LET'S BEAT DIABETES
OPERATIONAL PLAN 2005/2006

FINAL PLAN
Endorsed by the Board of Counties Manukau District Health Board
07 September 2005

Let's Beat Diabetes - Overview

On 02 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 'in principle' over 5 years to support its implementation. The Board also invited CMDHB to report back by July 2005 with a proposed work programme (operational plan). This is the report-back.

Background

Let's Beat Diabetes (LBD) is a catalyst for social action, health innovation, enhanced intersectoral collaboration and community partnerships and action aimed at "beating diabetes" in Counties Manukau.

The *LBD: A Five Year Plan to Prevent and Manage Type 2 Diabetes in Counties Manukau* strategic plan is a five year, district-wide plan aimed at long-term, sustainable change to prevent or delay the onset of Type 2 Diabetes ("diabetes"), slow disease progression and increase the quality of life for people with the diabetes in Counties Manukau. The plan 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.

The *LBD Operational Plan 2005/2006* outlines the interventions/initiatives that will be implemented over 2005/2006 as part of the process to meeting LBD's five year outcomes.

Both plans, including the interventions/initiatives for 2005/2006, are the result of an extensive 15 month consultation and development process.

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.

Operational Plan Outline

Operational Approach

LBD 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 – a process 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 Ten 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.

In order to create the implementation environment described above - whilst also meeting the requirements of performance and accountability frameworks, LBD's implementation design will:

- Work across broad domains from 'command and control' to 'advocate and influence', and
- Balance management and leadership techniques.

And strive for:

- Community ownership and governance
- Outcome focused management
- Whole system coordination
- Whole system learning, and
- Explicit accountability and performance.

Flagship Outcomes

LBD's (draft) flagship outcomes for 2025 are:

- There will 5,000 less people with diabetes than without LBD
- 10% drop in rate of population that is overweight
- 50% drop in obesity rate for Year 9 students
- 5% drop in obesity rate for adults
- 50% drop in rate of people under 65 on renal dialysis due to diabetes
- 10% increase in life expectancy for people with diabetes, and
- The life expectancy for Maori and Pacific peoples with diabetes is the same as the general population.

Key Performance Indicators

LBD's performance will be measured via Key Performance Indicators (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 (5 year) and short term (1 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.

The proposed 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 NZ Deprivation rating in order to reflect the risk factors and reducing inequalities goals of the

programme. Management reporting will be based on a balanced scorecard approach, with the dimensions of clinical, community, activity and financial performance being monitored.

Evaluation Framework

The evaluation of LBD will be done via a programme logic model, which fits with CMDHB's and LBD's outcome based performance models. The proposed evaluation framework will:

- Be based on the US Centres for Disease Control and Prevention (CDC) model
- Allow an independent assessment of the progress of LBD, whilst still providing opportunities for continuous learning and quality improvement throughout the duration of the plan
- Include nationally/internationally bench-markable measures, and
- Recognise Maori and Pacific peoples in Counties Manukau as priority population groups, and incorporate practices and measures that are culturally appropriate and meaningful to these groups and the wider community

Its key focus for 2005/2006 will be on baselines/datasets, capacity development and process evaluation.

Phased Development

The operation plan for 2005/2006 is a mix of interventions/initiatives and developmental activity, depending on state of knowledge and existing services in each area. It includes significant work-up of actions in all areas, of which much of the ground work has been completed. The key focus for 2005/2006 will be on process outcomes – with a shift to output and outcome measures as the programme develops.

Where possible, the interventions/initiatives identified in the plan will include a focus on and/or impact on high at risk populations, such as Maori, Pacific and low socio-economic populations. Wherever possible, LBD's health and process outcomes will be reported by ethnicity and NZ Deprivation rating in order to reflect the risk factors and reducing inequalities goals of the programme.

The Management of LBD

In response to the Board's call for strong management of the LBD programme, CMDHB has developed the design and implementation infrastructure described in this document, and strengthened the LBD team within the Planning and Funding Division to support the implementation of LBD. The broad competencies of the LBD team include programme management, Maori and Pacific co-ordination, medical leadership, social marketing and general programme support.

LET'S BEAT DIABETES – Context for Implementation

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 Ten 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.

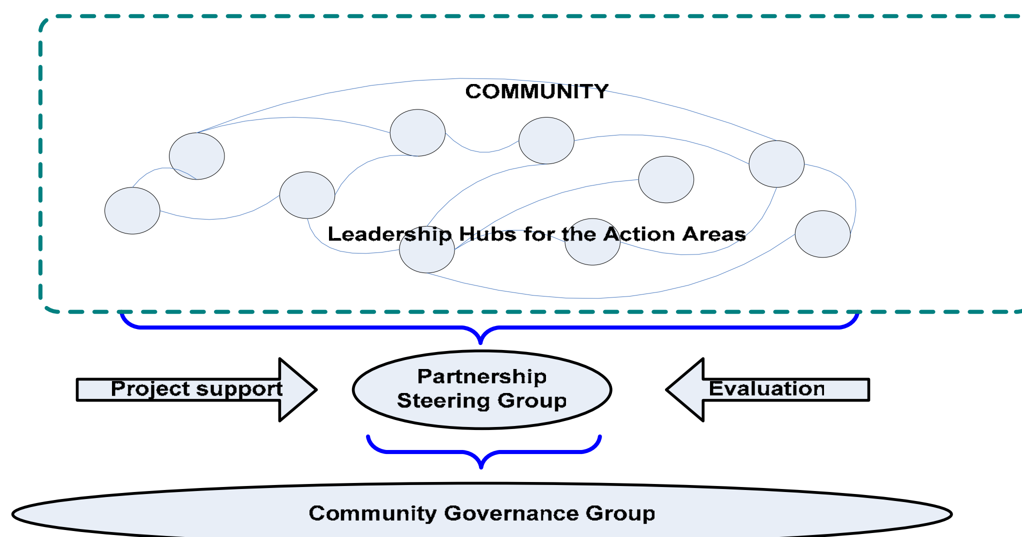
1.2 Implementation Challenges

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 Ten 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.

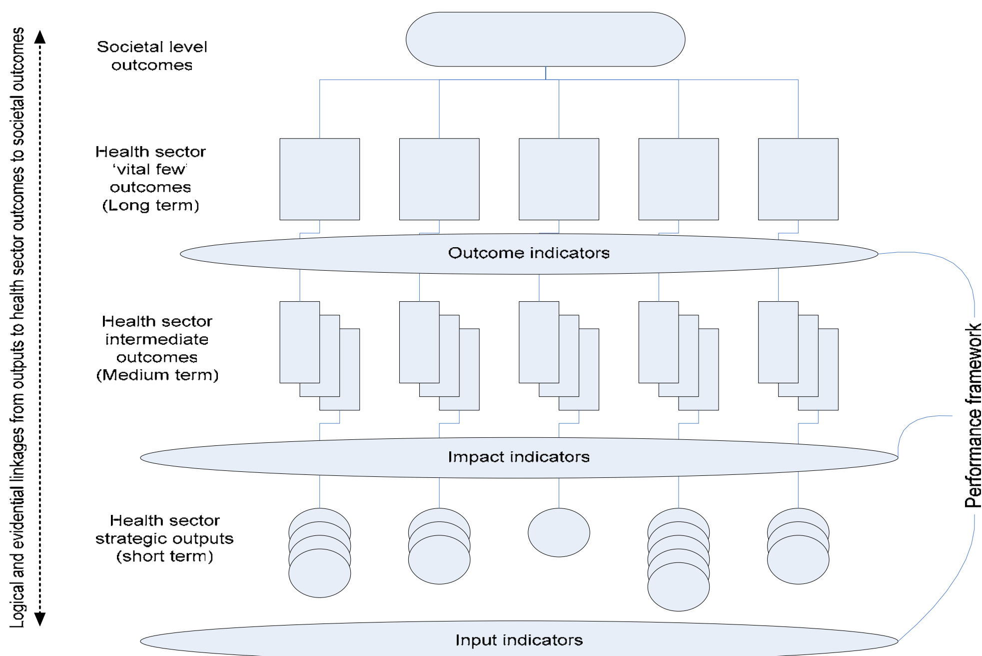
ii. *Partnership Steering Group* (PSG): The PSG is the key information-sharing and decision-making body for LBD, and is responsible for driving the operational management of LBD, and ensuring its outcomes are achieved. The group is comprised of leaders from each of the action areas, and representatives 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 Group* (CGG): The CGG encompasses broad community ownership of LBD. The group, comprised of individuals and organisations with an interest in LBD, will meet up to three times a year in a forum-style group. The purpose of these meetings will be for the PSG 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 CGG meeting.

1.2.2 Outcomes Focused Management

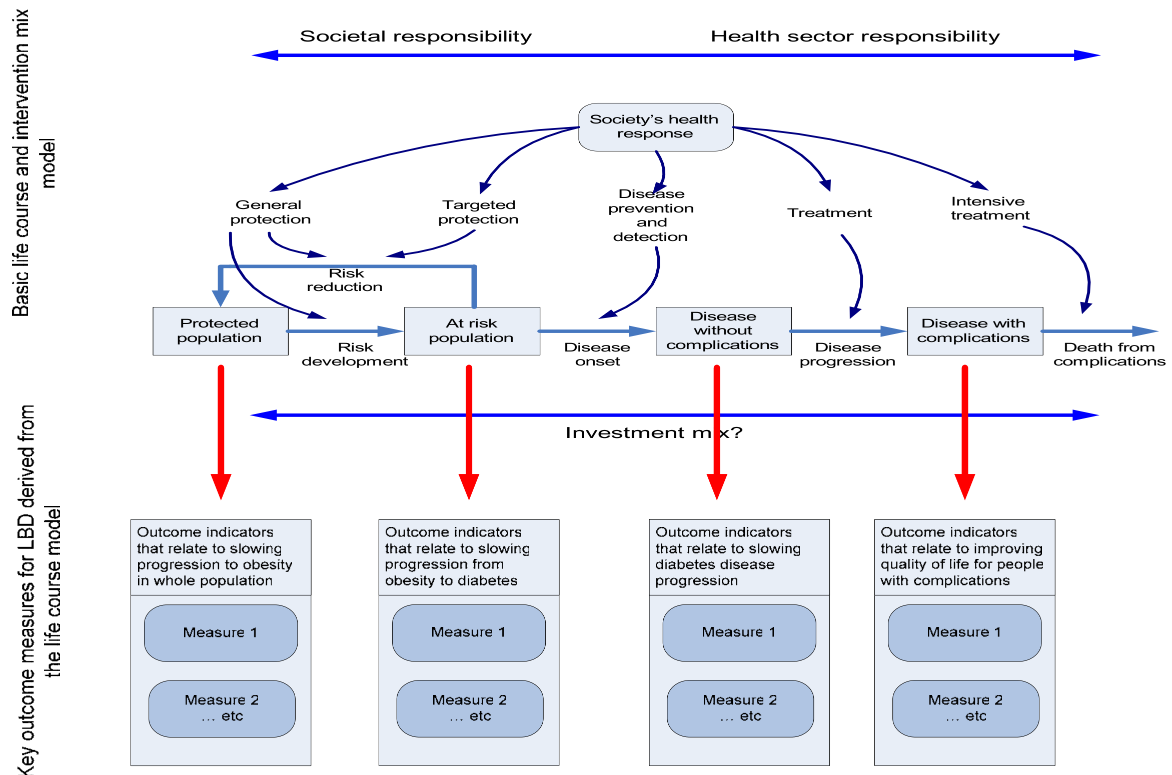
Manage a broad set of initiatives so that they are well designed, effectively implemented and tightly focused on outcomes that help prevent and manage diabetes.

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 is being developed for LBD and is being integrated with the evaluation framework to ensure that the evaluation team[1] 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 (see Section 2).

1.2.3 Whole System Coordination

Support co-ordination across the Ten 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 will seek the 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

[1] The evaluation team referred to in this document is the University of Auckland School of Population Health (SOPH). The SOPH was contracted on a 6 month contract to 30 June 2005 to develop the evaluation process and framework for LBD. CMDHB is currently in discussions with the SOPH re: it being contracted to implement the evaluation framework over the next 5 years.

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 framework will have a focus on outcomes for high at risk groups such as Maori and Pacific peoples. The evaluation approach aims to:

- 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 will regularly feed 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.

[The evaluation approach is described in more detail in section 3 of this document, and the accompanying report entitled '*Developing a framework and plan for evaluating Let's Beat Diabetes'* by the SOPH].

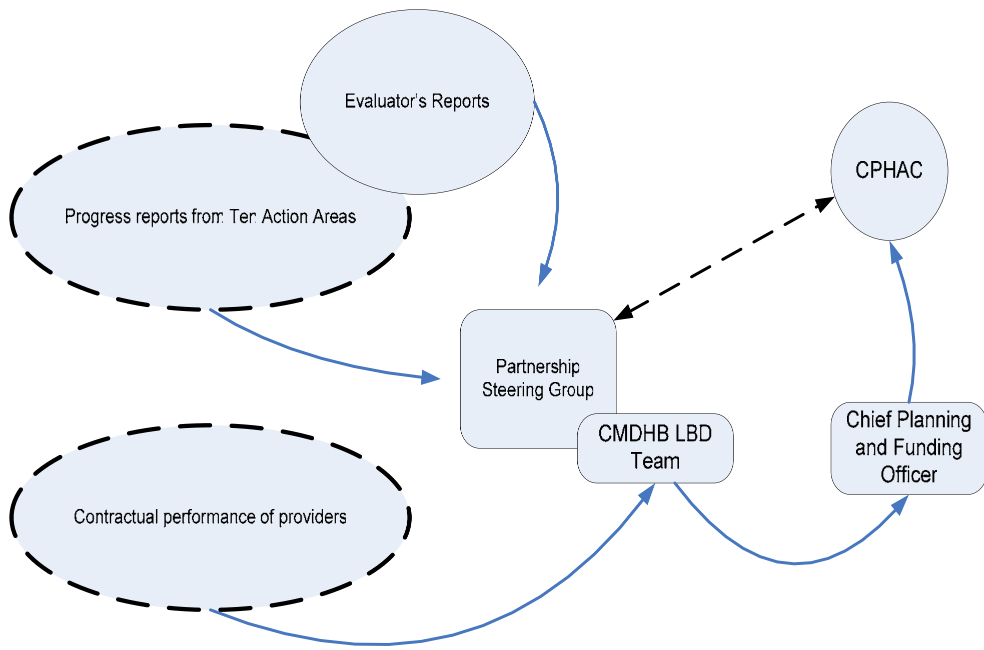
1.2.5 Explicit Accountability and Performance

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.


Evaluator's Reports
CPHAC
Progress reports from Ten Action Areas
Partnership Steering Group
CMDHB LBD Team
Chief Planning and Funding Officer
Contractual performance of providers

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 (5 year) and short term (1 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 will need to be formally reported to the following groups:

- the Community Public Health Advisory Committee (CPHAC), the Board of CMDHB, Pou[2] and Pacific Health Advisory Committee (PHAC)
- CMDHB Executive Management Team (EMT)
- LBD Partnership Steering Group (PSG)
- LBD Community Governance Group (CGG)
- Various community and health service meetings, as requested.

Note: The evaluation process will measure the performance of LBD across a large number of areas and in greater detail. The detailed evaluation feedback will compliment the KPIs.

2.2 Proposed Approach to KPIs

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

[2] In July, the Maori Health Advisory Committee (MHAC) was disestablished and replaced by a new representative Maori governing body, Pou. Pou is expected to convene officially in August.

- Health Outcomes
- Process Outcomes
- Management Outcomes.

Where possible the health and process outcomes should be reported by ethnicity and NZ 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. 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
Heath Outcomes 20 year high level whole population health outcomes for LBD. 5 year high level whole population health outcomes for LBD.	Risk groups, including: Maori, Pacific, South Asian (Indian), 'other' and income (NZ 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 5 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 (NZ 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 will need 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 5,000 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.
5 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
5 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	**Activity**
▪ Average age of diagnosis for diabetes. ▪ Reduced macrovascular end points	▪ 80% of provider contracts signed by Sept 30, 2005.

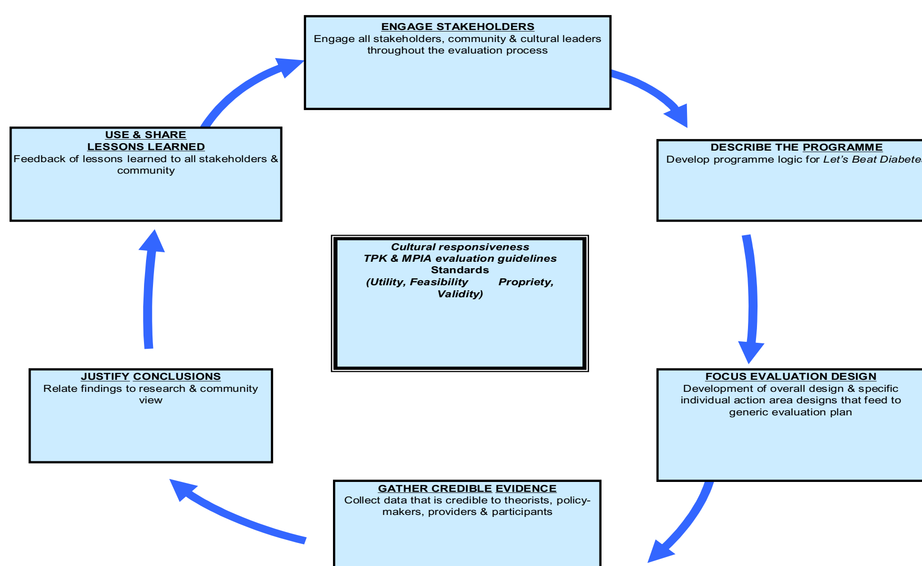
(cardiovascular death, CVA, MI, angina, cardiac revascularisation). ▪ Reduced progression to end stage renal disease. ▪ Reduced premature death from diabetes.	▪ Social marketing programmes under way by Feb 2006.
Community ▪ PSG remains effective and well attended. ▪ Ten Action Areas have functional leadership hubs. ▪ Three CGG meetings held.	**Financial** ▪ Programme stays within budget. ▪ Regular financial reports.

3. Evaluation Framework

The University of Auckland School of Population Health (SOPH) was contracted to develop the evaluation process and framework for *Let's Beat Diabetes* (LBD). 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. In its final report, the SOPH proposed 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 Ten 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 report recommends 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.



The SOPH's report also recommends the SOPH participate in the LBD Partnership Steering Group (PSG) so it is aware of developments and issues as they arise first-hand; and that it form a LBD Evaluation 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 bi-annual 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.

Counties Manukau District Health Board (CMDHB) is currently in discussions with the SOPH regarding it being contracted to implement the evaluation framework over the next 5 years. Any subsequent 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 (the contractor). This reporting might 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 5 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.

[See the accompanying report entitled '*Developing a framework and plan for evaluating Let's Beat Diabetes'* by the SOPH for a more detailed account].

4. Detailed Operational Plan 2005/2006

Let's Beat Diabetes (LBD) has ten 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 describes the interventions/initiatives for each of these action areas and their key performance indicators (KPIs) and/or milestones, process outcomes, health outcomes and CMDHB's LBD budget estimates.

It should be noted and understood that the budget estimates given in this document is the new funding CMDHB is contributing to the implementation of the LBD operational plan 2005/2006, and does not include the significant activity CMDHB already funds and/or resources from key partner organisations.

1. Supporting Community Leadership and Action

– Whole Population

During the extensive community consultation phase of 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 improved support for people with diabetes. But resources and support were seen as barriers.

Seed funding can leverage local motivation and ideas and, through enabling successful local initiatives, help to create and sustain local leadership and community empowerment. Subsequently, 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.

To 30 June 2005, seven community organisations and groups had received CAF grants. In 2005/2006, $100,000 will be available under the CAF. 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	Process Outcomes	Health Outcomes	CMDHB LBD Budget Estimate[3]
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	▪ Review/audit reveals funds used in appropriate manner.	▪ 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.	▪ Improved nutrition in the community. ▪ Improved physical activity in the community.	$100,000
TOTAL				**$100,000**

[3] It should be noted and understood that the budget estimates given in this document is the new funding CMDHB is contributing to the implementation of the LBD operational plan 2005/2006, and does not include the significant activity CMDHB already funds and/or resources from key partner organisations.

– 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 LBD. To this end, the initial focus for LBD will, therefore, be 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	Process Outcomes	Health Outcomes	CMDHB LBD Budget Estimate
1.2 Supporting Marae to become healthy, active environments/health promoting environments. Facilitate a hui for Marae in Counties Manukau to discuss this intervention/initiative, possible activities, and their support for, and interest in, being involved. Each (interested) Marae to identify the key activities they're going to implement. CMDHB/providers to provide support through training, resources and mentoring. Note: Marae target/KPI to be confirmed at hui. <u>Key partners</u>[4] - ARPHS, ProCare <u>Key linkages</u>[5] - LBD 1.3; action area 2; 4.3 – 4.5; 5.2 – 5.4; action area 6; 7.1 & 7.3; 8.5; 9.4 – 9.5; 10.6 – 10.10; and the evaluation.	▪ By end Sept 2005, hui facilitated. ▪ By end Sept 2005, Marae target/KPI confirmed. ▪ By June 2006, x% of Marae are healthy, active environments /health promoting environments.	▪ Marae become healthy, active environments/health promoting environments. ▪ Marae become positive Maori health settings. ▪ Improved community and whanau support for diabetes self management.	▪ Improved nutrition and physical activity for at risk population. ▪ Slowing of disease progression. ▪ Improved management of complications.	$25,000

[4] The key partners are those organisations and/or units who have confirmed their support and resources (actual or in kind) to the implementation of that specific intervention/initiative. During 2005/2006, the LBD programme management team (LBD team) will target other key organisations/units whose core responsibilities are or are closely aligned to LBD's agenda to get their buy-in into the programme.

1.3 Kaumatua and Kuia Leadership Programme Kaumatua and Kuia are influential leaders in the Maori community. Many want to influence positive health messages, including diabetes, but may not have the knowledge to speak with confidence about the disease or to provide appropriate advice to their communities. This programme looks to support identified Kaumatua and Kuia to become role models within their whanau and communities through enhanced knowledge on diabetes prevention and management by: - Facilitating an education hui, and by - Facilitating opportunities for Kuia and Kaumatua to support diabetes messages and programmes. <u>Key partners</u> • ARPHS, ProCare. <u>Key linkages</u> • LBD 1.2; action area 2; 4.3 – 4.5; 5.2 – 5.4; action area 6; 7.1 & 7.3; 8.5; 9.4 – 9.5; 10.6 – 10.10; and the evaluation.	▪ By (date 2005), education hui facilitated. ▪ Opportunities for Kuia and Kaumatua to support diabetes messages and programmes to be determined on an 'as needs' basis.	▪ 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.	▪ Improved nutrition and physical activity for at risk population. ▪ Slowing of disease progression. ▪ Improved management of complications.	$5,000
TOTAL				**$30,000**

[5] Key linkages are the linkages across the LBD plan and CMDHB service plans.

– Pacific peoples

Suamalie i le gutu a’e oona i le manava – fa’alalo le ma'i suka.

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.

Tamate i te toto vene.

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 early childhood centres (ECEs) as being the starting point for LBD. To this end, the initial focus for LBD will, therefore, be on supporting Pacific churches and Language Nests (7.2) to develop and implement nutrition and physical activity initiatives within their communities; empowering Pacific leaders about obesity and diabetes so they can become agents of change; and improving nutrition and 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 process of increasing community knowledge, and supporting Pacific cultural institutions to become leadership hubs for change.

Interventions/Initiatives	KPIs/ Milestones	Process Outcomes	Health Outcomes	CMDHB LBD Budget Estimate
1.4 Supporting Pacific churches to develop and implement nutrition and physical activity initiatives. CMDHB Pacific Health’s LotuMoui Grant initiative is supporting 50 Pacific churches to develop and implement community projects that will support their congregations to live healthy lifestyles. It includes: - Capacity building - Workforce development - Programmes/service delivery - Evaluation of the initiatives.		▪ Pacific churches become health promoting environments, with a focus on nutrition and physical activity.	▪ Improved nutrition and physical activity leading to a reduction in obesity for at risk population.	
LBD will support LotuMoui by: - Contracting provider(s) to facilitate 2 x series of ethnic-specific workshops for Pacific churches on obesity, diabetes prevention and management that is consistent with the LotuMoui framework, - Providing health promotion resources to the Church Health Committees, and	▪ By June 2006, 2 x series of ethic-specific workshops facilitated. ▪ By Nov 2005, resources provided/made available. ▪ Dec 2005, LotuMoui Fono	▪ Pacific churches’ knowledge about diabetes prevention and management is enhanced ▪ Motivated churches have access to high quality support and resources to achieve their	▪ Improved information, education and support will enhance awareness and behaviour change.	$20,000

- Supporting the LotuMoui Fono (Dec 2005 tbc). Key partners - CMDHB Pacific Health. Key linkages - LBD 1.5; action area 2; 4.3 – 4.5; 5.2 – 5.4; action area 6; 7.2; 9.4 – 9.5; 10.6 – 10.10; and the evaluation. - CMDHB Pacific Health Service Plan 2005/2006.	supported.	health objectives.		
1.5 Empowering self- identified and community identified leaders and organisations to become agents for change within their families and communities. Many Pacific church and community leaders acknowledge the diabetes problem and want to champion the fight against diabetes in the communities but do not have access to the knowledge to lead with confidence. Working with CMDHB Pacific Health, LBD will: - Contract provider(s) to facilitate 2 x series of ethnic-specific workshops on obesity, diabetes prevention and management, and - Build ongoing linkages, networks and support systems for the community leaders, and facilitate opportunities for community leaders to support diabetes messages and programmes. Key partners - CMDHB Pacific Health. Key linkages - LBD 1.4; action area 2; 4.3 – 4.5; 5.2 – 5.4; action area 6; 7.2; 9.4 – 9.5; 10.6 – 10.10; and the evaluation. - CMDHB Pacific Health Service Plan 2005/2006.	▪ By May 2006, workshops completed. ▪ By June 2006, linkages, networks and support systems for community leaders made and documented.	▪ Pacific leaders' knowledge about diabetes prevention and management is enhanced and they're supported to bring about change within their communities. ▪ Community supported in uptake of new ideas	▪ Improved nutrition and physical activity for at risk population. ▪ Slowing of disease progression. ▪ Improved management of complications.	$10,000
TOTAL				**$30,000**

– 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.

Auckland Regional Public Health Service (ARPHS) will, on behalf of LBD, lead this action area and support key organisations to enhance or develop and implement policies and initiatives that support healthy, active workplaces.

Interventions/Initiatives	KPIs/ Milestones	Process Outcomes	Health Outcomes	CMDHB LBD Budget Estimate
1.6 Supporting employers to develop and implement policies and initiatives that support healthy, active workplaces. Organisations that are actively participating to achieve the LBD objectives will be supported to introduce healthy, active workplace policies. The objective is that these organisations become sustainable exemplar workplace environments – in the areas of nutrition and physical activity. ARPHS will, on behalf of LBD: - Work with identified employers to enhance or develop and implement healthy, active workplace policies and programmes. Participant organisations in the first round could include: - Ministry of Social Development services (MSD) - Housing New Zealand Corporation (HNZC) - Manukau City Council (MCC) - Ministry of Pacific Island Affairs (MPIA) Over time the workplace programme will roll out to a wide range of partner organisations, such as the Food Industry. CMDHB has already started work in this area via its	▪ By Feb 2006, participant organisations enrolled, and working with ARPHS to develop and implement nutrition and physical activity policies and initiatives.	▪ 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.	▪ Improved nutrition and physical activity leading to a reduction in obesity.	$20,000

Wellness programme, which is to be launched in October 2005. Key partners - ARPHS. Key linkages - LBD action area 2; 4.3 & 4.5; 5.2 – 5.4; and the evaluation.				
TOTAL				**$20,000**
TOTAL FOR ACTION AREA				**$180,000**

ACTION AREA 5 YEAR WORKING GOALS:

Maori
- 90% of Marae are healthy, active environments/health promoting environments that actively support good nutrition and improved physical activity levels.

Pacific peoples
- 70% of Pacific churches are actively supporting good nutrition and improved physical activity levels.

Workplace
- A set of public sector and private sector exemplar workplaces that set standards for supporting employee health and create a model others can aspire towards.
- At least 10 major workplace sites in the public and private sector proactively supporting practical change in their environments, with another 20 smaller sites.
- Exemplar sites would achieve 20% increase in average daily workplace activity over the 5 year period.

2. Promoting Behaviour Change Through Social Marketing

A whole system communications programme changes people's behaviour.

There is good evidence that social marketing is an effective intervention when it is part of a broader programme of interventions/initiatives. Community consultation has indicated strong support for the social marketing component of *Let's Beat Diabetes* (LBD).

In early 2005, a contestable process was undertaken to select a social marketing partner(s) to work closely with Counties Manukau District Health Board (CMDHB) and the LBD social marketing leadership group to develop and implement a five year social marketing strategy. After an intensive short-listing process, a number of partners were selected to work on specific components of the strategy. A decision was also made to employ a project manager as part of the LBD to oversee this action area; to ensure CMDHB's and LBD partner organisations' strong Maori and Pacific linkages and networks are utilised in the social marketing approach; and to ensure effective linkages across the other action areas.

The fact that the social marketing will be applied within Counties Manukau constrains the use of communications mediums (e.g. television, regional newspapers, radio and magazines may be of questionable value) and means creative – and probably community based - approaches to social marketing will be required. Particular emphasis will be placed on the effectiveness of the social marketing for Maori and Pacific communities.

The approach to social marketing will be much like the rest of LBD, in that the strategy will not be set in stone, but there will be a strong sense of direction which is heavily influenced by evaluation and feedback about what is working. In the early years of LBD, the social marketing areas will be well supported with funds to gain awareness and impact for LBD and to support many of the other LBD action areas as they come on stream.

Interventions/Initiatives	KPIs/ Milestones	Process Outcomes	Health Outcomes	CMDHB LBD Budget Estimate
2.1 Consolidating the leadership hub for social marketing action area. The leadership hub to work in partnership with the social providers to develop and implement the social marketing programme will be consolidated. The hub is to comprise key community leaders and providers who have interest, expertise and influence in social marketing.	▪ Aug 2005, leadership group convenes.	▪ Community leadership, guidance and connection with the social marketing programme.		$2,000
2.2 Background Research **2.2.1 Review existing local research** Review of existing local research undertaken to: - ascertain awareness, knowledge, attitudes, behaviours to obesity, nutrition, physical activity, diabetes prevention & management - see whether sufficient data exists to form baseline	▪ By end Aug 2005, reviews and research completed.	▪ Existing knowledge gathered to form platform for, and to inform, social marketing programme. ▪ Social marketing partners and leadership hub informed.		$25,000

to measure success (and/or identify any gaps). **2.2.2 Review past campaigns** Review of past social marketing campaigns undertaken to: - identify issues that may influence and/or impact on effectiveness of communications programmes that aim to enhance knowledge, attitudes and promote behaviour change for Maori and Pacific peoples in CMDHB; and the critical success factors. **2.2.3 Formative research** Formative research with community and stakeholder group undertaken to: - to explore issues and consumer 'triggers' in-depth - to get success stories - to test hypotheses. **2.2.4 Information analysis** Analysis undertaken to identify whether sufficient information exists to proceed with strategy development (and/or any gaps) and/or whether a baseline survey is required.				
2.3 Baseline Survey (if required) A statistically valid baseline survey is needed to enable measurement of changes in target groups over time. The decision as to whether any further research is required to form the baseline and/or inform the strategy for the social marketing will be made as a result of 2.2	▪ If required, the baseline survey is likely to be undertaken in last quarter of 2005.	▪ 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.		$50,000 (if required)
2.4 Strategy Development				

Develop a five year social marketing strategy based on the reviews and research (2.2), the survey (2.3 – if required) and the broader interventions/initiatives in the LBD plan. In developing the strategy, the social marketing providers and leadership hub will be required to: - wherever possible, utilise or work closely with current community structures and partnerships to ensure appropriateness, acceptability and ownership of the strategy - be responsive to the population health and communication needs of Maori and Pacific peoples, and - align with HEHA strategies, and where possible, seek synergies with other local regional and national social marketing strategies.	▪ Nov 2005, strategy completed.	▪ Key messages and mediums defined for social marketing programme in medium term.		$50,000
2.5 Social Marketing Activity Initial social marketing activity will be initiated in the first six months of the 2005/2006 year. This activity is likely to be of small scale, while strategic work continues. The major social marketing activity will occur in the second six moths of 2005/2006. Key partners - Auckland Regional Public Health Service (ARPHS), Food Industry, CMDHB Pacific Health, CMDHB Maori Health. Key linkages - All LBD action areas; and evaluation. - CMDHB Primary Care Development (including Chronic Care Management programme - CCM); CMDHB Pacific Health Service Plan 2005/2006;	▪ By Nov 2005, small scale activity initiated. ▪ Feb 2006, major activity begins. ▪ Strong community support for social marketing concepts and approach.	▪ Target populations informed and motivated to change behaviour (exact outcomes will be based on actual activity for 2005/2006).	▪ Changed behaviour in relation to diabetes risks and disease management.	$473,000
TOTAL				**$600,000**

ACTION AREA 5 YEAR WORKING GOALS:

- Knowledge goal - to be determined
- Attitude goal - to be determined.
- Action goal - to be determined.
- All goals by priority groups – to be determined.
- Goals for niched audiences such as schools and health professionals - to be determined.

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.

LBD will be strongly supported in this action area by Auckland Regional Public Health Service (ARPHS), who will lead a number of the interventions/initiatives.

Interventions/Initiatives	KPIs/ Milestones	Process Outcomes	Health Outcomes	CMDHB LBD Budget Estimate
3.1 Developing a prototype neighbourhood 'activity park' in Counties Manukau. Housing New Zealand Corporation (HNZC) is undertaking a major housing redevelopment in Clendon, which is an area with a high rate of at risk population for diabetes. LBD will work with HNZC, Manukau City Council (MCC) and Counties Manukau Sport to redevelop Templeton Park into a prototype neighbourhood 'activity park', designed to support an increased level of family/community based physical activity. Initial consultation has already been completed by HNZC. The physical upgrade will be completed during 2005/2006, with a number of agencies contributing resources. <u>Key partners</u> - HZNC, MCC, Counties Manukau Sport, ARPHS. <u>Key linkages</u> - LBD 1.2 – 1.5; action area 2; action area 3; action	▪ By May 2006, physical upgrade of park completed and evaluation of usage and community response undertaken to guide LBD's Operational Plan 2006/07.	▪ Park facilities are more attractive for families and encourage activity, games and play. (It is anticipated that Templeton Park will become a prototype for developing 'activity parks' at numerous location throughout Counties Manukau).	▪ Increased levels of physical activity lead to lower obesity levels. ▪ Increased family play leads to social cohesion.	$45,000

area 6; action area 7; and the evaluation.				
3.2 Undertaking health impact assessments of major planning initiatives in Counties Manukau. ARPHS will, on LBD's behalf: - Review major planning initiatives in Counties Manukau and undertake health impact assessments in terms of their impact on physical activity, and - Make submissions to MCC on a case by case basis. <u>Key partners</u> - ARPHS. <u>Key linkages</u> - LBD 1.2 – 1.5; action area 2; action area 3; 5.2 – 5.4; action area 6; action area 7; and the evaluation.	▪ [date], prototype health impact assessment undertaken in collaboration with MCC. ▪ Submissions made within specified timeframes.	▪ Increased uptake of health issues in urban planning and design.	▪ Increased levels of physical activity lead to lower obesity levels.	Non budget item.
3.3 Providing advice on Flat Bush development. ARPHS will, on LBD's behalf, provide advice to MCC in terms of the healthy community's aspects of the Flat Bush development. <u>Key partners</u> - ARPHS. <u>Key linkages</u> - LBD 1.2 – 1.5; action area 2; action area 3; 5.2 – 5.4; action area 6; action area 7; and the evaluation. - CMDHB Primary Care Development.		▪ Health issues remain firmly on the agenda of the Flat Bush agenda and urban design lessons are applied elsewhere in Counties Manukau.	▪ Increased levels of physical activity lead to lower obesity levels.	Non budget item.
3.4 Advocating for health ARPHS will, on LBD's behalf:	▪ Submissions made within specified timeframes.	▪ Effective health input into district and regional public	▪ Increased levels of physical activity lead to lower obesity	Non budget item.

- write submissions and lobby on public transport and active transport infrastructure issues, especially in relation to Eastern Corridor transport links. ARPHS and LBD will work with MCC to ensure access to, and opportunities for, physical activity and recreation services 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. Key partners - ARPHS. Key linkages - LBD 1.2 – 1.5; action area 2; action area 3; 5.2 – 5.4; action area 6; action area 7; and the evaluation.		transport infrastructure decisions. ▪ Barriers to access and participation remain low.	levels. ▪ Increased levels of physical activity lead to lower obesity levels.	Non budget item.
TOTAL				**$45,000**

ACTION AREA 5 YEAR GOALS:

- Creating neighbourhood environments and parks that support family physical activity is standard Manukau City Council policy, supported by investment in infrastructure.
- There is a 20% measurable increase in the usage of parks that have had activity make-overs.
- The Flat Bush development remains true to the concept of it being a flagship for 'healthy communities' urban design. Health-based urban design concepts from Flat Bush have become standard in all new sub divisions and housing intensification projects.
- Any major redevelopment of urban hubs and transport corridors explicitly support improved public transport and walking/cycling transport options. There is a 20% increase in use of public transport and 20% increase in cycling uptake.
- Barriers to access and opportunities for physical activity remain low.

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 high risk of diabetes.

Over the twelve months, Counties Manukau District Health Board (CMDHB) and Auckland Regional Public Health Service (ARPHS) have been working with the Food Industry Group 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. It will, however, need careful development to ensure it is effective, sustainable and the needs of the Food Industry and Health are met.

To ensure this relationship is effective, sustainable and meets the needs of the Food industry and Health, the Food Industry and LBD have agreed to consolidate a Food Industry:Health governance/leadership structure; and the Food Industry and CMDHB to co-fund an advocacy position to develop and drive the joint Food:Health work programme. The governance structure is to be confirmed by July 2005. The advocacy position is expected to be filled in August 2005, with the joint work programme developed by Oct 2005, ready for implementation.

Notwithstanding this, progress has also been made during the past eight months, with the fast food and beverage industries looking at a specific initiative for Counties Manukau. This initiative will be one of the first concrete actions under this action area.

Interventions/Initiatives	KPIs/Milestones	Process Outcomes	Health Outcomes	CMDHB LBD Budget Estimate
4.1 Consolidating a leadership structure and action agenda for the food industry: health sector joint initiative in Counties Manukau. Food: Health Joint Initiative Group consolidated. Group to be comprised of members from the two sectors. Detailed action agenda for 2005/06 agreed. Joint Initiative Group is accountable for co-funded advocacy position. <u>Key partners</u> - Food Industry, ARPHS, National Heart Foundation (NHF).	▪ By July 2005, Food:Health Joint Initiative Group consolidated.	▪ A collaborative structure guides Food Industry initiatives. ▪ Consolidation of Counties Manukau as the 'demonstration pilot' area for the New Zealand Food Industry Accord.		Non budget item.
4.2 Co-funding of an advocacy position to develop and implement the joint Food: Health work programme. Person employed to develop detailed strategy and	▪ Aug 2005, co-funded advocacy	▪ Food Industry organisations	▪ Better nutrition and a	$50,000

implement specific projects, as defined by the Joint Initiative Group. Strategy to include high-level strategic initiatives as well as local initiatives such as working with ARPHS and MCC to improve fast food cooking practices and environments; and supporting the vulnerable families action area of LBD. <u>Key partners</u> - Food Industry, ARPHS, National Heart Foundation (NHF), MCC. <u>Key linkages</u> - LBD 1.2 – 1.6; action area 2; action area 4; 5.2 – 5.4; action area 6; action area 7; 8.3 & 8.5; 9.4 & 9.5; 10.6 – 10.10; and the evaluation.	position employed. ▪ Oct 2005, detailed strategy completed and agreed by Joint Initiative Group.	make changes that achieve health goals while also achieving their commercial goals. ▪ Change in the food supply towards healthier food.	reduction in obesity.	
4.3 Supporting fast food chains to make non sugar drinks the default drink option. LBD will continue to work with a major fast food to ensure its 'non sugar drinks as the default drink option' policy is implemented. <u>Key partners</u> - Fast food chain (confidential), ARPHS. <u>Key linkages</u> - LBD 1.2 – 1.6; action area 2; action area 4; 5.2 – 5.4; action area 6; action area 7; 8.3 & 8.5; 9.4 & 9.5; 10.6 – 10.10; and the evaluation.	▪ By Feb 2006, new drinks policy in place.	▪ Reduction in sugar intake for adults and children.	▪ Better nutrition and a reduction in obesity.	Non budget item.
4.4 Supporting schools drinks initiative. LBD will continue to work with drinks suppliers to reduce the uptake of sugar drinks in schools and their surrounding environments. <u>Key partners</u> - Drink suppliers (confidential), ARPHS. <u>Key linkages</u> - LBD 1.2 – 1.6; action area 2; action area 4; 5.2 –	▪ Initiative in place for start of 2006 school term.	▪ Reduction in sugar intake for children.	▪ Better nutrition and reduction in obesity.	Non budget item.

5.4; action area 6; action area 7; 8.3 & 8.5; 9.4 & 9.5; 10.6 – 10.10; and the evaluation.				
4.5 Ensuring the Food Industry supports local health promoting initiatives such as the ‘Healthy Kai’ initiative, food parcels, and the work of health hygiene and environment inspectors. LBD will work to develop direct linkages between the Food Industry and local health promoting initiatives such as the ‘Healthy Kai’ initiative, food parcels and health hygiene and environment inspectors to ensure collaboration and enhanced health outcomes. Key partners - Food Industry, ARPHS, NHF, MCC, Ministry of Social Development, Salvation Army Family and Social Services. Key linkages - LBD 1.2 – 1.6; action area 2; action area 4; 5.2 – 5.4; action area 6; action area 7; 8.3 & 8.5; 9.4 & 9.5; 10.6 – 10.10; and the evaluation.		▪ Improved food options in high at risk areas. ▪ Enhanced collaboration and outcomes. ▪ Localised responsiveness and action by the Food Industry.	▪ Better nutrition and a reduction in obesity.	Non budget item.
TOTAL				**$50,000**

ACTION AREA 5 YEAR WORKING GOALS:

- All schools and surrounding environments support improved nutrition.
- Non sugar drinks become dominant in the marketplace.
- Measurable change in the nutritional make-up of average fast food servings.
- Food Industry supports local health promoting initiatives to ensure enhanced health outcomes.

5. Strengthening Health Promotion Coordination 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, coordinated 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. Huge progress has been made over the past year in co-ordinating and aligning groups and ideas, understanding barriers to performance and identifying priorities. During 2005/2006, 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 coordination of the funding environment
- coordinated 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	Process Outcomes	Health Outcomes	CMDHB LBD Budget Estimate
5.1 Consolidating a community leadership hub for the health promotion action area. Consolidate a leadership forum to provide guidance for, and lead, the health promotion action area. The forum is to be comprised of health promotion leaders – Primary Health Organisation (PHO) and community-based – and be ethnically diverse. <u>Key partners</u> - ARPHS, PHO Health Promotion Working Group (PHO HPWG), Diabetes Projects Trust (DPT), CODA (Community Organisations Diabetes Awareness – which comprises MCC, NHF, Diabetes Auckland and PHOs), Whitiora Diabetes Service.	▪ Aug 2005, leadership hub convenes.	▪ Acknowledged leadership forum for diabetes-related health promotion.		$2,000
5.2 Supporting aligned actions through better coordination of the funding environment.				

Support funder organisations for health promotion in Counties Manukau to meet annually to share information on funding allocations and strategies as they relate to diabetes risk factors and disease management. It is proposed LBD's 'life course' model will be used to review funding strategies to minimise overlaps, identify gaps and ensure there are programmes operating in synergy with each other. Develop over time a consistent and transparent approach to describing contacted outputs in summary terms so that providers can understand what each other is doing and who they are targeting. The Qipps database and model provides an opportunity to support internet-based provider-to-provider sharing of strategic information. <u>Key partners</u> ARPHS, PHO HPWG, DPT, CODA. <u>Key linkages</u> - LBD all action areas. - CMDHB Planning & Funding; CMDHB Pacific Health; CMDHB Maori Health; CMDHB Primary Care Development (including Chronic Care Management programme - CCM);	▪ March 2006, funders meet to discuss funding allocations and strategies for 2006/2007 year. ▪ Feb 2006, health promotion providers have entered programme summary information in Qipps and it made available to all.	▪ More efficient use of funds to support diabetes objectives. ▪ Better decisions by funders and providers about service provision and design.		$2,000
5.3 Improving capacity of the health promotion workforce. Develop an e-mail/web-based information network for health promoters working in Counties Manukau, that provides information on programmes, training opportunities, events, policies, practical issues (such as equipment and resource availability) and available specialist help in order to support an informed and interacting workforce that is focused on self directed improvement.	▪ Sept 2005, e-mail/web-based network of health promoters in place and operational. ▪ March 2006, health promotion core competencies identified and developed to enable training to proceed. ▪ May 2006, training in core competencies begins and formal	▪ Informed and connected workforce. ▪ Workforce has improved standards, skill sets and language in relation to diabetes. ▪ Maori and Pacific peoples are supported to take up careers in health promotion.	▪ Improved impact on diabetes risk factors and disease progression. ▪ Improved capacity of workforce.	$45,000

Commission the development of health promotion core competencies for diabetes risk factors and disease management. (Need to ensure that any development does not duplicate – and aligns with - national processes) and provide training opportunities to support attainment of competencies. The training solutions may include services from independent providers and also the re-orientation of mainstream education service providers. Integrate formal health promotion competencies into career pathways. Capacity development needs to have a focus on supporting Maori and Pacific health promoters and ensuring mainstream health promoters have good skills to provide quality services for Maori and Pacific peoples. Based on the Pacific Diabetes Literature Review, key learning on effective interventions and approaches to Pacific health education can inform best/good practice to ensure Pacific community education is effective and built on long term learning about disease process and its impact on health. This must be developed in conjunction with any workforce development that is likely to target and/or impact Pacific populations. Key partners - ARPHS, CMDHB Primary Care Workforce Development, Whitiora Diabetes Service, CMDHB Pacific Health. Key linkages - LBD all action areas. - CMDHB Planning & Funding; Pacific Health Workforce Development; Maori Health Workforce Development; Primary Care Workforce Development;	training in mainstream educational institutions ready to proceed 2nd quarter 2006. ▪ 30 June 2006, develop best practice guidelines for health education and promotion resources for Pacific populations.	▪ Improved standards of health promotion.		
5.4 Improving communications resources for diabetes for use within health promotion and				

primary care. Undertake gap analysis for core diabetes communications resources for use in health promotion, obesity management and diabetes disease management. Gap analysis will look at issues of content, cultural applicability and quality. Health promotion leadership forum to oversee analysis process (multiple organisations have a stake in this process). Resources will be updated or new resources developed, as required. Development and style of new resources should be cognizant of LBD social marketing strategies and of opportunities with electronic media, and the needs of LBD's other action areas. Resources should also align with Patient Management Systems (where appropriate), the CCM programme and the New Zealand guidelines group. Resources must also be developed within a cultural, collective and relational context of how Pacific people learn and are more likely to sustain behaviour change. Translated print material in isolation of workforce development, models of care and service delivery are no longer an acceptable process. Evidence based resources for Pacific populations must reflect how Pacific people learn and are more likely to act on education and inform change. Develop a well publicized and accessible supply of quality resources available for all health organisations, community organisations and groups and the wider community. <u>Key partners</u> - ARPHS, PHO HPWG, DPT, CODA, CMDHB Primary Care Workforce Development, Whitiora Diabetes Service, CMDHB Pacific Health.	▪ Sept 2005, agreement on hosting, distribution and marketing of communications resources responsibilities within Counties Manukau. ▪ Oct 2005, gap analysis for communications resources completed and agreement on initial resources for upgrade or new development. ▪ From Nov 2005, upgrade of resources using best practice processes undertaken and based on evidence and literature review appropriate to each target group (e.g. Maori and Pacific populations).	▪ Communications resources known and accessible to all health providers. ▪ Communications resources are accurate, appropriate, effective and consistent.	▪ Improved uptake of knowledge, leading to behaviour change in relation to risk factors and disease management.	$38,000

Key linkages - LBD all action areas. - CMDHB Planning & Funding; ; Maori Health Workforce Development; Primary Care Workforce Development;				
TOTAL				**$87,000**

ACTION AREA 5 YEAR WORKING GOALS:

- Well defined skills/qualifications and career pathways for health promoters.
- A 50% proportional increase in Maori and Pacific health promoters.
- Integrated communications resources that are trusted and used by all health professionals.
- All providers part of a communications network and all are contributing to a district database of activities.

6. Enhancing Well 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.

A professional review of the Well Child framework is required, along with the development of detailed recommendation of practical changes and then the development of workforce training and supporting resources and systems before those changes can be implemented. The LBD agenda also has to sit alongside other reviews of Well child provision in Counties Manukau.

Interventions/Initiatives	KPIs/Milestones	Process Outcomes	Health Outcomes	CMDHB LBD Budget Estimate
6.1 Supporting the existing Well Child forum to be the leadership hub for the Well Child action area. The existing forum of Well Child providers has agreed to be the leadership hub for the LBD Well Child action area, and oversee its work programme.	▪ July 2005, leadership hub in place.			Non budget item.
6.2 Supporting the professional review of Well Child framework. A review of the Well Child assessment tool to include assessment for diabetes and/or childhood obesity risk factors. The review will also look at knowledge and resource provision for parents relating to appropriate nutrition and physical activity needs for growing children. The review needs to be robust and rigorous as it	▪ Sept 2005, terms of reference completed and expertise engaged. ▪ Feb 2006, review and recommendations completed, peer reviewed and presented to Well Child leadership hub for guidance on implementation.	▪ Updated evidence based review of Well Child framework in relation to early years and risk factors for diabetes for Counties Manukau population.	(Awaits outcome of review)	$40,000

deals with a nationally defined service and will come under scrutiny from national experts. It is anticipated that dietetic, paediatric and public health expertise will be required. Further action will be determined by the outcomes of the review. It is anticipated it will include developments to the Well Child framework and training. Key partners - Well Child Provider Group Forum and Well Child providers. Key linkages - LBD 1.2 – 1.5; action area 2; action area 7; action area 9; 10.6 – 10.10; and the evaluation. - CMDHB Child and Youth Health, Pacific Health, Maori Health;				
TOTAL				**$40,000**

ACTION AREA 5 YEAR GAOLS:

- All parents receive improved education on appropriate nutrition and physical activity for healthy children in line with Well Child contacts and framework service provision
- All young children at risk of obesity are identified and targeted with appropriate response.

7. Developing a Schools Accord 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 states 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 characterized 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 2005/2006, *Let's Beat Diabetes* (LBD) will focus on:

- enhancing the coordination of existing health promotion providers to minimise schools' confusion and fatigue
- establishing a leadership hub to oversee strategy development
- enhancing and supporting the AIMHI/NEW pilot in selected high risk secondary schools
- trialling and 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, and
- supporting Kohanga Reo, Kura Kaupapa and Pacific early childhood centres (ECEs) to enhance or develop and implement nutrition and physical activity policy and programmes.

Interventions/Initiatives	KPIs/Milestones	Process Outcomes	Health Outcomes	CMDHB LBD Budget Estimate
EARLY CHILDHOOD EDUCATION **7.1 Supporting Kohanga Reo to enhance or develop and implement nutrition and physical activity guidelines and programmes.** Counties Manukau District Health Board (CMDHB) Maori Health is developing a partnership relationship with Te Kohanga Reo Regional Unit to work together to support education and health outcomes for tamariki.				
LBD will support this by contracting provider(s) to: - Review 70% kohanga in Counties Manukau to assess their existing nutrition and physical activity policy and programmes - Work with the staff to enhance or develop and implement nutrition and physical activity policy and	▪ By Sept 2005, contracts for provision in place. ▪ 70% of kohanga in Counties Manukau have nutrition and physical activity guidelines and programmes.	▪ Sustainable changes to early childhood environment for high at risk children. ▪ Creation of relationships and platform for further interventions/initiatives in	▪ Reduction in obesity risk for young children.	$20,000

<table>
<tr>
<td>programmes
- Provide training for kohanga staff.
- Provide resources
- Link kohanga to local health promotion providers to provide mentoring/ongoing support.

<u>Key partners</u>
- Te Kohanga Reo Regional Unit, CMDHB Maori Health, Auckland Regional Public Health Service (ARPHS), National Heart Foundation (NHF).

<u>Key linkages</u>
- LBD 1.2 – 1.3; action area 2; 5.2 – 5.4; action area 6; action area 7; and evaluation.
- CMDHB Child and Youth Health; Maori Health;</td>
<td>▪ 70% of kohanga in Counties Manukau have received training.
▪ 70% of kohanga are linked to local health providers.</td>
<td>future years.
▪ Increased knowledge for children and kohanga staff.</td>
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<td>7.2 Supporting Pacific Language Nests to enhance or develop and implement nutrition and physical activity guidelines and programmes as part of programme delivery.

LBD will establish a partnership relationship with Ministry of Education (MOE) Pasifika and Early Childhood Units, ARPHS and the Ministry of Pacific Island Affairs. The target group for 2005/2006 is the licensed Pacific Early Childhood Centres (ECEs) in Counties Manukau. There are 33.

LBD will contract provider(s) to:
- Review 100% of the licensed Pacific ECEs in Counties Manukau to assess their existing nutrition and physical activity policy and programmes
- Work with the staff to enhance or develop and implement nutrition and physical activity policy and programmes
- Provide training for ECE staff
- Provide resources (to be developed & costed as part of health promotion action area)
- Link ECE staff to local health promotion providers to provide mentoring/ongoing support.</td>
<td>▪ Partnership relationship established.

▪ By Sept 2005, provider(s) contract in place.
▪ 100% of licensed Pacific ECEs in Counties Manukau have nutrition and physical activity guidelines and programmes.
▪ 100% of licensed Pacific ECEs in Counties Manukau have received training.
▪ 100% of licensed Pacific ECEs are linked to local health providers.
▪ ‘Nutrition and physical activity’ a</td>
<td>▪ Sustainable changes to early childhood environment for high risk children.
▪ Creation of relationships and platform for further interventions/initiatives in future years.
▪ Increased knowledge for children and ECE staff.</td>
<td>▪ Reduction in childhood obesity for high at risk populations.</td>
<td>$20,000</td>
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- Work with MOE Pasifika Unit it ensure 'active' guidelines and programmes are a key requirement for future ECEs. <u>Key partners</u> - MOE Pasifika and ECE Unit, APRHS, TaPasefika, NHF, CMDHB Pacific Health. <u>Key linkages</u> - LBD 1.4 & 1.5; action area 2; 5.2 – 5.4; action area 6; action area 7; and the evaluation. - CMDHB Child and Youth Health; Pacific Health;	key requirement for future ECEs.			
PRIMARY/INTERMEDIATE **7.3 Supporting Kura Kaupapa to enhance or develop and implement nutrition and physical activity guidelines and programmes.** CMDHB Maori Health is developing a partnership relationship with Kura Kaupapa (kura) to work together to support education and health outcomes for tamariki. LBD will support this by contracting provider(s) to: - Review 70% kura in Counties Manukau to assess their existing nutrition and physical activity policy and programmes - Work with the staff to enhance or develop and implement nutrition and physical activity policy and programmes - Provide training for kura staff - Provide resources - Link kura to local health promotion providers to provide mentoring/ongoing support. <u>Key partners</u> - Kura, CMDHB Maori Health, ARPHS, NHF. <u>Key linkages</u>	▪ By Sept 2005, contracts for provision in place. ▪ 70% of kura in Counties Manukau have nutrition and physical activity guidelines and programmes. ▪ 70% of kura in Counties Manukau have received training. ▪ 70% of kura are linked to local health providers.	▪ Sustainable changes to early childhood environment for high at risk children. ▪ Creation of relationships and platform for further interventions/initiatives in future years. ▪ Increased knowledge for children and kura staff.	▪ Reduction in obesity risk for young children.	$10,000

- LBD 1.2 & 1.3; action area 2; 5.2 – 5.4; action area 6; action area 7; and the evaluation. - CMDHB Child and Youth Health; Maori Health;				
7.4 Establishing a leadership hub and ongoing strategy development for approach to primary/intermediate schools, including explicit support for approach from national and district based MOE/Sport and Recreation New Zealand (SPARC), health agencies/providers. Maintain existing schools working group and develop into a sustainable leadership hub for schools action area. Develop explicit strategy to plot year on year actions required to improve the nutrition, physical activity and education environments in all Counties Manukau schools over a five year period.	▪ Aug 2005, schools leadership hub convenes. ▪ By Jan 2006, explicit medium term strategy is completed and supported by Ministry of Health (MOH), Sport and Recreation New Zealand (SPARC) and MOE.	▪ Aligned cross-district multi-sectoral communications and leadership. ▪ Strategic environment developed where LBD plans are supported.		$2,000
7.5 Improving school principals' and Boards of Trustees' awareness of the strong evidence supporting improved educational outcomes when children are achieving appropriate physical activity levels and nutrition (breakfasts). Develop an awareness/educational strategy for all school leaders that highlights importance of the 'fit, healthy and ready to learn' message. Awareness/education programme is likely to have many strands including social marketing/existing schools providers and specific programme for LBD. Note: Needs to link with existing Kids First school nursing role and Health Promoting Schools. <u>Key partners</u> - ARPHS, KidzFirst, Counties Manukau Sport, ProCare, NHF.	▪ By Nov 2005, all schools contacted in initial communication. ▪ By June 2006, 20% of schools receive dedicated educational visit for principals and trustees	▪ Increased knowledge of relationship between nutrition, physical activity and educational outcomes develops receptive environment for LBD vision. ▪ More children undertake 2.5 hours of heartbeat-raising exercise every week. ▪ School leaders support sustainable change to school structures, systems and skills.	▪ Reduction in obesity. ▪ Improved diet. ▪ Improved fitness levels. ▪ Improved educational outcomes.	$5,000

Key linkages - LBD 1.2 & 1.3; action area 2; 5.2 – 5.4; action area 7; and the evaluation.				
SECONDARY **7.6 Enhancing and supporting NEW/AIMIHI intervention in selected high risk secondary schools, and aligning it with University of Auckland OPIC intervention/research.** Support existing NEW/AIMHI programme in selected high risk secondary schools (Sir Edmund Hillary Collegiate, Southern Cross Campus, Mangere College), and align it to, and collaborate with, the University of Auckland (UOA) OPIC study for a co-ordinated approach to interventions across the three schools. Note: The secondary school strategy is initially focused on a high intensity intervention in a small number of schools, with rigorous associated evaluation. Results will be available in three years and will inform a broader district strategy for secondary schools. Key partners - UOA, DPT. Key linkages - LBD 1.2 – 1.5; action area 2; 4.3 – 4.5; 5.2 – 5.4; action area 7; and the evaluation.	▪ By Aug 2005, negotiations with UOA/OPIC about design and funding completed. ▪ By Sept 2005, contracting with Diabetes Projects Trust (DPT – the existing provider) for enhancements completed. ▪ From Feb 2006, enhanced interventions delivered (some likely to start earlier).	▪ 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.	▪ Reduction in rates of obese and overweight children in high at risk adolescent population.	$60,000
7.7 Trialling of the 'healthy canteen' business model. Trial 'healthy canteen' model at Tangaroa College. This model will be communicated to secondary schools during 2005/2006. To provide a tool for the development of healthy tuckshops in schools.	▪ During 2005/2006, healthy canteen model information trialled at Tangaroa College. ▪ During 2005/2006, healthy canteen model promoted to all	▪ Canteen contracts in secondary schools specify healthy only options for food and drink.	▪ Improved nutrition leads to reduction in obesity.	$5,000

<u>Key partners</u> - Tangaroa College. NEW. <u>Key linkages</u> - LBD 1.2 – 1.5; action area 2; 4.3 – 4.5; 5.2 – 5.4; action area 7; and the evaluation.	secondary schools in Counties Manukau.			
SECTOR-WIDE **7.8 Developing new funding streams to support schools to make sustainable changes.** The scope of the changes required in the school environment is larger than LBD resources can support – and there appear to be few other direct resources available at present from other sources. The opportunity to work with the South Auckland Health Foundation (SAHF) to develop potential funding/sponsorship resources for schools has been mooted. A fundraising design that is acceptable to schools/ the health sector/SAHF and sponsors will need to be developed. There are also opportunities to apply to SPARC's national funding pool for innovative initiatives. A proposal will be developed in collaboration with Counties Manukau Sport. <u>Key partners</u> - UOA, DPT, SAHF, Counties Manukau Sport. <u>Key linkages</u> - LBD 1.2 – 1.5; action area 2; 4.3 – 4.5; 5.2 – 5.4; action area 7; and the evaluation.	▪ By Sept 2005, SPARC funding application completed in collaboration with CM Sport. ▪ By Nov 2005, funding/sponsorship approach with SAHF support completed.	▪ Increased resources available to support change process for schools. (It is understood that the funding is not permanent and that Schools/ MOE/ SPARC will need to support sustainable change).	▪ Greater intensity of obesity reduction programmes.	Non budget item.
7.9 Supporting schools to improve 'drinks' environment in and around all schools. Working with principals and the Food Industry to reduce access to sugar drinks on schools premises,	▪ By Oct 2005, approach agreed to with the Food Industry.	▪ Changed attitudes towards and access to sugar drinks in	▪ Reduction in consumption of calories through sugar	Non budget item.

while working with Food Industry to reorient advertising and displays in the schools environment and vicinity to promote non sugar drinks. Key partners - Food Industry, ARPHS. LBD linkages - LBD 1.2 – 1.5; action area 2; 4.3 – 4.5; 5.2 – 5.4; action area 7; and the evaluation.	▪ By April 2006, action completed.	school and in surrounding environments.	drinks. ▪ Reduction in obesity.	
TOTAL				**$122,000**

ACTION AREA 5 YEAR WORKING GOALS:

- 100% of primary/intermediate schools enrolled in LBD 'fit, healthy and ready to learn' process.
- Measurable reduction in BMI of children at targeted secondary schools.
- Measurable change in attitudes/knowledge/behaviour of children at targeted secondary schools.
- Robust evidence base about what works in supporting BMI reduction in secondary school environment.
- 80% of primary/intermediate schools explicitly supporting 2.5 hours of vigorous activity each week.
- All school on-site food meets healthy standards.
- All Kohanga Reo and Kura Kaupapa actively promoting good nutrition and physical activity.
- All Pacific Language Nests and Early Childhood Centres actively promoting good nutrition and physical activity.
- A measurable reduction in obesity of Year 9 pupils in high risk schools.

8. Supporting Primary Care-Based Prevention and Early Intervention

Primary health care proactively and proficiently 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 the *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 NZ guidelines for screening, post diagnosis education and structured care, and
- investigate family/whanau approach as a means to improving management of disease and family risk.

To facilitate this, it has been agreed that the primary care component of LBD will be implemented by Counties Manukau District Health Board (CMDHB) Primary Care via its existing relationships and governance structures, with minor modifications to encompass the increased breadth of LBD. As a consequence, a new governance structure will be established and extra resources provided to support the extensive development work required to develop the LBD concepts. Responsibility for the national Diabetes Get Checked programme has also moved into the CCM team.

Interventions/Initiatives	KPIs/Milestones	Process Outcomes	Health Outcomes	CMDHB LBD Budget Estimate
8.1 Establishing a leadership structure to guide improvements of diabetes management in the primary care sector. A new advisory group will established to: - merge previously separate diabetes and CVD groups; - assume the responsibilities and accountabilities of the previous Diabetes Advisory Group (which is disbanded); and - assume an expanded terms of reference that includes the previous CCM activity and the LBD primary care action area. This advisory group (called DCAG) will provide advice on interpretation of evidence/analysis, programme design, implementation and performance. DCAG and its work programme will be managed by co-funded project management position.	▪ July 2005, new DCAG terms of reference completed. ▪ Aug 2005, initial DCAG meeting. ▪ Sept 2005, work programme signed off. ▪ From Oct 2005, DCAG monthly progress reports provided to GPHO.	▪ Informed debate guides implementation of LBD primary care action area. ▪ Key organisational and professional groups are aligned with approach. ▪ Comprehensive approach across CVD/diabetes and disease state reduces inefficient silo thinking.		$55,000

(Note: The accountability for implementation of LBD within the primary care environment sits with the CMDHB primary care team. LBD is represented on DCAG while primary care is represented on the LBD Partnership Steering Group). Key partners - CMDHB Primary Care Development (including CCM). Key linkages - LBD action area 8; LBD action area 10; and the evaluation. - CMDHB Primary Care Development (including CCM).				
8.2 Developing a Diabetes care framework for Counties Manukau. Develop a model for implementing the NZGG Type 2 Diabetes guidelines from screening to management of people with complications, and identify key areas for improvement. The model is to include: - translation of the guidelines into an explicit model of primary care service provision - incorporation of learnings from CCM and other DHBs approaches - identification of the degree to which current practice differs from this goal model - identification of a few key intervention points that will lead to improved services - development of proposals for projects to address these key areas, and - identification of key clinical indicators that are collected through current data systems and can be used to monitor progress. Resources will be required for expert advice and activity in developing care model and implementing. Likely to involve training and capacity development for practices.	▪ By Nov 2005, Care model developed to cover all of diabetes (adapt WDHB model) - with action recommendations. ▪ Feb 2006, service provision process outlined and provider identified. ▪ April 2006, recommendations implemented.	▪ 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.	▪ Slowing of disease progression.	$10,000

CMDHB Maori and Pacific Health will provide input to ensure appropriateness for Maori and Pacific populations. <u>Key partners</u> - CMDHB Primary Care Development (including CCM), CMDHB Pacific Health and CMDHB Maori Health. <u>Key linkages</u> - LBD 5.2 – 5.4; action area 8; LBD action area 10; and the evaluation. - CMDHB Primary Care Development (including CCM).				
8.3 Improving use of brief interventions for modifying obesity risk factors. Develop, pilot and evaluate use of brief intervention in primary care setting, based on work undertaken by the Community Nutrition Project and business case development for surgical and pharmacological interventions for morbidly obese people. Project components to include: - needs assessment of training needs and current practices in weight management in primary care - recruitment of PHOs for pilot study - recruitment of Practice Nurses and Community Health Workers to complete training - development of training programme (including nutrition curriculum, screening and selection, brief intervention, group sessions, goal setting, motivation, teaching toolkit) - development of supporting educational resources for trainees - delivery of training programme - evaluation of training programme - ongoing support of trainees - recruitment of clients for weight management, and - evaluation of client outcomes. - Business case development for surgical and/or	▪ July 2005, PHOs and Practice Nurses recruited. ▪ Sept 2005, recruitment of clients for weight management. ▪ Dec 2005, evaluation commences.	▪ Improved management of obesity risk factors in primary care setting. ▪ Improved primary care capacity. ▪ Evaluation of group intervention. ▪ Evaluation of whether the intervention has an impact on weight loss.	▪ Reduction in obesity. ▪ Slowing of disease progression.	Non budget item.

pharmacological interventions for morbidly obese people and establishment of an integrated care team across provider arm and CCM. <u>Key partners</u> - CMDHB Primary Care Development (including CCM), Primary Health Organisations (PHOs), CMDHB Pacific Health. <u>Key linkages</u> - LBD 5.2 – 5.4; action area 8; LBD action area 10; and the evaluation. - CMDHB Primary Care Development (including CCM); Primary Care Workforce Development;				
8.4 Improving uptake of best practice post diagnosis education. Develop criteria for, and implement, Diabetes Self Management Education (DSME) programme in primary care. Approach to include: - A stock take of existing DSME programmes/providers will be done. This will include the package being developed by Waitemata DHB. Programmes will be assessed against criteria - Estimates of the incidence of new type 2 diabetes will be obtained by ethnicity and geographical area. This will be linked to the delivery framework to establish what capacity is required to deliver DSME (internal) - A delivery framework for DMSE will be developed (or adapted) based on the above and other evidence of best practice. Likely resource availability will also be considered in its development and in light of evidence on effective health education approaches and techniques targeting culturally diverse groups, and - A provider contracted to develop training of facilitators for DSME using the new delivery framework and provide this training to an initial	▪ Nov 2005, stock take completed. ▪ By March 2006, delivery framework completed, with PHO buy in. ▪ April 2006, training underway.	▪ 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.	▪ Reduction in obesity. ▪ Reduction in smoking. ▪ Slowing of disease progression. ▪ Reduction in CVD risk.	$20,000

group of facilitators CMDHB Maori and Pacific Health will provide input to ensure health education appropriate for Maori and Pacific populations. <u>Key partners</u> - CMDHB Primary Care Development (including CCM), CMDHB Pacific Health, CMDHB Maori Health. <u>Key linkages</u> - LBD 5.2 – 5.4; action area 8; LBD action area 10; and the evaluation. - CMDHB Primary Care Development (including CCM); Primary Care Workforce Development;				
8.5 Trialling and evaluating increased use of family/whanau/group support for obesity risk factors and diabetes management. Contract a provider to run focus groups with people with diabetes and their families to find out what the pilot programme should include. Group members to be obtained through CCM or Whitiora. Review of current information and literature on effective interventions and approaches to working with families centred care from minority and/or ethnically diverse groups, the workforce skills required to ensure safe family centred practice and resources to support this work. Develop a survey aimed at people with diabetes (via Whitiora, CMDHB Maori and Pacific Health) to explore: - their perception of family risk - their ability to influence this risk - their ability and interest in taking this role - and their needs for family support.	▪ March 2006, survey of 200 patients completed and report written. ▪ By 2006, pilot sessions run and evaluation completed.	▪ 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.	▪ Slowing of disease progression. ▪ Reduction in obesity in at risk community (and family/whanau of person with diabetes). ▪ Reduction in harm from complications.	$20,000

Develop and run at least 2 pilot programmes based around CCM families (priority Maori and Pacific). Evaluate the success of the pilots to see if this model should be developed further. <u>Key partners</u> - CMDHB Primary Care Development (including CCM), CMDHB Pacific Cultural Support Unit, CMDHB Maori Health. <u>Key linkages</u> - LBD 1.2 – 1.5; action area 2; 5.2 – 5.4; action area 8; LBD action area 10; and the evaluation. - CMDHB Primary Care Development (including CCM); Primary Care Workforce Development;				
8.6 Investigating and developing whole system approach to improving rate of diagnosed type 2 diabetes to expected population with diabetes. A proposal has been made that from 1 July 2007, there is a proactive approach to support increased diabetes/CVD risk screening. This would be supported by social marketing and health promotion programmes. Before any such action, however, a number of issues require further analysis: - Consider NZGG recommendations on CV risk screening and whether diabetes screening needs to occur beyond these groups - Consider methods of improving primary care implementation of screening including o Systems interventions (including IT) o Practitioner interventions o Patient interventions - Consider implications of increased screening on primary care, wider CMDHB services, and patients including: o Increased numbers of type 2 diabetes diagnosed	▪ By Oct 2005, DCAG makes decision in principle about Counties Manukau's approach to screening. ▪ By March 2006, design completed. ▪ By June 2006, implementation started.	▪ If appropriate, design and development of integrated screening for CVD and diabetes.	▪ Identification of diabetes early to provide improved opportunity for control.	$20,000

○ People diagnosed with IFG or IGT ○ People identified with other CV risk factors ○ People who are not identified as being at risk but who still need to be aware of their lifestyle risks (avoiding false reassurance).				
TOTAL				**$125,000**

ACTION AREA 5 YEAR WORKING GOALS:

- 80% of expected people with diabetes diagnosed.
- 80% of people diagnosed enter approved/ benchmarked care process from point of diagnosis.
- 70% of practices actively providing evidence based brief interventions for obesity
- Appropriate primary care based prescribing for diabetes increases by 40%
- Adherence to prescribed medication for diabetes increases by 20%

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, 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.

This action area operates in a complex multi-agency environment.

Interventions/Initiatives	KPIs/ Milestones	Process Outcomes	Health Outcomes	CMDHB LBD Budget Estimate
9.1 Establishing a leadership hub for the Vulnerable Families action area. Strengthening Families Steering Group (SF) has agreed to be the leadership hub for the Vulnerable Families action area to lead and drive the work programme. SF is an existing cross sector collaborative process for case management of vulnerable families, with multiple problems.	▪ By July 2005, SF has officially incorporated *Let's Beat Diabetes* (LBD) into its work programme.	▪ Approaches to vulnerable families coordinated across agencies. ▪ LBD agenda taken up by other agencies focusing on risk factors for poor health and social outcomes.		Non budget item.
9.2 Improving referral pathways. *Note: The new Family Start service offers great opportunity for improved services targeting young families. Identification and referral criteria will need to reflect nutrition/activity issues for families.* Developmental area/outputs reliant on how Family Start develops. <u>Key partners</u> - FACS, SF.		▪ Vulnerable families receive support to improve nutrition for children.	▪ Reduction in childhood obesity.	Non budget item.

<u>Key linkages</u> - LBD 1.2 – 1.6; action area 2; 5.2 – 5.4; action area 6; action area 8; action area 9; 10.6 – 10.10; and the evaluation. - CMDHB Healthy Housing; Paths;				
9.3 Enhancing SF by including diabetes risk factors and complications into their review processes, with defined linkages and referrals to the health sector. Improving 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 management programme. Supporting improved risk identification and referral pathways for appropriate support. <u>Key partners</u> - FACS, Salvation Army Family and Social Services. <u>Key linkages</u> - LBD 1.2 – 1.6; action area 2; 5.2 – 5.4; action area 6; action area 8; action area 9; 10.6 – 10.10; and the evaluation. - CMDHB Healthy Housing; Paths;	▪ By 2006, obesity and diabetes prevention and management workshops facilitated for SF. ▪ By 2006, resources provided/made available to SF. ▪ Linkages/relationships between SF and other related services such as Well Child, Family Start established	▪ Improved multi agency skills and processes for identifying families at risk and appropriate referral and interventions.	▪ Improved nutrition for at risk families. ▪ Reduction in obesity.	Non budget item.
9.4 Improving 'in home' nutrition and health service access by providing training for agencies that access at-risk families. Improving health triage for families presenting with multiple problems. Organisations such as the Salvation Army already have access to large numbers of vulnerable families through support networks and peer support systems, but do not have an awareness and skills about the importance of good nutrition and so cannot pass on this information and knowledge to the families.	▪ By Nov 2005, training introduced for Salvation Army staff and volunteer workers. ▪ By Feb 2006, in home education commences. ▪ By Feb 2006, improved triage	▪ A new workforce that can access high need families with skills and motivation in the area of obesity risk factors. ▪ Community champions for	▪ Improved nutrition, reduced obesity, improved disease identification and improved disease management for high needs populations.	$40,000

The Salvation Army's existing parenting and mentoring programmes will be enhanced to include include nutrition, obesity and diabetes prevention aspects; and its staff and volunteer workers will be upskilled to be able to provide nutrition, obesity and diabetes prevention aspects. <u>Key partners</u> - FACS, Salvation Army Family and Social Services. <u>Key linkages</u> - LBD 1.2 – 1.6; action area 2; 5.2 – 5.4; action area 6; action area 8; action area 9; 10.6 – 10.10; and the evaluation. - CMDHB Healthy Housing; Paths;	and referral.	LBD. ▪ Improved in home nutrition for vulnerable families. ▪ Children eat breakfasts at home.		
9.5 Ensuring food parcels are healthy, well-balanced and nutritious. It has been identified that food parcels are not well prepared in terms of nutritious food being accessed by vulnerable families. LBD will work with food parcel providers and the Food Industry to improve quality of food parcels. Healthy and appropriate recipes will be included in the parcels to inform/assist recipients. <u>Key partners</u> - FACS, Salvation Army Family and Social Services, Food Industry, ARPHS <u>Key linkages</u> - LBD 1.2 – 1.6; action area 2; 5.2 – 5.4; action area 6; action area 8; action area 9; 10.6 – 10.10; and the evaluation. - CMDHB Healthy Housing; Paths;		▪ Vulnerable families access more nutritious food and are able to prepare raw ingredients in to meals in home.	▪ Improved in home nutrition leads to a reduction in obesity.	Non budget item.
TOTAL				**$40,000**

ACTION AREA 5 YEAR WORKING GOALS:

- 20% increase in children from vulnerable families eating breakfast at home
- A new health promotion capability in the sector of trained volunteer workers who have access to vulnerable families and communities
- Nutrition issues forming part of family risk assessments is cross agency processes

10. Improving Service Integration and Care for Advanced Disease

People with diabetes are managed according to the 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. The *Let's Beat Diabetes* (LBD) project management team (LBD team) will work closely with the myriad of health services to identify pathways to improved service integration, where accountabilities lie in terms of operational accountability, and what role LBD will play.

Community consultation has supported diabetes in pregnancy as a priority for service improvement and integration.

Interventions/Initiatives	KPIs/ Milestones	Process Outcomes	Health Outcomes	CMDHB LBD Budget Estimate
10.1 Establishing a leadership hub for in-hospital service integration and reducing harm from diabetes complications. A forum is required to provide guidance on in-hospital and integration issues relating to diabetes complications from involved specialties. Note: this may be a new forum or grafting this responsibility on an existing clinical leadership group. The integration leadership group would have a complimentary role with the DCAG role.	▪ From Sept 2005, leadership hub established and operational.		▪ Optimised multifactorial management of diabetes.	$5,000
10.2 Developing Whitiora Diabetes Service's role as clinical centre of excellence and supporter of system-wide capacity development. The 5 year strategic review (2005-2010) for Whitiora development suggested the following key points for the service: - increased audit cycles - increased roll-out of primary care support/community clinics - more active peer review	▪ By May 2006, audit of clinical practice completed.	▪ Improved secondary care management of diabetes.	▪ Reduction in harm from complications. ▪ Increased support of primary care workforce.	$20,000

- encourage internships (Doctors/Nurses/others) between primary care and Whitiora - greater funded training role - more group education, and - enhanced practice flexibility Develop effective clinical leadership for the delivery of integrated diabetes management. This includes increased non-clinical time to develop resource and QA/research activities. Increased resource to upskill and support primary care, secondary care services Support research in service delivery design as it relates to the prevalence and progression of complications. Note: implementation of strategic review recommendations not explicitly part of LBD and are mostly part of normal service development. However, some aspects have overlap with LBD as they relate to specific new initiative programmes. Note: also links between Whitiora and LBD, with the medical director of LBD also the clinical director of Whitiora. <u>Key partners</u> - CMDHB Primary Care Development (including Chronic Care Management programme – CCM). <u>Key linkages</u> - LBD action area 5; LBD action area 8; action area 10; and the evaluation. - Whitiora Diabetes Service				
10.3 Ensuring diabetes management activities across primary and secondary care are implemented in a consistent manner. - Aligning to 8.2 to ensure the management				$10,000

activities and framework developed in primary care is consistent with that developed for secondary; and that there is consistency in their approach and implementation. Key partners - DCAG, CMDHB Primary Care Development (including Chronic Care Management programme – CCM). Key linkages - LBD action area 5; LBD action area 8; action area 10; and the evaluation.				
10.4 Improving the integration of primary and secondary care diabetes IT systems. This area includes improved functionality for access to patient information, care co-ordination and clinical decision support. It will, to some extent, be dependent on broader issues such as development of the diabetes secondary care database at WDHB and Enigma services. Area of interest during 2005/2006, with more active involvement in 2006/2007. Key partners - DCAG, CMDHB Primary Care Development (including CCM). Key linkages - LBD action area 5; LBD action area 8; action area 10; and the evaluation.	▪ Oct 2005, develop clear view on CMDHB response to WDHB diabetes secondary care database developments regarding migration to Middlemore.	▪ Improved record management, coordination, efficiency, decision support.		Non budget item.
10.5 Improving clinical data and ethnicity data collection and analysis in order to provide regular performance reports relating to indicator outcomes by ethnicity. Clinical reports will provide key feedback to LBD whether strategies are having an impact – especially	▪ By April 2006, development complete and reporting begins.	▪ Improved understanding of service performance for	▪ Reduction in complications in high needs populations.	$20,000

in relation to reducing inequalities. Areas of data collection include (by ethnicity where possible): - Glycaemic control - Management guidelines met - % given lifestyle management advice/self management education - Rates of hospitalisation due to diabetes or complications - Rates of renal dialysis, and - Rates of premature mortality (using Get Checked, CCM, Census and NMDS data) <u>Key partners</u> - DCAG, CMDHB Primary Care Development (including Chronic Care Management programme – CCM). <u>Key linkages</u> - LBD action area 5; LBD action area 8; action area 10; and the evaluation. - CMDHB Planning and Funding; Pacific Health; Maori Health; Primary Care Development (including CCM).		different population groups provides a basis for response to reduce disparities. ▪ Improved information for hospital management and clinical leaders.		
10.6 Supporting Diabetes in Pregnancy. Develop service integration for comprehensive care in diabetes in pregnancy, including; lead maternity provider, women's health, secondary care diabetes service, cultural support, community support and primary care. Specific components of the service review and development to include: - External review - Database development along CCM framework, and - Review of cultural support quality and availability	▪ Nov 2005, external review completed. ▪ May 2006, database development.	▪ Improved service delivery for at risk patients.	▪ Improved detection of diabetes in pregnancy. ▪ Improved management of diabetes in pregnancy. ▪ Improved post pregnancy care and preconceptive advice/education/care	$40,000

Data capture and audit processes developed to cover the following: - Proportion of mothers with diabetes (gestational or chronic) during pregnancy - 100% post-pregnancy GTT-performed in women with diabetes diagnosed in pregnancy - 100% diabetic (gestational or chronic) woman referred to and followed by primary care post pregnancy - 80% + post-pregnancy contraceptive/preconceptive counselling - Rates of neonatal hypoglycaemia (analysed by DM and GDM) - Rates of Macrosomia (BW > 4500g, or 90%) (analysed by DM and GDM) - Rates of perinatal death (analysed by DM and GDM) - Operative delivery rates (analysed by DM and GDM) - Rates of Birth Trauma (baby and mother) (analysed by DM and GDM) - Rates of congenital defect/anomaly (analysed by DM and GDM) - Rates of developing (permanent) T2DM (for GDM mothers) Note: LBD is supporting the external review and service process and some data capture issues. However, it is seen that the actual service improvements will be supported by mainstream funding sources. <u>Key partners</u> - DCAG, CMDHB Primary Care Development (including Chronic Care Management programme – CCM), CMDHB Pacific Health. <u>Key linkages</u> - LBD action area 5; LBD action area 8; action area 10; and the evaluation. - CMDHB Planning and Funding; Pacific Health;				

Maori Health; Primary Care Development (including CCM); Whitiora Diabetes Service.				
10.7 Supporting Diabetic Eye Disease. Support diabetic eye disease identification and treatment into a more integrated service design by redesigning the service of retinal screening for example DNA management and follow-up. LBD will also support improved service capacity planning, modelling disease progression to develop a retinal screening algorithm and integrating screening information back into chronic care support intelligence. Note: retinal screening advisory groups already exist. <u>Key partners</u> - DCAG; CMDHB Primary Care Development (including CCM). <u>Key linkages</u> - LBD action area 1.2 – 1.5; action area 2; 5.2 – 5.5; action area 8; action area 9; and the evaluation. - CMDHB community DRS.	▪ May 2006, retinal screening status reports to CCM record. ▪ Aug 2005, reduced DNA and effective recall section.	▪ Improved information for clinical management and improved information for service management. ▪ Improved service quality and access for people requiring retinal treatment.	▪ Improved detection and care of diabetic eye disease. ▪ Improved management of other diabetes complications.	Non budget item.
10.8 Supporting Diabetic Renal Disease. Supporting diabetic renal disease through: - Implementation of National Guidelines (T2DM) - Predictive modelling of for service capacity planning (within LBD modelling) and dialysis review (Regional Review), and - research in service delivery, prevalence and progression of complications. <u>Key partners</u>	▪ 90%= application of treatment guidelines for prevention of progressive renal disease.	▪ Reduction in rate of renal disease in persons with diabetes. ▪ Improved service delivery for people with diabetes renal disease. ▪ Enhanced service capacity development.	▪ Reduction in complications.	Non budget item.

<u>Key linkages</u> - LBD action area 1.2 – 1.5; action area 2; 5.2 – 5.5; action area 8; action area 9; and the evaluation. - CMDHB renal.				
10.9 Diabetes and Mental Health Supporting the links between diabetes and mental health by: - developing a management resource for prevention, detection and management of diabetes in people with mental health problems - supporting the implementation of the depression module in CCM in 3 pilot PHOs - providing psychological/mental health support for patients with diabetes, and - developing a screening/assessment tool for depression. <u>Key partners</u> <u>Key linkages</u> - LBD action area 1.2 – 1.5; action area 2; 5.2 – 5.5; action area 8; action area 9; and the evaluation. - CMDHB Mental Health;	▪ By May 2006, widespread (90%+) implementation of ADA/APA/AACE recommendations for screening. ▪ Nov 2005, implementation of pilot depression module in CCM. ▪ July 2005, development of Health, Psychologist Role in Acute Care. ▪ Development of Health Psychologist Role in Primary Care. ▪ Oct 2005, implementation of Depression assessment tool.	▪ Improved recognition of interplay between mental and physical health.	▪ Reduction in psychosocial problems in persons with diabetes. ▪ Prevention, recognition and optimal management of diabetes in people with mental health problems.	Non budget item.

10.10 Supporting Therapeutics.
 	
Supporting best practice utilisation of medication by:
- Community Pharmacy
  o Advice
  o Adherence
- Advocacy for best treatment
  o Representation to Pharmac
- Encouraging clinical research in CMDHB population.
 	
<u>Key partners</u>
	▪ June 2006, development of pharmacy advice resource.
	▪ June 2006, evaluation and research.
		▪ Guidelines reflect best evidence, encouraging compliance.	▪ Improved compliance with treatment to improve outcomes.	$5,000

- CMDHB Planning and Funding. <u>Key linkages</u> - LBD action area 1.2 – 1.5; action area 2; 5.2 – 5.5; action area 8; action area 9; and the evaluation. - CMDHB Pharmacy Strategy.				
10.11 Texting Trial Trial a text-based reminder system at one clinic, evaluate impact on DNAs and client perceptions of the service. <u>Key partners</u> <u>Key linkages</u> - LBD action area 1.2 – 1.5; action area 2; 5.2 – 5.5; action area 8; action area 10; and the evaluation.	▪ By May 2006, trial completed and evaluated.	▪ Improved understanding of DNAs and client perceptions of service.	▪ Improved compliance with treatment to improve outcomes.	$10,000
TOTAL				**$110,000**

ACTION AREA 5 YEAR WORKING GOALS:

- 80% of expected people with diabetes diagnosed.
- 80% of people diagnosed enter approved/ benchmarked care process from point of diagnosis.
- Increased number and proportion of people with diabetes being referred for screening and specialty care advice.
- Primary and secondary care supported by integrated information support.
- Enhanced audit and improved care.
- Secondary Care capacity based on increased prevalence and acuity of care needs, and developed from prediction modelling and audit activities.

5. Support Systems for *Let's Beat Diabetes'* Implementation and Sustainability

5.1 Enablers

The Ten Action Areas for *Let's Beat Diabetes* (LBD) are supported by support areas or 'enablers' that must be managed in order to implement the plan in a sustainable manner. They are:

1. *Consumer involvement:* An effective consumer forum is actively involved in the development of new programmes and evaluation design.
2. *Maori:* Ensuring all processes and programmes across the Ten Action Areas are culturally responsive to Maori, and that Maori needs are addressed and aspirations achieved.
3. *Pacific peoples:* Ensuring all processes and programmes across the Ten Action Areas are culturally responsive to Pacific peoples, and that Pacific peoples' needs are addressed and aspirations achieved.
4. *Funding environment:* The funding environment is modified and aligned to support the Ten Action Areas.
5. *Learning environment:* Evaluation and learning systems are explicitly supported as part of the overall investment.
6. *Sustainable governance:* Governance and leadership for the whole plan and for each of the Ten Action Areas is developed and supported.
7. *Organisational development:* Investment in workforce, particularly in primary care, will be required as will the development of an ongoing centre of excellence for whole system diabetes prevention and management in Counties Manukau.
8. *Information systems:* The many disconnected systems and programmes used for supporting diabetes management need to be brought together over time to align with the whole system approach outlined in LBD.

Some of these areas are targeted in the Ten Action Areas, while others need to be supported via the support infrastructure. The information systems enabler does not feature significantly in the 2005/2006 LBD Operational Plan but will need to in future years.

5.2 Co-funders

The investment Counties Manukau District Health Board (CMDHB) has allocated to LBD is significant, however, the total resource applied to LBD is larger and growing. One of the objectives of the LBD approach was to catalyse investment by other parties into the LBD agenda. This has been achieved to some degree with food industry contributions, increased contributions from Auckland Regional Public Health Service (ARPHS), Ministry of Social Development (MSD) input and Manukau City Council (MCC) input and specific revenue generating proposals such as the schools sponsorship scheme with South Auckland Health Foundation (SAHF). During 2005/2006, the LBD project management team (the LBD team) will continue to target

other key organisations whose core responsibilities are or are closely aligned to LBD's agenda to get their buy-in into the programme.

5.3 Evaluation

Significant revenue will be allocated to the evaluation process. LBD pushes the boundaries for a health programme in New Zealand. LBD approaches are based on good evidence but they are often applying that evidence in new situations and circumstances. In this type of situation, the generally accepted international figure is expenditure of 10% of the programme cost to go on evaluation. This figure is being applied to LBD. LBD is also requiring the evaluation to support a learning process across providers. (See section 3 and full report for detail).

Support system costs

Enablers	Description of 2005/2006 activity	$ CMDHB
Programme management	▪ Supporting programme management, Maori and Pacific co-ordination, medical leadership, social marketing and general programme support.	396,000
Governance	▪ Supporting governance processes and improving consumer involvement in decision making.	5,000
Evaluation	▪ Evaluating the whole programme and each of the Ten Action Areas. ▪ Supporting learning processes and progress reporting. ▪ Supporting workforce capacity development for evaluation.	200,000

6. Financial Breakdown

The financial summary is based on the most accurate assumptions about the expected cost of programmes and activity. As a number of the areas of activity are new and result from further analytical work the exact nature of expenditure in some areas will be fine tuned during the year.

There is not a risk of over expenditure as the budget does not include any demand driven areas for cost. It is all wages or programme budgets. If there is a risk it is of under expenditure, which would result where there was programme timing and development slippage. Such slippage may occur in programmes where there are many new programmes, contracts and relationships as with *Let's Beat Diabetes* (LBD).

This risk has been managed to a significant extent by detailed planning and relationship development prior to this operational plan being put together.

It is expected that as LBD develops the allocation of funding across the Ten Action Areas may change. For example, social marketing is strong funded in the early years of LBD. It is likely expenditure in the primary care stream will grow over time and social marketing may decrease. Future investment decisions will be guided to some extent by the feedback from the evaluation process.

Enablers	Description of 2005/2006 activity	$ CMDHB
Programme management	▪ Supporting programme management, Maori and Pacific co-ordination, medical leadership, social marketing and general programme support.	396,000
Governance	▪ Supporting governance processes and improving consumer involvement in decision making.	5,000
Evaluation	▪ Evaluating the whole programme and each of the Ten Action Areas. ▪ Supporting learning processes and progress reporting. ▪ Supporting workforce capacity development for evaluation.	200,000
Ten Action Areas		
1. Supporting Community Leadership and Action	▪ Community Action Fund. ▪ Maori specific programmes (Marae, Kaumatua and Kuia leadership). ▪ Pacific specific programmes (Pacific churches, leaders) ▪ Workplace initiatives.	180,000
2. Promoting Behaviour Change through Social Marketing	▪ Research and development of a five year social marketing strategy, and activity.	600,000
3. Changing Urban Design to Support Healthy Active Lifestyles	▪ Developing prototype neighbourhood 'activity park' to guide upgrading of existing parks. ▪ Undertaking health impact assessments of major planning initiatives. ▪ Providing advice on Flat Bush development. ▪ Advocacy and advice.	45,000
4. Supporting a Healthy Environment through a Food Industry Accord	▪ Establishing a governance structure between the Food Industry and Health. ▪ Co-funding of an advocacy position to develop and drive he agreed health/industry agenda. ▪ Supporting non sugar drinks initiatives.	50,000

	▪ Ensuring the Food Industry supports local health promoting initiatives.	
5. Strengthening Health Promotion Co-ordination and Activity	▪ Supporting aligned activity through better coordination of the funding environment. ▪ Improving communications resources for diabetes for use within health promotion and primary care. Available in multiple languages. ▪ Improving workforce capacity.	87,000
6. Enhancing Well Child Services to Reduce Childhood Obesity	▪ Reviewing and redesigning Well Child framework in Counties Manukau so it better responds to the need for young families to improve the nutrition and physical activity status for young children.	40,000
7. Supporting Schools to Ensure Children are 'Fit, Healthy and Ready to learn'	▪ Supporting Kohanga and Kura Kupapa to become healthy, active environments. ▪ Supporting Pacific early childhood centres to become healthy, active environments. ▪ Improving coordination of health services for primary/intermediate schools. ▪ Enhancing and expanding the NEW/AIMHI programme in selected secondary schools, in collaboration with the University of Auckland. ▪ Trialling of the 'healthy canteen' business model, and its wider promotion. ▪ Developing new funding streams to support schools to make sustainable changes. ▪ Supporting schools to improve 'drinks' environment in and around schools.	122,000
8. Supporting Primary Care-Based Prevention and Early Intervention	▪ Establishing a leadership hub. ▪ Improving diabetes screening. ▪ Improving post diagnosis education. ▪ Improving care pathways that align with national guidelines. ▪ Community Nutrition Project (pilot). ▪ Family/whanau based prevention pilot, working with CCM patients.	125,000
9. Enabling Vulnerable Families to Make Healthy Choices	▪ Working with vulnerable families to improve in-home nutrition. ▪ Improving referral to, and coordination between, health services and support agencies.	40,000
10. Improving Service Integration and Care for Advanced Disease	▪ Developing Whitiora Diabetes Service to become a centre of excellence. ▪ Ensuring diabetes management activity across primary and secondary care is consistent. ▪ Improving clinical and ethnicity data collection and analysis. ▪ Trialling text-based reminder system to evaluate impact on DNAs and client perceptions of the service. ▪ Supporting diabetes in pregnancy. ▪ Supporting diabetics eye disease. ▪ Supporting diabetes renal disease. ▪ Supporting the links between diabetes and mental health.	110,000
TOTAL		**2,000,000**