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2ND Interim Report of the Irish Partners on the EU CHRODIS JA (Joint Action) Project

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1. JA CHRODIS AT A GLANCE

1.1 Purpose

The purpose of this report is to document the work undertaken to date by the Irish Partners on the CHRODIS project with a particular focus on the outputs of Work Package 5 on health promotion and activities in the last year (2015 to 2016) of the Joint Action (JA)-CHRODIS project.

1.2. Overview of JA-CHRODIS

JA-CHRODIS is a European collaboration that brings together over 60 associated and collaborating partners from national and regional departments of health and research institutions, from 26 Member States. These partners work together to identify, validate, exchange and disseminate good practice on chronic diseases and healthy ageing across the life cycle in EU Member States and to facilitate its uptake across local, regional and national borders.

The main objective of JA-CHRODIS is to promote and facilitate a process of exchange and transfer of good practices between European countries and regions, addressing chronic conditions, with a specific focus on health promotion and prevention of chronic conditions, multi-morbidity and diabetes.

A key deliverable is a 'Platform for Knowledge Exchange', which will include both an online help-desk and a web-based clearinghouse offering policy makers, practitioners, caregivers, patients, and researchers an up to date repository of best practices and the best knowledge on chronic disease programmes and policies. JA-CHRODIS is a three-year initiative (2014-2017) led by the Institute of Health Carlos III, Spain and is being funded by the European Commission and the participating parties.

CHRODIS is divided into seven work packages (WP), three of which are cross-cutting packages, while four are core, thematic work packages. Work packages 1, 2 and 3 are cross cutting and cover the project co-ordination, communication and dissemination of information and project evaluation. The core JA-CHRODIS Work Packages (5, 6 and 7) will select criteria and identify good practices which will form the basis for the creation of the Platform for Knowledge Exchange (WP 4). Ireland's contribution to JA CHRODIS is primarily through Work package 5. JA-CHRODIS is governed by an Executive Board comprised of all WP leaders. In addition, a Forum of representatives from Health Ministries in EU Member States, as well as an Advisory Board of experts in the field, nominated by JA-CHRODIS content-related WP leaders, will support JA-CHRODIS. JA CHRODIS Work packages 1 to 7 are detailed in Appendix 1.

The Health Service Executive and the Institute of Public Health in Ireland are representing Ireland in work package five. In addition, the European Institute of Women's Health, which is based in Dublin, is supporting several work packages. WORK PACKAGE 5 (WP 5) is led by BZgA/Germany and co-leader EuroHealthNet. A detailed project plan for WP 5 is shown in Appendix 2.

1.3. Expected outcome of CHRODIS

The outcome of CHRODIS-JA will be a mechanism for the collection, validation, scaling up and transferring of good practices in relation to chronic diseases, with particular attention to health promotion and disease prevention, multi-morbidity and diabetes. It is anticipated that the exchange and transfer of good practices will result in improved outcomes of policies, programmes and clinical or public health interventions on chronic conditions.

1.4 Achievements of Irish Partners in JA CHRODIS WP 5 on Health Promotion and Chronic Disease Prevention

1.4.1 Country Reports

In 2014 the Irish partners submitted a 'country report' to CHRODIS, describing elements of policies, services and programmes relevant to the prevention of chronic disease in Ireland. The country reports were compiled based on detailed reviews of policy, service plans and evaluations and a structured engagement process with key national leaders. The final report provides a useful reference point on chronic disease prevention in Ireland. The Irish report was collated with 13 other country reports to establish a baseline understanding of the policy context for primary prevention of chronic conditions across Europe (http://www.chrodis.eu/our-work/05-health-promotion/wp05-activities/country-reports/). Key findings indicated a diverse mix of approaches in systems and structures, levels of development and prevention capacity. There was an identified gap in available funding, structural approaches to monitoring and evaluating activity, dedicated funding for evaluation to establish good practice and appropriate dissemination and use of good practice in health promotion. In addition, a comparative overview of all 14 European countries summarising key policies, approaches, gaps and needs is available at http://www.chrodis.eu/wp-content/uploads/2015/07/FinalFinalSummaryofWP5CountryReports.pdf

1.4.2 Developing Assessment criteria to identify Good Practice in Health Promotion

Between December 2014 and April 2015, the Irish partners engaged in a DELPHI process to develop a set of criteria to assess good practice in the primary prevention of chronic disease in Ireland. A set of criteria to assess good practice of interventions in the field of health promotion and primary prevention of chronic conditions was produced from the DELPHI process which will be used to assess future Good Practices uploaded to a Platform of Knowledge Exchange (PKE), a repository of good practice interventions from EU countries. A report detailing the Delphi process and selection of criteria entitled ***INTERIM REPORT 1: Delphi Panel on interventions in the area of health promotion and primary prevention of chronic diseases*** *is available at* http://www.chrodis.eu/wp-content/uploads/2016/03/Delphi-1-report_HPPP.pdf

1.4.3 Documenting Good Practice Interventions from Ireland

After an active consultation process in Ireland, the Irish partners identified and submitted five models of good practice to CHRODIS:

1. Tobacco Free Ireland
2. SafeFood/HSE All island Childhood Obesity campaign
3. Active School Flag

4. Community Food Initiative (CFI) Programme
5. Croí MYAction

A suite of documents were produced by WP5 detailing 41 good practice examples submitted by CHRODIS partners across Europe. The JA-CHRODIS approach defines as a 'good practice' one that is worth disseminating because it is based on best available evidences, is associated with good outcomes and may inspire practices in different contexts. All documents are available as follows:

***Good practices in health promotion & primary prevention of chronic diseases*: http://chrodis.eu/our-work/05-health-promotion/wp05-activities/selection/**

***Executive summary. Good practices*: http://chrodis.eu/wp-content/uploads/2015/10/CHRODIS-WP5-Task-3-Executive-Summary-V1_1.pdf**

1.4.4 Presenting Good Practices from Ireland at Vilnius Conference

On 24th & 25th November 2015, JA-CHRODIS organized a conference in Vilnius, Lithuania, entitled *Joining Forces in Health Promotion to Tackle the Burden of Chronic Diseases in Europe*. The aim of this conference was to provide JA-CHRODIS partners and relevant EU level, national and local policy makers, and practitioners, the opportunity to discuss the state of health promotion and primary prevention in Europe, how to move forward the recommendations resulting from the European Union's Reflection Process on Chronic Diseases in this area, and to share examples of good practices. The conference also reflected on whether good practices can be transferred to other contexts and, if so, how these can be identified, what criteria should be applied in order to choose them. Also discussed were the criteria to promote a series of study visits and recommendations on practical measures that EU Member States and the EU can take to strengthen outcomes and secure more investments in this field.

Representatives from Ireland at the conference included: Dr. Fenton Howell, Dept. of Health, who presented on Ireland's Tobacco Free Ireland Policy; Dr. Cate Hartigan, HSE who contributed to an expert panel discussion on how Member States can work together to overcome barriers, address gaps and needs and strengthen investments and the effectiveness of health promotion and primary prevention measures.

In addition, four other Good Practices from Ireland were presented in poster format as follows:

- Croí MYAction –Dr. Siobhan Jennings,
- Safefood/HSE Childhood Obesity campaign – Dr .Teresa Bennett,
- Safefood Community Food Initiative Programme – Dr. Teresa Bennett,
- Active Schools Flag – Maeve Cusack and Dr. Olga Cleary.

Details and outcomes of the Conference are available at http://www.chrodis.eu/event/joining-forces-in-health-promotion-to-tackle-the-burden-of-chronic-diseases-in-europe/

1.4.5 General Assembly and WP5 meeting February 2016: Madrid

At the beginning of February, JA-CHRODIS held a series of meetings in Madrid. The 2nd General Assembly held on February 4th2016, involving all Associated and Collaborating Partners of the Joint Action, covered various topics concerning the promotion, use and sustainability of the PKE as well as the transferability and scaling up of practices in the areas of health promotion, multi-morbidity and type 2 diabetes.

A specific focus was on promoting and operationalizing the continuous exchange of good practices, planning for the transfer of practices, promoting the use of the PKE, and *Collaborating with other EU initiatives*, in particular, exploring how to make JA-CHRODIS the reference initiative on chronic conditions at European level.

The WP 5 meeting held on February 5th 2016 focused on planning for the Study Visits between April and July 2016 as well as examining strategies for the dissemination of results and information of WP 5 beyond the lifetime of JA CHRODIS.

1.4.6 Study Visits, April to June 2016

Five study visits were selected on the basis of their potential to demonstrate good practice in health promotion and primary prevention of chronic diseases as well as their potential for transferability to other countries. The purpose of the Study visits was to identify, assess quality and present good practice interventions and policies across Europe with a view to improving and sharing knowledge of good practices with an emphasis on transferability and adaptation to a local context and situation.

Study visits took place in The Netherlands, Portugal, Iceland, Italy and the UK and were well attended by Irish CHRODIS partners. Some study visits such as The Netherlands and Iceland show cased a number of Good Practice interventions. Further details of the Study visits are shown in Chapter 2 of this report.

1.5 Current work of Irish Partners

The Irish partnership is involved in the following tasks as part of Work package 5 of JA CHRODIS.

1.5.1 Ireland has contributed to the development of the Platform for Knowledge Exchange (PKE) from December 2015 to date through:

- Reviewing material and content for the PKE including page views, functionality and User Manual documentation and providing feedback to Work Package Leader and PKE Helpdesk Team.
- Contributing to documentation under development by the PKE Help Desk Team for those selected to review and assess good practices uploaded to the PKE.
- Uploading of examples of Good Practices from Ireland to the PKE.
- HSE and IPH will participate in the Review and assessment process of Good practices that are submitted by practitioners from other EU countries to the PKE.

1.5.2 Ireland has highlighted a need to use and apply the Delphi criteria in practical terms to identify and assess good practice in health promotion interventions. To that end a tentative collaboration has commenced between Ireland, Portugal and Italy to identify an approach and develop a tool to apply the Delphi criteria to assess good practice interventions.

1.5.3 HSE and IPH will contribute to the drafting and scoping of a Health Promotion Work package in the new JA on chronic diseases (Chapter 4 includes details on the new JA on chronic diseases).

A summary of WP 5 outputs results is documented in ***WP 5 Results at a glance*** and can be found at: http://www.chrodis.eu/our-work/05-health-promotion/wp05-activities/selection/

2. STUDY VISITS

2.1 Introduction

Five study visits were selected on the basis of their potential to demonstrate good practice in health promotion and primary prevention of chronic diseases as well as their potential for transferability to other countries. Some of the study visits show cased more than one good practice interventions

2.2 Aims

The aims of the study visits were to:

1) Identify, assess quality and present good practice interventions and policies across Europe,

2) Improve and share knowledge of good practice interventions in Europe, with an emphasis on transferability and adaptation to a local context and situation and

3) Assist the EU - JA CHRODIS Work Package 5 in clearly identifying and documenting the learning from these the study visits.

At the end of the study visits a report describing success factors and barriers for transferring or scaling up promising practices into different contexts was collated and will be available on www.chrodis.eu

All five Study Visits were very well represented by the Irish CHRODIS partners, with at least one Irish representative attending each Study Visit (Table 1).

Table 1: Study Visits and Good Practice Interventions

THE NETHERLANDS Study Visit Utrecht and Amsterdam 19th to 21st April 2016	
I. Good Practice Intervention	**Databases of Good Practices (The Netherlands, Italy & Germany)**
Purpose	To provide information and to share knowledge of three good practice database and assessment systems in Europe, specifically from The Netherlands, Germany and Italy.
Attended by	Dr. Siobhan Jennings, Dr. Teresa Bennett, Dr. Olga Cleary
II. Good Practice Intervention	**Platform for Knowledge Exchange (PKE) – in development by CHRODIS JA**
Purpose	To share information and updates on development of the Platform for Knowledge Exchange (PKE), one of the key deliverables arising from the JA CHRODIS. The PKE, currently in development, is envisaged as an online tool to facilitate the sharing and exchange of good practice interventions on prevention and care of chronic diseases across EU Member States. The platform will include an up-to-date repository of the good practices, in the areas of health promotion, primary prevention, multi-morbidity, diabetes, organisational interests and patient empowerment.
Attended by	Dr. Siobhan Jennings, Dr. Teresa Bennett, Dr. Olga Cleary
III. Good Practice Intervention	**JOGG**
Purpose	To provide information and to share knowledge on key elements of the JOGG strategy, the evaluation framework, the translation of the national strategy to a local strategy and the resources needed, project and process management. **JOGG** is a community based initiative, to reduce overweight and obesity among children and young people.
Attended by	Dr. Siobhan Jennings, Dr. Teresa Bennett.
IV. Good Practice Intervention	**Amsterdam Healthy Weight Programme**
Purpose	To provide information, share knowledge and discuss how the municipality of Amsterdam adapted a national strategy to address childhood overweight and obesity in the local context, giving consideration to elements such as the driving forces at local level, the collaboration with local partners and the lessons learned over the past years. The **Amsterdam Healthy Weight Programme** is a community based initiative, to reduce overweight and obesity among children and young people in the city of Amsterdam.
Attended by	Dr. Siobhan Jennings, Dr. Teresa Bennett.
Further details	http://www.chrodis.eu/event/health-promotion-study-visit-1-the-netherlands/

Table 1: Study Visits and Good Practice Interventions (continued)

PORTUGAL Study Visit	
Lisbon, 22nd & 23rd May 2016	
Good Practice Intervention	**National Programme for the Promotion of Healthy Eating (*PNPAS*)**
Purpose	To provide information and to share knowledge on the approach, key elements of Portugal's National Programme for the Promotion of Healthy Eating (***PNPAS***), and key contributory factors in its development.
Attended by	Dr. Teresa Bennett
Further details	http://www.chrodis.eu/event/health-promotion-study-visit-3-portugal/
ICELAND Study Visit	
Reykjavik, 1st & 2nd June 2016	
Good Practice Interventions	**The National Curriculum Guides on Health and Well-Being** **The Welfare Watch**
Purpose	To showcase two examples of good practice, **The National Curriculum Guides** and **The Welfare Watch**, as good practice examples of health in all policies approach. The National Curriculum Guides were introduced in 2011 in Iceland as a national policy and are currently being rolled out with a first wave evaluation under way. The Welfare Watch was initiated in 2009 in Iceland as the Well Being Watch in direct response to the collapse of the Icelandic banks in 2008 and a period of civil protest.
Attended by	Dr. Olga Cleary
Further details	http://www.chrodis.eu/event/health-promotion-study-visit-4-iceland/
ITALY Study Visit	
Milan, 23rd & 24th June 2016	
Good Practice Intervention	**Lombardy Workplace Health Promotion Network**
Purpose	To assess the quality of the workplace health promotion good practice intervention and the supporting national policies and strategies.
Attended by	Ms. Maeve Cusack and Ms. Biddy O' Neill
Further details	http://www.chrodis.eu/event/health-promotion-study-visit-5-italy/
UNITED KINGDOM Study Visit	
London, 28th to 30th June 2016	
Good Practice Intervention	**Well London**
Purpose	To explore the **Well London** programme and hear from local and regional stakeholders involved in programme development and implementation as well as visiting various Well London neighbourhoods and witnessing some of the Well London activities. Well London is a framework for local communities and organisations to work together to improve health and well-being, build resilience and reduce inequalities.
Attended by	Dr. Helen McAvoy
Further details	http://www.chrodis.eu/event/health-promotion-study-visit-6-uk/

2.3. The Netherlands Study Visit

Purpose 1) To provide information and to share knowledge of three good practice databases (The Netherlands, Italy & Germany) and assessment systems in Europe with an emphasis on criteria and procedures employed, resources required as well as use and value of databases in that country.

2) To show case a national strategy, JOGG, and a local programme, Healthy Weight Amsterdam, to address childhood overweight and obesity in The Netherlands. Key elements of JOGG focused on an evaluation framework, the translation of the national strategy to local strategy with regard to resource requirements, project and process management. Healthy Weight Amsterdam focused on the local context such as the driving forces at local level, the collaboration with local partners and the lessons learned over the past years.

I. Databases of Good Practices from The Netherlands, Italy and Germany

Ia. Database of Good Practices - The Netherlands

Brief overview The Netherlands Good Practice Portal (and Dutch recognition system) is a system for collecting and assessing good practice interventions in primary prevention and health promotion. The driver behind this initiative in 2005 was the recognition by the Ministry of Health (MoH) that while there were 3000 interventions there was no information on quality, effectiveness or coherence at local level. So in tandem with a cyclical policy driver, support from local municipalities and national stakeholders as well as cohesion with research partners the database was developed. The main goals were to provide an overview of health promotion interventions in the Netherlands, to improve the quality of interventions on a structural basis, to stimulate professionals to choose and implement the best interventions in order to improve local health promotion policy and practice, to provide value for money for investing in health promotion.

The database currently contains 1900 interventions organised into five settings (pre-school, school, neighbourhood, workplace and primary healthcare with 350 graded as GPs). It is hosted and managed by The National Institute for Public Health and the Environment (RIVM) in association with 7 organisations mainly from health services, public health research and academia. There is a stepwise process of defining and assessing good practices with first level being practices which are well described, then next level comprising description of intervention but including a theoretically sound basis for the intervention and lastly an intervention which sets out all of the above including evidence that it is effective. This process of review and assessment of health promotion interventions is.is known as the Dutch recognition system for Interventions (http://www.chrodis.eu/wp-content/uploads/2016/01/Dutch-Recognition-System-for-Health-Promotion-Interventions.pdf)) and Appendix 3.

Target audience The Ministry of Health, Welfare and Sport and local practitioners situated in local municipalities. Public health research and academia are significant partners.

Success factors a) Support from the Ministry of Health in a number of areas especially continuity of funding for the database as well as the need to meet specific conditions, b) Coherence with research environment e.g. research projects obliged to upload the project to the Dutch database, c) Support from local municipalities and involvement of national stakeholders involvement at development stages, d) kept it SMART, developed brand awareness, e) Provision of a one-stop-shop for health promotion interventions in the Netherlands, f) Provision of knowledge on quality and effects of interventions in the Netherlands, g) Improved collaboration between local and national level health promotion and links policy to practice, h) One uniform system to assess the quality and effects of interventions within several domains (youth, sports, mental health, substance abuse, sexual health, overweight and obesity, prevention and care).

Barriers and challenges a) the volume of interventions to assess is considerable and is an on-going commitment, b) the costs of initial development, maintenance, communication and dissemination are sizeable, c) the need for flexibility to align with governmental priorities across governmental departments, d) differential attitudes of practitioners to the importance of maintaining an Open Access Database and understanding of evidence based working, e) collaboration with seven national organisations and all local municipalities as well as government departments, f) decentralisation along with health insurance environment can promote a 'grow your own' culture, g) currently demonstrating 'return on investment' is difficult – can only demonstrate ROI though web statistics e.g. visitors to the site or number of users/practitioners submitting practices.

Costs and funding Database: Initial development (€500 K) with annual maintenance (€25 K), seed investment in establishing the Dutch recognition assessment system (€100 K) with annual costs for on-going assessment of approx. 50 to 60 good practices, (€300 K), Implementation and communication/promotion (€90 K).

Evaluation While there is information on the number of visitors to the database (2,700 visits p/week) with most viewed pages being the recommended good practice interventions (700 times p/week) there is no evaluation of the take up of recognised good practices at local community level as the primary outcome measure for the portal.

Outstanding Issues Questions still remain on how to increase the local implementation of the database of good practices and how to incentivise good practice in health promotion as well as establishing a minimum requirement of GP's for effective functioning of health promotion in the Netherlands. In addition, the duration for which a good practice should be awarded for and the mechanism for standardising and transferring good practices across settings and regions have yet to be explored.

Ib. Database of Good Practices - Italy

Objectives To document and validate prevention and health promotion projects with emphasis on identification geographically and in relation to equity. To help development of interventions by elaborating methodological guides. To evaluate and promote good practices. To monitor development of interventions with focus on mapping.

Target audience Both the general population with a public area in website and regional participants with restricted access website.

Brief overview This programme, with its database, was initiated in 2004 within one region (Piedmont) initially but is now a national programme (2011). The components are: a project guide to promote description of practices, an assessment including an algorithm with 18 criteria resulting in four categories from 'recognised good practice' to' insufficient practice'. Currently there are 1440 interventions with 12 categorised as good practices and 5 others under assessment. The centre in charge of this programme provides training regarding the application and assessment process.

The purpose of the database is not only to evaluate and highlight good practices but also to collect and share local and regional data on health promotion activities, project materials and results with a view to improving health workers knowledge and competencies. It also helps develop evidence based projects and interventions through providing methodological guides and provides a synthesis monitoring maps of regional and local activity.

Success factors This programme has improved reputation and reliability of health promotion interventions, the good practice application form is kept simple, and the database highlights reliable project leaders and their institutions.

Barriers and challenges The challenge of updating, timeliness of assessment/evaluation process, number of resources required to evaluate/assess practices, need for training tools, the need for social marketing of Good Practices which have been uploaded. Often practitioners don't see the importance of the assessment system and the database and very few submitters apply for their practice to be evaluated.

Ic. Database of Good Practices - Germany

Objective The overall focus was to share information i.e. knowledge management

Brief overview This database was set up by BZgA in 2003 and has evolved over time. Of 2,798 HP projects uploaded initially 119 are classified as good practices and a total of 1200 are currently regarded as active on the database. There are two sections in the database - a self entry section and a Good Practice (GP) section

with the latter focussed on social disadvantaged groups. GP's are judged against 12 criteria which are applied by a number of experts and an Advisory Board and are arranged into settings, by target group and by topic areas.

Success factors The database is very accessible, the practitioner 'on the ground' has help from organiser in describing and uploading, the database used especially by practitioners to reflect on own practice and share experiences.

Barriers and challenges No monitoring of use of database or uptake of GPs, difficulty in getting projects submitted.

II. Platform for Knowledge Exchange (PKE)– development of CHRODIS

Aim To facilitate the sharing and exchange of good practice interventions on prevention and care of chronic diseases across EU Member States.

Brief description The Platform for Knowledge Exchange (PKE), currently in development, is envisaged as an online tool to facilitate the sharing and exchange of good practice interventions on prevention and care of chronic diseases across EU Member States. The platform that will include an up-to-date repository of good practices, in the areas of health promotion, primary prevention, multi-morbidity, diabetes, organisational interests and patient empowerment. To be categorised as a good practice intervention submitted practices will be evaluated by a number of experts using 10 criteria and 28 categories agreed following an extensive Delphi process (http://www.chrodis.eu/wp-content/uploads/2016/03/Delphi-1-report_HPPP.pdf). The PKE will also include an **on-line help-desk** for users and a **digital library** (repository) containing contents of interest for stakeholders as well as a **search engine** and a **registration process**.

Target audience Policy makers and practitioners in EU Member States

Challenges *Sustainability:* Currently the PKE is only a 'proof of concept'. *Language barrier*: Not all practices submitted to and accessed through the PKE will be available in English. *Terminology* used in the PKE relates to clinical terms and not health promotion terms. *Impact of PKE*: The impact of the PKE is dependent on the number of users and visitors to the PKE as well as the perceived quality of the information, and the functions and processes within the PKE – this will be dependent in the first instance on promoting the PKE. *Sourcing reviewers and referees*: the review process relies on experts to volunteer their time, and the process to review a practice may be quite lengthy.

Conclusions of Databases Study Visit

As a result of hearing about the three examples of databases of good practices in the Netherlands, Germany and Italy we summarise our observations for transferability as follows:

1. **Documentation**

   It is clear to us that simple clear description of health promotion interventions in tandem with a cycle of appraisal has a lot to recommend it as a first step in promoting scrutiny, reducing duplication, improving quality and raising the bar in provision of health promotion and primary prevention in general. This underpins governance and structured intervention/programme review processes. Further development can then be decided upon such as moving to a structure for assessing good practice and onwards to collation into a database.

   It is important that there is a balance between sufficiently described practice without creating so much work as to act as a disincentive to submitting practices.

2. **Assessing good practice**

   Following on from the exercise of description and clarity of purpose the process of assessing good practice then offers the next step in improving effectiveness and quality in health promotion interventions. The availability of the CHRODIS criteria, using a Delphi consensus, provides Ireland with an internationally agreed approach to assessing currently established as well as new interventions. Of interest is that one member of the Irish partnership (Teresa Bennett) has been supporting the submission and review process and is currently looking at the development of a 'tool' to apply criteria to assess GPs in Health Promotion in Ireland as well as in EU setting.

3. **Databases**

   The value of a database lies in the fact that it is a repository for documented and assessed practices with measurement of the degree of evidence underpinning these practices. It may have potential in supporting a governance function. However we think it is important to point out that while a database brings together 'pieces of the jigsaw' it can only act as a promotional agent if aligned closely with a proactive review/assessment process and a suite of communications to professionals. Ultimately, the success of any database development hinges on identifying the needs and benefits to policymakers and health promotion practitioners, seeking high level support and buy-in from stakeholders, particularly at the concept and development stages.

   The Dutch rationale for developing their database is that it provides a system for providing the evidence base to all practitioners and helps avoid duplication of efforts and practices, thus encouraging evidence based practice and avoiding investment in 'what doesn't work'.

Setting up and maintaining a database is costly. From assessment of the three GP portals presented it was agreed that the required budget for developing and maintaining a GP portal could be substantially reduced given that there is now a blueprint for a National Open Access Database. Furthermore, the PKE itself, using a micro site within the PKE, may function as a country specific repository of good practices which could be an alternative to developing an Irish repository or used as an interim measure while examining the feasibility of developing a database in Ireland.

4. Innovation

While much emphasis is necessarily given to decisions on current practice the area of developing health promotion and promoting innovation is crucial to nurture. The assessment criteria and supporting tools are likely to be of particular value in this area.

5. Evaluation

It is noticeable that the evaluation of the outcome of setting each databases has not been undertaken in any of the three countries. The Dutch can demonstrate the use of the site via web statistics e.g. visitors to the site or number of users/practitioners submitting practices. All three can describe the reduction in number of programmes but little else in regard to evaluation is available.

6. Policy context, drivers for development of health promotion practice and governance

As found especially in the Netherlands the tight fit between the policy cycle and HP developments meant that the database (known as the Dutch recognition system for Interventions) played a definitive role and appears to have achieved at least some elements of reduction in variation in practice and quality improvement. We would also say that each step as outlined in this section can only have an impact if it is aligned to a programme of development and a structured governance function.

7. Knowledge Transfer

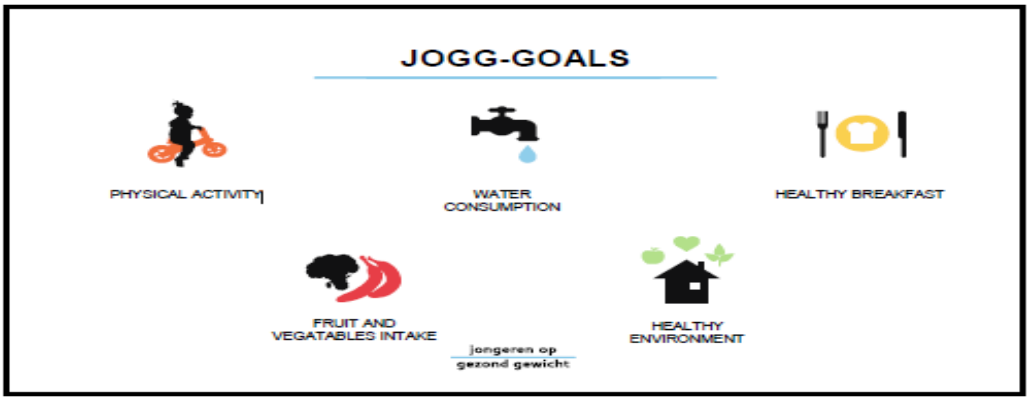
Having information available in a language accessible to the majority of EU countries (e.g. English) would support the knowledge transfer between jurisdictions.

8. Additional Important pointers

a. It is important to create collaboration and commitment within the Department of Health.
b. Close working relationships should be forged with knowledge institutes, research institutes, experts in the field.
c. To be effective 'Keep it Smart' - start with a restricted number of issues.
d. While costing we witnessed can be reduced, financial support is essential, nonetheless and is an essential ingredient in guaranteeing continuity!
e. Also stimulate research on the effectiveness of interventions or on the implementation of effective practices.

f. Do not support interventions that are ineffective and be concerned regarding the ones that have insufficient evidence.
g. Develop communications and focus on a 'brand awareness' in regard to whichever element of the improvement pathway is developed such as refer to the database and recognition system in letters, white papers etc.

III. JOGG



Brief description JOGG is a movement and an integral community based initiative that aims to reverse the increasing trend of overweight and obesity among children and young people aged 0 to 19 years. JOGG encourages all people in a city, town or neighbourhood to make healthy food and exercise an easy and attractive lifestyle option for young people. Its mission is to reach **1 million young people aged 0-19 years** (representing 25 % of the Dutch youth population) by working towards a healthy environment with a focus on structural and built environment to promote a healthy lifestyle and promote a healthy weight. Within most JOGG municipalities the programme specifically focuses on the neighbourhoods most challenged in terms of socio-economic and health status.

The Dutch JOGG approach is based on the successful French project EPODE and consists of five pillars:

1. Political and governmental support; 2. Cooperation between the private and public sector (public private partnership); 3. Social marketing; 4. Scientific coaching and evaluation; 5. Linking prevention and health care (A key difference between JOGG and EPODE is that JOGG incorporates prevention and healthcare pillar unlike EPODE).

Aim and Objectives The aim of JOGG is to reduce the increasing trend in overweight and obesity among children and young people aged 0 to 19 years in the Netherlands.

Key objectives (based on the 5 main themes of JOGG) are to:

1) Increase the amount of young people that achieve the recommended level of daily physical activity,

2) Reduce the intake of sugary drinks and increase the intake of water,

3) Increase the amount of young people that consume a healthy breakfast,

4) Increase the daily intake of fruit and vegetables and

5) Encourage every setting (neighbourhood, school, home and health care) to offer a healthy option, and promote physical activity.

Target audience and Setting JOGG advocates a local approach in which not just the parents and health professionals, but also shopkeepers, companies, schools, sports clubs and local authorities collaborate to promote healthy weight for children and young people (0-19 years) with each city/municipality having a JOGG-coordinator, who is responsible for planning activities to support JOGG.

Local Level Implementation: Municipalities commit to JOGG for at least 3 years, pays a yearly fee to appoint a local JOGG program manager who coordinates the local implementation of the JOGG. Various activities are planned by the JOGG co-ordinator which are based on the 5 JOGG pillars and the specific needs of the municipality. There are 6 national private partners and about 120 local partners, ranging from the nutritional, sport, water, societal, financial and educational sectors.

National Level Co-ordination: JOGG is coordinated at national level by the national JOGG foundation in The Hague, which is part of the Covenant on Healthy Weight (i.e. a broad platform of partners/parties committed to tackling the obesity problem and initiated by the Ministry of Health). Activities and supports at national level include: advice on creating political and managerial support; training in the JOGG approach for locally involved parties, provision of information on successful interventions and best practices, designing and providing municipalities with communication and information materials, directions on how to implement the JOGG approach, undertaking or commissioning scientific research on how to measure the effects of the approach.

Results and Evaluation In April 2016, 109 municipalities in the Netherlands, from a total of 380, were using the JOGG approach to promote healthy weight among their youth. In 75 municipalities, there has been an increase in the number of young people with a healthy weight. The number of beneficiaries is estimated to be around 500,000 inhabitants.

A key feature of JOGG is *Monitoring and Evaluation* in terms of both process and outcome. Almost all municipalities are undertaking monitoring and evaluation activities. Over half of municipalities have developed an evaluation plan. Health outcomes that are measured include BMI, health behaviour (physical activity, fruit and vegetable intake, water and breakfast consumption), the healthy environment of young people in JOGG communities and the process outcomes are those underpinning the 5 pillars of JOGG. A range of *JOGG Tools and Instruments* have been developed to guide the process and outcomes evaluation measurement, e.g. tools, instruments, action plans, checklists, recommended goals to be achieved, template to conduct evaluation and action plans for conducting tools and instruments for data collection.

Costs/Funding Per annum costs include: €3.8 million base funding provided by Ministry of Health; €5,000 to 10,000 fee paid by each JOGG municipality; €5,000 contribution by each Covenant of Healthy Weight Platform partners and €50,000 contribution by each Private Partner.

Success Factors

a) A key driver was the '*Sense of urgency' to tackle the issue of overweight and obesity'* and the resultant political commitment at national and local levels.
b) Support from the *Ministry of Health,* both at policy and financial levels.
c) *Commitment and financial support* from a wide variety of sectors: - *Public Private Partners* (Nutricia, Danone, Albert Heinz (Larger Dutch retailer), to provide financial support; *Political commitment* (strong politician and ambassador – very active in the public arena and well known by general public in The Netherlands)

Commitment from *academic sector* (provides credibility); the adoption of a community approach (to develop the local actions).

d) *Cooperation between public private sectors* is governed by clear established guidelines.

e) *The governance structure* is key to the JOGG approach. (Ministry of Health, Public Private Partnership, local municipality buy-in, National Oversight and strategic direction from JOGG Programme Coordinator, and Local JOGG managers).

f) *The Methodology:* JOGG is based on EPODE which has been proven to be effective (long term initiative – reduction in overweight and obesity observed after 8 yrs) and the adoption of a community approach to develop the local actions).

g) *Focused efforts on those in most need and where the problem is greatest.* Formerly, the target groups for the JOGG programme was all age groups, but since 2010, the focus shifted to youth only (0-19 years) and specifically focuses on the neighbourhoods that experience the greatest challenge in terms of socio-economic and health status.

h) A *Logic Model for JOGG programme* developed – supports measuring and monitoring of inputs, outputs and outcomes.

i) JOGG project management and project governance supports

- Customized support /advice for all the Municipalities through JOGG coach, JOGG expert, JOGG adviser
- Knowledge transfer/sharing: training workshops, meetings, online platform
- Tools and materials: JOGG wiki, communication materials, campaigns
- JOGG program manager is responsible to overview all pillars

j) The establishment of a *knowledge transfer process* is one of the biggest successes of JOGG. A team in the NL works to provide guidance, advice and materials to JOGG personnel at local and national levels and also for interested international partners. The EPODE academy which seeks to sustain the knowledge transfer process on an international level is currently well established but not ready yet to train international colleagues on a bigger scale. JOGG team in NL is contemplating the setting up of an EPODE academy. JOGG materials will be translated into English and a JOGG team will be available to train and advise other countries in the JOGG approach.

Barriers/Challenges

a) A key question that arises is how to prove impact and show results from JOGG.

b) JOGG approach/Programme has received criticism regarding the engagement with some Public Private Partnerships.

c) Cost – the cost of the programme is substantial – with a large yearly contribution (3.8 million) from the MoH, and €50,000 from each private partner; €5,000 from each platform partner; and €5K to €10 K pa from each municipality.

d) In terms of monitoring and evaluation, some issues include, access to reliable data (as not all JOGG co-ordinators at local level are trained in data collection), access to skills and expertise to conduct evaluation.

IV. Amsterdam Healthy Weight Programme

Brief description Overweight and obesity levels among 10 year olds living in Amsterdam (24 %) are double the prevalence rates nationally (12 %). 19 % of children aged 2 to 8 years in Amsterdam compared to 13 % nationally are overweight or obese. Overweight and obesity levels also differ between districts within Amsterdam city with higher levels among those of non-western migrant background, those experiencing poverty and with problems accumulating in lower-class suburban areas. The mission of Amsterdam Healthy Weight Programme is a healthy weight for all children in Amsterdam by 2033. The vision is that a healthy weight is a collective responsibility of all of society and not only the responsibility of families and parents. The approach is focused on long term, sustainable efforts, inclusive of all people in all domains, sharing responsibility among all sectors in the city.

Objectives

1. To improve the supply and availability of healthy food and drink,
2. To increase active lifestyles
3. To focus on getting sufficient sleep.

Activities focus on healthy parenting; healthy schools; healthy neighbourhoods; designing a 'Moving City'; comprehensive care of children already overweight or obese and lobbying the food industry. There is a focus on 3 types of intervention including; influencing individual lifestyle factors though healthcare professionals, influencing children's immediate social and physical environment and influencing relevant living and working conditions at the general city level.

Targets of Amsterdam Healthy Weight programme (2015 to 2018)

1. Amsterdam must demonstrably become a more healthy organised city,
2. Significant reduction in the number of children who are overweight and obese in the five heaviest neighbourhoods,
3. A neighbourhood approach must be extended to cover five other 'too heavy' neighbourhoods,

4. Fewer primary schools with more than 25 % pupils overweight or obese,
5. All children who are obese or morbidly obese must be given appropriate care,
6. No attrition in the chain: right type of care at the right time,
7. Demand driven service package, with scope for one's own responsibility and empowerment,
8. BMI of 5 year olds in Amsterdam no higher than 5 % above national average,
9. Higher number of children classified as being of healthy weight than in 2013.

Two key features of the Healthy Weight Amsterdam programme are that**:**

1. Efforts are focused and targeted only at age groups where the biggest problem of overweight and obesity exists (i.e.) children aged 9 months to 2.5 years; 2.5 years to 12 years; youth, teenage girls (only) 12yrs and older and children who are already obese. Efforts are focused only in neighbourhoods that are most deprived in terms of poverty and education and not focused on all neighbourhoods. A key requirement to facilitate a focused and targeted approach is the availability and accessibility of good quality data & data surveillance systems.
2. All children who are obese or morbidly obese (n= 2,300) must be given appropriate care through treatment and a follow up sustainable lifestyle intervention – the culture is shifting now in the Netherlands and it is viewed that when a child is denied the appropriate care and treatment for overweight and obesity, it is categorised as 'child-abuse'. In addition, there is more of an emphasis among the wider society that, nutrition and healthy weight of children is not solely the responsibility of parents, but all sectors in society play a role.

Results

Trends in prevalence rates of Overweight and obesity are decreasing in general. However, prevalence rates are still rising in one ethnic group.

Success Factors/Drivers

a) *Data and Evidence*: Seeking Financial support and buy-in from Stakeholders, local Government and budget holders was conditional on having good data and evidence to demonstrate the precise extent of the problem of overweight and obesity at the sub population and neighbourhood levels of Amsterdam and being able to demonstrate the results and impact of the programme. This in turn forced improvements in data surveillance, monitoring and analysis.

- continuous monitoring of the primary outcome such a BMI, annually and monitoring of outputs quarterly.
- Communicating absolute numbers affected by the issue (i.e.,"25,000 of children" instead of "25% of all children") was more effective in demonstrating the extent of the problem to Stakeholders and thus seeking financial support.

b) Seek to influence public perception

- Making it clear that nutrition and healthy weight of children isn't just the responsibility of parents, but an issue for all sectors of society.
- Framing the problem of obesity such that society views that when a child is denied the appropriate care and treatment for overweight and obesity, it is categorised as '**child-abuse'**.

- Shaping positive public perception of the programme, for example, by overcoming general concerns and resistance among some parents (e.g. some parents adopted a 'Mind Your Own Business' attitude as they felt it was their own business if their child was overweight/obese and not the business of the local city council).

c) Programme management

- Adopting a 'Plan-Do-Act' cycle to regularly adjust programme goals and objectives every year, according to the biggest issues that needs addressing most.

- Supporting healthcare professionals through a continuous learning approach, ensuring that key healthcare professionals and those who directly engage with children at key nodal points are informed about the supports and services that are available in the locality to help parents support their children to achieve a healthy weight.

e) Use of a Research & Development approach through:

- Conducting evaluation studies (both process and effect) of interventions (both preventative and care)
- Establishment of an Internal Quality expert team to review effectiveness of new interventions, including cost effectiveness, and capture the learning from other interventions/programmes or from doing new things) and an external scientific advisory board
- Large budget exists for R&D and Training of Healthcare professionals of approximately Eur 700 K p/a.
- Very strong links between academic researchers at local Universities and Research/Knowledge Institutes (e.g RIVM) and the local Public Health Dept., Academic researchers help inform the Public Health/Health Promotion Dept., on strategic direction.
- The Sarphati Cohort is a unique dynamic research infrastructure in place in Amsterdam. It is a Biobank of data from approximately, 150 K children/youth in Amsterdam (10,000 newborns/year), collected through the child registration process aswell as through consultation (through patient digital files) or outside of consultation (through questionnaires) at key visits/engagements between child and midwife/practice nurse/healthcare visits.

In summary

Success factors highlighted by the Netherlands Childhood Obesity Prevention programmes that warrant further consideration in an Irish context are:

i. The importance of having good systems to provide **evidence and surveillance data** to identify the extent and context of the problem and in turn focus efforts proportionately on those in most need. In terms of the frequency of measuring outcomes, there appears to be value in measuring outcomes (e.g. BMI, physical activity levels, fruit consumption etc.,) yearly, and out puts more regularly (quarterly).

ii. Awareness of the need to **influence public perception** of the problem. The culture is now shifting in the Netherlands so that it is viewed that when a child is denied the appropriate care and treatment for overweight & obesity, it is categorised as 'child-abuse'. There is also a greater emphasis on all sectors of society having a responsibility for nutrition and healthy weight of children as distinct from it being the sole responsibility of parents. This has been met with resistance from some parents.

iii. Seeking **funding support** from local level, from the private sector and Ministry of Health is key to success.

iv. The reliance on **Public Private Partnerships** is a feature underpinning the JOGG Programme and also the Portugal's National Healthy Eating Programme (see Section 2.4). Often much criticism is levelled at such partnerships given the potential conflicts of interest resulting from the involvement of the private sector and therefore it is important to establish clear and agreed structures and guidelines governing such partnerships.

v. Establishing **Research and Development Partnerships and Supports:** In Amsterdam a strong collaboration between local public health/health promotion departments with the local University has resulted in the University providing some of the research and data needs and strategic direction of the local Public Health Department; Establishment of an Internal Quality expert team within the Public Dept., enables review of effectiveness of new interventions as well as capturing the learning from other interventions/programmes or from doing new things. Some examination of cost effectiveness is also conducted. A Very large budget is available for R&D and Training of Healthcare professionals (approx. €700 K p/a. Engagement of other important *knowledge sector partnerships* in the Netherlands, is the Institute for Food and Public Health (RIVM) who provide support with evidence and knowledge around effectiveness of health promotion interventions.

vi. **Continuous Learning approach for key Healthcare professionals** to educate and inform those who directly engage with children at key nodal points about the supports and services that are available in the locality to help parents support their children to achieve a healthy weight.

vii. Having a **knowledge transfer process**/guidance is important in enabling adaptation and transfer of interventions between jurisdictions, taking account of local contexts. A key barrier in transferring good practice interventions between EU countries is the lack of availability and access to information and material in an accessible language, e.g. English.

viii. If **implementing** the JOGG programme, the advice is to start small with 1 or 2 pilot sites, of approximately a population size of 10 K to 20 K and limit the themes to one at a time per school or one theme per year. Focus on both environmental and lifestyle interventions, in all settings, using multiple partnerships. Seek support from MoH, other Government Departments/agencies as well as the expertise and the willingness of the communities locally. Use well known/important ambassadors or champions at national and local levels in the fields of science and policy to get support for the implementation of the intervention.

2.4 Portugal Study Visit

National Programme for the Promotion of Healthy Eating (PNPAS)

Purpose of Study Visit To provide information and to share knowledge on the approach, key elements of Portugal's National Programme for the Promotion of Healthy Eating (**PNPAS**), and key contributory factors in its development.

Brief Description The PNPAS is a National Programme, based on a healthy eating policy incorporating a concerted and cross cutting set of actions focusing on health education, availability of healthy food in schools, workplaces and public spaces and collaborating with other public and private sectors, in the areas of agriculture, sports, environment, education, social security and municipalities with the objective of improving the nutritional status and health of the Portuguese population. Implementation lies at national level with regional level support. The economic recession and lack of finances to develop any new national nutrition programme were drivers for the establishment of the PNAPS in 2012. The Directorate-General for Health (DGS) were forced due to budgetary constraints to review and assess current nutrition initiatives and projects to ensure more efficient implementation and use of resources. PNPAS is one of eight priority health programmes delivered by the DGS.

Target audience All populations in Portugal but with a particular focus on vulnerable and disadvantaged groups. Settings include, schools, urban, rural, and workplaces.

Aim To improve the nutritional status and health of the Portuguese population through ensuring improved access to and consumption of healthy foods.

The PNPAS objectives are:

1. To increase the knowledge about food consumption by Portuguese population, its determinants and consequences.
2. To modify the availability of certain foods, namely in schools, workplaces and public spaces.
3. To inform and empower the population in general, especially the most disadvantaged groups, on how to purchase, cook and store healthy foods.
4. To identify and promote cross-cutting actions to encourage the consumption of good nutritional quality foods in coordination and integrated with other public and private sectors, namely in the areas of agriculture, sports, environment, education, social security and municipalities.
5. To improve the qualification and mode of action of the different professionals who, through their activity, may influence knowledge, attitudes and behaviours in the food area.

Key Activities to achieve objectives

a) **The systematic collection and aggregation of indicators** of nutritional status, food consumption and its determinants over the life cycle, the assessment of food insecurity situations, and the assessment, mapping,

monitoring and dissemination of best practices with the goal of promoting healthy eating habits or eating habits that protect from disease at the national level.

b) ***Reducing availability of and access to unhealthy foods*** (high in sugar, salt and fat), in schools, health and social support institutions and in the workplace, and increasing greater availability of other foods like water, fresh fruit and vegetables, and the encouragement of nutritional reformulation of food products through a coordinated action with the food industry and the catering sector.

c) ***Improving food and nutrition literacy***, the empowerment of citizens from different socioeconomic and age groups, towards healthy choices and eating practices, and the encouragement of best practices on labelling, advertising and marketing of food products.

d) ***Collaboration and promotion of cross-sectoral actions*** with agriculture, sports, environment, education, municipalities and social security, to promote the adoption of a Mediterranean eating pattern, with a view to increasing the consumption of foods of vegetable origin, seasonal, national, using packaging or means of transport that reduce the emission of pollutants, developing electronic tools that enable planning healthy, easy-to-use and affordable menus with price information for individuals and families, and developing a network at municipal level for monitoring best practices and projects in the area of the promotion of healthy eating for citizens.

e) ***Improving the education, the qualifications and supporting of different professionals*** to help influence quality eating habits, at the level of the health sector, schools, municipalities, the tourism and catering sector or social security.

f) ***Improving the co-ordination and structures*** of professionals in addressing the issue of overweight and obesity.

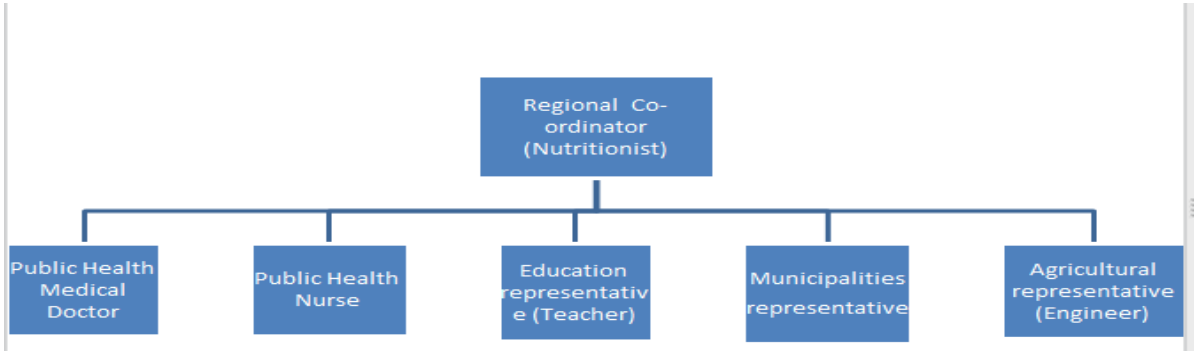
Evaluation The impact of the strategies underpinning the PNPAS programme will be evaluated in 2016 and will focus on the modulation of knowledge and behaviour of the population towards healthy eating through the change in availability in the 'food environment', evaluation of the partnerships with other sectors and the empowerment of professionals dealing with nutrition and healthy eating will be important components of the evaluation.

Success Factors

Leadership is provided by the DGS and is the lead agency in developing and providing nutrition knowledge and content for all nutrition matters in Portugal and collaborates with other Ministeries to influence and modify food supply, availability, food security and the food environment. e.g. A coordinated approach between PNAPS and strategies of other partners e.g. in the food and agriculture sector ensures improved food supply chains providing

better access to seasonal, locally grown traditional foods in particular among rural communities , DGS is working with local food producers to ensure food is marketed as a 'healthy food'.

Particularly relevant is the cross sectoral working and collaboration at local and regional level with professionals from health, education, agriculture working together in delivering health education and nutrition initiatives at municipality level in response to identified local need. Given the absence of a health promotion delivery service throughout Portugal, a Nutritionist is appointed at regional level to co-ordinate a team at municipality level comprising of specialists from Public Health, Education, Agriculture, and municipality representatives to address identified local health needs.



Data and Evidence

DGS has initiated **a mapping** of national, regional and local nutrition initiatives to seek a better understanding of the range of initiatives delivered by provider and location with a view to reducing duplication of efforts and improve efficiencies has also been a feature. A database of nutrition interventions is in development.

DGS has led on a process to improve **integration of nutrition data sources** (e.g. nutritional status, nutrition & disease, determinants of nutrition status) to improve quality of data. A key driver in the process was the MoH, requesting all data providers and researchers to collaborate and agree on data sets and quality of data. In practical terms this took a very long time to achieve (more than 20 years). A key driver in this change process in integrating data sources was the networks among professionals and personal relationships as well as having a central person with a clear vision with good negotiating skills to bring people along.

DGS has introduced a system of collection of national nutrition indicators which are cascaded to regional and local levels where Primary health care professionals are responsible for collecting and reporting of indicators.
A Logical model for the national programme (PNPAS) has been developed and is under review with WHO.

Public private partnerships are a feature of the PNPAS programme with organisations such as Nutri-ventures, a global brand and business to promote the consumption of healthy foods among children and a partnership with one of the largest food distribution chains in Portugal, LIDL.

Training and Education of allied health care professionals to promote healthy eating

There is legislation to support 7 different types of healthcare professional (e.g., psychologists, nurses, doctors etc.) to deliver nutrition information and support to the general public.

Barriers/Challenges

- Given the extensive use of digital and social media by young people nowadays, it is very difficult for both healthcare professionals and parents to keep pace.
- Ensuring sufficient and effective IT resources and capacity at national level to support data/indicator collection and monitoring is challenging.

Transferability/Points for Consideration in an Irish context

Having one overarching programme, that integrates identified key themes and activities under one high level national programme may help strengthen recognition, and momentum for a programme, rather than having multiple non-integrated initiatives with various themes delivered regionally and locally.

Having one centrally recognised high level authority, with lead responsibility in developing and providing nutrition knowledge and content for all nutrition matters in Portugal, targeting both professionals and the general public as well as promoting collaboration and networking between nutrition professionals has been valuable in the Portuguese context.

Developing an agreed set of national nutrition indicators that are cascaded to regional and local levels encouraged streamlining of local programmes and initiatives in Portugal. However, ensuring sufficient and effective IT resources and capacity at national level to support data/indicator collection and monitoring is essential.

Training and education to support different types of healthcare professional (e.g., psychologists, nurses, doctors etc.) to deliver nutrition information and support to the general public is essential given the absence of a health promotion delivery service/mechanism in Portugal. Whether something similar could be achieved in Ireland remains to be explored.

2.5 Icelandic Study Visit

Purpose of Study Visit The purpose of this study visit was to showcase two examples of good practice: The National Curriculum Guides and The Welfare Watch. These are presented as good practice examples of health in all policies approach. The National Curriculum Guides were introduced in 2011 in Iceland as a national policy and are currently being rolled out with a first wave evaluation under way. The Welfare Watch was initiated in 2009 in Iceland as the Well Being Watch in direct response to the collapse of the Icelandic banks in 2008 and a period of civil protest. The Nordic Council of Ministries adopted the principles of the Icelandic Well Being Watch and funded the Nordic Welfare Watch between 2014 and 2016. The first day of the study visit was dedicated to a number of presentations from the Icelandic Well Being Watch and the Nordic Welfare Watch and the National Curriculum Guides were presented on the second day of the visit.

I. The National Curriculum Guides and Health and Wellbeing as one of six fundamental pillars of education in Iceland, background and implementation.

Brief Description The Ministry of Education, Science and Culture published new National Curriculum Guides in 2011, providing a policy framework for Icelandic schools across all educational levels including pre-, compulsory and upper secondary. Six fundamental pillars have been developed within this framework forming the essence of the educational policy in Iceland. Defining "health and wellbeing" as one of these six fundamental pillars, was a milestone for educational policy, confirming the mutual importance of health and education in Iceland. The other pillars are "literacy", "sustainability", "democracy and human rights", "equality" and "creativity". The National Curriculum Guides have the same status as regulations in Iceland.

Aim and Objectives The overall aim of the health and wellbeing pillar in the Curriculum Guides is to create a supportive school environment that promotes healthy behaviours and a healthy lifestyle throughout childhood and the teenage years. It is intended to permeate all school activities, all levels and aspects of education, be long-term in nature and apply the whole school approach. The main health factors that are to be encouraged are: positive self-image, physical activity, nutrition, rest, mental wellbeing, positive communication, security, hygiene, sexual health and understanding of one's own feelings and those of others.

Setting and Target Audience The Guides apply across all school levels targeting children in pre-schools (2-5 years), compulsory schools (6-15 years) and upper secondary schools (mainly 16-19 years). They clearly set out that responsibility for implementation lies with the whole school community and schools should make an effort to encourage and support a good working atmosphere and positive school spirit characterised by mutual trust, respect and shared responsibility, where security and a healthy lifestyle are valued.

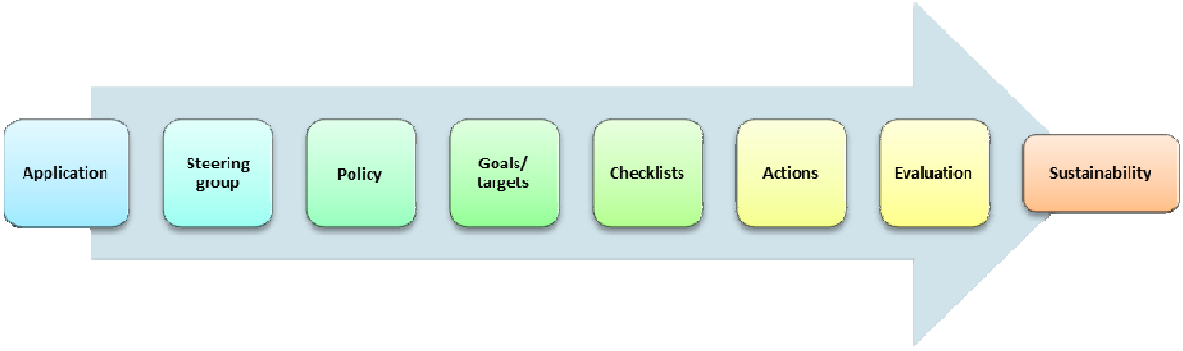
Process The Guides involve some key elements:

- A whole school approach
- Individual school responsibility for implementing the curriculum
- School principal ultimately responsible
- Introduction documentation
- Interactive support website with individual school tailored portal (currently in development)
- Training events to disseminate the approach, process and good practice
- Focused support from the Health Promoting Schools Projects team

The Guides provide an important policy foundation for the Health Promoting Schools Projects in Iceland; run by the Directorate of Health in collaboration with The Ministry of Education, Science and Culture, The Ministry of Welfare and many other, key stakeholders. Health Promoting Schools provides an important support for schools to implement the Health and Wellbeing pillar and it is promoted by the Ministry of Education to ensure schools deliver on the curriculum. As a result, the Health Promoting Schools Projects for all school levels are becoming well-established. The number of health promoting neighbourhoods or municipalities is also increasing and one of their priorities is to encourage and motivate schools in the locality to take part in the Health Promoting Schools projects.

Figure 1 details the process of support offered to schools. The school sends an application signed by the principal to participate in the Health Promoting School Projects – a coordinator is then appointed for the school. A whole school steering group must then be formed including teaching staff, administrators, PE teacher, parents, students, school nurse, school counselors and a representative of the canteen where relevant. A policy is agreed and added to the school curriculum detailing gooals, targets and expected actions. An evaluation plan is established and schools are encouraged to focus on sustainable action.

Figure 1. Process of support from the Health Promotion Schools Projects



Evaluation The evaluation of the Guides forms part of the overall approach to evaluation of school activities by the Ministry of Education and is required by law. The Ministry of Education makes a plan for the evaluation of activities at all school levels and publishes it on its website. The institute "Námsmatstofnun"

conducts an external evaluation on behalf of the Ministry of Education. The prime objective is to examine whether school activities are in line with the provisions of law, regulations and the national Curriculum Guide. Separate to this, the Ministry of Health is currently supporting a process evaluation to assess how well the health and wellbeing pillar is being implemented at all school levels. It is reported that 90% of compulsory schools and upper secondary schools have begun implementing health promotion approaches to achieve the objectives of the health and wellbeing pillar. To date 80 of the 177 compulsory schools and all 31 of the upper secondary schools are actively implementing health promotion activity in line with the health and wellbeing pillar. Implementation is now being rolled out in pre-schools but no evaluation data has been collected for these. Evaluation data promising so far although it is still early days. The process evaluation has received positive feedback from schools and the Ministry of Education as well as from health promoting schools team and the Ministry of Health.

The interactive website which is currently under development has a dual function: to support schools in implementing the Health and Wellbeing Guides and also to collate a wide variety of detailed data through each school's portal which is analysable for a comprehensive evaluation of health promotion activity in schools.

Success Factors This is an excellent example of a health in all policies approach and learning from early process evaluation findings show that this policy measure is likely to be far more effective compared to the earlier voluntary model of Health Promoting Schools in Iceland. Some of the reasons behind its success include:

- Formal support from the Ministry of Education - considered essential to implement an effective approach to health and wellbeing across school curriculum.
- Effective cross departmental partnership working with due consideration for key supports and governance structures.
- Attributing responsibility to the school principal distinct from a nominated teacher for agreeing and implementing the health and wellbeing curriculum across the school. Focused support from skilled, experienced professionals in the Health Promoting Schools Projects.
- Triangulation of educational policy with focused implementation support provided by experienced, skilled professionals through the Health Promotion Schools Projects.
- Seed funding for development of on-going supports including training and a tailored interactive website. This is ultimately considered good value for money as investment in well-functioning resources cuts down on staff resources. The Health Promotion Schools Projects team reported a substantial reduction in the hours required to support schools through the process - attributed to the development of useful support documentation and the website as well as an onus on the school themselves to implement the curriculum.
- Implementation across all school levels normalises health and wellbeing within the school context and promotes spiral learning: a 'spiral curriculum' can be defined as a course of study in which students will

see the same topics throughout their school career, with each encounter increasing in complexity and reinforcing previous learning[1].

- Formal external evaluation of school curriculum activities.
- Embedding schools health promotion within a healthy communities' approach which supports the activities of the school in the community and visa versa looks like it will be very effective.

Barriers

- Have not yet agreed additional time allocation for health and wellbeing activities in the school curriculum.
- Although the level of support and time required for implementing the process per school has been substantially reduced, providing support to the full school sector requires a greater number of skilled school health promotion staff.
- Policy is only sustainable if it is supported by Ministers.

Key considerations for transferability to an Irish context

I. Iceland is a small country with a well-defined school population.
II. The Irish school governance structure contrasts considerably with Iceland where a significant majority of schools are State managed and funded.
III. The health and wellbeing agenda in schools was driven by the Minister of Education, recognising the important contribution health has to play in education and vice versa.
IV. There is a current focus on a broad community commitment to health promotion embedded in a settings approach – community health promotion initiative provides mutual support to the model.
V. Ireland is now considering an approach to embedding health and wellbeing within the Junior Cycle. It remains to be seen how or to what extent lessons from the Icelandic model might be incorporated into this approach.

II. The Welfare Watch, intersectoral work aimed at vulnerable groups, transferred from National level (Iceland) to local level (the Surdurnes Region in Iceland) and intersectoral level (the Nordic Welfare Watch).

Brief description The Welfare Watch was initiated in 2009 in Iceland as the Well Being Watch in direct response to the collapse of the Icelandic banks in 2008 and a period of civil protest. In response to the civil protests, all political parties promised to protect the welfare system in Iceland. A New Government was elected

[1] Educational Psychology Help and Review, Chapter 8 Instructional Pedagogy. Retrieved from www.study.com (Accessed on 23rd August 2016).

and they initiative the 'Well-being Watch' in September 2009 to monitor the consequences of the financial crises on individuals and families with a particular focus on maintaining the wellbeing of vulnerable groups. A cross-sectoral steering group was established to progress work and included input from a wide group of NGO's, social actors and local and State bodies. The process was overseen by the Minister of Welfare. In response to the success of the Icelandic Wellbeing Watch, the Nordic Council of Ministries adopted its principles and funded the Nordic Welfare Watch between 2014 and 2016.

Aim and objectives The overall aim of the Wellbeing Watch was to adopt an active social policy, engaging the Welfare State model to protect those affected by the crises. It aimed to monitor population wellbeing during the economic crises and protect the most vulnerable in society. It established an Independent observing body responsible for making proposals to the Government, Local Authorities and NGO's.

Specific objectives were to:

- Collect information regarding the consequences of the financial crisis
- Collect information on measures that had already been put in place since the crises and assess what measures, if any, were working in alleviating the challenge to wellbeing during the crises.
- Present recommendations to the Minister of Welfare, the Government and local authorities on measures to address the crises and protect population wellbeing.

Setting and Target Audience This was a national policy approach with a particular focus on protecting the wellbeing of children and low income families, unemployed and other groups deemed to be vulnerable at the time of the crises.

Process The Icelandic Minister of Welfare established a Steering Group in 2009 to oversee the work of the Wellbeing Watch and develop actionable recommendations relevant to government policy and local implementation. A wide range of Working Groups were then established to support the Steering Group and assist on specific areas. There were 9 Working Groups established to address particular concerns:

- Children (under 18 years)
- Youth and Young Persons (15–25 years)
- Marginalized Individuals and Groups
- The Unemployed
- The Financial Situation of the Family
- Health in Times of Crisis
- Social Indicators
- The Basic Services provided by the Local Authorities and the State
- Cooperation across municipalities in one vulnerable area

Children's welfare was a common thread between the working groups and was a key focus of the Steering Group. Over 100 officials and individuals actively contributed to the process which facilitated in the mutual exchange of issues and actions between the community and Government which led to more informed implementation at a

local level. A key element of the process was the support of the academic sector in contributing voluntary research capacity.

Some key actions of the Wellbeing Watch were:

- Free school lunch to all school children and extra school costs to be kept at a minimum for all families
- A letter circulated to all MPs on behalf of the Minister of Welfare to challenging them to focus on the most vulnerable in their constituency and prioritise them accordingly
- Active and joint advocating for maintenance of Welfare Services and entitlements
- Appeals to the Minister for Health to ensure adequate provision for dental health services for children in poor families
- Advocating for employment and access to training for young people
- Advocating for maintenance of maternity/paternity leave and parental leave entitlements as a protection mechanism for children's wellbeing.

Evaluation A formal evaluation of the Icelandic Wellbeing Watch is currently underway (2014-2016) as part of the Nordic Welfare Watch programme. This will focus on the effects of the Icelandic crises and the Icelandic response on economic wellbeing indicators including poverty, unemployment, reduction in disposable income, material deprivation. Collection of comprehensive baseline data enabled tracking on key priorities.

Some important findings have already been reported from a variety of studies and data sources. Further studies are however required to fully quantify the impact of the approach. The process itself was seen as a very positive experience with strong leadership from the Minister of Welfare, positive voluntary engagement and interest among members, broad ownership for the issues raised, consensus reached easily on main issues and on all recommendations. Cooperation within the watch resulted in the unintended side effect of improved cooperation between institutions and the administration of welfare provisions. The development of social indicators allows for monitoring of key social factors and population wellbeing, although there was quite a time lag between the start of the crises and the release of these indicators in 2013.

Preliminary evaluation findings show a good level of success in preventing serious consequences of the economic crises on the wellbeing of the Icelandic population. For example:

- Children and vulnerable groups were prioritised and this focus remains
- Studies generally report that children's wellbeing was protected. It appears that both schools and parents increased their focus on child wellbeing during the crises as a result of the work of the Wellbeing Watch.
- Particular vulnerable communities in deprived areas report increased wellbeing overall for example in the Suðurnes region.
- There are now lower levels of unemployment (unemployment fell from 8.5% in January 2011 to 2.9% in January 2016) and poverty in Iceland due to the economic crises compared to other European countries.

Success Factors This social policy approach appears to have achieved its aim to protect the most vulnerable during a time of severe economic crises. Further studies are required to elucidate the full impact of the approach a number of factors could be seen as particularly successful:

- A specialist group was established to compile useful indicators for the State to monitor population wellbeing. Preparatory work was completed by the group and collection of data and responsibility for reporting was handed over to the National Statistics Office to embed it within existing Icelandic State services. The Social indicators have been released annually since 2013 and are now considered an essential element in national statistics. Each year reporting focuses on a specific issue, such as children and poverty in 2014. These indicators provide an important resource for monitoring areas for future action.
- While the Welfare State was actively employed to shield those most acutely affected by the crises, the Icelandic Government were able to do this while also consolidating governmental finances. This highlights that a strategy of redistribution during economic crises is a feasible approach and offers a viable alternative to fiscal policies based solely on Keynesian stimulus.

Barriers and key considerations for transferability to an Irish context

The evaluation of the Nordic Welfare Watch considered the different policy responses to the crises across Europe. They focused on the Irish response as a direct contrast to the Icelandic response, albeit that both countries shared a very similar experience in terms of the intensity and fiscal impact of the crises itself.

Social Policy in Iceland

- Benefits raised
- Rights to unemployment benefits extended
- Special housing benefits introduced
- Tax burden on lower income groups decreased
- Unprecedented household debt relief

Social Policy in Ireland

- Benefits reduced (from Jan 2010)
- Rights to unemployment benefits shortened and increased conditioning (from Jan 2009)
- Housing benefits reduced (from June 2009)
- General tax increases on all income groups (from Jan 2009)
- No systematic debt relief

The Irish and Icelandic contexts were quite similar in terms of the precursors to the economic crises. Both countries had an extensive bubble economy and Ireland was the only country to experience similar debt accumulation to Iceland. As such both were hit hardest by the economic crises. The success in Iceland's recovery has been attributed to its focus on economic wellbeing incorporating social action rather than the focus adopted by Ireland (and the rest of Europe) on fiscal policy measures and Keynesian stimulus.

Some important considerations apply:

- A key difference in the country context was the autonomy of the Icelandic Government to devalue their currency. Their autonomy from the Euro provided increased autonomy from the EU compared to Ireland. It was reported that IMF restrictions imposed on Iceland were not as austere as those imposed by the EU on Ireland.
- Iceland is a small country and has a small population compared to Ireland. This coupled with the success of the Wellbeing Watch partnership approach allowed for streamlined interaction between national and local actors and resulted in timely implementation of prioritised actions.
- While it could be argued that Iceland was predisposed to adopt a State Welfare response, they reported that they have a much weaker Welfare State compared to other Nordic Countries and would situate their political leanings closer to 'Dublin than Stockholm'. It is however unclear the impact that political culture had on the approach adopted by both countries and this could be studied in more depth.
- Two key success factors of the Wellbeing Watch that warrant further consideration in an Irish context were:
    i. the important influence of the Minister of Welfare who responded directly to the population protests and drove the social action programme to ensure provisions were made for population wellbeing at a time of crises.
    ii. awareness of the need to collect baseline social indicators and embed these within the national statistics monitoring framework.

2.6 Italian Study Visit

Purpose of Study Visit The purpose of this site visit was to assess the quality of the workplace health promotion good practice intervention and the supporting national policies and strategies.

Brief Description The Lombardy Workplace Health Promotion Network (WHP) is a public-private network. It developed by building partnerships and collaboration with workplace main stakeholders: associations of enterprises, trade unions and the regional health system. The development of this Italian project started in 2011 in Bergamo, by identifying and selecting good practices, and by experimenting the feasibility and effectiveness in two mid-sized companies before extending the project to other companies. The areas of good practice are: nutrition, tobacco, physical activity, road safety, alcohol and substances, and well-being. The WHP Network expanded on a regional scale during 2013 and is made up of companies which recognise the value of corporate social responsibility and undertake to be an "environment conducive to health" in conjunction with the scientific support of the local Health Unit. Evidence based WHP staff programmes include smoking cessation, healthy eating and physical activity. Company canteens, snack vending machine and agreements with local gyms for membership are also included in the programmes.

Aim In Italy Non Communicable Diseases (NCDs) are an increasing concern for the national health service, Cardiovascular diseases account for 38% of deaths, cancers for 30% of deaths, and the incidence is increasing. Several national plans have been developed to deal with the prevention of NCDs and to support the promotion of national health and well-being. The Lombardy Workplace Health Promotion (WHP) initiative aims to reduce the risk factors for chronic disease among the participating staff through implementing healthy eating, physical activity and smoking cessation programmes.

Objectives The objectives of the Lombardy Workplace Health Promotion Initiative are to;

1. Build public-private networks through collaborating partnerships with identified regional workplace main stakeholders: associations of enterprises, trade unions and the regional health systems
2. Develop a system of accreditation so that enlisted companies can implement good practice activities over three years and sustain and maintain four new activities every year to maintain the "Workplace Health Promotion Site"-logo. The areas of good practice are: nutrition, tobacco, physical activity, road safety, alcohol and substances, and well-being.

Target Audience As of June 2016, 453 companies in Lombardy were involved in WHP, including 212.673 workers; out of this 100 companies were involved in the province of Bergamo, representing 24.000 workers. The chosen interventions and strategies influence multiple levels of the organisation including the individual employee and the organisation as a whole.

Evaluation The one year Bergamo impact evaluation showed that after 12 months there was a reduction in some important risk factors for chronic diseases in workers participating in the programme, particularly for fruit and vegetable intake and smoking cessation.

Setting The Lombardy region has a population of about 10 million people. The healthcare system is governed by the DG welfare (regional governance), 8 ATS (Health Protection Agency) and 27 local social and health authorities. Lombardy's Regional prevention plan for 2015-2018 includes 13 programmes that contribute to the national goals and objectives such as efficacy/effectiveness, sustainability, multidisciplinary approach, inter-sectoral approach, accountability and equity. Overall in the region there are six programmes developed which aim to improve healthy lifestyles and to promote a healthy work environment as well as preventing NCD risk factors. The Workplace Health Promotion (WHP) Networks is one of these programmes.

Success Factors The ability of the WHP Network to motivate and communicate with companies through providing data on the outcome of risk factor modifications among staff.
Partnership opportunities. Since the beginning of the intervention the WHP Network has developed strong business partnerships with industrial unions, workers unions, institutions and scientific societies.

Barriers The ability to identify and engage with 'hard to reach groups' in the selected companies has not been proven. Methods of motivating and encouraging sustained behaviour change among 'hard to reach groups' has not been demonstrated.

Key elements for transferability The WHP team in the Lombardy region will provide guidance and advice materials for interested partners from the JA CHRODIS project. At the outset of the initiative establishing concrete relationships with the identified companies and continuously throughout the planning process is key to engagement. Other points include the importance of voluntary adhesion, developing a comprehensive communication plan, company adaptability and freedom to choose priorities. Support is provided to companies by the WHP network on an on-going basis through the availability of social media, online resources and tools.

2.7 UK Study Visit

Purpose To learn about the history and development of the Well London model, in theory and in practice; To understand the vision for Well Communities as a national framework; To understand and explore the parallel programme of evaluation, research and development; To consider the transferability of the model to Ireland.

Brief description Well London is a framework for local communities and organisations to work together to improve health and well-being, build resilience and reduce inequalities. It engages and supports people to develop their individual and community knowledge, skills and capacity to take action on the issues affecting their health and well-being. Very importantly, it also integrates with, strengthens and adds value to what is already going on locally and informs the development of services to better meet local needs.

Aim The Well London programme is one of the largest initiatives of its kind in the UK to improve health and wellbeing, reduce inequalities and build resilience in disadvantaged communities through an asset-based community development and co-production approach.

Objectives

(Phase 1)

1. To develop a locally focussed, integrated, community-led approach that improves community health and well-being and is effective and sustainable in even the most deprived neighbourhoods.
2. To engage and empower people to build and strengthen the foundations of good health and wellbeing in their communities by:

- Significantly increasing community participation in health and wellbeing enhancing activities
- Building individual and community confidence, cohesion, sense of control and self-esteem
- Stimulating development of formal and informal community and social support networks
- Integrating with and adding value to what is already going on locally
- Building capacity of the community and local organisations to deliver activities and making strategic links locally and regionally so the improvement in health and wellbeing is sustainable for the long term.

(Phase 2)

1. To develop a robust, evidence-based framework for community action for health and wellbeing that will influence policy and practice to secure real enhancements to well-being and reductions in health inequalities across all communities in the capital city and beyond.

Targets were set. These targets were self-reported behaviour changes , based on a percentage change from the baseline level. These targets included:

(a) the number of people provided with opportunities to improve their mental wellbeing, levels of physical activity and healthy eating

(b) the number of people (and proportion of the community) reporting improved mental wellbeing and positive community perspectives on mental well-being
(c) numbers of people (and proportion of community) reporting increased levels of physical activity
(d) numbers of people (and proportion of community) reporting increased uptake of healthy eating choices including enhanced access to affordable healthy foods.

Target Audience and Setting

(Phase 1) - residents of 20 of the most deprived areas of London (n=46,918 attendances at projects and activities; est. 17108 different people participated)

(Phase 2) - residents of 11 neighbourhoods in 9 London Boroughs.

Evaluation (Outputs & Outcomes) There are two comprehensive evaluation reports. Well London Phase 1 (2007-2011) – A multilevel evaluation (Ogilvie et al, 2013) and Well London Phase 2 Evaluation – Participant Outcomes (Tobi et al, 2015). 10% of programme budget was allocated to evaluation.

The aim of the phase 1 evaluation was to understand the impact of the Well London programme on health well-being and the social determinants of health. The evaluation was built upon the MRC Guidelines for evaluation of complex interventions. A multi-level and multi-methods evaluation framework was designed to examine impacts of the intervention at participant, project, community and programme level. Process learning was captured and independent evaluations of individual projects were commissioned by lead partners. A cluster randomised controlled trial was conducted to look at health and social outcomes at population level.

Participation was high with significant reach beyond the target community. Positive outcomes were reported in terms of the health behaviour outcomes on physical activity and healthy eating. There were also positive outcomes on community cohesion, co-ordination and improved relationships between communities, decision makers and service providers.

The phase 2 evaluation found that the targeted proportion of participants showing improvement/positive change between baseline and follow up was exceeded in all five outcome areas of physical activity, healthy eating, mental wellbeing, social connectedness and volunteering. Participants in high fidelity areas had significantly higher odds of reporting increased levels of physical activity and a better understanding of mental wellbeing.

Success Factors

- Seed funding from Big Lottery (£9.46 million).
- Comprehensive well-designed, executed and documented evaluation.
- Flexible – builds on community strengths and brings added value to existing initiatives.
- Addresses both social determinants and health behaviours.
- Local co-ordinator key success factor.

Barriers

- Delays in establishment of local leadership in some communities.
- Mobile communities – high turnover of residents makes it difficult to track progress.

Key elements for transferability/ Points of note/ interest to Ireland

- Could build upon existing strengths in community development in Ireland including the Healthy Cities movement.
- Represents a tangible programme on broad health inequalities without highlighting/ stigmatising particular groups such as Travellers, ethnic minorities as has been the case with the social inclusion agenda.

3. Lessons learned and Benefits for Ireland

3.1 Introduction

The purpose of JA CHRODIS is to exchange, transfer and facilitate scale-up of good practices related to chronic disease prevention for the benefit of EU partner countries. This section concentrates on the lessons for Ireland and how benefits may be maximised.

3.2 Lessons Learned

A. Partnership Development

Irish partnership As a result of Ireland's involvement in the JA CHRODIS initiative, the Irish CHRODIS partners (HSE, IPH, and EIWH) formed a learning and cooperative alliance which benefitted the work to be done but also has potential to facilitate closer links in future endeavours of mutual interest. The different but complimentary expertise of each organisation within the Irish partnership provided the links between practice on the ground with policy and research which benefited the collective contribution to the business of CHRODIS and provided a platform for exploring ways to apply our learning's from CHRODIS to improve practice and policy. Each organisation also has the ability to reach different target audiences.

European networking, sharing and exchanging information Irish partners have gained experience and exposure at EU Level through collaboration on various tasks with partners in JA CHRODIS. Ireland has been acknowledged at EU level for its strong contribution to JA CHRODIS in particular, in identifying and presenting on Good Practices from Ireland, contribution by Dr. Cate Hartigan to the panel discussion at the Vilnius Conference, having the national Tobacco Adviser, Dr Fenton Howell, present to the conference and contributing to the development of the PKE and a tool to identify and assess good practices in health promotion.

Ireland's contribution to shaping JA CHRODIS The Irish team was considered to be among a core group of about five countries (including The Netherlands, EuroHealthNet Belgium, Italy and Germany) that were driving the process, raising issues, trying to identify shortcomings and finding solutions and overall driving the JA. The Irish team was also acknowledged for their committed participation, ensuring there was a practical and pragmatic basis for work and also keeping the focus on practices being evidence based, as well as pushing for evaluation and promoting cost effectiveness analysis.

B. Integrating Practice Development and Research The nature of the relationship between research and service delivery on the ground is more developed and more fluid in other countries e.g. The Netherlands and Portugal. The perception that the relationships between academia/researchers and practitioners are less developed in Ireland compared to other countries may be due in part to factors such as the relationship between funding streams within academic institutions and practice priorities. An observation then is that the Irish Health Service would benefit from exploring how to improve and integrate the work of research, policy and practice with

a view to improving evaluation of interventions overall, assessing and improving quality of service delivery, reducing variation in practices as well as addressing the match between need for health promoting intervention and actual provision.

C. Better understanding of what is happening in Ireland

- **Awareness of Irish work** Due to engaging with various tasks the Irish team are more aware of the range of policies and programmes relevant to chronic disease prevention in Ireland. There is a lot happening in Ireland in health promotion and primary prevention of chronic diseases but it is not always visible and readily accessible.
- **Descriptions and documentation of interventions** is often patchy and when available is not always clearly set out or may be incomplete.
- **Establishing the evidence base for interventions** appears to be either very well set out or not done at all.
- **Evaluation** is undertaken at varying levels of scientific rigour from tight research to descriptive accounts.

D. Practical Application of knowledge learned from CHRODIS in Ireland

Application of Processes and Systems

- **Identifying and assessing good practices** Establishing a process to identify and assess good practice in health promotion interventions, using the Delphi criteria holds potential in Ireland. Benefits could include, for example, having a systematic and standardised approach to describing, documenting and reviewing practices, which could potentially contribute to improving effectiveness, reducing variation, improving quality while allowing for innovation.

- Starting with the discipline of describing and documenting interventions under key headings would be a useful first step and likely to be of benefit in its own right. Second, studying and comparing the described programmes with the established evidenced based interventions i.e. ensuring that interventions reflect or are aligned with 'what works for example, aligned to WHO 'Best Buys'.

- **Assessing good practice** Another area which is likely to evolve is that of systematic review of current programmes. An important next step is clarifying and agreeing that robust evaluation is supported for key priority areas (topic specific or major strategies/policies). The value of assessing and identifying good practices by using the Delphi criteria (tool to be developed by CHRODIS) and/or other criteria may be worth exploring.

- **Evaluation** One of the gaps highlighted at EU level is in relation to evaluation of health promotion interventions, in that it is often limited to process evaluation. The lack of well evaluated interventions is often due to the availability of funding to conduct evaluation. In order to demonstrate effectiveness of health promotion interventions evaluation is a central requirement of any health promotion practice/intervention.

- Finally, structuring an approach to economic evaluation of interventions in tandem with relevant Masters and PhD courses in our Universities.

E. Databases of health promotion activities and interventions The databases developed in The Netherlands, Germany and Italy appear to have helped to reduce the wide variety of similar programmes and brought a focus on quality. The potential and need to develop a database or repository of health promotion interventions in Ireland to share and disseminate information amongst practitioners to improve collaboration and efficiencies remains to be explored. The potential of the PKE to Ireland as a repository to host Good Practices from Ireland as an alternative approach to developing an Irish database also remains to be explored.

F. Applying the learning from the study visits to Ireland

Eight Good Practice interventions were show cased at the five Study Visits, attended by Irish partners from the 41 good practices submitted by participating countries http://www.chrodis.eu/wp-content/uploads/2015/09/Annex-Report-CHRODIS-WP5-Task-3_Version-1.3-.pdf.

Key features of note were

1. Intervention Description/Mapping/Assessment

- The suite of activities from mapping of initiatives, setting out clear programme descriptors to assessing effectiveness of interventions to collating interventions into a database appears to have promoted standardisation, improved quality and reduced variation in health promotion services in three countries.

- **Evaluation & Monitoring** are central components of any programme. In general, while there appeared to be a lack of well evaluated good practice interventions in some EU countries, The Netherlands has provided an infrastructure to support evaluation ensuring that guidance documents, monitoring and evaluation tools/instruments are readily available and accessible together with training, to ensure the evaluation was a central activity in implementation of the National JOGG Programme.

2. Use of Data

- The use of routine surveillance data to measure and assess a problem before and after intervention resulted in considerable by-in from funders (local authorities). This in turn promoted a targeted approach for subpopulations at most need (The Netherlands).
- Establishing a set of agreed indicators at local level for key priority areas that are linked to a suite of national indicators has re-focused the delivery of interventions by practitioners to ensure better co-ordination, improve efficiencies and reduce duplication of efforts (Portugal).

3. Partnerships and Stakeholder Involvement

- Support and commitment from the **Ministry of Health (all countries)**

- **Public Private Partnerships** are a key feature of the way of working in both the Netherland's JOGG programme and in Portugal's National Healthy Eating Programme. However, establishing clear guidelines on engagement between parties need to be clearly set out. (The Netherlands and Portugal).
- **Academic/knowledge sector Partnerships** could be furthered in a number of areas to support a) clarifying the evidence and adjudicating on effectiveness and b) evaluation of effectiveness and cost effectiveness.
- For workplace settings, establishing concrete relationships with identified companies involved in the Lombardy Workplace Health Promotion initiative at the outset and continuously throughout the planning process is a key to a successful outcome of this initiative.

4. Knowledge Transfer Processes

- Having a knowledge transfer process/guidance is important in enabling adaptation and transfer of interventions between jurisdictions, taking account of local contexts. The establishment of a **knowledge transfer process** is one of the biggest successes of JOGG. A team in the NL works to provide guidance, advice and materials to JOGG personnel at local and national levels which is also available to interested international partners.
- A key barrier in transferring good practice interventions between EU countries is the lack of availability and access to information and material in an accessible language, e.g. English.
- The Lombardy Workplace Health Promotion team has offered guidance and advice on the materials they have developed to interested partners from the JA CHRODIS project.
- Robust and comprehensive communication plans supported by social media, online resources and tools are essential in providing on-going support to companies involved in the Lombardy WHP network.

4. Next Steps for Ireland

4.1 Dissemination of Findings of CHRODIS to Irish Stakeholders

The Irish CHRODIS partners envisage and are encouraged through participation in JA CHRODIS to disseminate the outcomes and findings of the initiative to a broad range of stakeholders. To this end we plan to engage with wider stakeholders including service users, and those from academic, policy and practice environments in early 2017. This event would mirror the first stakeholder engagement event held in June 2014.

4.2 EU JA-CHRODIS wrap up meeting, November 2016

A final meeting of Work package 5 will take place on 21st and 22nd November 2016 in Lisbon. The aim of the meeting is to reflect and discuss the work undertaken within WP5 with a particular focus on the study visits and the main lessons learned. The final report will also be discussed at the meeting. A final dissemination event for the overall Joint Action CHRODIS will take place in February/March 2017.

4.3 Contribution to the 2nd Joint Action on Chronic Diseases Proposal

Ireland's contribution to the new JA on Chronic Diseases commenced in April 2016 by way of submission of a paper (Appendix 3), identifying key areas that could potentially contribute to the health promotion agenda of a new JA on chronic diseases.

The HSE and IPH were nominated by The Department of Health to participate in preparatory meetings regarding the new JA on chronic diseases and to that end Teresa Bennett represented both the HSE and IPH at a planning meeting in Luxembourg on July 5th & 6th.

Aim of the new JA on Chronic Disease Prevention is *to* select and finance activities that help to identify efficient means to reduce the burden of chronic diseases, increase the sustainability of health systems and develop human capital. A key focus is to develop **tangible activities with a potential to trigger health and chronic disease policies** in Member States with a potential to improve health outcomes. **High priorities include:** *multi-morbidity, health promotion, diabetes, chronic diseases* **,** *inter-sectoral collaboration, knowledge transfer* and *change management.*

Low priorities include*: Indicator development and surveillance; Production of informative reports „what exists", mappings or recommendations and Actions with a research focus – primary data collection.*

Expected Outcomes are:

- To provide support to Member States in developing and refining national plans [*and implementation*], on chronic disease prevention.

- To develop strategies to address chronic diseases with facilitated and intensified exchange of good practices and knowledge the provision of 5 million € EU co-funding

Duration

The JA is of 3 year duration commencing in April 2017

Governance

Overall joint leadership of the JA has been assigned to the incumbent leader, Carlos Segovia Perez, Instituto de Salud Carlos III, Spain, and Rokas Navickas, Vilnius University Hospital, Lithuania and current leader of CHRODIS WP 6 on multi-morbidity. (Appendix 5 lists WP's and Leads/Co-leads). WP's 1-4 will be cross-cutting across all WP's and will focus on co-ordination, dissemination, evaluation, integration and sustainability. Remaining WP's will focus on health promotion, multi morbid conditions, diabetes, Chronic diseases and employment and Patient empowerment for chronic stress-related disorders

Work package on Health Promotion and Primary Prevention

Ireland's future involvement a Health Promotion WP is yet to be fully explored and is dependent on a number of factors, including the content and tasks identified and the perceived benefits for the IPH, HSE, EIWH. Currently, the leadership of the HP Work package is assigned to BZgA, Germany, and with co-leadership from EuroHealthnet and IPH. Both HSE and IPH will participate on the 'drafting' group of the WP on health promotion, along with Germany (BZgA), Eurohealthnet, Finland (THL), The Netherlands (RIVM), The Italian Ministry of Health to shape and develop the content.

Key areas identified for a WP on HP include:

- Older population (45+ years) in workplace setting
- Early Years/Pregnancy/early intervention – **Ireland has an interest in this area**
- Life course approach– but only focus on critical stages across life course
- health inequalities,/equity,
- health in all policies,
- focus on practical outputs from the WP e.g. study visits/knowledge transfer
- cost effectiveness analysis
- PKE development to support HP, - build on results of and continue current JA-CHRODIS; knowledge transfer – transfer of information, knowledge and practices, must account for language barriers – explore translation function to ensure
- identify the indispensable elements for transferability of practices/success factors and barriers to transferring and implementing a practice;
- Evaluation of interventions.
- focus on what information is there already and collate what has been done already and have a central type repository of information e.g. JA on Nutrition and Physical Activity (JANPA) on early years and work done on cost effectiveness by WHO and OECD;

- disadvantaged groups (minorities);
- mental health focus on transfer to local settings - the success factors/ barriers to implementation on the ground,

Appendix 1. Details of CHRODIS-JA Work Packages 1 to 7

Work package	Aim and Objectives of each WP of the Joint Action (JA)
WP1	**Coordination of the JA** WP1 will coordinate the whole project and manage the resources and will ensure the necessary coordination of different WPs, which is especially important for WP 4, 5, 6, and 7. Also, the coordination of JA-CHRODIS will involve collaboration with other stakeholders and European initiatives, specifically the European Innovation Partnership on Active and Healthy Aging (EIP AHA). The second objective of WP 1 is to build on the sustainability of the Joint Action working jointly with the Governing Board.
WP2	**Dissemination of the JA** WP2 will disseminate activities and results of JA-CHRODIS. WP2 is also directly involved in the process of dissemination of good practices by informing about the availability of the Platform for Knowledge Exchange (PKE) to stakeholders. In this sense, stakeholders are policy makers of the Ministries of Health, healthcare professionals and healthcare managers, the population across the life cycle with special focus on the elderly as the main receptor of healthcare. At the end, WP2 will crucially contribute to disseminate the project and the PKE in order to contribute to create a bidirectional flow of good practices.
WP3	**Evaluation of the JA** The evaluation of CHRODIS has to be able to assess to what extent JA-CHRODIS succeeds. This includes the assessment of the operations of CHRODIS according to plans, the functioning of the PKE and to the extent possible, the outcomes of these practices.
WP4	**Set-up of the EU Chronic Health framework** WP4 is dealing with the implementation of the PKE, including the clearinghouse and the help desk. It has to be closely coordinated with WP5, 6 and 7 to establish specific criteria to select good practices, to facilitate the self-evaluating process and to organize the flow of cases.
WP5*	**Good practices to address promotion of health and prevention of chronic conditions** WP 5 has to contribute with specific criteria to screen good practices in health promotion and disease prevention. It also has to contribute to identify potential good practices. WP5, together with WP2, has to contribute also to promote the use of the PKE among stakeholders identifying potential good practices across Europe in these areas.
WP6	**Development of common guidance and methodologies for care pathways for multi-morbid patients** WP6 will contribute to identifying good practice criteria in the field of multi-morbidity. In this case, an initial revision of existing evidences to support criteria for good practices may be necessary if not available. WP6, together with WP2, will contribute also to promote the use of the PKE among stakeholders identifying potential good practices across Europe in these areas.
WP7	**Diabetes: A case study on barriers to prevention screening and treatment** WP 7 will address diabetes with a similar methodology as WP 5 and 6. In this case a revision of national plans is an added area of interest, and included as specific practices along with other sort of practices such as programmes or interventions. WP7, together with WP2, has to contribute also to promote the use of the PKE among stakeholders identifying potential good practices across Europe in these areas.

Appendix 2: Detailed Project Plan for WP 5

Date	Task	Action	Outcome
2013	EU summit on chronic disease providing guidance to EU members on the issue of chronic disease as defined by diabetes, cardiovascular disease and stroke. Emphasis was on healthy aging.	Call for partners to enlist to the EU CHRODIS Joint Action (JA).	HSE/IPH/EIWH agreed to become involved in the CHRODIS WP 5 project.
April 2014	First WP 5 meeting in Cologne to establish the tasks involved in the project and the workplan.	Meeting attended by representatives from the Irish Partner group.	Documents provided by CHRODIS: 1. 'Needs Assessment Guidance' document 2. Questionnaire template on 'Good Practice in the Field of Health Promotion and Disease Prevention' to identify strengths, needs and gaps in these areas.
June 2014	Task 1: Situation and needs review of existing work, in relation to health promotion and primary prevention of cardiovascular disease, stroke and type 2 diabetes. The purpose was to develop an understanding of the existing situation in the participating EU countries.	Specific Irish stakeholders identified working in the area of Health Promotion and Disease Prevention. Stakeholders invited to workshop.	Irish workshop held to create awareness of the CHRODIS project among relevant Irish stakeholders.
September/ November 2014	Task 1	Following the workshop a consultation document and questionnaire was developed and	Irish Country Review developed and completed and available on the CHRODIS website.

		distributed to stakeholders with follow up interviews face to face or in person. Results from the questionnaire led to the development of the County Review submission from Ireland.	
Nov/Dec 2014	Task 2: Defining an approach - Delphi panel process established.	The Irish Partners were involved in agreeing and developing an inclusion and exclusion criteria to identify and assess good practices.	CHRODIS template for the description of good practices agreed.
Feb/April 2015	Task 3: Guideline on how to identify examples of good practices in the field of health promotion or primary prevention of cardiovascular diseases (including stroke) and type 2 diabetes.	Following the meeting in February the EU partners were requested to complete a questionnaire on the types/categories of practices/interventi ons from their country.	Questionnaire/Template developed.
April/May 2015	Task 3 continued.	Template for selecting good practices specifically from Ireland developed using Delphi criteria.	
May/July 2015	Identification of 3 good practices from associated countries that match the selection criteria.	Following consultation with Irish Stakeholders working in the area of Chronic Disease Health promotion and disease prevention and using the criteria/rationale, a selection of good practices was undertaken.	5 Good practices from Ireland identified and submitted to CHRODIS.

November 2015	Task 4: November conference. Policy and decision makers at the European and national levels and health promotion and diseases prevention stakeholders to attend conference.	Previously identified good practices to be presented and shared. Discussion re how good practices can be transferred, to address the gaps and needs identified.	Irish partners presented 5 Good practices from Ireland. Oral presentation by Dr. Fenton Howell on Tobacco Free Ireland. 4 Poster presentations as follows: Active School Flag, Croi My Action, Community Food Initiative, SafeFood/HSE Childhood Obesity campaign.
April to July 2016	Task 5: Study visits to be carried out across EU countries.	Each participating EU country to participate in identified study visits of specific interest.	Irish partners attended 5 study visits in The Netherlands, Portugal, Iceland, Italy and The UK.
December 2016	Description of success factors and barriers for transferring of good practices to other countries and settings.	Comparable descriptions for all visited study sites to be reviewed.	Irish partners contributed to a report on Transferability of practices to other countries. Report to be available by December 2016.
2016	Daft policy recommendations identified for local, national and EU level on what is needed to strengthen health promotion and primary prevention to reduce the burden of chronic diseases.	Focus group discussions on visited study sites.	

Appendix 3: Dutch Recognition System for Health Promotion Interventions

National Institute for Public Health and the Environment
Ministry of Health, Welfare and Sport

Dutch Recognition System for (health promotion) interventions

CHRODIS
ADDRESSING CHRONIC DISEASES & HEALTHY AGEING ACROSS THE LIFE CYCLE

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Aim

The Centre for Healthy Living (RIVM) developed a quality assessment system for health promotion interventions: the Dutch Recognition System. The aim of the recognition system is:

- to gain a better understanding of the quality and effectiveness of health promotion interventions and
- to support the professional practice in health promotion in the Netherlands through identifying, selecting and disseminating best practices.

Assessment procedure

An organization or other entity that wishes to have an intervention formally recognized, submits a description of the intervention according to a standard submission form. The minimal requirements for submitting an intervention are the availability of a manual of the intervention (if relevant) and a process evaluation. Following submission, two types of assessment procedures have been designed which may result in five different assessment outcomes:

1. Peer review by professionals (potential outcome: Well Described)
2. Assessment by an expert committee with representatives from science, practice and policy (potential assessment outcomes: Theoretically Sound; Effective)

In addition, both types of assessment procedures evaluate how feasible implementation is in practice (i.e. expertise/ skills, costs, dissemination plan, manual).

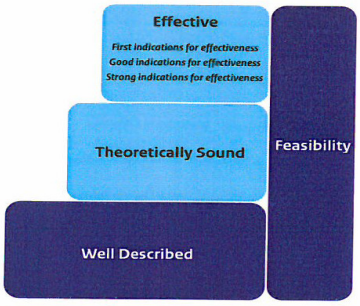

Figure 1. Levels of assessment according to the Dutch Recognition System. The recognition of an intervention is valid for 5 years.

36 interventions have received 'effective' qualification

The assessment system for health promotion interventions was first introduced in The Netherlands in 2008. The recognized interventions are available in the database Loketgezondleven.nl. After seven years, a total of 336 interventions were evaluated, (see figure 2), 36 of which were qualified as *effective* and 153 interventions as *theoretically sound*. Another 148 interventions are *well-described* (these are primarily interventions focusing on physical activity and sports).

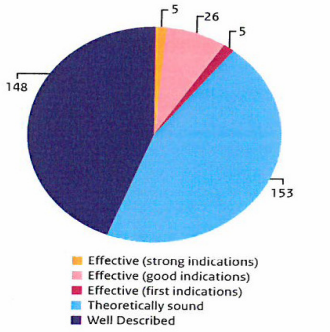

Figure 2. Number of interventions according to different assessment outcome levels, as included in national database in 2015.

Successes

- The stepwise system diminishes the barrier to submit an intervention
- Professionals appreciate the database with qualified interventions
- Support from the Ministry of Health, Welfare and Sports through funding initiatives encourages the submission and implementation of interventions
- Collaboration with other sectors within and outside of the health system (i.e, social services and care for older people) as assessment criteria are aligned to those applied within other sectors, resulting in one mutually agreed recognition system.

Challenges

- Submitting an intervention needs to be less time consuming
- The database contains few interventions for people with low socio-economic status. We need to add more assessment criteria with respect to equity, and empowerment
- Actual take-up of identified best practices in the municipalities is limited
- Professionals adjust best practices to the local context They need more information about the essential core elements of interventions which can't be left out.

Conclusion

The assessment system is a promising asset in quality improvements of health promotion. The Dutch Recognition System for health promotion interventions is well-known and supported by many stakeholders, as well as by the Ministry of Health, Welfare and Sports. Professionals appreciate the system but the scalability of best practices needs to be improved. Next year we focus our dissemination strategy on informing policymakers about the importance of the best practice portal in improving the quality of local health promotion.

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Appendix 4: Contribution of Irish CHRODIS Partners to new JA on Chronic Diseases

Key points on the need to address prevention of chronic disease in CHRODSIS 2

***Submission by Irish CHRODIS Partners**

Dr. Siobhan Jennings and Dr. Teresa Bennett: Health Service Executive (HSE),
Dr. Helen McAvoy and Dr. Olga Cleary: Institute of Public Health Ireland (IPH),
Ms. Peggy Maguire and Ms. Maeve Cusack: European Institute of Women's Health (EIWH).

We have developed our response on a possible CHRODIS 2 based on the 2016 annual work plan, with particular reference to Action 2.2.1.2 Action on chronic diseases pages 14 and 15 and also Action 2.1.1.4. Support to Member States and Stakeholders to address the chronic disease challenge pages 7 & 8 (re cost efficiency, and also evidence base, health information, health intelligence).

Question: What do you think is the added value of health promotion and prevention compared to simply focusing on single chronic diseases or multimorbidity?

[We assume the purpose of this question is to outline the added value of a broad focus on prevention adopting a health promotion approach and tackling the broader determinants of health rather than focusing on single risk factors for single conditions OR only care/treatment for conditions.]

Response:

1. It is well known that a sole focus on the management and treatment of chronic conditions will be ineffective in reducing the current and future burden of chronic conditions. There is an irrefutable argument for investment in prevention and health promotion from a health economics perspective which has often been cited in EU policy documents. It is well understood that a focus on prevention is imperative if the costs to health systems associated with chronic disease are to be mitigated into the future.

2. Risk factors are not generally unique to one chronic condition but are shared amongst common chronic conditions. Four particular health behaviours are strongly associated with and causally related to common chronic conditions: tobacco use, harmful alcohol consumption, physical inactivity and unhealthy diet. These four behaviours have been found to lead to four key metabolic/physiological changes: raised blood pressure, overweight/obesity, hyperglycemia and hyperlipidemia (Alwan, 2011). These factors then act as intermediary risk factors for a range of chronic conditions including cardiovascular conditions, diabetes and cancer. In addition, smoking is the leading risk factor for COPD and we feel that any further examination of chronic conditions in Europe should include chronic respiratory conditions as standard within the frame of chronic conditions.

As well as the impact of common behavioural risk factors, the broader determinants of health ie the circumstances in which people are born, grow, live, work and age, determine the likelihood of developing one or more chronic conditions. There is a clear socioeconomic gradient in the prevalence of individual chronic conditions such as CVD, diabetes and cancer. This means that certain population subgroups are at a higher risk of developing chronic conditions. Lifestyle risk factors cluster in these vulnerable population groups.

Having a chronic condition reinforces many of the social determinants of health by increasing the likelihood of affected individuals being pushed into poverty through disability or high healthcare costs.
A focus on addressing common shared risk factors among conditions will contribute to an overall reduction in incidence and prevalence of common chronic conditions as well as leading to greater population health gain as individuals and communities are enabled to make healthier choices.
A focus on the broader determinants of health has the potential to address multiple risk factors for those at high risk of developing chronic conditions. Targeting effective policy and health promotion interventions towards those from more deprived, lower socioeconomic status backgrounds will not only lead to a reduction in chronic condition prevalence in these groups but will lead to a greater reduction in prevalence overall as such targeted interventions have the potential to disproportionately impact on overall population prevalence of conditions and lead to greater population health gain.
There is an ethical imperative to tackle inequalities in health and this has often been put forward as a priority in European health policies and statements of the European Commission, Parliament and allied structures.

3. Multimorbidity, i.e. having two or more chronic conditions, is now the norm rather than the exception for older people in EU countries. Individuals living with one chronic condition are now more likely to develop additional chronic conditions than not. Lifestyle related factors have also been linked to an increased risk of multimorbidity including low physical activity, smoking and obesity. There is also a clear socioeconomic gradient in multimorbidity prevalence indicating that those living in more deprived communities from lower socioeconomic backgrounds are more likely to develop multimorbidity. This highlights that both the clustering of risk factors and incidence of multiple chronic conditions cluster in lower socioeconomic subgroups leading to a greater burden of chronic conditions in lower socioeconomic groups. Multimorbidity in lower socioeconomic groups develops at an earlier age compared to multimorbidity in middle or higher socioeconomic groups. This reinforces the need to address multiple risk factors through a broader determinants of health approach as espoused in health promotion policy and initiatives.

4. Health promotion approaches focus on the prevention of chronic conditions across all life stages, genders, and the lifecycle and have been refined with decades of experience in targeting policy and interventions to specific vulnerable population subgroups and settings. It is essential to capture this wealth of experience and ensure that health promotion is supported on a European platform to reach its full potential in tackling the growing burden of chronic conditions.

5. The development of effective prevention approaches is important across Europe but particularly important to support the health, social and economic development of new accession countries which experience a dual burden of disease – diseases of developing countries and the unhealthy health

behaviour burden of Western and Northern European states. For example childhood obesity is rising faster in eastern European and lower income states in Europe than in more developed nations.

Question: Why do you think a future continuation of the JA-CHRODIS should not miss this part?

1. Any future continuation of JA CHRODIS should build upon *the learning* of CHRODIS 1. WP5 Tasks in CHRODIS 1 highlighted some substantial common gaps in chronic condition policy and practice across some EU member states. These gaps include limited evaluations of health promotion initiatives (when they are evaluated this is generally limited to process rather than outcome or impact evaluations), limited evidence on intervention cost effectiveness (this is not built into the evaluation of programmes) and a lack of infrastructure to identify good prevention practice in European countries. In particular, partners noted a lack of political and financial support to implement health promotion policy and practice. The EU health programme offers a unique opportunity to share learning from other member states to address some of the gaps in prevention policy and practice. This enables knowledge sharing and good practice transfer to ensure duplication of effort is minimised and learning is consolidated in EU member states.

2. Any future continuation of JA CHRODIS should build upon *the achievements* of CHRODIS 1. Some of the main achievements of CHRODIS 1 have been developed in WP5 including the development of a DELPHI process to inform the selection of good practices in Europe and the identification of 41 good practice examples. This process has provided valuable guidance for the development of the PKE. The PKE fills a gap in prevention practice across Europe and could provide an extremely useful platform for member states for knowledge exchange, quality assurance and transfer of good practice. However, if the PKE is to realise its potential and be sustained into the future, it requires on-going input from member states to generate input on prevention programmes. It needs to be promoted among potential users, such as practitioners, health professionals, policy makers etc. this requires a concerted effort from relevant personnel in member states. It is unlikely that this will be provided on a voluntary basis.

3. CHRODIS 2 could continue to improve prevention networks across Europe for practitioners, policy makers and health professionals. This leads to formal and informal knowledge exchange and sharing of information which in turn consolidates learning across the EU and reduces duplication of effort and in-efficient use of financial resources to tackle the common burden of chronic conditions.

Question 1: What topics and issues around health promotion and primary prevention would you like to see covered in a second phase of a joint action?

We feel it is important to focus on advancing the learning and build upon achievements already gained in CHRODIS 1.

1. In particular, development of the PKE to a working sustainable resource with a dedicated function to collect and assess good practice in primary prevention and health promotion across EU member states would be very beneficial.

2. A follow up programme should seek to test the health promotion good practices identified by WP5 CHRODIS, in a wide range of EU Member States, and to assess the social and economic benefits of transferring these practices.

3. An exercise to identify key elements of 'what works' in good practice interventions would be useful to establish core element guidelines for interventions that are being developed or transfered.

4. Certain population subgroups are particularly vulnerable and have the most to gain from the primary prevention of chronic conditions. They also have particular needs. It would be a useful task in CHRODIS 2 to identify these subgroups in a European context and then identify effective interventions that address risk factors in these subgroups that may be transferred across member states. Emphasis should be given to what works well in these particular subgroups. These subgroups can be divided into:

    a. Deprived or lower socioeconomic groups. Given the clustering of risk factors and chronic conditions, including multimorbidity, in this subgroup they should be a priority for primary prevention.
    b. Expectant parents and children. Many of the health behaviours that influence chronic condition burden are laid down in early childhood. Behaviours in early years track faithfully into mid and later life. Targeting primary prevention at expectant parents and children has potential to have the greatest impact on risk reduction and chronic condition burden.
    c. Particularly vulnerable groups such as ethnic minorities, people with disabilities and people with mental health problems. It has been shown that people with learning disabilities have a far greater than expected prevalence of multimorbidities. People with mental health problems also have an elevated rate of multimorbidity.

5. Certain risk factors for chronic conditions are emerging as priorities in relation to the burden of chronic conditions and policies and initiatives to address these are not as well developed or supported compared to some of the more established risk factors. In particular, physical activity and overweight and obesity present a major challenge in Europe and require a greater focus on what works in prevention. There was also an evident lack of initiatives on alcohol related harm represented in the selection of good practices.

6. We would also welcome a particular focus on the cost effectiveness of prevention interventions, to support and encourage health promotion interventions to adopt some element of cost effectiveness analysis into evaluations of promising interventions. This would support policy makers, investors and practitioners to determine the effectiveness of prevention and health promotion interventions from a cost perspective

7. Finally we wold welcome the identification of approaches to overcome health system silos towards better integration of prevention and healthcare to more efficiently address the chronic care burden.

Appendix 5: List of Work Packages and Leadership in the new JA on chronic diseases

Work package Name	Key Area of Focus	Name of Institution	Contact person
WP1	Overall coordination of new JA on chronic Diseases	Health Institute Carlos III, Spain	Carlos Segovia csegovia@isciii.es
WP1	Scientific coordination of new JA	Vilnius University Hospital, Lithuania Santariški Klinikos – VULSK, The Lithuanian Ministry of Health will chair the Governing Board.	Rokas Navickas rokas.navickas@santa.lt
WP 2	Dissemination	Co-lead by the Hungarian Semmelweis Univeristy and the Slovakian Ministry of Health.	András Terebessy terebessy.andras@med.semmelweis-univ.hu Zuzana Matlonova zuzana.matlonova@health.gov.sk
WP 3	Evaluation	Lead agency: Agència de Qualitat i Avaluació Sanitàries de Catalunya, Spain.	Mireia Espallargues mespallargues@gencat.cat
WP4	Chafea introduced a new mandatory work package 4 called "Integration in National Policies and Sustainability".	Lead agency: Instituto Aragonés de Ciencias de la Salud from Spain Co-learders EuroHealthNet and the Italian Ministry of Health and interest expressed by several other agencies.	

WP 5	Health Promotion/ disease prevention	Federal Centre for Health Education (Bundeszentrale für gesundheitliche Aufklärung), Germany, contact: Alexander Haarmann Alexander.Haarmann@bzga.de and EuroHealthNet, contact: Caroline Costings c.costongs@eurohealthnet.eu **Potential co-leadership by Ireland (IPH) to be confirmed**
WP 6	Multi-morbidity	Universita' Cattolica Del Sacro Cuore, Italy, contact: Graziano Onder graziano.onder@unicatt.it and Vilnius University Hospital Santariški Klinikos – VULSK, contact: Rokas Navickas rokas.navickas@santa.lt
WP 7	Fostering quality in prevention and care in chronic diseases: from diabetes to chronic diseases	Istituto Superiore Di Sanita, Italy, contact: Marina Maggini marina.maggini@iss.it and National institute of Public Health, Slovenia, contact: Jelka Zaletel, Jelka.Zaletel@nijz.si or jelka.zaletel@kclj.si
WP 8	Chronic diseases and employment	Fondazione Irccs Istituto Neurologico "Carlo Besta", Italy, contacts: Carla Finocchiaro, Carla.Finocchiaro@cf-c.it and Caterina Mariotti Caterina.mariotti@istituto-besta.it
WP 9	Patient empowerment for chronic stress-related disorders, on the basis of clinical decision support, advanced mobile services and recommenders	Universität Ulm (Ulm University), Germany, contact: Rüdiger Pryss, ruediger.pryss@uni-ulm.de and Centre For Research & Technology Hellas, Institute Of Applied Biosciences, Information , Greece, contact: Vasilios Koutkias, vkoutkias@certh.gr