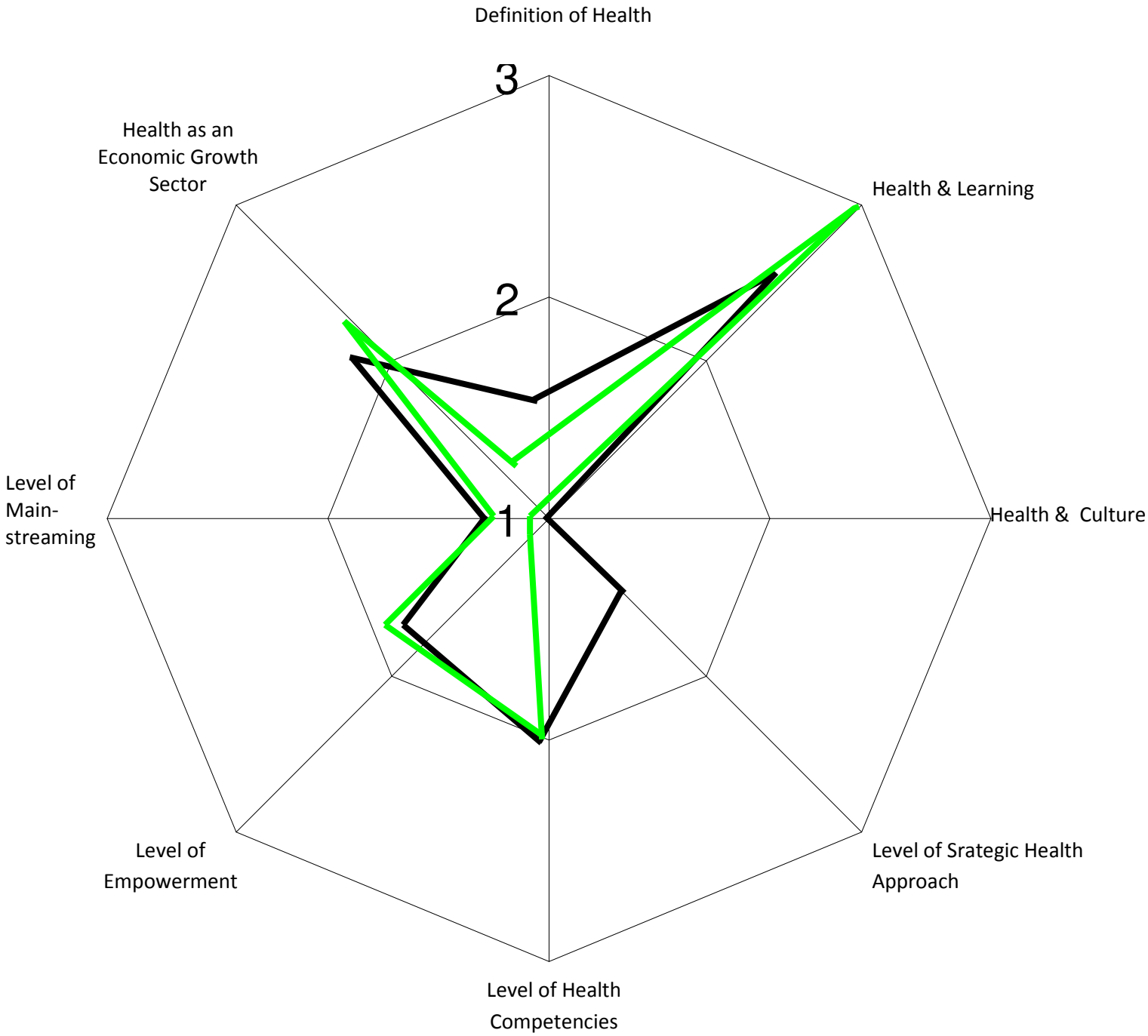
A full day should be allowed for this experience.

- Benchmarking workshop follow up aimed at drawing up an outline improvement action plan that should:
    - Prioritise areas for improvement;
    - Find real actionable strategies to achieve the performance required, by assigning responsibilities to nominated individuals who shall pursue the specific priority improvement areas identified;
    - Link, where possible, improvement actions to the business objectives of the partnership/partner organisations so that the improvements will provide tangible results;
    - Fix, as part of the continuous improvement process, some regular form of feedback reporting and progress review.

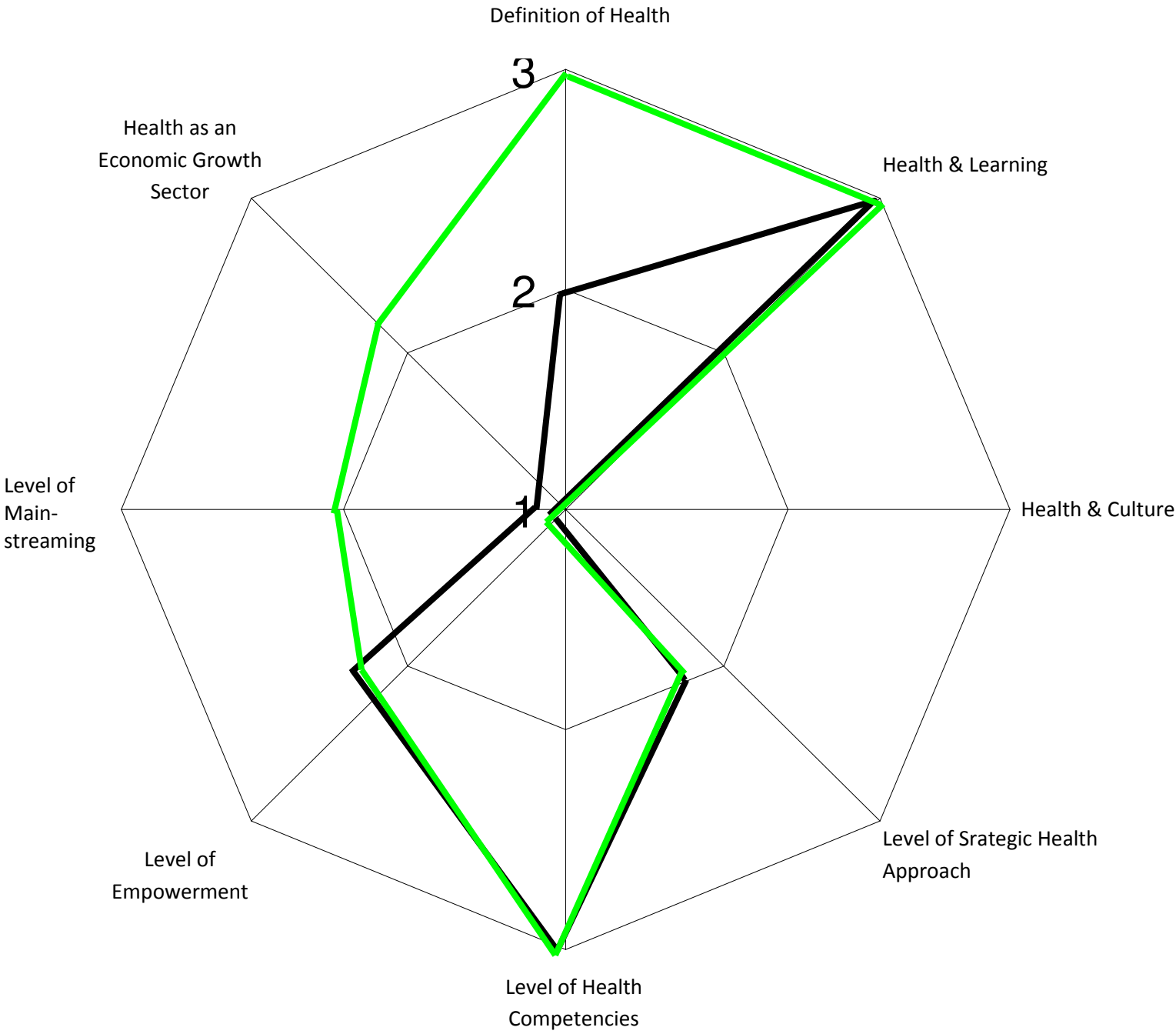
- Comparison between the pilot site findings: a workshop could be arranged to present the findings of each pilot site, discuss and compare them, paying particular attention to each pilot site's improvement action plan.
- A final report should be drawn up and presented to the Regional government: it should describe the piloting protocol and methodology, summarise and discuss the results, suggest future implementations and ways/actions of improvement.
- A conference could be held at regional level to spread the newly acquired information and experience from the benchmarking piloting among Directors of the other local health authorities that do not have taken part in the pilot study.

ANNEX I

1st Group



2nd Group


Definition of Health
3
2
1
Health & Learning
Health & Culture
Level of Srategic Health Approach
Level of Health Competencies
Level of Empowerment
Level of Main-streaming
Health as an Economic Growth Sector