LET'S BEAT DIABETES

OPERATIONAL PLAN 2006/2007

FINAL
30 June 2006

Contents

Executive Summary

Counties Manukau is experiencing a growing epidemic of Type 2 Diabetes ('diabetes'). Currently there are more than 12,000 people in Counties Manukau diagnosed with diabetes. As many people again may have undiagnosed diabetes. It is estimated that the number of people with diabetes will more than double over the next 20 years, given population growth, the ethnic, youthful and generally low socioeconomic make-up of our population.

In February 2005, the Board of Counties Manukau District Health Board (CMDHB) endorsed the draft *Let's Beat Diabetes (LBD): A Five Year Plan to Prevent and Manage Type 2 Diabetes in Counties Manukau*, and a funding envelope of $10 million over five years to support its implementation. This funding provides the base funding for LBD but is supported by funding and resources from partner organisations.

LBD is a five-year, district-wide strategy aimed at long-term, sustainable change to prevent or delay the onset of diabetes, slow disease progression and increase the quality of life for people with the diabetes in Counties Manukau. It recognises the significant activity that already exists to prevent and manage diabetes, and creates a long-term vision to align existing activity and a context for new investment, based on evidence and best practice. Fundamental to the plan is its 'whole society-whole life course-whole family/whanau' approach to preventing and managing diabetes. Annual operational plans outline the interventions/initiatives that will be implemented by CMDHB and partner organisations in order to achieve the long-term outcomes identified in *LBD: A Five Year Plan*.

The *LBD Operational Plan 2005/2006* comprised 54 interventions/initiatives, and was a mix of developing the infrastructure, capacity and functional relationships for longer term activities, and 'quick wins' to maintain programme momentum and profile. The *LBD Operational Plan 2006/2007* builds on the work done in 2005/2006 as part of the process to meeting the long-term outcomes identified in *LBD: A Five Year Plan*. The focus is more on operational delivery. Key components include:

- development and/or enhancement of human and organisational capital to create a platform of competency to support the effective delivery of programmes. It will also lead to leadership and emergent community-led initiatives and changes in social norms, which support behaviour change
- implementation of the evaluation and learning processes for the LBD programme
- a significant increase in community public relations associated with LBD to raise its profile and encourage ownership by the wider community
- implementation of a comprehensive social marketing programme to encourage positive behaviour change in our community
- development and/or enhancement of partner relationships and creation of opportunities for activity alignment and collaboration.

In 2005/2006, CMDHB's LBD funding pool had an underspend of $650,000. CMDHB's management board has agreed this underspend can be carried forward into the 2006/2007 year, making CMDHB's contribution to LBD for 2006/2007 $2.65 million.

LET'S BEAT DIABETES

1 Background

Counties Manukau is experiencing a growing epidemic of Type 2 Diabetes ('diabetes'). Currently there are more than 12,000 people in Counties Manukau diagnosed with diabetes. As many people again may have undiagnosed diabetes. It is estimated that the number of people with diabetes will more than double over the next 20 years, given population growth, the ethnic, youthful and generally low socioeconomic make-up of our population. A major change to the health sector and our broader society is required to stop the diabetes epidemic.

In February 2005, the Board of Counties Manukau District Health Board (CMDHB) endorsed the draft *Let's Beat Diabetes (LBD): A Five Year Plan to Prevent and Manage Type 2 Diabetes in Counties Manukau*, and a funding envelope of $10 million over five years to support its implementation. The plan is a five-year, district-wide strategy aimed at long-term, sustainable change to prevent or delay the onset of diabetes, slow disease progression and increase the quality of life for people with the diabetes in Counties Manukau. It recognises the significant activity that already exists to prevent and manage diabetes, and creates a long-term vision to align existing activity and a context for new investment, based on evidence and best practice.

Fundamental to the plan is its 'whole society-whole life course-whole family/whanau' approach to preventing and managing diabetes. Annual operational plans outline the interventions/initiatives that will be implemented as part of the process to meeting the long-term outcomes identified in *LBD: A Five Year Plan*.

The LBD plan and its activity is organised around 10 distinct but interrelated action areas. They are:

1. Supporting **Community Leadership and Action**
2. Promoting Behaviour Change Through **Social Marketing**
3. Changing **Urban Design** to Support Healthy, Active Lifestyles
4. Supporting a Healthy Environment Through a **Food Industry Accord**
5. Strengthening **Health Promotion** Co-ordination and Activity
6. Enhancing **Well Child Services** to Reduce Childhood Obesity
7. Supporting **Schools** to Ensure Children are 'Fit, Healthy and Ready to Learn'
8. Supporting **Primary Care-Based Prevention** and Early Intervention
9. Enabling **Vulnerable Families** to Make Healthy Choices
10. Improving **Service Integration and Care** for Advanced Disease

The plan aligns with Government policy directions and international best practice. Strategies that focus on improved Maori and Pacific outcomes are woven through all 10 action areas.

The *LBD: A Five Year Plan* and operational plans, including the interventions/initiatives for 2006/2007, are the result of extensive consultation and development processes since the programme's inception.

The LBD strategic and operational plans, including the interventions/initiatives for 2006/2007, are the results of extensive consultation and development processes since the programme's inception.

The funding package approved by the Board of CMDHB is to support the implementation of the operational plan and the identified interventions/initiatives. It is not to buy increased volumes of health sector activity for which there are already established funding streams, nor for activity where other funders have an explicit responsibility.

It is envisaged that LBD will support these activities until they are sustainable and/or have been incorporated into core business activity with established funding streams.

2 Context for Implementation

2.1 Operational approach reviewed

The design and implementation challenges for operationalising a plan and programme as complex and multifaceted as *Let's Beat Diabetes (LBD)* was outlined in detail in the *LBD Operational Plan 2005/2006*.[1] Before detailing activity to take place in 2006/2007, it is important to note the challenges and lessons from 2005/2006.

2.1.1 Design challenges

The design challenge identified was the need for LBD to be a balanced suite of activity that is constantly being informed by powerful learning processes and then modified: In other words, a process similar to a large scale action learning or continuous quality improvement framework.

LBD is a very complex programme but Counties Manukau District Health Board (CMDHB) and its partner organisations have managed to create this environment whilst also meeting the requirements of performance and accountability frameworks. Ongoing effort is required to co-ordinate and balance activities across multiple parts of CMDHB and its partner organisations. Implementation of LBD's evaluation and learning processes in 2006/2007 will strengthen its ability to learn, modify and progress with confidence.

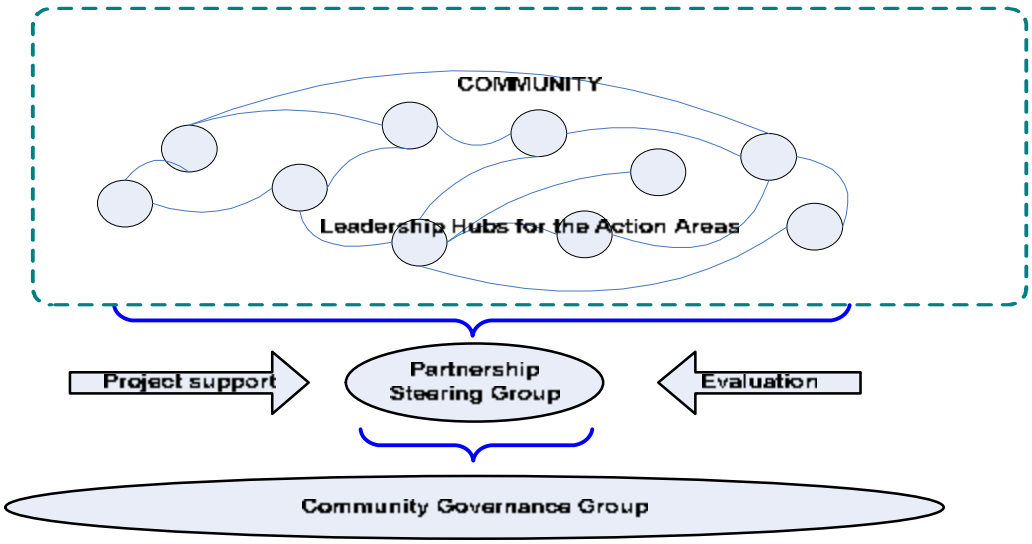
2.2.2 Implementation challenges

In order to create the environment described above whilst also meeting the requirements of performance and accountability frameworks, LBD's implementation was to be supported through five key operational parameters: community ownership and governance, outcomes focused management, whole system co-ordination, whole system learning and explicit accountability and performance. Each of these is discussed below.

i. Community ownership and governance

Broad community ownership of, and input into, the LBD vision and ongoing operational decisions was seen as vital to its success.

The following community governance and management structure was consolidated in 2005/2006 to support community ownership and ideas at multiple levels, and ensure tight accountability and a clear, well supported, decision-making forum in the Partnership Steering Group (PSG).



[1] See Appendix 1 in this document for extract.

Leadership hubs

The leadership hubs for the individual action areas functioned well and progressed activity within their respective action areas. They will continue to do so in 2006/2007.[2]

PSG

The PSG, established in April 2005, is and will remain the key information-sharing and decision-making body for LBD. Its objective is to support the implementation of LBD by:

- providing leadership for implementation of the operational plan(s)
- ensuring co-ordination and collaboration across LBD's 10 action areas and their specific interventions/ initiatives, and
- fostering collaboration across the sector and intersectorally where/as appropriate.

Comprised of leaders nominated by the action area leadership hubs and representatives from Counties Manukau District Health Board (CMDHB), Maori and Pacific communities, the LBD programme management group (referred to as the 'LBD team') and partner organisations, the PSG has grown in strength in maturity over the past 12 months. This operational plan and the success of LBD to date is a reflection of this and a genuine desire of organisations and groups to work together to 'beat' diabetes in Counties Manukau. Listed below are the PSG members and organisations who are integral to LBD's governance, design and implementation.[3]

Action area	PSG member	Title/Organisation
Community Leadership and Action – Maori	Riripeti Haretuku*[4] 2nd rep: Bernard Te Paa	LBD Maori Advisor, CMDHB General Manager Maori Health, CMDHB
Community Leadership and Action – Pacific	Rachel Enosa-Saseve* 2nd rep: Margie Fepulea'i	Pacific Contracting Manager, CMDHB General Manager Pacific Health, CMDHB
Community Leadership and Action – Workplace	Kerry Price 2nd rep: Jenny Bratty	Manager Health Outcomes, Auckland Regional Public Health Service (ARPHS) Workplace Manager, ARPHS
Social Marketing	Gerardene Waldron*	LBD Social Marketing and Communications Project Manager, CMDHB
Urban Design – council	Sue Zimmerman	Community Development, Manukau City Council
Urban Design – population health	Te Miha Ua-Cookson	Environmental Health Manager, ARPHS
Food Industry Accord	Brian Weaver	LBD Health/Food Industry Advocate, Joint Initiative Group (JIG)
Health Promotion – primary care	Louise McCarthy (Primary Health Organisation - PHO rep) (April–November 2005) Pam Williams (PHO rep) (from December 2005) Karen Pickering (Community Organisations for Diabetes Action - CODA rep)	Manager, Otara Health Inc Mangere Community Health Trust Manager, Diabetes Projects Trust
Health Promotion – physical activity	Melissa Noble (from February 2006)	Programmes Manager, Counties Manukau Sport (CM Sport)
Well Child Services	Adrianne Kinsey (July–December 2005) Annette King (from February 2006)	Plunket Plunket
Schools – primary	Kelvin Eglinton (PAC programme rep)(April–December 2005) Mike Truman (PAC programme rep) (from January 2006) Sue Grant (Health Promoting Schools – HPS rep) 2nd rep: Elizabeth Farrell (HPS rep)	Acting Regional Development Manager, CM Sport CM Sport Kidz First Public Health Nursing Kidz First Public Health Nursing

2 See Appendix 2 for leadership hub membership lists.

3 All PSG members were founding members unless otherwise stated.

4 Members with asterix (*) are also members of the LBD team.

Action area	PSG member	Title/Organisation
Schools – secondary	Karen Pickering 2nd rep: Kate Smallman	'GetWize2Health' and 'WizeEnvironment' Diabetes Projects Trust 'GetWize2Health' and 'WizeEnvironment' Diabetes Projects Trust
Primary Care	Shirley Miller* 2nd rep: Allan Moffitt	Primary Care, CMDHB Primary Care Director, CMDHB
Vulnerable Families	Robyn Rusher	Ministry of Social Development
Service Integration	Brandon Orr-Walker*	LBD Medical Director, CMDHB
LBD enablers		
Maori	Airini Tukerangi	Pou member, CMDHB Board Committee
Pacific peoples	Arthur Anae	Pacific Health Advisory Committee member, CMDHB Board Committee
Funding (sponsor)	Chris Mules	Chief Planning and Funding Officer, CMDHB
Evaluation	Janet Clinton/Faith Mahony	University of Auckland School of Population Health (SOPH)
CMDHB Board	Bill Mudgway	Board member, CMDHB Board
CMDHB LBD programme management team		
Programme Management – consultant	Paul Stephenson	LBD Programme Consultant to CMDHB
Programme Management	Amanda Dunlop Adrian Field	LBD Programme Manager, CMDHB Acting LBD Programme Manager (January–May 2006), CMDHB
Public Health (supporting Health Promotion, Primary Care, Social Marketing, Evaluation)	Tom Robinson	Public Health Physician, CMDHB
Youth Health (supporting Schools)	Gilli Sinclair	Youth Health/Schools, CMDHB
Programme support	Sandra Taylor	Programme Support Co-ordinator, CMDHB

Community Governance Group

A Community Governance Group forum was held in November 2005 to encompass broad community ownership of LBD and seek community feedback and guidance on key issues. Upon review, the PSG decided a targeted rolling 'road show' approach to achieve this would be more beneficial than quarterly LBD-wide meetings or forum.

ii. Outcomes focused management

The need to ensure the interventions/initiatives are well designed, effectively implemented and tightly focused on outcomes that help prevent and manage diabetes was identified as a challenge.

During 2005/2006 significant effort has gone into developing key performance indicators (KPIs) for LBD and to design a measurement framework that allows for monitoring of programme outputs and to ensure that programmes are focused on delivering outputs that are clearly linked to influencing obesity and diabetes.

iii. Whole system co-ordination

The need for whole system co-ordination across the plan's 10 action areas to ensure integration and alignment was identified as a key challenge.

LBD is a very complex programme and ongoing effort is required to co-ordinate and balance activities across multiple parts of CMDHB and across many other organisations. This type of network management is an emerging skill for CMDHB and requires constant attention and fine-tuning. The successful relationships LBD is forging are often built on the basis of relatively small funding from LBD, which have secured CMDHB a stakeholder role in many projects.

iv. Whole system learning

The need to create a learning environment in which multiple individuals and organisations can learn off each other, and from successes and challenges, to continuously improve quality was identified as a key challenge.

The evaluation required for LBD is extremely complex and technically demanding because of the programme's complexity. It is also clear that internationally the programme is ground-breaking, and taken together these features mean that there is very little evidence with which to derive benchmarks and best-practice. During 2005/2006, the evaluators of LBD (University of Auckland School of Population Health – SOPH) primarily focused on methodology, ethics approvals, obtaining baseline data, and building resources, relationships and structures. In 2006/2007, SOPH will be focused on gathering information, building self evaluation capability across multiple organisations and providing feedback to inform programme design.

v. Explicit accountability and performance

The need to ensure that there is clear accountability for LBD action areas and that there are good processes for performance reporting; and that CMDHB LBD funds are being wisely and prudently invested was identified as another key challenge.

CMDHB has developed an internal team with accountability across the 10 action areas. Partner agreements are also being developed within CMDHB and with other organisations so that there is greater clarity about leadership across the LBD action areas and around responsibility for particular areas. A new position of Programme Director has also been established for 2006/2007, which reflects the increasing scope and complexity of LBD and the need for high level leadership and accountability for performance.

3 High Level Key Performance Indicators

A proposed approach to developing the key performance indicators (KPIs) against which the performance and success of *Let's Beat Diabetes* (LBD) as a whole and its specific interventions/initiatives would be measured was outlined in detail in the *LBD Operational Plan 2005/2006*.[5]

The table below outlines the KPIs that have been developed for 2006/2007. Reporting will be based on the balanced scorecard approach with the dimensions of clinical, activity, community and financial performance being monitored. The following KPIs relate to the 'community and activity' components of the scorecard.

Balanced Scorecard	**Indicator KPIs**
Clinical	Under development. Will be included once completed (July 2006).
Activity	See details below.
1 Community Leadership and Action	
i. Maori	• Maori Women's Welfare League (MWWL) contracted to provide diabetes and healthy lifestyle training. • Four LBD marae co-ordinators established.
ii. Pacific	• Nutrition training and physical activity training modules available for LotuMoui churches; target of 250 people to attend. • Four ethnic-specific bilingual forms on diabetes.
iii. Workplace	• Uptake of workplace programme in at least two major food industry companies.
2 Social Marketing	• Launch of initial LBD social marketing programme by November 2006. • Baseline survey completed and final report received by June 2007.
3 Urban Design	• Completion of Templeton Park upgrade, evaluation and production of case study booklet. • Development of paper for Counties Manukau local government on design principles to support physical activity in urban design.
4 Food Industry Accord	• Support uptake of healthy canteen model in nine secondary schools. • No-sugar drinks initiative implemented by other fastfood chains. • Uptake of initiative to lower sugary drinks uptake in environments around schools.
5 Health Promotion	• Health promotion training programme developed and implemented. • Health promotion skills mentoring programme developed and implemented. • Development of physical activity workforce capacity training programme and activity opportunities (dependent on SPARC funding).
6 Well Child Services	• Development of upgraded 'nutrition/physical activity' toolkit for well child providers. • Development of research project for identifying obesity pathways for children aged 0–5 years.
7 Schools	• Implementation of nutrition and physical guidelines and programmes in 33 licensed Pacific early childhood centres (ECEs). • Expansions of versions of the Nutrition Exercise and Weight programme (NEW) 'GetWize2Health' into a total of nine secondary schools (three currently running). • Establishment of functional district-based tripartite (Health /Education/Sport and Recreation sectors) leadership process for development of healthier school environment.
8 Primary Care	• Completion of community nutrition pilot (CNP) with evaluation by March 2007. • Implementation of Self Management Education (DSME) programme across all primary health organisations (PHOs) by October 2006. • Completion of evaluation on family/whanau group support pilot by April 2007. • Development of detailed paper on diabetes/cardiovascular disease (CVD) risk screening in the community by September 2006. • Improved uptake of Diabetes Get Checked programme and data quality associated with programme.
9 Vulnerable Families	• Family Start programme linked to diabetes prevention networks in Counties Manukau. • Nutrition training for budgeting service staff and Family Start workers completed.
10 Service integration	• 'Acute Predict' clinical decision support system operational in secondary care settings. • Implementation of agreed recommendations from 'diabetes in pregnancy' review – align with Chronic Care Management (CCM) principles. • Research fellow position established to investigate best practice use of pharmaceuticals.

[5] See Appendix 3 in this document for extract.

Balanced Scorecard	Indicator KPIs
Community	• Partnership Steering Group (PSG) remains functional and effective.
Financial	• LBD does not exceed budget and provides accurate monthly financial reports. • LBD succeeds in achieving $500,000 investment in LBD interventions/initiatives from sources outside of CMDHB.

The clinical indicators are still under development and will be included once completed (July 2006). It is also expected that once the baseline survey is completed and the social marketing programme under way, there will be greater access to robust community indicators. The objective is to build the capability of LBD to be able to provide a truly balanced scorecard of information on performance.

4 Review of Operational Plan 2005/2006

In its first year (2005/2006), *Let's Beat Diabetes* (LBD) consolidated its governance functions, built a skilled and effective operational team within Counties Manukau District Health Board (CMDHB), developed functional relationships with external partner organisations, and successfully moved from a focus on planning to one of service delivery and sector co-ordination.

Service developments and delivery performed strongly, achieving anticipated milestones in most cases and in a number of areas breaking new ground with innovative approaches that are receiving widespread recognition.

LBD is a very complex programme and ongoing effort is required to co-ordinate and balance activities across multiple parts of CMDHB and across many other organisations. This type of network management is an emerging skill for CMDHB and requires constant attention and fine-tuning. The successful relationships LBD is forging are often built on the basis of relatively small funding from LBD, which have secured CMDHB a stakeholder role in many projects.

A number of aspects of LBD, such as the evaluation and social marketing programmes, are extremely complex and technically demanding and there has been some slippage against milestones associated with development of programme details. All action areas and enabling areas made sound progress during 2005/2006.

LBD is functioning effectively, meeting its milestones, staying within budget and delivering innovative programmes. Relationships with key partner organisations are being managed in a manner that will support collective action and pooling of resources to common ends.

Outlined below are some of the key highlights of 2005/2006. A more detailed, comprehensive report on the 2005/2006 Operational Plan will be presented to the Board of CMDHB in early 2006/2007.[6]

Action area	Achievement
1 Community Leadership and Action	
i. Whole Population	• By April 2006, 12 community organisations/groups had received a Community Action Fund grant to kick-start health promoting activity. Another six were being considered (LBD 1.1).
ii. Maori	• The first of six marae leadership hubs established to assist in supporting marae to become healthy, active environments, and support kaumatua and kuia leadership development in diabetes prevention and management (LBD 1.2). • Two three-day training courses on diabetes, nutrition and physical activity were completed, involving 20 kura (LBD 1.3 and 7.3).
iii. Pacific	• A diabetes workshop was held with approximately 50 Pacific church ministers (LBD 1.5). • Community nutrition education programmes delivered for Pacific communities and leaders, involving up to 250 people (LBD 1.5).
iv. Workplace	• Four organisations had begun implementing workplace programmes (LBD 1.6).
2 Social Marketing	• More than 350 people took part in the inaugural LBD Family Fun walk in Manukau, aimed at promoting LBD and supporting our community and families to be active and eat more healthily through participation and information (LBD 2.5). • Reviews on key learnings from previous social marketing campaigns targeting Maori and Pacific peoples, and options for social marketing baseline survey completed (LBD 2.2). • Development of three-year social marketing strategy and detailed 18-month programme completed (LBD 2.4). • Development commenced on design of social marketing baseline survey (LBD 2.5).
3 Urban Design	• 'Promoting physical activity' a core objective for Manukau City Council's design and development of neighbourhood parks following CMDHB's successful submission (LBD 3.1). • Community consultation on exemplar small urban park in Clendon (Templeton Park) to support increased community activity completed (LBD 3.1). • Health Impact Assessment of Manukau City's proposals to redevelop Mangere Town Centre and surrounding areas completed (LBD 3.2).

[6] The LBD interventions/initiatives references given in brackets refer to those for 2005/2006 and will often differ from those in this 2006/2007 operational plan.

Action area	Achievement
4 Food Industry Accord	• The Food/Health Joint Initiative Group (JIG) leadership group consolidated (LBD 4.1). Co-funded LBD Health/Food advocate position filled (Brian Weaver). JIG detailed action plan/work programme for 2005/06 endorsed and actioned (LBD 4.2). • Sugar-free drinks initiative implemented in all 21 McDonald's restaurants in Counties Manukau. Seen as a world-first, and the subject of positive coverage by local, national and international media (LBD 4.3). • Healthy tuckshop business model developed and applied at Tangaroa College. Ministry of Health funding obtained to roll programme out to most decile 1 and 2 secondary schools in Counties Manukau (LBD 4.3 and 7.7).
5 Health Promotion	• CODA (Community Organisations for Diabetes Action) co-ordinated meetings for planning, support and standardising. • LBD website live and operational. Includes progress updates on LBD and information on providers, events and resources (LBD 5.3). • Suite of resources for at-risk populations and post diagnosis education compiled (LBD 5.4). • Increased collaboration between different groups and organisations working in health promotion area (LBD 5.2).
6 Well Child Services	• Review of well child assessment tool to include assessment for diabetes and/or childhood obesity risk factors commenced (LBD 6.2).
7 Schools	• Kai Lelei (Eat Well) nutrition resources and teacher training package for Pacific early childhood centres (ECEs) developed (LBD 7.2). • First School Accords meeting held to discuss how education and health providers can work together to reach the objectives of the School Accord. Co-ordinator position established to complete needs analysis and gaps analysis and collate information to form a regional plan (LBD 7.4). • The school healthy canteen business model completed and piloted in Tangaroa College (LBD 7.7). • PANIC (Physical Activity and Nutrition Iwi Collective) established to co-ordinate existing service provision to Maori and identify gaps, with a focus on kohanga reo and kura kaupapa (LBD 7.1). • Enhanced 'Getwize2health' services contracted in three high risk secondary schools (LBD 7.6).
8 Primary Care	• New primary care leadership structure based around the Diabetes and Cardiovascular Advisory Group (DCAG) established (LBD 8.1). • Review on diabetes care framework for primary care completed (LBD 8.2). • Community Nutrition Project (CNP) pilot completed for 17 practice nurses and community health workers in brief intervention counselling to modify obesity risk factors (LBD 8.3). • Proposal to introduce improved post diagnosis self management education for people newly diagnosed with diabetes funded jointly by CMDHB and PHOs, developed and agreed to. A working group was also established to advise on improving family/whanau approach to self management education – aligning with Pacific/Maori activity streams (LBD 8.4). • DCAG endorsed using a model of systematic opportunistic screening. Project scoping undertaken to employ clinical resource to assess and cost the system changes required in general practice to implement this screening model (LBD 8.6).
9 Vulnerable Families	• Nutrition education training completed for social provider (Salvation Army) who interacts with high number of at-risk families. Focus included identification of healthy affordable food (LBD 9.4). • Strengthening Families' assessment and referral pathways have been extended to include LBD objectives (LBD 9.3).
10 Service Integration	• Informal leadership forum established with Division of Medicine (Clinical Heads Meeting) and Divisional Review (LBD 10.1) • Co-funded CMDHB/Diabetes Projects Trust Diabetes Fellow position established to undertake a Diabetic Nephropathy Research Project (LBD 10.3, 10.8). • DCAG participation in, and support for adoption and development of Cardiovascular disease (CVD) information systems in secondary care (Acute Predict) (LBD 10.3). • Review of current clinical and systematic barriers and opportunities for integrating the different providers/ services involved in diabetes in pregnancy and care into one comprehensive service; identification of any gaps or issues; and the provision of recommendations on specific changes that would be needed to address these gaps or issues completed (LBD 10.6).

5 Overview of Operational Plan 2006/2007

The *Let's Beat Diabetes* (LBD) *Operational Plan 2006/2007* builds on the work done in 2005/2006 as part of the process to meeting the long-term outcomes identified in *LBD: A Five Year Plan*.

During 2005/2006, the focus was primarily on the processes of development:

- building functional and sustainable leadership structures across all components of the programme
- designing and developing some of the more technical aspects of the programme, including baseline surveys, evaluation methodologies and social marketing strategies
- undertaking detailed design work across a number of areas
- developing resources and training programmes, and
- focusing on some practical programmes to develop exemplars and build profile.

The focus for 2006/2007 is more on operational delivery, although a number of programme components have been phased so they are still in developmental mode. Several interventions/initiatives that were designed and contracted in the 2005/2006 year are being rolled out in 2006/2007.

Interventions/initiatives that deliver education and training run across almost all 10 action areas. This investment reflects the need to build a new level of understanding and leadership across health and social sectors, and across society, in order to make the substantial behavioural changes required to slow risk and disease progression. The building of human and organisational capital is important in that it creates a platform of competency to support the effective delivery of programmes and it also leads to emergent community-led initiatives and changes in social norms, which support behaviour change.

The evaluation and learning process will also become more operational. In 2005/2006, the evaluators (University of Auckland School of Population Health – SOPH) primarily focused on methodology, ethics approvals, obtaining baseline data, and building resources, relationships and structures. In 2006/2007 they will focus on gathering information, building self evaluation capability across multiple organisations and providing feedback to inform programme design.

Communications is another key focus for 2006/2007. There will be a significant increase in community public relations associated with LBD, particularly in the early part of the year, to prepare the ground for the social marketing programme that will be launched by September.

Counties Manukau District Health Board (CMDHB) has made the decision to appoint a Programme Director to lead the LBD programme. This decision is a signal of the importance CMDHB places on the success of the programme and the scope and scale of the leadership challenge.

A number of important decisions will need to be made during the year. In the primary care action area, decisions around the approach to community cardiovascular disease (CVD)/diabetes screening and follow up will need to be made, which will have huge implications not only for LBD and its partners but for the community and the health sector. In secondary care, CMDHB will need to decide on its approach to the CVDIS secondary care database which is currently led by Waitemata District Health Board (WDHB). The creative content of the social marketing programme and how the programme will be rolled out will also require considerable management, care and expertise.

In terms of the budget, the management board of CMDHB has agreed for underspend of $650,000 from 2005/2006 to carried forward into the 2006/2007 year, making CMDHB's contribution to LBD for 2006/2007 $2.65 million. This will give LBD some flexibility.

At the same time, more effort will need to put into developing external funding sources for the programme, particularly from those organisations that have core responsibility and accountability for particular components. For example, CMDHB is currently collaborating with Counties Manukau Sport (CM Sport), ProCare, and the three local authorities in a substantive bid to Sport and Recreation New Zealand (SPARC) for improving physical activity-supporting social and environmental infrastructure. LBD is also closely aligned to the Ministry of Health's (MoH) national *Healthy Eating Healthy Action* (HEHA) strategy, and with the latter receiving extra funding recently, there a prime opportunity to ensure alignment of national and district programmes and enhanced collaboration.

6 Draft Budget 2006/2007

In 2006/2007, Counties Manukau District Health Board (CMDHB) will contribute $2.65 million new monies to support the implementation of the *Let's Beat Diabetes* (LBD) *Operational Plan 2006/2007*.

The table below outlines how CMDHB will apply its contribution. It also outlines other sources of funding that have confirmed for specific activities. It should be noted that:

- LBD's Partnership Steering Group (PSG) and leadership hubs helped determine the allocation of CMDHB's funding
- the other sources of funding identified are as at 1 June 2006. Other sources of funding or resources in kind are still being negotiated and/or sourced.

Action areas	Description of 2006/2007 activity	$ CMDHB LBD	Other funding sources
1 Community Leadership and Action	• Community Action Fund. • Maori specific programmes (marae, kaumatua and kuia leadership, diabetes training, iwi collective development). • Pacific specific programmes (Pacific churches, leaders) • Workplace initiatives.	265,000	Auckland Regional Public Health Service (ARPHS) supporting workplace initiatives.
2 Social Marketing	• Development of social marketing creative components and activities. • Social Marketing Baseline Survey.	800,000	Ministry of Health (MoH) supporting programme and baseline survey ($300,000).
3 Urban Design	• Developing two prototype neighbourhood 'activity parks' to guide upgrading of existing parks. • Undertaking health impact assessments of major planning initiatives. • Providing advice on local policy and planning issues. • Advocacy and advice. • Input into development of transport infrastructure.	90,000	Housing New Zealand Corporation (HNZC) and Manukau City Council (MCC) supporting parks upgrade. ARPHS supporting assessments, policy and advocacy.
4 Food Industry Accord	• Maintaining a governance structure between the food industry and health. • Co-funding of an advocacy position to continue driving the agreed health/industry agenda.	50,000	Food Industry Group (FIG) supporting co-funded position ($50,000).
5 Health Promotion	• Consolidating LBD leadership hub. • Improving health promotion and health education workforce development. • Supporting recent graduates from train-the-trainers programmes (pilot). • Developing nutrition and physical activity compendium. • Expanding physical activity workforce and developing 'activity hubs' in targeted areas of Counties Manukau (contingent on SPARC funding).	130,000	Ministry of Health (MoH) supporting workforce development and train-the-trainer pilot. Primary Health Organisations (PHOs) and ARPHS supporting.
6 Well Child Services	• Scoping current resources and where gaps exist, developing new resources to supplement the well child providers' toolkits, so as to assist young families improve their nutrition and physical activity.	45,000	
7 Schools	• Supporting kohanga and kura kaupapa to become healthy, active environments. • Supporting Pacific early childhood centres to become healthy, active environments. • Improving co-ordination of health promotion activity and health services in South Auckland schools. • Enhancing and expanding the NEW/AIMHI programme 'GetWize2Health' in selected secondary schools, in collaboration with the University of Auckland. • Rolling out the 'healthy canteen' business model, and its wider	200,000	Funding from SPARC anticipated. Ministry of Health (MoH) supporting 'healthy canteen' business model roll-out.

Action areas	Description of 2006/2007 activity	$ CMDHB LBD	Other funding sources
	promotion. • Developing new funding streams to support schools to make sustainable changes.		
8 Primary Care	• Supporting the DCAG leadership hub. • Reviewing and improving diabetes management framework. • Implement post diagnosis self management education. • Trial use of family/whanau/group support. • Community Nutrition Project (pilot). • Support increased Cardiovascular disease (CVD)/Diabetes risk screening. • Improving Get Checked programme.	175,000	PHOs supporting.
9 Vulnerable Families	• Working with vulnerable families to improve in-home nutrition. • Improving referral to and co-ordination between, health services and support agencies.	45,000	MSD supporting.
10 Service Integration	• Developing leadership hub. • Developing Whitiora Diabetes Service to become a centre of excellence. • Ensuring diabetes management activity across primary and secondary care is consistent. • Improving functionality of primary and secondary diabetes information technology (IT) systems. • Improving clinical data and ethnicity coding/reporting. • Developing integration for comprehensive care for diabetes in pregnancy. • Supporting diabetics eye disease. • Supporting diabetes renal disease.	145,000	Provider arm supporting.
Enablers			
Programme management	• Supporting programme management, Maori and Pacific co-ordination, medical leadership, service integration project support, social marketing and general programme support.	500,000	
Governance	• Supporting governance processes and improving consumer involvement in decision-making.	5,000	
Evaluation	• Evaluating the whole programme and each of the 10 action areas. • Supporting learning processes and progress reporting. • Supporting workforce capacity development for evaluation.	200,000	LBD research proposals are being prepared by SOPH for external funding
Total		**2,650,000**	

7 Detailed Operational Plan 2006/2007

Let's Beat Diabetes (LBD) and its activity is organised around 10 distinct but interrelated action areas. They are:

1. Supporting **Community Leadership and Action**
2. Promoting Behaviour Change through **Social Marketing**
3. Changing **Urban Design** to Support Healthy, Active Lifestyles
4. Supporting a Healthy Environment through a **Food Industry Accord**
5. Strengthening **Health Promotion** Co-ordination and Activity
6. Enhancing **Well Child Services** to Reduce Childhood Obesity
7. Supporting **Schools** to Ensure Children are 'Fit, Healthy, and Ready To Learn'
8. Supporting **Primary Care-based Prevention** and Early Intervention
9. Enabling **Vulnerable Families** to Make Healthy Choices
10. Improving **Service Integration and Care** for Advanced Disease.

This section outlines the interventions/initiatives that will be implemented over the 2006/2007 year; the key performance indicators (KPIs) or milestones that will be applied to measure their achievement; the process and outcome measures; and the resources that will be applied to support their implementation.

It should be noted and understood that:

- the key partners identified are those who have confirmed their support and resources (actual or in kind) to the implementation of a specific intervention/initiative, as at 1 June 2006. During 2006/2007, the *Let's Beat Diabetes* (LBD) programme management team within Counties Manukau District Health Board (CMDHB) will continue to establish relationships with other key partner organisations whose core responsibilities are or closely aligned to LBD's agenda to get their buy-in and support to the programme
- the monetary figures given in the 'resources' section is the funding CMDHB is contributing as part of its LBD funding package ($2.65 million for 2006/2007).
- LBD's Partnership Steering Group (PSG) and leadership hubs helped determine the allocation of CMDHB's funding.
- in many cases, CMDHB's LBD funding is supporting other CMDHB activities for which there are established funding streams. Where this occurs, the other funders and their contributions are noted and acknowledged.

Action Area 1 – Supporting Community Leadership and Action

Whole population

During the extensive community consultation phase of *Let's Beat Diabetes* (LBD), many community organisations and groups acknowledged the important role they could play in encouraging and bringing about healthy, active 'communities' by developing and implementing initiatives that support improved nutrition and physical activity, and support for people with diabetes. But resources and support were seen as barriers. In response to this, Counties Manukau District Health Board (CMDHB) established the Community Action Fund (CAF) which provides small grants (up to $5000) to support community 'grassroots' initiatives that encourage local participation in health promoting activities.

In 2005/2006, $100,000 was made available under the CAF. By April 2006, 12 community organisations and groups had received CAF grants with another six applications being considered.

In 2006/2007, $100,000 will again be made available. All initiatives will be monitored, reviewed and evaluated to ensure the funds are used appropriately, and the initiatives have contributed to improved health outcomes.

Interventions/initiatives	KPIs/milestones	Outcomes	Resources
1.1 Community Action Fund (CAF) Community organisations and groups are supported to develop and implement 'grassroots' initiatives that encourage local participation in activities that reduce diabetes risk, slow disease progression and/or improve the quality of life for people with diabetes. CMDHB and LBD key partners will: • actively promote the CAF throughout their community networks • assist Maori and Pacific community organisations and groups to apply for funding where/as required. CMDHB will also: • assess the CAF proposals • allocate CAF grants • monitor CAF-funded initiatives. **Key partners:** CMDHB, LBD partner organisations.	• Review/audit reveals funds used in appropriate manner. • Awareness of diabetes and healthy lifestyles addressing raised.	**Process outcomes** • Community organisations and groups are able to put their ideas into action. • Smaller community organisations and groups take on a health promoting role within their communities. • Community action. **Health outcomes** • Improved nutrition in the community. • Improved physical activity in the community.	**CMDHB** $100,000 Project management; contract management; networks; promotion **Key partners** Networks; promotion

Maori

Whakakorengia te mate huka i waenganui whanau na te mohio me te marama.
To prevent diabetes through knowledge and understanding.

Extensive consultations with Maori to ascertain their needs, aspirations, priorities and appropriate approaches to meeting these, were undertaken via marae-based hui, working groups and community consultations. Community representatives and providers consistently supported Maori cultural and leadership institutions as being the starting point for *Let's Beat Diabetes* (LBD). To this end, the key focus for LBD in 2005/2006 was, and will continue to be for the next two years, on supporting marae, kohanga reo (7.1) and kura kaupapa (7.3) to develop and implement initiatives that support improved nutrition and physical activity within their communities; and kaumatua and kuia as the champions for promoting healthy lifestyles within their communities. Underlying all of these interventions/initiatives is a process of increasing the knowledge of Maori leaders about obesity and diabetes, and supporting Maori cultural institutions to become leadership hubs for change.

Interventions/initiatives	KPIs/milestones	Outcomes	Resources
1.2 Developing marae leadership hubs as key focal points for diabetes awareness and action among Maori Counties Manukau District Health Board (CMDHB) will, in partnership with marae leaders, facilitate a discussion on the marae about diabetes from the perspective of a person with diabetes, and their need to successfully manage their care, and a whanau member at risk of diabetes and the supportive role they play. Maori and non-Maori professionals will attend these discussions to ensure accurate information is given in a culturally appropriate manner to ensure a clear understanding of diabetes is gained. CMDHB will, in partnership with marae leaders: • liaise with marae in Counties Manukau • recruit and co-ordinate appropriate health professionals • write an account of the process and develop a list of FAQs • develop a navigational tool for people with diabetes to ensure access to services within their locality. This tool will be developed after consultation with the Maori community (linking with LBD 10.1) • support the establishment of marae co-ordinator positions. Partner marae likely to include the following: • Pukaki Marae • Te Puea Marae • Makaurau Marae • Papakura Marae • Nga Tai e Rua Marae. The role each marae is to panui whanau and community to attend these proposed hui. This means that selection needs to be specific if we are attempting to address diabetes and obesity. This will require liaison and explanation with the community as to why attendance is important. The role of the marae after the hui is to form small forums that can act as conduits for further information if and when required. **Key partners:** CMDHB, Pukaki Marae, Te Puea Marae, Makaurau Marae, Papakura Marae, Nga Tai e Rua Marae.	• By December 2007, development of navigational tool completed. • By April 2007, establishment of marae co-ordinator positions. Other KPIs to be developed at later date in partnership with marae.	**Process outcomes** • Consultation to ensure that the needs of the Maori community are supported long-term. • Marae become healthy, active environments/health promoting environments. • Improved community and whanau support for diabetes self-management. **Health outcomes** • Improve marae participants' health by providing healthy food, physical activity opportunities, and healthy cooking guides.	**CMDHB** $45,000 Additional funding from Maori Health; project management; contract management; leadership, networks; health knowledge and expertise; diabetes expertise. **Partner marae** Participation; leadership; networks

Interventions/initiatives	KPIs/milestones	Outcomes	Resources
1.3 Kaumatua leadership To seek endorsement by Maori kaumatua to become advocates for diabetes prevention and management by using their influence on the marae within hui. CMDHB will, in partnership with marae or community leaders: • visit marae committees/Maori groups and present the intention of LBD • identify kaumatua role models to speak widely about this work in their areas of influence • create a kaumatua role model register • identify key kaumatua currently working in this area. Engagement with kaumatua is likely to occur in the following partner marae: • Pukaki Marae • Te Puea Marae • Makaurau Marae. These marae have formally formed a roopu called Hinana ki Tai with Eru Thompson as the kaumatua. It is important that we complete marae consultation and development in phases so that we can begin to sharpen our delivery. These marae are ready to commence consultation with community. **Key partners:** CMDHB, Pukaki Marae, Te Puea Marae, Makarau Marae.	• By April 2007, kaumatua role model register operational.	**Process outcomes** • The development of a kaumatua role model register. • Maori leaders gain knowledge about diabetes and are supported to work with and bring about change in their community. • Community supported in uptake of new ideas. **Health outcomes** • Improved management and prevention of diabetes. • Improved nutrition and physical activity for at risk population. • Slowing of disease progression.	**CMDHB** $10,000 Additional funding from Maori Health; project management; contract management; leadership; networks; health knowledge and expertise; diabetes expertise. **Partner marae** Participation; leadership; networks
1.4 Kuia leadership To seek the support of respected Maori women to advocate for the prevention and management of diabetes in Maori communities. The Maori Women's Welfare League (MWWL) is a national organisation that has a large membership. With these large networks and potential for advocacy at a national level the importance of diabetes and obesity can be filtered through the entire organisation. CMDHB will work with MWWL to develop 'Champion Leagues'. The formal training component will at the very least influence individual behaviours and workplace advocacy. A year of training, monitoring progress and small group trainings facilitated by the League will be held. CMDHB will: • consult with the MWWL on interest and potential participation in the programme • provide training in the area of diabetes, nutrition and physical activity • contract the MWWL to deliver training to Maori communities. **Key partners:** CMDHB, Nga Wahine Atawhai o Matukutureia (Manurewa branch), MWWL.	• By September 2006, MWWL support gained. • By December 2006, provision of training to MWWL completed. • By March 2007, MWWL contracted to deliver diabetes and healthy lifestyle training to Maori communities.	**Process outcomes** • Pilot with Manurewa MWWL branch and then extend to other branches within Counties Manukau, to develop kuia leadership. • Maori leaders gain knowledge about diabetes and are support to work with and bring about change in their community. **Health outcomes** • Whanau engagement in diabetes prevention and management. • Improved nutrition and physical activity for at risk population. • Slowing of disease progression. • Improved management of complications.	**CMDHB** $15,000 Additional funding from Maori Health; project management; contract management; leadership; networks; health knowledge and expertise; diabetes expertise. **MWWL** Participation; leadership; networks; facilitation of training.

Interventions/initiatives	KPIs/milestones	Outcomes	Resources
1.5 Strengthening the physical activity and nutrition iwi collectives in Counties Manukau In 2005/2006, CMDHB and Auckland Regional Public Health Service (ARPHS) oversaw the establishment of a coalition of Maori organisations working in the areas of physical activity and nutrition in Franklin and Manukau (PANIC). The key roles of the roopu was to co-ordinate, collaborate, pool resources, develop specific and effective resources, identify gaps and identify successes. In 2006/2007, CMDHB and ARPHS will further strengthen PANIC and look to consolidate other PANIC in the district. **Key partners:** CMDHB, Sport and Recreation New Zealand (SPARC), CM Sport, ARPHS, Raukura Hauora, Papakura Marae, Franklin PANIC, ProCare, Manukau City Council (MCC), Franklin Waka Ama (outrigger canoes).		**Process outcomes** • Efficiency and effectiveness of service provision to Maori through co-ordination and collaboration. **Health outcomes** • Reduction of diabetes in Maori communities.	**CMDHB** $10,000 Additional funding from Maori Health; project management; contract management; leadership; co-ordination; networks. **ARPHS** Funding; co-ordination. **SPARC** Funding (tbc). **Raukura Hauora, Papakura Marae, ProCare** Education; activities; training. **Franklin PANIC** Collaboration. **MCC** Administration, advocacy. **Franklin Waka Ama** Education, waka ama.

Interventions/initiatives	KPIs/milestones	Outcomes	Resources
1.6 Maori diabetes training In 2005/2006, a learning module was specifically developed for Maori community health workers in diabetes education by Te Hotu Manawa Maori. The module is made up of three components - nutrition, diabetes and physical activity. CMDHB will ensure the training provided to 80 workers over 2006/2007 and 2007/2008. Key steps include: • contracting appropriate trainers to develop the training • recruiting participants • training costs: food, training, location and follow-up • further developing learning module and resources • providing follow-up support for trainees. **Key partners:** CMDHB, Te Hotu Manawa Maori, ARPHS, Maori providers, Hapai te Hauora, ProCare.		**Process outcomes** • Trained Maori workers throughout Counties Manukau. **Health outcomes** • Improved nutrition and physical activity for at risk population. • Slowing of disease progression. • Improved management of complications.	**CMDHB** $20,000 Additional funding from Maori Health; project management; contract management; leadership; networks. **ARPHS** Funding; specialist skills; nutrition training. **Te Hotu Manawa** Maori training. **Maori providers** Participants. **Hapai te Hauora** Maori trainers. **ProCare** Nutrition training; marae support.

Pacific peoples

Samoan: Suamalie i le gutu a'e oona i le manava – fa'alalo le ma'i suka.
Tongan: A Tongan-led diabetes workforce, resourced to work together with the Counties Manukau community to serve our families.
Our aims: (1) Ke haofaki'i hotau ngaahi famili mei he suka and (2) Ke leva'i lelei e suka 'i he famili.
Cook Islands: Tamate i te toto vene.
Niuean: Omai ke kau fakalataha ke tuku hifo e gagao suka ki lalo.

Extensive consultations with Pacific peoples to ascertain their needs, aspirations, priorities and appropriate approaches to meeting these, were undertaken via fono, working groups and community consultations. Community representatives and providers consistently supported Pacific churches and language nests as being the starting point for *Let's Beat Diabetes* (LBD). To this end, the focus for LBD in 2005/2006 and again for 2006/2007 is on supporting Pacific churches and language nests (7.2) to develop and implement nutrition and physical activity initiatives within their communities; equipping Pacific leaders with information about Type 2 diabetes and its risk factors so they can become agents of change; and improving nutrition and physical activity for people who are obese and at risk of getting diabetes. Improving nutrition and physical for people who are already obese and at risk of diabetes has also been identified for priority action. Underlying all of the interventions/initiatives is a community development process of increasing community knowledge and capacity to support Pacific community groups to become leadership hubs for change.

Interventions/initiatives	KPIs/milestones	Outcomes	Resources
1.7 Pacific churches to develop and implement nutrition and physical activity CMDHB will continue to support the implementation of CMDHB Pacific Health's LotuMoui Operations Plan in which 50 Pacific churches implement healthy lifestyle activities in Counties Manukau. As part of this plan, a nutrition education module has been developed. CMDHB will: • support the LotuMoui churches to implement the module, and develop nutrition policies and healthier nutrition practices within their church settings. The target is for 250 people to attend the training. • Develop a physical activity toolkit and training module to ensure that physical activities undertaken within Pacific community and church settings are safe. • Incorporate key LBD and healthy lifestyle messages into the LotuMoui Symposium 2006. **Key partners:** CMDHB, LotuMoui churches, Pacific health professionals.	• By March 2007, nutrition education module available to LotuMoui churches which will support the development of nutrition policies and healthier nutrition practices in church settings • November 2006, LBD healthy lifestyle messages incorporated into the LotuMoui Symposium. • By June 2007, physical activity toolkit and training module developed to ensure that physical activities undertaken within Pacific community and church settings are safe.	**Process outcomes** • Pacific churches become health promoting environments, with a focus on nutrition and physical activity. • Pacific churches knowledge about preventing type 2 diabetes is enhanced. **Health outcomes** • Improved nutrition and physical activity levels leading to a reduction in obesity for at risk population. • Increased community knowledge leading to changes in behaviour towards healthy living.	**CMDHB** $45,000 Additional funding from Pacific Health; project management; contract management; leadership; expertise; implementation; networks. **LotuMoui churches** Participants; Nutrition Certificate graduate support for delivery of sessions. **Pacific health professionals** Support of delivery of nutrition education modules.

Interventions/initiatives	KPIs/milestones	Outcomes	Resources
1.8 Empowering self- identified and community identified leaders and organisations to become agents for change within their families and communities Communicating complex health issues in a cultural context can be complex where there are limited words to translate anatomy, body functions and the physiological impact of disease processes. The development of a language with oral traditions requires a critical mass of Pacific community leaders, language and health professional experts to discuss and debate those issues among themselves as a process for gathering consensus on how important health issues such as diabetes will be described consistently. CMDHB will hold four ethnic specific bilingual forums on diabetes. These forums will be created for language and cultural experts to debate and dialogue around cultural practices and language in relation diabetes. **Key partners:** CMDHB, community leaders, Pacific health professionals, language experts.	• By June 2007, four ethnic-specific forums on diabetes held.	**Process outcomes** • Provision of a forum for dialogue to occur around the language and terminology used to discuss diabetes as well as the cultural practices which impact on diabetes. **Health outcomes** • Healthier cultural practices for Pacific communities.	**CMDHB** $20,000 Additional funding from Pacific Health; project management; contract management; leadership; expertise; networks. **Community leaders, Pacific health professionals, language experts** Participation; provider specialist advice and expertise from ethnic-specific perspectives around cultural practices and language relating to diabetes.

Workplace

Healthy, active workplaces

The workplace is identified in public health literature as being one of the key intervention areas to support improved population health. Maori and Pacific peoples have also identified the workplace as an important setting for public health interventions.

In 2005/2006, Auckland Regional Public Health Service (ARPHS) lead this action area on behalf of *Let's Beat Diabetes* (LBD), and supported Counties Manukau District Health Board (CMDHB), Housing New Zealand Corporation (HNZC) and Ministry of Pacific Island Affairs (MPIA) to enhance or develop and implement policies and initiatives that support healthy, active workplaces. ARPHS will continue to lead this action area in 2006/2007, with factories the key target settings. Counties Manukau Sport (CM Sport) will support ARPHS by taking a lead role in the development of physical activity programmes and policies as part of the programme. CMDHB and the Food Industry Group (FIG) will also support ARPHS by influencing food industry employers to support healthy, active workplace initiatives (see LBD 4.2.6).

Interventions/initiatives	KPIs/milestones	Outcomes	Resources
1.9 Supporting employers to develop and implement policies and initiatives that support health, active workplaces Targeted organisations in 2006/2007 will primarily be factory settings linked to the food industry, with significant Maori and Pacific workforces. This approach is intended to extend food industry participation in the LBD programme, using healthy workplace development as a springboard. CMDHB, ARPHS and CM Sport will: • develop a strategy for approaching companies, and work in collaboration with these organisations to bring food industry workplaces into the Heartbeat Challenge • commission work targeting Heartbeat Challenge clients to develop case studies, reporting on outcomes of participation in programme, drawing on qualitative and quantitative data. This would also contribute to developing a tool for assessing impact of workplace programmes. **Key partners:** ARPHS, CM Sport, Food Industry Group (FIG).	• By March 2007, participant organisations enrolled and working with ARPHS to develop and implement nutrition and physical activity policies and initiatives.	**Process outcomes** • Improved nutrition and physical activity in workplace. • Change in workplace culture, catering and employer approaches to active employees. • A set of exemplar workplace that others can aspire towards. **Health outcomes** • Improved nutrition and physical activity leading to a reduction in obesity.	**CMDHB** $20,000 Advocacy. **ARPHS** Leadership; implementation. Will work with identified employers to enhance or develop and implement healthy, active workplace policies and programmes, through further implementation of the Heartbeat Challenge. Will also work with CM Sport on the development of physical activity programmes and policies.

Interventions/initiatives	KPIs/milestones	Outcomes	Resources
			ARPHS is committing additional funding ($40,000) to expanding and improving the Heartbeat Challenge Programme overall. **CM Sport** Leadership; implementation. Will work with ARPHS on implementation of Heartbeat Challenge in district, taking a lead role in physical activity programmes and policies, funding permitting.

Action Area 2 – Promoting Behaviour Change Through Social Marketing

The power of collective small steps towards achieving change.

There is good evidence that social marketing is an effective intervention when it is part of a broader programme of interventions/initiatives.

In 2005/2006, Counties Manukau District Health Board (CMDHB) contracted a provider to develop a three-year social marketing and communications strategy and a detailed programme of activities (i.e. action plan) for the initial 18-month period. A key requirement of the strategy was that it needed to be effective for high risk populations, in particular Maori, Pacific and low-income families, and would need to integrate with and support the wider LBD programme and its activities. The strategy was completed and endorsed by the LBD Social Marketing Leadership Group in April 2006.

In 2006/2007, the focus for the social marketing action area is:

1. *Implementation of the social marketing programme*. Implementation will be done in two phases. The first phase (Phase 1) will focus on encouraging individuals, families, people who influence household eating, drinking and physical activity behaviours to 'swap' and/or support others to 'swap' to healthier eating and physical activity choices; and on influencing the environment in which the families of Counties Manukau live, work and play (i.e. food manufacturers, retailers, employers etc) to make 'swapping' easier.

   Maori and Pacific peoples will be involved in, and inform, all facets of the development of the implementation programme so as to ensure the concepts, key messages and communications vehicles identified are appropriate and effective for their respective communities. It is anticipated community-based approaches will be used to ensure effective implementation.

2. *Baseline Survey*: A baseline survey will be undertaken to gain a comprehensive understanding of Counties Manukau's knowledge, attitudes and behaviours towards nutrition, physical activity, obesity, diabetes and diabetes management and indicators pre-LBD social marketing programme. This will enable us to measure the impact of LBD's social marketing programme at a later date. It will also inform the overall evaluation of LBD.

   Over-sampling of the Maori and ethnic-specific Pacific populations will be done to ensure we get a greater understanding of their knowledge, attitudes and behaviours, which will help us to develop effective programmes.

Interventions/initiatives	KPIs/milestones	Outcomes	Resources
2.1 Social marketing leadership hub CMDHB will reconvene the social marketing leadership hub to guide the development and implementation of the social marketing strategy. The hub includes individuals from a variety of relevant networks and skill sets (e.g. health, commercial sales and marketing, community leadership, Maori and Pacific expertise). **Key partners:** CMDHB, individuals with relevant skill sets and influence from partner organisations and the community will be invited to (re)join the leadership hub.		**Process outcomes** • The leadership hub will provide critical thinking and a pragmatic and inspired solutions focused approach to ensure that that the social marketing programme is implemented as optimally as possible (i.e. alignment with other social/commercial marketing programmes, availing of supplementary funding/sponsorship opportunities, ongoing learning through evaluation etc). **Health outcomes** • Improved nutrition and physical activity leading to a reduction in obesity, and prevention or delay of onset of diabetes.	**CMDHB** Project management; contract management; facilitation of meetings. **Key partners** Leadership; guidance; expertise; networks.
2.2 Implementing the LBD social marketing programme Phase 1 of the social marketing programme implementation or roll-out will focus specifically on addressing obesity, through encouraging: The general public of Counties Manukau (in particular parents and others who influence household eating, drinking and physical activity behaviours) to 'swap' (and support others to 'swap') to healthier eating and physical activity choices. Those that influence the environment in which the families of Counties Manukau live, work and play (i.e. food manufacturers, retailers, employers etc) to make 'swapping' easier. Subsequent phases will build on the initial 'swap' focus on eating and physical habits, to include 'swapping' from not knowing whether one has diabetes, to finding out (i.e. getting screened). The timing will be dependent on the readiness of Primary Care (a screening strategy is being developed in 2006/2007 – see LBD 8.6). The social marketing programme will target Maori, Pacific and low-income families specifically. Maori and Pacific leadership and input into the development and implementation phases is therefore critical to ensure what it developed and how it is implemented is appropriate for their respective communities. CMDHB is providing the base funding for this intervention/initiative, however, additional funding will be required. The Ministry of Health (MoH) has contributed significant funding. CMDHB will seek other sources of funding. Potential partners include: the South Auckland Health Foundation (SAHF), the food industry, Sport and Recreation New Zealand (SPARC), Health Sponsorship Council (HSC). **Key partners:** CMDHB, organisations, groups (public and private sector, social, cultural etc), agencies, families, individuals, communities across Counties Manukau.	• By November 2006, development phase completed. • By November 2006, implementation of programme underway. • By February 2007, review of programme and plan for expanded roll-out completed. • By March 2007, implementation of roll-out underway. • By June 2007, development phase for 2007/2008 implementation programme completed.	**Process outcomes** • Target 'household influencers' swapping how they eat, drink and move, and/or supporting their family and friends to 'swap'. • Target 'environment influencers' making it easier for people to make the 'right' eating/drinking and physical activity swaps (i.e. through product choice, design, pricing, access etc). **Health outcomes** • Improved nutrition and physical activity leading to a reduction in obesity, and prevention or delay of onset of diabetes.	**CMDHB** $600,000 Project management; contract management; sourcing of additional funding. **MoH** ($150,000) **Other sources of funding** Other sources of funding not yet specified but will be required.

Interventions/initiatives	KPIs/milestones	Outcomes	Resources
2.3 Baseline Survey – Measuring the impact of the social marketing programme and LBD programme CMDHB will undertake two baseline surveys of Counties Manukau residents to enable measurement of changes in target groups over time and therefore inform the evaluation of the LBD programme, including in particular the ongoing development of the social marketing programme. One survey will be conducted the general public, and another specifically with those with Type 2 diabetes. The survey with the general public will be designed to not only provide a benchmark of local attitudes and behaviours, but importantly to provide a first picture of the 'undiagnosed' population through offering all survey participants the opportunity to have their Type 2 diabetes risk assessed. CMDHB is providing the base funding for this intervention/initiative, however, additional funding will be required to support it. MoH has contributed significant funding. CMDHB will seek other sources of funding. **Key partners:** CMDHB, Phoenix Research, Primary Health Organisations (PHOs), SOPH.	• By December, baseline survey of general population completed. Dependent on ethics approval process. • By March, baseline survey of people with diabetes completed. Dependent on ethics approval process. • By June, final report due.	**Process outcomes** • A comprehensive understanding of Counties Manukau's knowledge, attitudes and behaviours towards nutrition, physical activity, obesity, diabetes and diabetes management and indicators pre-LBD social marketing programme.	**CMDHB** $200,000 Additional funding support from Pacific Health; project management; contract management; sourcing of funding. **MoH** ($150,000) **Phoenix Research** Design; implementation. **PHOs** Access to people with diabetes. **Other sources of funding** Other sources of funding not yet specified but will be required.

Action Area 3 – Changing Urban Design to Support Healthy, Active Lifestyles

The urban environment in Counties Manukau supports increased physical activity levels and improved social cohesion.

Urban environments impact on our lifestyle choices, and subsequently our health and risk of disease. There are a number of areas *Let's Beat Diabetes* (LBD) wishes to influence urban design. They include:

- park design and redevelopments
- urban planning and design
- urban developments and redevelopments
- public transport and active transport infrastructure issues, and
- enhanced access and opportunities to be physically active.

In 2005/2006, Auckland Regional Public Health Service (ARPHS) and Manukau City Council (MCC) led this activity in this action area on behalf of LBD. They will continue to do so in 2006/2007, and involve other key stakeholders including Franklin District Council (FDC) and Papakura District Council (PDC).

Interventions/initiatives	KPIs/milestones	Outcomes	Resources
3.1 Establishing a LBD leadership hub on health and urban design in Counties Manukau A leadership hub will be established to guide work in this action area and enhance alignment and collaboration. Membership to include Counties Manukau District Health Board (CMDHB), ARPHS, Housing New Zealand Corporation (HNZC), Counties Manukau Sport (CM Sport) ,FDC, MCC and PDC. Members will facilitate access to internal decision-making processes, community engagement, and act as a forum for cross-organisation information sharing. An initial project from the leadership hub will be the development of a directory of key players in the urban design/health interface in Counties Manukau. **Key partners:** ARPHS, CMDHB, MCC, HNZC, MCC, PDC, FDC, CM Sport.	• By August 2006, leadership hub established. • By November 2006, directory of key players in health and urban design completed.	**Process outcomes** • Partners will raise awareness of projects, developments, contacts and opportunities as they arise. • Enhanced collaboration in projects of mutual interest and benefit. **Health outcomes** • Long-term reduction in obesogenic environment assisted by heightened collaboration across sectors.	**CMDHB** Non-budget item. Participation; facilitation of meetings; co-ordination **Key partners** Participation

Interventions/initiatives	KPIs/milestones	Outcomes	Resources
3.2 Developing exemplar models for community activity parks In 2005/2006, CMDHB, HNZC and MCC collaborated to develop an exemplar neighbourhood activity park (Templeton Park, Clendon) to support increased levels of family/community based physical activity. In 2006/2007, the focus will be on: • completing the Templeton Park development • initiating development of one activity park in each city/district council in 2006/2007, and exploring different models for activity parks. Where possible or feasible, such parks will be centred within or near a HNZC neighbourhood. Potential locations are the Pershore or Mascot precincts in Manukau (areas of high Pacific populations), and the Papakura Army Camp • producing a small publication on the development of Templeton Park, including the partnership and consultation processes, designs, and evaluation finding. This will be distributed widely as a case study of park development to assist future activities. Through the development of exemplar models, we anticipate heightened public demand and expectations for local park development. This in turn will influence organisational decision-making to develop these facilities, with attendant impacts on physical activity and health for local populations as such developments occur. On completion of exemplar parks, generic lessons learned from these projects will be shared between partners and disseminated widely to assist their further development. CMDHB, HNZC and CM Sport will work with MCC, FDC and PDC to develop at least one more activity park. **Key partners:** CMDHB, MCC, FDC, PDC, HNZC, ARPHS, CM Sport.	• By December 2006, Templeton Park evaluation findings received. • By June 2007, Templeton Park completed. • By June 2007, production of Templeton Park publication completed. • By June 2007, new park(s) completed.	**Process outcomes** • Park development and process facilitates increased use by local children, families and adults, and encourage activity, games and play. **Health outcomes** • Increased levels of physical activity contribute to reduced risk factors for diabetes and heart disease. • Park usage contributes to increased social cohesion.	**CMDHB** $90,000 Project management; contract management; co-ordination; funding of evaluation. **HNZC** Funding, implementation, collaboration in park design and planning, negotiation with MCC, FDC and PDC and other key stakeholders over design implementation and resourcing. **MCC, PDC and FDC** Funding, implementation and collaboration in park design and planning, negotiation with other stakeholders over design, consents and approvals processes. **University of Auckland School of Population Health (SOPH)** Evaluation.

Interventions/initiatives	KPIs/milestones	Outcomes	Resources
3.3 Health impact assessment In 2005/2006, ARPHS funded a Health Impact Assessment (HIA) focusing on a component of the Mangere town centre development. In 2006/2007, ARPHS will *[to be confirmed],* on LBD's behalf undertake or fund a further HIA in 2006/07, with a particular view on the impact on physical activity. This is to facilitate the incorporation of health issues in local decision-making in an appropriate manner, and to further enhance partnerships between the health sector, local government and HNZC. **Key partners:** CMDHB, ARPHS, MCC, FDC, PDC, CM Sport.	• By June 2007, HIA completed.	**Process outcomes** • Increased uptake of health issues in urban planning and design. **Health outcomes** • Increased levels of physical activity, through better urban design, leading to lower obesity levels.	**CMDHB** Non-budget item. Input into scoping and planning, feedback on draft reports, dissemination of findings to key stakeholders. **ARPHS** Leadership, project management. Review major planning initiatives in Counties Manukau and undertake health impact assessments in terms of their impact on physical activity, in collaboration with relevant stakeholders, including HNZC, PDC, FDC, MCC CM Sport, health providers.
3.4 Advocating for health ARPHS will, on behalf of LBD, continue an advocacy role on aspects of urban design, liaising with MCC, FDC, PDC and HNZC on issues of significance in local policy and planning, such as the Mangere town centre development or the forthcoming Papakura army camp. ARPHS will also work with MCC, PDC and FDC to ensure opportunities for physical activity and access to services and amenities are enhanced. This includes: • free access to recreation facilities and swimming pools • safe cycling paths, walkways and pedestrian crossing, particularly around schools, and • safe parks. CMDHB will participate in planning activities where resources permit, and will facilitate linkages on specific health sector issues relating to urban development, such as primary care development. CM Sport have a particular interest in the orientation of urban design to supporting physical activity and will be linked into this and related processes. **Key partners:** CMDHB, ARPHS, MCC, FDC, PDC, CM Sport.	• Timely and active participation in planning processes. • Submissions made within specified timeframes.	**Process outcomes** • Effective health input into district and regional planning and infrastructure decisions. • Barriers to access and participation remain low. **Health outcomes** • Increased levels of physical activity, through better urban design, leading to lower obesity levels.	**CMDHB** Non-budget item. Project management; input into programme; feedback on papers; collaboration with MCC, FDC and PDC planning processes; identification of linkages with MCC, FDC and PDC business where impacts on LBD. **ARPHS** Leadership. Involvement in planning processes from an early stage, preparation of submissions and lobbying on planning and infrastructure issues on a case by case basis. **CM Sport** Experience and expertise in physical activity.

Interventions/initiatives	KPIs/milestones	Outcomes	Resources
3.5 Building a health-promoting transport system CMDHB, ARPHS, CM Sport, MCC, FDC and PDC (linking with ARTA, ARTNL, On-Track and other interested organisations) will collaborate in developing health promoting public transport (including active transport, such as walking and cycling). CMDHB, ARPHS and CM Sport will work with MCC, PDC and FDC on issues of significance on a case by case basis. Activity will include engaging with PDC in the development of public transport provision with a view to enhancing linkages to pedestrian and cycle routes, and to local services, facilities and amenities, so as to maximise the health potential of public transport; and ensuring opportunities for physical activity are enhanced. It is anticipated that development of an exemplar model will create increased public demand and expectations for infrastructure development, which will in turn influence organisational decision-making to develop such facilities, with attendant impacts on physical activity and health as developments occur. **Key partners:** CMDHB, ARPHS, MCC, FDC, PDC, CM Sport.	• Timely and active participation in planning processes. • Submissions made within specified timeframes.	**Process outcomes** • Effective health input into district and regional public transport infrastructure decisions. **Health outcomes:** • Increased levels of physical activity, through better urban design, leading to lower obesity levels.	**CMDHB** Non-budget item. Project management, input into programme, feedback on papers, collaboration with MCC, FDC and PDC planning processes, identification of linkages with MCC, FDC and PDC business where impacts on LBD. **ARPHS** Leadership. Involvement in planning processes from an early stage, preparation of submissions and lobbying on planning and infrastructure issues on a case by case basis. **CM Sport** Experience and expertise in physical activity. **PDC** Scoping, planning and consultation on public transport provision, as precursor to infrastructural development in subsequent years.

Action Area 4 – Supporting a Healthy Environment Through a Food Industry Accord

The food environment in Counties Manukau changes to increase healthy food availability and consumption, particularly for families with low incomes and at high risk of diabetes.

Over the past 18 months, Counties Manukau District Health Board (CMDHB) has been working with the Food Industry Group (FIG) to develop a collaborative approach to implementing the joint objectives of *Let's Beat Diabetes* (LBD) and the Food Industry Accord (aligns the Food Industry with the Government's *Healthy Eating Healthy Action* Framework). This is a new type of relationship, not only in New Zealand but globally, and has already caught the attention of the World Health Organisation.

A number of key milestones were achieved in 2005/2006 as a result of this collaborative approach:

- The health and food industry governance/leadership structure comprising CMDHB and FIG was consolidated. It is called the Joint Initiative Group (JIG).
- JIG co-funded and appointed a food/health advocacy position to develop and drive the joint Food:Health work programme for 2005/2006 (October to October).
- JIG's Food:Health work programme for 2005/2006 was endorsed and actioned.
- The sugar-free drinks initiative in McDonalds restaurants (considered a global 'first') was implemented and a healthy tuckshop business model for secondary schools developed.

In 2006/2007, the focus will be on completing the current work programme, and developing and implementing the work programme for October 2006 to June 2007.

Interventions/initiatives	KPIs/milestones	Outcomes	Resources
4.1 Strengthening the leadership structure for the food industry: health sector joint initiative in Counties Manukau The health and food industry governance/leadership structure, the Joint Initiative Group (JIG) will be strengthened, and continue to function as the leadership structure for this action area. **Key partners:** CMDHB, FIG.	• By August 2006, JIG strengthened.	**Process outcomes** • A collaborative structure guides Food Industry initiatives. • Consolidation of Counties Manukau as the 'demonstration pilot' area for the New Zealand Food Industry Accord. **Health outcomes** • Improved nutrition leading to a reduction in obesity.	**CMDHB** $50,000 Project management, contract management, facilitation of meetings, health leadership, guidance, advice, networks. **FIG** ($50,000) Food industry leadership, expertise, networks.

Interventions/initiatives	KPIs/milestones	Outcomes	Resources
4.2 Completing JIG work programme 2005/2006 JIG's work programme for 2005/2006 runs to October 2006. JIG's co-funded advocate will complete implementation of work programme by this date. The interventions/initiatives are as follows: 4.2.1 Soft drinks programme – To achieve a reduction in the consumption of full-sugar sweetened soft drinks by encouraging the conversion to less energy-dense alternatives (LBD 7.9). 4.2.2 White milk programme – To create a retail environment that actively encourages customers to purchase lower-fat white milk in preference to the full-fat product. 4.2.3 Healthy kai project – To review and provide recommendations to JIG and Auckland Regional Public Health Service (ARPHS) as to the future direction of the 'Healthy Kai' project. 4.2.4 Healthy food parcels – To explore ways in which the food industry can assist food parcel providers to offer healthy, well balanced and nutritious products for the most vulnerable families in the district (LBD 4.5; 9.5). 4.2.5 Healthy Canteen Business Model Pilot – To provide practical advice, support and assistance to the 'Healthy Canteen Pilot' being trialled at Tangaroa College so as to ensure it achieves its goals (LBD 7.7). Advice, support and assistance to include the sourcing, merchandising, pricing and promotion of a healthier school canteen menu. 4.2.6 Healthy, active workplaces – To support LBD's healthy, active workplace initiative by encouraging food industry employers to enrol and participate in the workplace programme – the 'Heartbeat Challenge' or HBC (LBD 1.9). 4.2.7 Social marketing programme – To provide marketing expertise and resources to the development and implementation of LBD's social marketing and communications strategy so as to ensure it achieves its goals (LBD 2.1). 4.2.8 HealthPoints – To evaluate the feasibility and possible mechanics of a card or stamps based system to reward healthier retail (food initially) purchases. 4.2.9 Communications on initiatives – To explore ways in which the community of Counties Manukau can be informed on and kept up to date on food industry initiatives that support improved health outcomes. **Key partners:** CMDHB, FIG.	• By October 2006, work programme for 2005/2006 completed.	**Process outcomes** • Reduction in sugar intake for children. • Improved food options in at risk areas. • Localised responsiveness and action by the food industry. • Food industry make changes that achieve health goals alongside commercial goals. **Health outcomes** • Improved nutrition leading to a reduction in obesity.	**CMDHB** Funding as per 3.1. Project management, contract management, health leadership, guidance, advice networks. **FIG** Funding as per 3.1. Food industry leadership, expertise, guidance, advice, networks.

Interventions/initiatives	KPIs/milestones	Outcomes	Resources
4.3 Developing and implementing a detailed work programme for 2006/2007. JIG's co-funded advocate will develop a detailed work programme for 2006/2007 and implement specific projects, as defined by JIG. The work programme is to include high-level strategic initiatives as well as local initiatives, and to be aligned to and support other LBD interventions/initiatives. **Key partners:** CMDHB, FIG, LBD partners.	• By October 2006, draft work programme for 2006/2007 presented to JIG for endorsement. • By October 2006, implementation of work programme for 2006/2007 commenced.	**Process outcomes** • Reduction in sugar intake for children. • Improved food options in at risk areas. • Localised responsiveness and action by the food industry. • Food industry make changes that achieve health goals alongside commercial goals. **Health outcomes** • Improved nutrition leading to a reduction in obesity.	**CMDHB** Funding as per 3.1. Project management, contract management, health leadership, guidance, advice networks. **FIG** Funding as per 3.1. Food industry leadership, expertise, guidance, advice, networks. **LBD partners** Input, support, networks, guidance, advice.

Action Area 5 – Strengthening Health Promotion Co-ordination and Activity

A vibrant, skilled and co-operative health promotion sector that works effectively with all groups and in all settings to reduce the incidence and impact of diabetes and health inequalities. All actions must be culturally responsive to the needs and aspirations of Maori, Pacific peoples, Asians and other ethnic groups. To this end, Maori, Pacific peoples, Asians and other ethnics groups will be involved in all facets of design, development and implementation.

Strong, co-ordinated and targeted health promotion is integral to the success of *Let's Beat Diabetes* (LBD) and its aims of preventing diabetes, slowing the disease progression and improving the quality of life for people with diabetes. As a consequence, health promotion is undergoing a major transformation in Counties Manukau. Significant progress continues to be made in co-ordinating and aligning groups and ideas, understanding barriers to performance and identifying priorities.

During 2006/2007, LBD will work to enhance and support the sector by:

- consolidating a leadership hub to guide and lead the action area and its work programme
- supporting aligned actions through better co-ordination of the funding environment
- co-ordinated planning
- improving communications resources within health promotion and primary care
- improving workforce capacity, and
- enhancing Maori and Pacific programming and responsiveness.

Interventions/initiatives	KPIs/milestones	Outcomes	Resources
5.1 Consolidating the health promotion leadership hub for LBD In 2005/2006, the Community Organisations for Diabetes Action (CODA) forum agreed to be the leadership forum to provide guidance for, and take the lead for the health promotion area of LBD. CODA is facilitated by the Diabetes Projects Trust (DPT), and is comprised of health promotion leaders in nutrition and physical activity, and ethnically diverse. In 2006/2007, CODA will continue to be the leadership hub, and their role strengthened to include: • provision of advice to LBD on all matters relating to health promotion – resource development, workforce development, social marketing • provision of a central place for sharing information on health promotion activities relevant to diabetes prevention and management • provision of leadership for community health gain – organising health promotion organisations to work together on inputting into territorial authority and CMDHB plans and using other opportunities to influence towards a healthy community.	• By August 2007, contract with DPT completed.	**Process outcomes** • CODA provides effective leadership and facilitation on issues related to LBD health promotion. • Maori and Pacific workforce participate and are strengthened and supported. • Well informed, responsive and capable health promotion sector. • Enhanced collaboration in projects of mutual interest and benefit. **Health outcomes** • Long-term reduction in obesogenic environment and harmful lifestyles through an effective health promotion sector.	**CMDHB** $20,000 Project management, contract management. **DPT** Health promotion leadership, guidance, advice, networks, facilitation of meetings. **CODA** Health promotion leadership, guidance, advice, networks.

Interventions/initiatives	KPIs/milestones	Outcomes	Resources
Key partners: DPT, CODA which comprises: primary health organisations Health Promotion Working Group (PHO HPWG), Otara Health, East Health, TaPasefika, Auckland Regional Public Health Service (ARPHS), Manukau City Council (MCC), Diabetes Auckland, Whitiora Diabetes Service, National Heart Foundation (NHF), Royal New Zealand Foundation for the Blind (RNZFB), Lions Club, ProCare, Maori forum, Hapai Te Hauora, Mangere Community Health Trust.			
5.2 Developing and enhancing the health promotion and education workforce In 2005/2006, a health promotion core competencies framework for diabetes risk factors and disease management was developed (entitled *Upskilling Pathways for Health Promotion)*. The framework was developed in close consultation with Maori and Pacific providers, in recognition that all workforce development would require a particular focus on meeting the needs of Maori and Pacific providers, workforce and communities. In 2006/2007: • the framework report will be disseminated to all relevant organisations and groups in Counties Manukau • CMDHB and CODA will agree on which recommendations from the report are to be implemented, and provider(s) contracted to action. A basic level health education and promotion course for people working in diabetes prevention in Counties Manukau but have no formal qualifications will be developed and delivered. A single course would provide basic training for up to 25 people – with at least half of the participants Maori or Pacific peoples. The course, funded in partnership with the Ministry of Health (MoH), would provide generic health promotion skills and competencies but would also include a *Healthy Eating Health Action* (HEHA) and diabetes prevention focus. CMHDB will identify and contract a provider for the course. CMDHB and CODA will ensure the course is well marketed. CMDHB will ensure the course is evaluated to the MoH's satisfaction. Regular ongoing professional development for people involved in diabetes prevention and management health promotion and education would be provided via bimonthly meetings. CMDHB and CODA would decide the content of these meetings, but initial topics that have been identified include: • training in peer supervision models • how to provide input into territorial authorities, DHB and other organisations processes to bring about a healthier community. **Key partners:** CODA, MoH, Health Promotion Forum.	• By August 2006, core competencies framework report disseminated to all relevant organisations and groups. • By September 2006, recommendations from the core competencies framework to be actioned agreed to, and provider(s) contracted. • By August 2006, first basic level health education and promotion course held. • By June 2007, six professional development sessions held.	**Process outcomes** • More highly educated and skilled health promotion workforce. **Health outcomes** • Long-term reduction in obesogenic environment and harmful lifestyles through an effective health promotion sector.	**CMDHB** $40,000 Project management, contract management, leadership, promotion. **CODA** Health promotion leadership, guidance, advice, networks, promotion. **MoH** ($25,000). **Health Promotion Forum** Leadership, guidance, advice.

Interventions/initiatives	KPIs/milestones	Outcomes	Resources
5.3 Supporting recent graduates from train-the-trainer projects (pilot) CMDHB, supported by MoH, will contract a provider(s) to provide support for people who have completed train the trainer programmes within CMDHB. It has been identified that many of these people do not have the confidence, skills, or support to undertake the roles envisaged when they undertook the programmes. The project will take peer groups of people who complete a train the trainer programme and support them to become effective trainers. This will be done by: • establishing peer support groups supported by mentors • individual mentoring within the workplace as required • continuing educational events • working with other Train the Trainer services (e.g. DPT 'TTT2Prevent Diabetes') This project will be a pilot which will be evaluated. Its focus will be on Maori and Pacific peoples as this is where the greatest need has been identified. **Key partners:** CMDHB, MOH, Te Hotu Manawa Maori and Waipareira, mentors, Pacific provider(s) (tbc).	• By October 2006, four peer support groups (of 10–15 people) established and functioning. • By June 2007, all peer support groups have met three times a year. • By June 2007, mentors have visited peer support members 30 times (total). • By June 2007, continuing education events held.	**Process outcomes** • 50 people (predominantly Maori and Pacific peoples) mentored after completing train the trainer courses and feeling confident to take on training role. **Health outcomes** • Reduced obesity and diabetes amongst Maori due to increased community resource to support healthy lifestyles.	**CMDHB** $25,000 Project management, contract management, leadership, networks. **MoH** ($35,000) **Te Hotu Manawa Maori, Waipareira, Pacific provider(s) (tbc)** Provide train the trainer courses linking with the support programmes. Assist with evaluation.

Interventions/initiatives	KPIs/milestones	Outcomes	Resources
5.4 Developing nutrition and physical activity resources to support health promotion in the primary care setting Develop and compile together easy to use resources for general practices and other primary care members that provide clear, consistent, and best practice based ways to deliver health prevention in a primary care setting around healthy eating and healthy action. The aim is to ensure prevention work is easy to do, and that the information and key messages disseminated is consistent with that given by the wider health promotion sector. The resources will include those already developed by LBD such as the Community Nutrition Project, the resource project, health promotion and education competencies, and may include new resources such as: • guidelines • key messages • brief interventions teaching manuals • intensive interventions teaching manuals • background information • teaching resources • IT resources • patient resources • education available for health professionals • information on instituting good systems in primary care • community resources • linkages with health promotion activities, how they can support primary care, and how primary care teams can support them. All components will need to be developed in a way that enhances primary cares ability to undertake effective health promotion with high needs groups, including ensuring that resources are culturally appropriate. To this end, a steering group representative of key stakeholders will be established to oversee this work. All information will be developed in collaboration with PHOs (including Maori and Pacific PHOs and Maori and Pacific advisers from mainstream PHOs and other organisations) and introduced at a pace that primary care can sustain. The supportive resources will need ongoing funding. CMDHB will seek funding partners. Potential partners include PHOs and MoH. **Key partners:** CMDHB, PHOs, MoH, ARPHS, CM Sport, CODA.	• By July 2006, budget finalised. • By August 2006, steering group established. • By September 2006, provider(s) contracted to develop and/or compile resources. • By February 2007, resources completed and disseminated to primary care settings.	**Process outcomes** • Increased health prevention undertaken around healthy eating and healthy action within primary care. • Improved quality of health promotion undertaken in primary care. • Model for other areas of health promotion. • Increased collaboration between primary care and health promotion. **Health outcomes** Increased levels of physical activity and healthy eating particularly in risk groups.	**CMDHB** $15,000 (depending on co-funding. Total budget $100,000). Project management, contract management, sourcing of funding, establishment and management of steering group, health leadership and expertise. **PHOs** Health leadership, guidance and expertise; some have indicated funding (tbc). **ARPHS** Health leadership, support, funding (tbc). **MoH** Funding (tbc). **CODA** Community health promoter; consultation.

Interventions/initiatives	KPIs/milestones	Outcomes	Resources
5.5 Developing the physical activity workforce and activity opportunities (contingent on funding) CMDHB, CM Sport, MCC, FDC and PDC are currently developing a programme to achieve a sustainable increase in physical activity capacity and involvement in the district. Implementation of the programme is contingent upon obtaining significant funding from Sport and Recreation New Zealand (SPARC). A decision should be made by October 2006. The programme looks to build on existing work done through LBD and CMDHB's LotuMoui programme, and support Green Prescriptions and other physical activity programmes. The first strand of activity is a 'train the trainer' concept which would lead to a rapid expansion of the number of trained people and appropriate programmes for delivering physical activity in Counties Manukau (CM). This training would target Maori, Pacific and youth trainers to enable the extension of provision of activity to these target groups; and include community leaders, volunteers, facility and health promotion workforce. The settings for these trainings would include marae, churches and diabetes self-management education settings through primary care. The second and related strand of activity is the establishment of 'Activity Hubs' across the district to maximise capability for physical activity provision, through enhanced intersectoral collaboration between communities, schools, workplaces, sports clubs, health organisations/providers and local government. 'Activity Hub' co-ordinators would be appointed to develop the hubs, with an emphasis on building sustainable community infrastructure and provision. CM Sport is project managing the funding bid, and if the bid successful, will oversee implementation of the programme. CMDHB will co-fund the training, and work with CM Sport, MCC, FDC and PDC to identify and contract the appropriate training provider(s), and develop opportunities for implementing key learnings within local communities. MCC, FDC and PDC will co-fund activity hub development, Identify hub locations and plan activities to be promoted through hubs. The PHO Health Promotion Working Group (PHOHPWG) will co-fund relevant components of funding bid. Identify and action linkages between hubs and PHOs. **Key partners:** CMDHB, MCC, PDC, FDC, CM Sport, PHOHPWG.	• By September 2006, SPARC funding bid application finalised. • By November 2006, training provider(s) contracted. • By March 2007, first wave of trainings completed.	**Process outcomes** • Improved opportunities for physical activity in Counties Manukau, with particular improvements in areas of high need. **Health outcomes** • Improved physical activity leading to a reduction in obesity and diabetes in the long term.	**CMDHB** $30,000 (indicative only, and with ongoing contributions over subsequent three years). Health leadership, expertise, networks. **CM Sport** Project managing the funding bid, and if the bid successful, will over see the implementation of the programme. **MCC, FDC and PDC** Co-fund activity hub development; identify hub locations; and plan activities to be promoted through hubs. **PHOHPWG** Co-fund relevant components of funding bid. Identify and action linkages between hubs and PHOs.

Action Area 6 – Enhancing Well Child Services to Reduce Childhood Obesity

Children begin their lives in an environment that supports life long health.

The importance of the health of our young children was echoed in hui and fono undertaken as part of the *Let's Beat Diabetes* (LBD) planning process, where Maori and Pacific peoples gave strong guidance that LBD must focus strongly on our future generations, and place more effort on protecting children from obesity and subsequent disease. Childhood obesity can lead to early onset of diabetes and is a strong predictor of adult obesity.

There are currently a number of major changes in the services focusing on the early years, which create opportunities for review and redevelopment of approaches to improve nutrition and activity for young children. Counties Manukau District Health Board (CMDHB) is working with maternal and Well Child providers to review service provision. The Family Start programme offers opportunities for Well Child providers to be involved in broader whole-family multiple-issues approach to be taken with our most vulnerable families. There is a growing awareness at the levels of research, policy and practice that our current Well Child framework needs to place more emphasis on nutrition and activity in the early years and the long-term implications of early onset obesity. There has been mainstream adoption of the evidence that points to increasing risks of diabetes for children born from mothers who are in a pre-diabetic state. Recent changes to Well Child funding have allowed for more flexibility and intensity of service when dealing with vulnerable families.

Interventions/initiatives	KPIs/milestones	Outcomes	Resources
6.1 Supporting the existing Well Child forum to be the leadership hub for the Well Child action area In 2005/2006, the Well Child provider forum agreed to be the leadership hub for the LBD Well Child action area, and oversee its work programme. It will continue to do so in 2006/2007. The Well Child provider forum will provide leadership and guidance on the ongoing development of Well Child framework, and maintain linkages with the LBD programme to ensure shared learnings and opportunities for improving nutrition and physical activity in young families. **Key partners:** Well Child provider forum and individual Well Child providers (Plunket; Papakura Marae Tamariki Ora; Turuki Healthcare Tamariki Ora for Raukura o Tainui; South Seas Healthcare), CMDHB.	• Bi-monthly meeting held. • Well Child related LBD plans and actions presented for review and recommendation on a case by case basis. • Active scrutiny of plans and progress with recommendations and advice to CMDHB on a case by case basis, by the specified timeframes.	**Process outcomes** • Providers are supported to be actively involved on a regular basis. **Health outcomes** • Provider experience will contribute to ensuring initiatives planned are practical and can be successfully implemented. • Improved nutrition and physical activity in young families leading to a reduction in obesity and diabetes in the long term.	**CMDHB** Non-budget item. Funding from Child Health. **Well Child provider forum and individual providers** Knowledge and expertise, leadership, networks.

Interventions/initiatives	KPIs/milestones	Outcomes	Resources
6.2 Scoping and development of appropriate nutrition and diabetes resources to support Well Child providers In 2005/2006, a review of the literature available to establish any identifiable risk factors for diabetes and/or childhood obesity that could be factored into the Well Child assessment tool. . In 2006/2007, CMDHB and the Well Child provider forum will look to build on this review. A provider(s) will be contracted to; scope the resources available to Well Child providers to support young families around nutrition and physical activity needs for growing children and to also identify gaps in resources or the distribution of resources; and if needed, develop resources to supplement the toolkit available to Well Child providers. **Key partners:** Well Child provider forum, CMDHB.	• By August 2006, review and recommendations presented to Well Child leadership hub for guidance on implementation. • By November 2006, implementation commenced.	**Process outcomes** • Updated evidence based review of literature in relation to early years and risk factors for diabetes for Counties Manukau. **Health outcomes** (Awaits outcome of review) • Improved nutrition and physical activity in young families leading to a reduction in obesity and diabetes in the long term.	**LBD:** $40,000 Project management, contract management. **Well Child provider forum and individual providers** Knowledge and expertise, leadership, networks
6.3 Developing a research proposal exploring age 0–5 obesity pathways among current 5–10 year old children A research proposal for exploring age 0–5 obesity pathways among current 5–10 year old children will be developed to identify if there are new or notable obesity risk factors or trends for the Counties Manukau populations in the early years that could then be targeted for intervention. **Key partners:** CMDHB, Well Child providers, primary care, Public Health Nursing Service, paediatrician.	• By September 2006, proposal brief drafted, disseminated to key stakeholder groups for comment. • By November 2006, appropriate person to scope and develop proposal contracted. • By January 2007 proposal completed. • By January 2007, proposal presented to Well Child provider forum and other key stakeholders for review and guidance on practical implications. • By February 2007, submission for funding support for proposal completed (dependent on support from key stakeholders).	**Process outcomes** • Advancement of knowledge regarding possible risk factors for obesity in the under five age group population of Counties Manukau. **Health outcomes** • Earlier intervention and education of families leading to reduction of obesity risk factors and in the longer term obesity and diabetes	**LBD:** $5,000 Project management, contract management, sourcing of funding. **Well Child provider forum and individual providers** Knowledge and expertise, leadership, networks.

Action Area 7 – Supporting Schools to Ensure Children are 'Fit, Healthy and Ready to Learn'

Schools are an environment that protects against obesity.

Activity levels in Counties Manukau children are 15% below the national average. It is often schools that service the most at-risk communities which have the least resources to support good nutrition and physical activity. Anecdotal evidence indicates that schools have been placing less emphasis on physical activity over the past decade in favour of spending extra time on academic subjects. However, emerging international evidence shows that improved nutrition and physical activity levels in schools support improved behavioural and academic outcomes (and also financial outcomes) for schools. Schools need to understand that by becoming health promoting environments they are improving their children's potential for learning success.

The nutrition and physical activity environments in schools are characterised by multiple providers and programmes with no overall co-ordination or direction. Schools are confused and fatigued due to external providers raising expectations which cannot be met with internal school resources. During 2006/2007, *Let's Beat Diabetes* (LBD) will focus on:

- enhancing the co-ordination of existing health promotion providers to minimise schools' confusion and fatigue
- further developing the leadership hub to oversee strategy development
- enhancing and supporting the AIMHI/NEW pilot in selected high risk secondary schools
- rolling out the 'healthy canteen' business model, and supporting schools to improve 'drinks' environment in and around schools
- developing new funding streams to support schools to make sustainable changes
- supporting Kohanga Reo, Kura Kaupapa and Pacific language nests to enhance or develop and implement nutrition and physical activity policy and programmes

Interventions/initiatives	KPIs/milestones	Outcomes	Resources
7.1 Supporting kohanga reo and kura kaupapa in nutrition and physical activity Counties Manukau District Health Board (CMDHB) is developing a partnership relationship with Te Kohanga Reo Regional Unit. The aim of this relationship is for the two partners to work together to support education and health outcomes for tamariki. To support this work, CMDHB will contract a provider(s) to: • identify kohanga reo and kura kaupapa in the Counties Manukau region • do a stocktake of policy and current practice, and undertake a gaps and needs analysis • provide support to enhance or develop and implement nutrition and physical activity policy and programmes • provide training for kohanga staff • provide resources • link kohanga to local health promotion providers to provide mentoring/ongoing support • provide support to kura kaupapa / bilingual / immersion units involved in health promoting schools (HPS). Key organisations and groups to be involved in this process include Manukau City Council (MCC), key kohanga reo personnel, key kura kaupapa personnel, Hapai, Counties Manukau Sport (CM Sport), and health promotion providers. This initiative builds on activity done in 2005/2006 by MCC, CMDHB and partners. **Key partners:** CMDHB, Te Kohanga Reo Regional Unit, kohanga reo, kura kaupapa, MCC, CM Sport, Hapai, health promotion providers.	• By August 2006, stocktake completed. • By April 2007, training and resources developed.	**Process outcomes** • Sustainable changes to early childhood environment for tamariki. • Creation of relationships and platform for further interventions/ initiatives in future years. • Increased knowledge for tamariki and kohanga staff. • Increased knowledge for tamariki and school staff/community involved in Maori language classes. **Health outcomes** • Reduction in obesity and diabetes amongst tamariki Maori.	**CMDHB** $30,000 Funding from Maori Health. Project management, contract management, leadership. **Te Kohanga Reo Regional Unit, kohanga reo, kura kaupapa** Leadership, guidance, advice, networks. **MCC, CM Sport** Advice and input into programme development, physical activity.

Interventions/initiatives	KPIs/milestones	Outcomes	Resources
7.2 Supporting Pacific language nests to enhance or develop and implement nutrition and physical activity guidelines and programmes as part of programme delivery In 2005/2006, CMDHB in collaboration with Auckland Regional Public Health Service (ARPHS) and TaPasefika Health Trust developed and implemented a nutrition education training module and nutrition toolkit for 33 Pacific early childhood education centres (ECEs) in the district. Resources have been developed to support the ECE to implement nutrition guidelines for under fives as part of their Te Whaariki curriculum. Building on this work and relationships, CMDHB and ARPHS, together with CM Sport, will develop and implement a physical activity module for children aged five years and under. **Key partners:** CMDHB, ARPHS, CM Sport, Sport and Recreation New Zealand (SPARC), Pacific ECEs, Ministry of Education (MOE)	• By June 2007, physical activity resources, toolkit and training module that is appropriate for Pacific ECEs developed. • By June 2007, physical activity training modules delivered.	**Process outcomes** • Increased knowledge for children and early childhood education staff. **Health outcomes** • Reduction in childhood obesity levels.	**CMDHB** $30,000 Project management, contract management, leadership. **ARPHS** Support the delivery of and provide advice on the planning and development of physical activity resources. **CM Sport, SPARC** Provide expertise in the planning and development of physical activity resources, toolkit and training modules. **Pacific ECEs** Participation. **MOE** Support and provide advice on the planning and development of physical activity resources.

Interventions/initiatives	KPIs/milestones	Outcomes	Resources
7.3 Strengthening the Counties Manukau healthy schools leadership hub The schools leadership hub established in 2005/2006 will be strengthened to include wider representation from primary, secondary and intermediate schools' principals, staff and Board of Trustees; health service providers; recreation services providers and NGO groups. CMDHB will facilitate this process and meetings, and ensure close partnership relationships with existing forums such as NEW/AIMHI. The purpose of the group will to enhance and maintain existing work in developing School Accord strategies whereby children and young people will be supported in physical activities; whole school approaches; fruit in schools; school canteens will provide healthy menus and portion controlled diet drinks will be available. Fundamental to this will be its youth development approach/model. Further work will focus on improving school principals and Boards of Trustees' awareness of the evidence supporting improved educational outcomes when children are achieving appropriate physical activities levels and nutrition. Support will be sought from MOE, Ministry of Health (MoH) and Sport and Recreation New Zealand (SPARC). A key outcome of the leadership hub in 2006/2007 will be development and initiation of an exemplar collaborative project involving education, activity and health sectors, for which CMDHB will provide catalyst funding. **Key partners:** CMDHB, leadership hub comprising – primary, secondary and intermediate school principals, staff, board of trustees, MCC, CM Sport, Diabetes Projects Trust (DPT), ARPHS, Health Promoting Schools (HPS).	• By July 2006, scoping of related providers completed. • By September 2006, position paper. • By October 2006, needs analysis of schools completed. • By November 2006, regional implementation plan. • By December 2006, exemplar prototype activity in specific schools development and specification. • By December 2006, development of a district-wide funding plan. • By February 2007, initiation of exemplar project.	**Process outcomes** • Aligned cross-district multi-sectoral communications and leadership. • Strategic environment developed where LBD plans are supported. • Improved information available for schools. **Health outcomes** • Reduction in rates of obese and overweight children in at risk adolescent population. • Healthy eating patterns. • Increased youth participation. • Increased primary school student/ community involvement.	**CMDHB** $80,000 (includes project support). Project management; contract management; leadership; facilitation of meetings. **Counties Manukau schools** Advice and input; centres for co-ordination. **MCC** Support and development. **HPS** Support for 'whole school' approaches. **CM Sport** Provision of physical activities, advice and input into schools. **DPT** Advice and knowledge of secondary school approaches of working comprehensively to address health and nutrition and physical activities. **ARPHS** Advice and collaboration around collaborative projects.

Interventions/initiatives	KPIs/milestones	Outcomes	Resources
7.4 Enhancing and supporting NEW/AIMHI intervention in selected high schools CMDHB will continue to support the existing NEW/AIMHI programme GetWize2Health delivered by DPT into selected high risk secondary schools. The Nutrition, Exercise and Weight (NEW) programme provides modules of service, based on the needs of the students and school focusing on developing sustainable programmes for physical activity; and nutrition. Six new sites will receive a range of activities similar to but less extensive than the original NEW model. This is expected to cover 62% of Maori secondary students and 85% of Pacific secondary students. **Key partners:** CMDHB, DPT, the schools, MCC, HPS, CM Sport, ARPHS, Ministry of Health (MoH).	• By December 2006, roll-out of additional NEW sites.	**Process outcomes** • Changed school environment from a health risk to health promoting environment. • Sustainable changes into school systems, infrastructure teachers/ student leadership. • Research that provides powerful empirical evidence of effectiveness of population health interventions in secondary school environment. • Increased knowledge and attitudes to nutrition and physical activity for target youth. • Increased family/whanau knowledge and culture regarding obesity from influence of informed youth. **Health outcomes** • Reduction in rates of obese and overweight young people at risk. • Healthy eating patterns of young people. • Increased youth participation.	**CMDHB** $60,000 Project management; contract management. **DPT** Programme implementation; knowledge and expertise. **Counties Manukau schools** Advice and input; centres for co-ordination. **MCC** Support and development. **MoH** Funding.

Interventions/initiatives	KPIs/milestones	Outcomes	Resources
7.5 Enhancing and supporting ongoing development of whole school approaches and new initiatives in schools CMDB will support the ongoing development of whole school approaches and initiatives in designated schools, and ensure their alignment with other health interventions in schools to support collaborative cross agency schools interventions in the areas of physical activity and nutrition. **Key partners:** CMDHB, MCC, CM Sport, DPT, Oral Health, Hapai, ARPHS, Manukau Institute of Technology (MIT), School Principals Association, MoH.		**Process outcomes** • Changed school environment from a health risk to health promoting environment. • Sustainable changes into school systems, infrastructure teachers/ student leadership. • Increased knowledge and attitudes to nutrition and physical activity for target children. • Increased family/whanau knowledge and culture regarding obesity from influence of informed children. **Health outcomes** • Reduction in rates of obese and overweight children in at risk adolescent population. • Healthy eating patterns of young people.	**CMDHB** Non-budget item. Leadership; networks. **MCC, CM Sport, DPT, Oral Health, Hapai, ARPHS, MIT, Schools Principals Association** Support and co-ordination. **MoH** Funding for Fruit in Schools contracts.
7.6 Supporting the implementation of the Healthy Tuckshop Business model In 2005/2006, the Healthy Tuckshop Business model (pilot) was developed to enable schools to run viable businesses offering healthy, nutritious options. The model is currently being implemented at Tangaroa College and will be evaluated in 2006/2007. In 2006/2007, CMDHB, DPT and MOH will support the implementation of the Healthy Tuckshop Business model across most decile 1 and 2 secondary schools in Counties Manukau, as schools identify their needs and define the support they require. This is expected to cover 62% of Maori secondary students and 85% of Pacific secondary students. CMDHB will also share the key findings and learnings of the pilot evaluation once completed. This information will also be made available to all primary, intermediate and secondary schools in the district. **Key partners:** CMDHB, MoH, the schools, MCC, HPS, DPT, ARPHS.	• By June 2007, model implemented in all decile 1 and 2 secondary schools. • By February 2007, evaluation key findings and learnings shared with schools.	**Process outcomes** • Information shared with all relevant providers, schools and services. • Nine secondary schools will have active support to improve their tuckshop. **Health outcomes** • Reduction in rates of obese and overweight children in at risk adolescent population. • Healthy eating patterns.	**CMDHB** $15,000 Project management; contract management; leadership. **MoH** Funding. **Counties Manukau schools** Sharing of best practice and information. **MCC, HPS, ARPHS** Support in development. **DPT** Provision of the model and development of the initiative.

Interventions/initiatives	KPIs/milestones	Outcomes	Resources
7.7 Developing new funding streams to support schools and communities to make sustainable changes The scope of the changes required in school and community environments is larger than CMDHB resources can support, and there appear to be few other direct resources available at present from other sources. In 2006/2007, CMDHB will continue to look for potential funders and sponsors to support schools and communities to make sustainable changes. Potential funders or sponsors include the South Auckland Health Foundation (SAHF) and its partners and SPARC. As stated in LBD 5.5, CMDHB, CM Sport, MCC, Franklin District Council (FDC) and Papakura District Council (PDC) are submitting a collaborative proposal to SPARC for significant funding to support LBD activities. It is anticipated that if successful, some of this funding will be channelled to support this action area. A fundraising design that is acceptable to schools, councils, the health sector, SAHF and sponsors will be also developed. **Key partners:** CMDHB, SAHF.		**Process outcomes** • Increased resources available to support change process for schools and communities. **Health outcomes** • Reduction in rates of obese and overweight children in at risk adolescent population.	**CMDHB** Non-budget item. Leadership; sourcing of funding or sponsors.

Action Area 8 – Supporting Primary Care-Based Prevention and Early Intervention

Primary health care proactively works with patients and their families to reduce diabetes risk and improve disease management.

Improving primary care based prevention and management of diabetes is a key component of *Let's Beat Diabetes* (LBD). LBD will build on the foundations of the Chronic Care Management programme (CCM) to:

- move the primary care focus 'upstream' in the diabetes progression and improve primary care based prevention, early identification, patient education and self management
- ensure greater commitment to the New Zealand guidelines for screening, post diagnosis education and structured care
- investigate family/whanau approach as a means to improving management of disease and family risk, and
- improve the Get Checked programme through better reporting/feedback/transparency and increased case detection/management rates, especially for Maori.

In addition, primary care will link closely with other LBD activities particularly those relating to managing obesity, improving nutrition and physical activity. The seven primary care workstreams and their proposed activities/KPIs for 2006/2007 are outlined below.

Interventions/initiatives	KPIs/milestones	Outcomes	Resources
8.1 Strengthening the leadership structure to guide improvements of diabetes management in the primary care setting The Diabetes/Cardiovascular Disease (CVD) Advisory Group (DCAG) was established in 2005 to guide improvements of diabetes management within the primary care sector. It has a broad scope covering all the LBD primary care action areas as outlined in this section, as well as the previous Diabetes Advisory Group and the CCM advisory groups on CVD and diabetes. DCAG will require strong clinical leadership and ongoing review of its functioning to ensure the terms of reference are being met. • DCAG continues to meet monthly – ongoing. • Provide monthly progress reports provided to GPHO – ongoing. • Provide clinical support to Chair to develop strong leadership – ongoing. **Key partners:** DCAG is the key partner in all of the primary care activity areas. DCAG is a clinical advisory group representing PHOs, GPs, practice nurses, Whitiora Diabetes Services, community pharmacy, Maori and Pacific.	• By September 2006, review of DCAG to ensure the terms of reference are feasible and being met completed.	**Process outcomes** • Informed debate guides implementation of LBD primary care action area. • Key organisational and professional groups are aligned with approach. • Comprehensive approach across diabetes/CVD and disease state reduces inefficient silo thinking.	**CMDHB** $75,000 (includes project management). Leadership; facilitation and administration of meetings

Interventions/initiatives	KPIs/milestones	Outcomes	Resources
8.2 Developing a diabetes care framework for Counties Manukau In 2005/2006, work on developing a model for adopting the NZGG Type 2 Diabetes guidelines from diagnosis to management was commenced. It included identification of key areas for improvement and recommendations on the implementation of this model within Counties Manukau. In 2006/2007, the focus will be on: • further development of the model for implementing NZGG Type 2 Diabetes Guidelines including: identification of key intervention points that will lead to improved services; development of proposals to address these key areas, and identification of key clinical indicators • DCAG to consider the proposed model and assess its implications for implementation within Counties Manukau • enhance opportunities for primary care clinicians to improve linkages/training with secondary care outpatient services • consider ways to increase the awareness and uptake of Green Prescriptions. **Key partners:** CMDHB, DCAG, general managers of primary health organisations (GPHO).	• If appropriate, by November 2006 develop a series of recommendations for implementation. • By July 2006, development of the model completed. • By August 2006, presentation of the model to DCAG for consideration. • By March 2007, enhanced opportunities for primary care clinicians to improve linkages/ training with secondary care outpatient services. • By November 2006, ways to increase awareness and uptake of Green Prescriptions considered.	**Process outcomes** • An explicit guideline based approach creates a strategic framework for primary care response to diabetes. The approach is understood by and supported by DHBs and PHOs. • Increased uptake of guideline based structured care. **Health outcomes** • Slowing of disease progression.	**CMDHB** $15,000 **DCAG** Leadership, guidance and advice. **GPHO** To review and advise, and assist with implementation.
8.3 Supporting the improved use of lifestyle management skills for modifying obesity risk factors – community nutrition project In 2005/2006, CMDHB developed the Community Nutrition Project (CNP) – a brief intervention aimed at modifying obesity risk factors in a primary care setting. It was piloted in two PHOs – Te Kupenga O Hoturoa (TKOH) and Mangere Community Health Trust. In 2006/2007, the focus will be on completing the pilot, evaluating its effectiveness, modifying the programme (if necessary) and making a decision on its possible extension to PHOs. Key steps include: • production of final version of training manual • monitoring of patients for intervention • development and assessment of baseline core competencies for providing nutrition education support • evaluation of intervention • presentation of evaluation to DCAG to consider rollout. **Key partners:** CMDHB, DCAG, TKOH, Mangere Community Health.	• By December 2006, completion of evaluation on training and support programme. • By March 2007, presentation of evaluation to DCAG for consideration.	**Process outcomes** • Improved management of obesity risk factors in primary care setting. • Improved primary care capacity for managing lifestyle and weight management issues. • Evaluation of group versus individual intervention. • Evaluation of whether the intervention has an impact on weight loss. • Evaluation of whether the training of CHWs is an effective delivery method for nutrition education. **Health outcomes** • Reduction in obesity. • Slowing of disease progression.	**CMDHB** Non-budget item. Additional funding from Primary Care; project management, contract management, leadership. **PHOs** Participation, implementation.

Interventions/initiatives	KPIs/milestones	Outcomes	Resources
8.4 Supporting the implementation of the self management education programme to improve the uptake of best practice post diagnosis education In 2005/2006, CMDHB in partnership with DCAG, oversaw the development of criteria for a Self Management Education Programme (SME) in primary care to improve the uptake of best practice post diagnosis education. A draft programme and core competencies for SME facilitators to implement the programme were also developed. In 2006/2007, the focus will be on completing the development of the SME programme and overseeing its implementation. The programme will be a district-wide service using a central co-ordinator , Maori and Pacific facilitators, and PHO-based SME facilitators, with specific reference to development of SME groups in Maori and Pacific populations. Key steps include: • developing curriculum for trainers, credentialing, and evaluation criteria • developing service specification and RFP documentation • undertaking RFP process and select training provider • developing evaluation criteria and process. **Key partners:** CMDHB, DCAG, GPHO.	• By August 2006, curriculum, credentialing and evaluation criteria for trainers completed. • By August 2006, service specifications and training curriculum completed. • By September 2006, training provider(s) contracted. • By October 2006, SME facilitators and SME Coordinator in place. • By November 2006, DSME programme roll-out in PHOs. • By January 2007, development of evaluation criteria and process completed.	**Process outcomes** • Improved adherence to medication and lifestyle change interventions. • Enhanced role of person with diabetes as an educator for their own family on risk factors and lifestyle change. **Health outcomes** • Reduction in obesity. • Reduction in smoking. • Slowing of disease progression • Reduction in CVD risk. • Improved management of all chronic conditions.	**CMDHB** $25,000 Additional funding from Primary Care; project management; clinical expertise. **PHOs** Will work with CMDHB to enable the successful implementation of a PHO based SME programme.
8.5 Trialling and evaluating increased use of family/whanau/groups support for obesity risk factors and diabetes management In 2005/2006, CMDHB in partnership with DCAG: • developed the whanau support pilot for Maori which included hui, and focus groups, and • developed a proposal for the provision of family support for morbidly obese Pacific peoples. In 2006/2007, the focus will be on considering innovative ways to increase Whanau/ family/group participation within mainstream primary care and develop proposals to implement pilots with PHOs. **Key partners:** CMDHB, DCAG, GPHO.	• By July 2006, formative evaluations of the Maori and Pacific pilots underway. • By February 2007, evaluations completed. • By March 2007, decision on future of pilots made.	**Process outcomes** • Increased adherence to medication and lifestyle change. • Supported knowledgeable 'lay champions' for diabetes prevention and management within the community. • Changed lifestyle behaviour through entire family/whanau/group. • Improved self management of complications. **Health outcomes** • Slowing of disease progression. • Reduction in obesity in at risk community (and family/whanau of person with diabetes). • Reduction in harm from complications.	**CMDHB** $30,000 Additional funding from Primary Care. **GPHO** To assist with implementation.

Interventions/initiatives	KPIs/milestones	Outcomes	Resources
8.6 Developing a whole system approach to improving rate of diagnosed diabetes – risk screening In 2005/2006, CMDHB in partnership with DCAG, investigated ways of developing a whole system approach to improve the rate of diagnosing diabetes. In 2006/2007, the focus will be on reviewing the options/recommendations proposed in the diabetes/CVD risk screening scoping exercise, and pilot a number of initiatives with PHOs. A proactive approach to support increased risk screening will be taken, supported by LBD's social marketing and health promotion programmes. Key steps include: • development of options for increased screening via systematic opportunistic screening in primary care. The remaining activities will depend largely on the outcome of the above options report, but will include: consultation with key stakeholders, implementation of a pilot(s), evaluation of the pilot(s) and decision on roll-out. **Key partners:** CMDHB, DCAG, GPHO, PHOs.	• By September 2006, position paper refined and detailed proposal developed. • By August 2006, options for increased screening in primary care developed.	**Process outcomes** • If appropriate, design and development of integrated screening for diabetes/CVD. **Health outcomes** • Identification of diabetes early to provide improved opportunity for control. • Reduction in CVD risk.	**CMDHB** $30,000 Additional funding from Primary Care; project management; contract management; leadership. **DCAG and GPHO** Leadership, to review and advise, assist with prioritisation. **PHOs** Implementation.
8.7 Strengthening the Get Checked Programme in Counties Manukau CMDHB will provide ongoing monitoring of access to diabetes services, with a particular focus on Annual Diabetes Review. It will also, in partnership with DCAG, develop a long term cost effective strategy for improving the quality and data collection for the Get Checked programme and improving PHO performance. Key steps include: • working with individual PHOs to resolve various information technology(IT)/systems issues • providing quarterly reports to DCAG on PHO performance • working with PHOs to improve uptake and performance • reviewing and improving the quality of the Get Checked reporting from PHOs • establishing a DCAG working group to develop a long term cost effective strategy for collecting Get Checked data and improving PHO performance • undertaking a pricing review for the Get Checked service – August 2006 • considering extension of the programme to include people with high CVD risk. **Key partners:** CMDHB, DCAG, PHOs	• By August 2006, DCAG working group to work on project established. • By August 2006, pricing review for Get Checked service under way. • By February 2007, annual report provided to MoH on uptake of Annual Diabetes Review in CMDHB in 2005 including targets for 2006.	**Process outcomes** • Improved data quality and transparency. • Increased adherence to medication and lifestyle change • Improved management of complications. **Health outcomes** • Identification of diabetes early to provide improved opportunity for control. • Slowing of disease progression.	**CMDHB** Non-budget item. Funding from Primary Care. **DCAG** Leadership. **GPHO** To review and advise. **PHOs** Responsible for reporting and monitoring performance of practices.

Action Area 9 – Enabling Vulnerable Families to Make Healthy Choices

***Vulnerable families are able to make healthy choices*.**

Many families in Counties Manukau find it very difficult to live healthy lives and are vulnerable. Vulnerable families may have low incomes through unemployment or low-wage jobs, be new immigrants, have relationship difficulties, suffer from domestic violence or crime, or simply become isolated in their community. It is these vulnerable families, for whom a healthy lifestyle is a low priority, who are most at risk of diabetes.

The Ministry of Social Development (MSD) Family and Community Service (FACS) is working with Counties Manukau District Health Board (CMDHB) to provide leadership for the development of integrated services that focus on the situation and needs of vulnerable families to reduce the risk of obesity and diabetes, and to provide better support and opportunity for those with diabetes and complications.

In 2005/2006, the focus was on establishing the multi-sector leadership hub for this action area, and creating pathways for closer working relationships between health and social service providers. The focus for 2006/2007 will be on strengthening these and action.

Interventions/initiatives	KPIs/milestones	Outcomes	Resources
9.1 Strengthening the leadership hub for the vulnerable families action area In 2005/2006, the Ministry of Social Development's (MSD) Strengthening Families (SF) Steering Group agreed to be the leadership hub for the LBD Vulnerable Families action area, and verse its work programme. It will continue to do in 2006/2007, and together with CMDHB, identify shared outcomes and incorporation. SF is an existing cross-sector collaborative process for case management of vulnerable families. **Key partners:** MSD, SF, CMDHB.		**Process outcomes** • Approaches to vulnerable families co-ordinated across agencies. • LBD agenda taken up by other agencies focusing on risk factors for poor health and social outcomes. **Health outcomes** • Long-term reduction in diabetes risk factors (particularly obesity) assisted by heightened collaboration across sectors.	**CMDHB** Non-budget item. Participation; health knowledge and expertise; networks. **MSD, SF** Leadership; participation; information provision; collaboration.
9.2 Consolidating and implementing the work programme for 2006/2007 SF and CMDHB will consolidate the work programme for 2006/2007, which identifies shared outcomes and specific interventions/initiatives to be implemented. The work programme will include high-level strategic initiatives as well as local initiatives, and be aligned to and support other LBD interventions/initiatives. **Key partners:** CMDHB, SF.	• By October 2006, identification of shared outcomes and activities.	**Process outcomes** • Approaches to vulnerable families co-ordinated across agencies. • LBD agenda taken up by other agencies focusing on risk factors for poor health and social outcomes. **Health outcomes** • Long-term reduction in diabetes risk factors (particularly obesity) assisted by heightened collaboration across sectors.	**CMDHB** Non-budget item. Participation, health knowledge and expertise, networks. **MSD and SF** Leadership, participation, information provision, collaboration.

Interventions/initiatives	KPIs/milestones	Outcomes	Resources
9.2 Enhancing Strengthening Families by including diabetes risk factors into review processes, with defined linkages and referrals to the health sector The aim of this work area is to improve awareness and knowledge about the risks vulnerable low income families have in relation to obesity and diabetes, so SF is able to build it into their existing case co-ordination programme. This will be achieved through joint activities between CMDHB and FACS within MSD. Work in 2006/07 will focus on how vulnerable families can be assisted to adopt and/or afford healthier lifestyles. Possible work areas include: • developing information pack for SF staff on risk factors and support services • enhancing budgeting assistance to support purchase of healthy food options • raising awareness of benefit entitlements, including disability allowances and special benefits. **Key partners:** CMDHB, SF, MSD, FACS.	• By October 2006, information on benefit entitlements distributed to PHOs and other identified health services. • By December 2006, information packs on risk factors and support services completed. • By March 2007, development of resources on healthy food options completed. • By April 2007, nutrition training to budgeting service staff (depending on available resources).	**Process outcomes** • Improved multi-agency skills and processes for identifying families at risk and appropriate interventions. **Health outcomes** • Improved nutrition for at risk families. • Reduction in obesity.	**CMDHB** $20,000 Health knowledge and expertise; development and implementation of packs, resources and training modules. **MSD, FACS** Distribution of benefit information to primary care and other organisations.
9.3 Improving referral pathways The Counties Manukau Family Start service began in September 2005. The programme offers an intensive home visiting programme targeting young families. CMDHB will engage Community Organisations for Diabetes Action (CODA) through Diabetes Projects Trust (DPT) to assist Family Start to link with diabetes prevention services and networks, and align with services available in Counties Manukau. There will be a particular focus on identifying ways of improving nutrition and physical activity levels among young families. **Key partners:** CMDHB, CODA, DPT, Family Start.	• By July 2006, contract finalised.	**Process outcomes** • Family Start workers have awareness of appropriate linkages in health sector. • Vulnerable families receive support to improve nutrition for children. **Health outcomes** • Long-term diabetes prevention through reduction in childhood obesity.	**CMDHB** Budget TBC – contingent upon funding in LBD 5.1. Health knowledge and expertise; networks.

Interventions/initiatives	KPIs/milestones	Outcomes	Resources
9.4 Improving nutrition by providing training for agencies that access at-risk families In 2005/2006, training was provided to Salvation Army staff and volunteer workers in nutrition and brief intervention counselling. Exploration of similar training with Manukau Family Start was also initiated. In 2006/2007, work will focus on: • implementing the training for Manukau Family Start (up to 25 staff) • developing appropriate means of evaluation to ensure lessons of the training are being passed on to vulnerable families and positive changes are achieved • follow-up of those trained will also be conducted to assess how learnings have been applied • a questionnaire will be developed to evaluate the impact of this training on vulnerable families. **Key partners:** CMDHB, Manukau Family Start, Salvation Army, SF, School of Population Health.	• By August 2006, collection of baseline information regarding trainees and their practices under way. • By August 2006, first training for Manukau Family Start completed. • From September 2006, group support of trainees initiated. • By December 2006, second training for Manukau Family Start completed. • By December 2006, questionnaire developed and piloted for families to complete. • By February 2007, questionnaire circulated to Salvation Army and Family Start workers. • By March 2007, follow-up with Salvation Army and Family Start staff under way. • Learnings from nutrition training applied in ongoing work.	**Process outcomes** • Improved agency skills in dealing with nutrition issues facing vulnerable families. **Health outcomes** • Improved nutrition for at risk families. • Reduction in obesity.	**CMDHB** $5,000 Health knowledge and expertise; development and implementation of training modules, resources, questionnaires. **Manukau Family Start** Recruitment of staff and participation in nutrition training; application of learnings to vulnerable families. **School of Population Health** Advice and assistance in developing evaluation resources.

Interventions/initiatives	KPIs/milestones	Outcomes	Resources
9.5 Ensuring food parcels are healthy, well-balanced and nutritious In 2005/2006, exploratory work was undertaken by CMDHB to review the current system of food parcel provision and identify overall changes in product mix to improve overall nutrition. In 2006/2007, the focus will be on: • implementing a pilot based on the recommendations from the review • canvassing support from manufacturers, importers, suppliers to determine their ability to assist with appropriate products, and developing an action plan forward • producing a recipe book for distribution to vulnerable families through Family Start and social service agencies, with a Pacific flavour • cooking demonstrations at appropriate venues – this could include provision of a cooking implement (e.g. wok) and a complete meal for cooking by targeted families, depending on funding and/or industry support • raising awareness in different arms of the food industry of appropriate food to donate, with a view to enhancing quality of food in a targeted manner • investigating centralised food parcel distribution system, drawing on established models. **Key partners:** CMDHB, Food Industry Group (FIG), FACS.	• By August 2006, development and piloting of recipe book. • By August 2006, recipe book published and printed. • By October 2006, pilot completed and evaluated. • By March 2007, provider(s) contracted to deliver cooking demonstrations. • By December 2006, scoping paper on centralised food distribution model completed. • By January 2007, implementation of agreed recommendations underway.	**Process outcomes** • Vulnerable families access more nutritious food and are able to prepare raw ingredients for cooking meals at home. **Health outcomes** • Improved home nutrition contributes to reduced obesity.	**CMDHB:** $20,000 Development and publication of recipe book; organising cooking demonstrations; co-funded position canvassing support and engagement from food industry in healthy food parcel provision (refer to 4.2); collaboration in design and development of centralised food distribution system. **FIG** Co-funded position (refer to 4.2). **FACS** Co-funding and facilitating distribution of recipe book.

Action Area 10 – Improving Service Integration and Care for Advanced Disease

People with diabetes are managed according to New Zealand best practice guidelines.

Diabetes is a multi-system disorder, and consequently its complications involve many health services. Interventions have been shown to have benefits across the spectrum of complications, but conversely interventions may be contraindicated or become complicated by complications. Close integration of health services is important to timely, optimal and safe treatment of diabetes and its complications.

In 2005/2006, a review of the opportunities to developing an integrated approach to diabetes in pregnancy and care services was completed, and the *Let's Beat Diabetes* programme management team (LBD team) within Counties Manukau District Health Board (CMDHB) established and/or strengthened relationships with the myriad of health services to identify pathways to improved service integration.

In 2006/2007, the focus will be on further strengthening these relationships and converting them into collaborative action, the first two key 'actions' being implementation of the recommendations of the diabetes and pregnancy review (LBD 10.6) and improving the integration of primary and secondary care diabetes information technology (IT) systems (LBD 10.4).

Interventions/initiatives	KPIs/milestones	Outcomes	Resources
10.1 Establishing a leadership hub for in-hospital service integration A formally-established forum is required to provide guidance on in-hospital and integration issues relating to diabetes complications from involved specialties. This forum, provisionally titled 'Secondary Care User Group' will build on informal arrangements developed in 2005/2006. It will operate with two distinct aims. The first area of activity will be in establishing the governance arrangements, including co-ordination between services; leadership on management across secondary services; and input into guidelines/ service development. The second activity will focus on developing a navigational tool for consumers, working across primary and secondary care to detail the current provision of services and how to access them (links with LBD 1.2). **Key partners:** Division Medicine, Women's Health, Division Surgery, Kid's First, LBD team	• By July 2006, forum established. • By December 2006, navigational tool developed.	**Process outcomes** • Increased awareness of interdisciplinary issues. • Focus on quality communication. • Impact service planning. **Health outcomes** • Improved service provision. • Reducing delay for appropriate treatment.	**CMDHB** $30,000 from LBD.

Interventions/initiatives	KPIs/milestones	Outcomes	Resources
10.2 Developing Whitiora Diabetes Service's role as clinical centre of excellence and supporter of system-wide capacity development Linking with the Secondary Care User Group, activities in 2006/2007 will focus on: • accreditation/external review • audit activities • roll-out of primary care support and increased funding/recognition of training role • encourage internships • increased group education • develop career structure for future growth. CDMHB will develop stocktake report on Whitiora activities, to inform navigational tool (LBD 10.1). **Key partners:** Whitiora Diabetes Service, Primary Care (particularly the Chronic Care Management Programme), LBD team.	• By July 2006, Audit DKA to be completed. • By September 2006, stocktake report produced. • By (date), strategic document for future growth and development completed.	**Process outcomes** • Increased awareness of interdisciplinary issues. • Focus on quality communication. • Impact service planning. • Develop clearer vision of future service for planning and funding. • Improved secondary care and management of diabetes. **Health outcomes** • Improved management of diabetes. • Minimisation of complications.	**CMDHB** $10,000 from LBD. Additional funding from Secondary Care.
10.3 Ensuring diabetes management activities across primary and secondary care are implemented in a consistent manner Aligning to 8.2 and 10.4 to ensure the management activities and framework developed in primary care is consistent with that developed for secondary care, and that there is consistency in their approach and implementation. Provision of evidence-based cardiovascular disease (CVD) risk assessment tool in secondary care (acute predict). Implementation of Type 2 Guidelines to secondary care (where applicable). **Key partners:** LBD team, Primary Care DCAG, CCM, secondary care service leaders (medical, surgical), LBD team.	• Ongoing participation in DCAG. • By February 2007, workshop on integrated model of care held.	**Process outcomes** • Develop 'whole spectrum' of management/intervention/ programme for screening – advanced disease with LBD action area 8. **Health outcomes** • Best practice management of diabetes to reduce development of complications.	**CMDHB** $10,000 from LBD. Additional funding from primary care and secondary care.

Interventions/initiatives	KPIs/milestones	Outcomes	Resources
10.4 Improving the integration of primary and secondary diabetes information technology (IT) systems Improved functionality for access to information, care co-ordination and clinical decision support in secondary care with view to integration with primary care providers and other secondary care information systems. It will, to some extent, be dependent on broader issues such as development of the diabetes secondary care database at Waitemata District Health Board (WDHB) (CVDIS) and Enigma (Acute Predict) products. Key steps include: • roll-out of acute predict (see 10.3) and added enhancement (provisionally termed Predict 2)* • CVDIS project (led by WDHB), scoping development within CMDHB secondary service 'secondary care diabetes information project' • investigating exemplar models of diabetes secondary care information management. **Key partners:** HealthAlliance, Secondary Care User Group, LBD team.	• By December 2006, utilisation of acute predict in secondary care. • By December 2006, scoping paper on 'secondary care diabetes information project' completed.	**Process outcomes** Secondary care practice supported by an information rich environment. **Health outcomes** Best Practice management of diabetes to enhance care, audit and review activities and reduce development of complications.	**CMDHB** $75,000 from LBD Additional funding from Primary Care and Secondary Care
10.5 Improving clinical data/ethnicity data and reporting This intervention/initiative links strongly with 10.4, and aims to achieve improved demographic and ethnicity data, providing evaluation, feedback and audit tools. CMDHB LBD will work closely with Health Alliance and the secondary care user group (see 10.1) to: • develop 2005 proposal within 'Secondary Care Diabetes Mellitus Information Project' to ensure accurate representation and coding of ethnic groups using secondary care services • link with 10.1 and 10.4. **Key partners:** HealthAlliance, Secondary Care User Group, LBD team.	• By December 2006, development of dataset. • Co-development (with 10.4) of scope of 'Secondary Care Diabetes Information Project'.	**Process outcomes** • Fully characterised secondary care practice population. **Health outcomes** • Improved audit, evaluation and enhanced management of diabetes in secondary care.	**CMDHB** Funding part of LBD 10.4.
10.6 Supporting Diabetes in Pregnancy In 2005/2006, a review identifying the opportunities for integrating the different providers/services involved in diabetes in pregnancy and care into one comprehensive service; any gaps or issues; and recommendations on specific changes that would be needed to address these gaps or issues was completed. In 2006/2007, the focus will be on implementing the agreed recommendations of the review. **Key partners:** LBD team, Women's Health, Secondary Care Diabetes Service, Primary Care, Community maternity services.	• By September 2006, recommendations to be implemented agreed to.	**Process outcomes** • Implementation of review to service delivery scoping. **Health outcomes** • Improved multidisciplinary management of diabetes in pregnancy.	**CMDHB** $10,000 from LBD. Project management.

Interventions/initiatives	KPIs/milestones	Outcomes	Resources
10.7 Supporting diabetic eye disease LBD team will maintain a watching brief on the retinal screening project, proving advice and support where needed, and assist with implementation of National Diabetes Retinal Screening Grading System and referral recommendations (2005). LBD team will also ensure consistency in screening guidelines and CCM, and secondary care implementation (see also 10.3, and DCAG 8.1); and develop reporting tools for secondary care to monitor implementation of screening. **Key partners:** LBD team, Retinal Screening Project, Save Sight Society of NZ Inc.	Percentage of patients seen in secondary care with up-to-date-retinal screening.	**Process outcomes** • Consistency and implementation of process. **Health outcomes** • Improved screening and treatment of complications.	**CMDHB** Non-budget item for LBD. Project management. Additional funding from core services.
10.8 Supporting diabetic renal disease The secondary care user group (see 10.1) will support diabetic renal disease services. **Key partners:** LBD team, CMDHB Renal Service, secondary care user group, Auckland Regional Renal Project.		**Process outcomes** • Development of optimal treatment pathways. • Input into regional renal service planning (as appropriate). **Health outcomes** • Minimise complications of renal disease. • Optimise treatment of renal disease.	**CMDHB** Non-budget item for LBD. Project management. Additional funding from core services.
10.9 Aligning diabetes and mental health Diabetes is overrepresented in clients of mental health services, and mental health issues are more common in people with diabetes. Mental health medications may provoke or worsen diabetes. People with mental health problems are affected by disparities and obstacles for care within society. People with mental health problems may be more reliant on health care providers for support for lifestyle factors (e.g. residential care/meals, activity). This workstream is intended to enhance linkages between diabetes and mental health services in CMDHB. In 2006/2007, CDMHB LBD will: • engage mental health planning/funding arm • provide support/guidance to mental health team planning services. **Key partners:** LBD team, Mental Health, Vulnerable Families (LBD action area 9).	To be determined within Mental Health team.	**Process outcomes** • Strategy development, ongoing dialogue with mental health services. **Health outcomes** • Promoting physical health in people with mental illness. • Recognition and support of mental health issues in people with diabetes.	**CMDHB** Non-budget item for LBD. Project management; health promotion; nutrition support. Funding.

Interventions/initiatives	KPIs/milestones	Outcomes	Resources
10.10 Supporting therapeutics LBD team, the Chronic Care Advisory Group (CCMAG), Diabetes Projects Trust (DPT), CCREP and Division of Medicine will continue to support best practice utilisation of medication by: • community pharmacy • advice • adherence • advocacy for best treatment • representation to Pharmac • encouraging clinical research in CMDHB population. **Key partners:** LBD team, CCMAG, DCAG, DPT, Division of Medicine.	• Research Fellow position filled (2005, and ongoing funding). • Research papers produced. • Representation in Type 2 Diabetes Guidelines (next revision date).	**Process outcomes** • Optimisation of utilisation of cost effective therapeutics and monitoring of diabetes. • Active research in clinical therapeutics in CMDHB population with diabetes. **Health outcomes** • Improved management of diabetes in context of people within Counties Manukau.	**CMDHB** $10,000 from LBD. Project management. **CCMAG** Responsibility for community pharmacy workstream. **DPT, CCREP, Division of Medicine** Co-funding Research Fellow.

Appendix 1: *Let's Beat Diabetes* – Context for Implementation

(Source: *Let's Beat Diabetes Operational Plan 2005/2006*, pages 4–6.)

1 Operational approach

1.1 Design challenges

Let's Beat Diabetes (LBD) is a plan that provides a clear vision for diabetes prevention and management. It does not present a detailed blueprint for five years activity, rather it explicitly suggests that what is required is a balanced suite of activity that is constantly being informed by powerful learning processes and then modified and developed. In other words, the process that is proposed is similar to a large scale action learning or continuous quality improvement framework.

This way of working has risks associated with it, but it is believed that it will ultimately outperform a more rigid planning model. A rigid model is unlikely to be able to accommodate the rapid processes of change and integration required as the 10 action areas evolve and interact – and formal evaluation and community feedback create pressures for constant modification.

Developing this approach to programme design and implementation is an emergent area in health system design and management disciplines and creates challenges for governance and management.

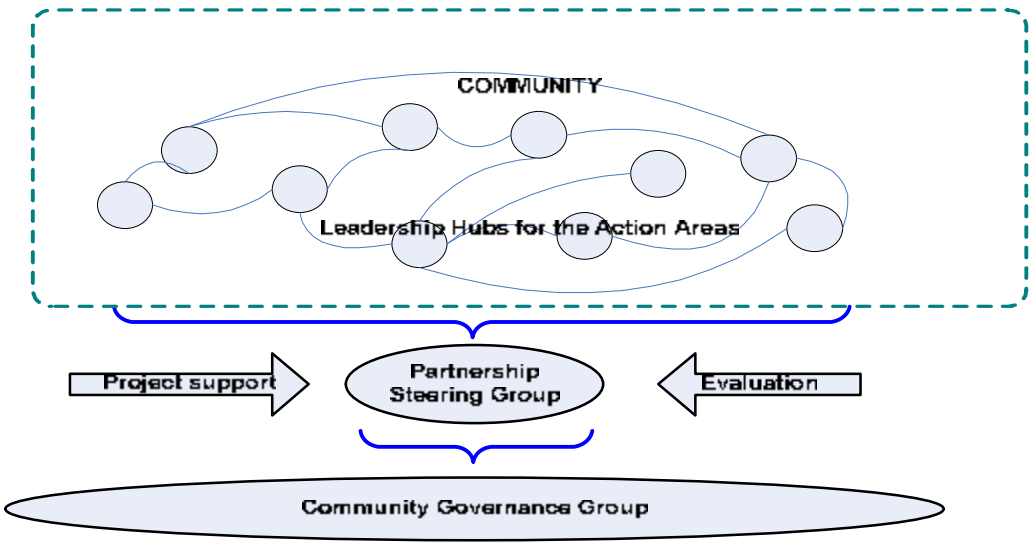
1.2 Implementation challenges

In order to create the implementation environment described above, whilst also meeting the requirements of performance and accountability frameworks, the implementation of LBD is supported through five key operational parameters.

1.2.1 Community ownership and governance

Enable broad community ownership of, and input into, the LBD vision and ongoing operational decisions.

Broad community ownership of, and input into, the LBD vision and ongoing operational decisions is vital to its success. The following community governance and management structure has been established to enable this.



The LBD governance and management structure not only aims to support community ownership and ideas at multiple levels, but to ensure there is tight accountability and a clear, well supported, decision-making forum in the Partnership Steering Group (PSG). The governance and management structure is comprised of three key levels:

i. *Leadership hubs:* Each of the 10 action areas has its own leadership structure or 'hub' which is responsible for progressing activity in their respective action area. The hubs are comprised of groups of motivated people and organisations, and have Maori and Pacific representation. They meet when/ as required. The groups network with each other.

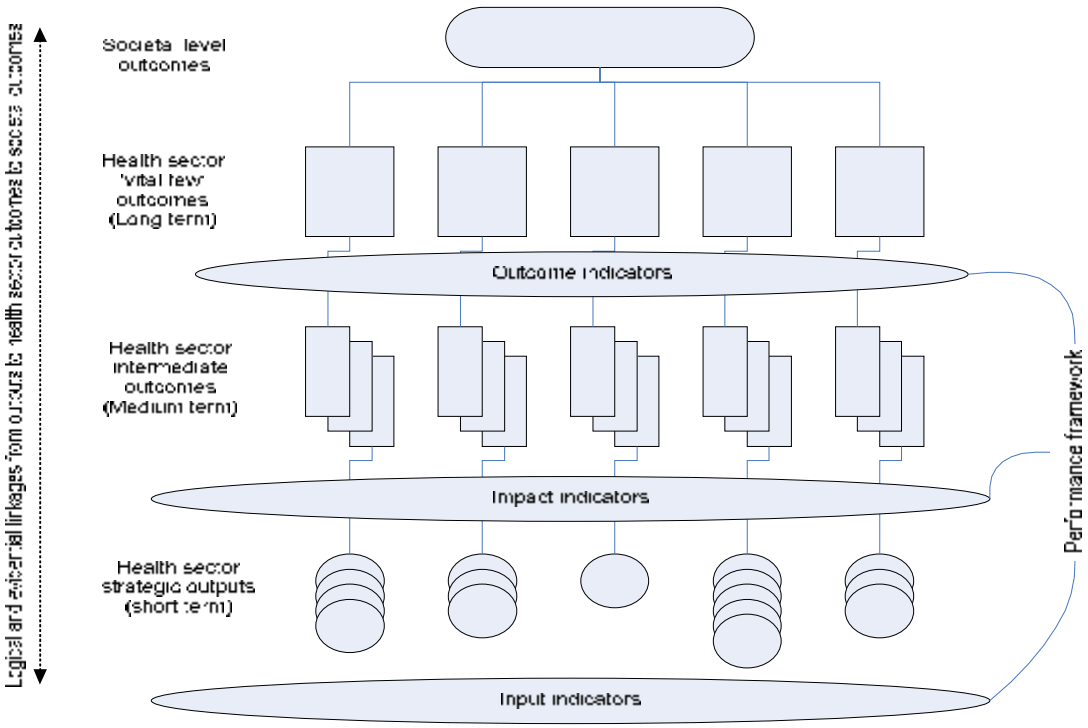
ii. *Partnership Steering Group* (PSG): The PSG is the key information-sharing and decision-making body for LBD, and is responsible for driving the operational management of LBD, and ensuring its outcomes are achieved. The group is comprised of leaders from each of the action areas, and representatives from the Board of Counties Manukau District Health Board (CMDHB), Maori and Pacific, CMDHB and the LBD project management team (referred to as 'the LBD team'). It meets monthly.

iii. *Community Governance Forum* (CGF): The CGF encompasses broad community ownership of LBD. The group, comprised of individuals and organisations with an interest in LBD, was originally intended to meet up to three times a year in a forum-style group. However, building on feedback from those participating in early forum meetings, CGF engagement will now occur in a rolling series of meetings with key stakeholders. This approach will permit greater interaction between LBD team members and the many and varied communities of interest in Counties Manukau. The purpose of these meetings will be to provide progress updates on LBD, and to seek community feedback and guidance on key issues. There is no restriction on who may attend a CGF meeting.

1.2.2 Outcomes focused management

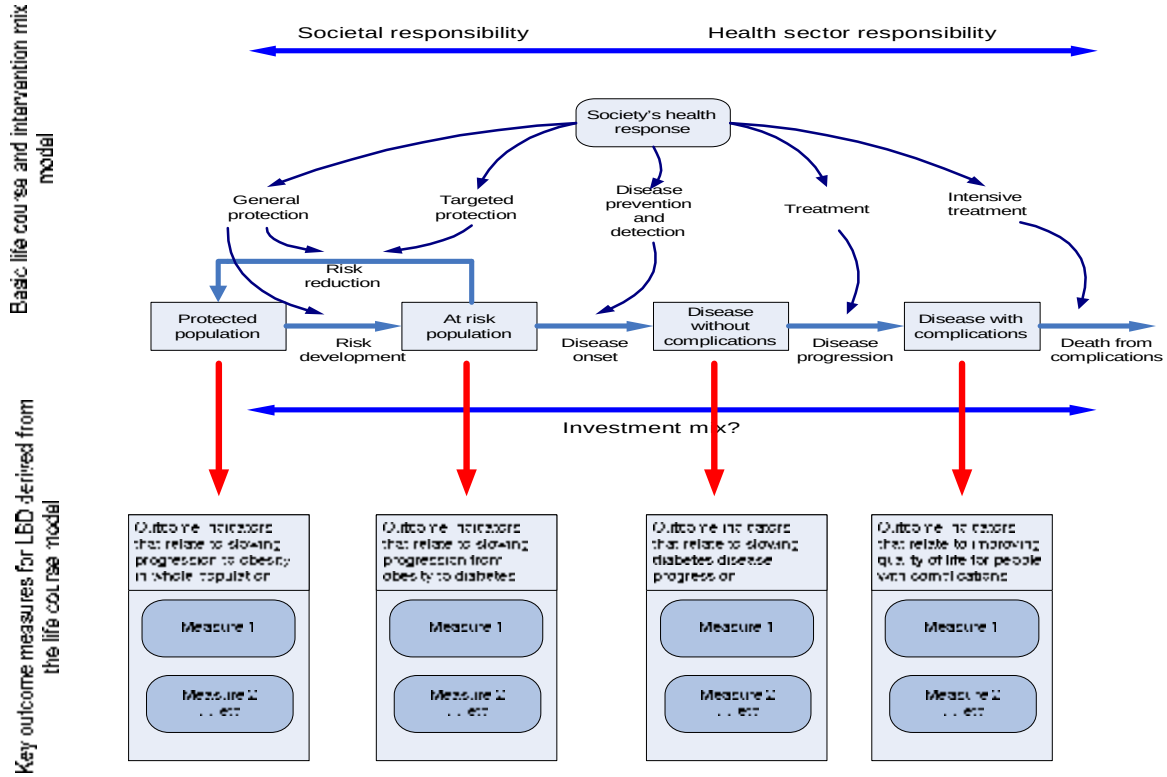
Manage a broad set of initiatives so that they are well designed, effectively implemented and tightly focused on outcomes that help prevent and manage diabetes.

CMDHB has adopted the basic outcomes-based-planning (OBP) framework (below) to support its strategic planning process. The OBP helps to ensure that actions are logically and evidentially aligned to the key outcomes being sought.



OBP emphasises the importance of developing a set of key 'intermediate outcomes' that are relevant and measurable in the medium term to help determine if programmes are delivering what they have set out to achieve.

An OBP framework has been developed for LBD and is being integrated with the evaluation framework to ensure that the evaluation team[7] deliver reports which support focused management. The OBP framework is based on the fundamental life course model that has guided much of the LBD planning. The 'vital' outcomes for LBD are to ensure that its programmes are delivering real change at each of the four key disease progression areas identified in the model. These are outlined below.



The OBP framework creates the context for the key performance indicators.

1.2.3 Whole system co-ordination

Support co-ordination across the 10 action areas to develop integrated interventions/initiatives across sectors.

Whilst CMDHB is putting significant resources into LBD, it is the PSG who is the key information-sharing and decision-making body for LBD, and is responsible for driving the operational management of LBD, and ensuring its outcomes are achieved. To this end, CMDHB has sought PSG's mandate and guidance as to how the funding is allocated and interventions/initiatives designed and developed.

The second key component of whole system co-ordination is ensuring that the LBD project management team (referred to as the LBD team) works alongside existing health sector service and supports strong linkages with other internal DHB planning, operational and clinical leaders.

1.2.4 Whole system learning

Create a learning environment in which multiple individuals and organisations can learn off each other, and from successes and challenges, to continuously improve quality.

The University of Auckland School of Population Health (SOPH) has developed an evaluation approach that is intended to evaluate outcomes, actively support community learning from the LBD implementation, and develop the critical evaluation capacity of Counties Manukau health organisations. The evaluation approach and the resulting evaluation plan has a focus on outcomes for high at risk groups such as Maori and Pacific peoples. The evaluation approach aims to:

[7] The evaluation team referred to in this document is based at the University of Auckland School of Population Health (SOPH), and is discussed in more detail in Section 3.

- evaluate outcomes
- evaluate processes to support community learning
- evaluate process to identify which interventions/initiatives are having the major impacts on outcomes
- support health sector capacity development in evaluation, and
- establish co-ordinated research to support the LBD objectives.

The SOPH regularly feeds back information to the LBD team, PSG and other key stakeholders to ensure that the learnings from one component of LBD are adopted by relevant organisations and communities.

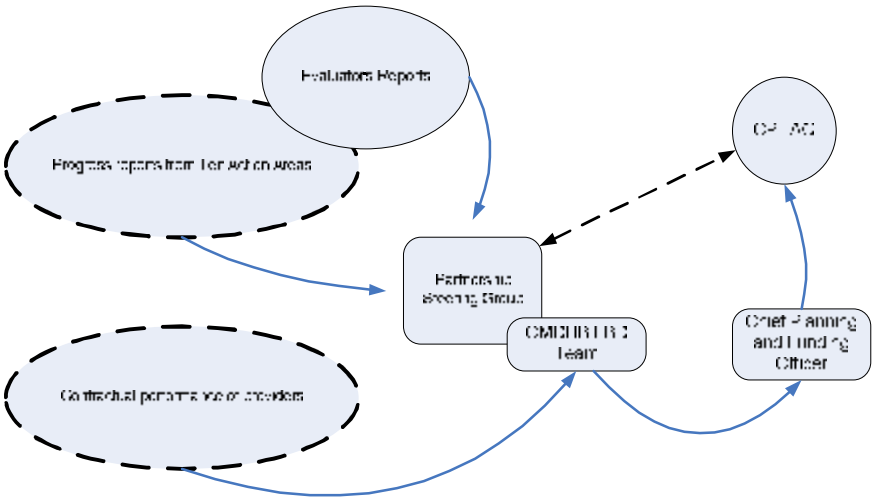
1.2.5 Explicit accountability and performance

Ensure that there is clear accountability for LBD action areas and that there are good processes for performance reporting. Ensure that CMDHB funds for LBD are being wisely and prudently invested.

The Board of CMDHB has reiterated the need for good management of the LBD programme. CMDHB has responded by developing the design and implementation infrastructure described in this document. It has also established the LBD team within the Planning and Funding Division to support the implementation of LBD.

The LBD team provides technical support to all areas of the LBD programme and manages the complex inter-organisational and contractual relationships that make up the web of activity that is LBD. The LBD team also works closely with other sections of CMDHB to ensure there is clarity of accountability for specific programmes and outputs.

The LBD team provides formal reporting to CMDHB management, the PSG and to the Community Public Health Advisory Committee (CMDHB) – which has delegated governance authority for LBD on behalf of the Board of CMDHB. The graphic below describes the reporting lines for LBD from a CMDHB perspective.



Appendix 2: *Let's Beat Diabetes* Leadership Hubs

Listed below are the members for the leadership hubs for the action areas.

Please note: participation in the leadership hubs for the Community Leadership and Action – Maori workstream and health promotion action area is open; and that the membership and representation on a number of the other leadership hubs is to be strengthened in 2006/2007.

Action area leadership hubs
Community Leadership and Action – Maori Riripeti Haretuku, Tony Kake, Caran Barratt-Boyes, Bernard Te Paa, Tuhakia Keepa, Amanda Dunlop (all Counties Manukau District Health Board – CMDHB), Eru Thompson, Isabella Potae, Gayle Sinclair (Auckland Regional Public Health Service (ARPHS), Gail Murray (ProCare), Sam Noon (Manukau City Council), Dale Sherman (ProCare), Ataroa Brampton, Karla Armstrong (Tainui MAPO), Te Kaanga Skipper, (additional lists outstanding)
Community Leadership and Action – Pacific peoples **Pacific churches activity:** Rachel Enosa-Saseve (CMDHB), Douglas McLeod, Melesiahi Mafi (Calvary Community Seventh Day Adventist), Ofa Fakalata, To'iata Ueleni (Church of Tonga Manukau), Sami Vea, To'iata Ueleni (Church of Tonga Manurewa), Peniamina Vai (Congregational Christian Church of Samoa in New Zealand), Victor Pouesi, Fepulea'I Sio/Tologata (Congregational Christian Church of Samoa Mangere East), Tautu Marli, Temata Marsters (Cook Island Christian Church), Haua Manuel, Mareta Tere (Cook Islands Christian Church Otara), Ngatokorua Patia, Temata Marsters (Cook Islands Christian Church Otara), Paora Teaukura (Cook Islands Seventh Day Adventist), Giovani Stowers, Linda Mulitalo (East Tamaki Samoan Seventh Day Adventist Church), Mose Alano, Epitama Hausi (Ekalesia Niue Church of NZ), Fiannu'usila Tuiloma, Caroline Masoe (Assembly of God), Sataraka Sanelivi, Caroline Masoe (Assembly of God), Keresome Galovale, Caroline Masoe (Assembly of God), Muavae Mika, Caroline Masoe (Assembly of God), Motu Mataia, Caroline Masoe (Assembly of God), Solomona, Caroline Masoe (Assembly of God), Albert Atoa, Logo-Perina Atoa (First Samoan Full Gospel Pentecostal Church), Sione Kaloni (Free Church of Tonga Mangere East), Chris Sola (Hosanna World Harvest Church), Pukerua Parai, Erita Parai (Mangere Church of the Nazarene), Fenunuti Poutu Fiaii, Leumalealofa Ausi Leao (Mangere East Samoan Methodist Church), Vaiora Robati, Maua Sola (Mangere Pacific Islanders Presbyterian Church), Seiuli Sam Seiuli, Anna Seiuli (Manukau Elim Christian Church – Samoan), Epeli Taugapeau, Mofua Lolohea (Manurewa Methodist Church), Vii Vii, Mose Sau (Manurewa Samoan Evangelical Wesleyan Methodist Church), Jake Ormsby, Joseph Vaine Williams (Manurewa Seventh Day Adventist Church), Pelikani Esau, Alisi Tameifuna (Mizpah Seventh Day Adventist), Setaita Veikune, Tunumafono Aufata (Otahuhu/Mangere Methodist Church), Uea Tuleia, Aotofaga Lemuelu, Aiolupotea Toleafoa (Otara PIC Church), Salafai Mika, Nesa Ieremia (Otara Samoan Methodist Church), Vaikoloa Kilikiti, Hingano Ha'unga (Otara Tongan Methodist Church), Sione Vuki Fatai, Ikilifi Pope (Papatoetoe Tongan Methodist Parish Church), Semitivai Alefaio (Papakura Pacific Island Presbyterian Church), William Hakaoro, Teakai Rasmussen (Punanga Tauturu Ote Kuki Airani), Kuki Aloalii, Tiatia Peseta (Samoan Evangelism Ministry), Leaula John Danielson (Samoan Methodist Church Mangere), Toetu Faraimo, Fetalai Faifua (South Auckland Samoan Seventh Day Adventist Church), Ken Café, Allan & Theresa Jones (St Anthony Family Support Services Trust), Tino Scanlan, Tepu Coombs (St Paul's Presbyterian Church), Ken Café, Pisila Foliaki (St Theresa Catholic Church Mangere East), Lealaitagomoa Teleiai, Lupetau (The Reformed Congregational LMS Church Mangere), Steven Drake, Allan Pelkowitz (The Spiritual Assembly of Bahai's of Manukau City), Tefuli Sale, Fred Leota (Tokelau Congregational Christian Church), Moi Kaufononga, Soana Muimuiheata (Tongan Methodist Church). **Pacific language nests activity:** Rachel Enosa-Saseve, Dr Aumea Herman, Amanda Dunlop (all CMDHB), Ta'i Matenga, Tai Fa'alogo (both Auckland Regional Public Health Service – ARPHS), Naita Puniani, Soana Muimuiheata, Siobhan Matich (TaPasefika).
Community Leadership and Action – Workplace Kerry Price (ARPHS), Jenny Bratty (ARPHS), Chris Weeks (ARPHS), Amanda Dunlop (CMDHB), Brian Weaver (Health/Food Industry Joint Initiative Group – JIG).
Social Marketing Gerardene Waldron, Chris Mules, Fepulea'i Margie Apa, Bernard Te Paa, Amanda Dunlop, Tony Kake, Brandon Orr-Walker (all CMDHB), Karen Pickering (Diabetes Projects Trust - DPT), Sefita Haouli (Pacific media), Barbara Lusk (Ministry of Health – MoH), Mark Champion (Communications Advertising Agencies New Zealand – CAANZ), Paul Stephenson (consultant – CMDHB).
Urban Design Sue Zimmerman, Janet Lang (both Manukau City Council – MCC), Naresh Goordeen, Raina Emery, Greg Freeman (Housing New Zealand Corporation – HNZC), Te Miha Ua-Cookson, Deepak Rama, Matt Soeberg (ARPHS), Anna McElrea (Franklin District Council), Nicola Mochrie (Papakura District Council), Amanda Dunlop (CDMHB), Paul Stephenson (consultant – CMDHB).
Food Industry Accord Joint Initiative Group (JIG): Jeremy Irwin (Advertising Agencies New Zealand – ANSA), Mark Champion (CAANZ), Lynne Lane (consultant – food industry group), Amanda Dunlop (CMDHB), Paul Stephenson (consultant – CMDHB), Brian Weaver (JIG).
Health Promotion Community Organisations for Diabetes Action (CODA): Kate Smallman (DPT), Bill Wiki (community), Tom Robinson, Franica Yovich, Amanda Dunlop (all CMDHB), Gary Brown (Hapai Te Hauora), Tai Faalogo (ARPHS), Pam Williams (Mangere Community Health), Daniel Teo (Royal New Zealand Foundation for the Blind), Vasu Moses (East Health PHO), Tai Matenga Smith, Cinnamon Whitlock, Andrew Lynch (ARPHS), Alan Grey (Lions Club), Moka Faleafa, Marina Wong Ling (both Otara Health), John Denton (Diabetes Auckland), Carnation Hetaraka (Procare), Kwang- Hee Kim (AUT school of podiatry), Cinnamon Whitlock, Makereta Davis (Otara Maori Forum), Nitin Chitre (ETHC), Moana Tamaariki-Pohe (MCC), Sue Zimmerman (MCC), Melissa Noble (Counties Manukau Sport – CM Sport), Lynne Ferguson (Whitiora Diabetes Service), Cheryl Hamilton, Nicola Young (Procare)

Action area leadership hubs
Well Child Services Well Child Provider Forum: Hine Tahere, Robin Waka, Peter Tahere (all Papakura Marae), Puna Tekii – Sila, Michael Chan (both South Seas Healthcare), Louise Troy, Annette King (both Plunket), Anne Heritage, Donna Henderson, Sue (all La Leche League), Sue Dashfield, Esther Bloomfield, Puna Foaeva, Marguerite Dalton, Fepulea'i Margie Apa, Rachel Enosa-Saseve (all CMDHB).
Schools Amanda Morse, Anna Mason (both National Heart Foundation), Barbara Lusk (MOH), David Wallis (Manurewa West School), Debbie Campbell (Team Solutions), Lizzie Farrell (Kidz First, CMDHB), Kate Sladden (ARPHS), Kate Smallman (DPT), Martin Dickson (MCC), Melissa Noble, Mike Truman (CM Sport), Nicola Young (Procare Network Manukau), John Heyes (Mangere High School), Karlynne Earp (Coordinator), Gilli Sinclair, Amanda Dunlop (both CMDHB), Paul Stephenson (consultant – CMDHB)
Primary Care DACG: Michael Wilson (Chair – PHO clinician), Andy McLachlan (secondary clinician), Kim Arcus, Tom Robinson, Brandon Orr-Walker (all CMDHB), Dolly Rewha (PHO clinician), Siobhan Matich (PHO manager), Donna Snell (PHO clinician), Peter Didsbury (PHO clinician), Deidre Cameron (PHO clinician), Andrew Kerr (secondary clinician), Caran Barratt-Boyes (Whitiora Diabetes Service), Gary Sinclair, Ian Johnson (community pharmacist).
Vulnerable Families Strengthening Families Steering Group: Gerry Walker (Chair – Salvation Army, Manukau), Robyn Rusher, Pat Masina, Sally Clarkson (all Ministry of Social Development), Amanda Eves (MSD – Work and Income New Zealand), Angie Tangere (Te Puni Kokiri), Beryl Riley, Chrissy Denison (both Ministry of Education), Denise Wiki, Madhuvan Raman (both Housing New Zealand Corporation), Tony Kake, Amanda Dunlop, Jude Woolston, Natalie Dawson (all CMDHB), Martin de Graaf, Sharon Tongalea (all Inland Revenue Department), Mike Fulcher (Counties Manukau Police), Dave Jackson, Lorinda Hardin (Child, Youth and Family), Sharon Lang (Sisters of Mercy – Wiri).
Service Integration (Under development.)

Appendix 3: Key Performance Indicators for *Let's Beat Diabetes*

(Source: *Let's Beat Diabetes Operational Plan 2005/2006*, pages 9–12.)

2 Key performance indicators for *Let's Beat Diabetes*

2.1 Developing key performance indicators (KPIs)

The performance framework for *Let's Beat Diabetes* (LBD) should recognise multiple stakeholder needs, and reflect that performance indicators are to fulfil a number of functions for LBD, for example, short-term outputs, medium-term outcomes and long-term outcomes.

2.1.1 Audiences

There are three key audiences for LBD, who have their own specific needs and requirements. Responsive key performance indicators (KPIs) will need to be developed for each of these audiences:

- **Community**: Provide a clear easily communicated set of long- and medium-term outcomes that are motivational and meaningful for the broader community.
- **Health services and health professionals:** Provide a direction and set of measures that are meaningful and motivational for health services and health professionals.
- **Management and governance**: Provide short-term management indicators that incorporate the balanced scorecard approach used by Counties Manukau District Health Board (CMDHB).

2.1.2 Characteristics of KPIs

The KPIs will need to:

- be driven by the core LBD approach (life course/risk progression model)
- provide a focus and shape to the programme over the long term by maintaining attention on key performance areas
- align long-term (20-year) and medium-term (five-year) and short-term (one-year) performance
- be linked to things we can actually measure (and intend to measure)
- manage the expectations of the community and health services
- be rational, logical, and evidential and fit with the intended evaluation framework, and
- reflect the focus LBD and the issue of inequalities.

2.1.3 Reporting requirements

Performance is formally reported to the following groups:

- the Community Public Health Advisory Committee (CPHAC), the Board of CMDHB, Pou (the representative Maori governing body in CMDHB) and the Pacific Health Advisory Committee (PHAC)
- CMDHB Executive Management Team (EMT)
- LBD Partnership Steering Group (PSG)
- LBD Community Governance Forum (CGF)
- various community and health service meetings, as requested.

2.2 Approach to KPIs

The approach to developing KPIs for LBD is to have three levels of KPI development and reporting:

- health outcomes
- process outcomes
- management outcomes.

Where possible the health and process outcomes should be reported by ethnicity and New Zealand deprivation rating in order to reflect the risk factors and reducing inequalities goals of the programme. Health outcomes and process outcomes will be reported annually, where possible. Some measures may only be available less regularly with the information collected in national surveys. Health and process outcomes will be based on the US Centers for Disease Control and Prevention (CDC)-derived life course/risk progression model that has influenced the LBD design and evaluation approach.

Management reporting will be based on a balanced scorecard approach, with the dimensions of clinical, community, activity and financial performance being monitored. This level of reporting requires significant development over 2006/07 to become operational within LBD. Reports will be collated quarterly. KPIs may change from year to year as the programme develops. The table below outlines the approach to the KPIs.

KPIs	Reported by	Based on	Reporting regularity
Health outcomes • 20-year high level whole population health outcomes for LBD. • Five-year high level whole population health outcomes for LBD.	Risk groups, including: Maori, Pacific, South Asian (Indian), 'other' and income (New Zealand deprivation 9/10).	Life course/risk progression model used in LBD programme design and evaluation.	Annually where possible (but in some cases it will be every four years due to national survey regularity).
Process outcomes • Five-year goals for changes in process outcomes that will contribute to achieving the LBD health outcomes.	Risk groups, including: Maori, Pacific, South Asian (Indian), 'other' and income (New Zealand deprivation 9/10).	Life course/risk progression model used in LBD programme design and evaluation.	Annually where possible.
Management outcomes • Annual targets for programme outputs. May change from year to year.	Will depend on which dimension of the balanced scorecard.	Balanced scorecard approach, using the dimensions of: • clinical • community • activity • financial.	Quarterly where possible.

Suggested KPIs for each of these dimension are described below. These are still in draft form and are undergoing further refinement and peer review by the evaluation team (the University of Auckland School of Population Health – SOPH) and key stakeholders such as clinical and community representatives.

2.2.1 Proposed health outcome KPIs

	Reduce the rates of obese and overweight people	Slow the rate of progression from obesity to developing diabetes (big and healthy)	Slow progression of diabetes so people remain complication free for longer	Reduce harm from diabetes complications
20-year goals 5000 less people with diabetes than without LBD.	10% drop in overweight from 2005 rates (stable over previous 20 years – so stretch). Halving of rate of obesity in year 9 students.	5% drop in obesity from 2005 rates (doubled over the previous 20 years – so a huge stretch).	*Needs more work as many different complications but a clear indicator of success could be* ... 50% drop in rate of people under 65 on renal dialysis due to diabetes.	10% (check) increase in life expectancy for people with diabetes and life expectancy for Maori and Pacific peoples with diabetes is the same as the general population.
Five-year goals (by 30 June 2010)	10% drop in obesity in year 9 students. Children as active as the rest of New Zealand (currently 15% below).	Rise in obesity levels in general population stopped.	10% drop in the rate of people under 65 on renal dialysis.	20% closing the gap on life expectancy for Maori and Pacific peoples with diabetes, compared to the general population.

2.2.2 Proposed process outcome KPIs

	Reduce the rates of obese and overweight people	Slow the rate of progression from obesity to developing diabetes (big and healthy)	Slow progression of diabetes so people remain complication free for longer	Reduce harm from diabetes complications
Five-year goals (by 30 June 2010)	70% of schools support 30 minutes of physical activity every day. 30% reduction in the proportion of sugar to non-sugar soft drink beverages sold in Counties Manukau.	20% of obese people appropriately managing their condition to remain healthy (need to define a cluster of actions that make up 'appropriate').	70% of people with diabetes have had their disease identified and are on a register.	70% of people on a register participating in best practice care (need to define a cluster that makes up best practice care).

2.2.3 Proposed management outcome KPIs – balanced scorecard

Clinical • Average age of diagnosis for diabetes. • Reduced macrovascular end points (cardiovascular death, CVA, MI, angina, cardiac revascularisation). • Reduced progression to end stage renal disease. • Reduced premature death from diabetes.	**Activity** • 80% of provider contracts signed by 30 September 2005. • Social marketing programmes under way by February 2006.
Community • PSG remains effective and well attended. • Ten action areas have functional leadership hubs. • Three CGG meetings held.	**Financial** • Programme stays within budget. • Regular financial reports.

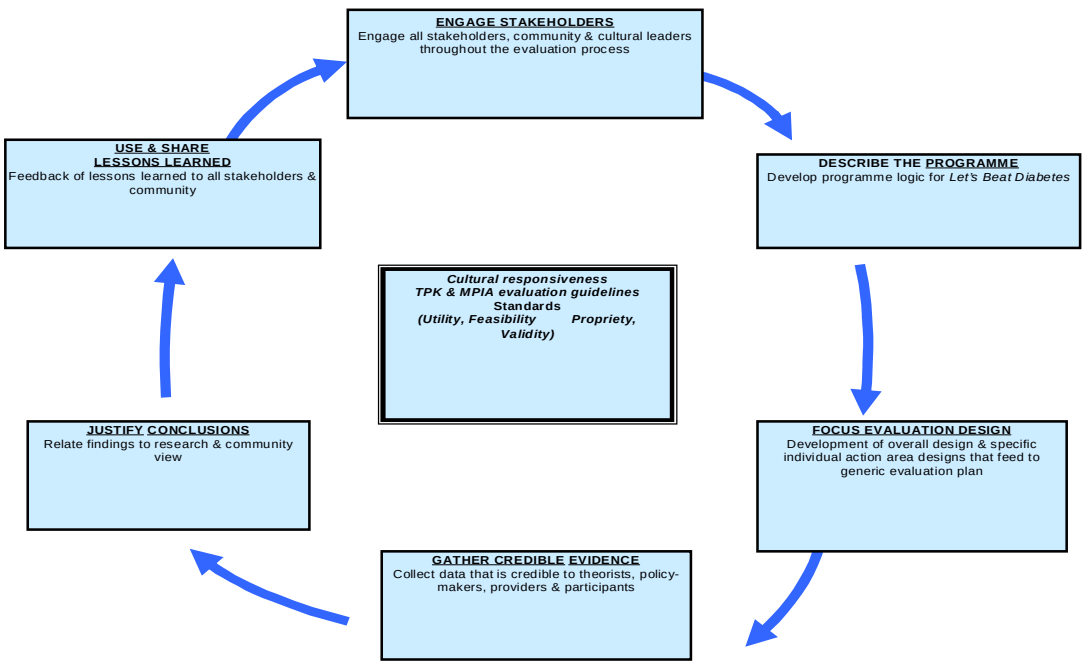
Appendix 4: Evaluation Framework

(Source: *Let's Beat Diabetes Operational Plan 2005/2006*, pages 13–14.)

The University of Auckland School of Population Health (SOPH) was contracted to develop the evaluation process and framework for *Let's Beat Diabetes* (LBD). A team led by Dr Paul Brown and Dr Janet Clinton at SOPH are carrying out the evaluation. The complexity of this task due to the breadth and complexity of LBD and the evaluation brief – which sought a framework to support process and outcome evaluation, as well as support for learning environment – was not underestimated. SOPH are implementing a framework that:

- identifies key indicators of the extent to LBD is meeting its goals
- describes a comprehensive framework identifying how the action areas link with the key indicators
- identifies how the specific initiatives undertaken by community groups and providers link to the 10 action areas
- describes the development of specific outcomes in parallel with programme design
- accommodates a range of interventions/initiatives from a variety of providers
- identifies and incorporates measures that are important to the communities and providers
- is flexible enough to accommodate initiatives at different stages of development
- involves frequent contact and capacity building within the community
- includes a continual reassessment of the goals and activities
- is responsive to changes in the implementation of the plan as a result of learning and reassessing goals, and
- sees the evaluation as an evolving process.

The team are implementing a modified version of the evaluation framework described by the US Centers for Disease Control and Prevention (CDC) be adopted. The framework allows an independent assessment of the progress of LBD, and yet provides opportunities for continuous learning and quality improvement throughout the duration of the plan. It also recognises Maori and Pacific peoples in Counties Manukau as priority population groups, and incorporates practices and measures that are culturally appropriate and meaningful to these groups and the wider community. These cultural considerations will be maintained throughout the evaluation process, adapting when/as required, and/or if other ethnic groups become priorities. The graphic below outlines the proposed evaluation approach for LBD, adapted from the CDC framework.



SOPH also participate in the LBD Partnership Steering Group (PSG) so it is aware of developments and issues as they arise first-hand. SOPH have also formed an Evaluation Working Group to:

- identify and develop consistent and reliable indicators that link the outcomes from the activities with the key indicators
- assess evaluation readiness in communities and organisations through:
  - meeting with organisations as directed by the LBD project management team (LBD team), in collaboration with SOPH
  - holding workshops with other organisations as directed by the LBD project management team, in collaboration with SOPH to assist in evaluation capacity building
  - liaising with organisations regarding gathering data about the activities
- identify ways to build evaluation capacity within the community as required
- analyse the results from the specific initiatives, the impact on the action areas, and changes in the key performance indicators (KPIs)
- provide regular feedback to organisations on progress as directed by the LBD project management team, in collaboration with the PSG, including:
  - participating in workshops with representatives from action areas
  - reporting on progress of initiatives
  - meeting regularly with PSG
  - reporting to CMDHB as directed.

At time of preparation of the 2006/07 Operational Plan, CMDHB was finalising a contract with SOPH to implement the evaluation framework over five years. The contract will explicitly state the need for:

- the provider to consult regularly with the LBD team with regards to data collection and other practical aspects of the evaluation
- the LBD Evaluation Group to report regularly to CMDHB. This reporting is likely to include:
  - quarterly reports on the status of the evaluation
  - quarterly review of progress and goals of action areas, and opportunities for learning and improvement
  - annual reports on:
    - status and outcomes from individual activities
    - progress on action areas, and
    - changes in key indicators
  - three-year update on progress in meeting goals of action areas and changes in key indicators
  - final report summarising five-year experience with LBD
- the Maori and Pacific components of the evaluation to be undertaken by Maori and Pacific researchers (includes communications, meeting facilitation, analysis and presentation), and
- clear lines of accountability and responsibility for the different components of the evaluation within the SOPH – and these are clearly communicated to the LBD team.

In 2005/06, the focus of evaluation activity was on the development of key performance indicators, baseline datasets, programme key performance indicators, capacity development and process evaluation.

A notable component of evaluation activity in 2005/06 was initiation of five focused studies of specific initiatives within the programme. The focussed studies examined initiatives to promote the health of Maori communities, an urban design initiative based on the development of a local activity park in Manurewa, the sugar-free drinks initiative at McDonald's restaurants, learning resources developed for Pacific language nests, and a community nutrition training programme for primary care nurses and community health workers. Activity was also initiated to work with LBD team members to examine performance across all action areas.