Auckland UniServices Limited

Monitoring Report: Reporting Period June 2005 to March 2007

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1. Introduction

The generic evaluation is the overall evaluation of the ten LBD Action Areas. Given the complex nature of the programme evaluation, it is important to collapse the interventions into manageable categories that identify the nature of the intervention and as a consequence can be measured using similar instruments. The following describes the three categories:

1. Individual/ Direct intervention with individual participants
2. Community wide/ indirect
3. Process and Organisational

This report focuses on the process and organisational evaluation of LBD. Process evaluation focuses on how a programme is implemented and operates. Further it identifies the procedures undertaken and the decisions made in developing the programme. It addresses whether the programme was implemented and is providing services as intended.

A number of processes involved in implementing LBD need to be investigated. The questions surrounding the evaluation of process will relate back to the programme logic presented in the LBD operational plan (Clinton, et al. 2006). It is also important that this information is fed back to stakeholders in a timely fashion, so that any necessary changes can be incorporated into the LBD programmes.

Monitoring information, the first component of process information, will also describe the type, quality and amount of activity that actually happens in the programme, it also provides a measure of the fidelity of the programme. Understanding the fidelity of implementation is important for the LBD programme. Fidelity of a programme is described as "The degree of fit between the developer-defined components of an intervention programme, and its actual implementation in a given organizational or community setting" (Centre for substance abuse and prevention, US Department of Health& Human Services. www.samhsa.gov 2002). The fidelity of a programme is measured in a number of ways:

- adherence to programme plans;
- degree of implementation;
- quality of programme delivery; and
- participant responsiveness.

The second area that needs to be considered in the process evaluation is the organisational development of LBD. This includes areas such as provider organisational structures, collaboration, sustainability, and evaluation readiness. Both the organisational development and collaboration areas are critical to the success of LBD. The evaluation team have adapted an integrated governance framework for use in understanding the organizational process of LBD (see the operational plan; Clinton, et al. 2006).

A documentary analysis of the available Partnership Steering Group (PSG), Action Area and initiative meeting minutes and interviews with the Action Area and initiative leaders are used to provide an overview of the progress of the LBD programme. The findings of these projects are combined to provide a valuable insight into the implementation and organisation of the LBD programme, as well as the collaboration, sustainability and evaluation readiness of the Action Area.

2. Methods

Data provided by the LBD programme was combined with additional data collected by the evaluation team to provide an insight into the current status of the LBD programme. Three key data sources were collected for this report. This included data provided by the LBD programme and additional data collected through interviews and questionnaires from Action Area and initiative leaders. This section identifies how these data sources were collected and analysed.

2.1 Data provided by the LBD programme

Information on the LBD Action Area and initiatives was provided to the evaluation team through the reports to CMDHB and the PSG via email. Some areas also provided minutes from their meetings and other programme resources when interviewed. A full description of the data sources and the methods of analysis are provided in the LBD documentary analysis report. This data has not be assessed by the evaluation team before and as a result the data sets incorporates the programme progress from June 2005 until March 2007. This report uses this data to assess each Action Area on the eight evaluation variables identified in section 2.4 and should be referred to for a more detailed description of the progress made by each Action Area and initiative.

2.1.1 Analysis

Documents were critically examined to identify the progress and developments within each Action Area and initiative. The analysis identified what activity had taken place, the achievement of Key Performance Indicators (KPIs), adaptation to the original programme plans or KPIs, the degree of programme implementation, and the organisational development, collaboration, sustainability and evaluation readiness of the Action Area.

2.2 In-depth Interviews

Action Area and initiative leaders were invited to take part in an in-depth interview through an initial contact via email, telephone or face-to-face contact. The interviews were conducted by a suitably qualified professional and lasted approximately 45 minutes. The interviews were conducted between October 2006 and February 2007 with 21 Action Area and initiative leaders (Table 1). A breakdown of the interviews by Action Area and initiative leaders is not provided to protect the anonymity of the interviewees. It is important to note that not all Action Areas have initiative leaders.

Table 1. Interviewees by Action Area

Action Area	Interviewees
1. Community Leadership	5
2. Social Marketing	1
3. Urban Design	1
4. Food Industry	1
5. Health Promotion	2
6. Well Child	1
7. Schools Accord	3
8. Primary Care	3
9. Vulnerable Families	2
10. Integrated Care	2
Total	**21**

2.2.1 Instrument Design

The evaluation team developed the interview instruments to encompass the needs of the evaluation and identify the current status of each Action Area or initiative. The in-depth interviews invited participants to discuss the status of their LBD initiatives and activities. Questions focused on their perceptions of the:

- Support in leadership;
- Collaboration with other Action Areas and organisations;

- Coordination within their Action Areas
- Funding of initiatives;
- Outputs and outcomes of their initiatives; and
- Immediate and long term effects of their initiatives.

All interviews were recorded following participant consent and transcribed by members of the evaluation team.

2.2.2 Analysis

A content analysis of the qualitative data identified key themes emerging in the data. The evaluation team were particularly interested in comments identifying what activity had taken place, the achievement of Key Performance Indicators (KPIs), any adaptation to the original programme plans or KPIs, the degree of programme implementation, organisational development, collaboration, sustainability and evaluation readiness of the Action Area.

2.3 Self-Completion Questionnaires

At the time of interview the Action Area and initiative leaders were also invited to complete three questionnaires including:

- The Collaboration Scale (Appendix 1)
- The Sustainability Scale (Appendix 3)
- Organisational Development Scale (Appendix 2)

The questionnaires were left with the Action Area and initiative leaders to be self-completed and returned to the SoPH. The findings were used to inform this report.

2.3.1 Analysis

The data was cleaned for analysis and entered into a Statistical Package for the Social Sciences (SPSS Inc, Chicago, II). Descriptive statistics provided a summary of the Action Area and initiative leaders' perceptions of the collaboration, sustainability and organisational development of their Action Area or initiative.

2.4 Combining the Data Sources

The key findings from the above data sources were combined to provide an overview of the current status of the initiatives, Action Areas and the overall LBD programme. The operational plan identified the following key evaluation variables to evaluate the LBD programme:

- Type quality and amount of programme activity
- Adherences to programme plans
- Degree of implementation
- Organisational development
- Sustainability
- Evaluation readiness

Subsequently, the LBD Action Areas, initiatives and the overall LBD programme will be evaluated on:

- Meeting Key Performance Indicators (KPIs).
    - These are the programme targets that are set by the Action Area leaders.

- Adaptation.
    - This stems from programme fidelity, as there needs to be a balance between programme change for growth and development to suit the context, and sticking to the goals and objectives of the programme plan.

- Degree of implementation.
    - This refers to how much intervention has occurred or whether the goals have been implemented.

- Organisational development.
    - This is the process through which an organisation can develop its capacity to be efficient, effective and sustainable.

- Progress
    - This refers to the overall progress the Action Area has made towards achieving its goals.

- Collaboration
    - This refers to the degree of partnership or relationships established by the Action Area.

- Sustainability
    - This refers to the development of a set of durable activities and resources aimed at Action Area related objectives.

- Evaluation Readiness
    - This refers to the capacity of the Action Area to carry out evaluation tasks and the willingness to engage in the evaluation.

The evaluation variables are summarised in Table 2, as is the scoring rubric used to assess each initiative, Action Area and LBD programme.

An expert group was used to conduct the scoring process. Three groups from the evaluation team independently assessed the progress of each Action Area on all of its stated initiatives. Areas of disagreement were discussed and an external reviewer was also available if necessary. The external reviewer was not required.

A scale of 10 was used to provide the sensitivity needed to represent the LBD programme. A means analysis then combined these scores to provide an overview of the ten Action Areas and the overall LBD programme. Additional scoring was also conducted for the ten Action Areas and the LBD programme to assess the collaboration, sustainability and evaluation readiness of the programme. Each data set was coded into MS Excel and graphs were created.

Table 2. Evaluation Variable Rubric

Evaluation Variable	Definition	Scoring	Evidence
Meeting KPIs	Degree to which the initiative or Action Area met their KPIs to date.	No information = 0 Unmet = 1-3 Partially met = 4-7 Met = 8-10	Programme reporting, meetings minutes and interview data.
Adaptation	Changes to plans or KPIs to suit context. Based on recorded change.	No information = 0 Low = 1-3 Medium = 4-7 High = 8-10	Programme reporting, meeting minutes and interview data.
Degree of Implementation	Degree to which the programme or goals have been implemented	No information = 0 Low = 1-3 Medium = 4-7 High = 8-10	Programme reporting, meeting minutes and interview data.
Organisational Development	Degree to which the Action Area or initiatives have organisational structures.	No information = 0 Low = 1-3 Medium = 4-7 High = 8-10	Programme reporting, meetings minutes and interview data.
Progress	Overall view of the progress made towards goals.	No information = 0 Low = 1-3 Medium = 4-7 High = 8-10	Programme reporting, meetings minutes and interview data.
Collaboration	Degree of partnership or relationship.	No information = 0 Low = 1-3 Medium = 4-7 High = 8-10	Programme reporting, meetings minutes and interview data.
Sustainability	Degree of programme sustainability.	No information = 0 Low = 1-3 Medium = 4-7 High = 8-10	Programme reporting and interview data.
Evaluation Readiness	The preparedness to begin evaluation.	No information = 0 Low = 1-3 Medium = 4-7 High = 8-10	Programme reporting. Return of self-completion questionnaires.

2.5 Issues for consideration

It is important to note, that these scores are based on the information made available to the evaluation team and it is probable that the progress of some Action Areas is not fully represented. It is anticipated that changes to the reporting and sharing of information in LBD will help to remedy this, as each Action Area becomes familiar with the evaluation.

2.6 Ethical Approval

The LBD evaluation received ethical approval from the Auckland Northern X Regional Ethics Committee and additional ethical approval was received for the in-depth interviews with Action Areas and initiative leaders.

3. Structure of the Report

The report is presented in four key sections; the first two provided an introduction to the report and describe the methods used to collect and analyse the data presented in this report. The third section focuses on the results. Graphs and a written summary are used to identify the progress of each Action Area in achieving its stated KPIs. The results section describes each Action Area and work stream individually. Data from June 2005 and March 2006 is presented for each Action Area and this is followed by a similar summary for the progress of each Action Area between June 2006 and March 2007. An overview of each Action Area is then provided, where the programme progress, collaboration, organisational development, impact, and key issues and the future directions are explored using the graphs, interview and questionnaire data. This information is then consolidated to provide an overview of the LBD programme on the eight evaluation variables. The report concludes through identifying key learning's based on the documentary analysis and interview data.

4. Results: Assessing Action Area Progress

This section focuses on the progress of the Action Areas and related work streams towards their KPIs and programme goals.

1. Community Leadership Action Area

The Community Leadership action area operates in four sections- Community Action Fund (CAF), Maori, Pacific and Workplace. Each stream is administered by separate Action Area leaders under

the general direction of the LBD programme manager. While the sections function to target separate and individual populations and needs, the strategic methods are based upon goals of the entire LBD programme. Support and sustainability outline the scheme of Community Leadership Action Area (Let's Beat Diabetes, 2005b).

1.1 Community Action Fund (CAF)

In 2005/2006, $100,000 was made available under the CAF to provide small grants (up to $5,000) to support community 'grassroots' initiatives that encouraged local participation in health promoting activities. During the first year, 14 community initiatives received a CAF, with a number of these initiatives receiving a second CAF grant in 2006/2007. For 2006/2007, ten community initiatives have so far received a CAF grant.

Due to a lack of KPIs for this initiative, the evaluation team was unable to assess the progress of the initiative using the scoring rubric. The evaluation team used the documentary analysis and the interviews to provide an assessment of the CAF.

CAF Progress

The initiative has successfully received applications and provided funding to 40 community programmes to promote physical activity and nutrition in Counties Manukau. The programmes support a number of Counties Manukau communities including the elderly, schools, other young people and a range of ethnic groups including Maori, Pacific, Indian and Chinese (Appendix 4). Overall, this initiative has experienced little programme change and continues to make good progress on its overall goal of supporting local communities. This is achieved through the promotion of the CAF by the initiative, as there is no funding to promote the CAF:

> *We have no budget for marketing promotion of this…it is just by word of mouth or me in my role as Community and liaison and this is one of the things out of a hundred that I do… Essentially I get out there and a lot of the groups approach me when I give presentations.*

Collaboration, Partnership and Support

The initiative identified strong internal support from the internal management and also the Council of Social Services. Interestingly, comments on collaboration tended to relate to the support provided to other groups or initiatives rather than the support given to the CAF. Given the goals of this

initiative however, this is not unsurprising. The role of the CAF resulted in the initiative developing a large network of partnership associations throughout Auckland:

> *I work with all the forums that the Manukau City Council, Papakura Council, and the Franklin District Council have…We are all contributing to outcomes and understand that our role in the community is developing.*

While the $5,000 grants are a one off payment, the CAF seeks to develop relationships with the groups they fund and receive feedback on progress and impact. This funding supports local communities to develop capacity through providing education and training to parents and other communities. The evaluation readiness of this area is good. Information is provided in a timely manner and applications for funding provide valuable information on the successfully funded interventions.

Impact

The interview data suggested that the CAF has impacted on the nutrition and physical activity of various communities throughout Counties Manukau. This included increasing the level of physical activity:

> *At any one time in any week I could tell you that you have about 2-3,000 people active in physical activity where a year and a half ago they wouldn't have been.*

The initiative has also reached a wide range of communities from young people to the elderly. The following example was cited:

> *A person couldn't even walk to her letterbox because she was too frail and because of these gentle exercises she can do that and [she] is setting further targets. Strengthening muscles through gentle exercise has enabled that person to now go to the shop, a fundamental thing.*

In terms of long term impact, the CAF was designed to provide a seeding funding to support communities in taking ownership of their physical activity and nutrition, rather than to provide a sustainable funding stream.

Key Issues and Future Direction

From the perspective of the evaluation team it would be useful for the initiative to establish a set of KPIs. The initiative however, seeks to continue to develop its work with the community groups, including Maori, Pacific churches and schools to support them in the planning, development and operationalisation of their own initiatives to promote change and healthy lifestyles.

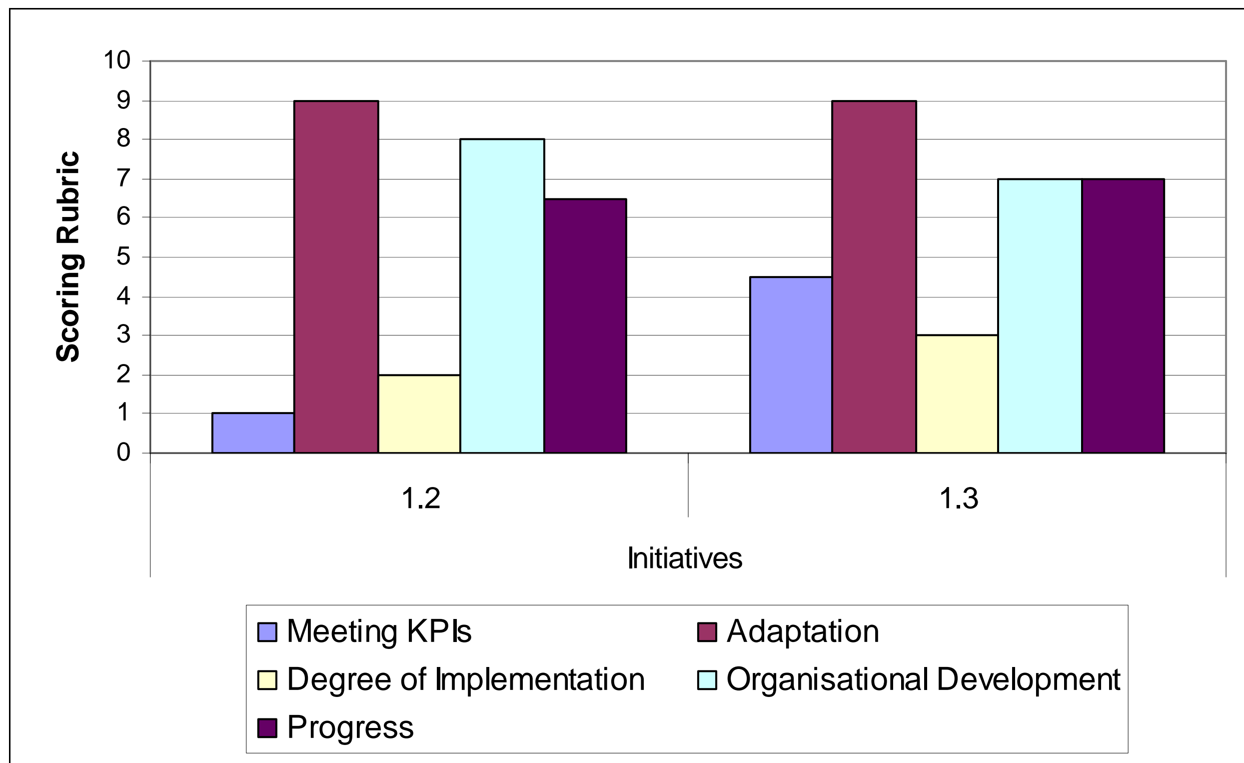
1.2 Maori Work Stream

To support Maori community leadership and action, the initial focus for LBD is on 'supporting Marae, Kohanga Reo and Kura Kaupapa to develop and implement initiatives that support improved nutrition and physical activity within their communities; and supporting Kaumatua and Kuia as 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' (Let's Beat Diabetes, 2005b)

Maori Work Stream for 2005/ 2006

Figure 1 identifies the progress of the Maori work stream on achieving the KPIs and goals identified through the documentary analysis and interviews during the 2005/ 2006 financial year. Each initiative is also identified in the key.

Figure 1. Maori 2005/2006



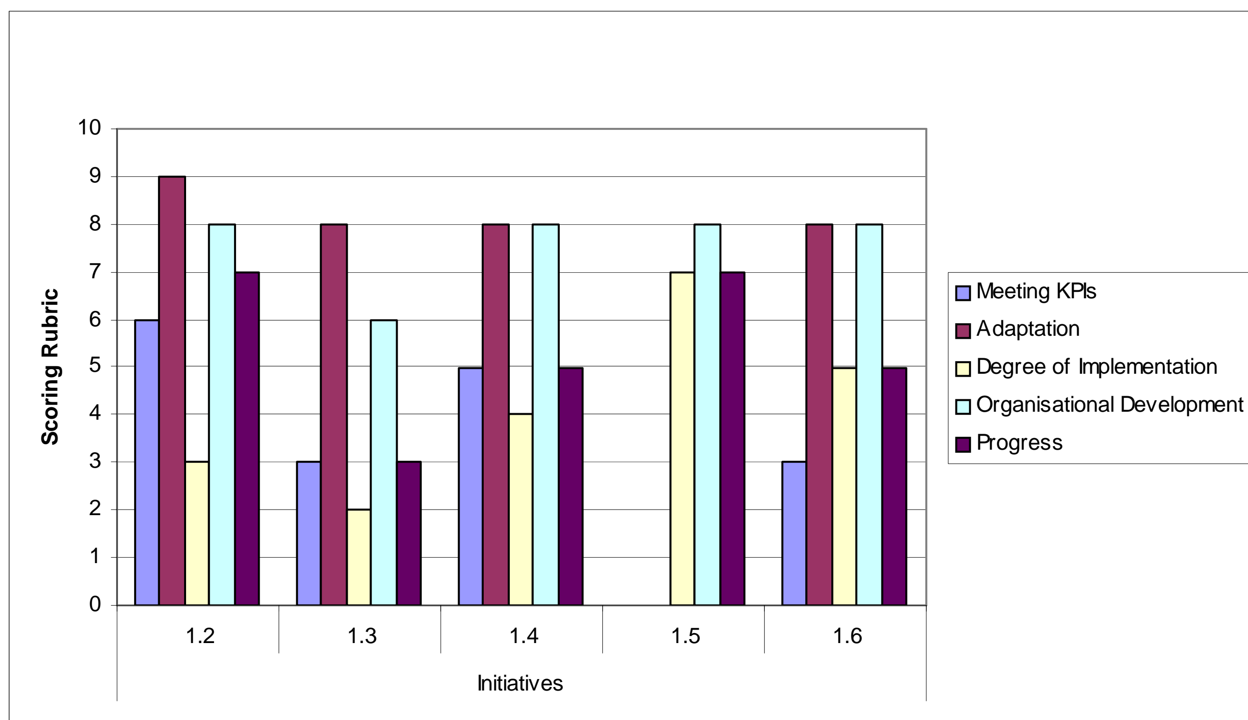
KEY: 2005/2006 Action Area: Maori	
1.2	Supporting Marae to develop Health Charters outlining their commitment to healthy active lifestyles
1.3	Kaumatua and Kuia leadership programme

As illustrated by Figure 1, KPIs were not met and the degree of implementation of the programme was also low. However, all other variables were rated highly. It should be noted that during this period the Maori Action Area made considerable changes to the programme plans. Further, tremendous progress was made towards setting up a workable system. The high degree of adaptation and organisational development resulted in a similar assessment of each initiative although there was a slight difference between the two initiatives for meeting KPIs.

Maori Work Stream for 2006/ 2007

In 2006/ 2007, the Maori work stream continued to support Marae to develop Health Charters, Kaumatua and Kuia leadership. The work stream was also working towards strengthening the physical activity and nutrition iwi collective in Counties Manukau, which was supported through Maori diabetes training. Figure 2 identifies the progress made towards these initiatives between June 2006 and March 2007.

Figure 2. Maori 2006/ 2007



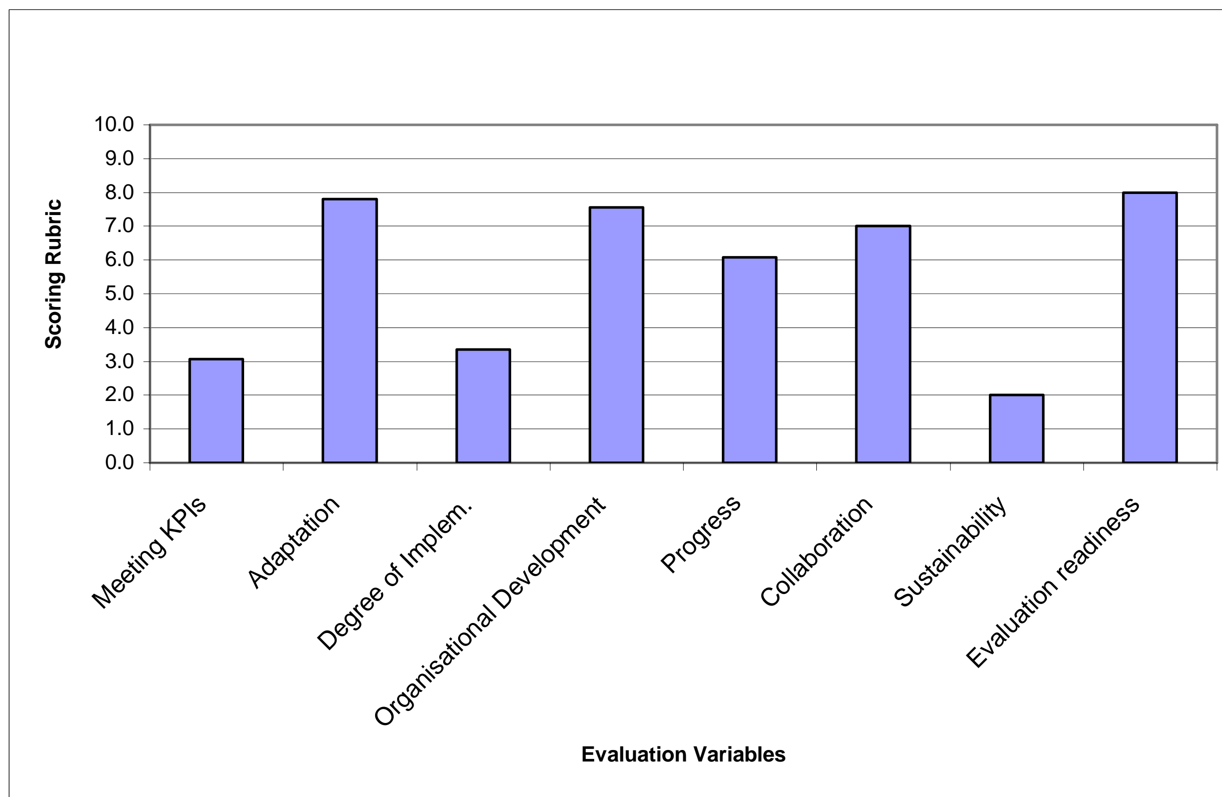
KEY: 2006/2007 Action Area: Maori	
1.2	Supporting Marae to develop Health Charters outlining their commitment to healthy active lifestyles
1.3	Kaumatua leadership
1.4	Kuia leadership
1.5	Strengthening the physical activity and nutrition iwi collective in counties Manukau
1.6	Maori diabetes training

Good progress was made towards meeting KPIs for 2006/2007. It should be noted that no KPIs were identified for initiative 1.5. Although the initiatives have low ratings for the degree of implementation, they score highly for the level of programme adaptation and organisational development. Currently, the kaumatua leadership initiative has a lower level of implementation and progress than other initiatives within the Action Area.

Overview of Maori Work Stream

A means analysis of the 2005/ 2006 and 2006/ 2007 data was used to provide an overview of the Maori work stream between June 2005 and March 2007. In addition, the Action Area was assessed on their collaboration, sustainability and evaluation readiness. Figure 3 illustrates these findings and the interview data is used to support the overview.

Figure 3. Overview of Maori Workstream



Programme Progress

The means analysis of the initiatives scores reflected the high degree of adaptation that occurred across the Maori work stream between 2005 and March 2007 (Figure 3). Subsequently, the work stream did not meet its KPIs and the degree of implementation is low. However, the organisational development, collaboration and overall progress of the work stream was medium to high. The evaluation readiness of this work stream was also high due to the degree of information made available to the evaluation team and their collaboration on a focussed study. When a programme is changing sustainability is at risk and the high adaptation to content of this work stream is reflected in the low sustainability score. Overall, the area is making excellent progress towards the revised goals.

Collaboration, partnership and support

For the Maori work stream collaboration is essential, as it is fundamental to the principles of participation, protection and partnership. The needs of Maori underpin each Action Area and the manager and advisor has sought to create relationships with most other Action Area leaders. This was reflected by in the comments:

Review the other Action Areas and see what it is that they have in their plan that is specifically Maori and making that a clever plan. And also making sure that the CMDHB Maori health complements that as well.

There is strong evidence that Maori leaders collaborate to promote health and well being of Maori populations and this is reflected in their relationships with Primary and Integrated Care services and the Self-Management Education programmes. Further, the Maori and Pacific streams often exchange ideas and models. Collaboration was also identified as a means of coordinating activities for Maori and avoiding repetition:

It is about seeing how we could all complement each others work, without us all working on our own. We sat down and talked about how we could achieve this. We need to make sure that we're not doubling up and doing more work than necessary.

Organisational Development

This work stream has invested a significant amount of time in developing a strategy to engage the Maori communities of Counties Manukau. This is illustrated in the high adaptation or programme changes of the area. The area made good progress in increasing the capacity of the work force through providing training to Maori community health workers and their links with the Diabetes Self-Management Education programme. While the work stream continues to develop its capacity, the information provided to the evaluation team suggests that the sustainability of the area is currently low because the systems developed have yet to be acted upon. Throughout the process of setting up a systematic process of implementation the Maori stream has been actively engaged in an evaluation process thus their evaluation readiness is high.

Impact

Currently, the low degree of implementation suggests that the impact of the Maori work stream is low. However, the Maori work stream provided a brief description of what they hope to achieve in the near future. Following the self-management education programmes the work stream hopes to identify a coordinator from each Marae to champion the LBD initiatives:

From each wananga we're looking to appoint a Marae coordinator, their job is to be our go between person. If we're going to have another wananga or activity, we just need to talk to them and they'll spread the work around their community. That's what we're looking to achieve.

While the impact on individuals appears low, the impact from an organisational development view appears high. A systematic implementation plan has been documented; KPIs have been changed to be more closely aligned with the community. There has also been considerable strengthening of existing partnerships and collaborations.

Key Issues and Future Direction

In continuation of their previous work the Maori work stream will continue to develop capacity through training their workforce:

> *Our plan for this year is workforce development. The whole focus is on whanau ora and working on prevention of diabetes and obesity. We want 50 people max, but these are people who will make changes within their whanau.*

Focussing on the impact of diabetes on the whanau was also a key issue for the Maori work stream:

> *The whole point of the wananga is to raise the awareness of what diabetes is and how it affects not only them, but their whanau as well.*

The data suggest that while the Maori work stream currently has low degree of implementation and sustainability, the ongoing work to develop the work force, relationships and capacity should enhance the organisational development and sustainability of the work stream.

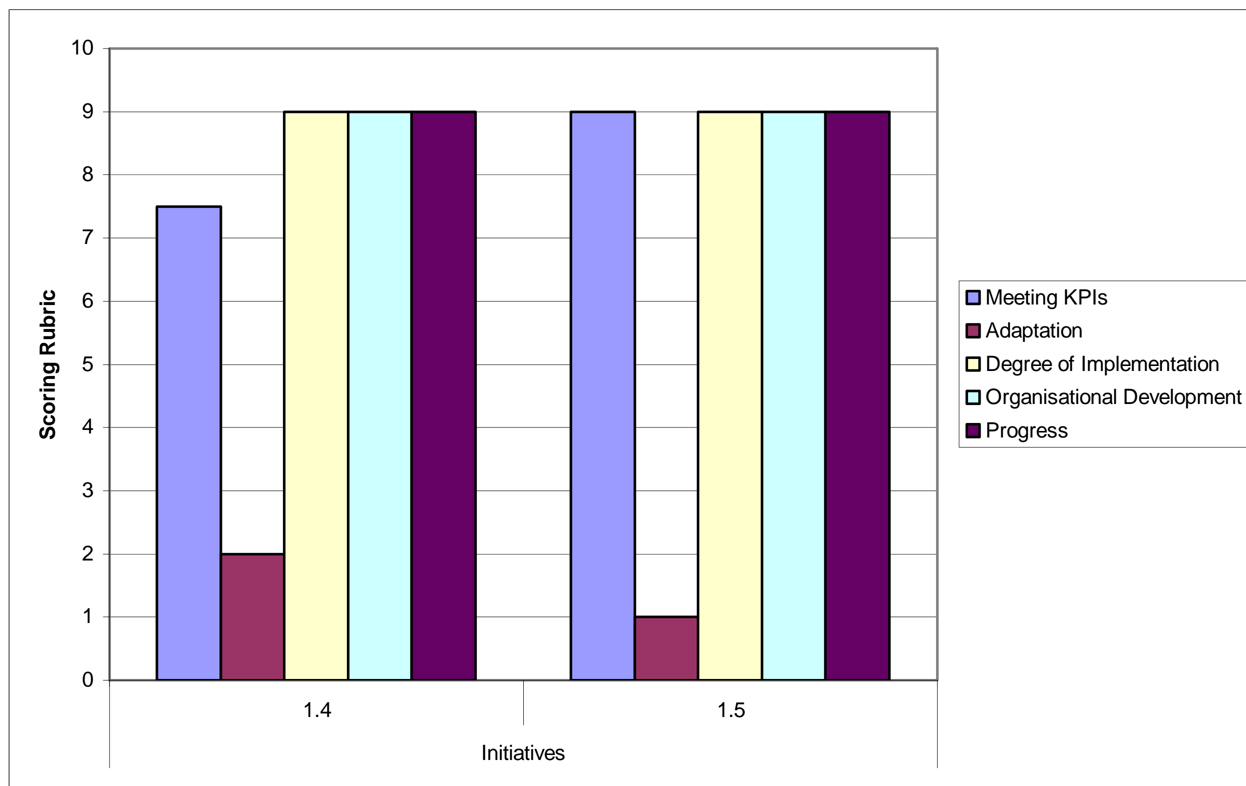
1.3 Pacific Work Stream

'LBD Pacific-specific initiatives were primarily focused on working in partnership with Pacific churches, community leaders and early childhood centre teachers to create health promoting environments (LBD 1.4, 1.5 and 7.2) and increasing human capital to create a platform of competency to support the effective promotion and/or delivery of initiatives' (CMDHB, 2005).

Pacific Work Stream for 2005/ 2006

Figure 4 identifies the progress of the Pacific work stream on achieving the KPIs and goals identified through the documentary analysis and interviews during the 2005/ 2006 financial year.

Figure 4. Pacific 2005/2006



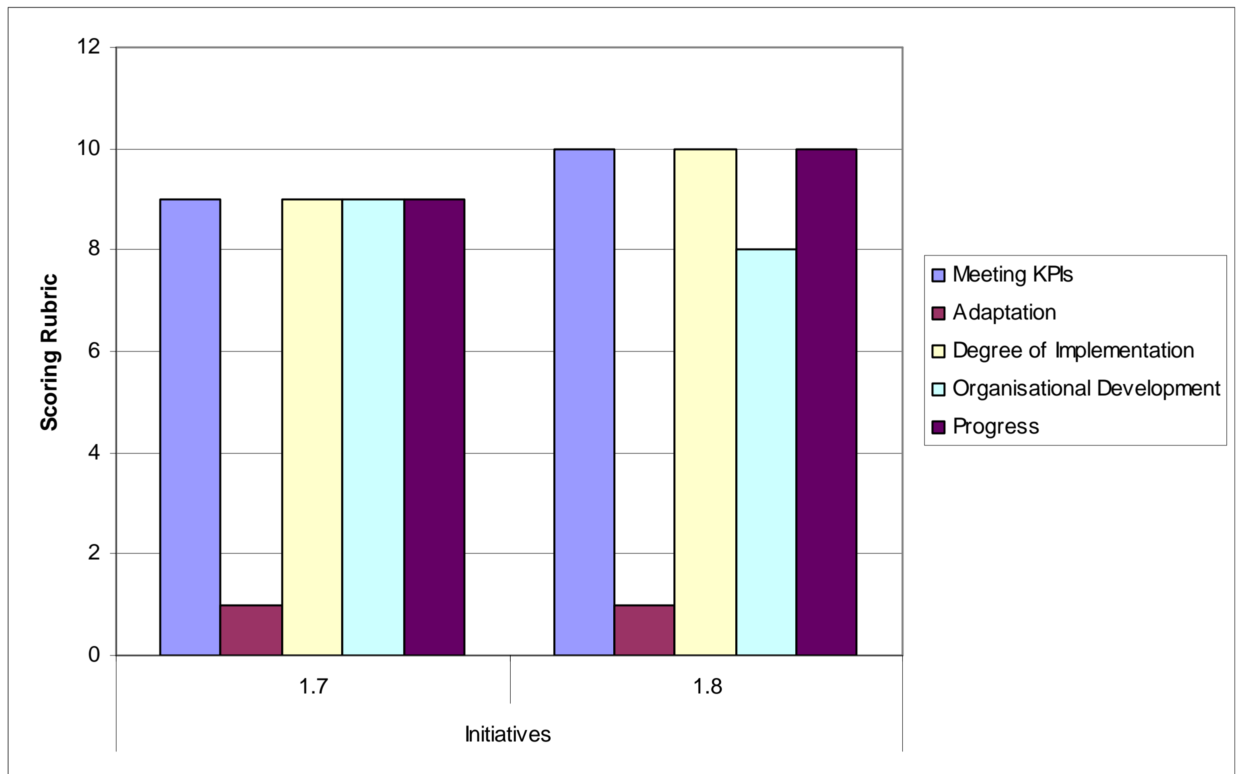
KEY: 2005/2006 Action Area: Pacific	
1.4	Supporting Pacific churches to develop and implement nutrition and physical activity initiatives
1.5	Empowering self-identified and community identified leaders and organisations to become agents for change within their families and communities.

Figure 4 illustrates that both initiatives rated very high for all variables, except adaptation. Both initiatives met KPIs; however the development of resources within the pacific churches initiative was not achieved on time. Due to the successful progress towards KPIs during this year there was little need for programme adaptation as is reflected in Figure 4. The structure of the Pacific churches and programme intervention also resulted in high ratings of organisational development and programme implementation for both initiatives.

Pacific Work Stream for 2006/ 2007

In 2006/ 2007 the Pacific work stream continued to support Pacific churches to develop and implement nutrition and physical activity programmes. The work stream also continued to empower self-identified community leaders and organisations to become agents for change within their families and communities. Figure 5 identifies the progress made by the work stream between 2006 and March 2007.

Figure 5. Pacific 2006/2007



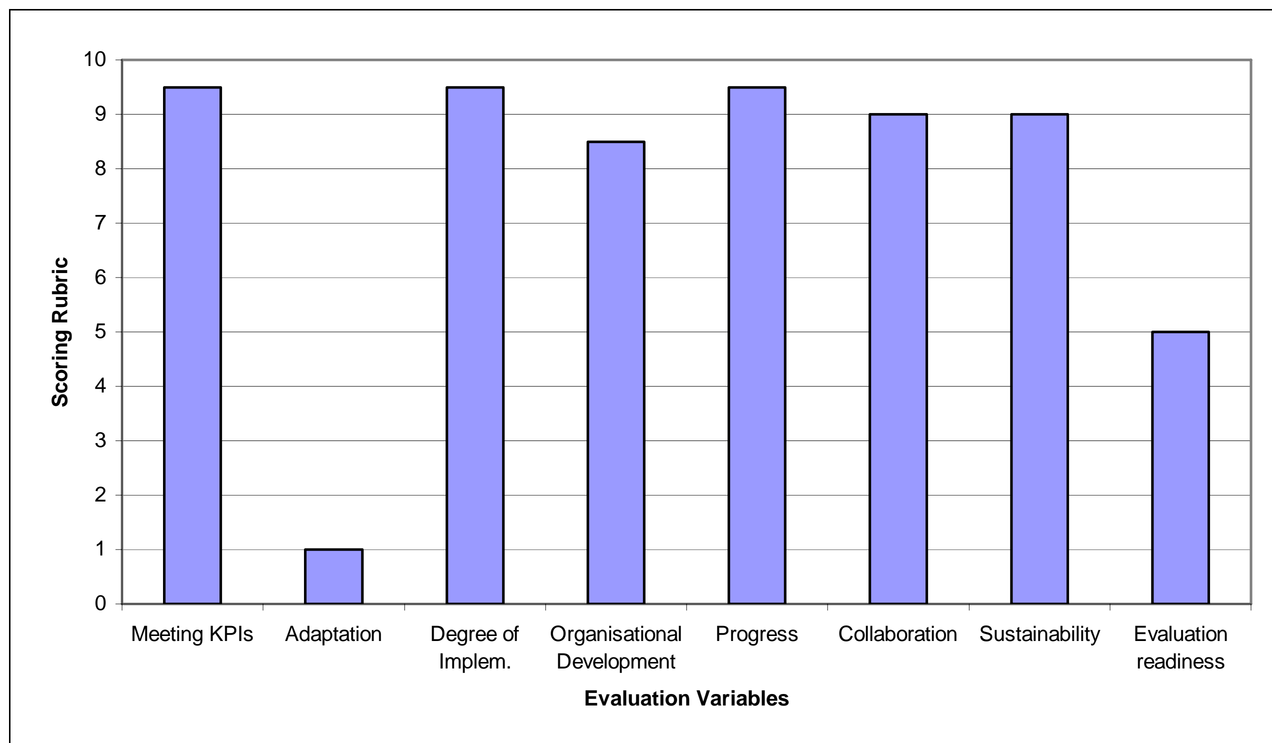
KEY: 2006/2007 Action Area: Pacific	
1.7	Pacific churches to develop and implement nutrition and physical activity
1.8	Empowering self-identified and community identified leaders and organisations to become agents for change within their families and communities

The ethnic specific workshops initiative had met their KPIs, while the Pacific churches initiative was progressing very well towards reaching KPIs set for 2006/2007. Both initiatives scored very highly for all evaluation variables and there was no adaptation of the programme.

Overview of Pacific Work Stream

A means analysis of the 2005/ 2006 and 2006/ 2007 data was used to provide an overview of the Pacific work stream between June 2005 and March 2007. In addition, the Action Area was assessed on their collaboration, sustainability and evaluation readiness. Figure 6 illustrates these findings and the interview data is used to support the overview.

Figure 6. Overview of Pacific Workstream



Programme Progress

The Pacific work stream achieved nearly all of its KPIs in the specified time frames (Figure 6). Subsequently, the work stream was also rated high on nearly all of the other evaluation variables including, degree of implementation, organisational development, collaboration and progress. Interestingly, the work stream received a moderate evaluation readiness score due to the lack of detail provided to the evaluation team. The high sustainability score for this work stream reflects the church infrastructure, which supports and delivers the programme.

Collaboration, Partnership and Support

The Pacific work stream provided a valuable insight into the support and partnership given to their initiatives, with Lotu Moui identified as a key project:

> *Auckland Regional Public Health is probably one of the key stakeholders that we work with, and they have been really supportive and pretty much partnership all the way. We have also worked with Pacifica PHO, they have been supportive… I think when we did the nutrition model a lot of it was 'in-house' and while it was LBD, it was actually Lotu Moui as well. So we had a lot of community support from agencies around Lotu Moui.*

Support was also received from the NZ Guidelines Group and Pacific Island Heart Beat, although Auckland Regional Public Health was often identified as a key partner.

Organisational Development

Similarly to the Maori work stream, the Pacific work stream needs to work with each Action Area. The infrastructure provided by the church and the leadership of the Lotu Moui project provides significant sustainability for the initiatives for 2005 to March 2007. The limited information provided about the process and procedures of the Pacific work stream however, resulted in an average evaluation readiness score.

Impact

The information provided to the evaluation team suggests that the Pacific work stream is having a high impact on Pacific churches through supporting them to develop physical activity initiatives and sharing knowledge on nutrition. Commenting on the direct impacts however, is difficult due to the lack of detail provided to the evaluation team. There were no additional comments on the impact of the programme.

Key Issues and Future Direction

The interview data suggests that the Pacific work stream is working to secure partners and collaborative relationships with Counties Manukau Sport and Manukau City Council. Continuing to develop these relationships was identified as a key task for the rest of the year. The developing relationship with Counties Manukau Sport was cited as a positive example:

> *Other groups…well we've just started with the physical activity module. We've just started [working] with Counties Manukau Sport and to date they're on board with what we're doing and support it and are going to have one person on our steering committee, so that's gong to work out well.*

The Pacific work stream is also working with the Schools Accord to enhance and develop physical activity and nutrition guidelines for 30 Pacific Language Nests. This initiative is also forming the basis of a focussed study for the evaluation team this year. Overall, the Pacific area appears to be moving ahead, however, there is concern over the lack of information provided to the evaluation team on the other initiatives. Information for this report was sourced from the PSG report, a Symposium that the evaluation team were kindly invited to attend and interview data.

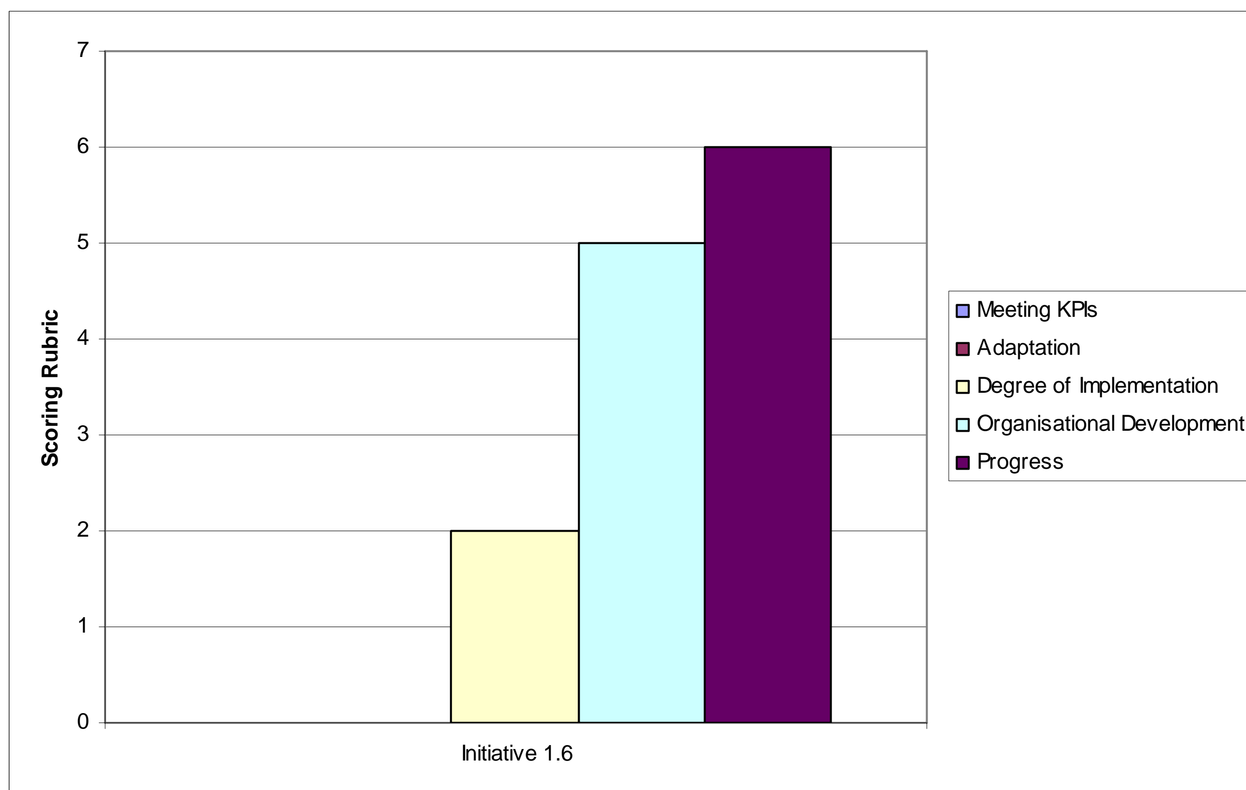
1.4 Workplace Work Stream

The workplace is identified in public health literature as 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. The work place initiative aims to support employers to develop and implement policies and initiatives that support health, active workplaces (CMDHB, 2005).

Workplace Work Stream for 2005/ 2006

Figure 7 identifies the progress of the Workplace work stream towards achieving its overall goals during the 2005/ 2006 financial year. It is important to note, that the documentary analysis and interview data did not identify any KPI's for the work stream for 2005/2006 and this is reflected in Figure 7.

Figure 7. Workplace 2005/2006



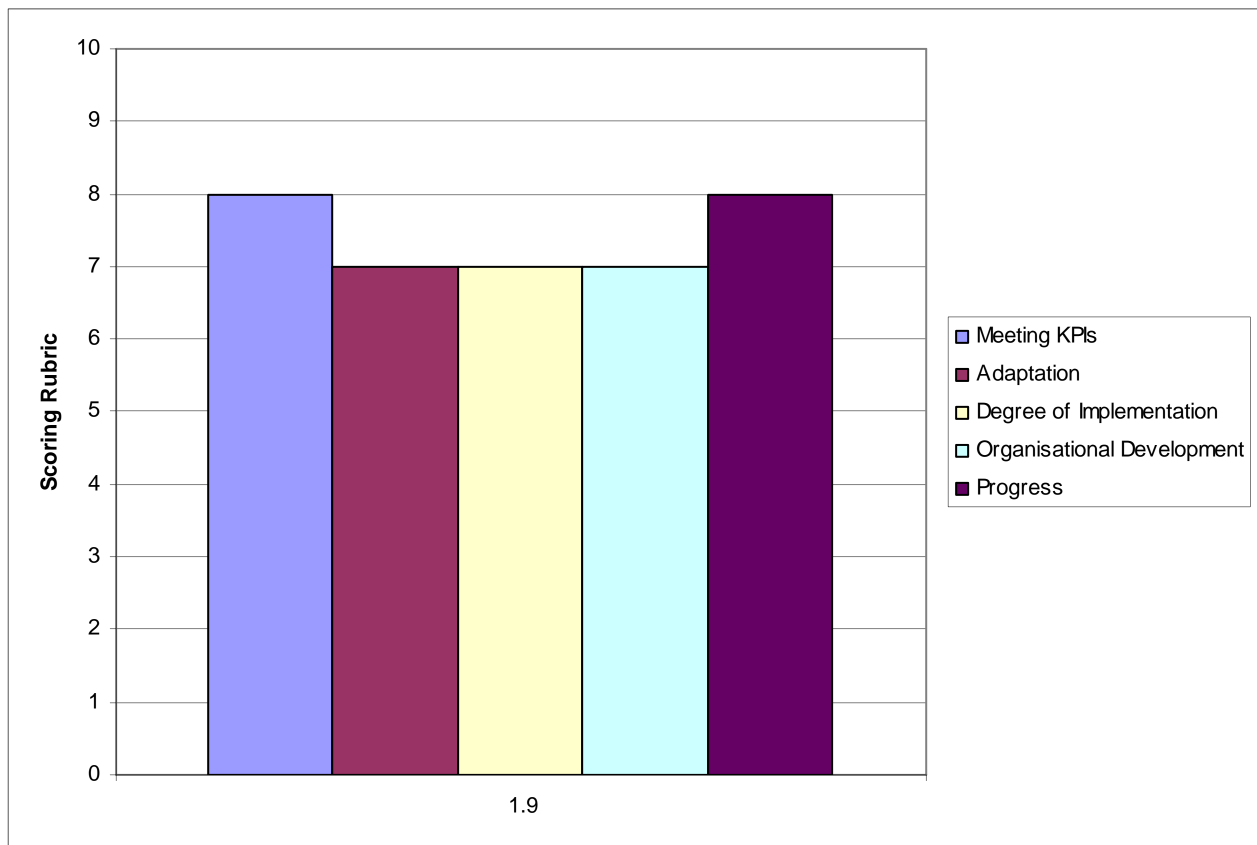
KEY: 2005/2006 Action Area: Workplace	
1.6	Supporting employers to develop and implement policies and initiatives that support health, active workplaces

No KPIs were identified for the workplace initiative; therefore the evaluation team were unable to measure meeting KPIs or adaptation within the initiative and this is represented through a score of zero on Figure 7. Although the initiative had a low level of implementation, the degree of organisational development and progress was rated medium as the initiative involved extensive collaboration between LBD and other organisations, such as Auckland Regional Public Health Service (ARPHS) and the National Heart Foundation.

Workplace Work Stream for 2006/ 2007

In 2006/ 2007 the Workplace work stream developed a partnership with the ARPHS to benefit from the Heart Beat Challenge work place programme designed and developed by the National Heart Foundation but delivered by ARPHS. Through this collaboration the LBD programme continued to support workplaces to implement policies and initiatives to develop healthy and active workplaces. Figure 8 identifies the progress made on the workplace initiative from 2006 until March 2007.

Figure 8. Workplace 2006/2007



KEY: 2006/2007 Action Area: Workplace	
1.9	Supporting employers to develop and implement policies and initiatives that support health, active workplaces

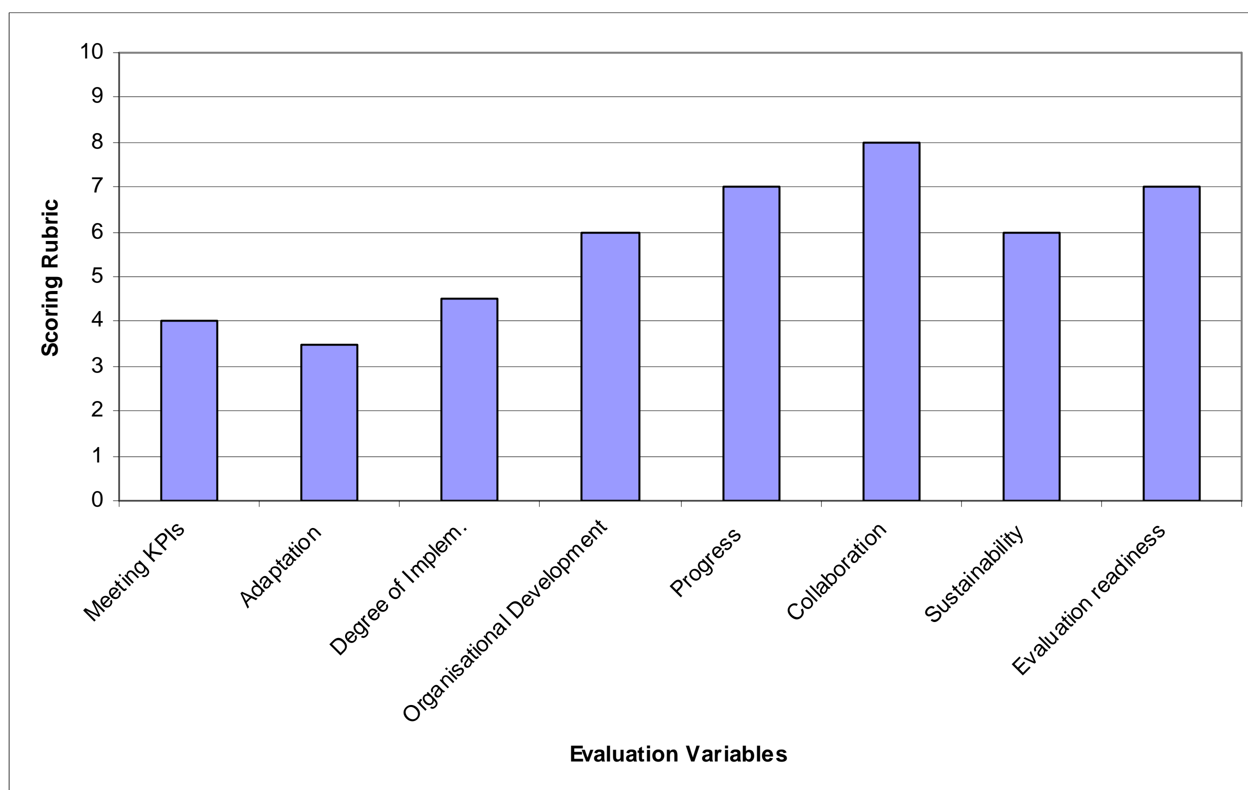
As illustrated by Figure 8, the work stream had met some of their KPIs for 2006/ 2007. Interestingly, while the initiative remained the same the moderate level of adaptation reflects the

decision to partner with ARPHS and implement the Heart Beat Challenge model rather than developing a specific programme for LBD. Following these changes and collaboration with ARPHS and the National Heart Foundation and the implementation of Heart Beat Challenge at CMDHB; the Action Area received a moderate score for the degree of implementation and organisational development. Overall the Action Area is making strong progress towards its original programme goals.

Overview of Workplace Work Stream

A means analysis of the 2005/ 2006 and 2006/ 2007 data was used to provide an overview of the Workplace work stream between June 2005 and March 2007. In addition, the Action Area was assessed on their collaboration, sustainability and evaluation readiness. Figure 9 illustrates these findings and the interview data is used to support the overview.

Figure 9. Overview of Workplace Workstream



Programme Progress

The collaboration with ARPHS and the National Heart Foundation resulted in a high collaboration score for the workplace initiative. Overall the area has made good progress in achieving its original aims and objectives. Therefore, there is little programme adaptation. Further, there is a medium level of implementation as the programme begins to evolve. The collaboration with an external

partner also resulted in a medium sustainability score. While an average level of information is provided to the evaluation team, the evaluation readiness score reflects their engagement in a programme evaluation with a project funded through the National Heart Foundation.

Collaboration, Partnership and Support

A good level of internal support was provided to the workplace initiative. The LBD programme the LBD programme was identified as a key support for Heart Beat Challenge. This collaboration was seen as two ways; this provides a valuable example of strengthening existing relationships. Community organisations were also identified as key supports:

> *We always call upon external community organizations to collaborate with us…I've started talking to the Department of Labour and ACC. I have a relationship with Manukau Community Gyms and YMCA that offer gym deals to workplaces.*

Employers are also a key partner when trying to implement Workplace initiatives, as a company needs to consent to take part in the programme. This stage of the programme was also recognised as an essential part of ensuring sustainability.

Organisational Development

The organisational development of Heart Beat Challenge was linked to the accessibility and effectiveness of the overarching LBD structure and programme:

> *[Heart Beat Challenge] was a ready made program that dropped in to LBD and they've always been extremely supportive. I can only say that I feel they have good structures in place that are efficient and accessible.*

Despite this structure the initiative received a medium organisational development score, as the capacity of the workforce and sustainability of the programme are dependent on the expansion of the programme to meet demand and the partnership of employees. For example, the initiative identified the limited resources and support available to workplaces to develop healthier environments and this was a potential risk to the current implementation of the programme.

Impact

Impact at this stage appears limited, perhaps immeasurable as a consequence of the lack of resources. Heart Beat Challenge is one of the only tools available to employers. It was suggested

that while many companies want to create a health work environment they do not know where to look for help. As a result the Heart Beat Challenge is:

> *… something they can use that provides them with support and help toward a goal of making healthy changes. There is an immediate feeling of support that the Heartbeat Challenge can support their wellness goals for their company.*

The overall vision of the initiative was to not only to engage the workforce but to also reach the family and the wider community through the programme:

> *…improving the health of the workers and raising their awareness of eating well and exercise and giving up smoking. Engaging the family, the wider family, the community.*

Key Issues and Future Direction

A key issue for the workplace initiative is the capacity and sustainability of the programme, while the programme is progressing very well it is important to consider the impact of increasing demand. The area suggested that this could be addressed through adapting the programme to produce a model to support workplaces in creating healthier environments rather than requiring significant support from Heart Beat Challenge. The initiative also anticipates that the links with LBD will support Heart Beat Challenge in developing stronger links with the community, yet will impact on the need for resources.

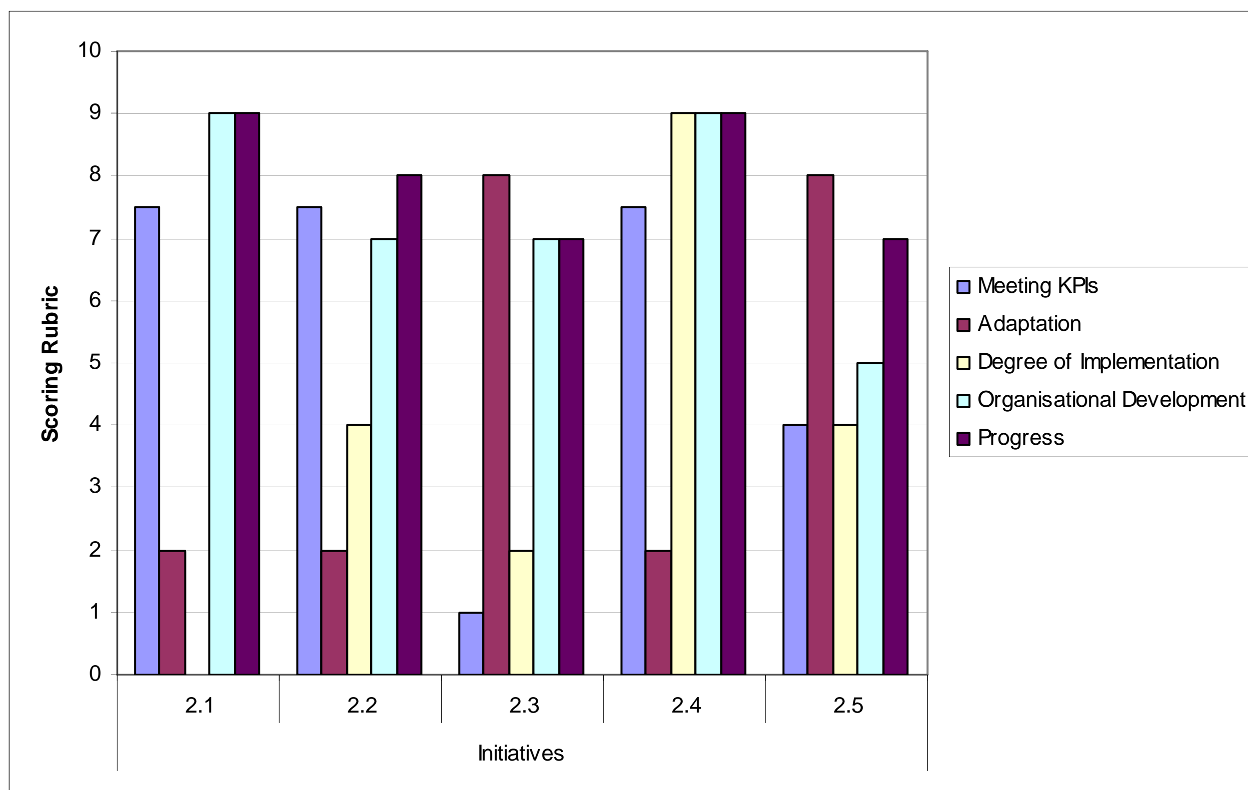
2. Social Marketing Action Area

The development of the LBD social marketing strategy began in October 2005. The brief was to develop a three year social marketing and communications strategy to meet the key behavioural objectives of LBD and a detailed programme of activities (i.e. action plan) for the initial 18 month period (Let's Beat Diabetes, 2005b).

Social Marketing Action Area for 2005/ 2006

Figure 10 identifies the progress of the Social Marketing Action Area on achieving the KPIs and goals identified through the documentary analysis and interviews during the 2005/ 2006 financial year.

Figure 10. Social Marketing 2005/2006



KEY: 2005/2006 Action Area: Promoting Behavioural Change through Social Marketing	
2.1	Consolidating the leadership hub for the Social Marketing action area
2.2	Background research
2.3	Baseline survey
2.4	Strategy development
2.5	Social Marketing activity

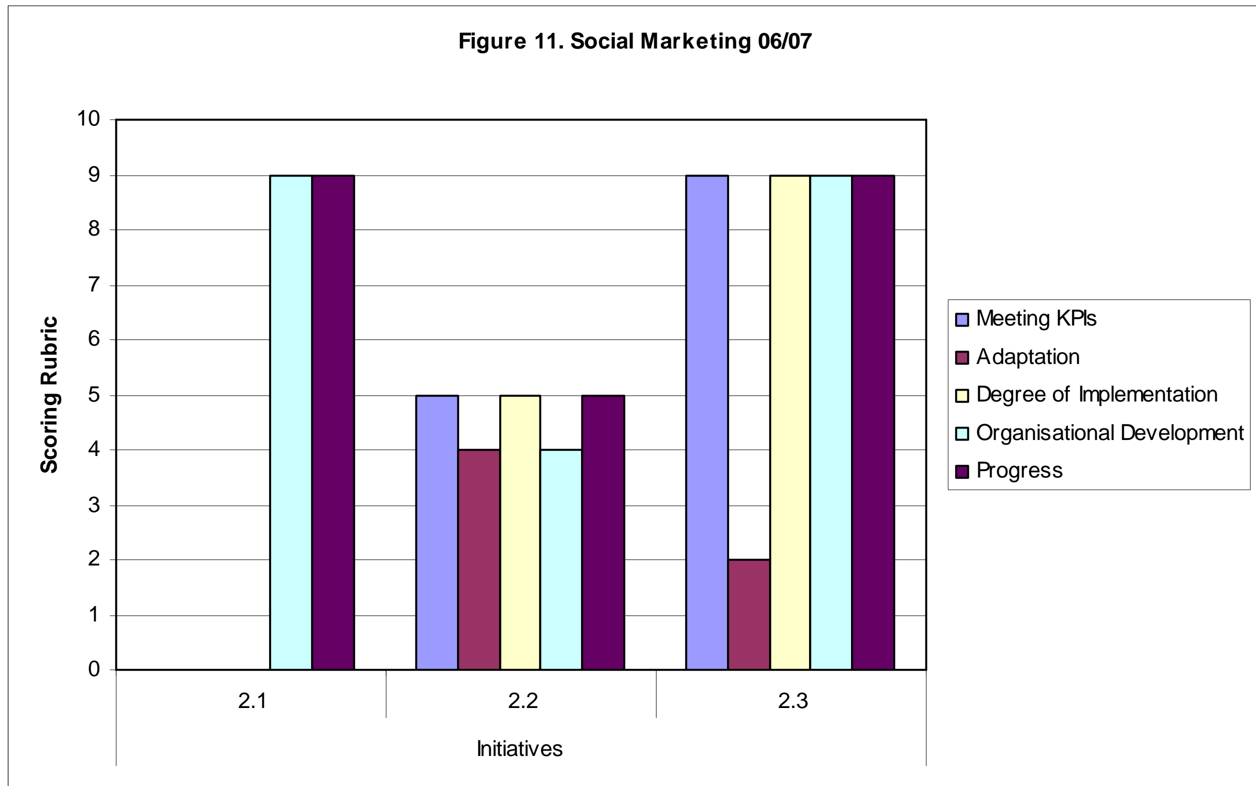
Figure 10 indicates that a number of initiatives within the Social Marketing Action Area had a high level of organisational development and progress towards meeting KPIs during 2005/2006. Although the strategy development initiative (2.4) scored highly for implementation, all other social marketing received low to medium ratings. This was due to delays in the implementation of the baseline survey and major social marketing activities which also led to low progress towards meeting KPIs. It should be noted that both of these initiatives received a high rating for adaptation as they were modified to address the delays. It is important to note that the leadership hub initiative (2.1) focuses on organisational development and is not an initiative that can be implemented within the community.

Social Marketing Action Area 2006/ 2007

In 2006/ 2007 the Social Marketing Action Area sought to establish a leadership hub, implement the LBD social marketing programme and complete the baseline survey with a sample of the general

population of Counties Manukau and a targeted sample of patients with Type 2 diabetes. Figure 11 illustrates the progress made between 2006 and March 2007.

Figure 11. Social Marketing 2006/2007



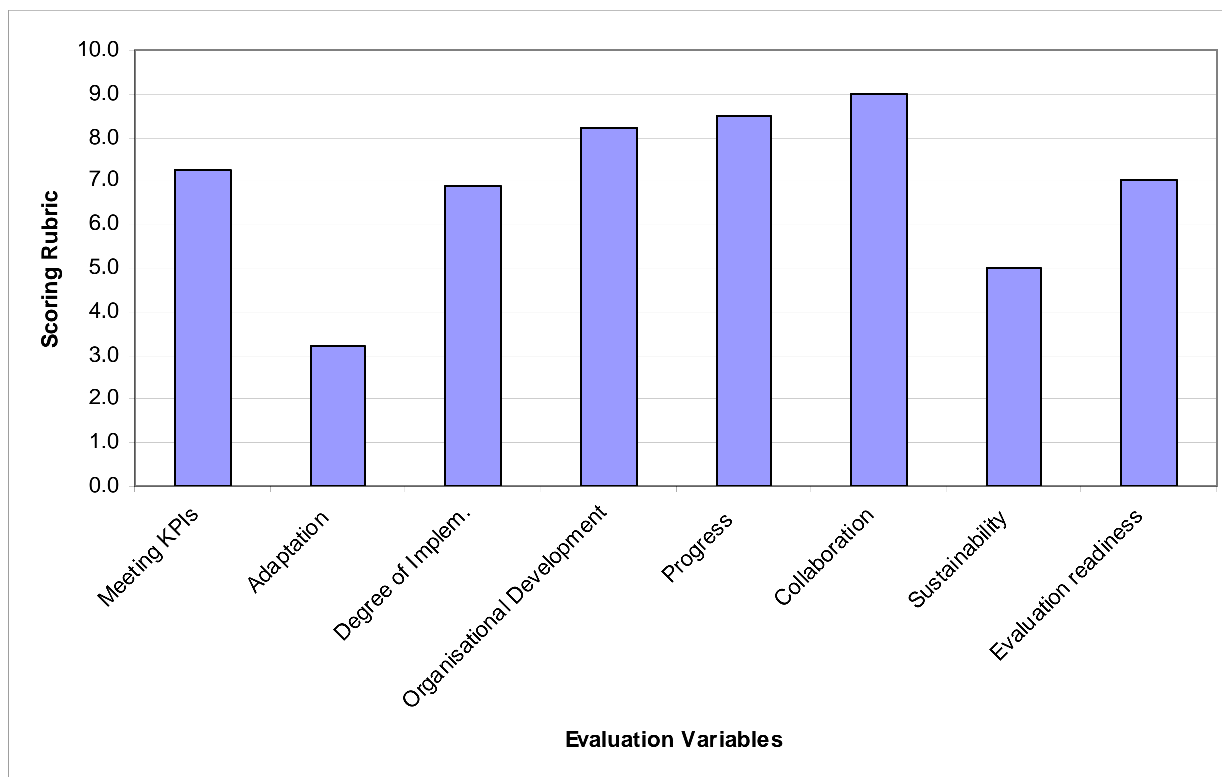
KEY: 2006/2007 Action Area: Promoting Behavioural Change through Social Marketing	
2.1	Social Marketing Leadership Hub
2.2	Implementing the LBD social marketing programme
2.3	Baseline Survey – Measuring the impact of the social marketing programme and LBD programme

For 2006/2007, no KPIs were identified for the social leadership hub; consequently the evaluation team was unable to measure success towards meeting KPIs and the level of adaptation. Despite this, the initiative scored very highly for organisational development and progress due to the high level of activity and collaboration within the leadership hub. The concept development process for the LBD social marketing (2.2) programme was well underway but implementation of the programme was delayed, therefore the initiative received medium ratings for all variables. The baseline survey initiative (2.3) was making excellent progress towards meeting KPIs and scored highly for the degree of implementation and organisational development. Very few changes to the programme occurred during this period, therefore the initiative did not experience a great deal of adaptation.

Overview of Social Marketing Action Area

A means analysis of the 2005/ 2006 and 2006/ 2007 data was used to provide an overview of the Social Marketing Action Area between June 2005 and March 2007. In addition, the Action Area was assessed on their collaboration, sustainability and evaluation readiness. Figure 12 illustrates these findings and the interview data is used to support the overview.

Figure 12. Overview of Social Marketing Action Area



Programme Progress

The Social Marketing Action Area had met the majority of their KPIs, although this did not always happen within the specified time frame. The action area made some minor adaptations to their original plans in the early phases. Despite this the degree of implementation remained high and tremendous progress was made towards developing the social marketing campaign and collaborating with other Action Areas. The sustainability of this initiative is moderate, as is the evaluation readiness given paucity of detailed information and mixed time frames.

Collaboration, Partnership and Support

While working to support the LBD programme and Action Areas it was noted that the key focus of the Action Area was to engage local communities and not to raise awareness of diabetes:

The role of communications and advertising is to support the behaviour change we are looking for in terms of diabetes. It is very much around preventing diabetes and healthy eating and drinking and physical activity. It is not a diabetes awareness raising project. It is around engaging people to adopt behaviour.

Social marketing underpins each Action Area of the LBD programme and as such seeks to collaborate and consult with each area. The ability to collaborate with other areas of the LBD programme was rated highly by the Action Area, as it helped to develop and inform the social marketing campaign:

Once I knew what questions to ask there was no problem in terms of people being really helpful and forthcoming. It's a fantastic culture here in that way people are very open and willing to inform you and lead and guide you.

The Action Area was also working with Social Marketing Action Area leader, Phoenix Research, FBC (advertising agency), SoPH and the Diabetes Projects Trust to develop the baseline survey. The Social Marketing Action Area hopes to ensure that social marketing strategies become a focus of each Action Area.

Organisational Development

Following the consultation of the Action Area with the different LBD Action Areas and particularly the Maori and Pacific work streams the area received a high organisational development score. It should be noted however, that the moderate sustainability of the programme is linked to the capacity of the social marketing team and the magnitude of the initiatives. Nonetheless, the Action Area does receive support from the LBD management, the leadership hub and the other Action Areas.

Impact

It is impossible to determine impact at this stage, however it is important that the other Action Areas acknowledge this stream. This awareness of the worth of social marketing appears to have increased. The Action Area had achieved a moderate degree of implementation due to its consultation with whanau and other organisations in Counties Manukau. It is anticipated that this rating will increase following the implementation of the campaign.

Key Issues and Future Tasks

When discussing the future direction of the Social Marketing Action Area, an ideal outcome would be for social marketing to be a collective focus of all the action areas:

> *Going forward I would prefer us to look at a model where we look at the LBD programme with the social marketing add on... then overall as a programme how are we working together to achieve these goals... it needs to be the whole programme and people are individually thinking about the programmes they are working on and their piece of service delivery and how it will work for nutrition and how this person over here might do physical activity. But I don't know that we are necessarily working collectively together to think, 'Here is a behaviour we want to sell- how are all of us (partners) working to achieve it?*

This collective approach might also support the area to develop its capacity and sustainability.

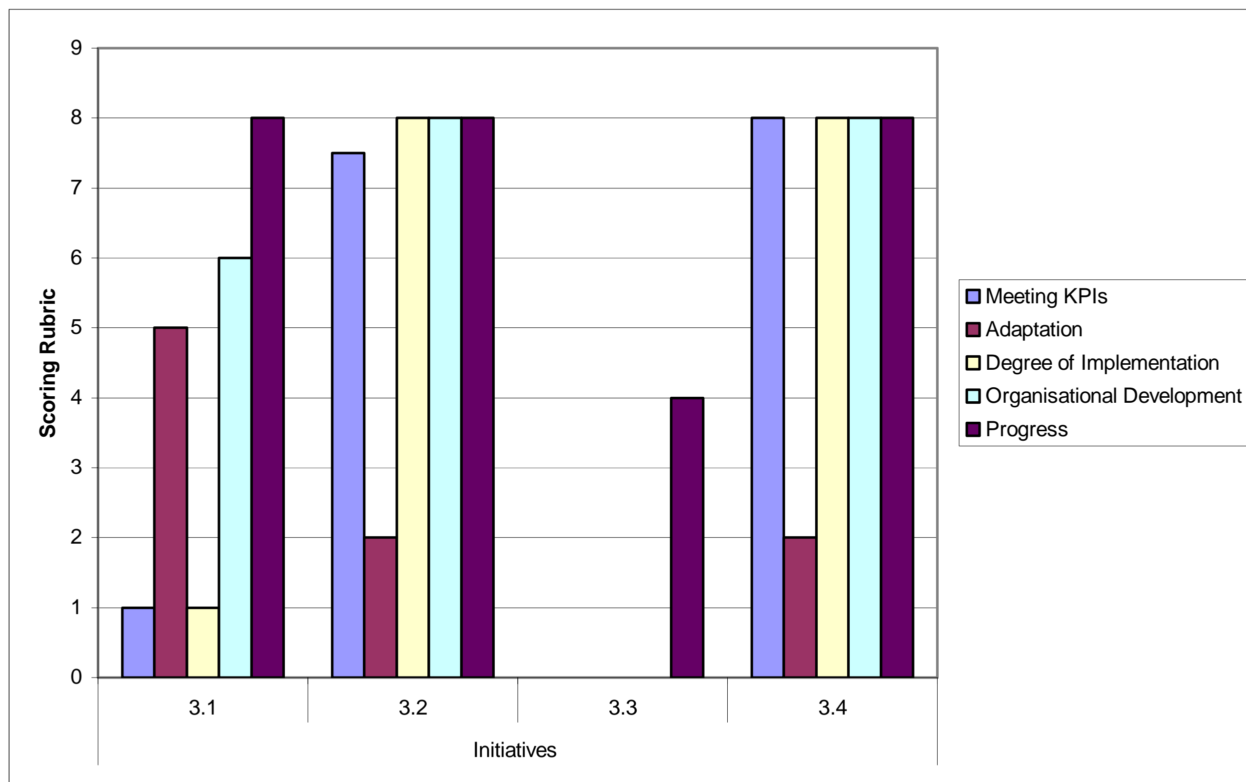
3. Urban Design Action Area

The Urban Design Action Area represents a community development initiative to support Counties Manukau in providing healthy environments. The area set out to develop a prototype 'activity park' in Counties Manukau, as well as providing advice on Flat Bush development. The area also sought to undertake health impact assessments of major planning initiatives and to advocate for health.

Urban Design Action Area 2005/ 2006

Figure 13 illustrates the progress made by the Urban Design Action Area on achieving the KPIs and goals identified through the documentary analysis and interviews during the 2005/ 2006 financial year.

Figure 13. Urban Design 2005/2006



KEY: 2005/2006 Action Area: Changing Urban Design to Support Healthy, Active Lifestyles	
3.1	Developing a prototype neighbourhood 'activity park' in Counties Manukau.
3.2	Undertaking health impact assessments of major planning initiatives in Counties Manukau.
3.3	Providing advice on Flat Bush development
3.4	Advocating for health

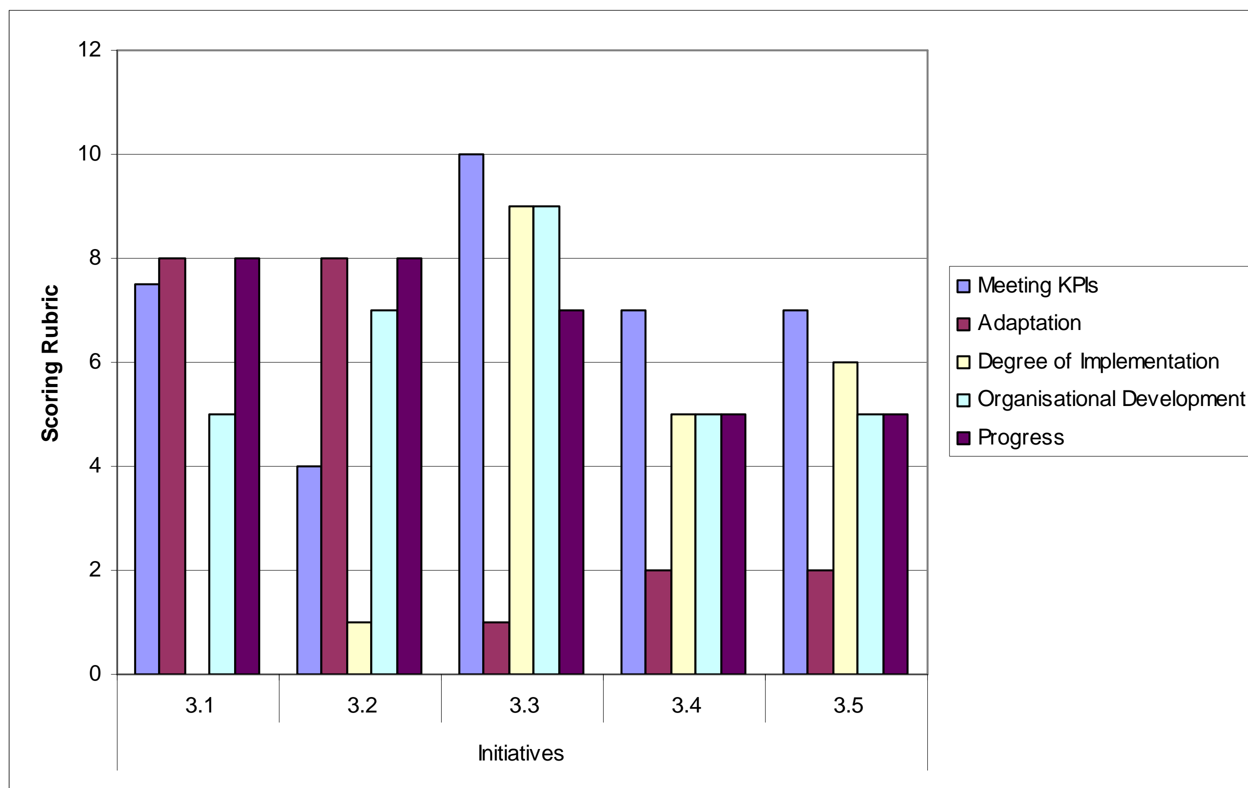
Figure 13 illustrates that although KPIs were not met and the degree of implementation was low for the redevelopment of Templeton Park, the initiative experienced a high level of organisational development and progress towards establishing relationships between the organisations that were collaborating on the initiative (3.1). In contrast, the Health Impact Assessment and advocating for health initiatives both had a high level of progress towards meeting KPIs and a high level of implementation and organisational development. No KPIs were given for the Flat Bush development initiative (3.3) and not enough information was provided to establish the level of adaptation, implementation or organisational development. This initiative was not part of the 2006/2007 Operational Plan and no explanation could be determined for this change.

Urban Design Action Area 2006/ 2007

In 2006/ 2007 the Action Area made some changes to its initiatives including the removal of the initiative to advise on the Flat Bush development. The Action Area was still working to provide a

prototype park in Counties Manukau, undertake health impact assessment of major planning initiatives in Counties Manukau and advocate for health. In addition, the area sought to build a health promoting transport system. Figure 14 illustrates the progress of the Urban Design Action Area between June 2006 and March 2007.

Figure 14. Urban Design 2006/2007



KEY: 2006/2007 Action Area: Changing Urban Design to Support Healthy, Active Lifestyles	
3.1	Establishing a LBD leadership hub on health and urban design in Counties Manukau
3.2	Developing exemplar models for community activity parks
3.3	Health impact assessment
3.4	Advocating for health
3.5	Building a health-promoting transport system

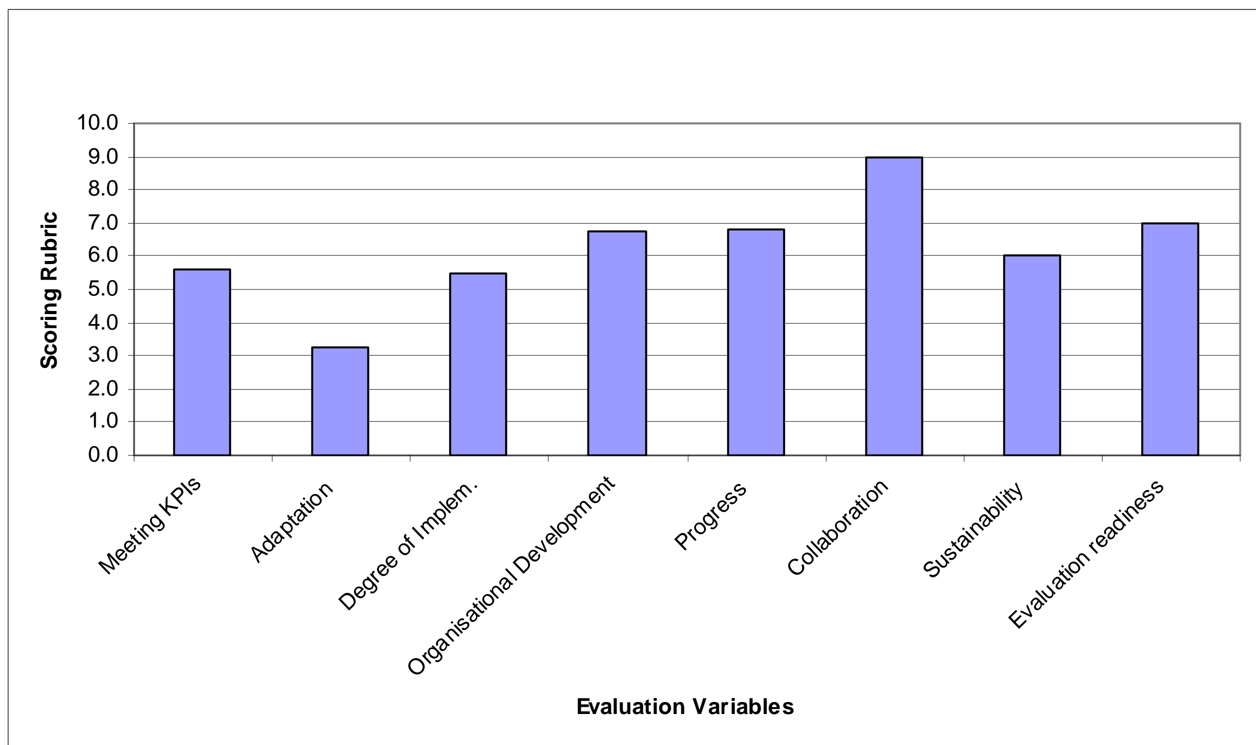
In 2006/2007, an informal leadership hub was established to guide work in this Action Area (3:1). This new initiative represented a high adaptation to the original programme plans, although the area made good progress towards meeting this objective through developing an informal leadership hub. Delays in implementation for the redevelopment of Templeton Park that meant not all of the KPIs were met, although it was noted that these would be revised to align with park redevelopment. The initiative continued to have a high rating for organisational development. The KPI for the Health Impact Assessment initiative (3:3) was achieved and the initiative scored very highly for degree of implementation, organisational development and progress. The advocating for health and health promoting transport system initiatives experienced a low level of adaptation and both initiatives

received medium scores for all other evaluation variables because the information available on these initiatives suggested that work towards these KPIs was still in progress.

Overview of Urban Design Action Area

A means analysis of the 2005/ 2006 and 2006/ 2007 data was used to provide an overview of the Urban Design Action Area between June 2005 and March 2007. In addition, the Action Area was assessed on their collaboration, sustainability and evaluation readiness. Figure 15 illustrates these findings and the interview data is used to support the overview.

Figure 15. Overview of Urban Design Action Area



Programme Progress

The Action Area made moderate progress on achieving their KPIs. The area also underwent some adaptation that impacted on its degree of implementation. The Action Area scored moderately on the majority of the evaluation variables including organisational development, sustainability and evaluation readiness. The level of collaboration for this Action Area was high and the general progress was good. The high level of formalities for this Action Area can hinder progress.

Collaboration, Partnership and Support

The re-design of Templeton Park was the main initiative discussed by the Action Area. Urban Design works closely with a myriad of partners and organizations to accomplish their KPIs and

goals including, CMDHB, Manukau City Council, Housing New Zealand, ARPHS, the Templeton Park Clendon community and Habitat for Humanity. When describing the partnership the Action Area stated:

> *The City Council and ARPHS are driving it… City Council and Housing New Zealand in terms of Templeton Park and ARPHS in bringing the leadership groups together and doing the transport system and Health Impact Assessment.*

Organisational support and collaboration were identified as an essential component of the Urban Design initiatives. The importance of support from local government and the council was also raised, although this could both facilitate and hinder progress. The sustainability of the initiatives is moderate, as a consequence of a high dependency on continuing resourcing.

Organisational Development

Urban Design received a moderate score for organisational development as they had established an informal leadership hub. The sustainability of the initiatives was moderate, particularly considering the funding and resources needed to develop and implement the proposed re-design of Templeton Park. Despite the ongoing delays, the Action Area was well organised and had developed a successful structure to collaborate with its partners.

Impact

Given the current status of the Urban Design initiatives it is impossible to establish the impact of the community. As a consequence, comments tended to relate to the successful collaboration with external organizations. Manukau City Council submissions and presentations were also identified as achievements. It was suggested that although the KPIs had not been met, significant progress on the Templeton Park initiative had been made:

> *It is not completed but the success is that we have Habitat for Humanity, the local Community Board, Housing New Zealand – we have had these people working together…partnership relationships and made great progress there. The success is that the community can see we are doing something…it is taking a long time.*

Key Issues and Future Direction

Receiving approval and support for the Urban Design plans were identified as key issues by this Action Area. In terms of sustainability or future projects, funding was also a concern, as Templeton

has required significant investment. The importance of urban re-design however, was also commented on:

> *The concept of Templeton Park – an exemplar park – it is a model, a very expensive model. It will be used to inform future park developments… Low socioeconomic people think it is all about going to the gym…they can't afford that so if we can make the local community park a more family oriented place, safer, more conducive to whatever their needs are then hopefully that will increase physical activity. There is a real need to get our parks into shape.*

With regards to future direction, health impact assessments were identified as a resource to stimulate change in high need communities. The Action Area stressed the need to be proactive with the evaluation, development and implementation of programmes.

> *Health Impact Assessments – they are very new in NZ. We did the one in Mangere and now we are looking to push the boundaries and be more innovative in terms of developing an implementation plan. It has never been done; also drilling down and looking at actual practical tangibles -looking at Housing New Zealand and how things impact on their housing designs. They are two new activities that have never been done before…It is a success that we did it and we are looking to do others but…iIt is one thing to do an Impact Assessment but you have to do something with it.*

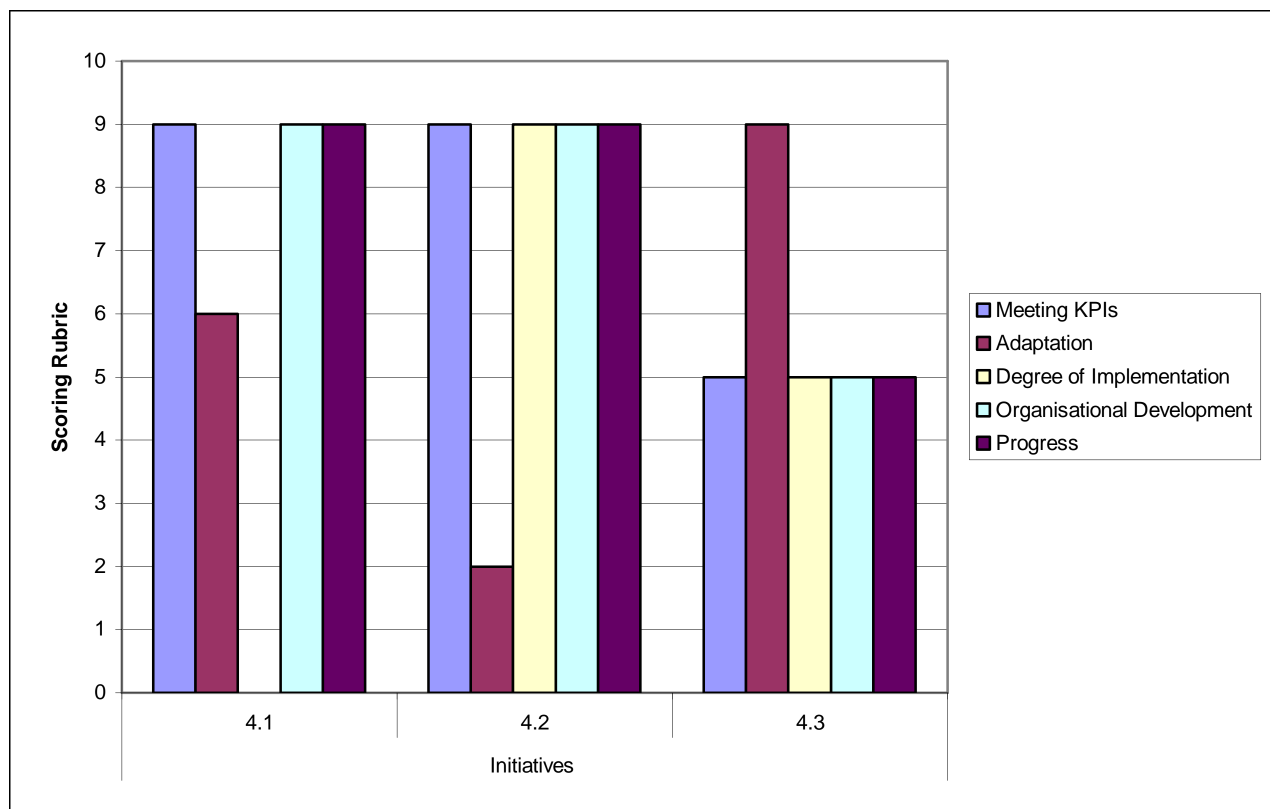
4. Food Industry Accord Action Area

CMDHB has been working with the Food Industry Group (FIG) to develop a collaborative approach to implementing the joint objectives of LBD and the Food Industry Accord. This type of relationship is new, not only in New Zealand but also globally. There are a number of initiatives planned for this Action Area, although the SoPH evaluation focused on the partnership between LBD and McDonald's restaurants in implementing the Low Sugar Trial in 2006. In 2007, the Healthy Kai initiative is the key focus of the Food Industry Accord.

Food Industry Accord Action Area 2005/ 2006

Figure 16 illustrates the progress made by the Food Accord Action Area on achieving the KPIs and goals identified through the documentary analysis and interviews during the 2005/ 2006 financial year.

Figure 16. Food Accord 2005/2006



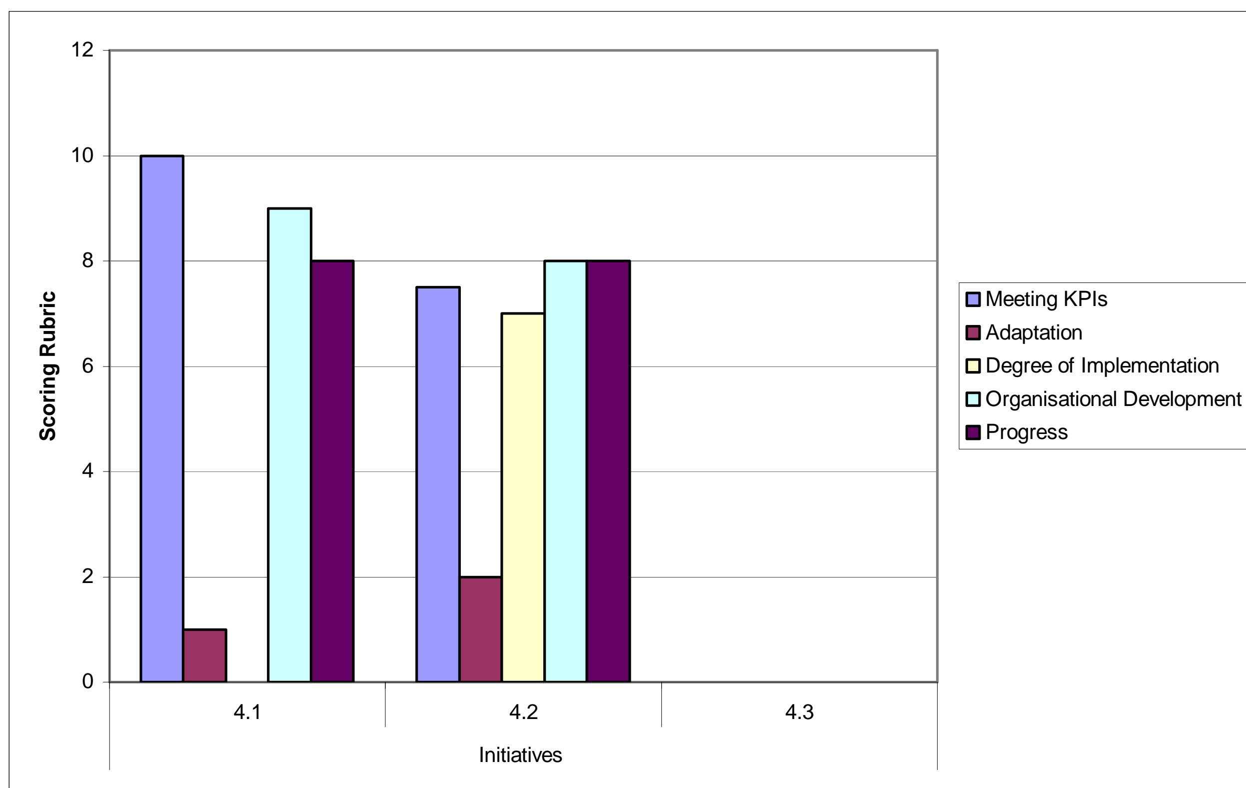
KEY: 2005/2006 Action Area: Supporting a Healthy Environment through a Food Industry Accord	
4.1	Consolidating a leadership structure and action agenda for the food industry: health sector joint initiative in Counties Manukau
4.2	Co-funding of an advocacy position to develop and implement the joint Food:Health work programme
4.3	Developing and implementing a detailed work programme for 2006/2007

In 2005/2006, the Food Health Industry Group (JIG) was established as the leadership hub for this Action Area. This initiative (4.1) received very high scores for all variables except implementation as the leadership hub initiative does not include an intervention. The work programme initiative (4.2) for 2005/2006 had a very high degree of implementation, organisational development and progress towards meeting KPIs. This initiative had very little adaptation. No progress was made towards developing a work programme for 2006/2007 as it was decided that the work programme from 2005/2006 would continue into the next year (4.3). Subsequently, this KPI was only partially met although the use of the previous plan is represented in moderate scores for the other evaluation variables.

Food Industry Accord Progress 2006/ 2007

In 2006/ 2007 the Food Accord sought to strengthen its leadership hub and complete the JIG programme. The area was also working on the soft drinks, white milk, healthy kai, healthy food parcels and a healthy canteen business model pilot. The Food Industry Accord also wanted to develop a social marketing programme, Health Points, a communications initiative and develop and implement a detailed work programme for 2006/ 2007. Figure 17 illustrates the progress made by the Action Area between June 2006 and March 2007.

Figure 17. Food Accord 06/07



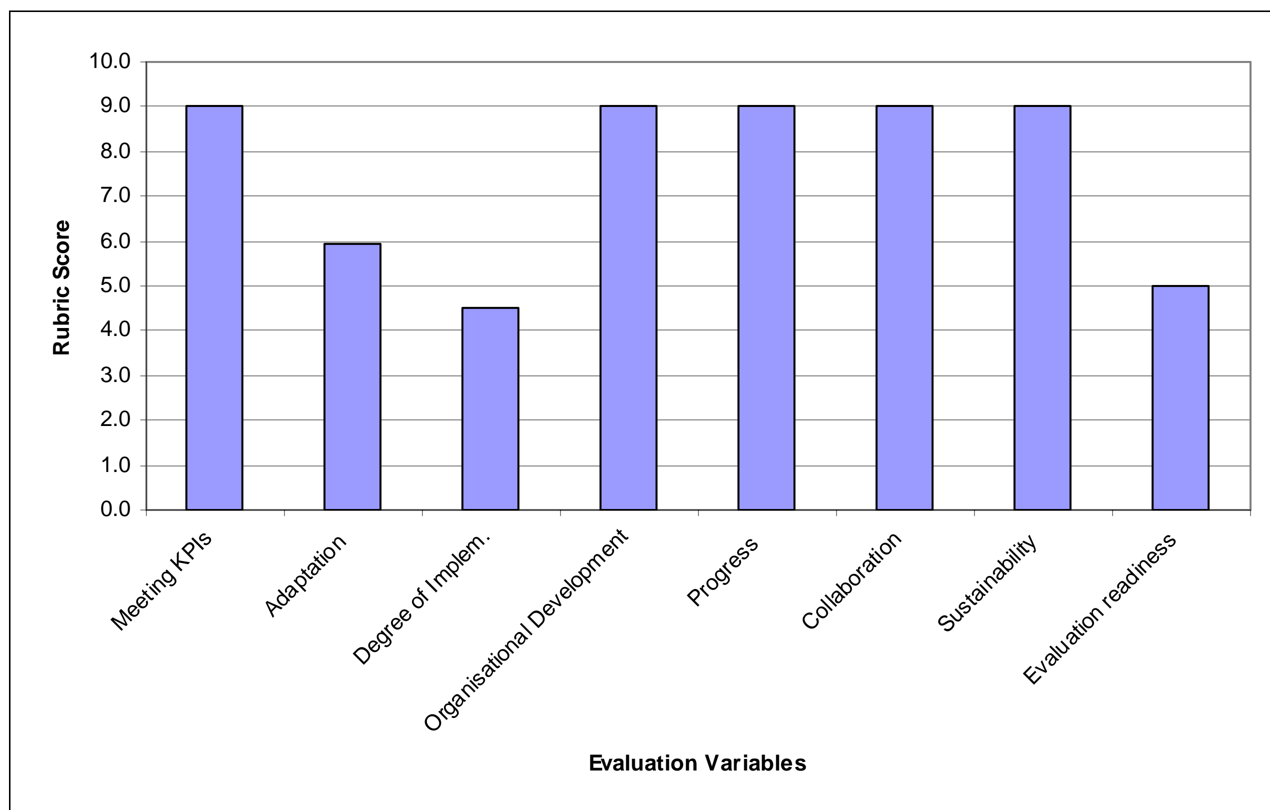
KEY: 2006/2007 Action Area: Supporting a Healthy Environment through a Food Industry Accord	
4.1	Strengthening the leadership structure for the food industry: health sector joint initiative in Counties Manukau
4.2	Completing JIG work programme 2005/2006
4.3	Developing and implementing a detailed work programme for 2006/2007

Figure 17 indicates that the leadership hub for this Action Area was strengthened and met the KPI for this year (4.1). It also continued to have a high level of organisational development and progress. The work programme initiative (4.2) that continued from the previous year received a medium to high score for each evaluation variable, although the activities within this initiative did not undergo a great deal of adaptation. No progress was reported for the initiative to develop a work programme for 2006/2007 for this Action Area (4.3).

Overview of the Food Industry Accord Action Area

A means analysis of the 2005/ 2006 and 2006/ 2007 data was used to provide an overview of the Food Industry Accord Action Area between June 2005 and March 2007. In addition, the Action Areas were assessed on their collaboration, sustainability and evaluation readiness. Figure 18 illustrates these findings and the interview data is used to support the overview.

Figure 18. Overview of Food Accord Action Area



Programme Progress

The Food Accord achieved virtually all of its KPIs and achieved highly on all of the evaluation variables during the first year. The means analysis also indicates a high level of adaptation, although this only represents the decision to not to develop a new work plan for 2006/2007. The collaboration of this Action Area was particularly successful and has resulted in a high level of sustainability particularly for the McDonald's initiative. Despite these achievements and the use of McDonald's as a focussed study the Action Area provided limited information to the evaluation team and received a moderate evaluation readiness score.

Collaboration, Partnership and Support

The Action Area identified collaboration as the key to its success and progress in meeting KPIs:

All our success is relationship based.

The development of a relationship between the health sector and the food industry was particularly interesting and of particular importance, as relationships needed to be developed to ensure that all parties were comfortable with the initiatives:

…they [LBD administrators] needed to feel comfortable with it. They are part of this LBD umbrella and when we did the McDonalds communication it had our LBD logo so they all needed to be comfortable. So that took a bit of time.

A number of supportive relationships helped to secure the success of the Food Industry Action Area and the area also identified a number if links with other LBD Action Areas:

Specific close relationships have been established with Coca Cola and McDonalds, Burger King at the management level. At the implementation level – Tangaroa College, the Diabetes Project Trust, Healthy Kai is ARPHS and our local health providers and they are now working with the food industry. ARPHS has been working with the food industry to get food manufacturing factories to do the Heartbeat Challenge.

Organisational Development

The organisational development of the Action Area was rated highly by the information provided to the evaluation team as resources and management were adequate. The sustainability of the initiatives identified under the KPIs was also rated highly. This high score also reflects the expansion of the provision of Sprite Zero to all McDonald's restaurants in New Zealand. The evaluation readiness of this Action Area was moderate as although the evaluation team were provided with significant information on the McDonald's initiative through the focussed study there is less known about the other Food Industry Accord initiatives.

Impact

The relationship between the health sector and McDonalds was identified as the most successful initiative by the Food Industry Accord. The co-funding of the advocate position for this initiative was identified as a critical success factor in implementing the low-sugar beverage choice in McDonald's. The reduction of sugar consumption in Counties Manukau was proudly shared as a major success:

McDonalds and the co-funding of the advocate position - both of those received international recognition. Even our partnership relationship to be working together received acknowledgement. It was great when the McDonalds' result came out that there was a 17% reduction. We took 7-8 tons of sugar out of the environment. How can anybody criticise that? I think that the gains are more long term that they are beginning to understand how their business does impact on health outcomes.

Key Issues and Future Direction

When considering future directions for the Food Industry Accord the area made some interesting comments about the successes achieved in working together without regulation when the needs of both the health sector and the food industry are being met:

We have shown that you can actually work together without regulation. Partnerships are working. I think the healthy tuck shop is a prime example. The food industry are really chuffed to be part of that. It is very grass roots, but we have taken out Coke and got Pump water- their products are still there. It is a real demonstration of their commitment.

Working to firmer KPIs was also cited as an appropriate direction for the Food Industry Accord:

We are carrying on and building on the gains made this year. I think we will be able to put more fixed milestones in place now that we know people better and we trust each other more now.

Continued relationship building and acceptance was also identified as a consistent goal for the Food Industry Accord.

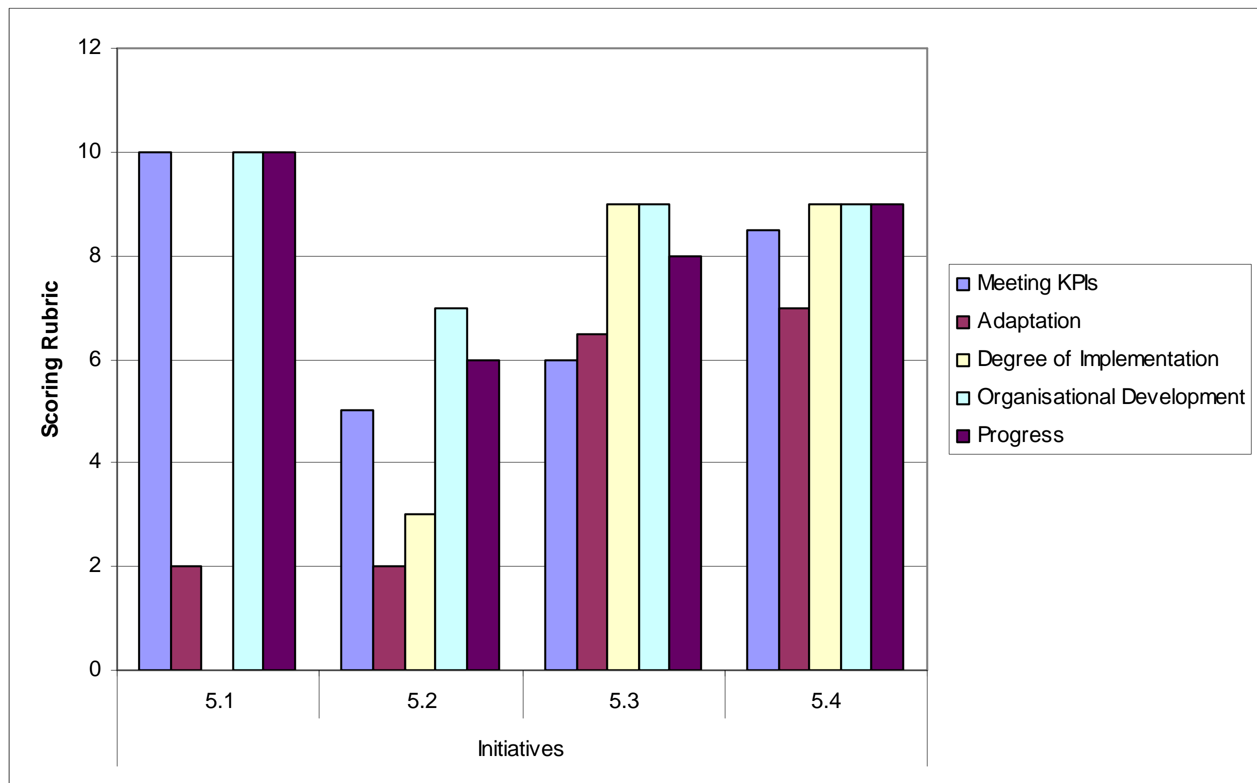
5. Health Promotion Action Area

Strong, coordinated and targeted health promotion is integral to the success of 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. In 2005/ 2006 the Action Area sought to establish a leadership hub and align actions through better coordination of the funding environment. Developing workforce capacity and improving communications resources for diabetes were also key initiatives for the area.

Health Promotion Progress 2005/ 2006

Figure 19 illustrates the progress made by the Health Promotion Action Area on achieving the KPIs and goals identified through the documentary analysis and interviews during the 2005/ 2006 financial year.

Figure 19. Health Promotion 2005/2006



KEY: 2005/2006 Action Area: Strengthening Health Promotion Coordination and Activity	
5.1	Consolidating a leadership hub for the health promotion action area
5.2	Supporting aligned actions through better coordination of the funding environment
5.3	Improving capacity of the health promotion workforce.
5.4	Improving communications resources for diabetes for use within health promotion and primary care.

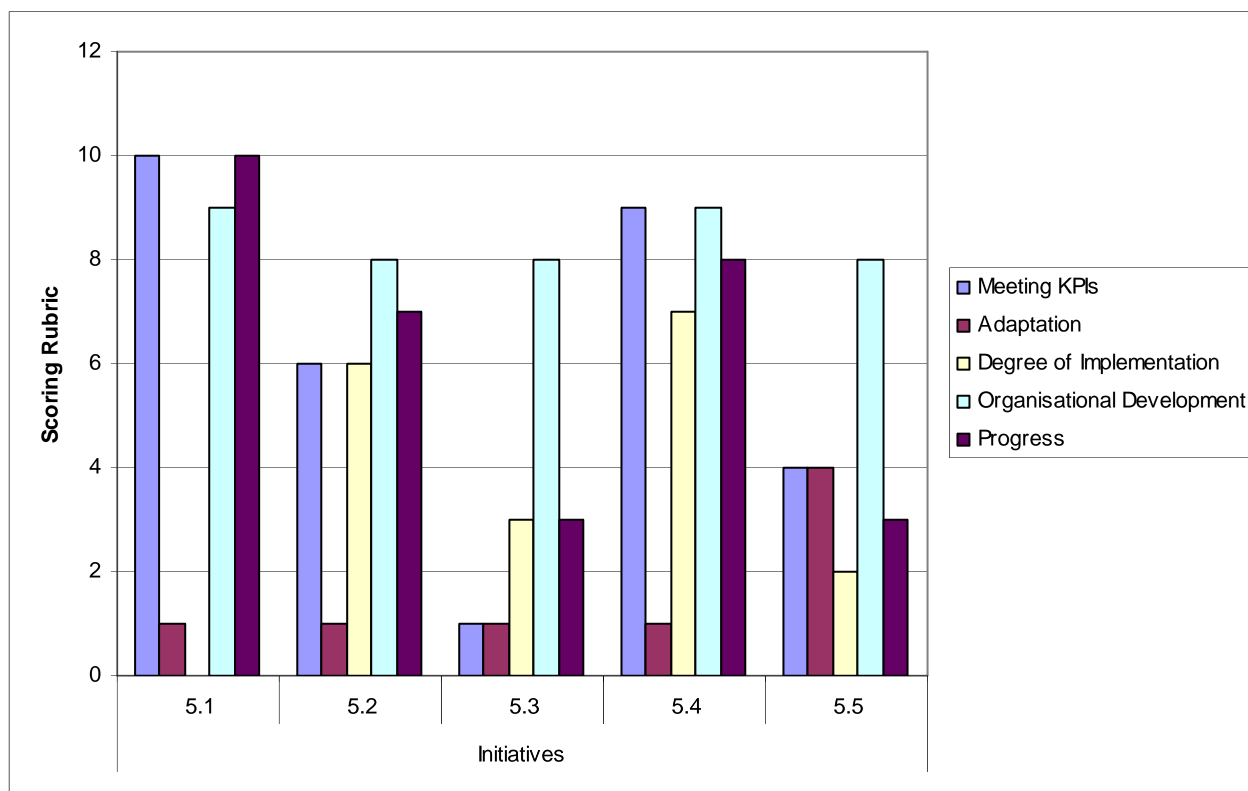
In 2005/2006, CODA was established as the leadership hub for this Action Area, meeting the KPI for this initiative and scoring extremely high for organisational development and progress (5.1). The initiative for supporting aligned actions for funding coordination had a low to medium score for meeting KPIs and a medium score for the degree of implementation (5.2). However, due to the high level of collaboration within this Action Area, this initiative scored a medium rating for organisational development and progress. Although the improving workforce capacity (5.3), and improving communications resources (5.4), initiatives did not meet all KPIs as outlined within the operational plan, both initiatives received extremely high scores for degree of implementation, organisational development and progress. These initiatives also had a medium level of programme

adaptation as changes to the original plans included a delay in the design or development of health promotion courses and the decision to develop two resource packs; one for new diabetics and one for adults at risk.

Health Promotion Progress 2006/ 2007

In 2006/ 2007 the Action Area sought to consolidate the health promotion leadership hub. Building capacity was also a key focus of the area through initiatives aimed at enhancing the health promotion and education workforce and supporting recent graduates from the train-the-trainer projects. An initiative to develop the physical activity workforce and activity opportunity was also proposed, although this action was dependent on funding. Figure 20 illustrates the progress made by the Action Area in achieving these initiatives.

Figure 20. Health Promotion 2006/2007



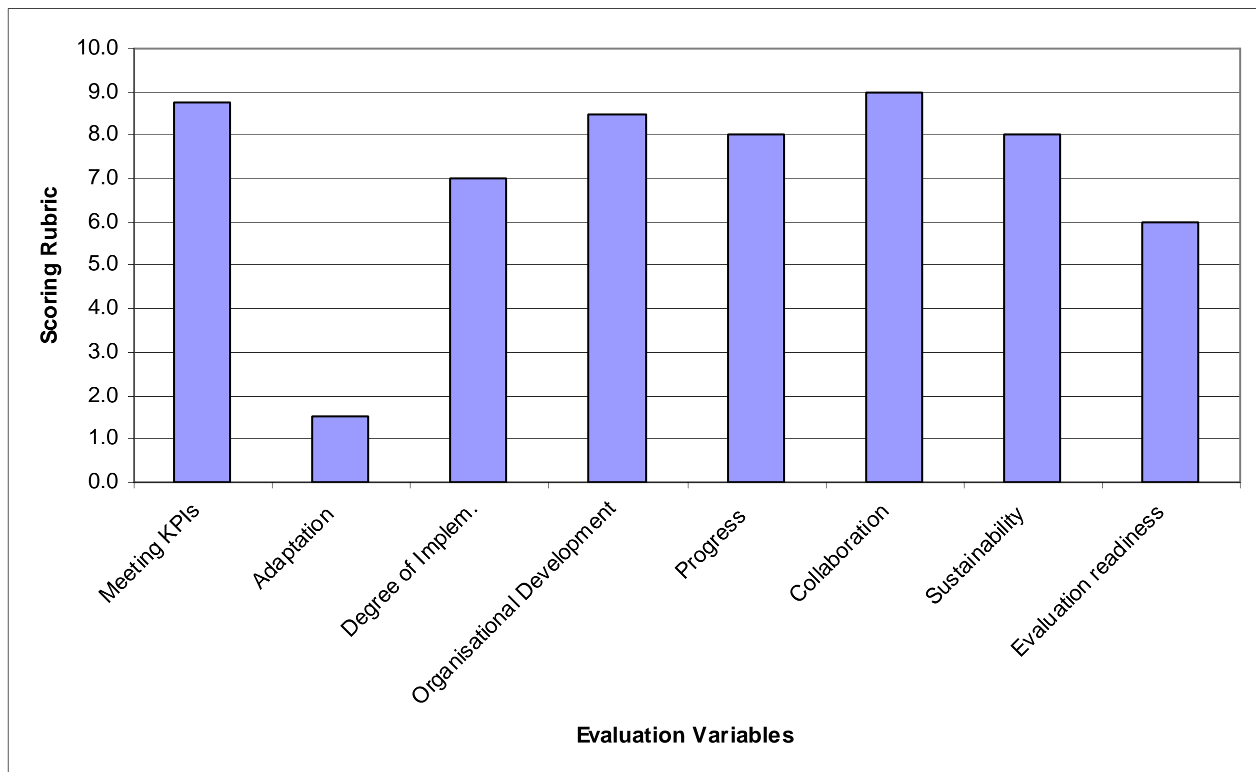
KEY: 2006/2007 Action Area: Strengthening Health Promotion Coordination and Activity	
5.1	Consolidating the health promotion leadership hub for LBD
5.2	Developing and enhancing the health promotion and education workforce
5.3	Supporting recent graduates from train-the-trainer projects (pilot)
5.4	Developing nutrition and physical activity resources to support health promotion in the primary care setting
5.5	Developing the physical activity workforce and activity opportunities (contingent on funding)

Figure 20 shows that the Action Area met the KPIs for the 2006/2007 year and continued to have an extremely high level of organisational development and progress. The developing nutrition and physical activity resources initiative (5.4), also progressed well towards meeting KPIs and had a high level of implementation and organisational development, while both the developing the health promotion workforce initiative and the developing the workforce and activity opportunities initiative received medium scores for each variable. Although supporting the train-the-trainers initiative scored highly for organisational development (5.5), the initiative received a low rating for all other variables.

Overview of the Health Promotion Action Area

A means analysis of the 2005/ 2006 and 2006/ 2007 data was used to provide an overview of the Health Pormotion Action Area between June 2005 and March 2007. In addition, the Action Area was assessed on their collaboration, sustainability and evaluation readiness. Figure 21 illustrates these findings and the interview data is used to support the overview.

Figure 21. Overview of Health Promotion Action Area



Programme Progress

Following an initial period of adaptation on some of the programmes goals to suit the context of the programme in 2005/ 2006, the Health Promotion Action Area went on to meet nearly all of their KPIs. The low level of adaptation presented in Figure 21 represents the low adaptation to the 2006/

2007 objectives. Following the high achievement on their KPIs the Health Promotion Action Area was rated highly for the organisational development and collaboration of the area. The degree of implementation was moderate, as was the evaluation readiness of the Action Area. Information on progress was made available to the evaluation team through CODA. The high level of collaboration and organisational development of the Action Area resulted in a high sustainability score. The Action Area illustrate a strong organisation and collaboration, with good implementation.

Collaboration, Partnerships and Support

The Diabetes Projects Trust leads the Health Promotion Action Area and collaborates closely with DHBs and the Ministry of Health. This is an existing relationship that has been strengthened by LBD. The Trust exists to prevent diabetes and its complications, thus they work with many organizations from prevention all the way to Primary and Integrated Care. The Action Area explored the mutual support provided through their collaboration with a number of key organisations:

> *We work with any other agency out there that wants to work with us. We have very open door policies- any NGO or PHO that needs our help or support. On our list of people we consult includes the Heart Foundation, Diabetes Auckland, Public Health, Eating Disorder. There is the Council too and all sorts of people we call on as needed.*

Relationships were identified as crucial to the work of this Action Area, especially the support and guidance provided by the Ministry of Health and the LBD programme. It was often remarked that health promotion was much like social marketing, Maori and Pacific Action Areas, in the respect that Health Promotion underpins the work of a number of Action Areas.

> *Health Promotion, education, communication, awareness and understanding underpins all the action areas, so it is fundamental like social marketing, Maori and Pacific.*

Organisational Development

The organisational development of the Health Promotion Action Area was rated highly. The Action Area operates through a strong leadership hub (CODA) that meets regularly and has considerable representation from other LBD Action Areas and external providers:

> *CODA which comprises primarily NGO organizations, health providers and other people interested in diabetes and obesity prevention and management. Examples include the Heart Foundation, Manukau*

City Council, the Royal Society for the Blind, Diabetes Projects Trust, PHOs. We also have the PHO health promotion working group. We make sure the PHOs and CODA communicate.

The interview data did suggest however, that difficulties in securing relationships with particular groups sometimes made it difficult to achieve some of the initiatives or coordinate their efforts.

Impact

Despite the initial challenges, consistency and collaboration of the Health Promotion Action Area were identified as the key to achievement to date. Another key factor of the Action Area was the consultation with PHOs and Maori to update and create consistent, culturally appropriate pamphlets on healthy living. The ultimate impact of the programme is to support changes in the health behaviour of local communities through providing people with the information and support to make informed choices:

Health promotion and education are very important tools to bring about behaviour change, so the more people know the more ability or the more informed they are to make choices. It doesn't equal behaviour change, but at least it is a tool and a step towards them considering making a change.

Key Issues and Future Direction

It is believed that the successful collaboration resulted in three leadership groups being formed, seeing how these groups continue to develop is of interest:

What has happened in the sector is that people are talking to one another more. They are developing real meaningful relationships and they are collaborating. We didn't have that before. No we have three leadership groups and will have to see how well they communicate.

The continued development of relationships and embedding health promotion throughout their partners and other organisations was also identified as a key task for the future by Health Promotion. The need for the involvement of key decision makers was also identified:

Also it is changing or widening mindsets and improving their understanding of our world and our philosophy… we need to have the managers and decision makers more engaged. It can be very hard for people to go back to their own environment…so we are looking at how we can embed our thinking even more closely into our contracting processes so managers are aware that these are our expectations…so we really start to get ownership and people… aligned to our philosophy.

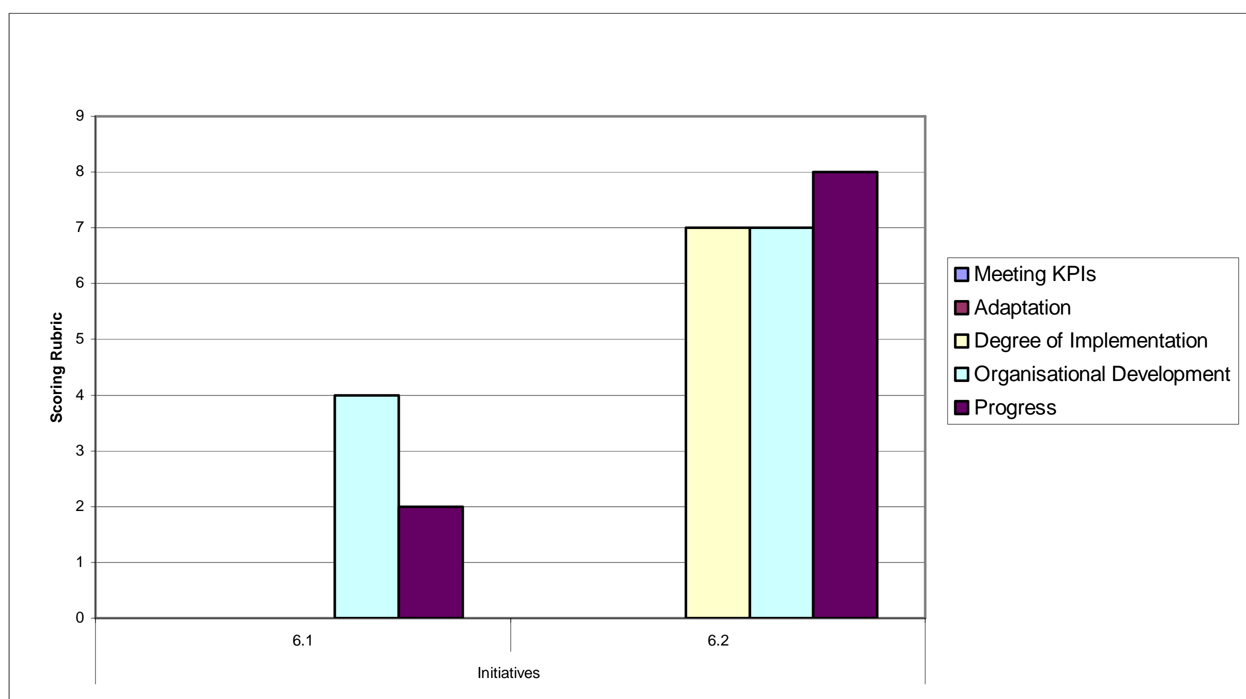
6. Well Child Action Area

The importance of the health of young children was echoed in hui and fono undertaken as part of the LBD planning process. Maori and Pacific peoples gave strong guidance that LBD must focus strongly on future generations, and place more effort on protecting children from obesity and subsequent disease. In 2005/ 2006 the Action Area wanted to develop the existing Well Child forum into the leadership hub and support the professional review of the Well Child framework.

Well Child Progress 2005/ 2006

Figure 22 illustrates the progress made by the Well Child Action Area on achieving the KPIs and goals identified through the documentary analysis and interview data during the 2005/ 2006 financial year.

Figure 22. Well Child 2005/2006



KEY: 2005/2006 Action Area: Enhancing Well Child Services to Reduce Childhood Obesity	
6.1	Supporting the existing Well Child forum to be the leadership hub for the Well Child Action Area.
6.2	Supporting the professional review of Well Child framework

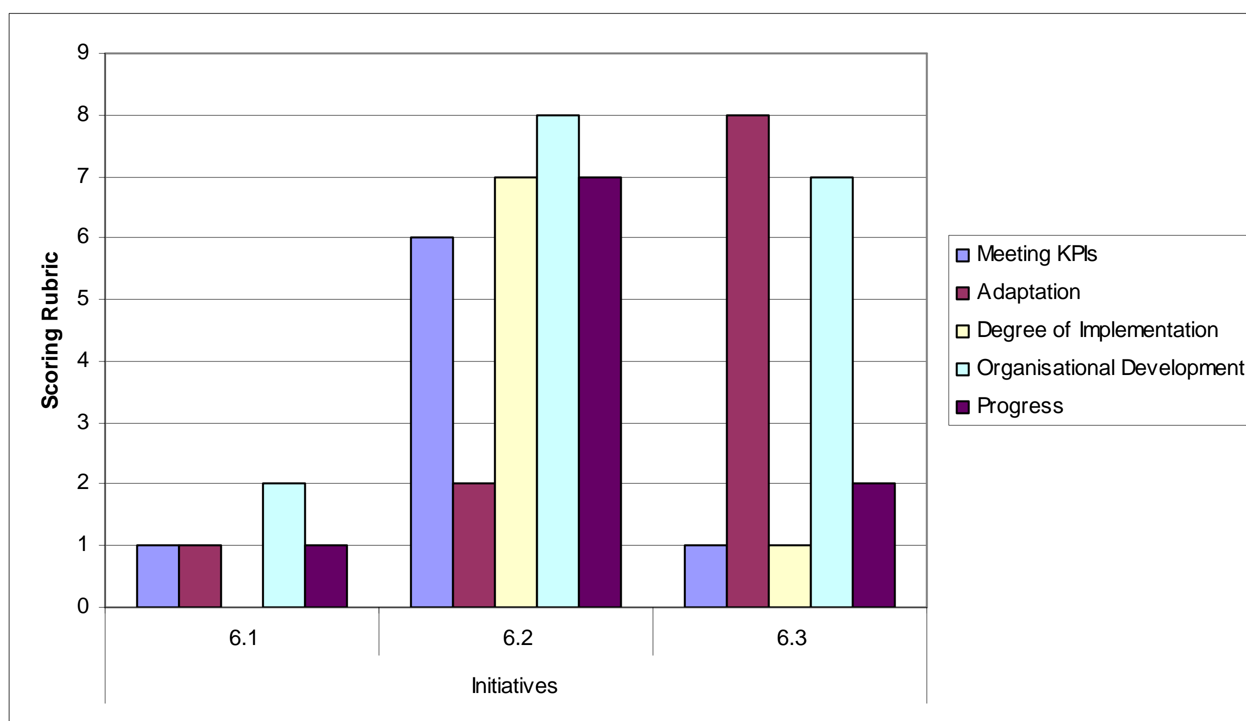
In 2005/2006, no KPIs were identified for either of these initiatives and very little progress information was given for the Well Child leadership hub initiative, contributing to low scores for

organisational development and progress. The professional review of the Well Child framework was given a medium to high score for all remaining evaluation variables.

Well Child Progress 2006/ 2007

The KPI to establish a leadership hub was also cited for the 2006/ 2007 financial year. Additional initiatives sought to develop nutrition and diabetes resources to support Well Child providers. A research proposal would also be written to explore the obesity pathways in children aged 0 to 5 years. Figure 23 illustrates the progress made by the Well Child Action Area between 2006 and March 2007.

Figure 23. Well Child 2006/2007

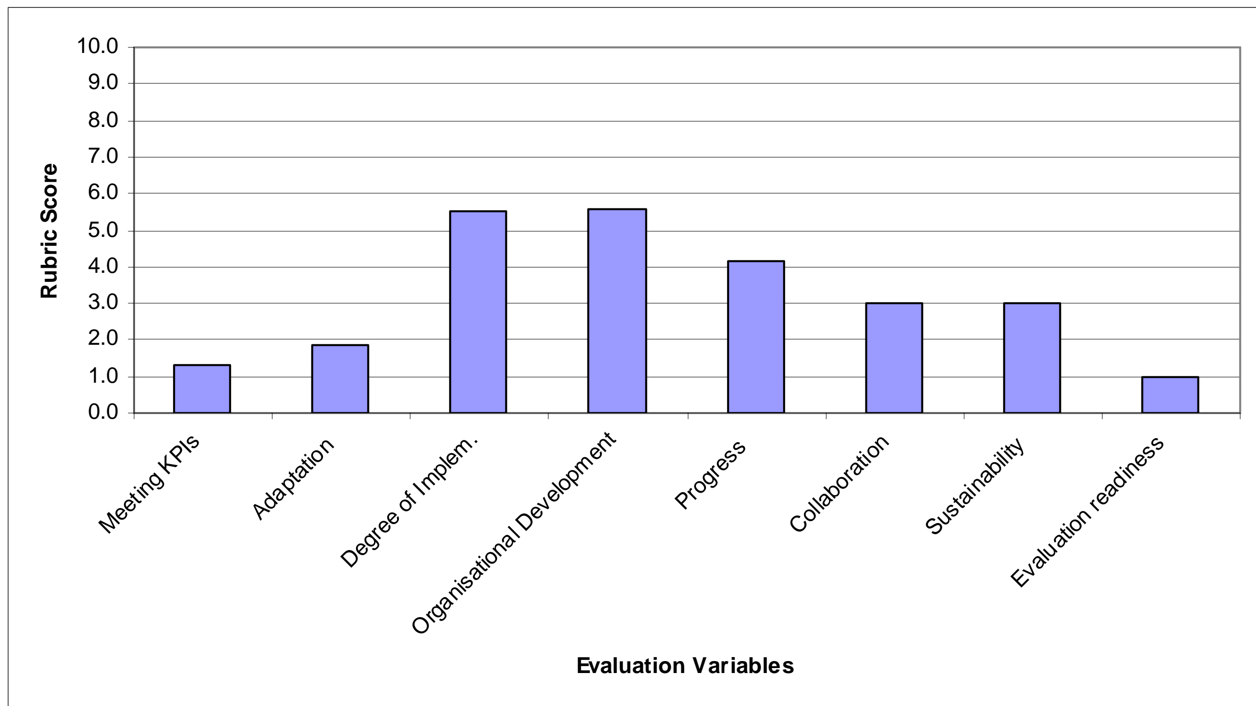


KEY: 2006/2007 Action Area: Enhancing Well Child Services to Reduce Childhood Obesity	
6.1	Supporting the existing Well Child forum to be the leadership hub for the Well Child action area
6.2	Scoping and development of appropriate nutrition and diabetes resources to support Well Child providers
6.3	Developing a research proposal exploring age 0–5 obesity pathways among current 5–10 year old children

Overview of the Well Child Action Area

A means analysis of the 2005/ 2006 and 2006/ 2007 data was used to provide an overview of the Well Child Action Area between June 2005 and March 2007. In addition, the Action Area was assessed on their collaboration, sustainability and evaluation readiness. Figure 24 illustrates these findings and the interview data is used to support the overview.

Figure 24. Overview of Well Child Action Area



Programme Progress

All except one of the KPIs for the Well Child Action Area were unmet, although there was a low degree adaptation. Overall, the Action Area had a moderate degree of implementation and organisational development due to the establishment of an informal leadership hub. The degree of implementation reflects the Action Areas completion of a review of appropriate nutrition and diabetes resources to support Well Child providers. The information provided to the evaluation team suggested that the collaboration, sustainability and evaluation readiness of the Action Area were all low. The Action Area was rated as having made low to moderate progress towards its aims and objectives.

Collaboration, Partnership and Support

In reflection of the low collaboration rating, the current lack of communication was recognised and it was suggested that the area looks to establishing relationships with some of the other LBD streams:

> *Our work stream has developed no direct partnerships in the community. I have identified a need to connect up with two people who are involved in other work streams… It's a bit complicated pulling all the bits together.*

While recognising the need for collaboration with schools, women's health, Maori and Pacific work streams, the Action Area suggested that securing relationships can be difficult, however this is a key task of the future.

> *I am looking at work that we can usefully link into the LBD project so we are not duplicating it… We are going to work with one of the statisticians associated with the programme to develop a guide to help interventions in breastfeeding, parenting and family activities.*

Organisational Development

In terms of developing a structure to support the development and implementation of the Well Child initiatives some progress was made in identifying the Well Child forum as the potential leadership hub. The Action Area received a moderate rating for its organisational development, as the Well Child group organised a literature review of current research on risk factors for diabetes in children under 5 years old, although the area suggests that this focus changed to obesity following the lack of evidence for diabetes risk factors in children:

> *The outcome of that was that there was no well researched data showing risk factors for diabetes, so we then looked at obesity. There is some work that has been done that shows trends and indications.*

The documentary analysis also indicates that the research is now focussing on Pacific families.

Impact

While little impact can be noted, the providers in the area identified the progress made on the Pacific family research within hospitals, communities and the Auckland University of Technology. The research was recognised as an opportunity to develop prevention and intervention plans for Well Child Services. The research was also identified as an opportunity to develop relationships with other Action Areas and external agencies.

Key Issues and Future Direction

A number of barriers to progressing on the specified KPIs can be identified. Initial unfamiliarity of the LBD programme and Action Areas, as well as concerns that the current KPIs did not reflect the aims and goals of Well Child, were some of the key barriers identified. It was suggested that the area required a degree of adaptation that was not noted in the KPIs for 2006/ 2007.

What we anticipated it would lead to has not happened and also as a result of that we did make an amended goal… So there is some work to do there with the team around changing some of the documented information around KPIs.

Another Well Child concern was the issue of engaging providers and communities on the basis of preventing obesity or through labelling children as at-risk:

I have a little bit of a concern around labelling children or babies 'obese' or 'likely to be obese.' Definitely feedback from providers is that they would prefer to focus on activity for those children who are emerging and looking like they might be on that pathway.

The area also wanted to ensure that their interventions were supported by sound research evidence to ensure future outcomes:

I think maybe a pressure to get some kind of results too soon could impede doing good solid well researched and supported work. Everyone is keen to get something done yesterday.

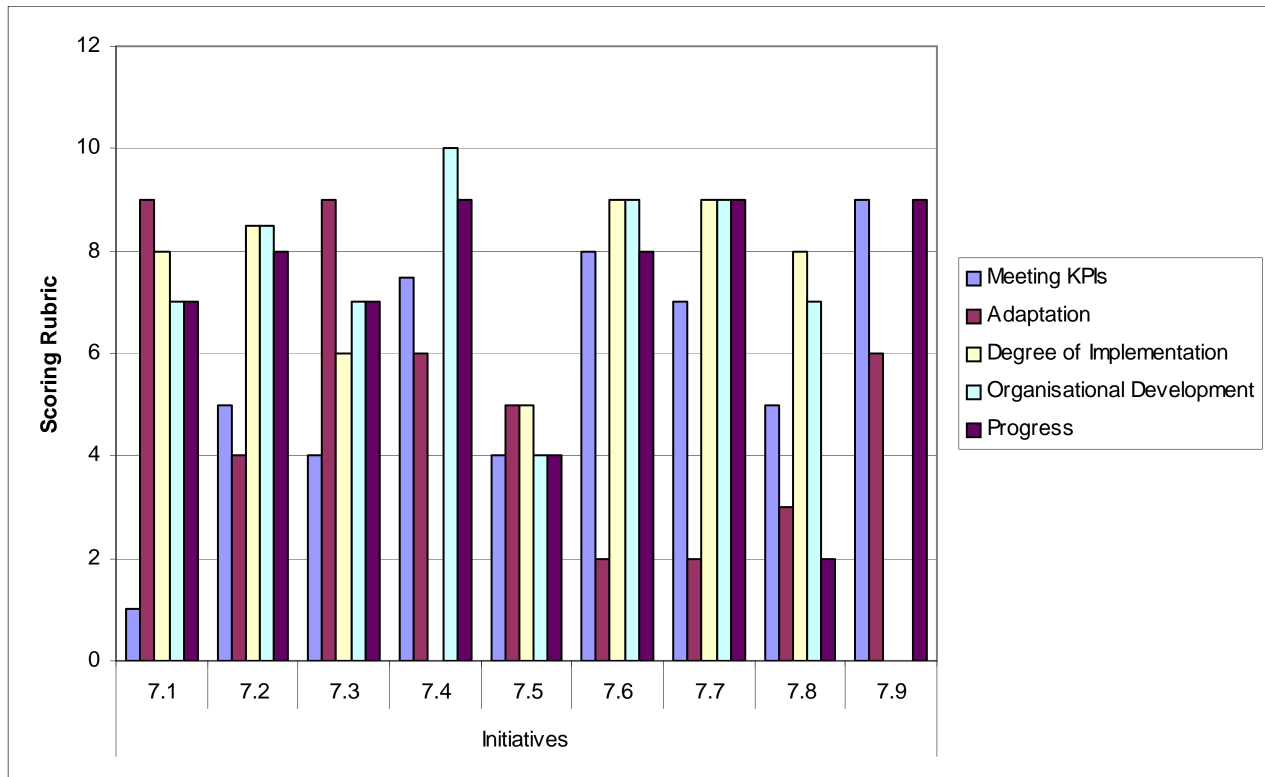
7. Schools Accord Action Area

The nutrition and physical activity environments in schools are characterised by multiple providers and programmes with no overall co-ordination or direction. Schools are confused and fatigued due to external providers raising expectations which cannot be met with internal school resources. To reduce this LBD is supporting the Schools Accord to develop a leadership hub to oversee the development of a strategy for working with schools. In 2005/ 2006 the area also wanted to support kohanga reo, Kura Kaupapa and Pacific Language Nests to develop and implement nutrition and physical activity guidelines and programmes. The Schools Accord was also seeking to improve principals' and Board of Trustees' awareness of the links between educational achievement, physical activity and nutrition. Nutrition, Exercise and Weight and Achievement in Multi-cultural High Schools (AIMHI) interventions would also be introduced to high need secondary schools and aligned to the OPIC research at the University of Auckland. Trials of a healthy canteen business model, developing new funding streams and supporting schools to improve the drinks available in schools were also key initiatives for the 2005/ 2006 year.

Schools Accord Progress 2005/ 2006

Figure 25 illustrates the progress made by the Schools Accord Action Area on achieving the KPIs and goals identified through the documentary analysis and interviews during the 2005/ 2006 financial year.

Figure 25. Schools Accord 2005/2006



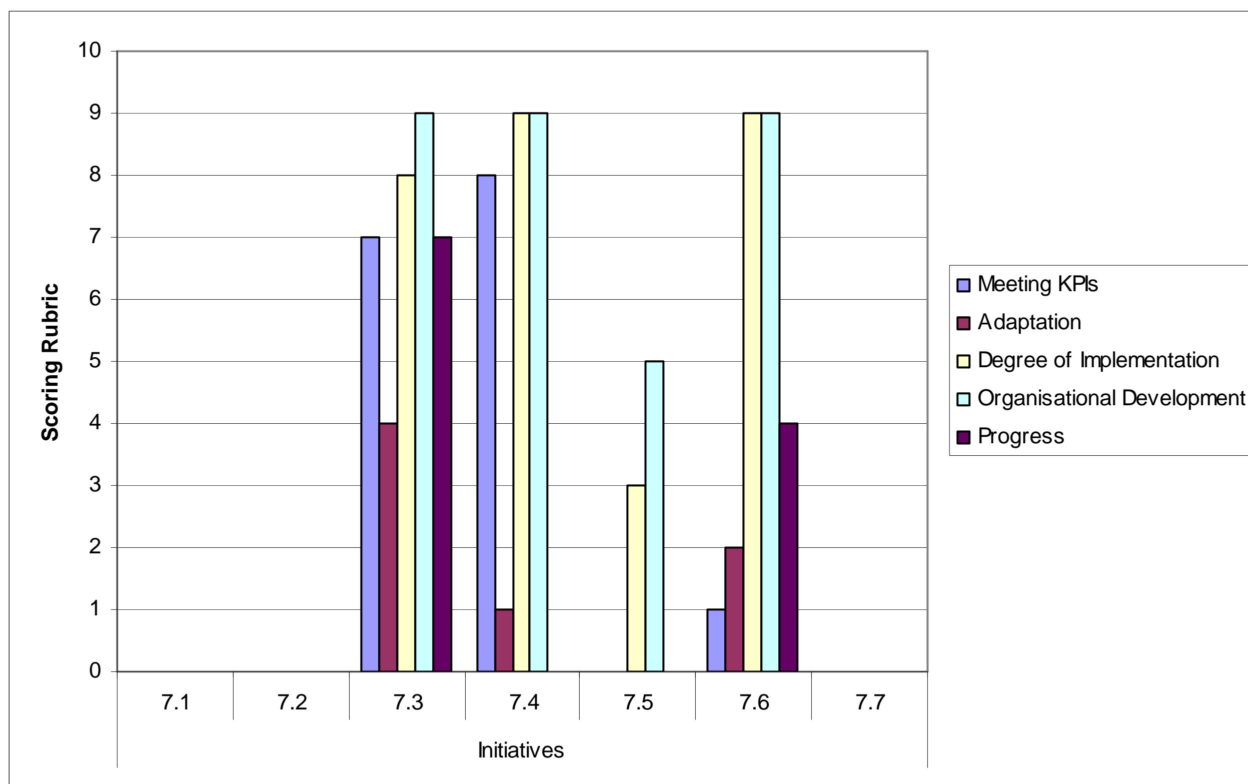
KEY: 2005/2006 Action Area: Supporting Schools to Ensure Children are 'Fit, Healthy and Ready to Learn'	
7.1	Supporting kohanga reo to enhance or develop and implement nutrition and physical activity guidelines and programmes
7.2	Supporting Pacific Language Nests to enhance or develop and implement nutrition and physical activity guidelines and programmes as part of programme delivery
7.3	Supporting Kura Kaupapa to enhance or develop and implement nutrition and physical activity guidelines and programmes
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
7.5	Improving school principals' and Board of Trustees' awareness of the strong evidence supporting improved educational outcomes when children are achieving appropriate physical activity levels and nutrition (breakfast)
7.6	Enhancing and supporting NEW/AIMHI intervention in selected high risk secondary schools, and aligning it with University of Auckland OPIC intervention/research
7.7	Trialling of the 'healthy canteen' business model
7.8	Developing new funding streams to support schools to make sustainable changes
7.9	Supporting schools to improve 'drinks' environment in and around all schools

Overall, the initiatives within the Schools Accord Action Area scored highly for organisational development, implementation and progress towards meeting KPIs. Although the Kohanga Reo, Pacific language nests and Kura Kaupapa initiatives did not meet their set KPIs, all three initiatives received medium to high scores for adaptation, degree of implementation, organisational development and progress. The Schools Accord leadership hub, NEW/AIMHI and healthy tuckshop initiatives all scored extremely high for progress towards meeting KPIS, degree of implementation and organisational development. The only initiative to receive low to medium scores for all variables was the initiative to improve Principles and Boards of Trustees awareness of improving educational outcomes through nutrition and physical activity awareness. The development of funding streams initiative made low progress towards meeting KPIs. However, this initiative did score highly for degree of implementation and organisational development as good progress was made. The improving schools 'drinks' environment initiative received high scores for progress towards KPIs and adaptation. However, this initiative was not assessed on the degree of implementation or organisational development, as the initiative was taken up by the Food Industry Accord.

Schools Accord Progress 2006/ 2007

Figure 26 chart illustrates the progress made by the Schools Accord Action Area on achieving the KPIs and goals identified through the documentary analysis between 2006 and March 2007.

Figure 26. Schools Accord 2006/2007



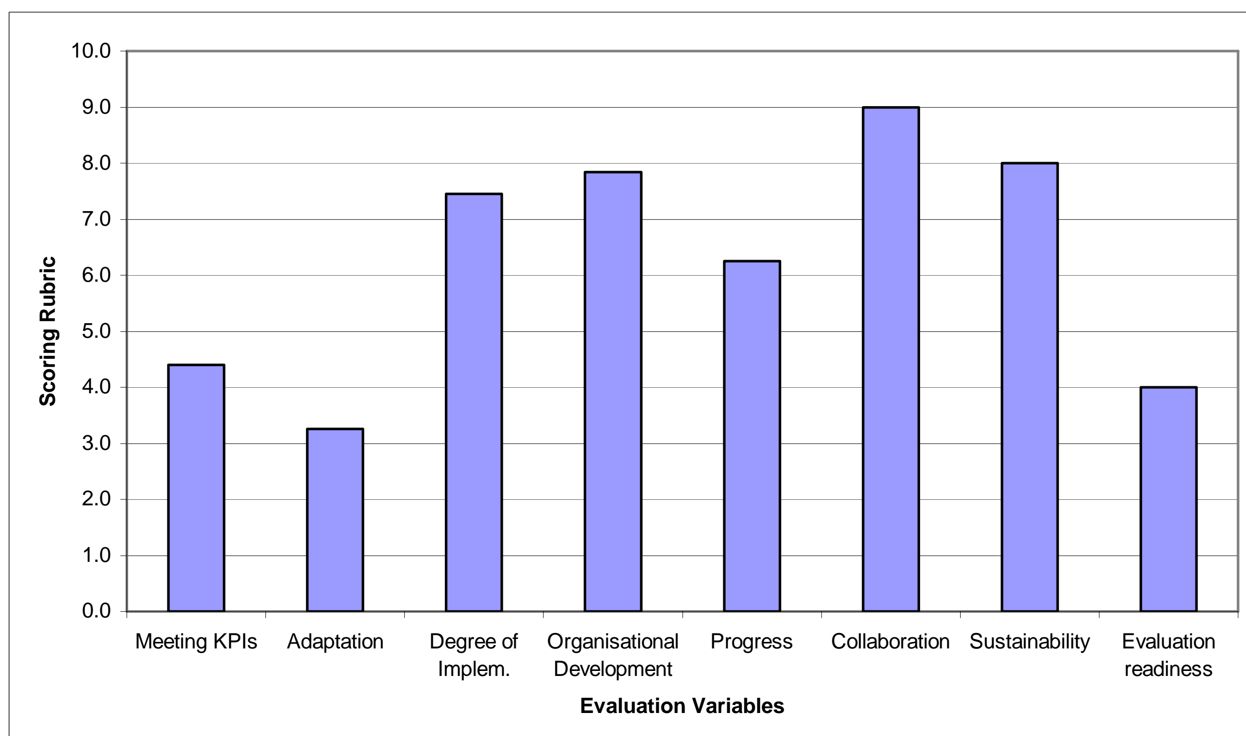
KEY: 2006/2007 Action Area: Supporting Schools to Ensure Children are 'Fit, Healthy and Ready to Learn'	
7.1	Supporting kohanga reo and kura kaupapa in nutrition and physical activity
7.2	Supporting Pacific language nests to enhance or develop and implement nutrition and physical activity guidelines and programmes as part of programme delivery
7.3	Strengthening the Counties Manukau healthy schools leadership hub
7.4	Enhancing and supporting NEW/AIMHI intervention in selected high schools
7.5	Enhancing and supporting ongoing development of whole school approaches and new initiatives in schools
7.6	Supporting the implementation of the Healthy Tuckshop Business model
7.7	Developing new funding streams to support schools and communities to make sustainable changes

In 2006/2007, not enough information was provided to evaluate the success of the Kohanga Reo and Kura Kaupapa, Pacific Language Nests and development of funding streams initiatives. This is reflected in the missing data in Figure 26. However, the Schools Accord leadership hub was progressing towards fulfilling their KPIs and continued to have a high level of organisational development. The NEW/AIMHI initiative also received high scores for all variables, except adaptation. No KPIs were identified for enhancing and supporting the development of whole school approaches, although it should be noted that this initiative had made a medium level of implementation and organisational development. It is important to note, that many of the other initiatives are being developed in collaboration and this may have resulted in the lack of detail provided to the evaluation team.

Overview of the Schools Accord Action Area

A means analysis of the 2005/ 2006 and 2006/ 2007 data was used to provide an overview of the Schools Accord Action Area between June 2005 and March 2007. In addition, the Action Area was assessed on their collaboration, sustainability and evaluation readiness. Figure 27 illustrates these findings and the interview data is used to support the overview.

Figure 27. Overview of Schools Accord Action Area



Programme Progress

The Schools Accord Action Area made moderate progress on meeting its KPIs, although it is important to note that they had at least seven initiatives for each year. The degree of adaptation was low, as was the evaluation readiness of the Schools Accord. The Action Area rated highly on the majority of the other evaluation variables including organisational development, collaboration and sustainability. The degree of implementation and overall progress of the Schools Accord towards it original goals was rated moderately. The Schools Accord is making fantastic progress in supporting to schools to provide healthier environments. Again, it is useful to note that a number of the Schools Accord initiatives are developed in collaboration or still in progress. This results in the moderate score for meeting KPIs.

Collaboration, Partnerships and Support
The Schools Accord had developed strong links with schools, key providers and other organisations to work as a leadership hub for the Action Area. The support of CMDHB was linked to the funding of initiatives including the Tuck Shop and the Diabetes Projects Trust was also identified as a key partner. The success of the Tuck Shop initiative was also linked to collaboration with the Food Industry Accord and the ability of the school to embrace the initiative:

> *[Name] did a fantastic job. The schools, food distributors, Diabetes Projects Trust…Coca-Cola have been fantastic… Without the school basically handing over their tuck show we would have never got this off the ground.*

The area stated that the LBD programme was collaborating with the Schools Accord through recognising and funding a number of existing initiatives, such as the Tuck Shop that was developed out of the AIMHI plan designed to raise the level of educational achievement in nine decile 1 urban secondary schools:

> *We see this as an important part of the LBD initiative and it did actually come out of AIMHI.*

Organisational Development
The Schools Accord has developed a well represented and managed leadership hub that meet regularly to discuss progress and future direction. The area had made great progress in commissioning a literature review on the links between educational achievement, nutrition and physical activity. The area had also completed a stocktake of local providers and coordinated a needs assessment of High schools in Counties Manukau. Interestingly, the organisational development of the area was also linked to the need to align or identified shared priorities for health and education:

> *The development of a position paper… has been done…The stock take of relevant providers is completed. The collating of provider information is completed.…Review of information on the gaps…we've done that.…broken it down into four areas. At the beginning of the year…a survey went out to all the schools identifying where they saw their needs were and that was collated. We are working cooperatively together… a lot of it is getting health and education on the same page.*

The sustainability of the Schools Accord was moderately high, as although the programmes exist outside of the LBD programme, capacity to meet the increasing demands of health and education is a potential issue:

The providers are working together like they weren't… they have all got the same experiences and problems…it's all capacity…enormous commitment, enormous passion…and not enough capacity to deliver…because of Mission on and all those initiatives that come out of that it's got a big focus and yet I don't think there has been anything to catch it.

Impact

The area identified a number of impacts on the school environment as well as the impact of their collaboration and partnerships with providers. The area suggested that the providers were more coordinated and that the interventions in schools were also starting to have an impact on teachers and students. The idea of changing the school culture was also cited:

I think it's about changing the culture in the school, teach the teachers to walk the talk.

Key Issues and Future Direction

The Schools Accord also recognised that while they were working in a number of schools reaching the young people and observing this cultural change would take time but is an anticipated outcome for the future:

With the education and the curriculum programme we're working on and we've implemented, I think the message is going to reach the young people. We've already had feedback from the hospital saying the blood tests of the pregnant teens were going from iron deficient to good iron levels. The outcomes are going to be slow. But teaching the kids to cook healthy, role modelling healthy food, and doing it with an education message- they will definitely get it!

As discussed previously, a key concern for the Schools Accord is the capacity to meet the increasing demands of future policies and strategic direction. For example, it was suggested that the inclusion of early childhood initiatives will impact on the School Accord's capacity to deliver.

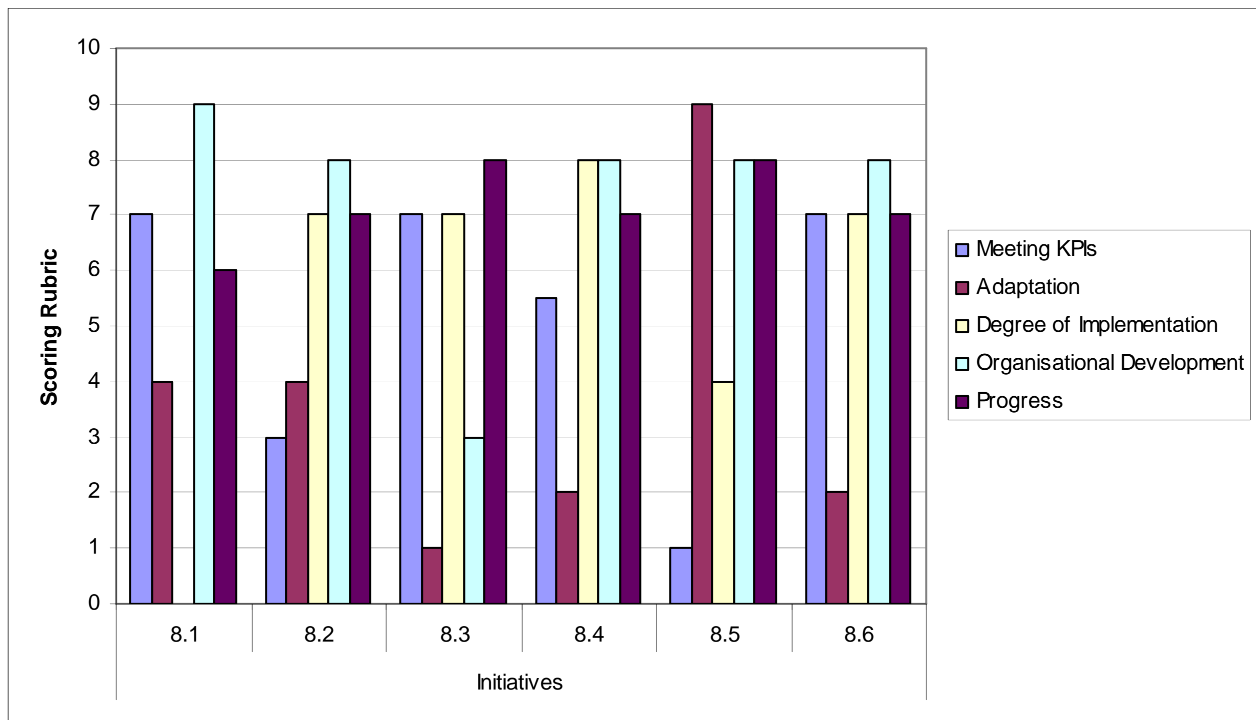
8. Primary Care Action Area

Improving primary care based prevention and management of diabetes is a key component of LBD. In 2005/ 2006 the Action Area sought to establish a leadership structure and develop a diabetes framework for Counties Manukau. The Action Area also includes a number of initiatives designed to improve the management of disease and encourage screening.

Primary Care Progress 2005/ 2006

Figure 28 illustrates the progress made by the Primary Care Action Area on achieving the KPIs and goals identified through the documentary analysis and interviews during the 2005/ 2006 financial year.

Figure 28. Primary Care 2005/2006



KEY: 2005/2006 Action Area: Supporting Primary Care-Based Prevention and Early Intervention	
8.1	Establishing a leadership structure to guide improvements of diabetes management in the primary care sector
8.2	Developing a diabetes care framework for Counties Manukau
8.3	Improving use of brief interventions for modifying obesity risk factors
8.4	Improving uptake of best practice post-diagnosis education
8.5	Trialling and evaluating increased use of family/whanau/group support for obesity risk factors and diabetes management
8.6	Investigating and developing a whole system approach to improving rate of diagnosed type 2 diabetes to expected population with diabetes

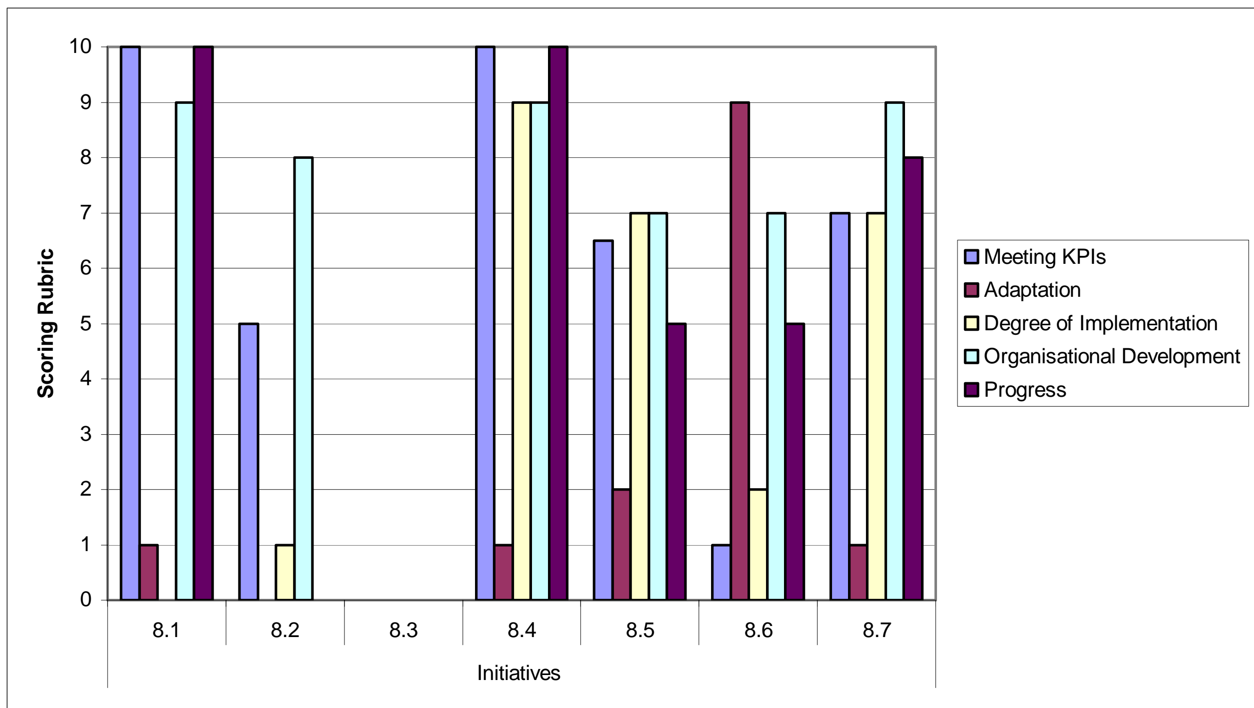
Figure 28 indicates that a number of initiatives within this Action Area had made medium progress towards completing KPIs, while the diabetes care framework and trial for increasing support for obesity risk factors and diabetes management initiatives were the only initiatives within this Action Area to receive low scores for meeting KPIs. Almost all of the initiatives had high levels of implementation, organisational development and progress, with the exception of the community nutrition project as this was part of the improving use of brief interventions initiative (8.3), which

received a low score for organisational development. The low degree of implementation for 8.1 reflects the development of a leadership hub for the Action Area.

Primary Care Progress 2006/ 2007

Key initiatives for the Primary Care Action Area for 2006/ 2007 included strengthening the leadership hub and developing a diabetes care framework for Counties Manuaku. Primary Care also aimed to support the implementation of local programmes designed to improve the life style management and self-care of diabetes patients. Strengthening the 'Get Checked' programme and improving the rate of diagnosed diabetes were also a key focus of the area. Figure 29 identifies the progress of the Action Area between 2006 and March 2007.

Figure 29. Primary Care 2006/2007



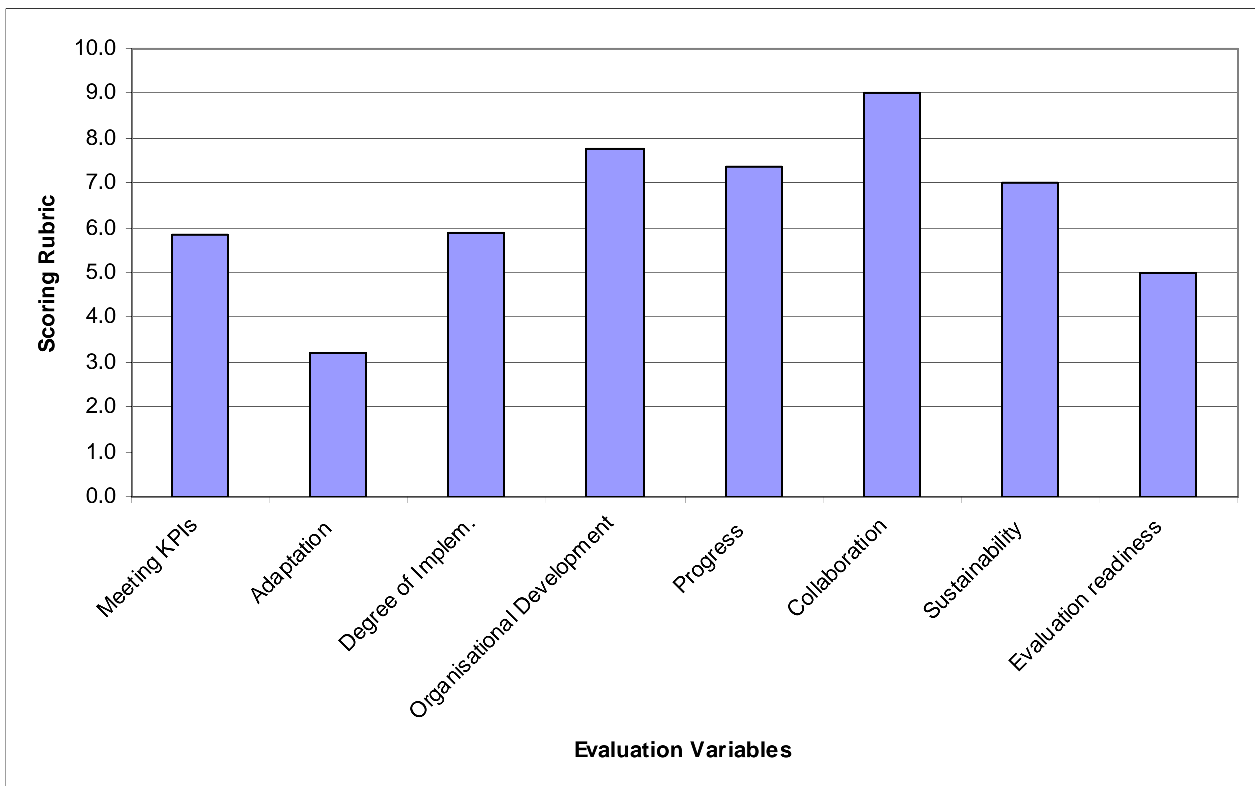
KEY: 2006/2007 Action Area: Supporting Primary Care-Based Prevention and Early Intervention	
8.1	Strengthening the leadership structure to guide improvements of diabetes management in the primary care setting
8.2	Developing a diabetes care framework for Counties Manukau
8.3	Supporting the improved use of lifestyle management skills for modifying obesity risk factors – community nutrition project
8.4	Supporting the implementation of the self management education programme to improve the uptake of best practice post diagnosis education
8.5	Trialling and evaluating increased use of family/whanau/groups support for obesity risk factors and diabetes management
8.6	Developing a whole system approach to improving rate of diagnosed diabetes – risk screening
8.7	Strengthening the Get Checked Programme in Counties Manukau

Figure 29, illustrates the lack of information available on initiative 8:3. In 2006/2007, the leadership hub for this Action area continued to meet their KPIs on their remaining initiatives, with a high level of organisational development and progress. Implementation of the diabetes care framework was delayed which contributed to low scores for implementation although this initiative did have a high level of organisational development. The self-management education initiative (8.4) scored extremely high for all variables, excluding programme adaptation. Both the trial for increasing support for obesity risk factors and 'Get Checked' initiatives were making good progress towards meeting KPIs and had medium to high levels of implementation and organisational development. The diabetes risk screening initiative did not meet KPIs. It needs to be noted that this initiative did undergo a high degree of adaptation and a medium level of organisational development and progress.

Overview of Primary Care Action Area

A means analysis of the 2005/ 2006 and 2006/ 2007 data was used to provide an overview of the Primary Care Action Area between June 2005 and March 2007. In addition, the Action Area was assessed on their collaboration, sustainability and evaluation readiness. Figure 30 illustrates these findings and the interview data is used to support the overview.

Figure 30. Overview of Primary Care Action Area



Programme Progress

The Primary Care Action Area had partially met their KPIs and had a low to moderate adaptation score. Degree of implementation for the Action Area was moderate. However, there was a significant change in evaluation readiness overtime. The Primary Care Action Area rated highly for collaboration, while progress, organisational development and sustainability received a high medium score. Interestingly, while the area forms the basis of two focussed studies the evaluation team were provided with limited information on the overall Action Area. Overall, the Primary Care Action Area was making good progress towards its overall goals and reaching the community through a number of interventions.

Collaboration, Partnership and Support

The area described strong support from the Public Health Organisations (PHOs), which had provided vital support both for the Community Nutrition Project and the Diabetes Self-Management Education programme. Interestingly, variations in support from GPs could impact on the implementation of the Primary Care initiatives. In contrast, the relationship between providers, especially supporting facilitators, was described as strong and communicative. The Primary Care Action Area was also working with the Pacfic and Maori work streams, although the data suggests that they had not established strong partnerships with other LBD Action Areas and their key focus is getting programmes up and running:

> *Its quite good though because they saw the "Get Checked" programme as a trigger to start all these other initiatives relating to diabetes. My portfolio in the Primary Care area doesn't have too much interaction with those groups…it is quite focussed on primary care and the treatment side of things so we are getting real programmes up and running.*

Organisational Development

The implementation of programmes through the Primary Care Action Area is linked to the development of its management structure and leadership. When describing coordination, providers tended to identify difficulties in securing support from General Practitioners. Primary Care had also taken considerable steps to develop capacity through the training of community staff to deliver physical activity and nutrition information to their local communities. The organisation of these initiatives was also well supported by the PHOs. The sustainability of the Primary Care Action Area was moderate to high as many of these programmes were previously operating through Chronic Care Management. Still, the continuing success of the programmes is linked to the varying support of GPs.

Impact

The Primary Care Action Area was open in recognising that some of the programmes had not reached as many people from the community as they would have liked:

> *The response has been poor, half as many people as we wanted.*

The area also commented on the difficulties in collecting follow-up data from participants to evaluate the CNP programme and referred to the difficulties in gaining outcomes from weight reduction programmes:

> *The second phase is the typical one of recruitment anywhere…that you get poor uptake…I personally think it (the evaluation of CNP) probably won't show much…it probably will show that yeah we didn't help but…from my point of view so much evidence shows that weight loss programmes don't work anyway…our aim was to get 5% - 10% weight loss. If we are achieving that then it is a start.*

Key Issues and Future Direction

Securing support from all GPs across Counties Manukau was identified as a concern or and an ideal outcome for the future by the Primary Care Action Area. Building workforce capacity was another issue, with the Action Area suggesting that deciding who to train and deliver the programmes in the community caused disagreement:

> *The type of people they needed to select- that was really difficult because a lot of people think that highly skilled diabetes nurses should be running these programmes. Others think it should not be medicalised and it should be lay people running them so you have this huge gap while you try and cater for all their needs. That was quite challenging.*

Continuing and building on the achievements of the previous two years is a key focus of the Primary Care Action Area. Securing funding for the screening programme is also of interest following the areas investment into the development of a screening paper.

9. Vulnerable Families Action Area

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

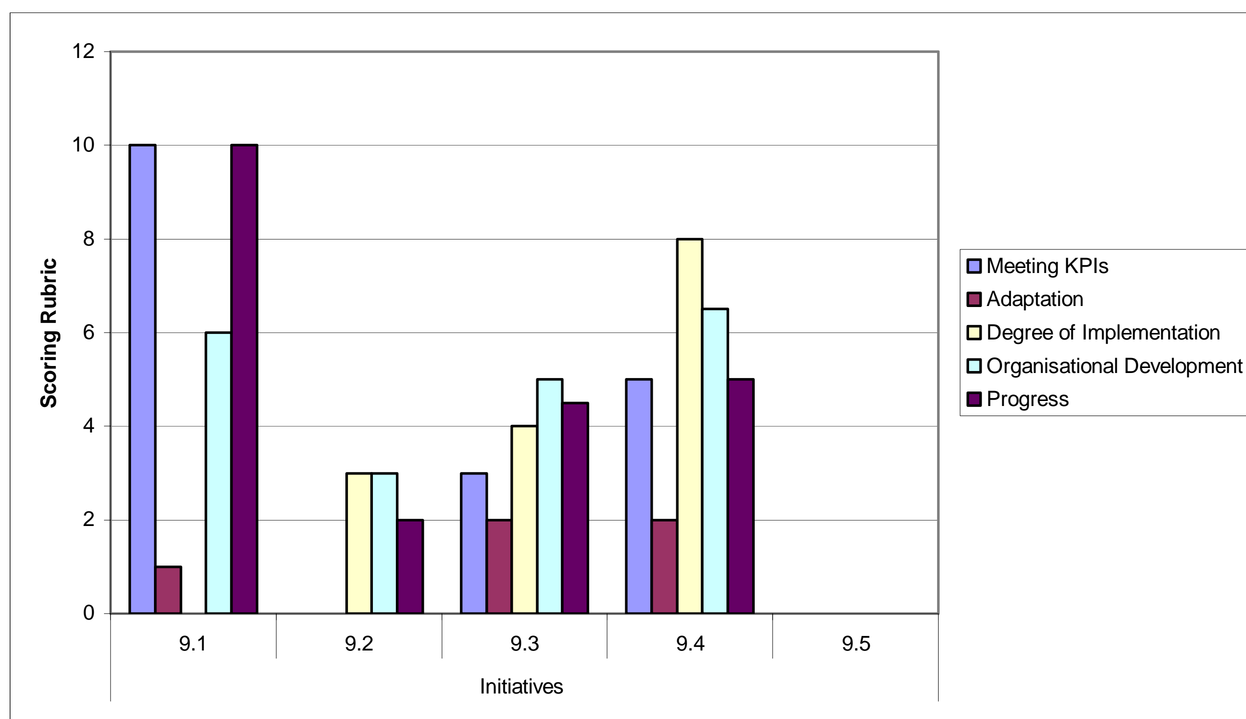
of obesity and diabetes, and to provide better support and opportunity for those with diabetes and complications.

In 2005/2006, the focus was on establishing the multi-sector leadership hub for this Action Area, and creating pathways for closer working relationships between health and social service providers.

Vulnerable Families Progress for 2005/ 2006

Figure 31 illustrates the progress made by the Vulnerable Families Action Area on achieving the KPIs and goals identified through the documentary analysis and interviews during the 2005/ 2006 financial year.

Figure 31. Vulnerable Families 2005/2006



KEY: 2005/2006 Action Area: Enabling Vulnerable Families to Make Healthy choices	
9.1	Establishing a leadership hub for the Vulnerable Families action area
9.2	Improving referral pathways
9.3	Enhancing Strengthening Families by including diabetes risk factors into review processes, with defined linkages and referrals to the health sector
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
9.5	Ensuring food parcels are healthy, well balanced and nutritious

Figure 31 illustrates that the Strengthening Families leadership hub initiative met the KPI to strengthen the existing leadership hub. However, the slow progress within the Action Area contributed to a moderate organisational development score. No KPIs were given for the improving

referral pathways initiative, which received low scores for all variables. Both the review processes and the training for agencies initiatives received low to medium scores for all variables based on the information provided. A lack of detail meant that they success of the healthy food parcel initiative could not be determined, although the interview data suggests that this initiative has been a success.

Vulnerable Families Progress for 2006/ 2007

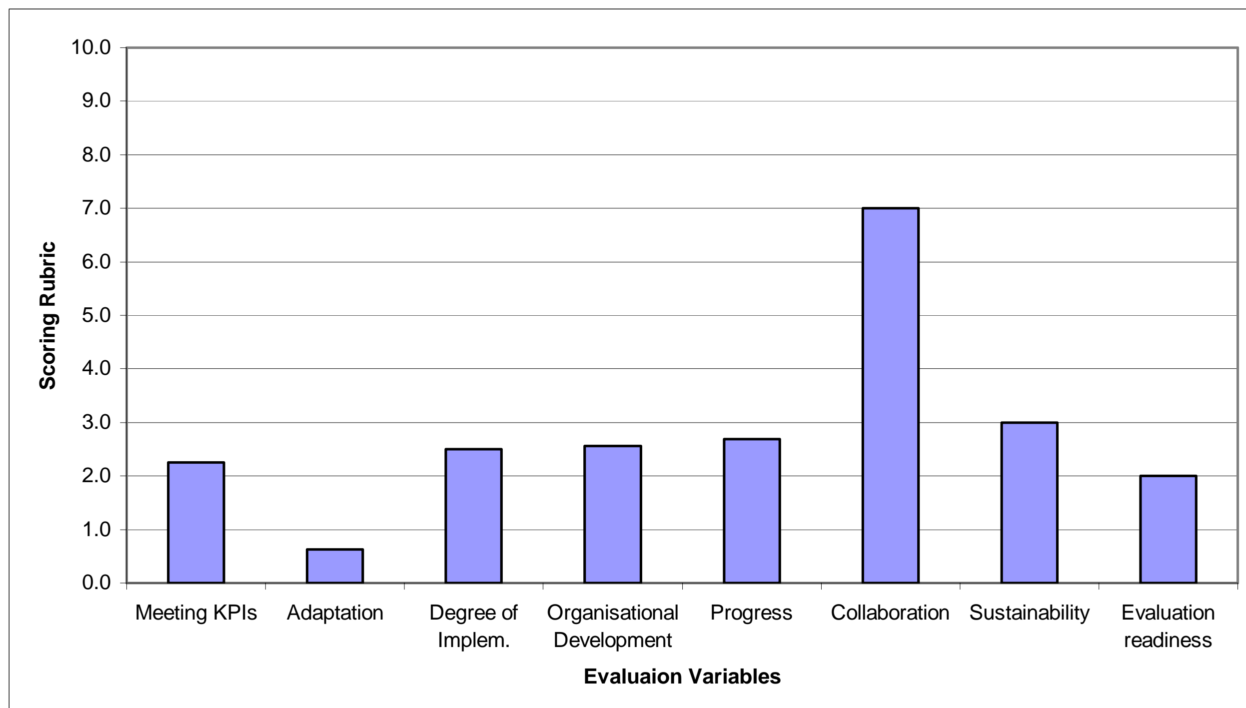
The focus for 2006/2007 will be on strengthening the 2005/2006 initiatives and action. The provision of healthy food parcels for vulnerable families is also a key initiative for the Action Area. This initiative is undertaken through the collaboration with key stakeholders, with the Salvation Army as a key partner.

In 2006/2007, the limited amount of information provided on the initiatives within this Action Area made it impossible to assess the Vulnerable Families Action Area on their progress towards meeting KPIs, adaptation, degree of implementation, organisational development or progress.

Overview of Vulnerable Families Action Area

Figure 32 illustrates the mean scores for the progress of the Action Area from 2005 until March 2007. It should be noted however, that these findings are based on the limited information made available to the evaluation team.

Figure 32. Overview of Vulnerable Families Action Area



Programme Progress

The KPIs for the Vulnerable Families Action Area were unmet and the degree of adaptation was also low. The Action Area also scored low on all other evaluation variables. An exception to these findings was the moderate rating given to the collaboration of the Action Area. This rating reflects the very successful collaboration with the Salvation Army in providing healthier food parcels. Overall, the Action Area has made great progress on providing healthier food parcels to vulnerable families. The Action Area has also provided physical activity and nutrition training to the workforce working with vulnerable families. It was unfortunate that this progress was not demonstrated through the LBD reports and other documentation. The interview data also suggests that the KPIs do not reflect the current progress and goals of the Action Area.

Collaboration, Partnership and Support

The Vulnerable Families Action Area described how their collaboration and partnerships were supporting high needs communities to make choices that support their health and well being:

> *To make sure that those most vulnerable and that means Maori and Pacific and low socioeconomic people are actually able to make healthy choices…it is one thing to tell people to eat healthy and nutritious but sometimes healthy nutritious options are more expensive…so that is what this is about – working with the food industry, working with social providers to hopefully make that a realistic option.*

Collaboration is at the core of the Vulnerable Family Action Area and the Ministry of Social Development was identified as a leading organisation and a key partner, along with the following organisations:

> *The Ministry of Social Development Strengthening Families committee is the leadership forum. More specifically down at the initiative level Vulnerable Families partners with the Auckland City Mission, the Food Industry and the Salvation Army in terms of the food parcel initiative, then the training [name] has done with Family Start programme – they have nutrition advice in their packages of tools and the Well Child and health providers.*

The Action Area was also collaborating with the Family Start programme and the Well Child team.

Organisational Development

The means analysis resulted in a low organisational development score, although the Vulnerable Families Action Area does have a leadership hub. Interestingly, while collaboration was central to this Action Area, it was suggested that the current direction or progress was not always reflected through the KPIs as they were developed by external partners. Given the challenges to coordinating this area, they were assessed as having a low sustainability rating. The interview data however, would suggest that the area has made considerable progress in developing workforce capacity although this was not confirmed through the documentary analysis.

Impact

The Food Parcel initiative was identified as the most successful initiative by the Vulnerable Families Action Area. This success was linked to the areas partnership with the Salvation Army and Auckland City Mission:

> *There were two key food bank providers to our district and that was the Salvation Army in Manukau and the Auckland City Mission. The success has been that we have been able to bring them together…and develop a proposal to take to the food industry and say, 'Here are the two providers; this is what they need on a weekly basis, how can you help us with the sourcing of that?'…[they] are working together.*

Collaboration was identified as a key impact for the Action Area, who also suggested that outcome results are being evaluated by the area.

Key Issues and Future Direction

Interestingly, while collaboration was essential for Vulnerable Families, the area suggested that the leadership of the partner organisations had not developed as expected and that this had impacted on progress. In response to these issues the Action Area aims to re-develop the KPIs of the Action Area to align with health and the current progress of the programme. From an evaluation perspective this will also be beneficial in providing an appropriate means to assess the Action Area.

10. Integrated Care Action Area

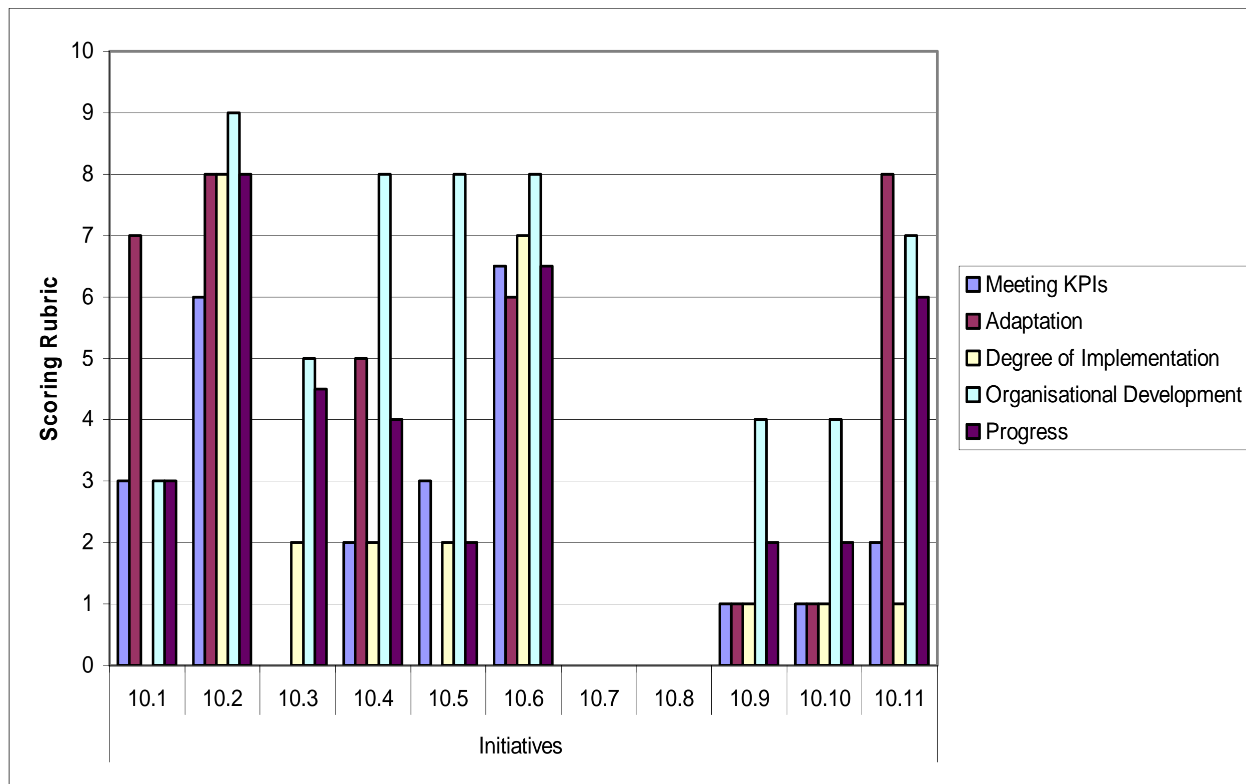
Close integration of health services is important to ensure timely, optimal and safe treatment of diabetes and its complications. The Integrated Care Action Area had a number of initiatives for 2005/ 2006 including establishing a leadership hub, developing the Whitiora Diabetes Service as a clinical centre of excellence, improving the integration of Primary and Secondary care IT systems and the collection of clinical data. The Action Area also sought to support:

- Diabetes in pregnancy
- Diabetic eye disease
- Diabetic renal disease
- Diabetes and mental health
- Supporting therapeutics
- A texting trial

Integrated Care Progress for 2005/ 2006

Figure 33 illustrates the progress made by the Integrated Care Action Area on achieving the KPIs and goals identified through the documentary analysis and interviews during the 2005/ 2006 financial year.

Figure 33. Integrated Care 2005/2006



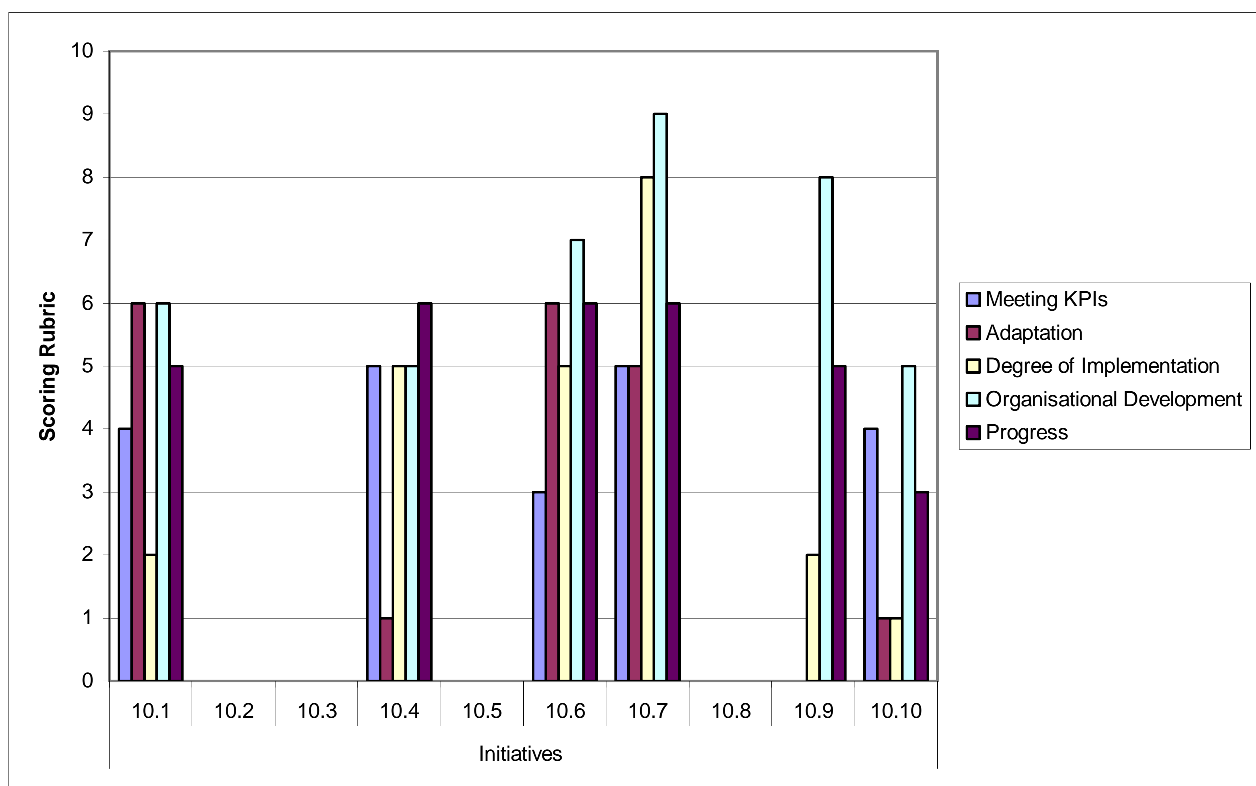
KEY: 2005/2006 Action Area: Improving Service Integration and Care for Advance Disease	
10.1	Establishing a leadership hub for in-hospital service integration and reducing harm from diabetes complications
10.2	Developing Whitiora Diabetes Service's role as clinical centre of excellence and supporter of system-wide capacity development
10.3	Ensuring diabetes management activities across primary and secondary care are implemented in a consistent manner
10.4	Improving the integration of Primary and Secondary Care diabetes IT systems
10.5	Improving clinical data and ethnicity data collection and analysis in order to provide regular performance reports relating to indicator outcomes by ethnicity
10.6	Supporting diabetes in pregnancy
10.7	Supporting diabetic eye disease
10.8	Supporting diabetic renal disease
10.9	Diabetes and mental health
10.10	Supporting therapeutics
10.11	Texting trial

Figure 33 shows that the Whitiora diabetes services and diabetes in pregnancy initiatives had made progress towards meeting KPIs, with a medium to high level of organisational development. Adaptation and degree of implementation for these initiatives were at a medium level. Both the mental health and therapeutics initiatives did not meet their KPIs and scored low for all other variables. Not enough information was provided for the diabetic eye disease and diabetic renal disease initiatives to determine their success. The remaining initiatives scored low to medium for all variables, except organisational development, which received a medium score.

Integrated Care Progress for 2006/ 2007

In 2006/ 2007 the initiatives for the Integrated Care Action Area remained the same. A key focus for this Action Area is the integration of services for diabetes in pregnancy. The Action Area has completed a review of the opportunities to develop an integrated approach to diabetes in pregnancy and care services. In 2006 and 2007 a myriad of health services will be building relationships to work together to implement the recommendations of the diabetes and pregnancy review and improve the integration of primary and secondary diabetes care. Figure 34 illustrates the progress of the Action Area between 2006 and March 2007.

Figure 34. Integrated Care 2006/2007



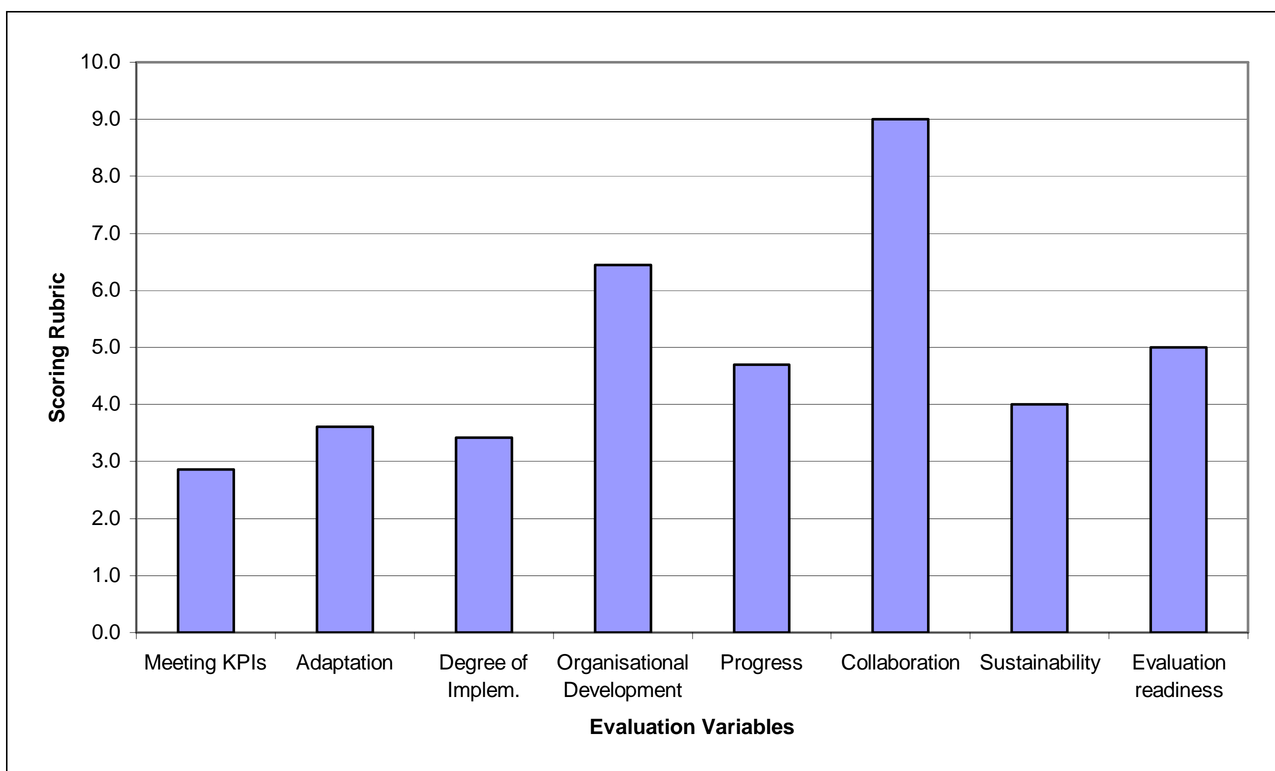
KEY: 2006/2007 Action Area: Improving Service Integration and Care for Advance Disease	
10.1	Establishing a leadership hub for in-hospital service integration
10.2	Developing Whitiora Diabetes Service's role as clinical centre of excellence and supporter of system-wide capacity development
10.3	Ensuring diabetes management activities across primary and secondary care are implemented in a consistent manner
10.4	Improving the integration of primary and secondary diabetes information technology (IT) systems
10.5	Improving clinical data/ethnicity data and reporting
10.6	Supporting Diabetes in Pregnancy
10.7	Supporting diabetic eye disease
10.8	Supporting diabetic renal disease
10.9	Aligning diabetes and mental health
10.10	Supporting therapeutics

Figure 34 illustrates that KPIs were not met for any of these initiatives. However, progress towards achieving KPIs did take place, with the leadership hub improving IT systems and diabetes in pregnancy initiatives all receiving medium scores for implementation, organisational development and progress. The diabetic eye disease initiative received a high score for degree of implementation, organisational development and progress. The mental health and supporting therapeutics initiatives received low scores for all variables, except organisational development within the mental health initiative, which was high. Not enough information was provided for the Whitiora Diabetes Service initiative, consistent implementation of diabetes management initiative, improving clinical data and reporting initiative or the diabetic renal disease initiative. KPIs were also missing for 10.2 and 10.8. Due to this lack of information, evaluation of these initiatives could not take place.

Overview of Integrated Care Action Area

A means analysis of the 2005/ 2006 and 2006/ 2007 data was used to provide an overview of the Integrated Care Action Area between June 2005 and March 2007. In addition, the Action Area was assessed on their collaboration, sustainability and evaluation readiness. Figure 35 illustrates these findings and the interview data is used to support the overview.

Figure 35. Overview of Integrated Care Action Area



Programme Progress

The Integrated Care Action Area had ten initiatives, although the KPIs were unmet and the area also had low adaptation. The Action Area also scored low to moderate on the progress, sustainability and evaluation readiness score. In reflection of the needs of the area, Integrated Care had a very high collaboration score and a moderate organisational development score. Overall, the Action Area was making significant progress in securing relationships across Primary and Secondary care to support patients with diabetes and especially pregnant women. It is important to note however, that these scores are based on the information made available to the evaluation team and may not fully reflect the work of the Action Area.

Collaboration, Partnerships and Support

Integrated Care collaborates with doctors, nurses, PHOs, community health providers, other LBD Action Areas, and new relationships are formed all the time. The Action Area 10 also partners with Primary Care on some of the initiatives and leadership forums:

> *We work closely with some people in Primary care who do chronic care management which is one of our gold chip products in terms of innovations. We are trying proactively to manage chronic diseases.*

Certain members of Middlemore Hospital were identified as key supports to the Integrated Care Action Area and specifically the diabetes in pregnancy initiative. Key supports also included staff at the Super Clinic, community midwives, Maori and Pacific Health teams:

> *[Name] is a resource person for me. She works as part of the Whitiora team over in Middlemore hospital. We just have a new appointment – an endocrinologist who has got an interest in diabetes in pregnancy. I have [name] over there in the clinic at the Superclinic. Then there are two community midwives who have a special interest in diabetes so I want to work with them. There is the Maori health team and there are two people in Pacific health I want to work more closely with who again are working in the community.*

CMDHB was also identified as supportive in developing workforce capacity and providing support to the Action Area:

> *Within Counties in the learning and development area we have people who will assist on facilitating planning days. In terms of the LBD team it is a very open team and if I felt I needed some assistance and needed to take it to a wider group I would feel there would be a lot of assistance there.*

Organisational Development

Interestingly, while the Action Area had established a leadership hub the Action Area recognised that the organisational development of Integrated Care was in the early stages of development and that this was both an exciting and crucial time:

> *It is still in the planning phase. It's wonderful that we are at this stage because we can basically do what we want. I feel quite privileged to be in this position. But I know there is a lot of responsibility attached to that. I think there can be mistakes made if you move too quickly and on the other hand it is frustrating if we don't get our teeth into it and get going so it is just being careful rather than coordinating a lot of things at the moment.*

Given the low degree of programme implementation and the current status of the Integrated Care Action Area the sustainability of current progress is moderate.

Impact

When discussing the impact of the initiatives the Integrated Care Action Area identified the increased awareness of health services to make improvements to current service provision as a key output:

> *I think the immediate effects have been that the existing service providers have become more aware of a need to actually improve what is happening for people. I don't mean that in a derogatory way…a lot of those clinicians are thankful that somebody is looking at it. Now our challenge is to make it happen.*

In the long term, the area identified the key initiatives of the Action Area as the ultimate outcomes.

Key Issues and Future Direction

The data suggests that a key issue for the Action Area is securing collaboration and integration of Primary and Secondary care. The area also suggests that capacity is an issue for the initiatives due to the current and increasing demand of diabetes care. Securing funding was also a concern mentioned by the Action Area. With regards to the future direction of the Integrated Care Action Area, the area suggests that they must secure buy-in, develop workforce capacity, focus on the needs of the patients, be innovative and prepared to recognise limitations:

They include high level buy in, team development, be patient focussed, put other things aside, be willing to innovate but also make sure that you know if the innovation is not working, clinical championing good information systems to support that.

LBD Programme

This section uses the means analyses to provide an overview of the LBD programme between 2005 and March 2007. Graphs will be presented to compare the key work streams and Action Areas on the eight evaluation variables including meeting KPIs, adaptation, degree of implementation, organisational development, progress, collaboration, sustainability and evaluation readiness. Graphs will be presented first and then a summary of the LBD programme will be provided. Finally the report will conclude through identifying the key learnings.

Programme Progress

Figure 36 illustrates the progress each Action Area made towards achieving its stated KPIs between 2006 and March 2007.

Figure 36. Meeting KPIs

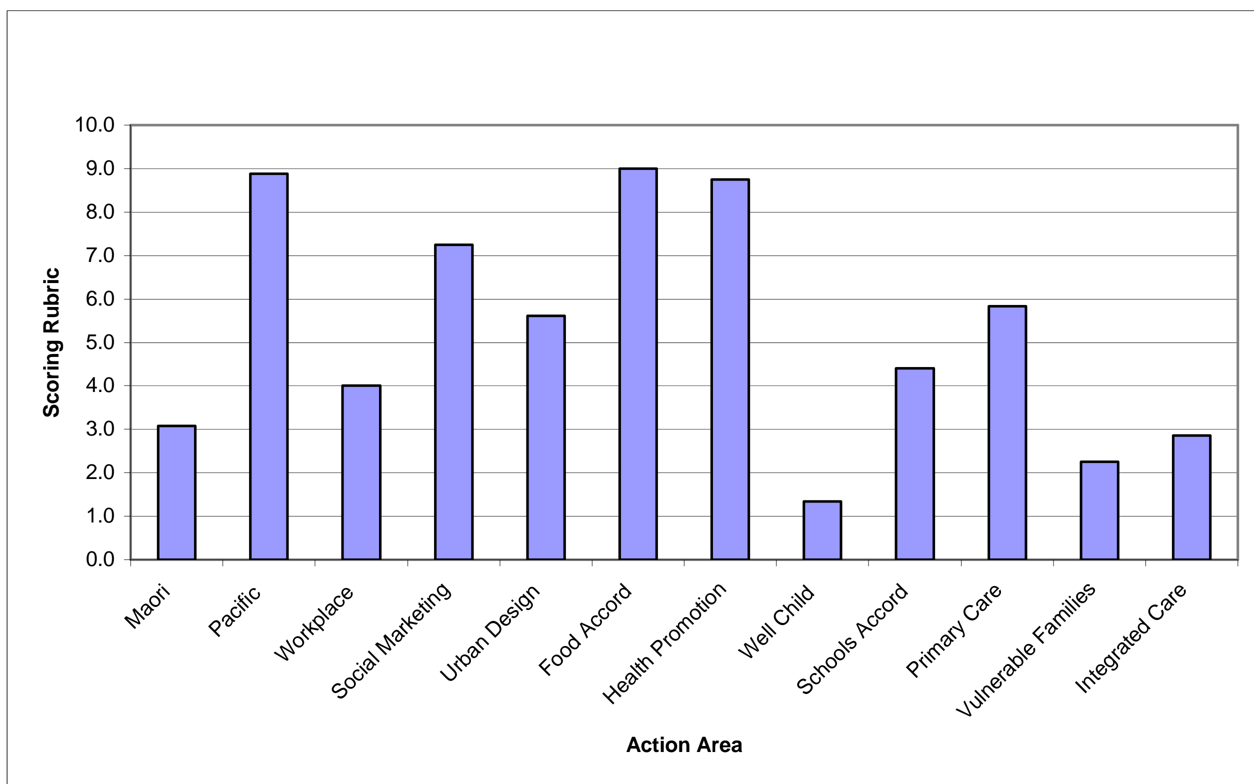


Figure 37 illustrates the degree of adaptation each Action Area made to their original goals or plans.

Figure 37. Adaptation

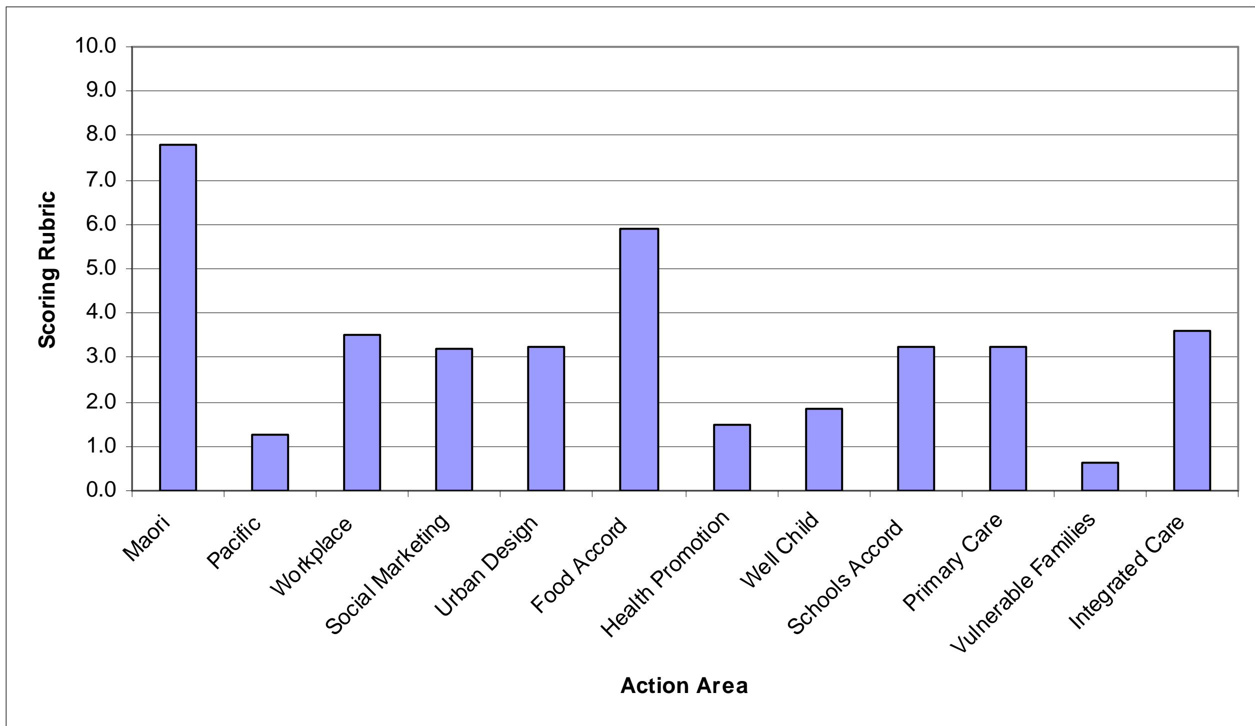


Figure 38 illustrates the degree to which the programme or goals of each Action Area have been implemented between 2005 and March 2007.

Figure 38. Degree of Implementation

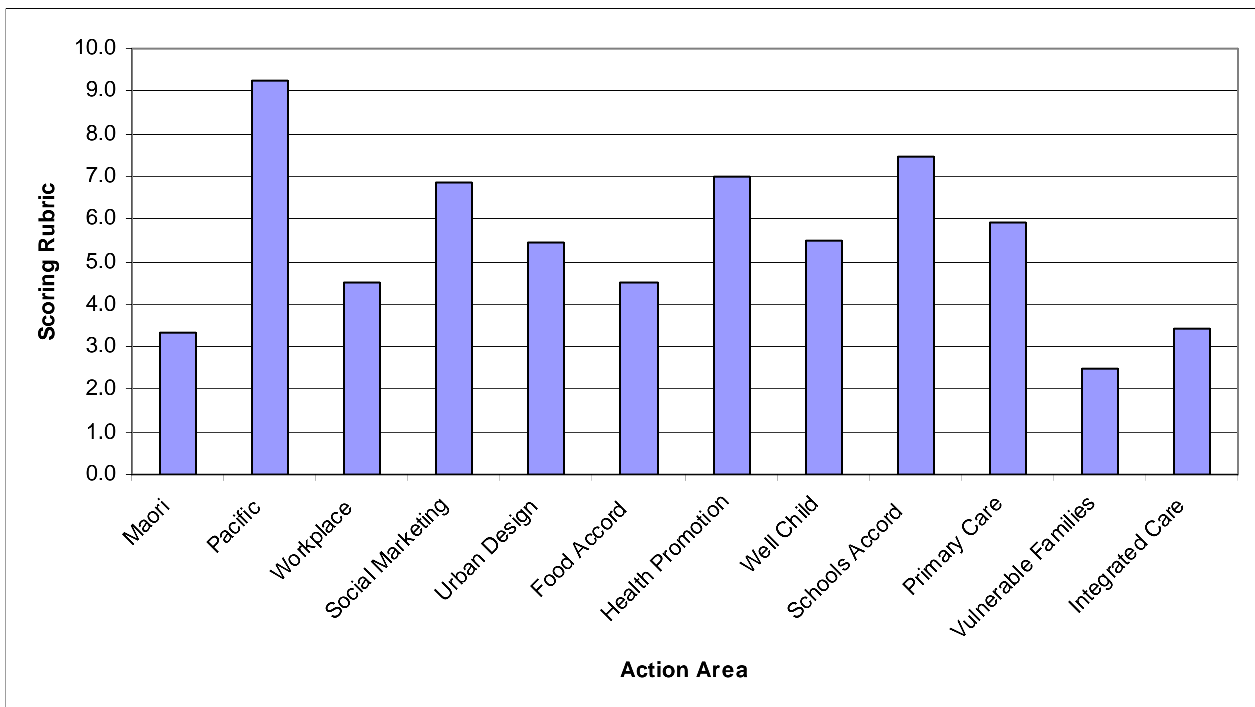
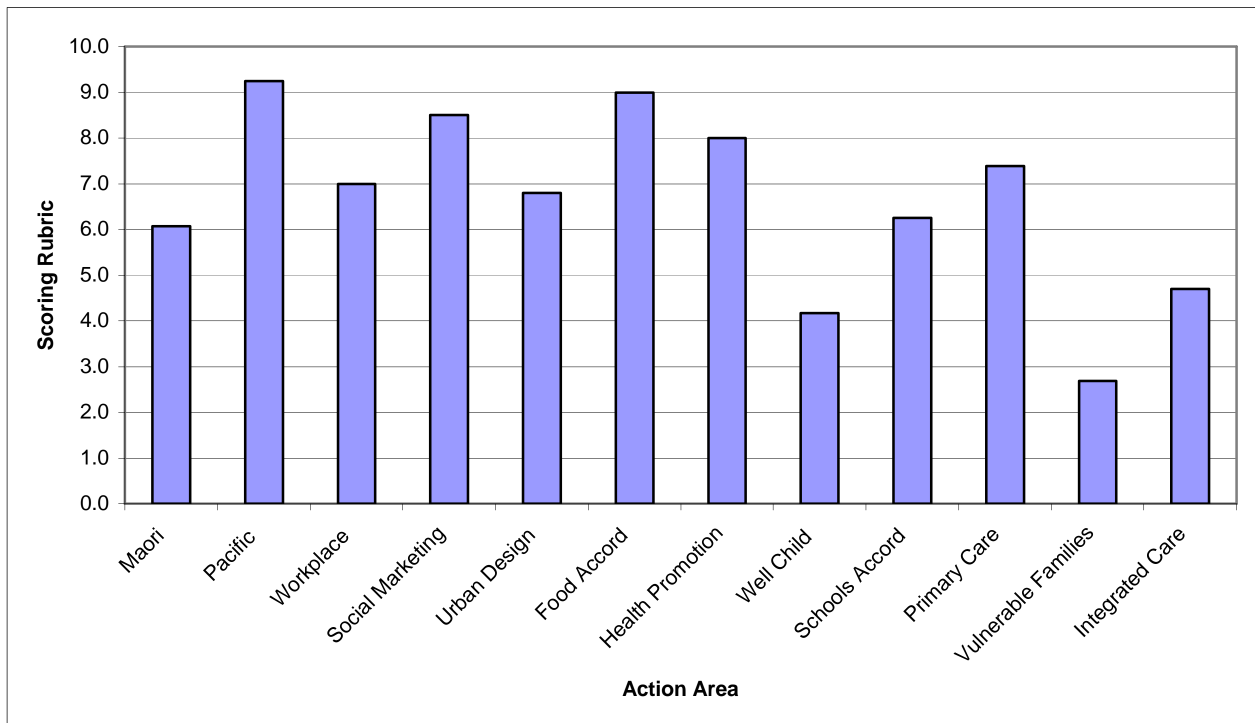


Figure 39 illustrates the overall progress each Action Area made towards their goals between 2005 and March 2007.

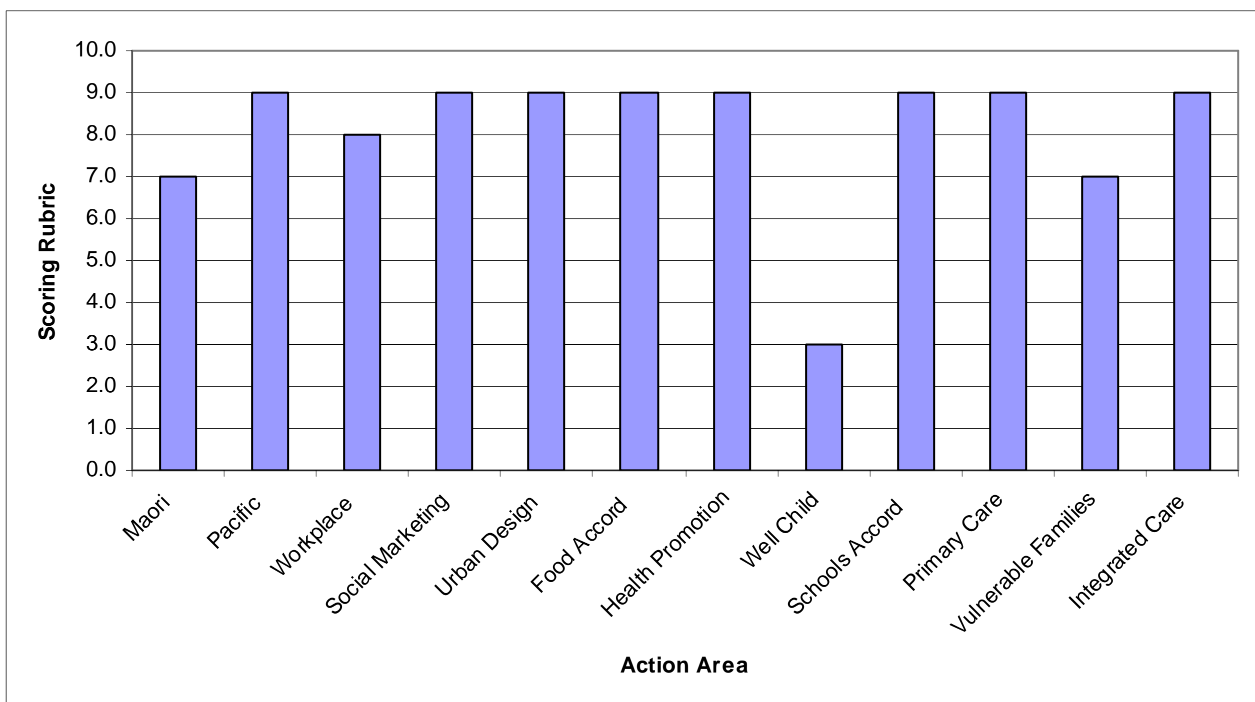
Figure 39. Progress



Collaboration, Partnership and Support

Figure 40 illustrates the degree to which the Action Area is working in partnership with external providers and the other LBD Action Areas.

Figure 40. Collaboration



Organisational Development

Figure 41 illustrates the degree to which each Action Area or initiatives have organisational structures to support the areas goals and objectives.

Figure 41. Organisational Development

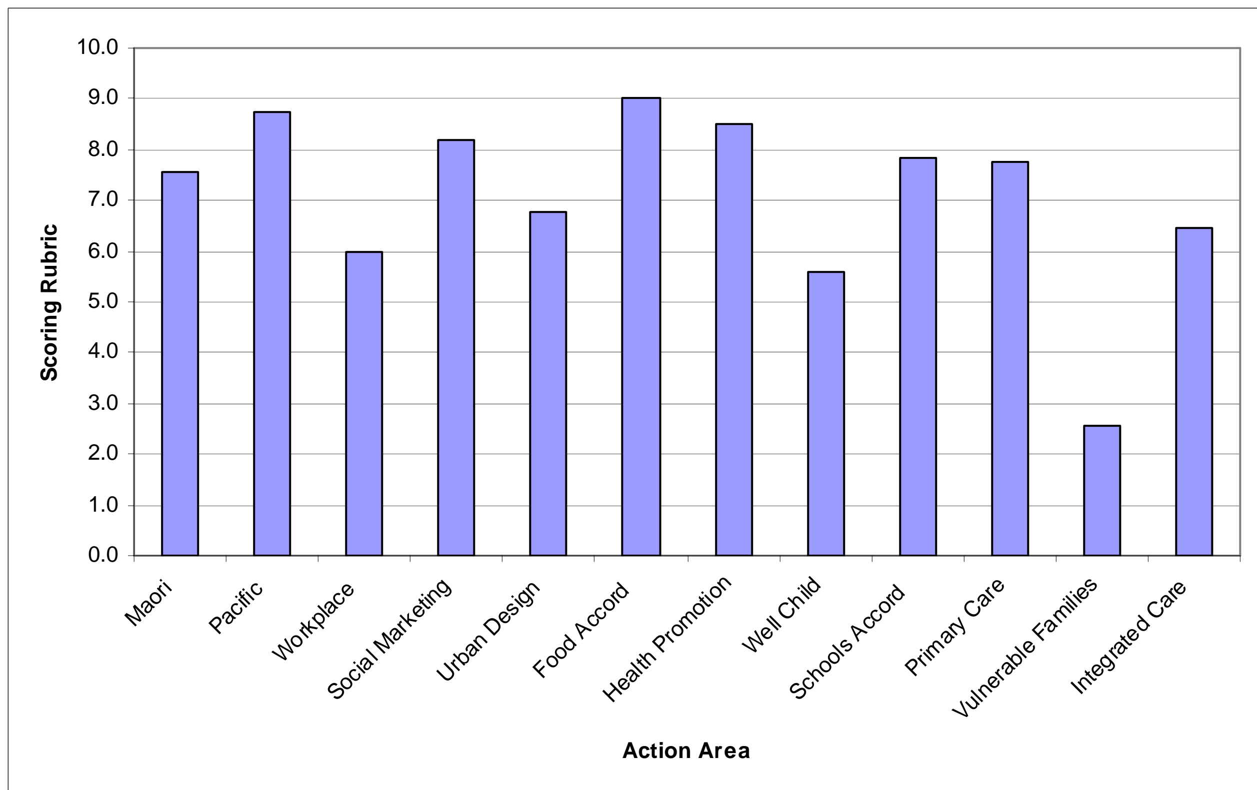


Figure 42 illustrates the degree of sustainability or the degree to which the Action Area has a set of durable activities and resources.

Figure 42. Sustainability

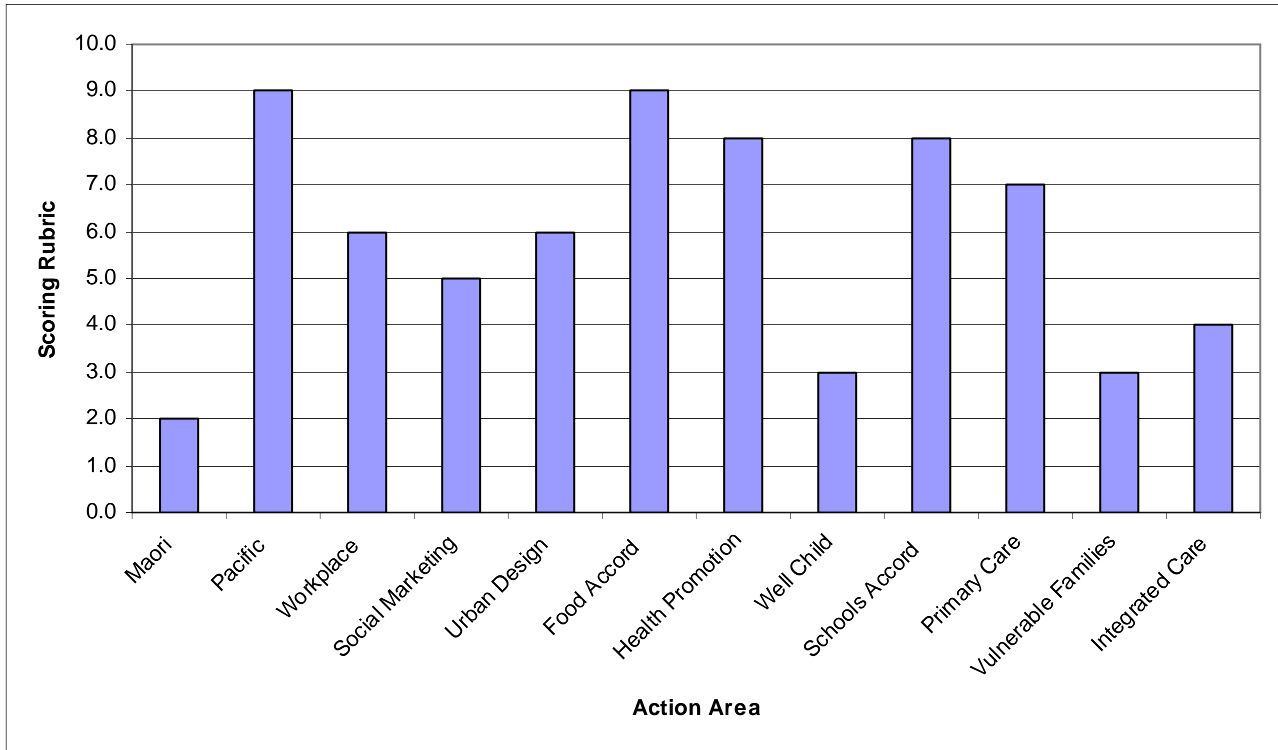
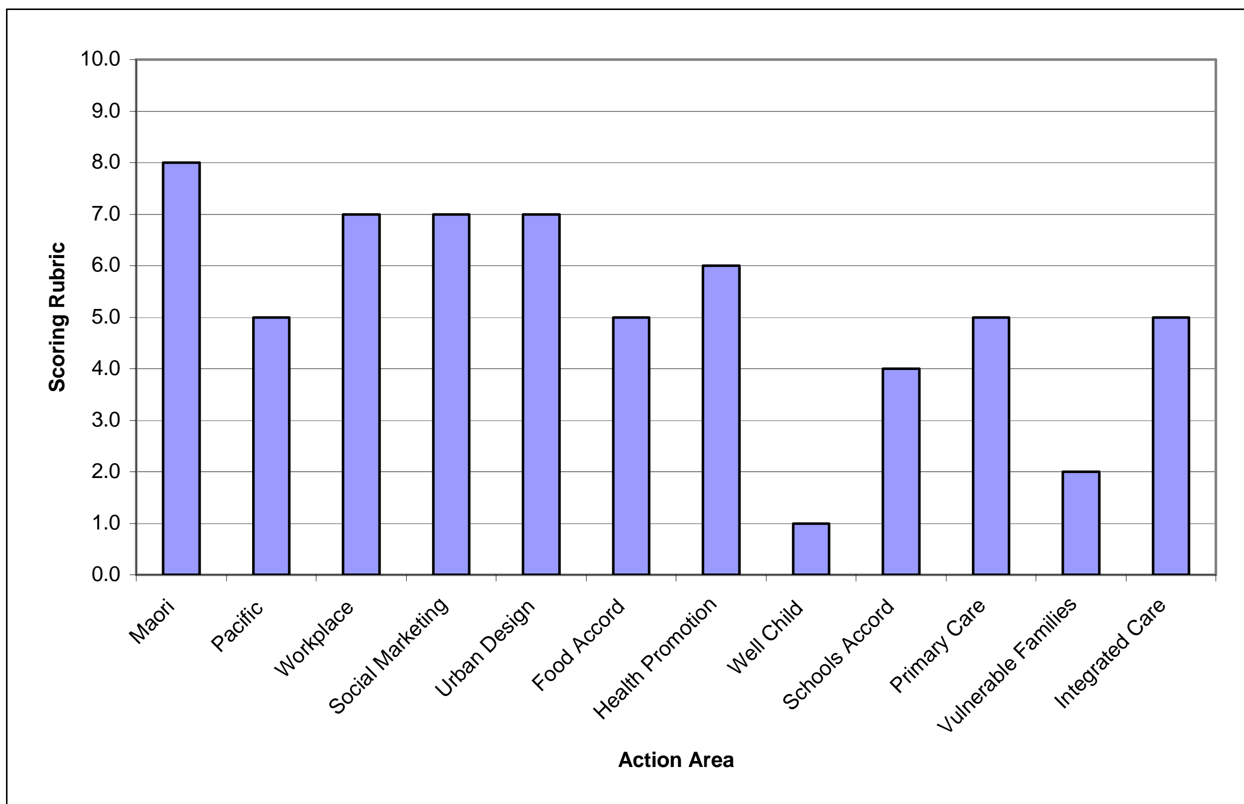


Figure 43 illustrates the preparedness of the Action Area to begin evaluation and is based on the capacity of the Action Area to carry out the evaluation tasks and engage in evaluation.

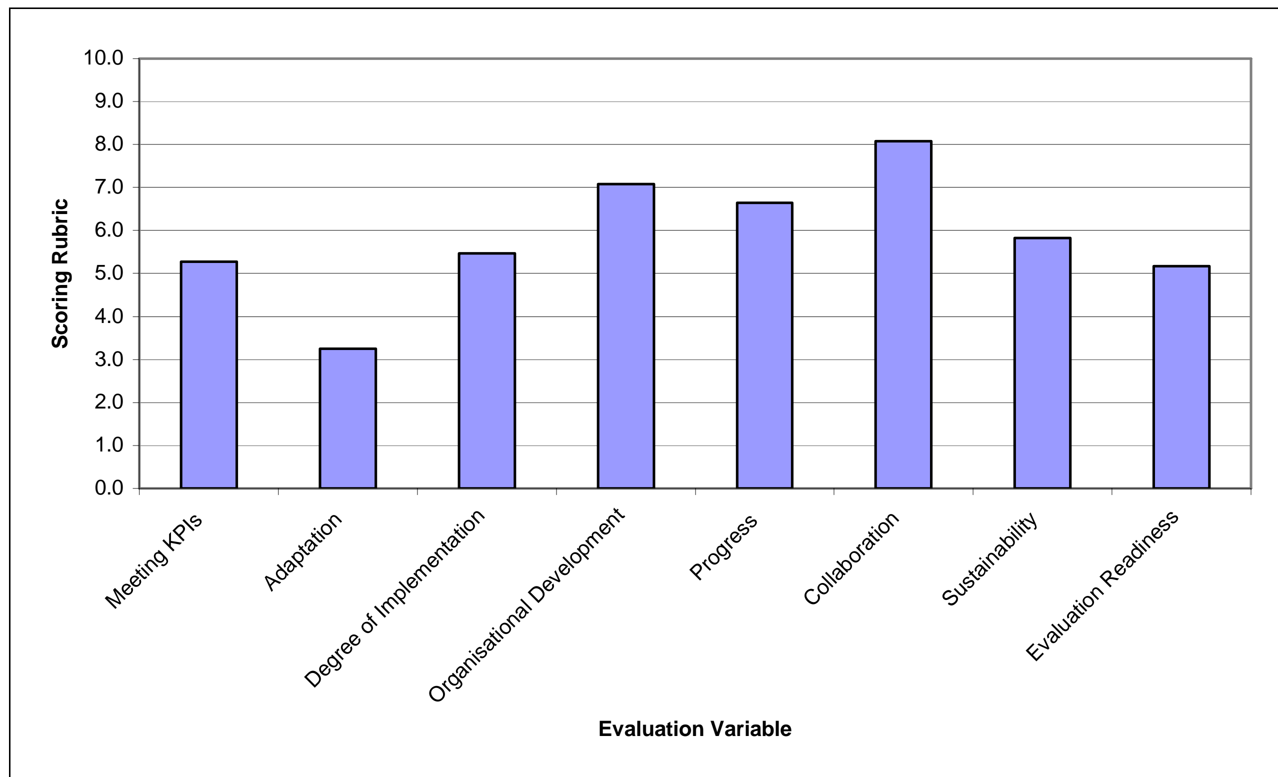
Figure 43. Evaluation Readiness



Overview of LBD Programme

Figure 44 is based on a means analysis of all the Action Areas and work streams. This graph provides an overview of the current status of the LBD programme based on the information and data collected by the evaluation team.

Figure 44. Overview of LBD Programme



Programme Progress

The LBD programme made moderate progress towards meetings its stated KPIs in the Action Areas. The LBD programme had a moderate degree of implementation and yet the overall degree of adaptation from the original goals and objectives was low. It would be expected that there would be either some balance between these variables or a strong inverse relationship. For example if a programme is not meeting their KPI's then there you would expect there to be some programme change in either programme direction, procedure or development. What we see from the overall graph is some semblance of balance, i.e. while KPIs are not quite met, there is a small about of programme change. Finding the amount of programme fidelity is often difficult in very complex programmes like LBD. Overall, the programme appears to be making good progress towards its aims and objectives and in the life cycle of a complex and complicated programme it is where you would expect it to be. While many programmes are still to see output and observable outcomes data

would suggest that LBD is on the right pathway towards supporting and improving the health of the Counties Manukau population.

Organisational Development

The LBD programme scored higher for its organisational development, the programme is at an exciting phase of its fruition. Many of the implementation plans are coming together, several have established infra-structures for there programme areas. It is important to note that in those areas where a previous infra structure existed it would appear to be easier to implement the initiatives, Pacific Island churches are a useful example. The LBD programme had made good progress in securing structures to support the LBD initiatives. Four of the Action Areas also rated highly following the establishment of well attended and highly functioning leadership hubs. Overall, the findings suggest that the Workplace work stream, Well Child and Vulnerable Families Action Area might need support to develop an organisational structure or securing buy-in from members of their leadership hubs. Building workforce capacity was a key focus of the LBD programme and this had been successfully undertaken by a number of Action Areas and also remains an ongoing goal. The evaluation readiness for the overall programme is not perceived as high, only one Action Area received a high score. This is reflected more in the capacity to complete and engage in evaluation, rather than the Action areas willingness to engage. However, it should be noted there is a small group that perceives evaluation as a wasted resource and burden.

A survey was designed to measure the level of organizational development of each action area. During the interviews with action area leaders a survey was left for completion. This survey was completed by seven out of the 13 activity leaders who were interviewed. Respondents were asked to indicate the extent they agreed with each item on a scale from 1 (strongly disagree) to 6 (strongly agree). Examples of items included statements such as “this activity has a high level of strategic thinking” or “this activity has a high level of coordinated resources”. Similar to the Activity Sustainability Survey, responses to the Organisational Development survey were generally positive. One area of difficulty was human resources management with more respondents indicating they disagreed than agreed that there was a high level of management in this area.

Collaboration, Partnerships and Support

Overall the collaboration across the whole project is high. Figure 40 identifies the outstandingly high rates of collaboration occurring across nearly all of the Action Areas or work streams. This is a great outcome considering the desire of the programme to increase the collaboration of Counties Manukau and secure partnerships with the community to support the overall programme goals.

During the interviews with action area leaders a survey was left for completion. This survey was completed and returned by three out of the 13 activity leaders who were interviewed. The survey was designed to measure the level of collaboration within the action area that the activity was categorised under. Respondents were again asked to indicate the extent they agreed with each item on a scale from 1 (strongly disagree) to 6 (strongly agree). Examples of items included statements such as "The activities share financial resources" or "providers of the activities provide each other with feedback without it becoming an issue". While there were only three respondents they all raised an interesting slide to collaboration, which is collaboration within the action areas. There was a common perspective that they were not sharing as much as was feasible. The group also raised some interesting ideas for collaboration:

- the participation in community activities together;
- exchange of information on conferences and workshops;
- the offering of certain services jointly;
- sharing financing responsibilities with other activities;
- sharing of material resources;
- sharing human resources;
- sharing financial resources; and
- sharing responsibilities for project evaluation

During the interviews many of the Action Areas spoke highly of the relationships that they had secured both within the LBD team and the community. The success of the initiatives was often linked to these partnerships and it is clear that LBD has worked hard to develop mutually supportive relationships with key organisations and community groups. These partnerships also served to support the LBD programme, although CMDHB was often identified as a key support for the Area Areas. Developing these relationships is critical to the on-going development of the programme.

Sustainability

Overall the programmes appear to be at variable stages of development in establishing themselves. As a consequence of this flux in many programmes the probability of programme sustainability is seen as unstable. It is difficult to determine programme sustainability when the programme is still in such a developmental phase and quite understandable

A survey was designed to measure the level of sustainability within each activity of the LBD initiative. During the interviews with action area leaders a survey was left for completion. Respondents were asked to indicate the extent they agreed with each item on a scale from 1 (strongly disagree) to 6 (strongly agree). Items under the implementation difficulties scale were reverse scored to match the rest of the survey responses. Questions all pertained to the activity that the person was associated with and included items such as "partnerships in this activity have been developed" or "the needs of the community are driving this activity".

In total, eight out of the 13 activity leaders who were interviewed completed the survey. Activities that were included came from the action areas of primary care, vulnerable families, schools accord, Maori health, Pacific health, workforce development and social marketing. Overall, the results indicate that there was a higher level of agreement than disagreement with the majority of the sustainability questions asked. This suggests that activity leaders in general believe that their initiatives are sustainable. Two areas that did demonstrate potential problems with sustainability were related to policy implications and whether the activity leader felt that the initiative was recognised and supported by government.

Impact

The degree of programme implementation for LBD was moderate and this reflects the developmental stage of some of the LBD Action Areas and also the adaptation of the original programme goals and objectives. The Action Areas shared some great examples of success and how the programme was reaching the communities of Counties Manukau. The high level of collaboration in the LBD programme was also identified as a key success for many of the Action Areas. It was noted that some of the outcome data is not currently available and the areas are working hard towards supporting people to make informed choices about their health related behaviours.

Key Issues and Future Directions

For the future, each Action Area was continuing to work towards its KPIs or programme goals. Interestingly, some Action Areas suggested that their KPIs were no longer appropriate. Ideally, the KPIs should be aligned to the work of the Action Area in order for the evaluation to effectively identify the progress of the initiatives. Further setting success indicators (were appropriate) for each KPI would be very valuable exercise for the action area and initiatives. Some Action Areas

also had over 7 initiatives whereas, other areas KPIs were smaller and more achievable. When developing future KPIs they should be relevant to the work of the Action Area, sustainable, measurable, achievable, realistic and timely.

Learnings

- There is a correlation between organisational development and collaboration.
- There should be a balance between meeting KPIs and adaptation or at least an inverse relationship.
- Active collaboration needs to happen between action areas and initiatives.
- There needs to be a amore systematic approach to programme reporting.
- Goals, objectives, KPIs and success indicators all need to be related to one another and developed by programme planners.
- Programme plans including goals etc need to be documented
- Progress towards goals needs to be monitored regularly
- The importance of organizational development for each action needs to be recognised and supported by the LBD management team. For example, providing professional development in this area and mentoring would be extremely valuable.
- Programme sustainability is highly correlated with sustainability of programme effects.
- The probability of sustainability can be improved by paying attention to a number of variables such as organizational development and internal and external support.
- As has been previously recognised it is important to encourage the development of capacity in the area of programme management.
- Collaboration is critical to the LBD programme.

References

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Appendix 1

CENTRE FOR HEALTH SERVICES RESEARCH AND POLICY

THE UNIVERSITY OF AUCKLAND
FACULTY OF MEDICAL AND HEALTH SCIENCES
School of Population Health

Let's Beat Diabetes Action Area Collaboration Scale[1] (For Providers)

COMMON ACTION:	*SD*[2]	*D*	*SW*	*A*	*SA*
The action areas :					
Have developed a common structure					
Plan common activities					
Share material resources					
Participate in community activities together					
Have developed a common vision					
Exchange information on activities and services offered					
Exchange information on conferences or workshops					
Offer certain services jointly					
Share financing responsibilities					
Share human resources					
Share responsibilities for project evaluation					
Share premises (meeting places)					
Share financial resources					
Share canvassing responsibilities					
CLIMATE					
Providers in the action areas:					
Support each other					
Validate each other (recognize each other)					
Provide each other with feedback without it becoming an issue					
Identify what works and what doesn't					
Share certain values					
COORDINATION:					
Action area providers					
Modify their activities in order to avoid the duplication of services					
Modify their principle objectives in order to better meet the needs of the					
population					
Modify the groups and territories targeted by their services in order to					
better meet the needs of the population					
Modify their financing strategies in order to reduce competition between					
organizations					
Modify their timetable in order to mutually accommodate each other					

[1] Adapted from the Montreal Collaboration Scale (MCS) : N Cormier & C. Bouchard (1999)
[2] Definitions of rating scale – SD: Strongly disagree, D: Disagree, SW: Somewhat agree, A: Agree, SA: Strongly agree.

Appendix 2

Let's Beat Diabetes Project Sustainability (For Providers)

This measure is to be completed by the Action Area Leader in collaboration with the evaluation team.

In this programme	*SD*[3]	*D*	*SW*	*A*	*SA*
A programme champion (i.e. strong advocate for continuation of the project) has been active					
Staff have received:					
Official training					
On the job training					
Mentoring					
Ongoing support and supervision					
The intervention has been evaluated:					
Internally					
Externally					
Plans for sustainability have been:					
Discussed					
Written					
Activated					
Modifications to the intervention have occurred:					
Undergone change in level of action					
Changes in provider					
Positive changes in intervention staff have occurred					
There is a good fit between the intervention and provider					
Providers' experience:					
Providers' health experience is high					
Collaboration occurs:					
Between LBD and Action Areas					
Internally within the Action Area					
With multiple external agencies					
Partners in this programme:					
Listened to suggestions					
Freely shared information					
Involved in most decisions regarding intervention					
Played a key role in the development intervention					
Have good relationships					
Competent Staff:					
Can deliver the programme					
Have the skills to deliver					
Can problem solve in area					
Have good interpersonal skills					
Management is supportive of staff					
Management:					

[3] Definitions of rating scale – SD: Strongly disagree, D: Disagree, SW: Somewhat agree, A: Agree, SA: Strongly agree.

In this programme	*SD*[3]	*D*	*SW*	*A*	*SA*
Support the intervention					
Can solve problems					
Would support intervention in face of controversy					
Supports continuation					
Prepared clear strategies for gradual financial self-sufficiency					
Readily invest finances and other resources					
There were some implementation difficulties that have been actioned:					
Finances					
Recruiting participants					
Recruiting staff					
Time to prepare intervention					
Not enough staff					
Time lags					
Developing agreed interventions and measures					
Perceived success includes:					
Clear need for the intervention					
High level of interest					
Helped build partnerships					
Intervention was timely					
Achieving the desired outcomes					
Had an impact					
Community support for, intervention:					
Known about by local community leaders					
Mentioned positively by local community leaders					
Mentioned favourably by local media					
Has Community support:					
Ensured that the needs of the community are driving this programme					
Administration system:					
Plans are articulated					
Documents approved					
Implementation plan					
Evaluation plan					
Admin process identifiable					
Accepted as policy:					
Discussion of policy implications					
Recognised and supported by state					

Appendix 3

Let's Beat Diabetes Action Area Leader's Organization Development Survey

The LBD programme has high levels of:	1 Strongly Disagree	2 Disagree	3 Neutral	4 Agree	5 Strongly Agree
Organization					
Collaboration					
Partnerships					
Communication					
Networks					
Co-ordination					
Sustainability					
Management systems &structures					
Resources developments					
Fiscal management					
Human resource management					
Evaluation and learning					
Program Development & implementation					
Initiative Management					
Strategic thinking					
Governance					
Vision Values and Mission					

Appendix 4

Summary of individuals, organisations, and communities reached.

2005/2006:

- Individuals: 4692
- Communities 37
- Organisations 110

2006/2007:

- Individuals: 616 + Unknown
- Communities 19
- Organisations 20

TOTAL:

- Individuals: 5308 + Unknown
- Communities 56
- Organisations 130

Table 1. Community Action Fund Stream Initiatives, 2005-2006

Initiative	Initiative Action	Who it Reached
1.1 Community Action Fund	5km walk/ run	800 people
	3 aerobic sessions per week	Wiri residents
	20 healthy lifestyle education sessions	Wiri residents
	weekly after school activities for children	children
	weekly fitness sessions for elderly residents	elderly residents
	3 day diabetes awareness expo	12 schools
	weekly Tai Chi classes	1 school
	diabetes awareness classes	new immigrants and Chinese
	weekly exercise and healthy eating programme	New Settlers
	6 weeks of after school activity for 40 weeks	children
	Emply 2 teacher aides	Schools
	Monthly nutrition education	Parents
	2 Community Consultation Forums	Indian Community
	Yoga classes	Indian Community
	Cooking classes	Indian Community
	5 in-depth case studies to promote healthy choices	Indian individuals

	2 workshops to explore burden of diabetes	South Asian community
	Raising awareness of key signs, symptoms and modalities of care for diabetes	South Asian community
	2 healthy eating and physical activity sessions	South Asian community
	10 'Have a Go' Waka Ama events	coastal CM locations
	Walking classes 3 times a week	Makaurau Marae
	Promotion of smoke free, drug and alcohol free Marae and home environment	Makaurau Marae
	Nutrtional and physical activity awareness	Makaurau Marae
	6 healthy kai promotion sessions	Maori Womens Welfare League
	Aqua-aerobic, exercise and walking sessions	Maori Womens Welfare League
	Weight management and monitoring	Maori Womens Welfare League
	Healthy kai receipe book	Maori Womens Welfare League
	Weekly fitness and exercise classes	Wiri residents
	6 week programme to improve health behaviour and knowledge	School children
	Recording and monitoring food in-take and physical activity	School children
	Parent education through newsletters and posters	Parents/ carers
Summary for CAF:		**Individuals Reached: 800** **Organisations Reached: 1** **Communities Reached: 8**

Table 2. Maori Stream Initiatives, 2005-2006

Initiative	Initiative Action	Who It Reached
1.2 Supporting Marae to develop Health Charters outlining their commitment to healthy active lifestyles	2 hui for iwi were organised for consultation	Maori communities
	Liasing with Maori Women's League	Maori Women's League
	Collaboration with MCC, Te Ora a Manukau for PANIC	MCC and Te Ora a Manukau
	Introductory course on diabetes, nutrition and physical activity	8 Maori community health workers
	Collaboration with ARPHS and ProCare	ARPHS and ProCare
	One new Marae leadership hub	Marae
	Development and implementation of nutrition education module	Community health workers
1.3 Kaumatua and Kuia leadership programme	2 three day training courses on nutrition	20 Maori
Summary for Maori:		**Individuals Reached: 20 Maori and Unknown Amount of Community Health Workers** **Organisations Reached: 5** **Communities Reached: 1**

Table 3. Pacific Stream Initiatives, 2005-2006

Initiative	Initiative Action	Who it Reached
1.4. Supporting Pacific churches to develop and implement nutrition and physical activity initiatives	Collaboration between CMDHB, Pacific providers and ARPHS to deliver ethnic specific workshops	Pacific Churches
	LotuMoui Minister's forum to educate the group about Type 2 diabetes	Pacific Church Ministers
1.5 Empowering self-identified and community identified leaders and organisations to become agents for change within their families and communities.	LotuMoui Minister's forum and plans to meet quarterly	50 LotuMoui Churches
	Diabetes workshop	50 Pacific Church Ministers
	MCC Pacific Community Group ran fund raising stalls	Polyfest
Summary of Pacific		**Individuals Reached: Unknown Amount** **Organisations Reached: 51** **Communities Reached: 1**

Table 4. Workplace Stream Initiatives, 2005-2006

Initiative	Initiative Action	Who it Reached
1.6 Supporting employers to develop and implement policies and initiatives that support health, active workplaces	Collaboration between ARPHS and CMDHB to discuss intiative	ARPHS and CMDHB
	Collaboration with CMDHB dieticians to discuss nutrition policy, onsite food and cafeteria	LBD and CMDHB
Summary for Workplace		**Individuals: 0** **Organisations: 2** **Communities: 0**

Table 5. Social Marketing Initiatives, 2005-2006

Initiative	Initiative Action	Who it Reached
2.1 Consolidating the leadership hub for the Social Marketing action area	Appointing of project manager	
	Leadership hub meets	
2.2 Background research	Reviewed of existing local research	
	Reviewed past campaigns	
	Completed information analysis	
2.3 Baseline survey	By June 2006, planning and design had begun for two LBD baseline surveys to be undertaken in Counties Manukau	-2300 general CM public -700 people with Type 2 diabetes
2.4 Strategy development	3 year strategy and 18 month plan of action presented to leadership hub	
2.5 Social Marketing activity	LBD Family fun walk held on 26th of November 2005	-347 people -volunteers and members of health promotion teams
Summary of Social Marketing:		**Individuals: 3,347** **Organizations: Unknown Amount** **Communities: 1**

Table 6. Urban Design Initiatives, 2005-2006

Initiative	Initiative Action	Who it Reached
3.1 Developing a prototype neighbourhood 'activity park' in Counties Manukau.	Consultation day on 6th December	Community
	Meeting with design group to draft plan.	
3.2 Undertaking health impact assessments of major planning initiatives in Counties Manukau.	Meeting between CMDHB, MCC and ARPHS to discuss collaboration	CMDHB, MCC, ARPHS
	Workshops held in Mangere and focus area identified	Pershore Precinct
3.3 Providing advice on Flat Bush development	Public workshops held for Flat Bush Community Development Plan	Flat Bush Community Members
3.4 Advocating for health	Collaboration between CMDHB, CM Sport, ARPHS, HNZC, Manukau City Council and Papakura District Council to discuss Activities	CMDHB, CM Sport, ARPHS, HNZC, MCC, PDC
	Bikewise week activities: 'Bike to Work Day', Pohutakawa coast ramble and Manukau on the Move	Manukau Communities
	Rotary launched children's cycleway at Lloyd Elsmore Park	Children
Summary of Urban Design:		**Individuals: Unknown Amount** **Organisations: 6** **Communities: 3**

Table 7. Food Accord Initiatives, 2005-2006

Initiative	Initiative Action	Who It Reached
4.1 Consolidating a leadership structure and action agenda for the food industry: health sector joint initiative in Counties Manukau	JIG meetings held to discuss initiatives and additional projects	
4.2 Co-funding of an advocacy position to develop and implement the joint Food:Health work programme	Interviews for the advocacy position were held on 15 August 2005 and by September 2005 an advocate had been appointed.	
4.2.1 Soft Drinks Programme	By June 2006, discussions between McDonalds and the SoPH were held to promote low energy soft drinks	McDonalds
4.2.2 White Milk Programme	JIG would reapproach dairy suppliers to get an up-dated appreciation for their plans and see opportunities for the active promotion of lower fat milk	Dairy suppliers
4.2.3 Healthy Kai Project	Workshops had been held with the Otara Healthy Kai group to discuss plans	Otara Healthy Kai
4.2.4 Healthy Food Parcels	By March 2006, the nutritional evaluation of current parcels was completed	
	By June 2006, the hub and wheel approach of centralised parcel production for distribution by local providers was accepted	
4.2.5 Healthy Canteen Business	By March 2006, the tuckshop trial at Tangaroa had opened	Schools
4.2.6 Healthy, Active Workplaces	By June 2006, a potential pilot company had been identified to participate in a documented trial which could then be presented to other businesses	

4.2.7 Social Marketing Programme	In April 2006, the work began on the implementation phase of the programme and management of agency and client process	
	By June 2006, JIG was actively working at the interface between CMDHB staff and FCB on the communications package for LBD.	
4.2.8 Health Points	By April 2006, the concept was discussed with Foodtown/Woolworths, who have shown interest in the idea as part of their existing 'One Card' programme	Foodtown/ Woolworths
4.2.9 Communications on Initiatives	By June 2006, the Executive Director of the FIG created a web based system to capture and distribute information on food industry initiatives that could be promoted in Counties Manukau retail outlets	
4.3 Developing and implementing a detailed work programme for 2006/2007	JIG approved 7 of the 9 proposed initiatives	
Summary of Food Accord		**Individuals: Unknown Amount** **Organisations: 4** **Communities: 1**

Table 8. Health Promotion Initiatives, 2005-2006

Initiative	Initiative Action	Who It Reached
5.1 Consolidating a leadership hub for the health promotion action area	By August 2005, CODA had been identified as the leadership hub for this Action Area.	CODA
5.2 Supporting aligned actions through better coordination of the funding environment	Meetings held with MoH reps to discuss funding	MoH
5.3 Improving capacity of the health promotion workforce.	By December 2005, the website was up and running with plans to update it on a regular basis	
	By June 2006, the final competencies and report were received and development of a plan for implementation of these competencies commenced.	
5.4 Improving communications resources for diabetes for use within health promotion and primary care.	By April 2006, the resource project was completed and planning for producing packages to be delivered later in 2006 was underway	
	By June 2006, LBD had contracted DPT to complete resource suite development, delivery and promotion to users	Diabetes Project Trust
Summary of Health Promotion:		**Individuals: 0** **Organisations: 3** **Communities: 0**

Table 9. Well Child Initiatives, 2005-2006

Initiative	Initiative Action	Who it Reached
6.1 Supporting the existing Well Child forum to be the leadership hub for the Well Child Action Area.	By July 2006, the leadership hub was in place	
6.2 Supporting the professional review of Well Child framework	In February 2006, the review and the recommendations were completed, peer reviewed and presented to the Well Child leadership hub for guidance on implementation	
Summary of Well Child:		**Individuals: 0** **Organisations: 0** **Communities: 0**

Table 10. Schools Accord Initiatives, 2005-2006

Initiative	Initiative Action	Who it Reached
7.1 Supporting kohanga reo to enhance or develop and implement nutrition and physical activity guidelines and programmes	He Oranga Poutama Kaiwhakahaere had supported Yandera ECC to hold an inter-kindergarten Sports Day using traditional Maori games	300 people from whanau and tamariki
	Tikanga o Te Ngahere Wananga was delivered	8 kohanga reo teachers and the Coutnies Manukau Sport Active Movement Coordinator
	Collaboration between SPARC of the MCC, MCC Leisure Planner, SPARC and Manukau Kohanga Reo	
7.2 Supporting Pacific Language Nests to enhance or develop and implement nutrition and physical activity guidelines and programmes as part of programme delivery	By October 2005, a workshop had been held between CMDHB, ARPHS and TaPasefika Health Trust to discuss the shaping of nutrition sessions within Pacific early childhood centres	
	By June 2006, the Active Movement Coordinator had provided information, training and support on Active Movement to a number of language nests	3 Language Nests
	Professional develop on Active Movement was also provided	South Seas Health Care Well child providers
7.3 Supporting Kura Kaupapa to enhance or develop and implement nutrition and physical activity guidelines and programmes	By June 2006, He Oranga Poutama Kaiwhakahaere had facilitated teaching traditional Maori games to all children at Te Whare Akonga o Manurewa and Te Huringa Reo (Maori Unit) Schools	Schools
	Funding opportunities were provided to Te Kura Kaupapa o Manurewa, Te Kura Kaupapa o Mangere and Te Kura Kaupapa o Piripono.	Schools
7.4 Establishing a leadership hub and ongoing strategy development for approach to primary/intermediate schools,	10 December 2005, a meeting was held between Manukau City Council, Counties Manukau Sport, Maori Health Promoting schools (HPS), CMDHB HPS and the National Heart Foundation, to rate schools based on Ministry and local criteria	

including explicit support for approach from national and district based MOE/Sport and Recreation New Zealand (SPARC), health agencies/providers	In April 2006, the leadership hub met and endorsed the School Accord plan and the Leadership terms of reference	
	MCC Health Promoting Schools principals' were supported to evaluate the 'Moove and Groove' product	Principals
7.5 Improving school principals' and Board of Trustees' awareness of the strong evidence supporting improved educational outcomes when children are achieving appropriate physical activity levels and nutrition (breakfast)	By June 2006, a presentation had been made to the Board of Trustees of Te Kura Kaupapa Maori o Manurewa regarding physical activity, nutrition and funding for resources	
7.6 Enhancing and supporting NEW/AIMHI intervention in selected high risk secondary schools, and aligning it with University of Auckland OPIC intervention/research	The NEW Adolescent obesity prevention project continued to be delivered in Mangere College, Southern Cross Campus and Sir Edmund Hillary Collegiate by DPT	3 Secondary Schools
	By December 2005, the 'GetWize2Health' programme in three AIMHI schools had finished for 2005	3 Schools
	In April 2006, the DPT 'GetWize2Health' programme was working well in three schools, with the enhanced programme set up in one school	3 Schools
	Through Te Oranga Poutama Kaiwhakahaere, traditional Maori games were taught to lead teachers at Santa Maria, Te Whae Kura o Mangere and Te Whare Kura o Manurewa	Teachers at 3 schools

	Te Whae Kura o Mangere, Te Whare Kura o Manurewa and Te Whare Kura o Piripono all signed off SportFit contracts which included physical activity and nutrition policy	3 Schools
	One day workshop was also delivered at Mahi Tuna Wananga about traditional Maori games, cultural identity and participation	15 Students
7.7 Trialling of the 'healthy canteen' business model	Work continued at Tangaroa to implement key concepts of the proposed model, with progress being made at a range of levels including staff training, food choices and alterations to the premises	
7.8 Developing new funding streams to support schools to make sustainable changes	December 2005, CMDHB, MCC and CM Sport were working on an 'expression of interest' for SPARC's Active Community Funding	CMDHB, MCC, CM Sport, SPARC
	Collaboration between CMDHB, CM Sport, Procare Manukau, MCC, Papakura District Council and Franklin District Council	ProCare Manukau, MCC, PDC, FDC, CMDHB
7.9 Supporting schools to improve 'drinks' environment in and around all schools	By June 2006, sugary drinks in the pilot tuck shop were removed. Flavoured milk and orange juice were introduced in 250 ml containers	
Summary of Schools Accord		**Individuals: 315 plus unknown amount** **Organisations: 7** **Communities: 4**

Table 11. Primary Care Initiatives, 2005-2006

Initiative	Initiative Action	Who It Reached
8.1 Establishing a leadership structure to guide improvements of diabetes management in the primary care sector	DCAG was established in September 2005 and continued to expand	PHOs
8.2 Developing a diabetes care framework for Counties Manukau	In October 2005, a student was identified to develop a diabetes care framework as part of his dissertation for a Masters of Public Health	
	By March 2006, these tasks were completed and the student began to develop a model of care using a systems thinking approach	
8.3 Improving use of brief interventions for modifying obesity risk factors	By September 2005, a contract was in place with two PHOs, Mangere Community Health Trust and TKOH to recruit and train trainers	17 trainers from PHOs
	A second training programme was conducted in December 2005	3 more trainers
	Recruitment of patients	85 patients
8.4 Improving uptake of best practice post-diagnosis education	In December 2005, the SME working group met with the Maori and Pacific Diabetes Project Teams to discuss similarities and overlap with their LBD initiatives and the Primary Care SME initiative	DPT, Maori, and Pacific
	A workshop with PHOs and other stakeholders was organised for 8 August 2006	PHOs

8.5 Trialling and evaluating increased use of family/whanau/group support for obesity risk factors and diabetes management	Initial discussions were held with Whitiora and DCAG members were added to the PHO Working Group	
	In October 2005, a Steering Group was formed and it was agreed that the SME initiative would work with the Maori Diabetes Initiative Project to merge their common activities	Maori Diabetes Initiative Project
	SME Working Group met with Pacific and Maori to discuss specific population needs	Pacific and Maori
8.6 Investigating and developing a whole system approach to improving rate of diagnosed type 2 diabetes to expected population with diabetes	In March 2006, CMDHB secured clinical resources to assess and cost the system changes required in general practice to implement the proposed screening model	
	DCAG received and discussed Jocelyn Tracey's report on implementing diabetes and CVD risk screening in primary care	
Summary of Primary Care:		**Individuals: 105** **Organisations: 5 plus PHOs** **Communities: 2**

Table 12. Vulnerable Families Initiatives, 2005-2006

Initiative	**Initiative Action**	**Who it Reached**
9.1 Establishing a leadership hub for the Vulnerable Families action area	In March 2006, a meeting was held between CMDHB, MSD and Strengthening Families to discuss the 2006/2007 work plan	CMDHB, MSD, and Strengthening Families
	By June 2006, Manukau City Council (MCC) and the MCC Child Advocacy Group were maintaining a child poverty focus in strategic planning	MCC
9.2 Improving referral pathways	Meetings held between CODA and Family Start to work on collaboration	CODA and Family Start
9.3 Enhancing Strengthening Families by including diabetes risk factors into review processes, with defined linkages and referrals to the health sector	Referral pathways for appropriate support were circulated to the Salvation Army and the SF Coordinator for dissemination to their Family Support Workers and SF Facilitators	
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	Meeting was held between the Action Area Leader, Project Leader, Salvation Army, SF Coordinator and the identified provider of nutrition training to agree to a plan for providing training	Salvation Army, Strengthening Families
	In March 2006, an agreement was reached between CMDHB and Manukau Family Start for a CMDHB dietician to provide brief intervention nutrition counselling for Family Start workers in order to assist Vulnerable Families	CMDHB, Family Start
9.5 Ensuring food parcels are healthy, well balanced and nutritious	In December 2005, it was decided that this initiative would be done as part of 4.2 (JIG Work Programme).	
Summary of Vulnerable Families:		**Individuals: 0** **Organisations: 6** **Communities: 0**

Table 13. Integrated Care Initiatives, 2005-2006

Initiative	Initiative Action	Who it Reached
10.1 Establishing a leadership hub for in-hospital service integration and reducing harm from diabetes complications	In March 2006, it was acknowledged that the existing leadership group was not appropriate for progressing hospital service integration	
10.2 Developing Whitiora Diabetes Service's role as clinical centre of excellence and supporter of system-wide capacity development	Audits of clinical practice occurred	
10.3 Ensuring diabetes management activities across primary and secondary care are implemented in a consistent manner	Meetings were held between DCAG and Green Prescprition managers	DCAG and Green Rx
10.4 Improving the integration of Primary and Secondary Care diabetes IT systems	Meetings were held between DCAG and Health Alliance to discuss scoping	DCAG and Health Alliance
10.5 Improving clinical data and ethnicity data collection and analysis in order to provide regular performance reports relating to indicator outcomes by ethnicity	From August 2005, discussions were held with Health Alliance regarding IS support	Health Alliance
10.6	A review of the current clinical and systematic barriers and	

Supporting diabetes in pregnancy	opportunities for integrating the different providers and services involved in diabetes in pregnancy and care into one comprehensive service was conducted	
	Recommendations for screening criteria were circulated	
10.7 Supporting diabetic eye disease	None	
10.8 Supporting diabetic renal disease	None	
10.9 Diabetes and mental health	In June 2006, Counties Manukau Sport and the Green Prescription Manager met to establish formal processes to better link these two services	CM Sport and Green Prescription Manager
10.10 Supporting therapeutics	A key issue that was identified in March 2006 was the need to formalise linkage with the Community Pharmacy Project	
10.11 Texting trial	In March 2006, the initiative was referred to the Strategic Initiatives funding	
	In June 2006, it was also noted that Counties Manukau Sport and ARPHS had a similar motivational text service planned for Green Prescription	
Summary of Integrated Care:		**Individuals: 0** **Organisations: 4** **Communities: 0**

Table 14. Community Action Fund Stream Initiatives, 2006-2007

Initiative	Initiative Actions	Who It Reached
1.1 Community Action Fund	20 week sports/nutrition education programme	13-24 years, Franklin Districts
	3x12 week exercise training and healthy eating programmes	Youth
	community seminars on food labels and cooking; >10 Tai Chi seminars	diabetics; Chinese community in Manukau
	Healthy Kai' based menu at Youth Café	Papakura youth, Papakura High, Rosehill College
	Healthy Lifestyles programme	Families of Otara and Manurewa
	Weekly golf tuition	children 7-10 in Counties Manukau
	2x10 week Whanau Sport, 2x10 week Housewives Netball programmes	Papakura general population
	Healthy lifestyle changes in school	Staff and Students of St Josephs School
Summary for Community Action Fund:		**Individuals: Unknown** **Organizations: 1** **Communities: 7**

Table 15. Maori Stream Initiatives, 2006-2007

Initiative	**Initiative Actions**	**Who it Reached**
1.2 Supporting Marae to develop Health Charters outlining their commitment to healthy active lifestyles	Te Tiriti o Waitangi Committee meeting	
	CMDHB Maori Health Plan presented	
	6 Wanaga planned - Diabetes info	Maori whanau, Diabetics
	Work on navigational tool	
1.3 Kaumatua leadership	Kaumatua photo shoot planned, with testimonial opportunities	Kaumatua
1.4 Kuia leadership	8 obesity/diabetes education workshops	
	Training session with Young pregnant mothers group	
1.5 Strengthening the physical activity and nutrition iwi collective in counties Manukau	Terms of Reference Developed	
	Assessing usefulness of diabetes resources	Maori diabetic audience
1.6 Maori diabetes training		
Summary for Maori:		**Individuals: Unknown** **Organizations: 1** **Communities: 1**

Table 16. Pacific Stream Initiatives, 2006-2007

Initiatives	Initiative Actions	Who It Reached
1.7 Pacific churches to develop and implement nutrition and physical activity	2nd Pasefika LotuMoui Health Symposium held	600 Representatives of Pacific Churches and the community
	Health education workshops held on: Heathier weight and undertaking a health risk assessment; men's health; women's health; nutrition; Physical activity; Smoking.	
	Grant launched supporting church based healthy lifestyles initiatives	Pacific Church goer's
1.8 Empowering self-identified and community identified leaders and organisations to become agents for change within their families and communities	Health symposium in Counties Manukau	Pacific chuch community representatives
	4 ethnic specific forums held as part of LotuMoui Symposium	
Summary of Pacific:		**Individuals: 600 plus unknown amount** **Organizations: Unknown amount of churches** **Communities: 1**

Table 17. Workplace Stream Initiatives, 2006-2007

Initiative	Initiative Actions	Who It Reached
1.9 Supporting employers to develop and implement policies and initiatives that support health, active workplaces	Various companies working towards a HBC Award	Employees
	ARPHS online nutrition messages project piloted	
	Relationship developed with Manukau City Council 'Community Gyms'	
	Workplace reference group formed	
	Various companies received HBC award	
Summary of Workplace:		**Individuals: Unknown** **Organizations: Unknown** **Communities: 0**

Table 18. Social Marketing Initiatives, 2006-2007

Initiatives	Initiative Actions	Who it Reached
2.1 Social Marketing Leadership Hub	Leadership Hub met	individuals from a variety of relevant networks and skill sets (e.g. health, commercial sales and marketing, community leadership etc)
2.2 Implementing the LBD social marketing programme	2nd round of creative developed and tested with target audience	Maori, Pacific and low income families.
	pitch seeking support from members of the food industry group - 20 signalling interest in being involved in swap2win campaign	Food industry
2.3 Baseline Survey – Measuring the impact of the social marketing programme and LBD programme	Baseline survey of general population half complete (1773 of 2400)	General population
Summary of Social Marketing:		**Individuals: Unknown** **Organizations: 0** **Communities: Unknown**

Table 19. Urban Design Initiatives, 2006-2007

Initiatives	Initiative Actions	Who it Reached
3.1 Establishing a LBD leadership hub on health and urban design in Counties Manukau	Informal leadership hub established	
	Manukau Urban Design guidelines presented	PSG
3.2 Developing exemplar models for community activity parks	Land swap between HNZC and Habitat for Humanity competed.	
	construction of park begun (ground leveled)	
3.3 Health impact assessment	None	
3.4 Advocating for health	active living and population health needs/determinants advocated for consideration and inclusion in the START project	
	Advocacy to promote HEHA objectives at Council sponsored events demonstrated	Council staff participants of Barry Curtic 10K Classic
3.5 Building a health-promoting transport system	Advocacy for inclusion of 'Smart Growth through Public Health' principles in the MCC draft Transport Strategy made	Manukau general population
	Review of planning initiatives related to transport and active transport infrastructure being undertaken	Manukau General population
Summary of Urban Design:		**Individuals: Unknown** **Organizations: Unknown** **Communities: 1**

Table 20. Food Accord Initiatives, 2006-2007

Initiatives	Initiative	Who it Reached
4.1 Strengthening the leadership structure for the food industry: health sector joint initiative in Counties Manukau	JIG strengthened	
	Executive Director of the Food Industry Group joined the group increasing alignment to HEHA	
4.2 Completing JIG work programme 2005/2006	None	
4.2.1 Soft drinks programme	Sprite swapped fro Sprite Zero in 21 McDonald's outlets.	McDonald's customers
4.2.2 White milk programme	Foodtown to use Manukau City store as a potential trial base for merchandising and pricing initiatives around lower fat milk	Consumers of milk in Manukau
4.2.3 Healthy kai project	Workshops to develop a structure approach to the business plan for Otara	Otara businesses/residents
4.3.4 Healthy food parcels	Links made between Food Parcel suppliers and food manufacturers/suppliers	Vulnerable families in Counties Manukau
4.3.5 Healthy Canteen Business Model Pilot	Trial at Tangaroa College	Tangaroa College students
	Extension to other trial schools underway	Schools
4.3.6 Healthy, active workplaces	None	Workplaces
4.3.7 Social marketing programme	Ongoing contribution to the social marketing plan	
4.3.8 HealthPoints	None	
4.3.9 Communications on initiatives	MCC staff involved in Town Centre renewal and Environmental Health Services, support Mangere and Otara Healthy Kai	Mangare and Otara populations
4.3 Developing and implementing a detailed work programme for 2006/2007	None	
Summary of Food Accord:		**Individuals: Unknown** **Organizations: 1** **Communities: 5**

Table 21. Health Promotion Initiatives, 2006-2007

Initiative	Initiative Actions	Who it Reached
5.1 Consolidating the health promotion leadership hub for LBD	Collaboration with CODA	
	Contract with DPT completed	
5.2 Developing and enhancing the health promotion and education workforce	Core Competencies Framework disseminated for final comment	All relevant organisations and groups involved in its development
	Collaboration with CMDHB Programme managers	
5.3 Supporting recent graduates from train-the-trainer projects (pilot)	Discussions with Maori and Pacific providers	
	Maori Service ready for delivery	Maori Train the trainers
5.4 Developing nutrition and physical activity resources to support health promotion in the primary care setting	800 resource folders compiled	
	Contract with DPT signed	
	2 new resources developed and translated	
5.5 Developing the physical activity workforce and activity opportunities (contingent on funding)	Draft EOI submitted to SPARC	
	MCC developed Partnership Agreement with CM Sports	
Summary of Health Promotion:		**Individuals: Unknown** **Organizations: 7** **Communities: Unknown**

Table 22. Well Child Initiatives, 2006-2007

Initiative	**Initiative Actions**	**Who it Reached**
6.1 Supporting the existing Well Child forum to be the leadership hub for the Well Child action area	None	
6.2 Scoping and development of appropriate nutrition and diabetes resources to support Well Child providers	Literature Review completed	
	Recommendations accepted by the Well Child Provider Group	
	Information systems altered to include BMI	
	Availability of resources review completed	
6.3 Developing a research proposal exploring age 0–5 obesity pathways among current 5–10 year old children	Collaboration with Pacific Family Study	Pacific research study
Summary for Well Child:		**Individuals: 0** **Organizations: 1** **Communities: 0**

Table 23. School Accord Initiatives, 2006-2007

Initiative	Initiative Actions	Who it Reached
7.1 Supporting kohanga reo and kura kaupapa in nutrition and physical activity	None reported	
7.2 Supporting Pacific language nests to enhance or develop and implement nutrition and physical activity guidelines and programmes as part of programme delivery	None reported	
7.3 Strengthening the Counties Manukau healthy schools leadership hub	Stock-take was completed	
	LBD supported MCC in launch of Fruit in Schools	MCC
7.4 Enhancing and supporting NEW/AIMHI intervention in selected high schools	By October 2006, roll out had commenced	
7.5 Enhancing and supporting ongoing development of whole school approaches and new initiatives in schools	None	
7.6 Supporting the implementation of the Healthy Tuckshop Business model	MCC continued development of the HPS Action Plan	MCC
	Student Health Team Training for Manurewa schools completed	Manurewa schools
	By February 2007, nine schools in total were in discussion about how to implement the healthy tuck shop Model	
	New tills were being installed at Tangaroa Collage	Tangaroa College

7.7 Developing new funding streams to support schools and communities to make sustainable changes	None reported	
Summary of School Accord:		**Individuals: Unknown** **Organizations: 1** **Communities: 2**

Table 24. Primary Care Initiatives, 2006-2007

Initiative	Initiative Actions	Who it Reached
8.1 Strengthening the leadership structure to guide improvements of diabetes management in the primary care setting	The review was completed and found that DCAG had made good progress	DCAG
8.2 Developing a diabetes care framework for Counties Manukau	By February 2007, the dissertation work by the public health registrar was completed and assessed by DCAG, who found it to have limited relevance	Public Health Registrar
8.3 Supporting the improved use of lifestyle management skills for modifying obesity risk factors – community nutrition project	None reported	
8.4 Supporting the implementation of the self management education programme to improve the uptake of best practice post diagnosis education	The Maori SME Facilitator and SME Coordinator commenced work and the Acting Pacific SME Facilitator was in place	Maori and Pacific SME facilitators
	By February 2007, the Diabetes SME training programme was completed and 16 participants were assessed as successful SME Facilitators.	16 trainers
	Facilitators developed their own implementation plans with the sub groups active and developing support resources for the SME programme.	facilitators
8.5 Trialling and evaluating increased use of family/whanau/groups support for obesity risk factors and diabetes management	By October 2006, the Maori pilot was completed and the evaluation report was received by DCAG	
	By February 2007, the Pacific pilot focusing on the qualitative study of obese surgical patients who lost weight was delayed due to due to lack of Ethics Committee approval	

8.6 Developing a whole system approach to improving rate of diagnosed diabetes – risk screening	Funding Forum rejected DCAGs proposal for funding	
8.7 Strengthening the Get Checked Programme in Counties Manukau	Get Checked was audited	
Summary of Primary Care:		**Individuals: 16 facilitators plus unknown amount** **Organizations: 1** **Communities: Unknown**

Table 25. Vulnerable Families Initiatives, 2006-2007

Initiative	**Initiative Actions**	**Who it Reached**
9.1 Strengthening the leadership hub for the vulnerable families action area	The MSD Social Report results 2006 were promoted to Elected members and Staff	
9.2 Consolidating and implementing the work programme for 2006/2007	None reported	
9.3 Enhancing Strengthening Families by including diabetes risk factors into review processes, with defined linkages and referrals to the health sector	None reported	
9.4 Improving referral pathways	None reported	
9.5 Improving nutrition by providing training for agencies that access at-risk families	None reported	
9.6 Ensuring food parcels are healthy, well-balanced and nutritious	None	
Summary of Vulnerable Families:		**Individuals: 0** **Organizations: 0** **Communities: 0**

Table 26. Integrated Care Initiatives, 2006-2007

Initiative	Initiative Actions	Who it Reached
10.1 Establishing a leadership hub for in-hospital service integration	None	
10.2 Developing Whitiora Diabetes Service's role as clinical centre of excellence and supporter of system-wide capacity development	None	
10.3 Ensuring diabetes management activities across primary and secondary care are implemented in a consistent manner	None	
10.4 Improving the integration of primary and secondary diabetes information technology (IT) systems	Acute Predict 2 was the preferred model for primary care	
10.5 Improving clinical data/ethnicity data and reporting	The feasibility study for CVDIS model was underway by Health Alliance	
10.6 Supporting Diabetes in Pregnancy	By February 2007, presentations had been made to the CMDHB General Manager Forum, Whitiora Team, Primary Care, Women's' Health, Community Midwives, Maori Health, Pacific Health	CMDHB, Whitiora, Women's Health, Community Midwives, Maori and Pacific Health
10.7 Supporting diabetic eye disease	Working with DCAG was facilitating the work on the retinal screening and grading classifications in the CCM database	DCAG
10.8 Supporting diabetic renal disease	None reported	

10.9 Aligning diabetes and mental health	In September 2006, development of "A New Zealand Mental Health Metabolic Working Group Initiative" Consensus Statement produced	
10.10 Supporting therapeutics	None	
Summary of Integrated Care:		**Individuals: Unknown** **Organizations: 7** **Communities: Unknown**