



Auckland UniServices Limited



THE UNIVERSITY OF AUCKLAND
FACULTY OF MEDICAL AND
HEALTH SCIENCES



CENTRE FOR HEALTH SERVICES
RESEARCH AND POLICY

A Descriptive Summary of the LBD Programme Progress: Initiatives and Action Areas Supplement

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1. Introduction

Let's Beat Diabetes is a five year, district-wide plan for Counties Manukau, aimed at long-term sustainable changes to prevent and/or delay the onset of Type II Diabetes, slow disease progression and increase quality of life for people with diabetes. It incorporates ten distinct but interrelated areas of activity that have been identified by Counties Manukau District Health Board (CMDHB) as the mechanisms by which to achieve the aims of LBD. Each of these Action Areas contain a number of initiatives.

Documentary evidence of the progress and developments that have taken place within the LBD Action Areas and initiatives will inform the overall evaluation of the LBD programme. This type of information will support the evaluation team in determining the progress of initiatives and whether they are on track to fulfil KPIs and milestones.

This section provides background for the documentary analysis. Due to the large amount of data within the documentary analysis, the full analysis of the initiatives is presented here as an appendix.

2. Methods

The documentary analysis examined and collated information from a number of different sources, including:

- Operational Plans for 2005/2006 and 2006/2007.
- Monthly progress reports from July 2005 to June 2006.
- Quarterly progress reports from July 2006 to February 2007.
- PSG Minutes from April 2005 to September 2006.

The evaluation team obtained these documents through the LBD project team and the PSG. It is important to note that during the 2005/2006 year, Action Areas completed monthly progress reports to record progress and developments that occurred within the initiatives. However, this format for reporting changed to quarterly progress reports for 2006/2007.

The information presented within this documentary analysis was dependent upon the data that was provided by each Action Area or initiative within the progress reports and the PSG minutes.

3. Analysis

Documents were critically examined to record what progress and developments had taken place, whether milestones were achieved, assess the level of adaptation within the initiatives and to identify any issues, challenges or risks that may have emerged.

An Excel worksheet was created that separated each initiative within their corresponding Action Area. The KPIs for each initiative were obtained from the operational plan for that year and recorded on the worksheet. Each initiative was then divided into monthly sections from July 2005 to June 2006 and quarterly sections from July 2006 to February 2007.

Each LBD document was critically examined and information was recorded next to the appropriate initiative. During this process, any supporting activities or key issues that were identified within the available documents were also recorded within the worksheet. The results of the documentary analysis were then drawn from the information contained within the worksheet.

4. Results

Due to a change in the format of the progress reports between 2005/2006 and 2006/2007, the results from the analysis are separated into two sections. The first section focuses on progress that occurred during the 2005/2006 year. Each initiative is identified separately within the respective Action Area. A short summary of the initiative is provided, followed by the KPIs for 2005/2006 and the progress that was recorded for that initiative within the documents.

The second section focuses on 2006/2007 progress to date. Once again, each initiative is identified separately within the respective Action Area. A short summary of progress over 2005/2006 and the direction of the initiative for 2006/2007 is provided, followed by the KPIs for 2006/2007.

It should be noted that the 2006/2007 KPIs differ to the KPIs 2005/2006 KPIs in a number of initiatives. Following the KPIs is a section that outlines the progress and developments for the

initiative, any highlights or milestones that were met and any issues, challenges or risks that emerged within that initiative.

2005/2006

Action Area 1 - Supporting community leadership and action.

1.1 Community Action Fund (CAF)

Community organisations and groups are supported to develop and implement 'grassroots' initiatives that encourage local participation in activities that reduce diabetes risk, slow disease progression and/or improve the quality of life for people with diabetes.

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 encourage local participation in health promoting activities.

The following are organisations that received CAF grants for 2005/2006:

Tainui MAPO – Hikoi Hauora

A 5 km community walk/run was organised to raise awareness for healthy lifestyles and diabetes amongst the Maori community. Around 800 people registered for the event, which was held at the Bruce Pullman Park in Papakura on the 9 April 2005. An accountability report was received on the 4 July 2005. This was the group's first application for a CAF grant.

Sisters of Mercy Wiri – Nutrition, Physical Activity and Community Participation

The Sisters of Mercy provided residents of Wiri with an opportunity to participate in a localised healthy eating and regular exercise programme over a 12 month period. The programme included a minimum of three aerobic sessions per week, 20 healthy lifestyle education sessions and weekly after-school activities for children. The focus of the programme was local action by local residents. This was the group's first application for a CAF grant.

Clevedon Anglican Parish – Elderly fitness and exercise

Weekly fitness and exercise classes were provided for elderly residents living in the Clevedon area. These classes were held at the St Marks Church Hall and aimed to promote regular exercise and social wellness. This was the group's first application for a CAF grant.

Papakura Youth Expo – Youth Activat8 Expo

Over 12 local schools participated in a 3 day expo that was held in Papakura to promote diabetes awareness. The Activat8 expo involved exhibitions and activities with healthy lifestyle messages that promoted the need for regular physical activity and exercise. This was the group's first application for a CAF grant.

Chinese New Settlers Service Trust – Weekly Tai Chi Classes

This 6 month programme encouraged ongoing participation in an exercise programme with weekly Tai Chi classes and two diabetes awareness seminars for new migrants and the Chinese community.

Highland Park Community House – Weekly Physical Activity Exercise Programme

A weekly exercise and healthy eating programme that targeted new settlers in the Howick, Pakuranga and Botany area ran over a 12 month period. Individuals signed up to a 10 week programme under the guidance and supervision of a qualified aerobic instructor. They were then encouraged to continue with their healthy lifestyle programme after the 10 weeks with quarterly follow ups and reassessment. The healthy eating programme focused on lowering sugar and fat intake, healthier ways of cooking, labelling on products as well as cooking demonstrations and visits to the supermarket. This was the group's first application for a CAF grant.

Red Hill Primary Schools – Nutrition and Physical Activity Programme

This physical activity programme targeted children and their parents residing in the Red Hill School area. The programme included:

- A minimum of six hours after-school supervised physical activity per week for 40 weeks;
- Employment of two teacher aids with current first aid certificates;
- Basketball, touch, rugby, athletics and a range of both indoor and outdoor activities; and
- A nutrition programme with monthly nutritional education for the term of the contract targeting children and their parents. The focus was on healthy eating, healthy lunches, a balanced diet and how to beat the convenience of junk food.

The programme encouraged the school community to get involved and eventually pick up the supervisory aspects of the programme. This was the group's first application for a CAF grant.

Probase Bengalese Association – Community Engagement and Healthy Lifestyle Programme

Community engagement forums targeted the Indian community residing in the Counties Manukau area. The programme included:

- A minimum of two community consultation forums targeting the Indian communities of Counties Manukau identifying the issues and perceptions associated to diabetes risks, harms, preventative mediums and diabetes management;
- Yoga classes;
- Cooking classes and instruction to improve general knowledge of diabetes within an Indian diet and context;
- A minimum of five in-depth case studies on individuals and their families highlighting the socio-cultural experiences, behaviours attributed to healthy lifestyles; and
- A detailed report including key analysis and recommendations that will reduce the incidents of diabetes amongst Indian peoples in Counties Manukau.

This was the group's first application for a CAF grant.

Swaasthh Charitable Trust – Beating Diabetes: A Health Promotion Initiative

The Swaasthh Charitable Trust coordinated and ran a series of Diabetes workshops and demonstration forums targeting the Indian, Bangladesh, Nepal, Pakistan, Sri Lanka, Bhutan, Tibet and Maldives communities in the Counties Manukau District. The programme included:

- A minimum of two workshops that explored the current and proposed burden of diabetes within the South Asian community here in Counties Manukau;
- Identifying the role that SWAASTHH can play in minimising the risks of diabetes within the South Asian community;
- Promotion of the key concepts outlined in the 'Lets Beat Diabetes' Plan;
- Raising awareness of the key signs, symptoms and 'modalities of care' related to diabetes prevention and management;
- Evaluation from workshop participants; and
- A minimum of two healthy eating healthy physical activity demonstration sessions.

This was the group's first application for a CAF grant.

Counties Eastern Outrigger Canoe Club – 'Have a Go' Waka Ama

Co-ordination of a series of 10 'Have a Go' Waka Ama events and healthy lifestyles workshops. The programme included:

- A minimum of 10 'Have a Go' Waka Ama events and workshops at various coastal Counties Manukau locations;
- Each event encouraged first timers at outrigger canoeing to participate in healthy activities such as Waka Ama;
- Promotion of healthy lifestyles through diabetes awareness;
- Diabetes awareness and nutrition education through games and specific nutrition workshops;
- Lifestyle enhancement; and
- An evaluation from event and workshop participants.

This was the group's first application for a CAF grant.

Makaurau Marae – Healthy Lifestyle Programme

This programme was known as 'E Tu Hauora' 'Stand-up and be Healthy' and aimed to encourage Te Ahi Waru Iwi to take responsibility for ones own health and well-being through regular exercise, nutrition and healthy living. The programme involved:

- Walking classes 3 times per week for 6 - 12 months;
- Exercises, warm-ups;
- Promoting a smoke free, drug free and alcohol free Marae and home environment;
- Encouraging regular Podiatrist and GP check-ups;
- Nutritional advice and physical activity awareness and monitoring; and
- Monitoring and celebrating the success'.

This was the group's first application for a CAF grant.

Nga Wahine Atawahi o Matukuturia – Obesity and Weight Loss Programme

Nga Wahine Atawhai o Matukuturia, Manurewa branch of the Maori Women's Welfare League ran a 12 week obesity and weight loss programme targeting branch members and their whanau.

The programme included:

- A series of 6 health promotion sessions focussing on healthy kai;
- Aqua-aerobic sessions, exercise and walking classes;
- Weight management and monitoring through a whanau supportive setting; and
- Healthy kai recipe' book compilation.

This was the group's first application for a CAF grant.

TAONGA Education Centre – 1 Year Nutrition Education and Physical activity Programme

This programme targeted teenage mothers and focused on lifestyle and behaviour change. The nutrition programme included: Healthy kai, healthy cooking on a budget, growing your own vegetables. The physical Education programme included: Pilates & volleyball, baby gym, aquatic exercise programmes run twice weekly for 40 weeks. Finally, the health programme included: All enrolled to achieve 'food safety certificates, Diabetes awareness, lifestyle change health goal agreements. This was the group's first application for a CAF grant.

Highland Park Community House – Weekly Exercise and Healthy Eating Programme

A weekly exercise and healthy eating programme that targeted new settlers in the Howick, Pakuranga and Botany area ran over a 12 month period. Individuals signed up to a 10 week programme under the guidance and supervision of a qualified aerobic instructor. They were then encouraged to continue with their healthy lifestyle programme after the 10 weeks with quarterly follow ups and reassessment. The healthy eating programme focused on lowering sugar and fat intake, healthier ways of cooking, labelling on products as well as cooking demonstrations and visits to the supermarket. This was the group's second application for a CAF grant.

Chinese New Settlers Service Trust – Weekly Tai Chi Classes

This 6 month programme encouraged ongoing participation in an exercise programme with weekly Tai Chi classes and two diabetes awareness seminars for new migrants and the Chinese community. This was the group's second application for a CAF grant.

Sisters of Mercy Wiri – Nutrition, Physical Activity and Community Participation

The Sisters of Mercy provided residents of Wiri with an opportunity to participate in a localised healthy eating and regular exercise programme over a 12 month period. The programme included a minimum of three aerobic sessions per week, 20 healthy lifestyle education sessions and weekly after-school activities for children. The focus of the programme was local action by local residents. This was the group's second application for a CAF grant.

Clevedon Anglican Parish – Elderly fitness and exercise

Weekly fitness and exercise classes were provided for elderly residents living in the Clevedon area. These classes were held at the St Marks Church Hall and aimed to promote regular exercise and social wellness. This was the group's second application for a CAF grant.

Takanini School – Health Promotion and Health Education

Delivery of a curriculum based health promotion, nutrition and physical activity programme that included:

- 6 week classroom based programme that looks at improving student nutrition, levels of fitness, understanding & knowledge of diabetes, risks associated with diabetes behaviour change that embeds healthy lifetime practises;
- Recording and monitoring student food in-take and physical activity diaries;
- Parent education through regular newsletters and presentations by students to parents; Physical education over and above the regular education programme that is monitored tested and its effectiveness attributed against this initiative; and
- An analysis of the school culture, attitude and commitment to healthy lifestyles.

This was the group's first application for a CAF grant.

1.2 Supporting Marae to develop Health Charters outlining their commitment to healthy active lifestyles.

A hui for each Marae in Counties Manukau would be held to discuss this intervention/initiative and possible activities as well as to gain their support for being involved. Each interested Marae would then identify the key activities they were going to implement. CMDHB/providers were to provide support to these Marae through training, resources and mentoring.

2005/2006 KPIs

- By September 2005, provider(s) contracted to deliver service.
- By June 2006, 70% of Marae develop Health Charters.
- By June 2006, 70% of Marae received training.
- By June 2006, resources are provided/made available.

- By June 2006, 70% of Marae are linked to health promotion providers.

In November 2005, the direction of the Maori initiative was modified as it was determined that meeting the original key performance indicators within the LBD Operational Plan 2005/2006 was an unrealistic goal. The Operational Plan was revised in order to focus on developing the capacity and infrastructure for the Maori initiative within LBD.

- Development of and support for six Marae leadership hubs to become role models within their whanau and communities through enhanced knowledge on diabetes prevention and management.
- Development of virtual Marae; urban one-stop-shop settings where Maori could receive health information, education, assistance and support.
- Establishment of, and coordination of provider networks who deliver programmes and services to Maori to identify gaps, with particular focus on kohanga reo and kura kaupapa.

Progress

By August 2005, a number of potential providers had been identified; however there was need to hold discussions with Auckland Regional Public Health Service (ARPHS) to establish a collaborative approach with coordinated activities. In September 2005, an action to consult with marae was requested by POU, CMDHB Board's Maori advisory committee. During this time, two hui for iwi were organised to consult with Maori communities regarding the CMDHB Maori Health Action plan and to discuss the potential of the Let's Beat Diabetes project for Marae and with Maori whanau. The first hui was to be held on the 19 of September at Pukaki Marae in Mangere and the second was to be held at Nga Tai e Rua Marae in Tuakau. Panui were sent out and follow up calls were also made to ensure that Marae secretaries and committees were aware of these hui. During this time, a number of key issues for both Marae and CMDHB were identified. Issues for Marae included: organisational development; policy; and the monitoring of policy implementation. Issues within CMDHB included: direction and variation to work programme; timeframes; budgets; organisational development vs. outcomes and language (te reo).

By December 2005, the Maori Community Advisor was liaising with the Maori Women's Welfare League, who had established a working group around diabetes education. Within the PANIC roopu, a number of key decisions had been made, including: brainstorming better ways

to work smarter; ensuring that work became seamless; completing a stock take of resources; developing Maori specific resources; combining diabetes education with exercise and nutritional advice and increasing membership. Key issues included the need for resources to launch a training and education programme for the members of the working group for 2006 and aligning national objectives with regional work efforts.

By March 2006, a hui had been planned at Pukaki Marae around Self-Management Education (SME), diabetes, whanau at risk and discussion around the development of a navigational tool for Maori with diabetes, linking Marae to health promotion. It was intended that a Maori diabetes nurse and a psychologist would be present. From this hui a core group would develop who could receive ongoing support. Unfortunately this hui was cancelled due to difficulties in organising a time to suit the professionals and whanau involved.

During this time, a number of collaborative activities were taking place. In collaboration with MCC, Te Ora a Manukau became involved with the establishment and development of the PANIC group. A partnership between CMDHB and the Maori Women's Welfare League also continued with plans to develop a 'virtual marae' pilot in Manurewa. By April 2006, plans to reschedule the hui at Pukaki Marae were underway and another hui of this nature was being planned for Port Waikato, helping Marae to receive training.

During this time, eight Maori community health workers had been through an introductory course on diabetes, nutrition and physical activity. It was acknowledged that ProCare and ARPHS were actively involved in these developments. While valuable, a key issue that was identified through delivering the training was that there was difficulty around getting Maori trainers and that there were territorial considerations around nutrition and physical activity education as some organisations and individuals had been planning programmes and initiatives in their own areas and there were concerns around the duplication of work. Fortunately, successful collaboration between these organisations resolved this issue, although the risk of this issue reoccurring in other areas was noted by the Action Area leader.

By June 2006, one new marae leadership hub had been developed. LBD was also supporting the work of the marae facilitators in Franklin, which was established and funded by ProCare, to achieve this outcome. During this time, ARPHS and CMDHB funded the development and implementation of a nutrition education module for community workers specifically for diabetes

prevention and management. The training sessions were delivered by Te Hotu Manawa and were considered very successful by the Action Area leader. A key issue that was highlighted during this time was the need to develop Maori capacity to begin to remove a stigma associated with diabetes. The potential risk of getting diabetes could be minimised by education programmes that include Maori whanau and Maori communities, in the form of awareness raising hui.

1.3 Kaumatua and Kuia leadership programme.

Kaumatua and Kuia were identified as influential leaders in the Maori community. This programme looked to support identified Kaumatua and Kuia to become role models within their whanau and communities through enhanced knowledge on diabetes prevention and management by:

- Facilitating an education hui, and by
- Facilitating opportunities for Kuia and Kaumatua to support diabetes messages and programmes.

2005/2006 KPIs

- Kaumatua and Kuia are identified and educated for every Marae that completes a Health Charter (1.2)
- By (date 2005), education hui facilitated and opportunities for Kaumatua and Kuia to support diabetes messages and programmes to be determined on an 'as needs' basis.

Progress

In September 2005, it was acknowledged that the kaumatua and kuia programme offered two types of learning opportunities on Marae. The first part of the leadership programme focused on understanding and managing day to day diabetes. This learning would take the form of a Maori specific support group. The second was the opportunity for whanau and the community to learn about diabetes and how to support whanau with diabetes and to reduce their own potential risk of getting diabetes. This effort would raise the level of awareness throughout the Maori community and change the face of service delivery and care for diabetic patients.

A key concern acknowledged during this time was the need to develop a model of working that would also take the wellness/illness of members into account to ensure that health care could be offered in a timely way and that others can take up the responsibility if and when required.

By March 2006, two three-day training courses delivered by Te Hotu Manawa Maori had been completed. These courses involved 20 Maori from a number of different organisations including: the Maori Women's Welfare League; Kura Kaupapa; urban marae as well as other organisations. There was the potential for further courses to be scheduled in 2006, linking Te Hotu Manawa Maori with Hapai te Hauora and provided Kuia with the training to support diabetes messages and programmes. During this time, Kaumatua and Kuia leadership was being developed separately for the purposes of this project as Kuia are more easily seconded to this work through the Maori Women's Welfare League. Kaumatua who had been involved were few but extremely influential in encouraging people to attend meetings and hui by way of Maori ritual and their korero to the people.

By April 2006, the MWWL had successfully gained a grant to undertake diabetes activities within their branch. They had also formed a core group to be trained in diabetes so that they would be able to facilitate education and promotion around diabetes. Other key activities supporting the education initiative included active promotion by kaumatua from Te Puea, Makaurau and Pukaki to generate more interest and active participation in diabetes on their marae.

A roopu (organisation) named 'Hinana ki Tai' was formed with the responsibility to facilitate the first proposed hui at Pukaki. Key issues around organising and holding these hui were the length of time and focused effort that they required. It was acknowledged that it was difficult for the part time project leader to cover strategic direction; advise widely (both regionally and nationally); initiate hui; encourage community activity; implement ideas and monitor progress; consider evaluation and research as well as advise on contracts and support other action areas. This role needed more support.

The work of the Action Area continued and by June 2006, CMDHB had been in discussions with the MWWL, seeking their endorsement to be champions for the LBD Maori Action Area. The MWWL agreed and it was intended that in 2006/2007, CMDHB would look to providing training to the MWWL so that they were able to educate the wider Maori community, whether it

be in their branches, on the marae or kohanga reo and kura kaupapa. These trainings would also be opened up to kaumatua, with a key action point for 2006/2007 being the establishment of a register of kaumatua who are able to educate the wider community. A supporting activity within MANukau City Council (MCC) during this time was the identified focus on coordination and advocacy for Maori health and wellbeing as a priority activity for Tomorrow's Manukau/Manukau Apopo.

1.4 Supporting Pacific churches to develop and implement nutrition and physical activity initiatives.

CMDHB Pacific Health's LotuMoui Grant initiative was established to support 50 Pacific churches to develop and implement community projects that would support their congregations to live healthy lifestyles. It included:

- Capacity building;
- Workforce development;
- Programmes/service delivery; and
- Evaluation of the initiatives.

2005/2006 KPIs

- By June 2006, two x series of ethnic-specific workshops facilitated.
- By November 2005, resources provided/made available.
- By December 2005, LotuMoui Fono supported.

Progress

In August 2005, a number of possible providers were identified to facilitate the ethnic-specific workshops for Pacific churches. It was intended that these workshops would be phased in to fit in with the wider CMDHB Pacific service plan. As well as these workshops, LotuMoui planned to hold a Health Forum Open Day on the 3 December 2005 that would also incorporate information from LBD; however this was deferred until 2006.

In March 2006, CMDHB Pacific Health began to scope the delivery of the diabetes workshops to LotuMoui churches. As a number of session plans were already being developed for LBD initiative 7.2 (implementing nutrition and physical activity guidelines for under five's) it was

intended that the diabetes workshops would build on these resources and session plans. It was also recognised that the workshops would require a collaborative approach to delivery between CMDHB, Pacific providers and ARPHS. The workshops would also need to be linked to the SME initiative to ensure that these initiatives were aligned. Resource development to support the Community Nutrition Education sessions was also underway. It was planned that the Nutrition Education Sessions would be held within Pacific church communities including, Cook Island churches, Tongan churches, Niuean churches, Samoan churches and Pacific churches.

During this period the Manukau City Council's Draft Pacific Peoples' Policy and Action Plan was approved for consultation. This Policy and Action Plan also included health objectives to support LBD and Tomorrow's Manukau/Manukau Apopo.

The LotuMoui Minister's forum was held on 29 March 2006 at the Telstraclear Event Centre, with around 30 churches represented. The focus of the forum was to educate the group about Type 2 diabetes, with opportunities for participants to break out into ethnic-specific groups to discuss how Pacific churches could contribute to reducing the impact of diabetes by applying a theological perspective to LBD's activities.

1.5 Empowering self-identified and community identified leaders and organisations to become agents for change within their families and communities.

Many Pacific church and community leaders acknowledged the diabetes problem and wanted to champion the fight against diabetes in the communities but did not have access to the appropriate knowledge to lead with confidence.

2005/2006 KPIs

- By May 2006, workshops completed.
- By June 2006, linkages, networks and support systems for community leaders made and documented.

Progress

By August 2005, a number of possible providers to facilitate the ethnic-specific workshops had been identified. By September 2005, a meeting had been held with the Ministry of Pacific Affairs, who were keen to support this initiative.

On the 2 November a LotuMoui Ministers Forum was held and it was intended that these would continue to be held on a quarterly basis. The forum would involve representatives from the 50 LotuMoui churches as well as other church leaders from the district. By March 2006, a diabetes workshop had been planned with approximately 50 Pacific church Ministers. The outline of the workshop included:

- An overview/introduction to Type 2 diabetes;
- Why is diabetes an important topic for Pacific people;
- Ethnic-specific discussion groups; and an
- Overview of LBD.

By June 2006, a number of supporting activities within MCC had occurred. The MCC Pacific Community Group had run fundraising food stalls at Polyfest and provided My Food Stall Brochures and ARPHS resources (Healthy Food Choices) as part of occasional food premise licensing procedures.

Discussions had taken place with the Health/Wellbeing team and policy staff with the Pacific Island Advisory Committee and Coordinator (PIAC) around the inclusion of health/wellbeing issues as priorities for 2006/2007 work plan.

1.6 Supporting employers to develop and implement policies and initiatives that support health, active workplaces.

Organisations that were actively participating to achieve the LBD objectives would be supported to introduce healthy, active workplace policies. The objective was that these organisations would become sustainable exemplar workplace environments in the areas of nutrition and physical activity.

2005/2006 KPIs

The Operational Plan 2005/2006 did not identify any key performance indicators for this initiative.

Progress

By August 2005, CMDHB and ARPHS had met twice to discuss what the workplace intervention/initiative might look like and how it would be packaged. Initial thinking was that it would be similar to the 'Heartbeat Challenge' that was already running, but with subtle differences. Once confirmed, it was intended that CMDHB and ARPHS would approach the participant organisations. By September 2005, ARPHS was working with CMDHB to implement Heartbeat Challenge within their own organisations. ARPHS had also:

- Met with the LBD project team to finalise that Heartbeat Challenge (HBC) would be the workplace programme used for LBD and that LBD would co-brand any material with their logo. The National Heart Foundation was notified about this.
- Met with CMDHB dieticians to discuss nutrition policy, catering and function guidelines, onsite food and the cafeteria.
- Completed a nutrition audit questionnaire with CMDHB dieticians and developed a draft simplification of the nutrition policy.
- Began facilitating the HBC process at CMDHB. Pat Flanagan was to lead a representative group to facilitate the implementation of the HBC at CMDHB. An initial audit as completed and a needs assessment process was to be designed.

It was acknowledged that MPIA was also ready to begin HBC within its workplace. A number of key meetings were held with organisations who were interested in commencing HBC, including Housing New Zealand Corporation (HNZC). HNZC already had a Health and Wellness committee structure which would aid implementation. At the meeting, it was suggested that they expand the group to include a management representative and someone from communications

Action Area 2 – Promoting Behavioural Change through Social Marketing

2.1 Consolidating the leadership hub for the Social Marketing action area

The leadership hub was to work in partnership with the social providers to develop and implement the social marketing programme. The hub was comprised of key community leaders and providers who had an interest, expertise and influence in social marketing.

2005/2006 KPIs

- By August 2005, leadership group convenes.

Progress

A project manager was appointed for the Action Area and commenced work on the 29 August 2005. During this period, leadership hub members were identified and the first Social Marketing hub meeting was scheduled for the end of August. The August/September meeting was cancelled due to some issues with the social marketing providers.

The leadership hub met on the 11 October and Thinkspace presented the proposed strategy development process. It was intended that Thinkspace would take the lead in developing the social marketing strategy, with input as appropriate from FCB (communications strategy) and Maori and Pacific advisors. There was also some discussion around defining boundaries of the social marketing strategy, such as focusing on the prevention of diabetes rather than also aiming to improve self-management amongst those individuals who have been diagnosed.

At the meeting on the 12 December, Thinkspace provided an update of key learning's from the professional immersion process. On the 16 March 2006, the leadership hub reviewed the draft social marketing strategy. From May 2006, MCC consulted with the CMDHB social marketing programme development team and opportunities were flagged as part of the MCC Events Strategy Review.

2.2 Background research

The background research for the Social Marketing Strategy was divided into four separate reviews: Existing local research; past campaigns; formative research with community and stakeholder groups; and analysis to identify whether there was sufficient existing information to begin strategy development.

2005/2006 KPIs

- By the end of August 2005, reviews and research completed.

2.2.1 Review existing local research

Progress

By August 2005, Phoenix Research had commenced work on this review with the paper due by the end of August. By September 2005, Phoenix research had completed the review and recommended that a baseline survey be conducted. The report was circulated among members of the LBD social marketing group.

2.2.2 Review past campaigns

Progress

The review was due to be completed by the 18 August 2005 and would not include the successful local HepB campaign as the key contact people were unavailable and information was inaccessible. By September 2005, Nancy Sheehan & Associates had completed this review and the report was circulated among members of the LBD social marketing group and members of the CMDHB staff, as it was potentially relevant to other teams.

2.2.3 Formative research

Progress

Consumer immersion was to be conducted in early February 2006 as part of the social marketing and communications strategy development.

2.2.4 Information analysis

Progress

Information from the social marketing AA provides no indication of progress for this task but does indicate that the analysis was completed.

2.3 Baseline survey.

A statistically valid baseline survey was needed to enable measurement of changes in target groups over time. The decision as to whether any further research was required to form the baseline and/or inform the strategy for the social marketing depended upon the results of 2.2.

2005/2006 KPIs

- If required, the baseline survey is likely to be undertaken in the last quarter of 2005.

Progress

In September 2005, following a review of existing research (see 2.2.1), Phoenix Research recommended that a baseline survey of the community be conducted. A meeting was held with SoPH, Phoenix research and Thinkspace during late October 2005 to discuss the baseline survey and wider evaluation activities. Phoenix research would conduct the baseline with the general public, given their experience in conducting consumer research.

By December 2005, further meetings had been held with the SoPH who agreed that an ongoing quantitative monitor with the general population would be used to meet the needs of both the social marketing action area and the evaluation. Along with the baseline survey, a separate survey specifically for people with diabetes in the community was to be investigated.

The Baseline survey proposal was due from Phoenix research by 17 March 2006. It was intended that scoping and design would take place before June and that the survey would be conducted at either the end of 2005/2006 financial year or the start of 2006/2007 financial year.

By June 2006, planning and design had begun for two LBD baseline surveys to be undertaken in Counties Manukau in the early 2006/2007 financial year. One would be conducted with the

general public (total sample size of n=2300) and another specifically with people who have Type 2 diabetes (total sample size n=700). Maori, Pacific and Asian populations would be over sampled to ensure valid sample sizes for analysis and to ensure comparisons could be made over time. This was consistent with the direction from CMDHB Board's committees that the survey meets standards of cultural excellence.

2.4 Strategy development

Develop a five year social marketing strategy based on the reviews and research (2.2), the survey (2.3 – if required) and the broader interventions/initiatives in the LBD plan.

2005/2006 KPIs

- By November 2005, strategy completed. This KPI was revised in October 2005 to extend the timeline of completing the strategy to late February 2006 due to slippage in engaging preferred supplier(s).

Progress

In September 2005, the contract with the preferred supplier for the strategy development was still to be finalised. By October 2005, Thinkspace and FCB had been engaged to develop the social marketing strategy. Thinkspace would lead the development of the strategy and FCB would play a key role in developing the communications strategy and conducting consumer research. It was also intended that Maori and Pacific advisors would be contracted by CMDHB to provide input.

In December 2005, the professional immersion process was two thirds of the way through. A peer review of the strategy was obtained from Ed Maibach, an international expert in social marketing. His response was positive and he was keen to maintain an ongoing dialogue.

On the 16 March 2006, the three year strategy and 18 month plan of action was presented to the LBD Social Marketing Leadership Group. The overall strategic approach was approved by this group, with the understanding that the final report would:

- Include further detail and recommendations regarding the targeting of social marketing and communications activities for Maori and Pacific communities.
- Give clearer indications of success.
- Revise the proposed timing of the 'find out' phase related to screening services.

- In May 2006, the Social Marketing Strategy was presented to PHAC and again to POU and PHAC in June before it was substantially finalised.

2.5 Social Marketing activity.

Initial social marketing activity was to be initiated in the first six months of the 2005/2006 year. This activity was likely to be of small scale, while strategic work continued. The major social marketing activity would occur in the second six months of 2005/2006.

2005/2006 KPIs

- By November 2005, small scale activity initiated.
- By February 2006, major activity begins.
- Strong community support for social marketing concepts and approach.

Progress

By September 2005, feedback and modelling work pointed to the need to get 'bigger people' more physically active. The social marketing team decided to focus on this as one of the first key social marketing messages for LBD. It was intended that this message and a focus on whanau/family activity would occur through a community event in Manukau to launch LBD and kick-start diabetes awareness week in South Auckland. Planning for this event was discussed with relevant stakeholders including, Community Organisations Diabetes Awareness (CODA), Diabetes Project Trust (DPT) and MCC.

By October 2005, these stakeholders had confirmed their support for a community event to tie in with Diabetes Awareness Week. The inaugural LBD Family Fun Walk was held on the 26 November 2005 and was a great success despite the weather conditions. Three hundred and forty seven people registered to take part in the walk, plus volunteers and members of the health promotion teams. One hundred and ninety five people visited all nine health promotion stalls as part of the smart card initiative. This event was a good example of inter-sectoral collaboration, as the organising committee consisted of CMDHB, Counties Manukau Sport and the DPT.

By March 2006, the main focus for the Action Area was finalising the development of the 3 year strategy. It was intended that once the 3 year strategy was approved, the first steps towards bringing the strategy into action would include: media planning, contracting creative work,

sharing the strategy with those who were involved in the development process and broader promotion of the social marketing strategy to all relevant stakeholders.

By June 2006, the initial roll-out of the social marketing strategy was planned for November 2006. Given their role in developing the overall social marketing strategy, the advertising agency FCB were commissioned to develop the creative concepts and resources required to bring the social marketing strategy to life. Specialist in Maori and Pacific advertising and communications were involved as core members of the team. FCB was to work closely with the LBD social marketing project manager as well as with relevant members from the CMDHB Maori and Pacific health teams during the development process.

During this time, planning across the LBD Action Areas and with the LBD Maori and Pacific teams was taking place to ensure optimal alignment with their respective 2006/2007 activities and for ongoing advice and guidance to ensure that the social marketing programme remains relevant and effective for their respective communities. Lauren Young and Associates, a marketing firm, were also briefed and would play a key role in the roll-out of the programme by ensuring inclusion of relevant success stories in general and community media, as well as in media targeted specifically at 'environmental influencers', such as food and retail publications.

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

3.1 Developing a prototype neighbourhood 'activity park' in Counties Manukau.

HNZC was undertaking a major housing redevelopment in Clendon, which is an area with a high rate of at risk population for diabetes. LBD would work with HNZC, MCC and Counties Manukau Sport to redevelop Templeton Park into a prototype neighbourhood 'activity park', designed to support an increased level of family/community based physical activity.

Initial consultation had already been completed by HNZC. It was intended that the physical upgrade would be completed during 2005/2006, with a number of agencies contributing resources.

2005/2006 KPIs

- By May 2006, physical upgrade of park completed and evaluation of usage and community response undertaken to guide LBD's operational plan 2006/2007.

Progress

In October 2005, the initiative was on track and a consultant had been chosen to design the upgrade of Templeton Park in Clendon. Work towards forming a partnership with MCC and HNZN had also begun. In December 2005, a community consultation day was held with residents of the Templeton Park neighbourhood to gain baseline information on park usage and an understanding of what they would like to have in the park.

By March 2006, two meetings had been held with the design group to discuss priorities and draft the concept plan. By April 2006, the park designs were at an advanced stage and LBD was seeking to invest in the construction of an activity circuit.

In June 2006, the completed park design was presented to the Community Board. During this period the land swap also occurred. CMDHB funding continued for 2006/2007 in order to support design implementation. An issue was highlighted by MCC councillors who were concerned about 'over' investment and risk management plans.

3.2 Undertaking health impact assessments of major planning initiatives in Counties Manukau.

2005/2006 KPIs

- A prototype health impact assessment undertaken in collaboration with MCC.
- Submissions made within specified time frame.

Progress

In August 2005, CMDHB, MCC and ARPHS had met to discuss their respective roles and how collaboration was to occur. By October 2005, discussions had been held with ARPHS regarding this work and they were investigating areas to focus on for Health Impact Assessments (HIAs). By December 2005, Mangere Town Centre had been confirmed as the site for the HIA.

The initial workshop for the Mangere Town Centre Growth Plan was held at the Cosmopolitan Club on the 7 February. Council staff and community representatives were involved in the scoping, which was funded by ARPHS. Pershore Precinct was identified as a focus area. The community stakeholder workshop and draft report were planned to be completed by the 30 June 2006. Council support for the HIA were reported in presentation to a PHA conference, 'working with local government' in Palmerston North on the 4 July.

3.3 Providing advice on Flat Bush development

ARPHS would, on LBD's behalf, provide advice to MCC in terms of the healthy community's aspects of the Flat Bush development.

2005/2006 KPIs

No Key Performance Indicators were provided within the Operational Plan 2005/2006.

Progress

By October 2005, the initiative was on track and had been discussed with the Environmental Health team at ARPHS. By March 2006, the Flat Bush Community Development plan was made available for public comment. Public workshops were held on the 14 and 15 March, for finalising in June 2006.

3.4 Advocating for health

ARPHS would, on LBD's behalf:

- Write submissions and lobby on public transport and active transport infrastructure issues, especially in relation to Eastern Corridor transport links.

ARPHS and LBD would work with MCC to ensure access to, and opportunities for, physical activity and recreation services were enhanced. This included:

- Free access to recreation facilities and swimming pools;

- Safe cycling paths, walkways and pedestrian crossing, particularly around schools; and
- Safe parks.

2005/2006 KPIs

- Submissions made within specified time frames.

Progress

By August 2005, discussions had been held between CMDHB, MCC and ARPHS regarding their respective roles and how they were going to work together. On 6 December CMDHB presented an oral submission to MCC on its neighbourhood parks management plan. Key points made were the need for policy to support community and family physical activity. The submission was well received, with the hearing committee saying that it was inspirational.

In March 2006, a meeting was convened between CMDHB, CM Sport, ARPHS, HNZC, Manukau City Council and Papakura District Council representatives to discuss activities in this work-stream in 2006/2007. The draft programme was detailed in a separate report to the PSG. A supporting activity to this initiative was the MCC Healthy City Survey of Mangere pool users to identify barriers to cycling access. Additional activities included the Bikewise week activities from the 1st to 3rd of March, such as 'Bike to Work Day', Pohutakawa coast ramble and Manukau on the Move. A Rotary project launched a children's cycleway at Lloyd Elsmore Park.

By June 2006, it was noted that a large proportion of the Green Prescription Area Manager's work was involved in ensuring access to facilities for high needs groups beyond the Green Prescription and that there was the potential for better linkages here. During this time, MCC's CPTED strategy for Council was in progress and on the 20 June EOI had submitted an application for 'Active Communities' to SPARC.

Action Area 4 – 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

The Food: Health Joint Initiative Group was to be comprised of members from both the food industry and health sector.

2005/2006 KPIs

- By July 2005, Food:Health Joint Initiative Group (JIG) consolidated.

Progress

By August 2005, the Joint Initiative Group (JIG) had been consolidated, with the first meeting on 15 August also doubling as an interview for a co-funded position. By October 2005, the group was operational and had presented to the MOH and other health representatives on the CMDHB food industry initiative.

On the 30 November, a JIG meeting was held to consider the draft detailed action plan/work programme for 2005/2006. JIG agreed to seven of the nine proposed initiatives, with the co-funded advocate for JIG to work on the remaining two. JIG then prioritised the initiatives. By June 2006, a number of additional projects were identified to be reviewed at the next JIG meeting which was planned in August.

4.2 Co-funding of an advocacy position to develop and implement the joint Food:Health work programme.

The Advocate for JIG would develop a strategy that was to include high-level strategic initiatives as well as local initiatives such as working with ARPHS and MCC to improve fast food cooking practices and environments; and support the vulnerable families Action Area of LBD.

2005/2006 KPIs

- By August 2005, co-funded advocacy position employed.
- By October 2005, detailed strategy completed and agreed by Joint Initiative Group.

Progress

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 (linked to LBD 4.3; 4.4; 7.9)

The aim was to achieve a reduction in the consumption of full-sugar sweetened soft drinks by encouraging the conversion to less energy-dense alternatives.

2005/2006 KPIs

- McDonalds Trial commenced by December 2005.
- If deemed successful, plan progressive substitution or addition of other low-energy variants by March 2006.
- Other Quick Service Restaurants (QSRs) progressively on board from February 2006.
- Retail outlet trials commenced from April 2006.

Progress

By March 2006, the results from the McDonalds trial were being evaluated by the SoPH, who had developed an evaluation protocol for the project. Approaches had also been made to Burger King and Subway and JIG were seeking a retail partner for the merchandising trial. By April 2006, meetings had been secured with Restaurant Brands and Burger King to discuss the project. Progressive Enterprises was also considering a proposal to test a new merchandising layout of their soft drink section.

By June 2006, discussions between McDonalds and the SoPH had proven the success of the project. Based on these findings, discussions continued with other QSR's and it was intended that appropriate data from the trial would be released to give them confidence with their own initiatives.

Discussions also continued with major supermarkets in the area to trial merchandising layouts giving greater prominence to low energy drinks. It was noted that this would probably occur as part of the Social Marketing plan where communications around the benefits of low energy

drinks will need to be supported by changes in the retail environment. This had been successful with McDonalds and would be used as a template for other QSR's.

4.2.2 White Milk Programme

The aim was to create a retail environment that actively encourages customers to purchase lower-fat white milk in preference to the full-fat product.

2005/2006 KPIs

- Proposal for retail consideration developed by the end of February 2006.
- Proposal presented to retail by March 2006.
- Trial commenced by May 2006.

Progress

In March 2006, a meeting was held with Fonterra to review options for the initiative. JIG also received a positive response from a meeting with Progressive Enterprises and awaited their decision. It was noted that Milk suppliers claim that there is active support for lower fat milks in their existing marketing plans. It was intended that 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.

4.2.3 Healthy Kai Project (linked to LBD 4.5)

The aim was to review and provide recommendations to JIG and ARPHS as to the future direction of the 'Healthy Kai' project.

2005/2006 KPIs

- Review of existing programme completed by February 2006.
- Review presented to key stakeholder groups by February 2006.
- Agreed recommendations implemented from April 2006.

Progress

In March 2006, an internal review of the programme was completed. By June 2006, a series of workshops had been held with the Otara Healthy Kai group to allow them to develop both a strategic and annual plan. This was to be presented in mid July 2006. From here, small teams would be formed to implement key Action Areas in the agreed plan. Leadership would require the DPT, ARPHS and Otara Health on the Otara plan.

Several meetings were held to consult stakeholders and the strategic plan was discussed and a draft action plan was developed. The need for capacity building for the Otara Building Association to support Otara Healthy Kai was promoted to the Town Centre revitalisation team at MCC. It was noted that there is limited MCC resources to support the Healthy Kai project and develop a transferable model, even though there was good support and synergy with the Town Centre.

4.2.4 Healthy Food Parcels (linked to LBD 4.5; 9.5)

The purpose of this initiative was to explore ways in which the food industry could assist food parcel providers to offer healthy, well balanced and nutritious products for the most vulnerable families in the district.

2005/2006 KPIs

- Review completed by February 2006.
- Review presented to manufacturers, importers and suppliers by March 2006.
- Action plan developed and supported from May 2006.

Progress

By March 2006, the nutritional evaluation of current parcels was completed and the proposal for a central distribution system was tabled. In April 2006, a key meeting was held. The proposal to model Western Australia's approach was tabled and was to be discussed by key stakeholders.

By June 2006, the hub and wheel approach of centralised parcel production for distribution by local providers was accepted and a meeting with key stakeholders was planned for July. It was

noted that there was a need to develop a brief business plan to present to the Food Industry for consideration regarding ongoing donations and subsidised prices on key parcel components.

4.2.5 Healthy Canteen Business Model Pilot (LBD 7.7)

The aim was to provide practical advice, support and assistance to the 'Healthy Canteen Pilot' that was trialled at Tangaroa College. Advice, support and assistance was to include the sourcing, merchandising, pricing and promotion of a healthier school canteen menu.

2005/2006 KPIs

- Pilot implemented by the start of the first term 2006.

Progress

By March 2006, the tuckshop trial at Tangaroa had opened on new premises, with healthier foods being sold. Financial consideration was being looked at to see the viability of the tuck shop. Advertising of the food was also being examined. Combination meal options were being discussed as well as the possibility of pre-ordering of these meals. The initial results of uptake for the new menu were positive.

By April 2006, work by the DPT was progressing well for the tuck shop. Discussions were still being held with food providers on healthier options and food companies were very happy to be working on the project. A review of prices and the cost from food retailers was being conducted. After this, the menu and the pricing of the 'Kai Kombo' structure was finalised and the design layouts for the menu merchandising was completed. Within CMDHB, the final round of consultation was underway and there were plans to disseminate all CDs to schools in June 2006. There were also an additional eight decile one and two schools who will be implementing the Tuckshop model over the next year.

By June 2006, the project was completed with plans to install a cash register with sales recording facilities to undertake simple tracking of sales by item and category.

4.2.6 Healthy, Active Workplaces (LBD 1.6)

The purpose of this initiative was to support LBD's healthy, active workplace initiative by encouraging food industry employers to enrol and participate in an existing workplace programme, Heartbeat Challenge (HBC).

2005/2006 KPIs

- Review completed by 2006 and presented to CMDHB and ARPHS for consideration and endorsement.
- Advice and support provided to ARPHS when and as required.

Progress

By March, work had begun with an ARPHS own internal review. A review meeting with LBD management was completed by April 2006. By June 2006, a potential pilot company had been identified to participate in a documented trial which could then be presented to other businesses. Work with ARPHS continued as required.

4.2.7 Social Marketing Programme (LBD 2.4; 2.5)

To provide marketing expertise and resources to the development and implementation of LBD's social marketing and communications strategy to ensure that it achieved its goals.

2005/2006 KPIs

- Review completed by February 2006 and presented to CMDHB and ARPHS for consideration and endorsement.
- Advice and support provided when and as required.

Progress

By March 2006, a review of all phases of the proposed programmes with the Social Marketing team, Think Space and FCB commenced. In April 2006, the work with the Social Marketing Manager and Project Manager 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

To evaluate the feasibility and possible mechanics of a card or stamps based system to reward healthier retail (food initially) purposes.

2005/2006 KPIs

- Present feasibility report to JIG for consideration by August 2006.

Progress

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.

4.2.9 Communications on Initiatives

To explore ways in which the community of Counties Manukau could be informed on and kept up to date on food industry initiatives that support improved health outcomes.

2005/2006 KPIs

- Strategy presented to JIG for consideration by April 2006.
- Agreed recommendations implemented from May 2006.

Progress

By March 2006, the Australian Food and Grocery Council model for the web site was presented to food industry partners for consideration. By June 2006, the newly appointed Executive Director of the FIG was charged with implementing 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

2005/2006 KPIs

- By October 2006, draft work programme for 2006/2007 presented to JIG for endorsement.
- By October 2006, implementation of work programme for 2006/2007 commenced

Progress

On the 30 November, a JIG meeting was held to consider the draft detailed action plan/work programme for 2005/2006, which was presented by the JIG advocate. JIG agreed to seven of the nine proposed initiatives, with the JIG advocate to work on the remaining two. JIG then prioritised the initiatives for the advocate to allocate his time accordingly. By June 2006, a number of additional projects were identified to be reviewed at the next JIG meeting which was planned in August.

Action Area 5 – Strengthening Health Promotion Coordination and Activity

5.1 Consolidating a leadership hub for the health promotion action area

The leadership forum would provide guidance for, and lead, the health promotion action area. The forum was to be comprised of health promotion leaders, Primary Health Organisation's (PHO's), community-based and ethnically diverse.

2005/2006 KPIs

- By August 2005, leadership hub convenes.

Progress

By August 2005, CODA had been identified as the leadership hub for this Action Area. At the CODA meeting on 31 August, although PHO representatives were not present, it was proposed that CODA would become the leadership hub, working with PHO groups, and would meet on a regular basis, every six weeks or so, to consider LBD matters. The group were supportive of the concept and planned to develop the terms of reference prior to the next meeting, to be held on 12 October. A letter was sent to all identified organisations informing them and asking them for their support.

During November 2005, members of CODA contributed significantly to activities as part of the national diabetes awareness week that ran from 22 to the 28 November, including the LBD community walk. During December, one CODA meeting was held which discussed resource development, joint planning of initiatives, competencies and a community screening tool upgrade. The documents indicate that during this period, CODA had around 60 members on record and an average attendance of 15 to 20 members per meeting.

During the beginning of 2006, CODA continued to meet on a regular basis, providing input to 2005/2006 projects and the 2006/2007 operational plan. The 2006/2007 operational plan increased funding to enhance the role of CODA and provide increased leadership in a number of areas. A key issue during this period was the need to ensure that there was continued growth in the recognition of CODA as a forum for leadership in this area.

5.2 Supporting aligned actions through better coordination of the funding environment

To support funder organisations for health promotion in Counties Manukau and to meet annually to share information on funding allocations and strategies as they relate to diabetes risk factors and disease management.

2005/2006 KPIs

- By February 2006, health promotion providers have entered programme summary information in Qipps and made it available to all.
- By March 2006, funders meet to discuss funding allocations and strategies for 2006/2007 year.

Progress

In August 2005, a meeting was held with a representative from the Ministry of Health, who supported holding an annual meeting. The first funder meeting was held in February 2006 with attendance from all parties except education, who gave their apologies. A second meeting was arranged for March to discuss Active Communities and ARPASS.

MCC 2007 -2016 budgets for Advocacy and Programmes for Health were aligned with LBD objectives. There was also joint planning for the Active Communities funding application and

reports to the Council committees were to proceed with the application. Another meeting for the Funder Forum was planned for the 27 April to discuss the Auckland Regional Physical Activity Strategy and Active Communities.

5.3 Improving capacity of the health promotion workforce.

To improve capacity a number of initiatives would take place. These ranged from developing an email or web-based information network, to identifying and providing training for core competencies and developing best practice guidelines.

Capacity development also needed to have a focus on supporting Maori and Pacific health promoters and ensuring mainstream health promoters had good skills to provide quality services for Maori and Pacific peoples.

2005/2006 KPIs

- By September 2005, email and web based network of health promoters in place and operational.
- By March 2006, health promotion core competencies identified and developed to enable training to proceed.
- By May 2006, training in core competencies begins and formal training in mainstream educational institutions ready to proceed for the second quarter of 2006.
- By 30 June 2006, develop best practice guidelines for health education and promotion resources for Pacific populations.

Progress

In August 2005, CMDHB were in discussions with a website design provider to design a site which would meet the needs of the sector, Action Area and the wider LBD plan. On the 4 August, CMDHB EMT agreed for LBD to approach a third party to design the website. Black Sheep, an IT organisation, were contracted and their brief was to design a website that is the central information and communications site for LBD and has the capacity and capabilities to allow health promotion providers, in areas such as nutrition and physical activity were able to register their services and self-post what programmes they are running, where, when and if any costs are involved. These programmes could include workshops, training, events or consultations. The website was due to be operational by 28 October, with more features phased in at a later date.

During this period a meeting was also held with ARPHS to discuss using ARPHS health promoter competencies (9 skill areas); developing further competency in physical activity and nutrition messages; consulting with stakeholders; and identifying training needs. By September, a provider had been identified and the initial scope was completed. The provider was involved in an ARPHS project to develop competencies and training for its workforce and also in the national project around health promotion workforce competencies. CODA expected to be fully involved in the development of these competencies.

A consultant was contacted to work with the DPT, to pull together a 'toolkit' or 'basket' of basic resources suitable for the industry. CODA would provide direction to the project and provide access to consultation. The project would be coordinated with the Social Marketing Action Area.

By October 2005, the provider had presented her plans to the LBD project group and CODA, which were well received. An issue that was identified during this time was that training needed to be identified by June 2006 and consultation had to take place with providers. However, it was acknowledged that educational institutions typically needed much longer to alter course design or develop new courses.

By December 2005, the website was up and running with plans to update it on a regular basis. Further enhancements to the website would be made to support the Social Marketing strategy. During this time, wide consultation occurred with stakeholders to develop an initial draft of competencies for the health promotion workforce and to identify existing training packages and gaps.

By March 2006, a resource section still needed to be developed for the website and a decision needed to be made regarding what resources would be best and what other tools and information could be relevant.

In April 2006, the first draft of competencies was presented to CMDHB and underwent consultation with stakeholders, however the initial report on workforce training still needed to be presented. By June 2006, the final competencies and report were received and development of a plan for implementation of these competencies commenced.

Funding was received from the Ministry of Health for an entry level training course in health education and promotion as well as for mentoring and peer support for people who have attended Maori and Pacific train-the-trainer courses.

During this period, a number of supporting activities occurred within MCC. The MCC Health Promoting Schools Programme was revised in consultation with principals and teacher training days that were provided for a number of identified health action priority area. Te Ora o Manukau – Manukau the Healthy City communications system and planning was revised and the newsletter was aligned with MCC communications planning, with an emphasis on promoting collaboration, advocacy and training opportunities. Revision of the MCC website included community and health/wellbeing promotion activities of Council. There was also Council support for ‘Getting Started’, with Otara Health and an evaluation project was conducted to inform staff and service delivery.

5.4 Improving communications resources for diabetes for use within health promotion and primary care.

To improve communications resources for diabetes a number of initiatives took place. These included:

- Undertaking a gap analysis for core diabetes communications resources for use in health promotion, obesity management and diabetes disease management.
- Updating and developing resources as required.
- Develop culturally appropriate resources for Maori and Pacific communities.

2005/2006 KPIs

- By September 2005, agreement on hosting, distribution and marketing of communications resources responsibilities within Counties Manukau.
- By October 2005, gap analysis for communications resources completed and agreement on initial resources for upgrade or new development.
- From November 2005, upgrade of resources using best practice processes undertaken and based on evidence and literature review appropriate to each target (e.g. Maori and Pacific populations).

Progress

In August 2005, a meeting was held with ARPHS to discuss development of a core basket of resources, identifying gaps and marketing of these resources; however there was uncertainty over staff availability. By October 2005, scoping had been done, which was supported by the DPT. CODA members were involved in the preliminary work and clarifying the outcome of the project was being done. The contract was also scaled back to developing a basket of resources for two focus areas; new diabetes and adults at risk. It was proposed that when this was completed recommendations for additional work, such as resource development, would be considered and contracted separately.

By December 2005, consultation was occurring on two basic draft packages that were in English – one for individuals at risk of developing diabetes and the second for individuals with diabetes. Through consultation with the Maori and Pacific Action Areas of LBD, more suitable versions would be developed for these groups. By March 2006, the report on health promotion resources had been delivered. A number of further investments were also identified and discussed with providers, including the distribution of resources; completion and production of three resources; and the translation of resources.

By April 2006, the resource project was completed and planning for producing packages to be delivered later in 2006 was underway. Development of a proposal for distribution and ongoing support of the resources commenced. By June 2006, LBD had contracted DPT to complete resource suite development, delivery and promotion to users. ARPHS also agreed to stock resources for ongoing supply and pamphlets and other resources for the suites had been sources. The Green Prescription Manager provided a Green Prescription brochure and insert for the compendium.

Action Area 6 – 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.

The existing forum of Well Child providers agreed to be the leadership hub for the LBD Well Child action area, and to oversee its work programme.

2005/2006 KPIs

The Operational Plan 2005/2006 did not identify any Key Performance Indicators for this initiative.

Progress

A Well Child provider organisation meeting was held in December with discussion held around ways to enhance Well Child Services. Key points from providers included:

- User friendliness of the Well Child book.
- Dental cavities – changing from fizzy drinks and orange juice.
- Weight – proportional growth and head circumference.
- Breastfeeding – early discharge, not enough support or education, mothers working, incidence of breast infections.
- The need for the promotion of physical activity and healthy eating.

By July 2006, the leadership hub was in place.

6.2 Supporting the professional review of Well Child framework.

The review of the Well Child assessment tool would include assessment for diabetes and/or childhood obesity risk factors. The review also looked at knowledge and resource provision for parents relating to appropriate nutrition and physical activity needs for growing children. Further action was to be determined by the outcomes of this review.

2005/2006 KPIs

The Operational Plan 2005/2006 did not identify any Key Performance Indicators for this initiative.

Progress

In September 2005, a paediatrician was identified to undertake the review and service specifications were under development. By October 2005, the specifications for professional review were completed and referred for implementation. In December 2005, work began on

developing a report with recommendations on ways to enhance Well Child services to reduce childhood obesity in the first 5 years of life.

In February 2006, the review and the recommendations were completed, peer reviewed and presented to the Well Child leadership hub for guidance on implementation. The initial findings from the review were presented to GM Pacific and Well Child Managers in April 2006. Utility of an obesity assessment tool for the 0 to 5-year-old age group was discussed and conclusions from this meeting would inform the work programme for 2006/2007.

Action Area 7 – 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.

Counties Manukau District Health Board (CMDHB) Maori Health intended to develop a partnership relationship with Te Kohanga Reo Regional Unit to work together to support education and health outcomes for tamariki (children).

2005/2006 KPIs

- By September 2005, contracts for provision in place.
- 70% of kohanga in Counties Manukau have nutrition and physical activity guidelines and programmes
- 70% of kohanga in Counties Manukau have received training
- 70% of kohanga are linked to local health providers

Progress

When the initiative commenced in August 2005, CMDHB identified a number of potential providers but needed to ensure that the initiative was aligned with ARPHS for a coordinated approach. There were some timing issues around meeting with ARPHS to discuss the approach to activity before it started. As kohanga reo is a national organization it was also decided that discussions at a national level would need to occur in order to understand what current policies and practices were.

Due to this issue, in March 2006 a stock-take was conducted to determine how support could be offered to the tamariki within kohanga reo. It was hoped that this process would highlight where gaps and needs existed and where support could be offered. A Maori Nurse was seconded to conduct this stock-take.

By June 2006, a number of different activities had taken place within kohanga reo. He Oranga Poutama Kaiwhakahaere had supported Yandera ECC to hold an inter-kindergarten Sports Day using traditional Maori games. The Sports Day had 300 participants including whanau and tamariki. These traditional Maori games were also taught to the Active Schools Coordinator and 5 ECC. Tikanga o Te Ngahere Wananga was delivered to 8 kohanga reo teachers and the Counties Manukau Sport Active Movement Coordinator. Finally, training on appropriate tikanga for working with Maori was provided to Active Movement.

A supporting activity that occurred during this period was the national roll out by SPARC of the MCC, MCC Leisure Planner, SPARC and Manukau Kohanga Reo partnership development of a model for physical activity promotion.

7.2 Supporting Pacific Language Nests to enhance or develop and implement nutrition and physical activity guidelines and programmes as part of programme delivery.

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

2005/2006 KPIs

- Partnership relationship established.
- By September 2005, provider(s) contract in place.
- 100% of Pacific Language Nests in Counties Manukau have nutrition and physical activity guidelines and programmes.
- 100% of Pacific Language Nests in Counties Manukau have received training.
- 100% of Pacific Language Nests are linked to local health providers.

Progress

In August 2005, CMDHB had identified a number of potential providers but needed to ensure that the initiative was aligned with ARPHS for a coordinated approach. There were some timing issues around meeting with ARPHS to discuss the approach to activity before it started. 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. From this meeting, it was agreed that the development phase of the project would take place from October to December 2005 with implementation of the nutrition sessions to begin from January to June 2006:

- A total of five nutrition sessions would be held for each group which would target the ‘decision makers’ within the ECE – which are likely to be the cook, coordinator, teachers, administrator and parents;
- In terms of implementation, the running of the courses would be divided between TaPasifika and ARPHS and that this would be done on an ethnic basis; and
- As part of the evaluation process, a baseline data set will be completed before January 2006. CMDHB would work with the School of Population Health to progress this.

In December 2005, CMHDB, ARPHS and TaPasifika were involved in developing and completing the session plans. The scoping of resource development also began however this was contingent on the session planning. The teaching resource that was developed was named ‘Kai Lelei’ (eat well). It was intended that this resource would also be used for Action Areas 1.4 and 1.5.

By March 2006, the workshop session plans and resources were complete and at a final draft stage. It was planned that session delivery would take place from April to June 2006. It was also decided that it session plans and resources would be used as part of the Action Area 1.4 and implemented in Church Sunday Schools. By April 2006, the Kai Lelei resource was in the final stage of development. The School of Population Health evaluation team had also been approached to become involved in evaluating the use of the resource within the Pacific Language Nests and Sunday Schools.

By June 2006, the Active Movement Coordinator had provided information, training and support on Active Movement to a number of language nests, including: Te Reo Rarotonga; Tama Ale Eleele A’oga Amata; and Tu Manu Ae Le Tulogologo. Professional develop on Active

Movement was also provided to the South Seas Health Care Well child providers and workshops were run for AUT Pasifika early childcare students at the AUT Manukau campus.

7.3 Supporting Kura Kaupapa to enhance or develop and implement nutrition and physical activity guidelines and programmes.

CMDHB Maori Health intended to develop a partnership relationship with Kura Kaupapa (kura) to work together to support education and health outcomes for tamariki.

2005/2006 KPIs

- By September 2005, contracts for provision in place.
- 70% of Kura in Counties Manukau have nutrition and physical activity guidelines and programmes.
- 70% of Kura in Counties Manukau have received training.
- 70% of Kura are linked to local health providers.

Progress

By March 2006, it was determined that the initial approach to support health outcomes for tamariki in this area was to undertake a stock-take of current services and get a sense of what the gaps and needs were for Kura. An initial key issue was offering training to the kaiako (teachers) and the parents of tamariki and developing resources completely in Maori. SPARC also developed resources in Maori for under-fives.

A specifically designed training workshop began to train more workers within Kura to enable them to implement nutrition and physical activity knowledge immediately within Kura Kaupapa. A member on the Executive for Kura completed one of these training sessions and was eager to take these messages back to the organisation. This would require further meetings and negotiations.

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. Funding opportunities were provided to Te Kura Kaupapa o Manurewa, Te Kura Kaupapa o Mangere and Te Kura Kaupapa o Piripono.

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.

The aim was to maintain the existing schools working group and develop it into a sustainable leadership hub for the schools Action Area. From this hub an explicit strategy would be developed to plot year on year actions required to improve the nutrition, physical activity and education environments in all Counties Manukau schools over a five year period.

2005/2006 KPIs

- By August 2005, school leadership hub convenes.
- By January 2006, explicit medium term strategy completed and supported by the MOH, SPARC and MOE.

Progress

In August 2005, an Action Area leader was appointed. Although CMDHB had hoped to present its proposal to the national tripartite government group in November 2005, more time was needed until the beginning of 2006.

On the 8 November 2005, the Ministry of Health presented the Fruit In Schools (FIS) concept to DHBs. Each region was given the responsibility for identifying which schools would be included in the programme, with the requirement that there be a defined number of students (1040) and schools (2-3) involved with each cluster, and supporting the initiative. On the 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.

This criteria included: their HPS status; previous engagement with health, sport, physical activity and personal health issues; school food programme; and 'clusterability'. The following clusters were identified:

- Cluster 1 (1190 students): Nga Iwi (476 students), Rongomai (250 students) and Wiri Central (464 students);

- Cluster 2 (970 students): East Tamaki (327 students), Wymondley (197 students) and Sir Edmund Hillary College (383 students); and
- Cluster 3 (1081 students): Papakura (148 students), Roscommon (568 students) and Ta Maturanga (365 students).

Total number for Clusters: 3241

It was also agreed that CMDHB HPS would lead the discussions with the nine schools and actively involve the people who provide service within these schools. The timeframe for sign off was for 8 December, when a proposal to the Ministry of Health with sign off from school board had to be completed. CMDHB HPS and Manukau City Council HPS would also meet and discuss the coordination preferred arrangements, given that there are two HPS providers in CMDHB. CMDHB would retain 1.5 coordinators and ADHB would have 0.5 coordinators. Both would sit within their HPS contracts and network and coordinate between each other.

On the 1 March 2006, a Schools Accord strategic meeting was held with all of the involved schools with the Ministry of Education and SPARC invited to participate. There was a clear direction forward with schools leading the initiative and providers supporting this initiative. In April 2006, the leadership hub met and endorsed the School Accord plan and the Leadership terms of reference.

By June 2006, Counties Manukau Sport was represented within the Leadership hub by Mike Truman, the CMS Education Development Manager. A Schools Accord Coordinator was in the process of being selected. MCC Health Promoting Schools principals' were supported to evaluate the 'Moove and Groove' product, which is aligned with the health and physical activity curriculum objectives being adopted in the Manurewa cluster.

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).

The purpose of this initiative was to develop an awareness/educational strategy for all school leaders that highlights the importance of the 'fit, healthy and ready to learn' message. The awareness/education programme was likely to have many strands including social marketing/existing schools providers and specific programme for LBD.

2005/2006 KPIs

- By November 2005, all schools contracted in initial communication.
- By June 2006, 20% of schools receive dedicated educational visit for principals and trustees.

Progress

By October 2005, it was decided that this initiative was on hold while the proposal was put to the tripartite group. LBD presented on the Counties Manukau situation and the need for high level tripartite support and resources. LBD also highlighted the opportunity to see Counties Manukau as a national demonstration site for schools and health.

By April 2006, the time frame for the position paper had been extended until June. This paper would identify the importance of nutrition and physical activity and their impact on educational outcomes. Following that, it was intended that regular monthly newsletters would be provided in conjunction with the Social Marketing group. 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 aim was to support the existing NEW/AIMHI programme in selected high risk secondary schools (Sir Edmund Hillary Collegiate, Southern Cross Campus, Mangere College), and align it to, and collaborate with, the University of Auckland (UOA) OPIC study for a co-ordinated approach to interventions across the three schools.

2005/2006 KPIs

- By August 2005, negotiations with University of Auckland/OPIC about design and funding completed.
- By September 2005, contracting with Diabetes Projects Trust (the existing provider) for enhancements completed.
- From February 2006, enhanced interventions delivered, some are likely to start earlier.

Progress

In August 2005, CMDHB began negotiations with the School of Population Health (SoPH) regarding collaboration and a way forward. CMDHB also made a commitment to extend the DPT contract to December 2005. By September 2005, a formal negotiation and agreement still needed to be reached with the OPIC team. The NEW Adolescent obesity prevention project continued to be delivered in Mangere College, Southern Cross Campus and Sir Edmund Hillary Collegiate by DPT. A meeting was planned for the 12 September to attempt alignment. While this happened, two postgraduate students from the SoPH worked on evaluating the current NEW programmes in absence of an OPIC agreement.

By October 2005, the 'GetWize2Health' programme was drawing to a close in three of the schools. Planning had commenced for the 2006 school year, with an extended service being offered to include a 'broader school approach'. There had been no contact from the OPIC group. By December 2005, the 'GetWize2Health' programme in three AIMHI schools had finished for 2005. Negotiations took place with principals and staff to plan for 2006 and to determine a new 'whole school approach' to interventions.

During this time the evaluation of the programme for 2005 was conducted. A series of meetings were also held with the OPIC study team to discuss and confirm working relationships. OPIC confirmed that they were not part of LBD or contributing to the evaluation of the above initiatives, therefore, there was no obvious overlap between their and LBD's funded interventions. However, given that both parties were working in the same schools, they agreed to keep each other informed and communicate on a regular basis.

By March 2006, all NEW contracts between CMDHB and schools were completed and underway. Within the DPT, all three schools were up and running with educational programmes and physical activity sessions in progress. All schools were involved in negotiations about new interventions for 2006.

In April 2006, the DPT 'GetWize2Health' programme was working well in three schools, with the enhanced programme set up in one school. Teaching sessions on healthy living and diabetes prevention were being planned with Year 11, 12 and 13 students. A Parents evening at one of

the other schools was also supported by the DPT. Within CMDHB, further developments were approved to extend the NEW model in a smaller form to all decile one and two schools.

By June 2006, the enhancement of the programme in the three schools was commencing and well accepted. Additional decile 1 and 2 schools were in negotiations and the package would include implementation of the tuckshop package. Funding had been sourced from the MOH for the development of a self implementation package for high 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. During this time, 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.

A one day workshop was also delivered to 15 students at Mahi Tuna Wananga about traditional Maori games, cultural identity and participation. There were also Kura representatives at the Captains workshop and Sports Ambassador training.

7.7 Trialling of the 'healthy canteen' business model

The 'healthy canteen' business model was to be communicated to secondary schools during 2005/2006 to provide a tool for the development of healthy tuckshops in schools. It was trialled at Tangaroa College.

2005/2006 KPIs

- During 2005/2006, healthy canteen business model information trialled at Tangaroa College.
- During 2005/2006, healthy canteen model promoted to all secondary schools in Counties Manukau.

Progress

In October 2005, the draft model was nearly ready for the final round of extensive consultation and trialling in Tangaroa. A workshop was held on 5 December 2005 with key stakeholders to review contents and make recommendations. The whole document was well received by those present and excellent recommendations were made.

During December, preliminary 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. The anticipated date for the release of model was May 2006, however, by June 2006 the documentation of the Healthy Tuckshop model was still in the final stages of completion. A menu discussion, pricing of foods and combos and the creation of display boards had all been completed.

During this time, MCC Food in Schools report to the Child Advocacy Group and Community Development committee was presented. This included a partnership developed with Red Cross and discussions with Auckland City Mission. A report was also made to Te Ora o Manukau, the Health City Outcome group.

7.8 Developing new funding streams to support schools to make sustainable changes.

It was acknowledged that the scope of the changes required in the school environment is larger than LBD resources can support – and there appear to be few other direct resources available at present from other sources. LBD would investigate other funding sources to support schools to make sustainable changes.

2005/2006 KPIs

- By September 2005, SPARC funding application completed in collaboration with CM Sport.
- By November 2005, funding/sponsorship approach with South Auckland Heart Foundation (SAHF) support completed.

Progress

In December 2005, CMDHB, MCC and CM Sport were working on an ‘expression of interest’ for SPARC’s Active Community Funding, which will help this initiative. The application was due in February 2006; however the SPARC funding bid was deferred to later in 2006. An Expression of Interest was then planned to be presented to SPARC in late March; as a collaboration between CMDHB, CM Sport, Procure Manukau, MCC, Papakura District Council and Franklin District Council.

7.9 Supporting schools to improve ‘drinks’ environment in and around all schools.

The aim of this initiative was to work with principals and the Food Industry to reduce access to sugar drinks on schools premises, while also working with Food Industry to reorient advertising and displays in the schools environment and vicinity to promote non sugar drinks.

2005/2006 KPIs

- By October 2005, approach agreed to with the Food Industry.
- By April 2006, action completed.

Progress

In October 2005, it was noted that the JIG advocate would take up this initiative as part of the Food Industry Action Area. By June 2006, sugary drinks in the pilot tuck shop were removed. Flavoured milk and orange juice were introduced in 250 ml containers.

Action Area 8 – 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.

A new advisory group was established to:

- merge previously separate diabetes and CVD groups;
- assume the responsibilities and accountabilities of the previous Diabetes Advisory Group (which is disbanded); and
- assume an expanded terms of reference that includes the previous CCM activity and the LBD primary care action area.

This advisory group (called DCAG) would provide advice on interpretation of evidence/analysis, programme design, implementation and performance. DCAG and its work programme would be managed by co-funded project management position.

2005/2006 KPIs

- By July 2005, new DCAG terms of reference completed.
- By August 2005, initial DCAG meeting.
- By September 2005, work programme signed off.
- From October 2005, DCAG monthly progress reports provided to GPHO.

Progress

The DCAG was established in September 2005 and the first meeting was held on the 7 September. The Terms of Reference were ratified at this meeting and it was planned that membership would be expanded to include more PHO representatives. Key issues that were discussed at this initial meeting were: the role of the DCAG; relationships with other groups; CVD and diabetes DSAG business; and the LBD work streams. It was decided that DCAG would meet monthly, with the second meeting planned for 12 October.

By October, the DCAG membership had expanded to include more PHO representatives. Various working groups were established to work on the initiatives within the Action Area. DCAG continues to meet on a monthly basis.

8.2 Developing a diabetes care framework for Counties Manukau

A model for implementing the NZGG Type 2 Diabetes guidelines was developed. It focused on a number of areas, from screening to management of people with complications, and identified key areas for improvement.

2005/2006 KPIs

- By November 2005, a Care model would be developed to cover all of diabetes (adapt WDHB model), with action recommendations.
- By February 2006, service provision process outlined and provider identified.
- By April 2006, recommendations implemented.

Progress

In October 2005, a student was identified to develop a diabetes care framework as part of his dissertation for a Masters of Public Health. He was seconded to LBD for 3 days a week from mid November 2005 up to the end of March 2006. Initial tasks included: a literature review of

relevant diabetes literature on coordinated care and integrated care in New Zealand, Australia and the United States; an assessment of CMDHB's diabetes services; and interviewing key stakeholders.

By March 2006, these tasks were completed and the student began to develop a model of care using a systems thinking approach. By July, the student was nearing the completion of his dissertation and was granted an extension by the University of Auckland to the 14 July. It was planned that the report would be presented to the DCAG in September 2006.

8.3 Improving use of brief interventions for modifying obesity risk factors.

This initiative developed, piloted and evaluated the use of a brief intervention in primary care setting, based on work undertaken by the Community Nutrition Project and the business case development for surgical and pharmacological interventions for morbidly obese people.

2005/2006 KPIs

- By July 2005, PHOs and Practice Nurses recruited.
- By September 2005, recruitment of clients weight management.
- By December 2005, evaluation commences.

Progress

By September 2005, a contract was in place with two PHOs, Mangere Community Health Trust and TKOH. Seventeen Trainers were recruited from these PHOs to undergo training by CMDHB nutritionists. It was intended that these trainers would provide the intervention to 200 patients.

The Community Nutrition Programme plans to align with the Ministry of Health funded DPT 'train the trainers to prevent diabetes', which includes brief intervention skills and other tools for effective delivery of activities aimed at changing behaviours. This programme has been underway since the end of 2003 and approaches the same health provider groups as the Community Nutrition Programme.

By October 2005, the training of 16 PHO trainers was completed. Support supervision of the trainees began and it was intended that this supervision would continue for five months. During this time, core competencies for trainees were developed and patient recruitment for the intervention commenced. A second training programme was conducted in December 2005, so that a total of 20 trainers had completed the programme. The recruitment of participants was delayed due to the need for ethics approval.

By March 2006, five trainees had dropped out of the programme due to job changes and early retirement. The recruitment of patients continued with approximately 85 enrolled participants. Initial core competencies for delivery of nutrition care were assessed during this time and a six-month post training knowledge questionnaire was completed. The programme evaluation also began in March 2006.

By April 2006, 20 trainees had been trained but only eleven of them were seeing patients in either an individual or group setting. During April, five more trainees completed the programme. Although it was intended that 200 patients would be enrolled with the programme, only 85 patients were enrolled with completed sets of data. A database was developed by the School of Population Health to collate patient data and responses to questionnaires as part of the programme evaluation.

By June 2006, ongoing support was still being provided for trainees and eight trainees had been reassessed for core competencies. Data from the six month trainee post-knowledge questionnaires and the initial baseline patient data were being analysed for the evaluation by the School of Population Health.

8.4 Improving uptake of best practice post-diagnosis education

This initiative would develop criteria for, and implement, a Diabetes Self Management Education (DSME) programme in primary care.

2005/2006 KPIs

- By November 2005, stock-take completed.
- By March 2006, delivery framework completed, with PHO buy in.

- By April 2006, training underway.

Progress

In August 2005, a SME working group was established with Jocelyn Tracey as the leader. In September 2005, Jocelyn Tracey presented the SME scoping paper to the DCAG. The proposed direction was approved and by October 2005 Jocelyn Tracey submitted the scoping paper to the CMDHB internal committees.

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. The original scoping paper was then redrafted to incorporate the Maori and Pacific SME activities already underway.

In April 2006, a project manager was appointed to liaise with PHOs as part of the SME initiative. A review of diabetes self-management material developed by WDHB was conducted to assess suitability for adaptation to CMDHB. In June 2006, a paper was presented to DCAG summarising the GPHO meeting and seeking endorsement on the following issues: a revised implementation time frame with a 1 November rollout for the delivery model parameters in terms of facilitator skills, location and access to SME group sessions; draft KPIs; and the concept of a PHO based SME Working Group as an effective support group for the Project Manager in this development and implementation phase. The DCAG agreed to these recommendations and also asked for a patient flowchart to be developed. A workshop with PHOs and other stakeholders was organised for 8 August 2006.

8.5 Trialling and evaluating increased use of family/whanau/group support for obesity risk factors and diabetes management.

It was intended that a provider would be contracted to run focus groups with people with diabetes and their families to find out what the pilot programme should include. A review was conducted on current information and literature on effective interventions and approaches to working with families centred care from minority and/or ethnically diverse groups and the workforce skills required to ensure safe family centred practice and resources to support this

work. From this, a survey would be developed aimed at people with diabetes (via Whitiara, CMDHB Maori and Pacific Health) to explore:

- Their perception of family risk
- Their ability to influence this risk
- Their ability and interest in taking this role
- And their needs for family support.

From this information, pilot programmes would be developed based around CCM families, with priority given to Maori and Pacific.

2005/2006 KPIs

- By March 2006, survey of 200 patients completed and report written.
- By 2006, pilot sessions run and evaluation completed.

Progress

In August 2005, a draft scoping paper was prepared to be presented to the DCAG on the 7 September. After presentation of the report, the preferred option was to use the \$20,000 funding on focus groups.

Initial discussions were held with Whitiara 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. In December 2005, a workshop was planned to consider a joint approach on all future activities and arrangements were made to contract a clinical psychologist with experience with diabetes services to undertake a formative evaluation of the Maori Diabetes Initiatives.

By March 2006, the SME Working Group was working with the Pacific team to develop proposals for the provision of whanau support for morbidly obese Pacific people and the Maori team in order to determine how the working group could support their diabetes initiatives. Through this collaboration, a proposal and service specifications for a Maori Whanau support pilot were developed. This was approved by DCAG and clinical staff were recruited for the pilot to begin in April. This hui was then rescheduled for 19 July, with a coordinator to work with a

replacement team member and psychologist to complete the outputs in the proposal. These included: developing a navigational tool; holding focus groups; and an analysis report.

In 2006/2007, this Action Area intended to focus on considering innovative ways to increase whanau/family/group participation within mainstream primary care. PHOs may be asked to submit proposals to implement suitable pilots in 06/07.

8.6 Investigating and developing a whole system approach to improving rate of diagnosed type 2 diabetes to expected population with diabetes.

A proposal was made that from 1 July 2007; there would be a proactive approach to support increased diabetes/CVD risk screening. This would be supported by social marketing and health promotion programmes.

2005/2006 KPIs

- By October 2005, DCAG makes decision in principle about Counties Manukau's approach to screening.
- By March 2006, design completed.
- By June 2006, implementation started.

Progress

Towards the end of 2005, a working group was established and met to discuss developing an issues paper to report back to the next DCAG meeting. In March 2006, CMDHB secured clinical resources to assess and cost the system changes required in general practice to implement the proposed screening model.

In April 2006, the Clinical advisor for Primary Care commenced work and met with a range of people involved in CVD and diabetes screening programmes. In June 2006, DCAG received and discussed the Clinical Advisor's report on implementing diabetes and CVD risk screening in primary care. It endorsed the following recommendations:

- Screening would be for CVD and diabetes;
- A mixed opportunistic and systematic recall approach would be used;
- A one-step programme may be viable for systematic screening but a multi-step programme may be necessary for opportunistic screening;

- Financial incentives may be useful although there appears to be no correlation between funding and success rates; and
- That workforce issues are significant and effect rate of change.

DCAG also endorsed the first draft of the CVD and Diabetes Risk Screening Implementation Guidelines.

Action Area 9 – Enabling Vulnerable Families to Make Healthy choices

9.1 Establishing a leadership hub for the Vulnerable Families action area

Strengthening Families Steering Group (SF) agreed to be the leadership hub for the Vulnerable Families Action Area to lead and drive the work programme. SF is an existing cross sector collaborative process for case management of vulnerable families, with multiple problems.

2005/2006 KPIs

- By July 2005, SF has officially incorporated LBD into its work programme.

Progress

By October 2005, the Vulnerable Families Action Area had become a standard item on the agenda for the SF Management Meetings. In March 2006, a meeting was convened of representatives from CMDHB, MSD and Strengthening Families to discuss the 2006/2007 work plan. By June 2006, Manukau City Council (MCC) and the MCC Child Advocacy Group were maintaining a child poverty focus in strategic planning.

9.2 Improving referral pathways

Development on areas for improvement relied on how Family Start developed.

2005/2006KPIs

No Key Performance Indicators were recorded within the Operational Plan 20052006 for this initiative.

Progress

In October 2005, the Family Start CEO was informed of the initiative and planned to develop outputs and referral criteria once Family Start had been operating for a couple of months. In April 2006, a meeting was held with CODA and Family Start to enhance communication between the two groups.

9.3 Enhancing Strengthening Families by including diabetes risk factors into review processes, with defined linkages and referrals to the health sector.

The aim of this initiative was to improve awareness and knowledge about the risks vulnerable low income families have in relation to obesity and diabetes, so that SF was able to build it into their existing case management programme. LBD would also support improved risk identification and referral pathways for appropriate support.

2005/2006 KPIs

- By 2006, obesity and diabetes prevention and management workshops facilitated for Strengthening Families.
- By 2006, resources provided and made available to Strengthening Families.
- Linkages and relationships between Strengthening Families and other related services such as Well Child and Family start established.

Progress

In September 2005, a provider to deliver the workshops had been confirmed. By October 2005, Strengthening Families had been under review and it was planned that once the new assessment forms for the case management were approved, the Diabetes Strategy/Vulnerable Families education and awareness would be built into the process. Referral pathways for appropriate support were also circulated to both the Salvation Army and the SF Coordinator for dissemination to their Family Support Workers and SF Facilitators respectively.

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.

LBD acknowledged that organisations such as the Salvation Army already had access to large numbers of vulnerable families through support networks and peer support systems, but did not have an awareness and skills about the importance of good nutrition and so could not pass on this information and knowledge to the families.

The Salvation Army’s existing parenting and mentoring programmes would be enhanced to include nutrition, obesity and diabetes prevention aspects; and its staff and volunteer workers would receive training to be able to provide nutrition, obesity and diabetes prevention aspects.

2005/2006 KPIs

- By November 2005, training introduced for Salvation Army staff and volunteer workers.
- By February 2006, in home education commences.
- By February 2006, improved triage and referral.

Progress

In September 2005, a provider to deliver the workshops had been confirmed awaited confirmation from Strengthening Families regarding the approach and dates. In October, a meeting was held with 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.

Training to existing parenting and mentoring staff would then commence on 27 October. By December, the workshops had been completed. An evaluation of the transferral of advice to the clients and their resulting behavioural changes was planned for.

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.

9.5 Ensuring food parcels are healthy, well balanced and nutritious.

It was identified that food parcels were not well prepared in terms of nutritious food being accessed by vulnerable families. LBD proposed to work with food parcel providers and the Food Industry to improve quality of food parcels. Healthy and appropriate recipes would be included in the parcels to inform/assist recipients.

2005/2006 KPIs

No Key Performance Indicators were recorded within the Operational Plan 2005/2006 for this initiative.

Progress

No progress had occurred within this initiative by October 2005, as it would follow on from the nutrition training provided. In December 2005, it was decided that this initiative would be done as part of 4.2 (JIG Work Programme).

Action Area 10 – 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.

It was acknowledged that a forum was required to provide guidance on in-hospital and integration issues relating to diabetes complications from involved specialities. This integration leadership group will have a complimentary role with the DCAG role.

2005/2006 KPIs

- From September 2005, leadership hub established and operational.

Progress

A discussion was held with the Clinical Board on 17 August 2005. In March 2006, it was acknowledged that the existing leadership group was not appropriate for progressing hospital

service integration. It was proposed that interested parties should be brought together to workshop ideas and develop the future model of care.

10.2 Developing Whitiora Diabetes Service's role as clinical centre of excellence and supporter of system-wide capacity development.

2005/2006 KPIs

- By May 2006, audit of clinical practice completed.

Progress

In September 2005, the audit of clinical practice was in development. By March 2006, a number of audits were underway. These included:

- An audit of secondary care utilisation;
- A DKA Audit;
- A Diabetes Renal Unit audit. A Research Fellow was co-funded with DPT to conduct this audit;
- Enhancement of standing orders within service; and
- A review of support to primary care practices for the development of successful integration.

Further work has been planned with the appointment of a Chair of Integrated Medicine.

10.3 Ensuring diabetes management activities across primary and secondary care are implemented in a consistent manner.

This initiative was aligned with 8.2 (Developing a diabetes care framework for Counties Manukau) to ensure the management activities and framework developed in Primary Care was consistent with that developed for Secondary care; and that there is consistency in their approach and implementation.

2005/2006 KPIs

No Key Performance Indicators were recorded within the Operational Plan 2005/2006 for this initiative.

Progress

In September 2005 it was noted that the initiative was waiting on DCAG. By March 2006, the initiative was under DCAG and was linked to the audit and service review areas. In June 2006, it was suggested that Green Prescription could be a supporting activity for this initiative as the Green Prescription Area Manager already has close links with the Cardiac and Pulmonary Rehab Units at Middlemore.

10.4 Improving the integration of Primary and Secondary Care diabetes IT systems.

This area included improved functionality for access to patient information, care coordination and clinical decision support. It would, to some extent, be dependent on broader issues such as development of the diabetes secondary care database at WDHB and Enigma services.

2005/2006 KPIs

- By October 2005, develop a clear view on CMDHB response to DHB diabetes secondary care database developments regarding migration to Middlemore.

Progress

In September 2005, the initiative was awaiting DCAG. By March 2006, discussions and scoping brief were held with Health Alliance. A key issue was also identified that the initiative needed Project Management Resource and that Capital funding was affecting Health Alliance's readiness to proceed.

10.5 Improving clinical data and ethnicity data collection and analysis in order to provide regular performance reports relating to indicator outcomes by ethnicity.

Clinical reports would provide feed back to LBD whether strategies are having an impact, especially in relation to reducing inequalities. Areas of data collection include (by ethnicity where possible):

- Glycaemic control
- Management guidelines met
- % given lifestyle management advice/self management education

- Rates of hospitalisation due to diabetes or complications
- Rates of renal dialysis, and
- Rates of premature mortality

(using Get Checked, CCM, Census and NMDS data).

2005/2006 KPIs

- By April 2006, development complete and reporting begins.

Progress

From August 2005, discussions were held with Health Alliance regarding IS support.

10.6 Supporting diabetes in pregnancy

Developing service integration for comprehensive care in diabetes in pregnancy, would include: lead maternity provider, women's health, secondary care diabetes service, cultural support, community support and primary care.

2005/2006 KPIs

- By November 2005, external review completed.
- By May 2006, database developed.

Progress

In August 2005, the external review was commissioned. By December 2005, a consultant had been contracted to review the current clinical and systematic barriers and opportunities for integrating the different providers and services involved in diabetes in pregnancy and care into one comprehensive service. The review would also identify any gaps or issues and provide recommendations on specific changes that would be needed to address these gaps or issues. The review was due in March 2006.

By March 2006, the review was almost completed and it was determined that the work-streams for the 2006/2007 operational plan would flow from the findings of the review. On the 10

March 2006, a national interested parties group assembled to give recommendations on screening criteria which was then circulated.

10.7 Supporting diabetic eye disease.

The aim of this initiative was to support diabetic eye disease identification and treatment into a more integrated service design by redesigning the service of retinal screening for example DNA management and follow-up.

LBD would also support improved service capacity planning, modelling disease progression to develop a retinal screening algorithm and integrating screening information back into chronic care support intelligence.

2005/2006 KPIs

- By May 2006, retinal screening status reports to CCM record.
- By August 2005, reduced DNA and effective recall section.

Progress

No progress was reported for this initiative within the LBD progress reports.

10.8 Supporting diabetic renal disease

LBD aimed to support diabetic renal disease through:

- Implementation of National Guidelines (T2DM)
- Predictive modelling of for service capacity planning (within LBD modelling) and dialysis review (Regional Review), and
- research in service delivery, prevalence and progression of complications.

2005/2006 KPIs

- 90% = application of treatment guidelines for prevention of progressive renal disease.

Progress

No progress was reported for this initiative within the LBD progress reports.

10.9 Diabetes and mental health

LBD aimed to support the links between diabetes and mental health by:

- developing a management resource for prevention, detection and management of diabetes in people with mental health problems;
- supporting the implementation of the depression module in CCM in three pilot PHOs;
- providing psychological/mental health support for patients with diabetes; and
- developing a screening/assessment tool for depression.

2005/2006 KPIs

- By July 2005, development of Health Psychologist role in Acute Care and development of Health Psychologist role in Primary Care.
- By October 2005, implementation of Depression assessment tool.
- By November 2005, implementation of pilot depression module in CCM.
- By May 2006, widespread (90%+) implementation of ADA/APA/AACE recommendations for screening.

Progress

A meeting was held on the 4 August 2005. In June 2006, Counties Manukau Sport and the Green Prescription Manager met to establish formal processes to better link these two services.

10.10 Supporting therapeutics

LBD proposed to support best practice utilisation of medication by:

- Community Pharmacy
- Advice
- Adherence
- Advocacy for best treatment
- Representation to Pharmac
- Encouraging clinical research in CMDHB population.

2005/2006 KPIs

- By June 2006, development of pharmacy advice resource.

- By June 2006, evaluation and research.

Progress

A key issue that was identified in March 2006 was the need to formalise linkage with the Community Pharmacy Project.

10.11 Texting trial

LBD would trial a text-based reminder system at one clinic and evaluate the impact on DNAs and client perceptions of the service.

2005/2006 KPIs

- By May 2006, trial completed and evaluated.

Progress

During August and September 2005, meetings were held. The proposal received from Manukau Super Clinic was forwarded to the DNA Steering Group in December 2005, to be considered as part of a wider DNA package.

In March 2006, the initiative was referred to the Strategic Initiatives funding. However, the proposal had significant asset and capital costs around four times the allocated budget and was beyond the LBD brief. In June 2006, it was also noted that Counties Manukau Sport and ARPMS had a similar motivational text service planned for Green Prescription.

2006/2007

Action Area 1 - Supporting community leadership and action.

1.1 Community Action Fund (CAF)

Community organisations and groups are supported to develop and implement ‘grassroots’ initiatives that encourage local participation in activities that reduce diabetes risk, slow disease progression and/or improve the quality of life for people with diabetes.

Accountability reports for applications approved in the 2005/2006 financial year were being received by February 2006. An appropriate use of funds review would also take place during this time and early analysis would indicate that the funds had been used appropriately. The CAF grants remained at \$5,000 per application from a total pool of \$100,000.

The following are organisations that received CAF grants for 2006/2007:

Alpha Training Group Charitable Trust – ‘Let’s Do It’

Coordination of a 20 week ‘Let’s Do It’ sports and nutrition education programme that targeted youth between the ages of 13 to 24 years within the Franklin Districts.

Auckland Youth Development Trust – Exercise and Nutrition

Coordination of a series of three x 12 week physical exercise training and healthy eating programmes. The programmes focused on changing behavioural patterns through:

- A ‘swap’ programme – healthy food options vs. ‘fast foods’;
- Nutrition education, meal preparation, nutritional shopping on a budget;
- Encouraging behavioural changes within the home setting; and
- Peer support and mentoring.

Chinese New Settlers Service Trust

A series of community seminars focussing on understanding food labels, community education and cooking instruction for people with diabetes. In addition, a minimum of 10 Tai Chi Seminars would be held that targeted the Chinese community of Manukau. The programme would include:

- Food labelling seminars targeting the Chinese community where English is a second language
- A minimum of four education cooking instruction sessions for Chinese community with diabetes
- A minimum of ten Tai Chi classes promoting healthy lifestyles through Tai Chi exercise and physical activity
- Ensure sustained, healthy lifestyle behaviour change

Cook Islands Seventh Day Adventist Church East Tamaki – Exercise and Nutrition

The Cook Island 7 Day Adventist Church East Tamaki application was a combined Lotu Moui/Com Action Fund initiative, funded through CAF and delivered in a Lotu Moui model. The components of the service are guided by the following overarching themes:

- Shifting paradigms and changing mindsets towards healthy living;
- Healing and wholeness for Pacific peoples; and,
- Working Collectively Towards a Shared Vision of Health and Prosperity.

The components of the Let's Beat Diabetes / "Lotu Moui Healthy Lifestyle Programme" include:

- Physical activity
- Physical fitness training
- First aid instructors
- Recording of participants key measurements
- Diet and nutrition
- Certificate of Nutrition training
- Mental Health workshop
- Drug and Alcohol workshop
- Sexual and Reproductive health workshop
- Diabetes workshop
- Spiritual health
- Church health and smoke free policy
- Workforce development training

Gateway Community Trust

This initiative aimed to incorporate a healthy kai, nutrition based menu into the Youth Café in Papakura. It targets the youth of Papakura with particular emphasis on Papakura High and Rosehill college students. The programme aims to expose young people to various healthy kai

options through the medium of a Youth Café. The programme aims to increase participant understanding and importance of good nutrition and healthy lifestyle choices. The programme intended to train a minimum of 15 volunteers over the next twelve months in healthy kai preparation and basic nutrition knowledge. The Café would expose young people to alternative eating and complimentary lifestyle behaviours that are consistent with the Let's Beat Diabetes messages.

Island Child Charitable Trust – Healthy Lifestyles Programme

The Island Child Charitable Trust would run a healthy lifestyles programme targeting families of Otara and Manurewa. The programme was planned a period of 6 months commencing in October 2006 and ending no later than 31 March 2007. The programme included:

Physical activity - Weekly exercise classes targeting youth and their families from Otara and Manurewa through the medium of Hip Hop dance and exercise:

- Participants were encouraged to practice at least three times per week in their own time and return weekly to the instructor coordinated sessions;
- A minimum of 15 physical activity 'Hip Hop' sessions;
- Resource material was made available to participant families so they can exercise in their own time;
- Out of class activity and attendance was monitored and recorded; and
- Through a train the trainer model of learning, a minimum of 20 people will be trained to a standard where they can lead a basic 'Hip Hop' class.

Nutrition - A minimum of 40 families participated in a healthy kai, nutrition programme based within the individual family home:

- Island Child Charitable Trust provided educational talks on the benefits of healthy kai, how to grow and prepare healthy meals;
- A healthy kai booklet, brochure / recipe book was to be produced and distributed to each family; and
- Peer support, monitoring and follow up were to be provided to all families participating.

Kiwi Kids Life Skills Trust – The First Tee Youth Programme

This youth programme aimed to involve a minimum of 500 children aged between the ages of seven to twelve years of which a minimum of 80% must reside in the Counties Manukau District. The programme included:

- Weekly tuition that encouraged regular exercise through the medium of golf;
- Encouragement to exercise outside of the prescribed weekly tuition and regular monitoring and recording of additional activity, nutrition and behavioural changes;
- The provision of subsidised attendance for 60 children (minimum) whom reside in high deprivation locations of Manukau;
- A monthly nutrition, education session attended by all participants complementing the physical activity, healthy lifestyles training;
- All instructors were to be certified instructor(s) / trainer(s) of exercise and with a current first aid certificates; and
- Results would include proven sustainability of healthy lifestyle behavioural change.

Lupe O Tala Lelei A Keriso Inc. Presbyterian Church – LBD/Lotu Moui

The components of the service are guided by the following overarching themes:

- Shifting paradigms and changing mindsets towards healthy living;
- Healing and wholeness for Pacific peoples; and,
- Working Collectively Towards a Shared Vision of Health and Prosperity.

The components of the Let's Beat Diabetes / "LotuMoui Healthy Lifestyle Programme" will include:

- Physical activity
- Physical fitness training
- First aid instructors
- Recording of participants key measurements
- Diet and nutrition
- Certificate of Nutrition training
- Mental Health workshop
- Drug and Alcohol workshop
- Sexual and Reproductive health workshop
- Diabetes workshop
- Spiritual health
- Church health and smoke free policy

- Workforce development training

Papakura Recreation and Fitness Centre

Papakura Recreation & Fitness Centre would coordinate two x ten week Whanau Sport programmes, a two x ten week Housewives Netball programme that would include nutrition and diabetes awareness. The programme will target the general population of Papakura and would include:

- Attendance by a minimum of 200 participants as players and or spectators of which all must be residents of Papakura or the wider Counties Manukau District
- Ten weekly whanau sports programmes that will expose participants to a variety of sporting, healthy activity codes
- Encouragement to exercise outside of the prescribed weekly programmed events
- Nutrition education and diabetes awareness session offered to participants at least two times per term
- All instructors must be certified instructor(s) / trainer(s) of exercise and with a current first aid certificates
- Proven sustainability of healthy lifestyle behavioural change

St. Josephs School Pukekohe

This initiative is a programme of school based physical activities that this would encourage children to develop life long attitudes, benefits and sustainable practices towards physical activity. The programme aimed to make students and staff more aware of healthy nutrition and lifestyle choices. The programme would bring on board community leaders and positive role models who promote and display good exercise habits and healthy lifestyle choices. The programme would include:

- Active participation by the whole school (which included all staff and students) through the provision of lunchtime physical activity;
- Use of Pedometers to increase classroom awareness of steps we should be aiming for every day. (10,000 min);
- Align current school health curriculum strands so that it compliments Let's Beat Diabetes nutrition information and advice;
- Introduce a healthy lifestyles monitoring system for staff and students. Curriculum based physical activity and food in-take measure;
- Encouragement to exercise outside of the school controlled activity (e.g. weekends through dance, sports, walking to the shop etc);

- Nutrition education and diabetes awareness session offered to participants at least once per term through a qualified dietician or diabetes expert;
- Bringing in a motivational speaker at least once per term to talk about healthy lifestyles and behaviours that contribute to good health;
- The provision of certified instructor(s) / trainer(s) of exercise if needed;
- The availability of a qualified certificated staff member that is duly responsible for the safety of children and staff during any programmed activity; and
- Proven sustainability of healthy lifestyle behavioural change.

1.2 Supporting Marae to develop Health Charters outlining their commitment to healthy active lifestyles.

CMDHB will, in partnership with marae leaders, facilitate a discussion on the marae about diabetes from the perspective of a person with diabetes, and their need to successfully manage their care, and a whanau member at risk of diabetes and the supportive role they play. Maori and non-Maori professionals will attend these discussions to ensure accurate information is given in a culturally appropriate manner to ensure a clear understanding of diabetes is gained.

2006/2007 KPIs

- By December 2007, development of navigational tool completed.
- By April 2007, establishment of marae coordinator positions.
- Other KPIs to be developed at later date in partnership with marae.

Progress

In July 2006, the inaugural meeting of Te Tiriti o Waitangi Committee was held. A supporting activity for this initiative was the appointment of Haare Williams as Kaiarahi Matauranga for MCC in September 2006. By October 2006, the CMDHB Maori Health Plan had been presented.

A series of Wananga were planned for the year 2007. The two key foci of these Wananga are to prevent diabetes by disseminating Diabetes information to Maori whanau and secondly to support individuals that have Diabetes through SME. The Wananga aims to involve the whole Whanau.

The main objective of the Wananga is to provide knowledge, advice, resources and motivation that supports whanau of people who have diabetes and individuals who have diabetes. Included in this information will be suggested swap ideas so household influences can make small, sustainable changes which will lead to healthier lifestyles.

Wananga would involve:

- A maximum of 50 people per Wananga;
- A minimum of 20 Self Management Education participants;
- Developing a navigational tool that is offered to participants which identifies people/group/activities in their local area to support their goals; and
- Appointing coordinators associated with each Marae in order to establish & maintain ongoing communications with Maori LBD.

The six Wananga are planned over one and a half days. They will each include sessions that cover healthy eating, physical activity and diabetes awareness. Wananga will be facilitated by CMDHB's Self Management Educator for Diabetes, the Maori Community Advisor and the Strategic Maori Manager for Lets Beat Diabetes. Sessions will include basic information on healthy lifestyles as well as suggested changes that can not only be easy to make but also easily sustainable. The end goal of the Wananga is to decrease avoidable risk factors for diabetes such as Obesity.

The Wananga are spaced about six weeks apart. This timeframe has been chosen to evaluate the previous Wananga, collect resources and advertise the Wananga. The first Wananga will be held in Mangere in February. The second Wananga held in Papakura in April, the third held in Pukekohe in June, the fourth held in Port Waikato in August, the fifth held in Waiuku in October and the sixth Wananga held in Kaiaua in December. Set dates are still to be confirmed.

By February 2007, work on the navigational tool was in progress. The first part of the tool was being collated and identified the clinicians, specialists, educators, counsellors and other relevant diabetes experts within the locality of the Marae. The second part identified current initiatives such as sports clubs, gyms, Maori specific activities, events etc in the local area. As the facilitators' of the Wananga we will ask Wananga participants to help us develop this part of the navigational tool and also amongst our own networks find out what is available in the areas.

Coordinators will be appointed after every Wananga in order to establish & maintain ongoing communications with Maori LBD.

1.3 Kaumatua leadership

LBD planned to seek endorsement by Maori kaumatua to become advocates for diabetes prevention and management through using their influence on the marae within hui.

2006/2007 KPIs

- By April 2007, kaumatua role model register operational.

Progress/developments

A kaumatua photo shoot would be held for the LBD programme as part of the Social Marketing Plan, with testimonial opportunities for some kaumatua.

Issues/challenges/risks emerging

With respect to kaumatua and the development of a formal register of Kaumatua, it was acknowledged that it was important to understand that the opportunities to speak about Diabetes specifically are few and far between. It was proposed to involve them more in the testimonials and photo opportunities of the Social Marketing Plan. Kaumatua will be involved in the Wananga planned for 2007. The issues arising with Kaumatua role models is that their own failing health seems to be the greatest testament of all, such as they are not well and are willing to tell others how to better take care of themselves. Tribal boundaries have also been an issue in terms of Kaumatua working outside their tribal rohe. This makes sense to those who continue to practice within a traditional paradigm.

1.4 Kuia leadership

LBD intended to seek the support of respected Maori women to advocate for the prevention and management of diabetes in Maori communities.

The Maori Women's Welfare League (MWWL) is a national organisation that has a large membership. With these large networks and potential for advocacy at a national level the

importance of diabetes and obesity can be filtered through the entire organisation. CMDHB proposed to work with MWWL to develop 'Champion Leagues'. A formal training component will at the very least influence individual behaviours and workplace advocacy.

2006/2007 KPIs

- By September 2006, MWWL support gained.
- By December 2006, provision of training to MWWL completed.
- By March 2007, MWWL contracted to deliver diabetes and healthy lifestyle training to Maori communities.

Progress/developments

By February 2007, the Maori Strategic Advisor for LBD was negotiating with Te Hotu Manawa Maori and a group of Maori Women who were qualified educators to deliver diabetes training to specific groups in the Maori community.

Highlights/ milestones achieved

The Manurewa branch of the Maori Women's Welfare League (MWWL) received a LBD community action fund grant to hold eight education workshops and by February 2007, had completed these workshops on obesity and diabetes. A training session was facilitated with their young pregnant mothers group. Continued training sessions are to be planned for 2007 however structural changes in the branch are currently underway

Issues/challenges/risks emerging

Initially it was envisioned that Maori women within the League could deliver the proposed training packages developed however this has not been the case taking into account, age, information retention, interest and generally the skills needed to transfer information to other audiences in a professional and skilled manner.

1.5 Strengthening the physical activity and nutrition iwi collective in Counties Manukau

PANIC is a coalition of Maori organisations working in the areas of physical activity and nutrition who oversee activities within the Counties Manukau District that impact on Maori communities. The key roles of PANIC include: coordinating services, pooling resources, developing specific and effective resources and identifying gaps and successes.

The roopu essentially developed out of the community in July 2005 as there was a need to coordinate services and provide consistent coverage throughout Counties Manukau. They have developed into an advocacy body who oversees coordination and collaboration between providers and services in the district.

2006/2007 KPIs

No Key Performance Indicators for this initiative were outlined within the Operational Plan 2006/2007.

Progress/developments

Intended initiatives for the group include examining resources already used within the district on physical activity, nutrition and diabetes to ensure that these resources are effectively coordinated. The roopu will also be involved in developing appropriate resources for the diabetes education workshops, including resources in Te Reo Maori for Kohanga reo and Kura kaupapa.

Highlights/milestones achieved

- Terms of Reference were developed.
- Goals and objectives are still being discussed in terms of management.
- Assessing the usefulness of diabetes resources and in particular pamphlets for a Maori audience.
- The roopu were excited and motivated to retain this new organisation for the clear purpose of working smarter.
- First meeting for 2007 was planned for the 16 of February.

Issues/challenges/risks emerging

There was some feeling that the objectives set by the PANIC committee were unrealistic. This is primarily due to resource availability or lack of it and the fact that the current members needed to justify their continued involvement in the roopu to their managers.

1.6 Maori diabetes training

At the request of the LBD CMDHB Maori Advisor, Te Hotu Manawa Maori developed in 2006 a training module for diabetes for Maori community educators. The training module is made up of three components (i.e. nutrition, physical activity, diabetes). A self management education component will now be added for those individuals with diabetes. Each lesson within the learning module is reinforced with activities that make complex information more practical and easier to understand. The first diabetes training session was provided by Te Hotu Manawa Maori in February 2006 with 30 participants taking part in the three day course. These participants are still active within their own organisations but are not part of the new mentoring programme.

The strategy for recruitment employed was threefold:

1. Identify 20 suitable Maori trainees for each course;
2. Identify availability of trainees to deliver Diabetes training sessions to Maori audiences upon completion;
3. Upon completion trainees can apply the knowledge learnt and have access to mentoring support.

2006/2007 KPIs

- Refine Kai Totika me Whakapakari Tinana Maori Training Course Manual.
- Increase through training the Maori Health Diabetes Workforce.
- Continue to develop the navigational tool (SME, Diabetes, Specialists etc).
- Appoint Marae Coordinators.
- Develop resources for Kohanga Reo, Kura Kaupapa and Marae.

Progress/developments

In 2007, two more training courses with Te Hotu Manawa Maori will be held. The first course is for MWWL educators and the current Maori health workforce who will target the MWWL branches, Kohanga reo, Kura Kaupapa and Bilingual Units and the Maori community generally. They may also support the various Marae initiatives being instigated through CMDHB and other organisations e.g. Procure.

- Part 1 – Traditional and urban Marae, Kura, Kohanga, Bilingual & MWWL
- Part 2 – Maori Workforce (PHO & DHB)

The second is a Maori tailored course specifically for kaiako (teachers). Some key changes have been made to the initial plan have now been taken into account:

- The timeframe of actual delivery at the receiving end;
 - The realistic gains that can be made within these settings;
 - The resources that need to be developed; and
 - Ways to achieve optimum outcomes through resource development, message medication and messengers.
-
- Part 1 – Marae, Kura, Kohanga, Bilingual & MWWL
 - Part 2 – Wananga

This second training acknowledges the Maori language, beliefs, values and rituals as being critical to transferring knowledge about Diabetes to Maori audiences in Maori settings. The emphasis here is on effectiveness of messages and messengers.

A tailored version of the Maori diabetes training course will be delivered taking into account that two hour education workshops providing information on physical activity, nutrition and diabetes is realistically how much time educators are going to have face to face time.

Issues/challenges/risks emerging

- Coordinating efforts that are aligned with te Hotu Manawa's timeframes and availability;
- Ensuring identified trainees are supported throughout the training and post training in terms of travel and costs;
- Ensuring adequate resources are available for delivery of training and resources proposed;

- Ensuring trainees identified are supported by their workplaces to attend the training course;
- Ensuring coordination for all the training being offered by CMDHB; and
- Encouraging participation of others in this training i.e. specialists, experts in Diabetes.

1.7 Pacific churches to develop and implement nutrition and physical activity

CMDHB will continue to support the implementation of CMDHB Pacific Health's LotuMoui Operations Plan in which 50 Pacific churches implement healthy lifestyle activities in Counties Manukau. As part of this plan, a nutrition education module has been developed.

2006/2007 KPIs

- By September 2006, nutrition education module available to LotuMoui churches which will support the development of nutrition policies and healthier nutrition practices in church settings.
- November 2006, LBD healthy lifestyle messages incorporated into the LotuMoui Symposium.
- By February 2007, physical activity toolkit and training module developed to ensure that physical activities undertaken with Pacific community and church settings are safe.

Progress/developments

The Planning for the LotuMoui Symposium was underway by October 2006 and nutrition and physical activity were to be the focus at the Symposium. During this time, the funding application to MCC Events Team was declined.

The Second Pasefika LotuMoui Health Symposium was held on the 22nd and 23rd November 2006. An estimated 600+ delegates attended the Symposium representing Pacific churches and community representatives. LBD healthy lifestyle messages were incorporated into the Symposium which included the Launch of the Social Marketing concepts for Pacific communities.

As part of the Symposium, health education workshops were held on the following topics:

- Healthier weight and undertaking a health risk assessment;
- Men's health issues (cardiovascular problems and lifestyle choices such as physical activity and nutrition);

- Women's health issues (nutrition, family health, cardiovascular risk factors);
- Nutrition (Kai Lelei module and basic principles of food and nutrition);
- Physical activity (incorporating it into your everyday life); and
- Smoking – smoke free environments and smoking cessation.

Highlights/milestones achieved

A service specification for a physical activity toolkit and training module was being developed and keynote speakers and the draft programme had been confirmed for the Symposium. A grant was launched for Pacific churches to support church based healthy lifestyle initiatives

1.8 Empowering self-identified and community identified leaders and organisations to become agents for change within their families and communities.

It was acknowledged that communicating complex health issues in a cultural context can be complex where there are limited words to translate anatomy, body functions and the physiological impact of disease processes. The development of a language with oral traditions requires a critical mass of Pacific community leaders, language and health professional experts to discuss and debate those issues among themselves as a process for gathering consensus on how important health issues such as diabetes will be described consistently.

CMDHB planned to hold four ethnic specific bilingual forums on diabetes. These forums will be created for language and cultural experts to debate and dialogue around cultural practices and language in relation to diabetes.

2006/2007 KPIs

- By June 2007, four ethnic-specific forums on diabetes held.

Progress/developments

A health symposium was held with Pacific church community representatives in Counties Manukau which provided an opportunity for community leaders to discuss healthy lifestyle issues in their Pacific languages.

Highlights/milestones achieved

Four ethnic specific forums were held as part of the LotuMoui Symposium (Samoan, Cook Islands, Tongan and Niuean). Information on healthy lifestyle issues for each ethnic group was gathered and was being compiled into a report that would be made available to ethnic specific workshop participants and planners and funders.

Issues/challenges/risks emerging

Feedback from the LotuMoui steering committee was that instead of there being a focus on diabetes specifically, the ethnic specific discussions needed to focus on the 'lifestyle issues' which lead to Type 2 diabetes.

1.9 Supporting employers to develop and implement policies and initiatives that support health, active workplaces.

Targeted organisations in 2006/2007 would primarily be factory settings linked to the food industry, with significant Maori and Pacific workforces. This approach intended to extend food industry participation in the LBD programme, using healthy workplace development as a springboard.

2006/2007 KPIs

- By March 2007, participant organisations enrolled and working with ARPHS to develop and implement nutrition and physical activity policies and initiatives.

Progress/developments

Food industry companies Nestle (renewal), Danisco and Pacific Flight Catering were working well towards a HBC Award. 'Kumfs's Shoe factory in Mangere was setting an excellent example for a workplace health programme to other factories. An ARPHS on-line nutrition messages project was being piloted. A relationship developed with Manukau City Council 'Community Gyms'. A Workplace Reference Group formed to support the HBC evaluation and development of best practice model and toolkit,

Participant organisations were AUT, SOPH, CTRU, ARPHS, NHF, MOH. By February 2007, LBD representatives had visited the Kumfs factory and presented information on the LBD marketing campaign and asked Kumfs to participate, which senior Management would consider.

Highlights/milestones achieved

CMDHB received the HBC Award and Simal Patel undertook a NHS student project to look at evaluation tools for workplaces. Coca Cola engaged in the HBC programme, although the organisation is based in Mt Wellington, most staff live in South Auckland. Kumfs shoe Factory in Mangere achieved the requirements to receive a HBC Award. The Engineers Dept. at NZ Steel, Glenbrook received their HBC award recently, the entire mill site was one initiative off receiving their Award. The Steel Mill canteen and CMDHB featured in media coverage-radio and Herald regarding vending machines and healthy canteens in workplaces.

Issues/challenges/risks emerging

CMDHB and HNZA are the only two LBD partner organisations making on-going progress on HBC to date. There is a need to develop a strong business case to encourage new businesses to take on workplace health promotion programme. MCC appointed a new HR director who is scoping the Wellness Policy. A plan to market the programme directly to Food manufacturers with factories in CMDHB area was supported by the food industry relationships forged and fostered by the LBD project team.

Action Area 2 – Promoting Behavioural Change through Social Marketing

2.1 Social Marketing Leadership Hub

CMDHB planned to reconvene the social marketing leadership hub to guide the development and implementation of the social marketing strategy. The hub includes individuals from a variety of relevant networks and skill sets (e.g. health, commercial sales and marketing, community leadership, Maori and Pacific expertise).

2006/2007 KPIs

No Key Performance Indicators for this initiative were outlined within the Operational Plan 2006/2007.

Progress/developments

The Leadership hub has met and is functioning well. The hub has provided ongoing guidance and advice into the development of the social marketing concepts.

2.2 Implementing the LBD social marketing programme

Phase one of the social marketing programme implementation or roll-out will focus specifically on addressing obesity, through encouraging: The general public of Counties Manukau (in particular parents and others who influence household eating, drinking and physical activity behaviours) to ‘swap’ (and support others to ‘swap’) to healthier eating and physical activity choices.

Subsequent phases will build on the initial ‘swap’ focus on eating and physical habits, to include ‘swapping’ from not knowing whether one has diabetes, to finding out (i.e. getting screened). The timing will be dependent on the readiness of Primary Care (a screening strategy is being developed in 2006/2007 – see LBD 8.6).

The social marketing programme will target Maori, Pacific and low-income families specifically. Maori and Pacific leadership and input into the development and implementation phases is therefore critical to ensure what it developed and how it is implemented is appropriate for their respective communities.

2006/2007 KPIs/milestones

- By November 2006, development phase completed.
- By November 2006, implementation of programme underway.
- By February 2007, review of programme and plan for expanded roll-out completed.
- By March 2007, implementation of roll-out underway.
- By June 2007, development phase for 2007/2008 implementation programme completed.

Progress/developments

The concept development process was well underway by October 2006 and the first stage of pre-testing, with household influencers, provided insights that helped refine thinking about the nature and roll-out of the campaign. Refined concepts were due to be tested before the end of October.

By February 2007, a second round of creative was developed and tested with the target audience. The refined approach was found to be much more effective than the initial round of creative, and insights from the research process will be used to further optimise the approach. A draft list of potential swap ideas for food and drink consumption and preparation has been circulated and feedback has been received to help refine what would be used for Phase one. Physical activity swap ideas were also being drafted. The planning for the communications and PR element of the campaign was underway.

Highlights/milestones achieved

A pitch seeking support from members of the food industry group was well received in January, with approximately 20 organisations signalling interest in being involved in the swap2win campaign and/or more broadly across LBD.

Issues/challenges/risks emerging

While the development of the final communications and advertising concepts would be completed by the end of November, the production of materials and a detailed media and activity plan will not have been completed. This should not have delayed the timing to launch to families and the wider community in March, so long as the social marketing team had enough detail to use for the stakeholder launch and planning activity that needed to happen before then.

It was acknowledged in the February reports that the draft drawings used to illustrate the fight against the four main factors that lead to obesity (i.e. too much fat, too much sugar, portion size and lack of exercise) were found to be a cause for concern among some stakeholders who felt that they were too aggressive and not appropriate for use in the context of their respective action areas. The feedback was taken on board and used to brief a photo-shoot which was done to give a clearer representation of what the final imagery could look like, especially when using real

people. This imagery has been tested again with the target audience to ensure effectiveness, and further consultation is also underway with LBD stakeholders and relevant organisations in the wider community.

The time-frame for signing off the creative concept took longer than anticipated, which mean a later launch date than planned (originally set for week beginning March 25). However, the upside should be a campaign that has greater support and consequently increased sustainability in the long term.

Forthcoming HEHA advertising campaigns from HSC and SPARC should compliment the LBD social marketing activity as both are also targeting behaviour in the home environment and also have a similar call to action in terms of motivating the family to adopt healthy eating and activity for the benefit of the younger generation. The SPARC Push Play parents campaign runs from February 11 to June 10 2007, and the first flight of HSC TVCs is due to be launched in May 2007.

2.3 Baseline Survey – Measuring the impact of the social marketing programme and LBD programme

CMDHB planned to undertake two baseline surveys of Counties Manukau residents to enable measurement of changes in target groups over time and therefore inform the evaluation of the LBD programme, including in particular the ongoing development of the social marketing programme.

One survey would be conducted the general public, and another specifically with those with Type 2 diabetes. The survey with the general public would be designed to not only provide a benchmark of local attitudes and behaviours, but importantly to provide a first picture of the ‘undiagnosed’ population through offering all survey participants the opportunity to have their Type 2 diabetes risk assessed.

2006/2007 KPIs/milestones

- By December, baseline survey of general population completed. Dependent on ethics approval process.

- By March, baseline survey of people with diabetes completed. Dependent on ethics approval process.
- By June, final report due.

Progress/developments

By October 2006, both components of the baseline study for the general public (i.e. survey and screening process) had been approved in principal by the Regional X Northern Ethics committee. The piloting of the survey was underway, and feedback from this was used to refine questions and survey length. The Diabetes Projects Trust agreed to provide the Study Nurse function for the baseline survey. This would involve following up with all survey participants who are interested in getting checked for diabetes as part of study, and guiding them all the way through the testing process. It would also include supporting anyone who gets diagnosed with diabetes as a result of their check by providing advice and support and linking them into appropriate care.

The baseline survey of the general population started on 02 November 2006. As of 21 January 2007, 1,773 people had been interviewed. The interviewing was due to be completed by end of February 2007 with a final sample size of 2,400. Of those interviewed to date, 6% said they had diabetes. The remaining 1,667 participants were offered a free diabetes screening test, on condition that they agree for the results to be shared with the study. To date 48% have agreed to get tested, with a further 19% interested but 'undecided'. All potential screening participants receive an information pack and are contacted by the study nurse to help make an informed decision about getting tested.

Issues/challenges/risks emerging

The start of the baseline survey with the general public was delayed to the end of October; therefore it was not likely to be completed until the end of January 2007 at earliest. The screening component was likely to take a further four to six weeks after the end of the survey. This would then complete the overall general public baseline study. During October 2006, a discussion paper was being reviewed which may mean that the baseline survey of people with diabetes would be postponed until FY 07/08. The delay of the baseline survey with the general public should not have any negative ramifications for the LBD programme as it will still have been conducted before the roll-out of the social marketing activity to the general public. It was noted that if it was agreed that the baseline survey with those with diabetes should be postponed

until FY 07/08, this should not have any negative impact on the LBD programme as this information would not be needed for specific evaluation or immediate planning activities in FY 06/07.

By February 2007, 15% (173 participants) of those who indicated an interest in getting tested have followed through and had their fasting glucose blood tests. Two participants have had results diagnostic of Type 2 diabetes and four of IGT/IFT. There was a drop-off in the number of people following through with tests during the summer holiday period as expected, and a reminder letter is being sent to encourage such participants to follow-through with their test as part of their new year's resolutions. Follow-up contact was also made by phone where possible. Discussions regarding if and how a baseline survey of people with diabetes should be conducted (in FY 07/08) would be held in February.

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

3.1 Establishing a LBD leadership hub on health and urban design in Counties

Manukau

A leadership hub was to be established to guide work in this Action Area and enhance alignment and collaboration. Membership was to include Counties Manukau District Health Board (CMDHB), ARPHS, Housing New Zealand Corporation (HNZC), Counties Manukau Sport (CM Sport), FDC, MCC and PDC. Members would facilitate access to internal decision-making processes, community engagement, and act as a forum for cross organisation information sharing.

2006/2007 KPIs/milestones

- By August 2006, leadership hub established.
- By November 2006, directory of key players in health and urban design completed.

Progress/developments

An informal leadership hub was established and a formal leadership hub was to be established upon completion of the directory, which was being compiled. The MCC Urban Design Panel

pilot project was initiated and in September 2006, with a presentation of the Manukau Urban Design Guidelines to the PSG.

3.2 Developing exemplar models for community activity parks

In 2005/2006, CMDHB, HNZC and MCC collaborated to develop an exemplar neighbourhood activity park (Templeton Park, Clendon) to support increased levels of family/community based physical activity. In 2006/2007, the focus will be on:

- Completing the Templeton Park development;
- Initiating development of one activity park in each city/district council in 2006/2007;
- Exploring different models for activity parks. Where possible or feasible, such parks will be centred within or near a HNZC neighbourhood. Potential locations are the Pershore or Mascot precincts in Manukau (areas of high Pacific populations), and the Papakura Army Camp; and
- Producing a small publication on the development of Templeton Park, including the partnership and consultation processes, designs, and evaluation findings. This would be distributed widely as a case study of park development to assist future activities.

2006/2007 KPIs/milestones

- By December 2006, Templeton Park evaluation findings received.
- By June 2007, Templeton Park completed.
- By June 2007, production of Templeton Park publication completed.
- By June 2007, new park(s) completed.

Progress/developments

By October 2006, the land swap between HNZC and Habitat for Humanity was completed. The house was removed and the land was ready for levelling and grass sowing and bollards by December 2006. Three stage programme to be developed/budgeted over three years. The MCC Parks team was planning implementation aligned with citywide funding availability.

By February 2007, the Project Steering Group comprising of representatives from Housing NZ Corporation, Lets Beat Diabetes Strategy Team, Habitat for Humanity NZ, Auckland University School of Population Health, and Manukau City Council were progressing with the implementation of the concept plan that has been prepared for the reserve. The project budget had been further refined and the group was looking to engage a project manager for developing

an 'interactive pathway' on the reserve. The reserve concept design was being presented to the newly formed independent Urban Design Team at Manukau City Council on 31 January 2007, to seek feedback regarding the design. The presentation also provided an opportunity to gain knowledge and experience from the panel on the best ways to implement specific components of the plan.

Highlights/milestones achieved

Templeton Park evaluation findings were received and informed the design.

Issues/challenges/risks emerging

The agreement to concept design and budget and the engagement of project management to carry this through towards construction design was delayed. The project would be developed in stages and therefore the completion time needed to be reviewed and updated accordingly.

KPI's/milestones needed to be revised

3.3 Health impact assessment

ARPHS would, on LBD's behalf, undertake or fund a further HIA in 2006/07, with a particular view on the impact on physical activity. This is to facilitate the incorporation of health issues in local decision-making in an appropriate manner, and to further enhance partnerships between the health sector, local government and HNZA.

2006/2007 KPIs/milestones

- By June 2007, HIA completed.

Progress/developments

The Mangere HIA report was to be presented in November 2006 at a meeting with the MCC Urban Design Panel. HIA Implementation Action Plan (Phase 2) was delayed pending progress on Mangere Growth Centre Concept Plan/Master Plan.

3.4 Advocating for health

ARPHS would, on behalf of LBD, continue an advocacy role on aspects of urban design, liaising with MCC, FDC, PDC and HNZC on issues of significance in local policy and planning, such as the Mangere town centre development or the forthcoming Papakura army camp. ARPHS would also work with MCC, PDC and FDC to ensure opportunities for physical activity and access to services and amenities are enhanced. This included:

- Free access to recreation facilities and swimming pools;
- Safe cycling paths, walkways and pedestrian crossing, particularly around schools; and
- Safe parks.

2006/2007 KPIs/milestones

- Timely and active participation in planning processes.
- Submissions made within specified timeframes.

Progress/developments

By October 2006, active living and population health needs/determinants were advocated for consideration and inclusion in the Regional Growth Strategy review process and framework development (START project). Advocacy to promote HEHA objectives at Council sponsored events demonstrated at the Barry Curtis 10K Classic Event on the 15 October, through discounted entry for Council staff, food served and information provided to participants.

By February 2007, a review of major planning initiatives in Counties Manukau were being undertaken in terms of their impact on physical activity.

3.5 Building a health-promoting transport system

CMDHB, ARPHS, CM Sport, MCC, FDC and PDC would collaborate in developing health promoting public transport, including active transport, such as walking and cycling.

2006/2007 KPIs/milestones

- Timely and active participation in planning processes.
- Submissions made within specified timeframes.

Progress/developments

Advocacy for inclusion of 'Smart Growth through Public Health' principles in the MCC Draft Transport Strategy made to consultant. This would align with Tomorrow's Manukau 'Healthy People' goals and targets as well as 'Moving Manukau'. The Cycling and Walking Strategy implementation planning was shared between the transport team, health team and community development planning and service delivery staff and the Bikewise Campaign and Events for 2007 were in planning stages.

By February 2007, a review of planning initiatives related to transport and active transport infrastructure was being undertaken. Submissions were being made regarding the promotion of opportunities for physical activity, including 'walkability' and CPTED in planning processes (including Regional Growth Strategy implementation, Urban Design Protocol, Resource Management Act).

Action Area 4 – 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

The health and food industry governance/leadership structure, the Joint Initiative Group (JIG) would be strengthened, and continue to function as the leadership structure for this action area.

2006/2007 KPIs/milestones

- By August 2006, JIG strengthened.

Progress/developments

JIG strengthened. The Executive Director of the Food Industry Group joined the group which now provides increased knowledge, experience, expertise and access to networks but increased alignment to the national HEHA group he sits on. Existing projects need to review how FIG member can best contribute and build on existing good work.

Highlights/milestones achieved

Other DHBs expressed an interest in the LBD model.

Issues/challenges/risks emerging

The goal for 2007 is to create greater connectivity between LBD and Industry so that LBD have many contacts for supporting the various projects. FIG endeavouring to shift focus of JIG role from consultant to facilitator if suitable to all parties

4.2 Completing JIG work programme 2005/2006

JIG's work programme for 2005/2006 ran to October 2006. JIG's co-funded advocate would complete implementation of the work programme by this date.

2006/2007 KPIs/milestones

- By October 2006, work programme for 2005/2006 completed

The interventions/initiatives are as follows:

4.2.1 Soft drinks programme

The aim was to achieve a reduction in the consumption of full-sugar sweetened soft drinks by encouraging the conversion to less energy-dense alternatives.

Progress/developments

The project has been successful in demonstrating the power of formulation substitution in high volume environments. It is estimated that approximately 17% sugar per year had been removed from soft drinks sold in the 21 participating trial McDonald's outlets. The next step is to work with both Coca-Cola and Pepsi to extend the trial to other willing QSRs; encourage the development of other improved taste profile low-energy soft drinks; review the project with McDonald's with a view to swapping other sugar-sweetened flavours for low-energy options; and extend the McDonald's trial nationally.

4.2.2 White milk programme

The aim was to create a retail environment that actively encourages customers to purchase lower-fat white milk in preference to the full-fat product.

Progress/developments

Milk suppliers, particularly Fonterra, were supportive of the shift from regular to lower fat milks and in fact, only market lower fat products. Foodtown (Progressive Enterprises) agreed to use their Manukau City store as a potential trial base for merchandising and pricing initiatives around lower fat white milk. The next step would be for lower fat milk consumption to become a specific element of the 2007 Social Marketing plan; use of specific consumer campaign to engage both milk manufacturers and retailers to support a shift in consumption from “dark blue” to “light blue” varieties

4.2.3 Healthy kai project

The aim was to review and provide recommendations to JIG and ARPHS as to the future direction of the ‘Healthy Kai’ project.

Progress/developments

LBD was actively involved in running workshops to develop a structured approach to the business plan for Otara and now part of a small group exploring some exciting new initiatives to encourage greater retailer participation in the programme. There was a much greater sense of purpose and direction within the group and the “carrot and stick” approach proposed for retailers in the centre. The next step would be to work with the group, MCC, shop fitters and retail merchandisers to progress the retailer makeover project.

4.2.4 Healthy food parcels

The purpose of this initiative was to explore ways in which the food industry can assist food parcel providers to offer healthy, well balanced and nutritious products for the most vulnerable families in the district.

Progress/developments

This initiative has brought the two major players in the food parcel supply programme in Counties Manukau (Salvation Army and the Auckland City Mission) together, committing to work to better utilize their resources. In addition it proposes a process by which food

manufacturers and suppliers could become involved in on-going supply of products to the food parcel programme while ensuring more nutritionally balanced parcels for all providers and their clients. The next step would need FIG to re-engage with the team regarding a critical communications plan for key identified product providers, using the resources and influence of the FIG.

4.2.5 Healthy Canteen Business Model Pilot

The aim was to provide practical advice, support and assistance to the ‘Healthy Canteen Pilot’ that was trialled at Tangaroa College so as to achieve its goals. Advice, support and assistance was to include the sourcing, merchandising, pricing and the promotion of a healthier school canteen menu.

Progress/developments

Successful trial at Tangaroa College. Extension to other trial schools underway.

4.2.6 Healthy, active workplaces

The purpose of this initiative was to support LBD’s healthy, active workplace initiative by encouraging food industry employers to enrol and participate in the workplace programme – Heartbeat Challenge (HBC).

Progress/developments

Ongoing. Will require more time to validate a successful model for business

4.2.7 Social marketing programme

To provide marketing expertise and resources to the development and implementation of LBD’s social marketing and communications strategy to ensure that it achieved its goals.

Progress/developments

Ongoing contribution to the social marketing plan particularly in agency/client relationship

4.2.8 HealthPoints

To evaluate the feasibility and possible mechanics of a card or stamps based system to reward healthier retail (food initially) purposes.

Progress/developments

Initiative is now with the as Executive Director of FIG. In place at the end of 2006.

4.2.9 Communications on initiatives

To explore ways in which the community of Counties Manukau can be informed on and kept up to date on food industry initiatives that support improved health outcomes.

Progress/developments

MCC Staff are involved in the Town Centre renewal and Environmental Health Services continue to support Mangere and Otara Healthy Kai.

4.3 Developing and implementing a detailed work programme for 2006/2007.

JIG's co-funded advocate was to develop a detailed work programme for 2006/2007 and implement specific projects, as defined by JIG. The work programme would include high-level strategic initiatives as well as local initiatives, and to be aligned to and support other LBD interventions/initiatives.

KPIs/milestones

- By October 2006, draft work programme for 2006/2007 presented to JIG for endorsement.
- By October 2006, implementation of work programme for 2006/2007 commenced

Progress/developments

No progress was recorded for this initiative within the progress reports.

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

5.1 Consolidating the health promotion leadership hub for LBD

CODA would continue to be the leadership hub, and their role would be strengthened to include:

- Provision of advice to LBD on all matters relating to health promotion – resource development, workforce development, social marketing;
- Provision of a central place for sharing information on health promotion activities relevant to diabetes prevention and management;
- Provision of leadership for community health gain – organising health promotion organisations to work together on inputting into territorial authority and CMDHB plans; and
- Using other opportunities to influence towards a healthy community.

2006/2007 KPIs/milestones

- By August 2007, contract with DPT completed.

Progress/developments

Meetings and activities as contracted for in 2006 were completed with CODA including planning, consulting regarding competency development and resource development. Plans for half day development session were underway for the end of 2006.

Highlights/milestones achieved

Contract with DPT completed.

5.2 Developing and enhancing the health promotion and education workforce

In 2005/2006, a health promotion core competencies framework for diabetes risk factors and disease management was developed (entitled Upskilling Pathways for Health Promotion). The framework was developed in close consultation with Maori and Pacific providers, in recognition that all workforce development would require a particular focus on meeting the needs of Maori and Pacific providers, workforce and communities.

In 2006/2007:

- The framework report would be disseminated to all relevant organisations and groups in Counties Manukau; and
- CMDHB and CODA would agree on which recommendations from the report are to be implemented, and provider(s) contracted to action.

A basic level health education and promotion course for people working in diabetes prevention in Counties Manukau but who have no formal qualifications will be developed and delivered. A single course would provide basic training for up to 25 people – with at least half of the participants Maori or Pacific people. The course, funded in partnership with the Ministry of Health (MoH), would provide generic health promotion skills and competencies but would also include a Healthy Eating Health Action (HEHA) and diabetes prevention focus. CMDHB would identify and contract a provider for the course. CMDHB and CODA will ensure the course is well marketed. CMDHB would ensure the course is evaluated to the MoH's satisfaction. Regular ongoing professional development for people involved in diabetes prevention and management health promotion and education would be provided via bimonthly meetings.

CMDHB and CODA would decide the content of these meetings, but initial topics that have been identified include:

- Training in peer supervision models; and
- How to provide input into territorial authorities, DHB and other organisations processes to bring about a healthier community.

2006/2007 KPIs/milestones

- By August 2006, core competencies framework report disseminated to all relevant organisations and groups.
- By September 2006, recommendations from the core competencies framework to be actioned agreed to, and provider(s) contracted.
- By August 2006, first basic level health education and promotion course held.
- By June 2007, six professional development sessions held.

Progress/developments

The core competencies framework report was disseminated to all relevant organisations and groups who provided input into its development for final comment. This included the CMDHB

programme managers. During September a meeting was held between the CMDHB Programme Managers, the provider who developed the framework and DPT on behalf of CODA. It was decided a measured process forward was required so as to maximise the opportunity and its success, and manage providers' angst and expectations. This included an impact assessment. An options paper was being developed for CMDHB General Managers' consideration in November, after which an implementation plan would be developed and implemented. However, this was not done because of resource constraints and capacity issues. It was anticipated that the new LBD project manager – health promotion/schools (to be appointed) would progress this work.

Highlights/milestones achieved

Key stakeholder agreement to the process forward.

Issues/challenges/risks emerging

Providers' concerns and expectations resulting from the framework and its recommendations as well as financial implications.

5.3 Supporting recent graduates from train-the-trainer projects (pilot)

CMDHB, supported by the Ministry of health, will contract a provider(s) to provide support for people who have completed train the trainer programmes within CMDHB. It has been postulated that many of these people do not have the confidence, skills, or support to undertake the roles envisaged when they undertook the programmes. The project will take peer groups of people who complete a train the trainer programme and support them to become effective trainers. This will be done by:

- Establishing peer support groups supported by mentors;
- Individual mentoring within the workplace as required;
- Continuing educational events; and
- Working with other Train the Trainer services.

2006/2007 KPIs/milestones

- By October 2006, four peer support groups (of 10–15 people) established and functioning.

- By June 2007, all peer support groups have met three times a year.
- By June 2007, mentors have visited peer support members 30 times (total).
- By June 2007, continuing education events held.

Progress/developments

By October 2006, the contract with the Maori provider to run the Maori pilot was being finalised. The mentoring support/peer groups would then emerge from the training programme that was to be run. Discussions with a Pacific provider to run the Pacific pilot were progressing slowly.

Lengthy contract negotiations with the Maori provider of this service (Te Hotu Manawa Maori) and the need for the service to be wrapped around an existing training programme resulted in milestone one not being achieved. These issues, however, were resolved, and CMDHB and Te Hotu Manawa Maori were ready to progress with the delivery of this service.

In terms of the Pacific component for this service, negotiations with the one provider able to deliver this service (Pacific Island HeartBeat) did not progress because of resourcing issues. CMDHB and LBD advised the co-funder of this initiative.

Issues/challenges/risks emerging

The Pacific pilot would not be completed by the specified timeframe and there was a need to source more funding to do the evaluation component for the pilot.

5.4 Developing nutrition and physical activity resources to support health promotion in the primary care setting

This initiative proposed to develop and compile together easy to use resources for general practices and other primary care members. These resources provide clear, consistent, and best practice based ways to deliver health prevention in a primary care setting around healthy eating and healthy action. The aim was to ensure prevention work is simple and that the information and key messages disseminated is consistent with that given by the wider health promotion sector.

2006/2007 KPIs/milestones

- By July 2006, budget finalised.
- By August 2006, steering group established.
- By September 2006, provider(s) contracted to develop and/or compile resources.
- By February 2007, resources completed and disseminated to primary care settings.

Progress/developments

Resources were being compiled into folders, with a total of 800 folders, and their distribution planned. Templates completed for additional information to be included, however release was delayed due to the wait for some items. The contract with DPT was signed.

Highlights/milestones achieved

Resource folders compiled and two new resources were developed and translated.

Issues/challenges/risks emerging

It was acknowledged that the translation of resources could be difficult and one resource was being reprinted. The resource folders were to be delivered to PHO's, CMDHB and NGO's once the printing was done.

5.5 Developing the physical activity workforce and activity opportunities (contingent on funding)

CMDHB, CM Sport, MCC, FDC and PDC were developing a programme to achieve a sustainable increase in physical activity capacity and involvement in the district. Implementation of the programme was contingent upon obtaining significant funding from SPARC. A decision should have been made by October 2006.

2006/2007 KPIs/milestones

- By September 2006, SPARC funding bid application finalised.
- By November 2006, training provider(s) contracted.
- By March 2007, first wave of trainings completed.

Progress/developments

The Draft EOI for Active Communities Funding was submitted to SPARC on 20 December 2006. MCC developed a Partnership Agreement with CM Sports, sponsored by the Chief Executive. Ongoing discussions were about the expected level of stakeholder contributions and leveraging ratios. The final date for submission to SPARC was March 2007 for release of funding by the 30 June 2007. Expected SPARC approval to the Application was due by 30 March 2007

Issues/challenges/risks emerging

Inconsistent processes and sponsorship criteria for different SPARC funded programmes that were operating in Counties Manukau. Other than the LBD, Health and CMS partner funding, the local government stakeholder financial contributions were not confirmed by February 2007. The current project scope was also contingent upon SPARC funding. The KPI's/milestones would need to be revised subject to funding.

Action Area 6 – 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

In 2005/2006, the Well Child provider forum agreed to be the leadership hub for the LBD Well Child action area, and oversee its work programme. It would continue to do so in 2006/2007.

The Well Child provider forum would provide leadership and guidance on the ongoing development of Well Child framework, and maintain linkages with the LBD programme to ensure shared learnings and opportunities for improving nutrition and physical activity in young families.

2006/2007 KPIs/milestones

- Bi-monthly meeting held.
- Well Child related LBD plans and actions presented for review and recommendation on a case by case basis.
- Active scrutiny of plans and progress with recommendations and advice to CMDHB on a case by case basis, by the specified timeframes.

Progress/developments

No progress or developments were recorded for this initiative within the documents.

Issues/challenges/risks emerging

Active Participation by the group who met on a regular basis and reviewed plans.

6.2 Scoping and development of appropriate nutrition and diabetes resources to support Well Child providers

In 2005/2006, a review of the Well Child assessment tool and its ability to include assessment for diabetes and/or childhood obesity risk factors was undertaken.

In 2006/2007, CMDHB and the Well Child provider forum would look to build on this review. Provider(s) would be contracted to: review the assessment tool in more depth; to include assessment for diabetes and/or childhood obesity risk factors; scope the resources available to Well Child providers to support young families to around nutrition and physical activity needs for growing children; identify gaps in resources or the distribution of resources; and if needed, develop resources to supplement the toolkit available to Well Child providers.

2006/2007 KPIs/milestones

- By August 2006, review and recommendations presented to Well Child leadership hub for guidance on implementation.
- By November 2006, implementation commenced

Progress/developments

The literature review was completed. The recommendations were accepted by the Well Child Provider Group - no evidence based risk factors in the under fives identified as yet – no change to assessment toolkit was required. New Information Systems Well Child check recording templates were all changed to include the BMI measure. The availability of resources review was completed and sources of currently available promotional material advised. Handy to use resource list was be compiled during October 2006. The pathway forward agreed for

augmenting what is currently available although no significant gaps. Representatives from each Well Child provider planning group were required to develop a brief for new age related combined activity and nutrition resources.

Issues/challenges/risks emerging

Appropriate person/contract for market testing and developing printed resource needed to be decided.

6.3 Developing a research proposal exploring age 0–5 obesity pathways among current 5–10 year old children

A research proposal for exploring age 0–5 obesity pathways among current 5–10 year old children would be developed to identify if there are new or notable obesity risk factors or trends for the Counties Manukau populations in the early years that could then be targeted for intervention.

2006/2007 KPIs/milestones

- By September 2006, proposal brief drafted, disseminated to key stakeholder groups for comment.
- By November 2006, appropriate person to scope and develop proposal contracted.
- By January 2007 proposal completed.
- By January 2007, proposal presented to Well Child provider forum and other key stakeholders for review and guidance on practical implications.
- By February 2007, submission for funding support for proposal completed (dependent on support from key stakeholders).

Progress/development

The proposal brief was to be drafted in October/November 2006. However, during consultation for development of the brief, it was decided not to repeat work that was being undertaken by the Pacific Family Study. Contact was made with this group who wished to tie up this interest and Well Child operational experience with their long term study.

Highlights/milestones achieved

Engagement of researchers/clinicians on existing Pacific Family Study

Issues/challenges/risks emerging

Issues with the availability of key personnel to progress joint work with the existing research and meet timelines in previously proposed milestones. There was also a need to review the milestones in light of the progress and developments.

Action Area 7 – 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

Counties Manukau District Health Board (CMDHB) Maori Health intended to develop a partnership relationship with Te Kohanga Reo Regional Unit to work together to support education and health outcomes for tamariki.

To support this work, CMDHB will contract a provider(s) to:

- Identify kohanga reo and kura kaupapa in the Counties Manukau region;
- Do a stocktake of policy and current practice, and undertake a gaps and needs analysis;
- Provide support to enhance or develop and implement nutrition and physical activity policy and programmes;
- Provide training for kohanga staff;
- Provide resources;
- Link kohanga to local health promotion providers to provide mentoring/ongoing support; and
- Provide support to kura kaupapa / bilingual / immersion units involved in health promoting schools (HPS).

2006/2007 KPIs/milestones

- By August 2006, stocktake completed.
- By April 2007, training and resources developed.

Progress/developments

No progress or developments were recorded for this initiative within the documents.

7.2 Supporting Pacific language nests to enhance or develop and implement nutrition and physical activity guidelines and programmes as part of programme delivery

In 2005/2006, CMDHB in collaboration with Auckland Regional Public Health Service (ARPHS) and TaPasefika Health Trust developed and implemented a nutrition education training module and nutrition toolkit for 33 Pacific early childhood education centres (ECEs) in the district. Resources have been developed to support the ECE to implement nutrition guidelines for under fives as part of their Te Whaariki curriculum.

Building on this work and relationships, CMDHB and ARPHS, together with CM Sport, would develop and implement a physical activity module for children aged five years and under.

2006/2007 KPIs/milestones

- By June 2007, physical activity resources, toolkit and training module that is appropriate for Pacific ECEs developed.
- By June 2007, physical activity training modules delivered.

Progress/developments

No progress or developments were recorded for this initiative within the documents.

7.3 Strengthening the Counties Manukau healthy schools leadership hub

The schools leadership hub established in 2005/2006 would be strengthened to include wider representation from primary, secondary and intermediate schools' principals, staff and Board of Trustees; health service providers; recreation services providers and NGO groups. CMDHB would facilitate this process and meetings, and ensure close partnership relationships with existing forums such as NEW/AIMHI.

2006/2007 KPIs/milestones

- By July 2006, scoping of related providers completed.
- By September 2006, position paper.
- By October 2006, needs analysis of schools completed.
- By November 2006, regional implementation plan.
- By December 2006, exemplar prototype activity in specific schools development and specification.
- By December 2006, development of a district-wide funding plan.

- By February 2007, initiation of exemplar project.

Progress/developments

The stock-take was completed and the analysis of the information obtained was underway. The literature review was in final editing stages and would be available in November 2006 for dissemination. Ongoing work continued for development of a combined needs analysis across all sectors of HPS, physical activity and nutrition. MCC hosted LBD Schools Accord meetings on the 20 and of 27 September and 10 of October. Supported the launch of the Fruit in Schools Programme.

The analysis of school providers was completed to identify gaps in schools. It was acknowledged that a number of schools had multiple providers already providing and the School Accord group was therefore looking at a combined assessment tool. Exemplar prototypes were identified in advance of the School Accord forum.

Highlights/milestones achieved

Provider information and the literature review were completed for circulation. The executive summary was completed and ready for dissemination.

7.4 Enhancing and supporting NEW/AIMHI intervention in selected high schools

CMDHB would continue to support the existing NEW/AIMHI programme GetWize2Health delivered by DPT into selected high risk secondary schools. The Nutrition, Exercise and Weight (NEW) programme provides modules of service, based on the needs of the students and school focusing on developing sustainable programmes for physical activity; and nutrition. Six new sites will receive a range of activities similar to but less extensive than the original NEW model. This is expected to cover 62% of Maori secondary students and 85% of Pacific secondary students.

2006/2007 KPIs/milestones

- By December 2006, roll-out of additional NEW sites.

Progress/development

By October 2006, roll out had commenced. Additional NEW sites were underway by February 2007 and new HEHA funding would continue this initiative for the next year.

7.5 Enhancing and supporting ongoing development of whole school approaches and new initiatives in schools

CMDB would support the ongoing development of whole school approaches and initiatives in designated schools, and ensure their alignment with other health interventions in schools to support collaborative cross agency schools interventions in the areas of physical activity and nutrition.

2006/2007 KPIs/milestones

No Key Performance Indicators were recorded for this initiative within the Operational Plan 2006/2007.

Progress/developments

The four new schools had been contacted by February 2007 and discussions were underway with staff and students regarding making the schools environment healthier.

Issues/challenges/risks emerging

Clarification of the definition for a generic whole school approach.

7.6 Supporting the implementation of the Healthy Tuckshop Business model

In 2005/2006, the Healthy Tuckshop Business model (pilot) was developed to enable schools to run viable businesses offering healthy, nutritious options. The model was being implemented at Tangaroa College and would be evaluated in 2006/2007.

In 2006/2007, CMDHB, DPT and MOH will support the implementation of the Healthy Tuckshop Business model across most decile 1 and 2 secondary schools in Counties anukau, as

schools identify their needs and define the support they require. This was expected to cover 62% of Maori secondary students and 85% of Pacific secondary students.

2006/2007 KPIs/milestones

- By June 2007, model implemented in all decile 1 and 2 secondary schools.
- By February 2007, evaluation key findings and learnings shared with schools.

Progress/development

Model implementation underway. MCC continued development of the HPS Action Plan and access of external providers. Student Health Team Training for Manurewa schools completed. HPS School Staff Coordinators meeting convened to share best practice models. Working with Fruit in Schools schools to develop health action plans. MCC planned to host and fund a Health in Schools Expo on 9 November 2006 for providers and schools to make contact and become more aware of the HPS Framework. The creator of Love to Sing and Move and Groove was introduced to Manurewa HPS school coordinator and schools accord membership.

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 and training and support given.

7.7 Developing new funding streams to support schools and communities to make sustainable changes

The scope of the changes required in school and community environments is larger than CMDHB resources can support, and there appear to be few other direct resources available at present from other sources.

In 2006/2007, CMDHB would continue to look for potential funders and sponsors to support schools and communities to make sustainable changes. Potential funders or sponsors include the South Auckland Health Foundation (SAHF) and its partners and SPARC.

2006/2007 KPIs/milestones

No Key Performance Indicators were recorded for this initiative within the Operational Plan 2006/2007.

Progress/development

No progress or developments were recorded for this initiative within the documents.

Action Area 8 – 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

The Diabetes/Cardiovascular Disease (CVD) Advisory Group (DCAG) was established in 2005 to guide improvements of diabetes management within the primary care sector. It has a broad scope covering all the LBD primary care action areas as outlined in this section, as well as the previous Diabetes Advisory Group and the CCM advisory groups on CVD and diabetes. DCAG will require strong clinical leadership and ongoing review of its functioning to ensure the terms of reference are being met.

2006/2007 KPIs/milestones

- By September 2006, review of DCAG to ensure the terms of reference are feasible and being met completed.

Progress/developments

The review was completed and found that DCAG had made good progress. It was agreed that DCAG would be reviewed again in 12 months. The documents indicate that DCAG continued to meet monthly with around 80% attendance rates.

8.2 Developing a diabetes care framework for Counties Manukau

In 2005/2006, work on developing a model for adopting the NZGG Type 2 Diabetes guidelines from diagnosis to management was commenced. It included identification of key areas for improvement and recommendations on the implementation of this model within Counties Manukau.

In 2006/2007, the focus will be on:

- Further development of the model for implementing NZGG Type 2 Diabetes Guidelines included: identification of key intervention points that would lead to improved services; development of proposals to address these key areas, and identification of key clinical indicators;
- DCAG to consider the proposed model and assess its implications for implementation within Counties Manukau;
- Enhance opportunities for primary care clinicians to improve linkages/training with secondary care outpatient services; and
- Consider ways to increase the awareness and uptake of Green Prescription.

2006/2007 KPIs/milestones

- If appropriate, by November 2006 develop a series of recommendations for implementation.
- By July 2006, development of the model completed.
- By August 2006, presentation of the model to DCAG for consideration.
- By March 2007, enhanced opportunities for primary care clinicians to improve linkages/training with secondary care outpatient services.
- By November 2006, ways to increase awareness and uptake of Green Prescriptions considered.

Progress/developments

Dissertation work by the public health registrar delayed and would be presented to DCAG on 1 November 2006. Other milestones were dependent on the outcome from this.

By February 2007, the dissertation work by the public health registrar was completed and assessed by DCAG, who found it to have limited relevance. It was acknowledged that there was a need to link this project into the external CCM evaluation. Discussions were held with Synergia regarding developments on the national Green Prescriptions programme

8.3 Supporting the improved use of lifestyle management skills for modifying obesity risk factors – community nutrition project

In 2005/2006, CMDHB developed the Community Nutrition Project (CNP) – a brief intervention aimed at modifying obesity risk factors in a primary care setting. It was piloted in two PHOs (Te Kupenga O Hoturoa (TKOH) and Mangere Community Health Trust).

In 2006/2007, the focus would be on completing the pilot, evaluating its effectiveness, modifying the programme (if necessary) and making a decision on its possible extension to PHOs. Key steps included:

- Production of final version of training manual;
- Monitoring of patients for intervention;
- Development and assessment of baseline core competencies for providing nutrition education support;
- Evaluation of intervention; and
- Presentation of evaluation to DCAG to consider rollout.

2006/2007 KPIs/milestones

- By December 2006, completion of evaluation on training and support programme.
- By March 2007, presentation of evaluation to DCAG for consideration

Progress/development

No progress or developments were recorded for this initiative in the documents.

8.4 Supporting the implementation of the self management education programme to improve the uptake of best practice post diagnosis education

In 2005/2006, CMDHB in partnership with DCAG, oversaw the development of criteria for a Self Management Education Programme (SME) in primary care to improve the uptake of best practice post diagnosis education. A draft programme and core competencies for SME facilitators to implement the programme were also developed.

In 2006/2007, the focus will be on completing the development of the SME programme and overseeing its implementation. The programme will be a district-wide service using a central coordinator, Maori and Pacific facilitators, and PHO-based SME facilitators, with specific reference to development of SME groups in Maori and Pacific populations. Key steps included:

- Developing curriculum for trainers, credentialing, and evaluation criteria;
- Developing service specification and RFP documentation;
- Undertaking RFP process and select training provider; and
- Developing evaluation criteria and process.

2006/2007 KPIs/milestones

- By August 2006, curriculum, credentialing and evaluation criteria for trainers completed.
- By August 2006, service specifications and training curriculum completed.
- By September 2006, training provider(s) contracted.
- By October 2006, SME facilitators and SME Coordinator in place.
- By November 2006, DSME programme roll-out in PHOs.
- By January 2007, development of evaluation criteria and process completed.

Progress/developments

SME program parameters, KPIs, evaluation criteria, training curriculum and schedule completed. Trainers were contracted and training was underway from 9 October (ten days over three weeks). The Maori SME Facilitator and SME Coordinator commenced work and the Acting Pacific SME Facilitator was in place.

By February 2007, the Diabetes SME training programme was completed and 16 participants were assessed as successful SME Facilitators. Work continued with the SoPH to develop suitable evaluation criteria for the process. The SME Coordinator was working closely with PHO based SME Facilitators to assist with the rollout of the programme. All trained Facilitators developed their own implementation plans with the sub groups active and developing support resources for the SME programme.

Highlights/milestones achieved

The progress report stated that the initiative had achieved of all milestones.

Issues/challenges/risks emerging

Coverage and capacity issues as some PHOs were more willing and prepared to implement SME than others.

8.5 Trialling and evaluating increased use of family/whanau/groups support for obesity risk factors and diabetes management

In 2005/2006, CMDHB in partnership with DCAG:

- Develop the whanau support pilot for Maori which included hui, and focus groups; and
- Develop a proposal for the provision of family support for morbidly obese Pacific peoples.

In 2006/2007, the focus would be on considering innovative ways to increase Whanau/family/group participation within mainstream primary care and develop proposals to implement pilots with PHOs.

2006/2007 KPIs/milestones

- By July 2006, formative evaluations of the Maori and Pacific pilots underway.
- By February 2007, evaluations completed.
- By March 2007, decision on future of pilots made.

Progress/developments

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 lack of Ethics Committee approval. A RFP was sent out to PHOs seeking proposals that focused on innovative ways to increase Whanau/family/group participation within mainstream primary care providers

Highlights/milestones achieved

Completion of the Maori pilot, which had extremely useful findings.

Issues/challenges/risks emerging

The Pacific pilot may not be viable due to specific objections raised by Ethics Committee.

8.6 Developing a whole system approach to improving rate of diagnosed diabetes – risk screening

In 2005/2006, CMDHB in partnership with DCAG, investigated ways of developing a whole system approach to improve the rate of diagnosing diabetes.

In 2006/2007, the focus would be on reviewing the options/recommendations proposed in the diabetes/CVD risk screening scoping exercise, and pilot a number of initiatives with PHOs. A proactive approach to support increased risk screening will be taken, supported by LBD's social marketing and health promotion programmes. Key steps include the development of options for increased screening via systematic opportunistic screening in primary care.

2006/2007 KPIs/milestones

- By September 2006, position paper refined and detailed proposal developed.
- By August 2006, options for increased screening in primary care developed.

Progress/developments

By October 2006, this initiative was undertaking modelling to develop a more detailed position paper for the Funding Forum. The documents indicated that by February 2007, a detailed position paper, including modelling, was presented to the Funding Forum seeking up to \$1.4 million per annum over the next 5 years. This was rejected by the Funding Forum as unaffordable. DCAG was asked to rework the proposal and look to other options, such as a pilot in two PHOs using SIA funding, funding an annual review only and PHOs to fund screening from SIA.

Highlights/milestones achieved

The progress report stated that the initiative had achieved of all milestones.

Issues/challenges/risks emerging

The scale of the task, such as the ability of the DHB to fund a universal risk screening programme and the ability of PHOs to implement this.

8.7 Strengthening the 'Get Checked' Programme in Counties Manukau

CMDHB would provide ongoing monitoring of access to diabetes services, with a particular focus on Annual Diabetes Review. It would also, in partnership with DCAG, develop a long term cost effective strategy for improving the quality and data collection for the Get Checked programme and improving PHO performance. Key steps included:

- Working with individual PHOs to resolve various information technology (IT)/systems issues;
- Providing quarterly reports to DCAG on PHO performance;
- Working with PHOs to improve uptake and performance;
- Reviewing and improving the quality of the Get Checked reporting from PHOs;
- Establishing a DCAG working group to develop a long term cost effective strategy for collecting Get Checked data and improving PHO performance;
- Undertaking a pricing review for the Get Checked service – August 2006; and
- Considering extension of the programme to include people with high CVD risk.

2006/2007 KPIs/milestones

- By August 2006, DCAG working group to work on project established.
- By August 2006, pricing review for Get Checked service under way.
- By February 2007, annual report provided to MoH on uptake of Annual Diabetes Review in CMDHB in 2005 including targets for 2006.

Progress/developments

By October 2006, the Get Checked Working Group was meeting every 6 weeks to resolve reporting issues and improve timeliness and quality of data. The pricing review had been completed and submitted to EMT for approval. The Get Checked Working Group focused on improving detection rates by raising provider/public awareness and working closely with PHOs and individual practices with improvements to IT systems. They participated in an in-depth audit of the Get Checked programme (and the impact it had on developing other diabetes related activities within the DHB) by the Audit Office. The results were to be presented to parliament in March 2007.

Highlights/milestones achieved

Milestones achieved/on target.

Issues/challenges/risks emerging

Ongoing low detection rates for Maori and poor management (HbA1c>8) rates for Pacific.

Action Area 9 – Enabling Vulnerable Families to Make Healthy Choices

9.1 Strengthening the leadership hub for the vulnerable families action area

In 2005/2006, the Ministry of Social Development's (MSD) Strengthening Families (SF) Steering Group agreed to be the leadership hub for the LBD Vulnerable Families action area, and verse its work programme. It would continue to do in 2006/2007, and together with CMDHB, identify shared outcomes and incorporation. SF is an existing cross-sector collaborative process for case management of vulnerable families.

2006/2007 KPIs/milestones

No Key Performance Indicators were recorded for this initiative within the Operational Plan 2006/2007.

Progress/developments

The MSD Social Report results 2006 were promoted to Elected members and Staff.

9.2 Consolidating and implementing the work programme for 2006/2007

SF and CMDHB would consolidate the work programme for 2006/2007, which identified shared outcomes and specific interventions/initiatives to be implemented. The work programme would include high-level strategic initiatives as well as local initiatives, and be aligned to and support other LBD interventions/initiatives.

2006/2007 KPIs/milestones

- By October 2006, identification of shared outcomes and activities completed.

Progress/developments

No progress or developments were recorded for this initiative within the documents.

9.3 Enhancing Strengthening Families by including diabetes risk factors into review processes, with defined linkages and referrals to the health sector

The aim of this work area was to improve awareness and knowledge about the risks vulnerable low income families have in relation to obesity and diabetes, so SF is able to build it into their existing case co-ordination programme. This would be achieved through joint activities between CMDHB and FACS within MSD.

2006/2007 KPIs/milestones

- By October 2006, information on benefit entitlements distributed to PHOs and other identified health services.
- By December 2006, information packs on risk factors and support services completed.
- By March 2007, development of resources on healthy food options completed.
- By April 2007, nutrition training to budgeting service staff (depending on available resources).

Progress/developments

No progress or developments were recorded for this initiative within the documents.

9.4 Improving referral pathways

The Counties Manukau Family Start service began in September 2005. The programme offered an intensive home visiting programme targeting young families. CMDHB would engage Community Organisations for Diabetes Action (CODA) through Diabetes Projects Trust (DPT) to assist Family Start to link with diabetes prevention services and networks, and align with services available in Counties Manukau. There would be a particular focus on identifying ways of improving nutrition and physical activity levels among young families.

2006/2007 KPIs/milestones

- By July 2006, contract finalised.

Progress/developments

It was noted in the documents that by February 2007, work was progressing well.

Highlights/milestones achieved

The progress report stated that all milestones had been achieved. However, the progress reports did not give enough information on the progress and developments that lead to these achievements.

Issues/challenges/risks emerging

Work commitments were making it difficult for staff to attend support sessions. The questionnaire for families was not developed as on reflection and work with staff it was decided not the best avenue for evaluation. Not working with Salvation Army staff but interviews had been completed with the first training group.

9.5 Improving nutrition by providing training for agencies that access at-risk families

In 2005/2006, training was provided to Salvation Army staff and volunteer workers in nutrition and brief intervention counselling. Exploration of similar training with Manukau Family Start was also initiated.

In 2006/2007, work will focus on:

- Implementing the training for Manukau Family Start (up to 25 staff);
- Developing appropriate means of evaluation to ensure lessons of the training are being passed on to vulnerable families and positive changes are achieved;
- Follow-up of those trained would also be conducted to assess how learnings have been applied; and
- A questionnaire would be developed to evaluate the impact of this training on vulnerable families.

2006/2007 KPIs/milestones

- By August 2006, collection of baseline information regarding trainees and their practices under way
- By August 2006, first training for Manukau Family Start completed.

- From September 2006, group support of trainees initiated.
- By December 2006, second training for Manukau Family Start completed.
- By December 2006, questionnaire developed and piloted for families to complete.
- By February 2007, questionnaire circulated to Salvation Army and Family Start workers.
- By March 2007, follow-up with Salvation Army and Family Start staff under way.
- Learnings from nutrition training applied in ongoing work.

Progress/developments

The progress report stated that work was progressing well. However, not enough information was provided to understand the progress and developments within the initiative.

Highlights/milestones achieved

Achievement of milestones. A recipe book was developed and had been evaluated.

Issues/challenges/risks emerging

A change in Salvation Army Manukau staff working on the project meant that no progress was made up to February 2007. Work slowed for Christmas which is always a busy time for the Food Bank.

9.6 Ensuring food parcels are healthy, well-balanced and nutritious

In 2005/2006, exploratory work was undertaken by CMDHB to review the current system of food parcel provision and identify overall changes in product mix to improve overall nutrition.

In 2006/2007, the focus will be on:

- Implementing a pilot based on the recommendations from the review;
- Canvassing support from manufacturers, importers, suppliers to determine their ability to assist with appropriate products, and developing an action plan forward;
- Producing a recipe book for distribution to vulnerable families through Family Start and social service agencies, with a Pacific flavour;
- Cooking demonstrations at appropriate venues – this could include provision of a cooking implement (e.g. wok) and a complete meal for cooking by targeted families, depending on funding and/or industry support;
- Raising awareness in different arms of the food industry of appropriate food to donate, with a view to enhancing quality of food in a targeted manner; and

- Investigating centralised food parcel distribution system, drawing on established models.

2006/2007 KPIs/milestones

- By August 2006, development and piloting of recipe book.
- By August 2006, recipe book published and printed.
- By October 2006, pilot completed and evaluated.
- By March 2007, provider(s) contracted to deliver cooking demonstrations.
- By December 2006, scoping paper on centralised food distribution model completed.
- By January 2007, implementation of agreed recommendations underway.

Progress/developments

The documents indicated that there was a need to decide how the recipe book would be printed.

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

10.1 Establishing a leadership hub for in-hospital service integration

A formally-established forum is required to provide guidance on in-hospital and integration issues relating to diabetes complications from involved specialties. This forum, provisionally titled ‘Secondary Care User Group’ will build on informal arrangements developed in 2005/2006. It would operate with two distinct aims. The first area of activity would be in establishing the governance arrangements, including co-ordination between services; leadership on management across secondary services; and input into guidelines/ service development. The second activity will focus on developing a navigational tool for consumers, working across primary and secondary care to detail the current provision of services and how to access them (links with LBD 1.2).

2006/2007 KPIs/milestones

- By July 2006, forum established.
- By December 2006, navigational tool developed.

Progress/developments

Development deferred until after the Royal Prince Albert visit, which would help in design of the navigational tool. Specific forum with Diabetes and Pregnancy is in progress and on track

10.2 Developing Whitiora Diabetes Service's role as clinical centre of excellence and supporter of system-wide capacity development

Linking with the Secondary Care User Group, activities in 2006/2007 will focus on:

- Accreditation/external review of audit activities
- Roll-out of primary care support and increased funding/recognition of training role
- Encourage internships
- Increased group education
- Develop career structure for future growth.
- CDMHB will develop stocktake report on Whitiora activities, to inform navigational tool (LBD 10.1).

2006/2007 KPIs/milestones

- By July 2006, Audit DKA to be completed.
- By September 2006, stocktake report produced.
- By (date), strategic document for future growth and development completed.

Progress/developments

Study trip to Royal Prince Alfred Hospital planned.

10.3 Ensuring diabetes management activities across primary and secondary care are implemented in a consistent manner

This initiative would align with 8.2 and 10.4 to ensure the management activities and framework developed in primary care is consistent with that developed for secondary care, and that there is consistency in their approach and implementation. Provision of evidence-based cardiovascular disease (CVD) risk assessment tool in secondary care (acute predict).

2006/2007 KPIs/milestones

- Ongoing participation in DCAG.
- By February 2007, workshop on integrated model of care held.

10.4 Improving the integration of primary and secondary diabetes information technology (IT) systems

The focus of this initiative was to improve functionality for access to information, care co-ordination and clinical decision support in secondary care with the view to integration with primary care providers and other secondary care information systems. It would, to some extent, be dependent on broader issues such as development of the diabetes secondary care database at Waitemata District Health Board (WDHB) (CVDIS) and Enigma (Acute Predict) products.

2006/2007 KPIs/milestones

- By December 2006, utilisation of acute predict in secondary care.
- By December 2006, scoping paper on 'secondary care diabetes information project' completed.

Progress/developments

Acute Predict 2 was the preferred model for primary care. A feasibility study for CVDIS model was underway by October 2006. In February 2007, it was acknowledged that prior to commencement of the pilot phase, Concerto needed to be upgraded to V6. This should be completed by May 2007.

10.5 Improving clinical data/ethnicity data and reporting

This intervention/initiative links strongly with initiative 10.4, and aims to achieve improved demographic and ethnicity data, providing evaluation, feedback and audit tools. CMDHB LBD will work closely with Health Alliance and the secondary care user group (see 10.1) to:

- Develop 2005 proposal within 'Secondary Care Diabetes Mellitus Information; Project' to ensure accurate representation and coding of ethnic groups using secondary care services; and
- Create linkages with 10.1 and 10.4.

2006/2007 KPIs/milestones

- By December 2006, development of dataset.
- Co-development (with 10.4) of scope of 'Secondary Care Diabetes Information Project'.

Progress/developments

The feasibility study for CVDIS model was underway by Health Alliance.

10.6 Supporting Diabetes in Pregnancy

In 2005/2006, a review identifying the opportunities for integrating the different providers/services involved in diabetes in pregnancy and care into one comprehensive service; any gaps or issues; and recommendations on specific changes that would be needed to address these gaps or issues was completed.

In 2006/2007, the focus was on implementing the agreed recommendations of the review.

2006/2007 KPIs/milestones

- By September 2006, recommendations to be implemented confirmed.

Progress/developments

Review findings were reported back to the stakeholder groups. A multidisciplinary working group was established to work through identified issues. Registration and co-ordination processes were being established. By February 2007, presentations had been made to the CCDHB General Manager Forum, Whitiora Team, Primary Care, Women's' Health, Community Midwives, Maori Health, Pacific Health. A further meeting with Womens' Health/Community Midwives management teams was planned to be undertaken prior to the planning day.

Highlights/milestones achieved

Documents indicated that milestones had been achieved.

10.7 Supporting diabetic eye disease

The LBD team would monitor the retinal screening project, providing advice and support where needed, and assist with implementation of National Diabetes Retinal Screening Grading System and referral recommendations (2005). The LBD team would also ensure consistency in screening guidelines and CCM, and secondary care implementation (see also 10.3, and DCAG 8.1); and develop reporting tools for secondary care to monitor implementation of screening.

2006/2007 KPIs/milestones

- Percentage of patients seen in secondary care with up-to-date- retinal screening.
- Grading classifications for all screening events are recorded according to classifications in National Diabetes Retinal Screening Grading System and Referral Guidelines 2006.
- Retinal Screening and grading classifications in CCM database correspond to classifications in National Diabetes Retinal Screening Grading System and Referral Guidelines 2006.
- All Primary and Secondary Care referrers are advised of the new National Diabetes Retinal Screening Grading System and Referral Guidelines 2006.
- Improve coordination with primary and secondary care referrers by June 2007.
- Facilitate improved access to Ophthalmology clinical record for interdisciplinary team.
- Patients requiring Ophthalmology intervention receive treatment according to National Diabetes Retinal Screening Grading System and Referral Guidelines 2006

Progress/developments

Systems for referral to Diabetic Retinal Screening Service were in place. Post consultation summaries available for viewing via VIP and work was undertaken to enable viewing of clinical summary via Concerto. By February 2007, a letter was sent to support the KPI for grading classifications for all screening events to be recorded according to classifications in National Diabetes Retinal Screening Grading System and Referral Guidelines 2006. Working with DCAG was facilitating the work on the retinal screening and grading classifications in the CCM database. A proposed upgrade to Houston VIP 2000 was planned to improve connectivity to other software applications.

10.8 Supporting diabetic renal disease

The secondary care user group (see 10.1) would support diabetic renal disease services.

2006/2007 KPIs/milestones

No Key Performance Indicators or progress were recorded in the documents analysed

Progress/developments

No progress or developments were recorded for this initiative within the documents.

10.9 Aligning diabetes and mental health

This workstream was intended to enhance linkages between diabetes and mental health services in CMDHB. In 2006/2007, CDMHB LBD will:

- Engage mental health planning/funding arm; and
- Provide support/guidance to mental health team planning services.

2006/2007 KPIs/milestones

- To be determined within the Mental Health team.

Progress/developments

In September 2006, development of “A New Zealand Mental Health Metabolic Working Group Initiative” Consensus Statement produced. The Medical Director was working with other local and national “opinion leaders”. By February 2007, it was documented that education sessions were required to increase awareness and adoption of guidelines.

10.10 Supporting therapeutics

The LBD team, the Chronic Care Advisory Group (CCMAG), Diabetes Projects Trust (DPT), CCREP and Division of Medicine will continue to support best practice utilisation of medication by:

- Community pharmacy;
- Advice;
- Adherence;
- Advocacy for best treatment;
- Representation to Pharmac; and
- Encouraging clinical research in CMDHB population.

2006/2007 KPIs/milestones

- Research Fellow position filled (2005, and ongoing funding).
- Research papers produced.
- Representation in Type 2 Diabetes Guidelines (next revision date).

Progress/developments

By October 2006, the initiative was on track. Recruitment for 2007 was in progress and awaiting notification.