



CENTRE FOR HEALTH SERVICES  
RESEARCH AND POLICY

# Monitoring Report: Reporting Period February 2008 to January 2009

## Final Report

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**Dr Janet Clinton, Dr Rob McNeill, Rebecca Broadbent,  
Kathryn Cairns, Sarah Appleton-Dyer, Dr Heidi Leeson,  
and Dr Paul Brown**

**Prepared by:** Kathryn Cairns and  
Kristina Clarke

**Prepared for:**  
Let's Beat Diabetes



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## Executive Summary

This report focuses on a process evaluation of LBD for the period February 2008 until January of 2009. It will provide information on the type, quality and amount of activity that is happening within the LBD programme based on two primary methods of data collection, as a measure of the progress of LBD towards its aims and objectives; LBD monthly progress reports and interviews with Action Area and Work Stream leaders. Specifically, this monitoring data is used to evaluate LBD, its Action Areas and Work Streams on meeting KPIs, implementation, adaptation to plans, organisational development, collaboration, cohesion, sustainability, evaluation readiness, and overall progress. It is important to note that the scores that were designated for each of these variables were based on the information made available to the evaluation team and it is probable that the progress of some Action Areas and Work Streams is not fully represented.

## Results

A summary of the key strengths and challenges for each Action Area and Work Stream are summarised below, followed by a summary of the overall LBD programme.

### ***Community Action Fund***

Key strengths within this Work Stream:

- Promotion of the fund is working well, and there is a high level of interest in the fund from the community
- The level of engagement with the community was noted to be high, as evidenced in the number of enquiries fielded each month

Key challenges within this Work Stream:

- Although the Work Streams focus is a collaborative one, collaboration and partnerships tended to be short-term and primarily of a funding nature
- The sustainability of the initiatives within the Action Area, and their associated outcomes, were noted to be dependent on receiving ongoing funding
- Limited evaluation readiness

### ***Maori***

Key strengths within this Work Stream:

- A significant amount of work had been undertaken to forge partnerships and build relationships both in the community, and with the various other LBD Action Areas and Work Streams
- There is a strong emphasis on empowering Maori to take ownership of their health concerns and issues, and a high level of engagement with the community across marae, Kura and Kohanga settings.
- The Maori Work Stream evidenced a strong commitment to using evaluation to enhance the work that is undertaken

Key challenges within this Work Stream:

- Capacity is a key challenge for this area; there were calls for more Maori staff within the Work Stream and LBD as an organisation, such that work undertaken to increase responsiveness across the organisation was not to the detriment of the work of the Action Area.
- The Action Area could benefit from more formal systems and structures to promote sustainability

- Greater autonomy was desired in terms of coordination and management, which was seen as a means of increasing momentum from conception of an initiative through to implementation

### ***Pacific***

Key strengths within this Work Stream:

- The project team has made great strides in establishing relationships with the Pacific community and in fostering collaboration and partnership within that community.
- The project team is working hard to build community capacity, and to improve the ability of the community to run initiatives on their own in an effort to enhance sustainability of the initiatives.
- The project team have indicated a willingness to engage in and learn from evaluation of their various initiatives.

Key challenges within this Work Stream:

- An increased focus on the management and coordination of the Work Stream would support the achievement of some tangible outcomes.
- There was a lack of cohesion as an Action Area, which was attributed to both capacity issues as well as a lack of integration of the project team with Pacific Health within the DHB
- There were calls for enhanced collaboration between the Pacific Work Stream and the other LBD Action Areas to support responsiveness to Pacific communities

### ***South Asian***

Key strengths within this Work Stream:

- Due to the early stage of the initiative, the nature of the work being carried out is different to other AA's in that it is foundational work and is focused on developing leadership structures, rather than initiatives. As such, leadership and governance in this area is functioning well, with a strong steering group, and a high level of strategic planning occurring within the Action Area
- There is a high level of stakeholder buy-in, with shared understandings of the visions and goals that have been established within this area
- There is a high level of consultation occurring with the South Asian community

Key challenges within this Work Stream:

- Although there is some linkages with certain Action Areas such as the Social Marketing Action Area, it is unclear how the Work Stream is engaged with the rest of LBD, and how the project team will work across the programme as a whole to ensure responsiveness to the needs of the South Asian community
- Although the development of relationships and partnerships is being prioritised, these are still in very early stages, and as such will require considerable effort to nurture and consolidate those relationships

### ***Workplace***

Key strengths within this Work Stream:

- A significant amount of work had been undertaken to forge partnerships and build relationships within this Action Area
- This Work Stream appears to have a culture of evaluation that could provide useful learnings for the other LBD Action Areas.
- Organisational development was a strength for this Work Stream; there appeared to be effective leadership in place, with good communication and information flow amongst the workplace team

Key challenges within this Work Stream:

- The limited identification of linkages and collaboration with other LBD Action Areas, particularly Maori and Pacific, may limit the potential impact and coverage of the Work Stream in relation to the Counties Manukau population

### ***Social Marketing***

Key strengths within this Action Area:

- Leadership and governance in this area is functioning well
- There was a high level of collaboration occurring at both an external and internal level
- There is strong commitment within this area to ongoing monitoring and evaluation of the campaign

Key challenges within this Action Area:

- The sustainability of the initiatives within the Action Area, and their associated outcomes, were noted to be dependent on receiving ongoing funding
- The level of adaptation occurring within this Action Area was fairly low, with little evidence to suggest that initiatives were responding constructively to setbacks in the achievement of these KPIs
- Greater connectivity with the other LBD Action Areas was desired.

### ***Urban Design***

Key strengths within this Action Area:

- Strong and enduring links had been established with certain organisations which were seen to greatly support the Action Area in achieving its mission
- A willingness to engage in and learn from evaluation was indicated, however limitations in terms of capacity have historically meant that this is not a priority for the Action Area
- There is a commitment to sharing information with respect to what is happening within the area, and trying to reduce the gap between this and the other LBD Action Areas

Key challenges within this Action Area:

- Organisational development within the area was a challenge, and there appears to be little or no structure to the Action Area, with all of the work falling to one individual. It appears that there is a need to develop stronger leadership structures and build capacity in this area to support the Action Area to achieve its set objectives and goals
- Despite receiving a low score for meeting KPIs, the level of adaptation occurring was fairly low, with little evidence to suggest that initiatives were responding constructively to setbacks in the achievement of their KPIs
- There appears to be a low level of buy-in from stakeholders who have been unable or unwilling thus far to commit to ongoing participation on a leadership hub

### ***Food Industry***

Key strengths within this Action Area:

- A significant amount of work had been undertaken to forge partnerships and build relationships with the Food Industry, a process which has been enabled by the project team's understanding of the Industry's needs, priorities and ways of working
- The Action Area has developed a good relationship with other LBD Action Areas despite the Food Industry being an area that is traditionally outside of the health sector
- Adaptation within this area was reasonably high, which reflects the flexible approach adopted by the Action Area, and a willingness to adjust plans based on changes in the environment to optimise uptake

Key challenges within this Action Area:

- Ongoing buy-in and commitment from the Food Industry has been identified as key to the success of the initiatives under this Action Area.
- There were calls for a greater level of community involvement in the development of initiatives under this Action Area

### ***Health Promotion***

Key strengths within this Action Area:

- The project team are collaborating well with the community
- The activities occurring within this Action Area were regarded as having a reasonable probability of sustainability
- A willingness to engage in and learn from evaluation was indicated, however there is limited internal capacity to conduct evaluations

Key challenges within this Action Area:

- The somewhat disparate nature of the initiatives makes it difficult to identify any cohesive strategic vision or goals guiding the Action Area as a whole, which influenced the cohesion of the team, and perpetuates the view of the Area as a 'holding pen' for initiatives
- Organisational development is a challenge; there was a call for organisational systems and structures to support and integrate the separate initiatives within this Action Area
- Securing leadership and oversight for the Action Area

### ***Well Child***

Key strengths within this Action Area:

- Strong relationships had been formed with providers and a considerable amount of work had been undertaken to work collaboratively with those in the sector to increase awareness and rates of breastfeeding in the community.
- The leadership structure for the Action Area was functioning well, although there was a desire to see a shift in focus away from the DHB and towards community/provider input in order to maximise the relevance and sustainability of the work undertaken
- The initiatives were seen as sustainable given the current level of resourcing provided the project team identify a clear focus moving forward

Key challenges within this Action Area:

- Little evidence of organisational systems and structures in place to support strategic thinking and communication across the Area as a whole
- Evaluation does not appear to be a priority, with few KPIs related to evaluation, and mixed opinions within this Action Area in relation to the value of evaluation

### ***Education Settings***

Key strengths within this Action Area:

- Good progress was made towards meeting KPIs and implementing programmes
- There was strong evidence that collaboration was occurring between organisations at both a grass-roots level (for example, with schools, ECEs and local community organisations) and at a more strategic level, resulting in alignment of visions and strategic planning across the Action Area
- There is a high level of engagement in the evaluation process, and willingness to learn from evaluation findings

Key challenges within this Action Area:

- There were calls for more information sharing and collaboration between the different education areas
- Limited capacity meant that project managers have little time to reflect on and be critical of the work that is undertaken, which is likely to impact on the quality and sustainability of outputs
- It was suggested that there is a need for increasing DHB support for early childhood initiatives

### ***Primary Care***

Key strengths within this Action Area:

- Good progress was made towards meeting KPIs and implementing programmes
- Organisational development within this area is a key strength; the project team have prioritised the establishment of integrated systems and structures to enhance communication and information sharing
- The likelihood of the initiatives within this Action Area, and their associated outcomes, being sustainable over time was perceived to be high, jointly due to the nature of the initiatives, the level of support from the primary care sector, and alignment with national directives

Key challenges within this Action Area:

- Connection of this Action Area to other Areas is limited due to its focus on the management and treatment of those with diabetes. The project team might benefit from working together with LBD management and the other Action Areas to identify potential linkages and opportunities for collaboration
- Securing confidence in the health sector for the implementation of self-management initiatives by those who are not health professionals. There were calls for the development of organisation-wide strategies to guide engagement with Primary Care
- Prioritising self-evaluation and monitoring of initiatives

### ***Vulnerable Families***

Key strengths within this Action Area:

- The Action Area was making good progress in promoting awareness of the relationship between health and social wellbeing to those within the social services sector
- There was a reasonable amount of evaluation occurring at a grass-roots level and a general willingness to engage in the evaluation process within the Action Area
- Strong partnerships have been established with several key organisations within the social service sector

Key challenges within this Action Area:

- Little evidence of organisational systems and structures to support the sustainability of the initiatives
- There is a clear need to identify a structure to provide leadership and governance for this Action Area, where progress has been delayed due to constant change and upheaval in previously identified leadership structures
- Given the work being done with evaluation, there were calls to build evaluation capacity within the Action Area

### ***Integrated Care***

Key strengths within this Work Stream:

- There was a reasonable level of collaboration occurring within this Action Area
- There is a willingness within the Action Area to engage in and learn from evaluation

Key challenges within this Action Area:

- Little evidence of organisational systems and structures in place to support strategic thinking and communication across the Action Area as a whole
- There was a call for greater oversight and higher level buy-in, to really drive the Action Area and help initiatives gain more momentum
- It was suggested that more leadership needs to come from the community to improve the appropriateness and sustainability of the initiatives

### ***Overall LBD Programme***

An evaluation of the individual Action Areas and initiatives identified the following key points:

- Overall the Action Areas and Work Streams scored moderately in relation to meeting KPIs and implementation.
- Although certain Action Areas and Work Streams were adapting well to changing environments, this was not always apparent.
- Systems and structures to support organisational development were not always in place or clearly defined.
- Collaboration and partnership was strong across the Action Areas in terms of community engagement; however apart from some notable exceptions, collaboration was not always occurring across the different levels of the programme or between Action Areas; and a greater level of connection with other Action Areas was desired.
- Team cohesion was relatively poor within Action Areas and many Action Areas and Work Streams indicated a sense of disconnection from LBD.
- The likelihood of sustainability of the activities occurring within the programme and their associated outcomes was moderate.
- Evaluation readiness was variable across the programme, but generally improved from previous years.

### **Conclusion**

Overall the LBD programme is making good progress towards meeting its stated objectives, and forging community partnerships and collaborations. There are however critical issues that have been highlighted that must be addressed if LBD is going to facilitate the sustainable changes within the community that it desires. The findings from this report, in conjunction with the recommendations provided in the Overview Report, will provide a means for LBD to move forward, to continue to pilot innovative initiatives, and to forge partnerships within the community, with a view to strengthening existing activity that is aligned with the overarching objectives of LBD.

# 1. Introduction

The generic evaluation is the overall evaluation of the ten LBD Action Areas. This is the third monitoring report for the evaluation of LBD as the second report was delivered at the beginning of 2008; subsequently this report focuses on LBD from February 2008 until January of 2009. Programme evaluation can include many different areas, including the effect of the programme on individual programme participants, indirect effects on the greater community, or the programme's process and organization. This report focuses on a process evaluation of LBD. Process evaluation focuses on how a programme is implemented and operates. It also identifies the procedures undertaken and the decisions made in developing the programme. It addresses whether the programme was implemented and is providing services as intended.

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

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

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

This report uses LBD monthly progress reports and interviews with the Action Area and initiative leaders as a measure of the progress of LBD towards the aims and objectives. Specifically, the monitoring data is used to evaluate LBD and its Action Areas on meeting KPIs, adaptation to plans, degree of implementation, organisational development, collaboration, cohesion, sustainability, evaluation readiness, and overall progress.

**It is important to note from the outset that the scores for the various evaluation variables that are presented in this report are not intended to be used as a means to draw comparisons across the Action Areas. Different Action Areas have evolved at different rates as a function of the history and the nature of the initiatives which they encompass, and variation in scores is therefore expected. For example, some Action Areas encompass initiatives which predated LBD and would thus be expected to be progressing further. Likewise Action Areas encompassing a large number of**

time-intensive KPIs would be expected to evidence lower scores. Rather than viewing the scores as an indication of each Action Areas relative standing, they should be used to gain an understanding of progress *within* Action Areas.

## **2. Structure of the Report**

The report is presented in four key sections; the first two provided an introduction to the report and describe the methods used to collect and analyse the data presented in this report. The third section focuses on the results. Results for each of the Action Areas and the programme as a whole are informed by both the monthly progress reports and interviews with key stakeholders. Graphs and a written summary are used to identify the progress of each Action Area in achieving its stated KPIs. An overview of each Action Area is then provided, where programme meeting KPIs, adaptation, degree of implementation, organisational development, progress, collaboration, sustainability, evaluation readiness, and team cohesion are discussed. The information from each Action Area is then consolidated to provide an overview of the LBD programme on the nine evaluation variables. The report concludes by identifying key learnings based on the documentary analysis and interview data both from individual Action Areas and across LBD as a whole.

## **3 Methods**

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

### **3.1 Data provided by the LBD programme**

Information on the LBD Action Area and initiatives was provided to the evaluation team through the reports to CMDHB and the PSG via email. Some areas also provided minutes from their meetings and other programme resources via email. A full description of the documentary evidence is in the LBD data supplement. This data reflects the programme progress from February 2008 until January 2009. This report uses this data to assess each Action Area on the nine evaluation variables identified in section 2.4.

#### **3.1.1 Analysis**

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

It is important to note that the monitoring period for this report covers two financial years; analysis is conducted mid-way through a financial/contracting period, and therefore the evidence provided doesn't give a full picture of progress and adherence to programme plans throughout the financial year.

### **3.2 In-depth Interviews**

Action Area and initiative leaders were invited to take part in an in-depth interview through an initial contact via email, followed by a phone call to secure arrangements. The interviews were conducted by a suitably qualified professional and lasted approximately 45 minutes. The interviews were conducted between November 2008 and January of 2009 with 21 Action Area and initiative leaders. A breakdown of the interviews by Action Area and initiative leaders is not provided to protect the anonymity of the interviewees. It is important to note that not all Action Areas have initiative leaders.

#### **3.2.1 Instrument Design**

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

- Progress towards KPIs
- Adaptation to plans
- Collaboration and cohesion with other Action Areas and organisations

- Coordination within their Action Areas
- Outputs and outcomes of their initiatives
- Immediate and long term effects of their initiatives, and
- Evaluation readiness.

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

### **3.2.2 Analysis**

The interview data was captured for analysis by taking complete notes on the interview, followed by a thematic analysis of the qualitative data to identify key themes emerging in the data. Key quotes pertaining to the identified themes were directly transcribed from the interview. The evaluation team were particularly interested in comments identifying what activity had taken place, the achievement of Key Performance Indicators (KPIs), any adaptation to the original programme plans or KPIs, the degree of programme implementation, organisational development, collaboration, sustainability and evaluation readiness of the Action Area.

## **3.3 Triangulation**

The key findings from the above data sources were combined to provide an overview of the current status of the initiatives, Action Areas and the overall LBD programme. Each of the data sources was combined to evaluate LBD on each of the following constructs:

- Meeting Key Performance Indicators (KPIs)
  - These are the programme targets that are set by the Action Area leaders.
- Adaptation
  - This stems from programme fidelity, as there needs to be a balance between programme change for growth and development to suit the context, and sticking to the goals and objectives of the programme plan.
- Degree of implementation
  - This refers to how much intervention has occurred or whether the goals have been implemented.
- Organisational development
  - This is the process through which an organisation can develop its capacity to be efficient, effective and sustainable.
- Progress
  - This refers to the overall progress the Action Area has made towards achieving its goals.
- Collaboration
  - This refers to the degree of partnership or relationships established by the Action Area.

- Cohesion
  - This refers to the level of team work, compatibility and cooperation within the Action Area.
- Sustainability
  - This refers to the development of a set of durable activities and resources aimed at Action Area related objectives.
- Evaluation Readiness
  - This refers to the capacity of the Action Area to carry out evaluation tasks and the willingness to engage in the evaluation.

The evaluation variables are summarised in Table 1, as is the scoring rubric used to assess each initiative, Action Area and LBD programme.

**Table 1: Evaluation Variable Rubric**

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

The initiatives were scored on each of the variables based on the 3 data sources identified previously. The initiatives were scored on meeting KPIs, adaptation, degree of implementation, organisational development, and overall progress. An average score for the Action Area was then

calculated based on the scores given to each initiative. Additional scoring was also conducted for the ten Action Areas to assess Collaboration, Sustainability, Team Cohesion, Evaluation Readiness, Organisational Development, Degree of Implementation and Adaptation.

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

The data from all sets of coding were entered into MS Excel and analysed.

A scale of 10 was used to provide the sensitivity needed to represent the LBD programme. A means analysis then combined these scores to provide an overview of the ten Action Areas and the overall LBD programme.

Specific markers were identified for each of these variables and documents provided from each Action Area were coded for the presence of these markers. Areas or teams that demonstrated many of these markers were coded as having high achievement under this variable (a score of 8-10). Teams that demonstrated only some of these markers obtained a medium level of achievement (4-7), while those characterised by little or none of these markers obtained a low level of achievement (0-3).

### **Adaptation**

In order to obtain a high level of achievement on the Adaptation variable, the functioning of the specific Action Area needed to have been characterised by several of the following specific markers. Action Areas had to possess the ability to alter factors within a programme to suit the changing needs and priorities of the community or environment for which they serve. These factors include; resources, aims, target populations, organisational structure, leadership, staff composition and competencies. They had to maintain the capability to identify potential obstacles in advance, and circumvent these by altering original aims and objectives. It was essential that as adaptation occurred within a programme the reliability and dependability of the programme was not altered.

### **Degree of Implementation**

In order to obtain a high level of achievement on the Degree of Implementation variable, the functioning of the specific Action Area needed to have been characterised by several of the following specific markers: proposed actions and key completion dates needed to be successfully accomplished, significant and fundamental milestones needed to be met, stakeholder participation achieved and key target audiences reached.

### **Organisational Development**

In order to obtain a high level of achievement on the Organisational Development variable, the functioning of the specific Action Area needed to have been characterised by several of the following specific markers. Governance structures had to be operating appropriately thereby implementing key roles such as guidance, decision making and information sharing. Organisational development had to routinely identify and implement strategies for improvement, along with clearly defining

team member roles and maintaining collaborative decision making processes. Goal formation, leadership engagement, information flow, innovation, reflective activities, communication, collaboration and coordination are all essential characteristics related to optimal organisational development. A key component of organisational development is the ability to smoothly and efficiently work in partnership with other organisations, establishing links and building co-operative relationships.

### **Collaboration**

Markers for Collaboration included a level of strong commitment and support at a senior level, with a shared vision, funding and values system. The level of collaborated planning mechanisms and timescales, with uniform systems of accountability and communication, was also a marker. This ensured that everyone in the partnership was kept up-to-date and informed with what other partners were involved with. Partners in teams with high collaboration felt a sense of ownership in the programme, and had a collective skill set that complemented the stated objectives. Contextual factors also played a role; those teams that scored high on this variable were working within a wider context that was conducive to collaboration (e.g., community characteristics, public and organisational politics). High collaboration was also indicated when partners involved displayed a high level of engagement and commitment to action, and interdependency between partners was promoted and fostered.

### **Team Cohesion**

Team Cohesion was identified with the presence of various markers. High achieving teams perceived their team as efficacious, and had a high level of team spirit or morale. Social support was readily available, and effective communication systems were in place allowing for maximal cooperation within the team. Members in a high-cohesion team perceived the extent of workload sharing between partners to be fair, and felt engaged in the decision-making process. High achieving teams were also characterised by goal interdependence; the success of one partner in achieving their stated objectives or aims was dependent to a certain extent on the success of other partners, thus facilitating cooperation and mutual aid.

### **Sustainability**

Markers for Sustainability included the presence of programme components that were designed in such a way as to allow for their continuation after initial funding and/or other impetus were withdrawn, and were demonstrated to be effective in reaching clearly defined goals and objectives. Another marker was the ability of the team to integrate their activities fully into well-established administrative systems, and often placed a strong emphasis on training and education. Another indication was the team's active involvement in networking to obtain additional sources of funding, as well as collaborating with other groups with similar missions. The recognition of the importance of being able to maintain the programme over an extended period of time in order to achieve meaningful change in health outcomes was also a marker for having achieved sustainability.

### **Evaluation Readiness**

In order to obtain a high level of achievement on the Evaluation Readiness variable, the functioning of the specific Action Area needed to have been characterised by several of the following specific markers. High achieving teams were fully aware of and engaged in the evaluation process, readily

providing the evaluation team with documentation of their progress in the form of one-on-one interviews, meetings minutes, progress reports and various other documents. These teams were responsive to constructive feedback that was provided by the evaluation team. Further, these teams displayed a keen interest in utilising the learnings from the evaluation to inform future practice and improve upon the current successes of the programme.

### **3.4 Issues for consideration**

It is important to note that these scores are based on the information made available to the evaluation team and it is probable that the progress of some Action Areas is not fully represented. Any scores can only be changed following documentary evidence of implementation or progress. All scoring reviews must also be completed in accordance with the scoring procedure outlined in the methods section.

Further, it is important to consider that progress was scored for the second half of the 07/08 financial year, and the first half of the 08/09 financial year only. Consequently, KPIs within an initiative were scored if they were encompassed by the reporting period for that financial year (i.e., for 07/08 from February to June, and for 08/09 from June to January), unless they were not achieved in the specified time frame and their achievement rolled over into the reporting period for the next financial year. Given that KPIs would still be expected to be progressing, a more moderate level of achievement might be expected.

### **3.5 Ethical Approval**

The LBD evaluation received ethical approval from the Auckland Northern X Regional Ethics Committee.

## **4. Results: Assessing Action Area Progression**

### **4.1 Community Leadership Action Area**

The Community Leadership Action Area operates in four sections- Community Action Fund (CAF), Maori, Pacific and Workplace. Recently there has also been the addition of a South Asian Work Stream. Each stream is administered by separate Action Area leaders under the general direction of the LBD programme manager. While the sections function to target separate and individual populations and needs, the strategic methods are based upon goals of the entire LBD programme.

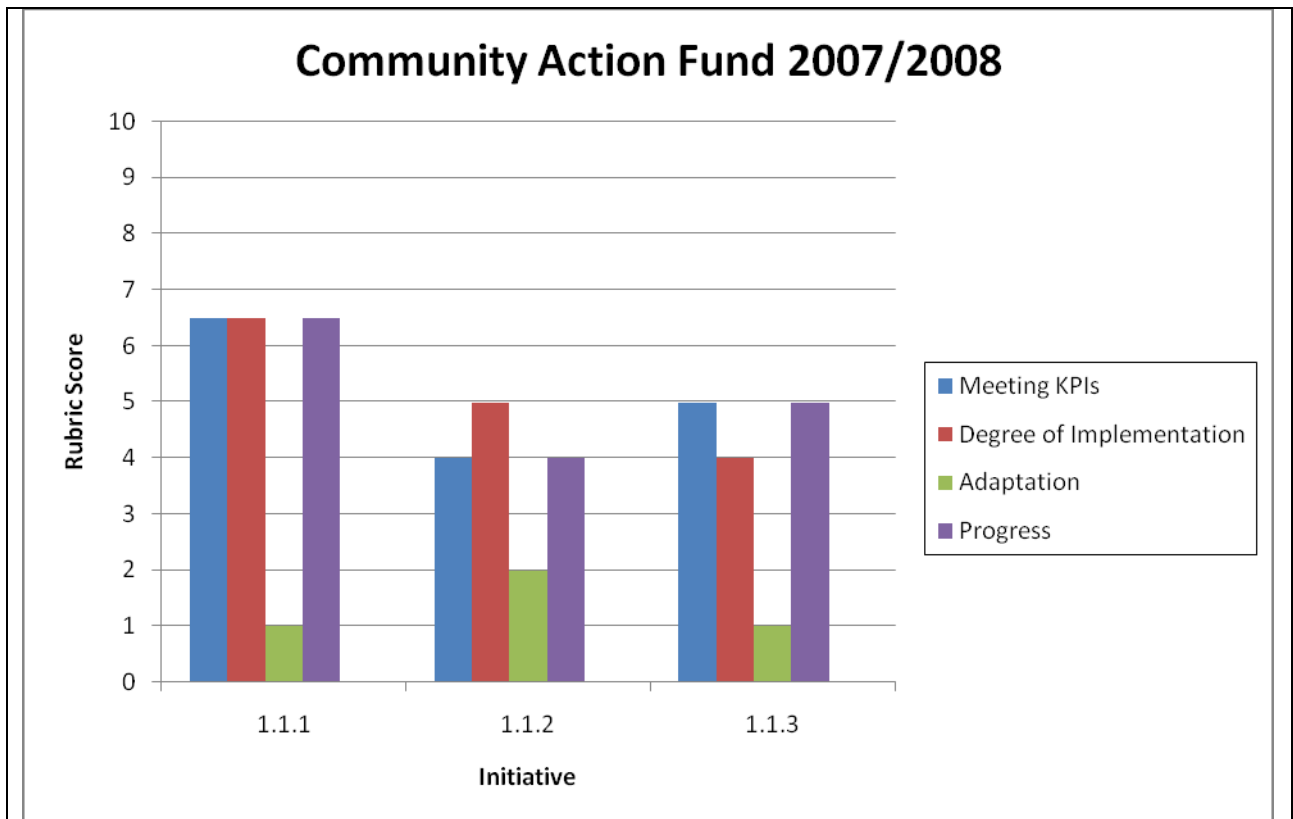
#### **4.1.1 Community Action Fund Work Stream**

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

In both 2007/2008 and 2008/2009, \$100,000 was made available under the Community Action Fund. All initiatives will be monitored, reviewed and evaluated to ensure the funds are used appropriately, and that the initiatives have contributed to improved health outcomes.

#### **Community Action Fund Work Stream Progress for 2007/2008**

The nature of the KPIs encompassed by each Action Area will impact on the scores on each of the evaluation variables that the Action Area is designated. It is of note that the initiatives under the Community Action Fund Work Stream were classified as comprising activities primarily involving collaboration. This should be taken into account when interpreting the Action Area's progress in achieving these KPIs, as the focus of the KPIs can make some more challenging than others.



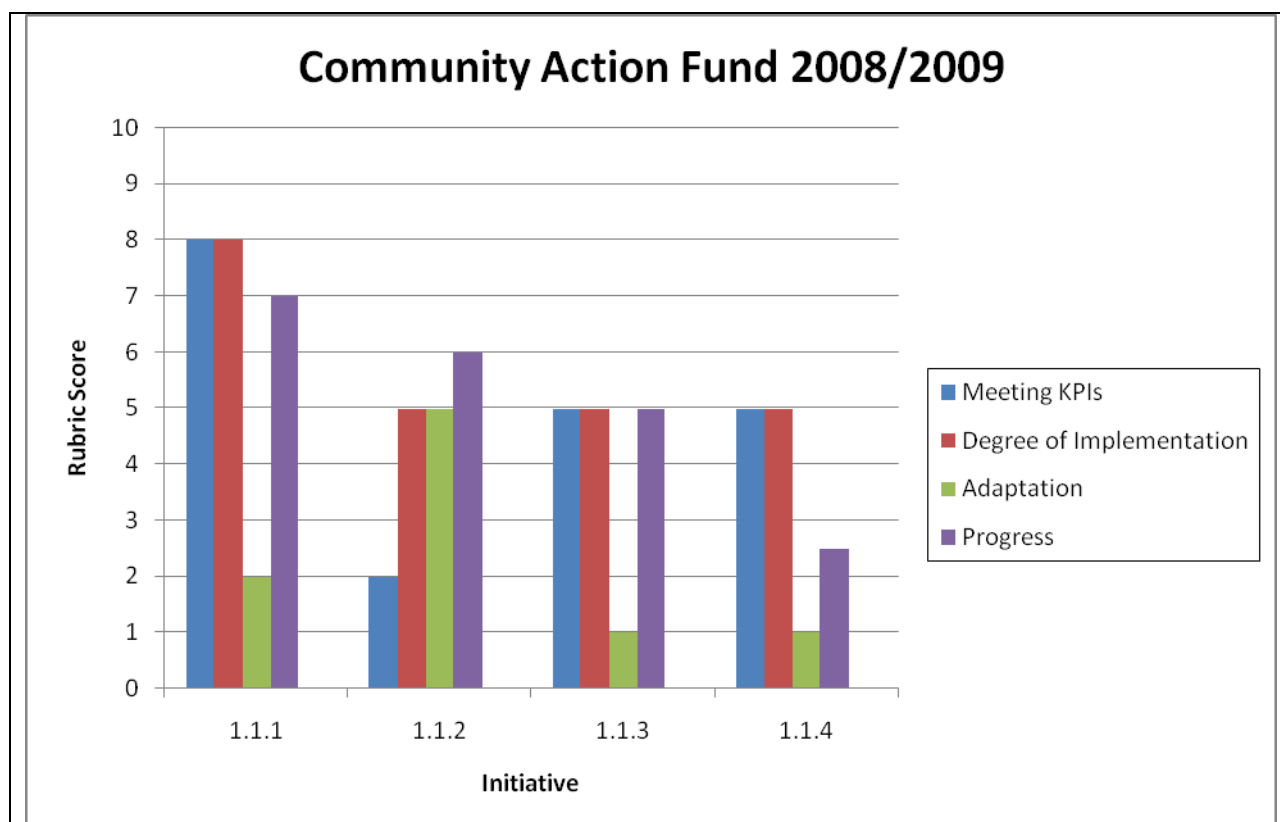
**KEY: 2007/2008 Action Area: Community Action Fund**

1.1.1	By June 2008, 100% of funds allocated
1.1.2	During 2007/2008 review/audit demonstrates that funds have been used in an appropriate manner
1.1.3	During 2007/2008, all initiatives approved will be aligned to the LBD social marketing campaign

**Figure 1: Community Action Fund Work Stream 2007/2008**

The scores for meeting KPIs, degree of implementation and progress across this Work Stream were moderate. This was largely due to the fact that by June 2008 only 13 applications had been approved, with a total of \$64,960 allocated. Thus approximately 35% of the total funds went unallocated for the 07/08 financial year. The evaluation team was provided with little evidence in relation to the process or outcomes of the review/audit process as specified under 1.1.2. It was noted that grant applicants with outstanding reports were being followed up; however the relatively small amount of money that is allocated might hinder applicants' willingness to participate in this process. As specified under 1.1.3, all applications approved were contractually obliged to incorporate and promote the Swap2Win messages; however there was no evidence as to how this was being monitored. The Work Stream received a low score for adaptation as there was little or no evidence of actions outside the work plan that were undertaken to try to bolster the funding allocation or to streamline the review process.

## Community Action Fund Work Stream Progress for 2008/2009



**KEY: 2008/2009 Action Area: Community Action Fund**

1.1.1	By December 2008, a review is conducted to determine the future implementation of CAF.
1.1.2	By June 2009, 100% of funds are allocated.
1.1.3	During 2008/09 conduct a review which demonstrates that funds have been used in an appropriate manner.
1.1.4	During 2008/2009 all approved initiatives will be aligned to the LBD social marketing campaign.

**Figure 2: Community Action Fund Work Stream 2008/2009**

In 2008/2009 the Community Action Fund Work Stream generally received moderate scores for meeting KPIs, degree of implementation and progress, with the exception of initiative 1.1.1 which received a high score for these variables; however this was often a function of the monitoring report being written halfway through the time period allocated for achieving these KPIs. It was initially envisaged that the CAF review (1.1.1) would be completed by October/November. However this was rescheduled to allow for the collection of specific data that would inform the review, which was the rationale for a slightly elevated score for adaptation. The review was completed in January 2009.

In relation to 1.1.2, there was evidence that there was a great deal of interest registered in relation to the CAF, with twenty interested parties from July to November, however only one application was approved. At this stage of the financial year 5% of the total funds has been allocated. This would suggest that the promotion of the fund is an area of strength, but that there may be a need to work

closer with potential applicants to craft their application to fit the criteria. However the initiative leader noted that some applicants are simply not eligible and thus will never fit the criteria, and that the criteria and CAF may benefit from modification based on the review that was undertaken. Scores for progress and degree of implementation for this initiative were higher due to the review of the application process and the work being undertaken to engage the community. Initiative 1.1.3 received moderate scores across the board, with the exception of adaptation which is low, however no real need was identified to adapt the plan at this stage. A review was planned for the second half of the 08/09 financial year. In relation to initiative 1.1.4, only one grant was approved; although it was stated that this initiative aligned with the social marketing campaign, there was no evidence of follow-up. The score for progress for this initiative is low due the low number of applications that had been approved.

### Overview of the Community Action Fund Work Stream

A combined analysis of the 2007/2008 and 2008/2009 data was used to provide an overview of the Community Action Fund Work Stream over this reporting period. In addition, the Action Area was assessed on their collaboration, sustainability, evaluation readiness and team cohesion. Figure 3 illustrates these findings, and the interview data is used to support the overview.

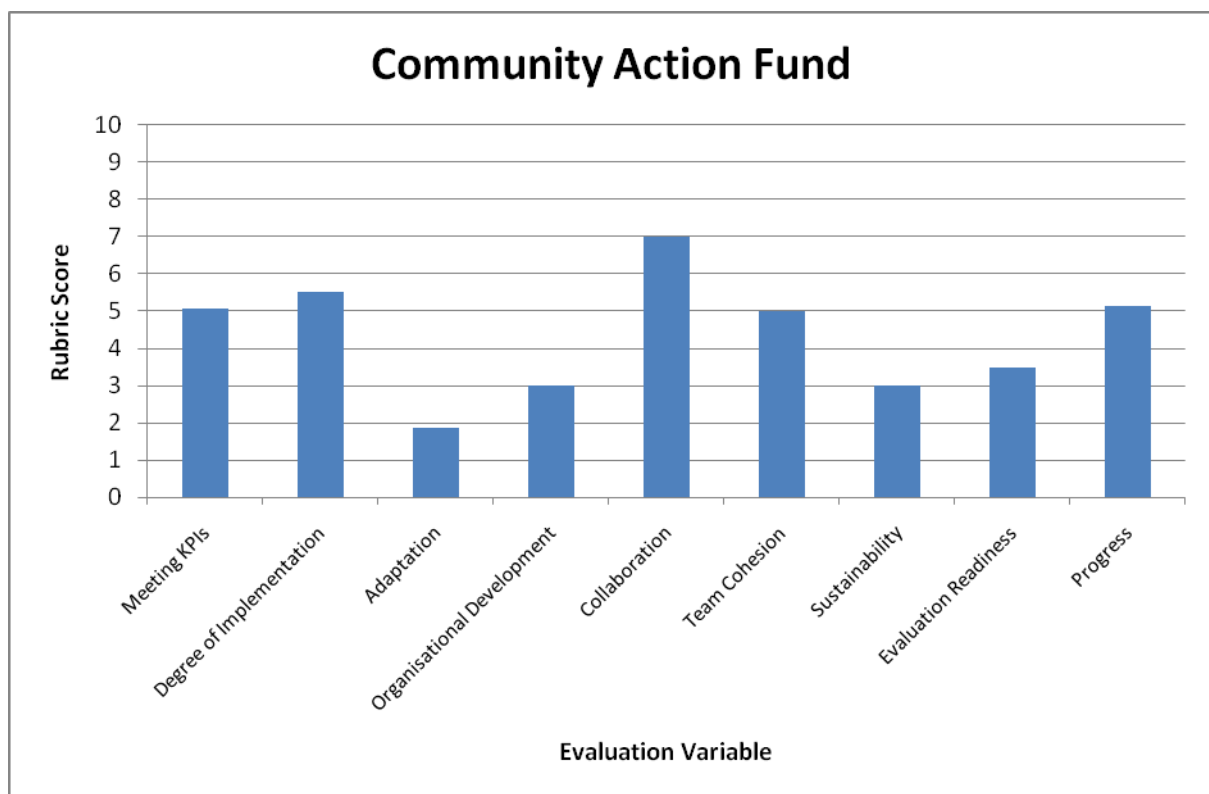


Figure 3: Overview of the Community Action Fund Work Stream

### Achievements and Adaptations

This Work Stream received a moderate score for meeting KPIs, and degree of implementation, and a low score for adaptation. The interview data identified the application process as a barrier to applications being processed and approved; given the maximum grant entitlement of \$5000 potential applicants are not motivated to spend the time and effort completing this process. There is

a lot of interest within the community, with many inquiries but little follow-through from this, which is a trend that continues from previous years

*There is low uptake of the fund and when I've looked at the last couple of years, that has been a pattern...*

It was noted that people are going to other (potentially larger) funding sources, such as those funding streams made available under HEHA, which might serve to diminish motivation to apply. It was noted that streamlining the application and monitoring process may improve uptake, or alternatively incentivising by increasing the amount of money each community group may be eligible for.

### **Functioning of the Action Area**

As there is only one individual working in the Action Area, variables such as organisational development and team cohesion were more difficult to score for this Work Stream. The addition of the new CAF Programme manager has added an element of structure to the Action Area, however there was no evidence of systems or structures in place to support communication. Since joining the LBD team, the CAF Programme Manager has made some connections with other Action Area leaders, which was seen as beneficial, both through bolstering awareness of what's happening under LBD as well as seeking out opportunities for joint initiatives. For example, The CAF Programme manager had collaborated with the Social Marketing Action Area leader on the Jump Jam & Fireworks and Whanau Sports initiatives in Papakura, and had worked collaboratively with the Gardening initiative leader to assist a community group to design a 'Garden to Plate' programme.

There appeared to be a disconnect between the Action Area and LBD as an organisation, with minimal support. This Action Area is very reliant on the commitment of one individual who has other responsibilities and obligations in her role as community liaison manager; however these roles were seen as complementary to a certain extent:

*I'm not in the LBD team, I administer the funds, because it was felt that I'm in the community with my job, it would be useful for that role...*

However there was a suggestion that the requirements of her role as administrator of the fund might interfere with certain aspects of her role, primarily relationship-building, as community liaison manager:

*My role is about forming good relationships with community, declining funding doesn't build good relationships, plus the fund doesn't align itself with the purpose of my role.*

The project manager's dual role means that collaboration is occurring with various groups in the community. The level of engagement was noted to be high, as evidenced in the number of enquiries being fielded each month; however this is hindered by the perceived restrictiveness of the eligibility criteria. The support of the councils was acknowledged (in particular, Manukau City Council, Papakura City Council and Franklin District Council), and the relationships with the numerous community networks across the community and participation on the PHO Health Promotion working group was seen as highly beneficial in facilitating progress. Collaboration at an internal level, i.e.

across Action Areas, is limited, although linkages have been made with Food Industry Accord and the Gardening initiative. The collaboration score was limited by the lack of evidence for follow-up of grant recipients, and a lack of evidence for support provided to potential applicants in completing or resubmitting applications.

### **Sustainability**

The Work Stream received a low score for sustainability, as it was noted that once the funding impetus was withdrawn not a lot would be happening within this area (although it was noted to be a kick-start. The emphasis on sustainability in the criteria for applicants is not as strong as it might be. It was noted that \$5000 was not a huge amount of money and that LBD's expectations with respect to the sustainability of the initiatives funded may be unrealistic:

*I think the expectation that it will be sustainable is a huge one for only \$5,000...*

There appears to be little accountability or follow-up, which may serve to reduce the sustainability of these initiatives if they deviate from what is deemed appropriate or best practice. There needs to be a renewed focus on working with the successful applicants to ensure the work that is undertaken is sustainable.

### **Evaluation Readiness**

Evaluation readiness appeared to be limited within this Work Stream, as evidenced by a lack of follow-up of the accountability reports which are to be submitted by successful grant applicants. There is very little monitoring occurring with respect to what is being done with the funds, however a review of the implementation of the CAF is in progress. Progress monitoring was noted to occur via the submission of monthly progress reports to the LBD programme manager. The interviewee was unaware about what was happening with the evaluation being conducted by the School of Population Health.

### **Summary of Progress**

The Work Stream evidenced low to moderate progress towards its overall goals during the reporting period covered by this report. Although there is a high level of community interest, a startlingly low proportion of those who enquire about the fund go on to apply for the fund, and those that do apply frequently fail to meet the eligibility criteria. The delay in the appointment of the current PM and the lengthiness and involvedness of the application process were identified as key barriers:

*...because I haven't been in the organisation for that long...the benefits that could be there haven't been able to be realised...the lack of applications I believe has been because, the fund...there hasn't been that continual oversight this year...and the criteria is fairly tight and the process for allocating money is lengthy*

### **Changes over Time**

A decrease across most of the evaluation variables was evident with the exception of cohesion and adaptation which remained constant. There were a number of factors which may be seen to have contributed to this. A large proportion of the total funds for the 08/09 financial year has yet to be allocated, and 35% of the funds from the 07/08 financial year went unallocated, which in the interviewees view is a reflection of the restrictiveness of the criteria for the fund. Consequently the

scores for meeting KPIs, implementation and progress were lower. Although the Work Streams focus is a collaborative one, there appeared to be little connection to the other LBD Action Areas, which was seen to limit the potential of the initiative in failing to leverage of the networks which have been established in these different areas. It was noted that this Work Stream is an isolated one, and there is perhaps a need for greater support to facilitate links between this area and others within LBD.

#### ***Issues for Consideration***

- Although there is a high level of interest in the fund the current eligibility criteria and the ceiling on the funds available to each applicant appear to reduce the number of applications that are formally submitted. LBD should consider reviewing these criteria with the PSG.
- There is only one individual within the Work Stream, who has competing work obligations and it was suggested that there was a low level of connection to LBD.
- Progress towards KPIs for the 08/09 financial year is not fully represented given that reporting is occurring midway through the financial year.
- Any recommendations that were made in the review of the CAF have yet to be implemented, which may impact on the progress of the Work Stream.

#### **4.1.2 Maori Work Stream**

Extensive consultations with Maori to ascertain their needs, aspirations, priorities and appropriate approaches to meeting these, were undertaken via marae-based hui, working groups and community consultations. Community representatives and providers consistently supported Maori cultural and leadership institutions as being the starting point for Let's Beat Diabetes (LBD). To this end, the key focus for LBD will continue to support marae, kohanga reo and kura kaupapa to develop and implement initiatives that support improved nutrition and physical activity within their communities. Underlying all of these interventions/initiatives is a process of increasing the knowledge of Maori communities about obesity and diabetes, and supporting Maori cultural institutions to become agents for change.

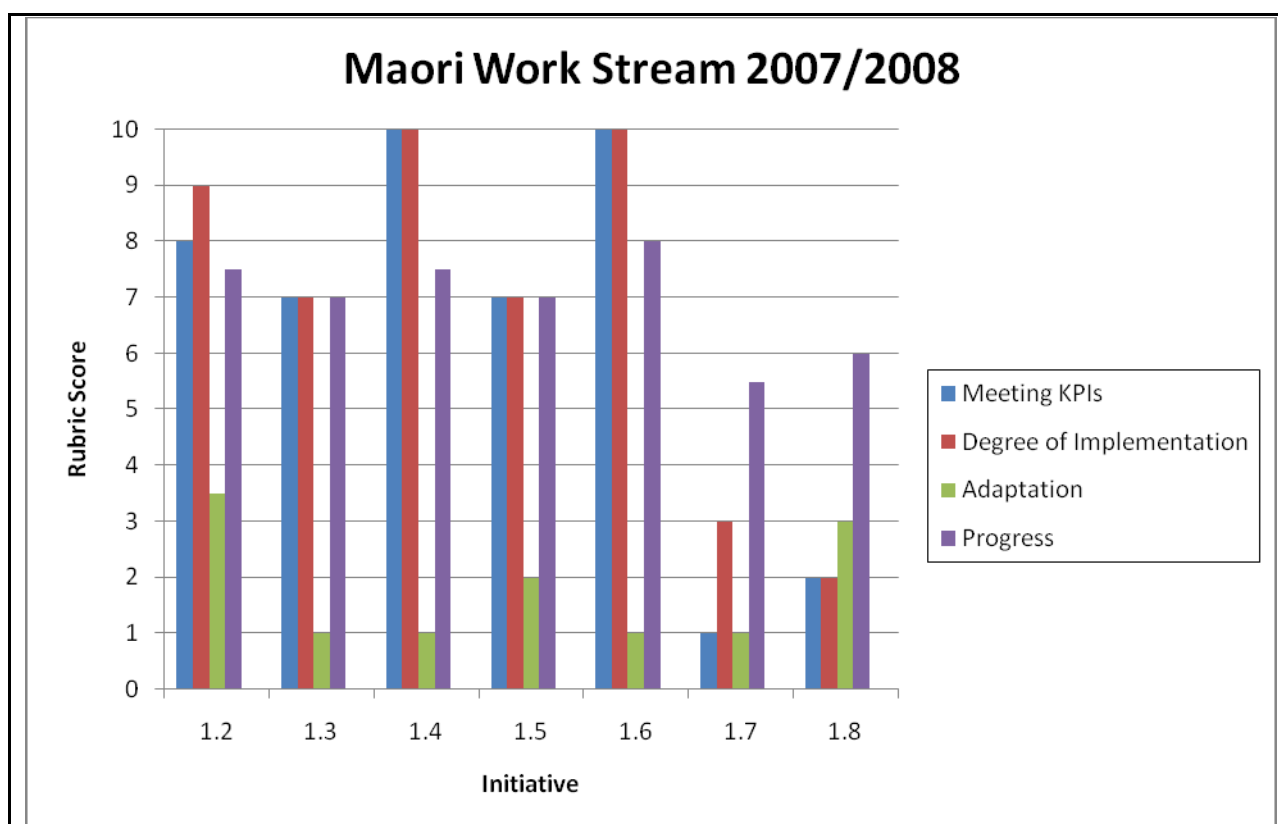
During 2007/08 a review of the current approach and objectives for the Maori action area will be undertaken and changes implemented. The focus of 2008/09 is the establishment and implementation of Maori Obesity Community Action Plan (MOCAP) will ensure that there are community initiated, developed and led projects across the Counties Manukau region.

#### **Maori Work Stream Progress for 2007/2008**

The nature of the KPIs encompassed by each Action Area will impact on the scores on each of the evaluation variables that the Action Area is designated. The Maori Action Area's progress is commendable given that the number of individual KPIs that were set out for each initiative was typically high. It is also of note, that several of the initiatives under the Maori Work Stream were classified as comprising activities involving collaboration, programme development and interventions aimed at prevention. These types of KPIs are relatively labour intensive and those that focus on relationship building are perhaps harder to monitor. This should be taken into account when interpreting progress.

It should also be noted that the Maori Work Stream involves a number of sub-initiatives under each initiative. The breadth of activity occurring under each initiative was often considerable. Progress for

each sub-initiative was scored and then these scores were collapsed to generate one overall score for each initiative. Consequently the reader is advised to refer to the data supplement that accompanies this report for a more thorough breakdown of progress by sub-initiative.



**KEY: 2007/2008 Action Area: Maori Work Stream**

1.2	Developing Marae as key settings for diabetes awareness and prevention among Maori communities
1.3	Kaumatua leadership
1.4	Kuia leadership
1.5	Strengthening Maori leadership in nutrition and physical activity
1.6	Maori diabetes 'train the trainer' education
1.7	Supporting kohanga reo, kura kaupapa and whare kura to include nutrition and physical activity within their curriculum/teaching programmes
1.8	Develop an LBD Maori Leadership Hub

**Figure 4: Maori Work Stream 2007/2008**

The Maori Work Stream scored highly on the meeting KPIs, degree of implementation and progress variables. For initiative 1.2, all of the KPIs were completed, and although some were completed behind schedule others were exceeded. The adaptation score was elevated, as there was evidence that actions were being undertaken that were outside the work plan in response to the changing environment and/or needs of the community. For example the project team were looking at extending successful models of practice and resources to other Marae in the region etc. The initiative received a high score for progress given the wealth of evidence with regards the work that was being undertaken to develop Marae as key settings for diabetes awareness.

Initiative 1.3 appeared to be progressing well, with marae visits occurring, although the extent of these visits was unclear from the evidence provided. Kaumatua are engaged and involved in LBD, and were supporting marae visits. Progress was noted to be high in terms of supporting involvement on marae.

All of the KPIs under initiative 1.4 were completed, albeit behind timeline, due to delays as a result of staff turnover. However it was noted that the number of workshops to be delivered had been exceeded and delivered ahead of timeline, which elevated the implementation score for this initiative. Progress was high as plans were in place for ongoing engagement with the MWWL.

All KPIs were reported to have been met under initiative 1.5, albeit some significantly behind timeline; however no supporting evidence for this was provided. Scores for implementation and progress for this initiative were moderate as the project team were starting to make recommendations e.g. to the DHB. Adaptation occurred to some extent in response to delays due to staff turnover.

This initiative received high scores for the meeting KPIs, implementation and progress variables, as all KPIs under initiative 1.6 were achieved, with the exception of 1.6.4<sup>1</sup>, where there were delays in this being achieved. This was due to activity in relation to this sub-initiative being picked up by the Health Promotion Action Area.

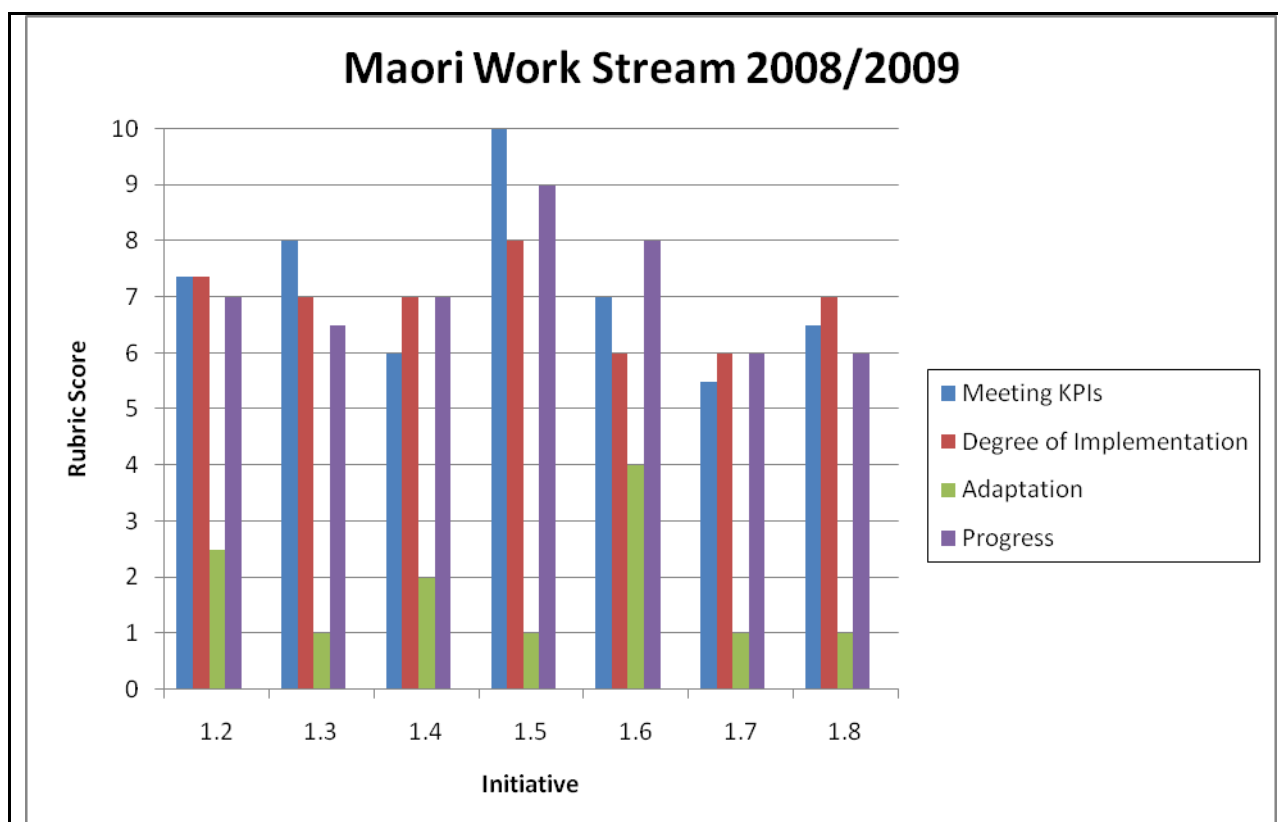
Under initiative 1.7, work was occurring to make sure that workshop content was appropriate for people from Kohanga reo, Kura Kaupapa and whare kura settings, which suggests that places have been kept for them, although there was no mention of this in the data provided to the evaluation team. There was a sense that work was being undertaken, however the lack of evidence necessitated conservative scoring across the board for this initiative.

Given that a leadership hub was not developed during the reporting period, it was difficult to score the work that was undertaken in relation to initiative 1.8. It was noted that terms of reference had been created, and presentations given to the Action Areas, which lead to higher implementation and progress scores. However the project team were in the process of reviewing whether the leadership hub was appropriate, which meant that the KPI had not been achieved as such which resulted in a lower score for that variable, but a higher score for adaptation (refer to the February 08 data supplement).

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<sup>1</sup> Sub-initiative 1.6.4: Aligning proposed mentoring programme with training

## Maori Work Stream Progress for 2008/2009



**KEY: 2008/2009 Action Area: Maori Work Stream**

1.2	Maori leadership
1.3	Maori workforce development
1.4	Marae
1.5	Maori Women's Welfare League (MWWL)
1.6	Kohanga Reo/Kura Kaupapa
1.7	Locality Specific Community Action
1.8	Community/district events

**Figure 5: Maori Work Stream 2008/2009**

As in 07/08, the Maori Work Stream scored highly on the meeting KPIs, degree of implementation and progress variables. A significant amount of work was being undertaken under initiative 1.2 in relation to promoting Maori leadership, with support provided to other Action Areas. Although the PANAK group was meeting regularly, and the collaboration fostered out of this was noted to be positive, it was unclear as to the ways in which the group were providing support and guidance to LBD. In addition, the initiative leader responsible for Community hubs and reference groups (initiative 1.2.2) noted that it would be more appropriate to develop partnership agreements with the hubs instead of formal terms of reference as stated in the KPIs. This accounted for the reasonably high score for adaptation. Progress was scored highly as the project team were well on their way to achieving their stated objectives despite being only halfway through the financial year.

Initiative 1.3 was progressing well, as evidenced in the high scores for meeting KPIs, degree of implementation and progress. The project team were supporting activity, had scoped the mentoring programme, but hadn't implemented this work yet, although it was noted that this KPI was not designed to be met until February 09. There was no evidence of support for specific workforce development programmes. The initiative received a low score for adaptation, as there was no need for activity to occur outside of the stated KPIs.

Initiative 1.4 received moderate to high scores for meeting KPIs, implementation and progress. At the time of writing of this report 10 of the 14 workshops had been delivered. No information was provided to the evaluation team in relation to the sub-initiatives 1.5.5 and 1.5.6 (possibly because these were being run by Maori Health). There was evidence of collaboration with Gardening project manager. The adaptation score for this initiative was somewhat elevated as there was evidence that the project team were integrating mentoring and support around diabetes into other healthy lifestyles workshops.

Initiative 1.5 received high scores for meeting KPIs, degree of implementation and progress as all of the KPIs were met well ahead of the set timeframes. The initiative was scored modestly for the adaptation variable however there was little cause for this to occur.

Sub-initiatives 1.6.2<sup>2</sup> and 1.6.3<sup>3</sup> were achieved; however the project team appeared to have taken a different route with 1.6.1 and the formation of the steering group; the KPI was met, however a different approach to engaging with Kura was adopted which accounts for the high adaptation score. The initiative received a lower implementation score because the work that was being undertaken was at the scoping/pilot level, rather than identifying gaps/needs etc.; the project team had identified a key individual to go into Kura and identify their needs, and thus it was noted that the project team are on track to achieving this KPI.

Initiative 1.7 was progressing reasonably well, noting the large number of sub-initiatives, with moderate scores for meeting KPIs, degree of implementation and progress. Sub-initiatives 1.7.1<sup>4</sup>, 1.7.2<sup>5</sup> and 1.7.3<sup>6</sup> were completed, although possibly delayed, and the project team were working towards the achievement of 1.7.4<sup>7</sup> and 1.7.5<sup>8</sup> although these again were delayed. No information was provided in relation to progress towards 1.7.6<sup>9</sup> or 1.7.7<sup>10</sup>. The implementation score was higher due to the establishment of the community hubs. It was noted that there had again been staff turnover within the area which had caused some delays. The overall progress for this initiative was scored as moderate; certain sub-initiatives were progressing well, however the project team were not achieving everything under the overarching aims, for example there was no evidence for

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<sup>2</sup> Sub-initiative 1.6.2: Complete the pilot of the Kohanga Reo resource

<sup>3</sup> Sub-initiative 1.6.3: Provide recommendations for the Kohanga Reo resource implementation

<sup>4</sup> Sub-initiative 1.7.1: Consultation hui held in Maori community settings will be completed

<sup>5</sup> Sub-initiative 1.7.2: Establishment of the 3 hubs

<sup>6</sup> Sub-initiative 1.7.3: Representatives have been identified to attend the Mo-Cap

<sup>7</sup> Sub-initiative 1.7.4: Identify appropriate facilitators and establish an evaluation plan

<sup>8</sup> Sub-initiative 1.7.5: Identify areas in targeted hubs that require further support

<sup>9</sup> Sub-initiative 1.7.6: Provide support for identified community initiatives

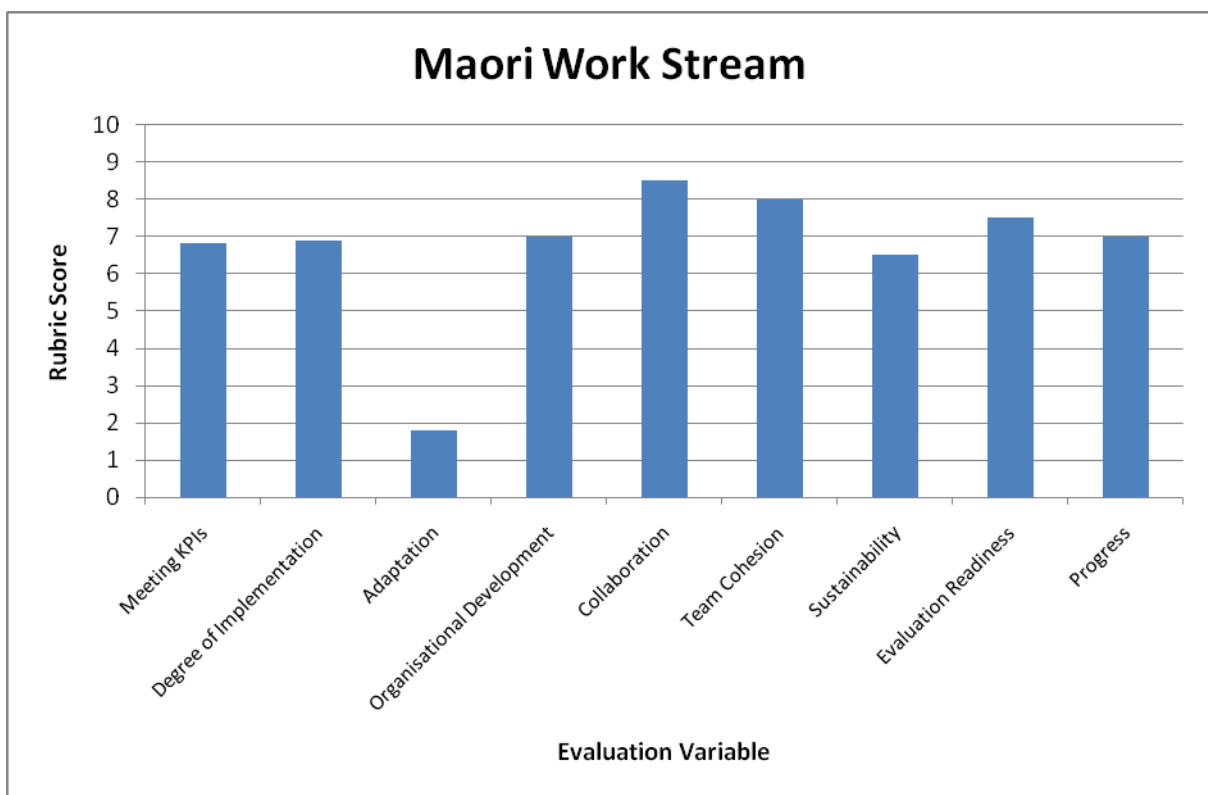
<sup>10</sup> Sub-initiative 1.7.7: Evaluation of MOCAP

supporting existing initiatives, and the evaluation was not yet complete, although it was noted that this was not entirely under the project team’s control.

Initiative 1.8 received moderate scores for meeting KPIs, degree of implementation and overall progress. At the time of writing of this report, a proposal had been signed off for Waitangi Day and the Tuakau College event had been successfully completed.

**Overview of the Maori Work Stream**

A combined analysis of the 2007/2008 and 2008/2009 data was used to provide an overview of the Maori Work Stream over this reporting period. In addition, the Action Area was assessed on their collaboration, sustainability, evaluation readiness and team cohesion. Figure 6 illustrates these findings, and the interview data is used to support the overview.



**Figure 6: Overview of the Maori Work Stream**

**Achievements and Adaptations**

There was a high level of achievement within the Maori Work Stream across the reporting period. The project team noted that they were charged with achieving a large number of initiatives and sub-initiatives within their area, as well as serving as advisor for all of the other Action Areas with respect to Maori issues:

*...we have been working closely with the other project managers to look at what they are doing in their Action Area around Maori responsiveness and we are actually in quite a lot of demand... We do our own role but we also have another role which is advising project managers on anything that is to do with Maori. That’s been a success ... We’re not actually just doing our role, but we’re doing things outside of our job description.*

There was some minor adaptation occurring within the Maori Work Stream, in response to a mismatch between what was identified in the original plan and the most pragmatic and appropriate approach for the target community. A prime example of this was the Maori Steering Group

*We've gone into it with a plan for initiatives, and we've found that that plan might not work so we've had to change it and think about what does actually work for the community ... we've had to slightly adapt some of the initiatives...*

### **Functioning of the Action Area**

The Maori project team are working well with the community, and have a number of different working groups, e.g. MOCAP, PANAK, which provide structure to the area. Strong links were identified with PHOs, NGOs marae, kaumatua and kuia, Kura and Kohanga, and in particular, the MWWL, the Taonga education centre and the Maori Health team. There is a high level of collaboration occurring not just externally but also internally, with strong links between the Maori Work Stream and the various other LBD Action Areas. The Maori project team are working well with other LBD project managers to ensure there is a high level of responsiveness to Maori issues across LBD. This appeared to occur through more informal channels rather than through formalised systems and structures to support communication, although the project team were noted to be active in representing Maori on a number of steering groups:

*We sit on steering groups with all of the other Action Areas. Our relationship with the Action Area is on a real 'when we need you we call you' [basis], when it comes to Maori responsiveness and support...*

Team cohesion was noted to be high for this area, particularly in the 08/09 financial year with the two project managers working closely together to enhance the impact and outputs of the Work Stream:

*The coming together of the Maori team, we do support each other, because we meet fortnightly we support each other in what we do. I think that's what gets us through.*

### **Sustainability**

The project team is working hard to strengthen leadership within the community, to build community capacity, and to improve the ability of the community to run initiatives on their own, with a strong emphasis on training and empowering community organisations to do what they do better:

*The Kaiwhakahaere training is sustainable as it is a train the trainer approach and has been picked up by the community... At the end of the day sustainability comes down to funding, but if the approach of the initiative is that it is a community approach, that key stakeholders can support within a reasonable budget, then it's going to be sustainable.*

Responsiveness to the community was noted to enhance the sustainability of the initiatives, whereas a lack of Maori understanding and responsiveness within LBD was seen as a barrier:

*We run an initiative that our community wants and that increases the sustainability.*

*There is a lack of Maori staff within LBD. There is a lack of knowledge of Maori communities within the LBD structure and understanding Maori communities.*

### **Evaluation Readiness**

The Maori Work Stream evidenced a strong commitment to using evaluation to enhance the work that is undertaken, evaluating the resources and pilot programmes that are developed, and making appropriate changes following feedback:

*We evaluate everything that we do, because we want to know what's working, it's about reviewing the process of our initiatives.*

It was noted that evaluation of initiatives was an important part of the process of procuring funding for the work that is undertaken, and in ensuring the sustainability of this work. Reporting on progress was generally adequate although gaps were noted at times.

### **Summary of Progress**

The Maori Work Stream have worked hard over the previous financial year to foster sustainable partnerships and develop initiatives that support improved nutrition and physical activity, and that are appropriate and feasible for their target community.

There is a strong emphasis on empowering Maori to take ownership of their health concerns and issues, and a high level of engagement with the community across marae, kura and Kohanga settings. This may be attributed in part to the commitment of the project managers and the relationships they have established with Maori in the community.

Some frustrations were expressed with respect to the bureaucracy and challenges involved in procuring funding and getting the go-ahead with initiatives, and this was seen as a real barrier to progress within the area, particularly in terms of its effect on the community they serve:

*I know what's needed, you don't hire people to be managers and then not let them do it... I'm not managing the whole process, I want to manage the whole process. There are too many hoops to jump through to get the money... I think the biggest frustration for our people, is that we are too slow as an organisation, we talk and talk and talk, then we agree and then it takes months to get funding...*

*We in the Maori Action Area know our community and how to work with our community but basically to go ahead with initiatives we have to have it signed off at all levels and it can be quite hard to get it through all of the levels, it has slowed us down on the ground...*

### **Changes over Time**

Significant increases were observed in scores for this workstream in terms of meeting KPIs and cohesion, which is a reflection of the strength of the two Maori project managers in working collaboratively to achieve their set objectives and the large amount of work being carried out in this Action Area.

### ***Issues for Consideration***

- The number and breadth of the initiatives which the Work Stream is charged with, in addition to their advisory role within LBD.
- Interviewees indicated a need for more Maori staff within the Work Stream and LBD as an organisation, as those that were employed were stretched to fulfil the ad-hoc advisory role which they had inherited. The appropriateness of sending Pakeha people into Maori communities to do work that should be delivered by Maori was also questioned.
- Progress towards KPIs for the 08/09 financial year is not fully represented given that reporting is occurring midway through the financial year.

#### **4.1.3 Pacific Work Stream**

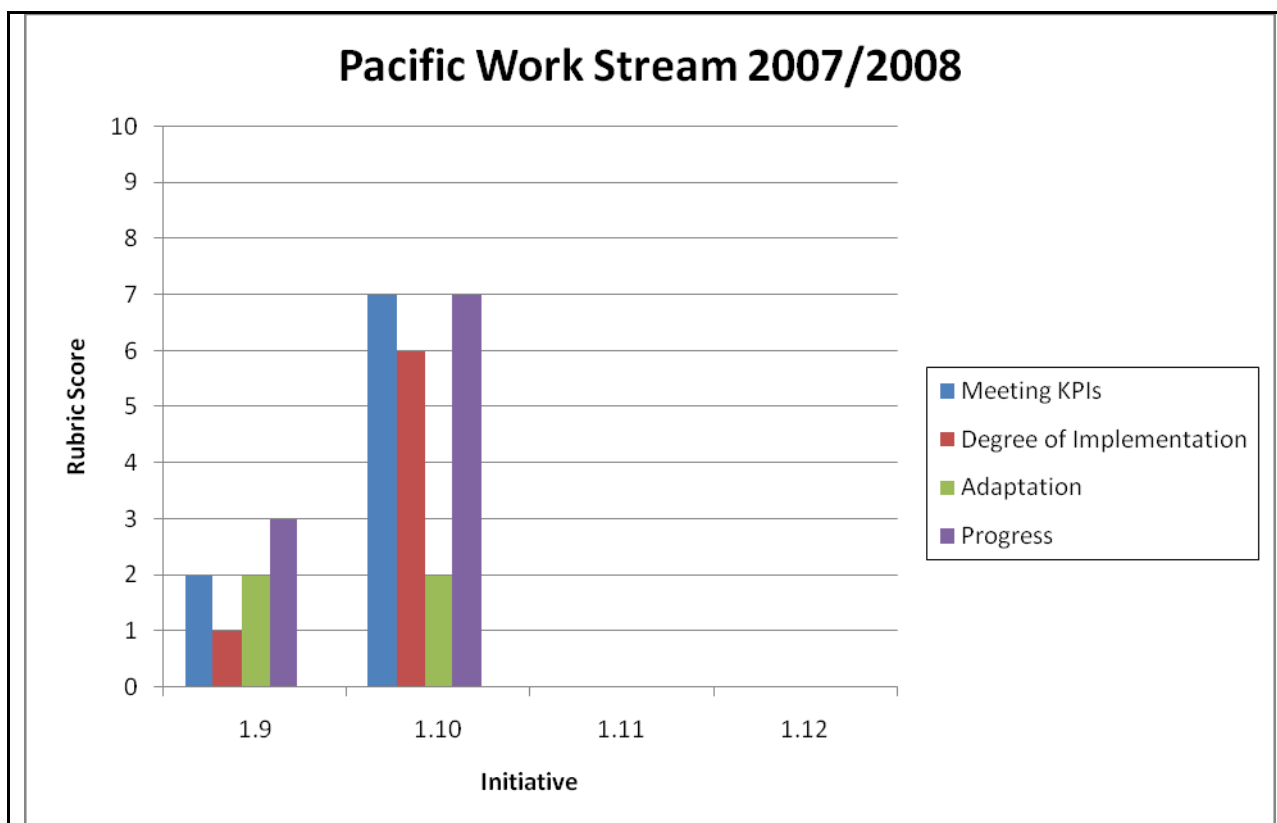
Extensive consultations with Pacific peoples to ascertain their needs, aspirations, priorities and appropriate approaches to meeting these, were undertaken via fono, working groups and community consultations. Community representatives and providers consistently supported Pacific churches and language nests as being the starting point for Let's Beat Diabetes (LBD). To this end, the focus for LBD in 2008/09 is on supporting Pacific churches and language nests (7.6) to develop and implement nutrition and physical activity initiatives within their communities; equipping Pacific leaders and their congregations with information about Self Management Education of Type 2 diabetes and its risk factors so they can become agents of change; and improving nutrition and physical activity for people who are obese and at risk of getting diabetes has been identified for priority action. Underlying all of the interventions/initiatives is a community development process of increasing community knowledge and capacity to support Pacific community groups to become leadership hubs for change.

The Pacific Community Obesity Plan 08/09 focuses on extending the program reach to non-church attending and ethnic specific Pacific people. It also focuses on Pacific youth as future decision makers in the prioritisation of nutrition and physical activity in the home.

#### **Pacific Work Stream Progress for 2007/2008**

The nature of the KPIs encompassed by each Action Area will impact on the scores on each of the evaluation variables that the Action Area is designated. It is of note that the majority of the initiatives under the Pacific Work Stream were categorised as involving elements of interventions targeted at prevention or programme development, the nature of which is relatively labour intensive.

The Pacific Work Stream involves a number of sub-initiatives under each initiative. The breadth of activity occurring under each initiative was often considerable. Progress for each sub-initiative was scored and then these scores were collapsed to generate one overall score for each initiative. Consequently the reader is advised to refer to the data supplement for a more thorough breakdown of progress by sub-initiative.



**KEY: 2007/2008 Action Area: Pacific Work Stream**

1.9	Empowering self-identified and community identified leaders and organisations to become agents for change within their families and communities
1.10	Pacific churches to develop and implement nutrition and physical activity initiatives
1.11	Kids in Action
1.12	LotuMoui Church Aerobics

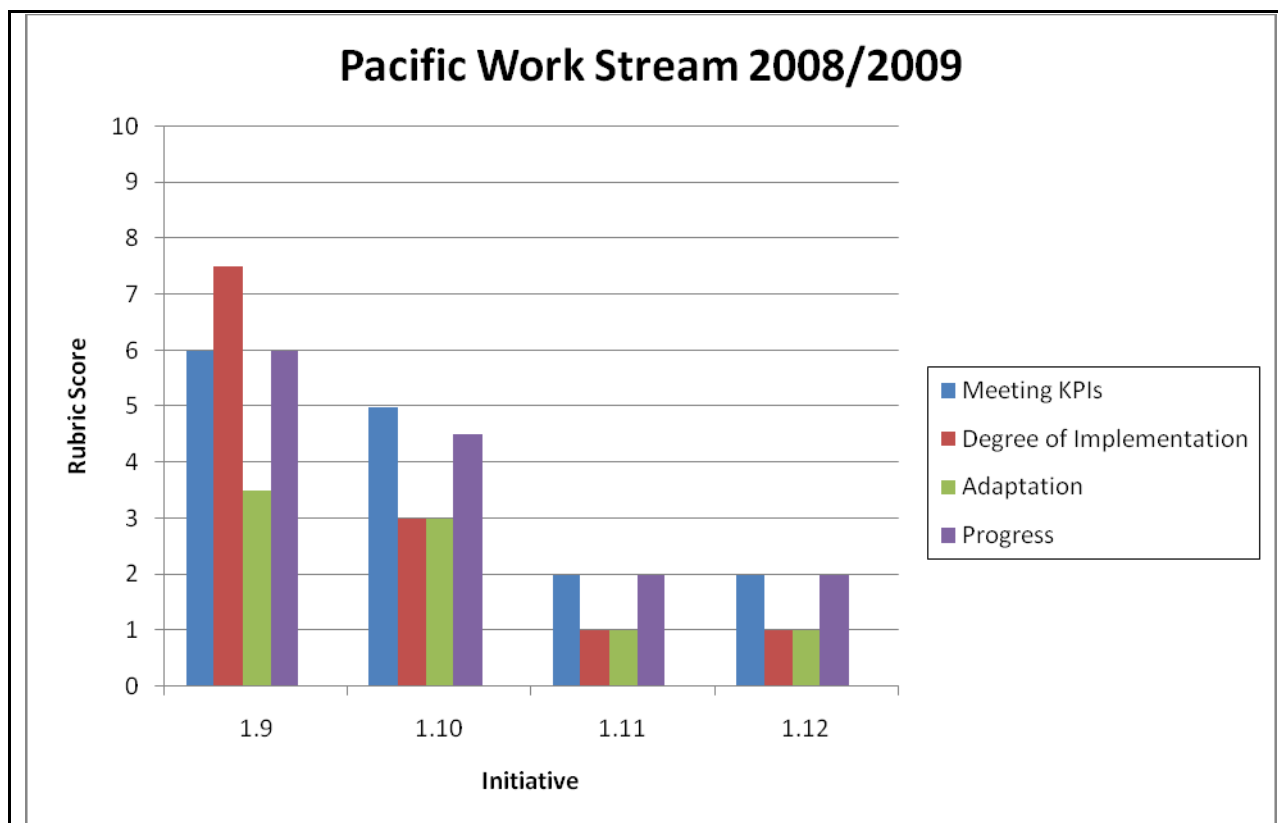
**Figure 7: Pacific Work Stream 2007/2008**

The KPIs under initiative 1.9 had been deferred until the 08/09 financial year, which meant that the initiative received a low score for meeting KPIs, implementation and progress, and a somewhat elevated score for adaptation. Some meetings were held, albeit no actual forums in line with the goal of having debate and dialogue around cultural practices and language in relation to diabetes.

There is a lot of activity that falls under initiative 1.10, with a great number and breadth of sub-initiatives. Consequently although a lot of work was being undertaken not all of the stated objectives had been achieved, which resulted in more moderate scores for meeting KPIs, implementation and progress. The project team had achieved some of the sub-initiatives, e.g. the workshops (although it was unclear from the evidence provided exactly how many had been held), the delivery of special training to the 30 people for nutrition, and incorporating key messages from the LBD social marketing campaigns, and were still progressing others. The SME pilot had been implemented, and was in the process of being evaluated. The LotuMoui Games were deferred until Oct, and some of the training had to be deferred until 08/09 also due to lack of capacity, which meant the initiative had a slightly elevated score for adaptation.

No information provided in relation to initiatives 1.11 and 1.12; consequently the evaluation team were unable to score these initiatives.

### Pacific Work Stream Progress for 2008/2009



**KEY: 2008/2009 Action Area: Pacific Work Stream**

1.9	Pacific churches and other Pacific communities to develop and implement nutrition and physical activities
1.10	Kids in Action
1.11	LotuMoui Church Aerobics
1.12	LotuMoui Ministers leadership and modelling pilot

**Figure 8: Pacific Work Stream 2008/2009**

Initiative 1.9 received a moderate score for meeting KPIs and progress and a higher score for implementation. This was an artefact of the efforts of the project team being primarily directed towards the Games, which meant that not all of the set KPIs were achieved. This also accounts for the significantly elevated adaptation score; the project team recognised the potential impact the games could have and so refocused their activity to strengthen this impact. Aside from planning for the Games, the project team was working informally in the churches to build relationships.

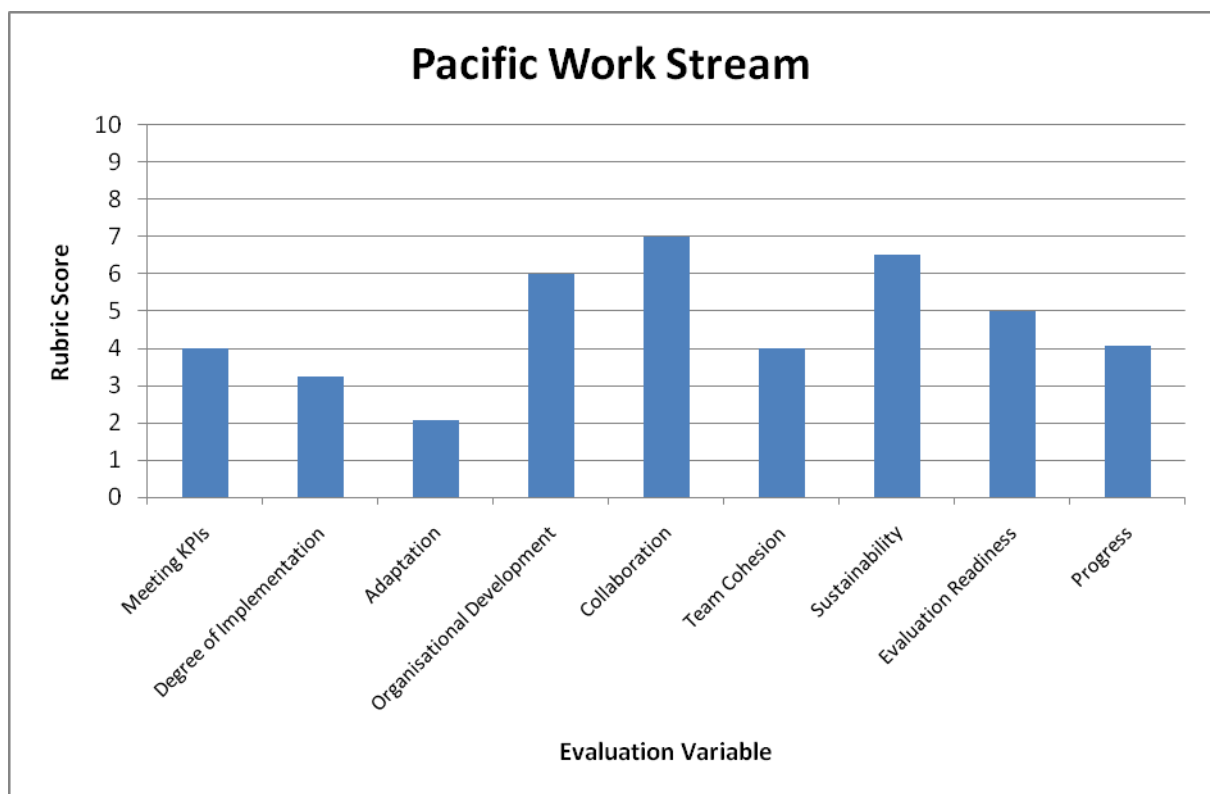
Initiative received low to moderate scores across the board, in part due to the fact that there was a significant gap in reporting in relation to this initiative. No information was provided to the evaluation team as to the total number of people attending the KIA programme. It was noted that the evaluation had been completed and that the project team were learning from this and using it to

guide and inform programme development. Some resources were being provided to families although it was noted that these needed to be refined. The evaluation team could not justify a higher score for progress because not enough information was provided as to the actual implementation of the programme.

The evaluation team was provided with very little information in relation to initiative 1.11, which made it difficult to score these initiatives and give an accurate reflection on progress. This was also the case for initiative 1.12; the information provided indicated that the project team were still trying to identify providers, however no contracts had been formalised. Consequently the implementation of the pilot programme was significantly delayed, which resulted in a low score across the board, with no evidence of positive adaptation which might have justified a higher score on this variable.

**Overview of the Pacific Work Stream**

A combined analysis of the 2007/2008 and 2008/2009 data was used to provide an overview of the Pacific Work Stream over this reporting period. In addition, the Action Area was assessed on their collaboration, sustainability, evaluation readiness and team cohesion. Figure 9 illustrates these findings, and the interview data is used to support the overview.



**Figure 9: Overview of the Pacific Work Stream**

***Achievements and Adaptations***

The Pacific Work Stream received moderate scores for the meeting KPIs and progress variables, and a low score for degree of implementation. The Pacific team undertook a significant amount of work in preparation for the LotuMoui Games in both 07/08 and 08/09 financial years which took precedence over the other activity assigned to the project team, which meant that a lot of the

initiatives which were to be undertaken got put on hold and were not achieved within their set timeframes, or at all.

The games were highlighted as a key achievement, providing an opportunity to showcase the changes that are starting to occur within that community related to physical activity and nutrition. The interview data highlighted that there is frequently a mismatch between what the DHB and the Ministry see as key outcomes, and what the individuals involved at the coalface see as important:

*It would be great to get this [the success of the Games] captured, instead of KPI's all the time...so not just focussing on figures, which are important, but the stories need to be also heard which are equally and perhaps more important – how do you measure it though to show MOH and LBD....so attitude changes, positive behaviours...*

The LotuMoui programme has been identified as a key vehicle moving forward for driving improvements in Pacific health, and so the time spent building relationships with key individuals in the churches is vital. This is where the Pacific team appear to be excelling; there is a high level of engagement and awareness within the churches, and it was felt that the time and effort spent nurturing and maintaining these relationships is not reflected in the KPIs for this Work Stream:

*The success is the relationship that has really been developed with the churches and that really important and I think we really need to enhance that. Those relationships really are key because without those relationships you can forget about anything else!*

It would appear however, that the project team need to strike a balance between this focus on relationship-building and partnership, and achieving their set KPIs in a timely fashion. There was minimal adaptation evident in the actions undertaken by the Pacific Work Stream, other than deferring a number of initiatives until after the LotuMoui Games.

### **Functioning of the Action Area**

The organisational development of the Pacific Work Stream was seen as hindered by capacity issues. Although the leadership was seen as appropriate, as the programme has grown a need for new Pacific staff has been identified. The project team feel that they are limited in what they can achieve with the current resourcing. A need for more strategic planning was also identified in order to maximise the sustainability of the work that is undertaken:

*...we need to plan out and manage and coordinate for the next 10 years. Also evaluation needs to be done regularly*

There is also a need for the LotuMoui work to be better integrated with other Pacific projects, in order to fully realise the potential of the programme. The flow of information is far from optimal due to the disconnect between these different programmes that are so clearly aligned. There is also a distinct lack of communication across the LBD Action Areas, which limits both the Pacific team and the other Action Areas in terms of their responsiveness to Pacific issues. The Work Stream scored relatively low on the team cohesion variable due to the issues identified in relation to capacity and the Pacific Health Team/LotuMoui split.

In terms of collaboration, the Pacific team are doing well with partnering with the churches, as well as their funders and providers. The LotuMoui Games is a good example of how collaboration can be enacted:

*In terms of the relationships with communities...it is really good. The brand, LotuMoui is becoming very trusted now.*

*It's about the community...we don't want to have the mentality of do unto them. That's something we want to avoid at all cost. But to actually be in true partnership...*

Opportunities were identified for the project team to work closer with the Pacific Health team (particularly with mental health programmes), general practitioners, the Ministry of Education, the police, and social development agencies such as ACC, Work and Income New Zealand, and Inland Revenue.

### **Sustainability**

The sustainability of the work being undertaken by the Pacific team was highlighted as a concern by interviewees. Although on the one hand, the approach is inherently sustainable in its focus on capacity building, and putting the onus onto the church and community leaders to develop initiatives, concerns were expressed about becoming overly reliant on the community to deliver these programmes:

*LBD is based on community development within our LotuMoui and I feel that sometimes we undervalue that. I think we should be putting more funding into that area to support the ongoing development of people. So it's about capacity, it's about capability, but it's also about workforce development...*

*We're working with the churches, which are voluntary groups, they're delivering programmes within their churches which are funded by us...But the buy-in to that is probably less successful because those same people are either full time students, full time workers, they've got families to take care of, they've got churches to take care of...So when you are asking those people to deliver from a voluntary point of view that might be ok at the beginning...but actually you don't get complete buy-in...The other issue is that people need to be valued for the work they do.*

A related concern with respect to the sustainability of the LotuMoui work was the likelihood of being able to secure ongoing funding:

*I think in some respects there is a huge concern over the sustainability of the programme...I think the key hinder would be lack of money to continue the work and that's through the whole prioritisation issue...*

A number of enablers to the sustainability of the programme were identified by the interviewees. Reducing capacity issues, increased collaboration and better alignment with strategic partners were identified as crucial to the sustainability of the work:

*To increase the impact we need better collaboration, better linkages, to try to spread the workload as much as we can. We're trying the community development model, but even that*

*takes quite a long time for people to be comfortable going out on their own and doing it, so maybe there could be a much better alignment of our strategic partners and our operational type things going on*

The spiritual aspect of the programme and the social networks afforded through church communities were also seen to enhance the sustainability of the initiatives, and the targeting of Pacific youth was seen as an important next step:

*Because it's a Christian programme with Christian values it has helped sustainability...Targeting Pacific youth also in the future would be very important for sustainability...*

Finally it was stressed that the relationships that been established would need to be maintained at all levels, that is with communities, providers, and funders, if the LotuMoui programme is to continue the successes that have been seen to date.

### **Evaluation Readiness**

The Pacific Work Stream appeared to have little awareness of the evaluation that was being undertaken by the School of Population Health and was not engaged in this process. There were significant gaps in the information that was made available to the evaluation team to inform this report. With respect to monitoring their own progress, the project team is reliant on the submission of reports from the churches on a 6-monthly basis regarding what is being done with the funding and any changes that are being effected as a consequence of this funding and mentoring.

The project team reported a commitment to evaluation, although this is not necessarily consistently demonstrated in the work undertaken:

*It is well over-due, the evaluation. It will tell us exactly what we need for MOH reports and for the future of the LotuMoui programme...*

However the findings from the Kids in Action evaluation are being used to develop and expand the programme which is a key achievement in and of itself and is likely to enhance the sustainability of the initiative. The evaluation of the SME pilot was also underway.

### **Summary of Progress**

The Work Stream suggested that there is huge potential housed within the LotuMoui model, not only to promote awareness and behaviour change around the risk factors for type 2 diabetes, but also as a vehicle to drive other health-related changes:

*[LotuMoui can be used] as a vehicle to look at other areas, for example, mental health, LBD smoking cessation, women's health (particularly cancers, including cervical and breast), also looking in the future around men's health (prostate) and gout...*

The project team has made great strides in establishing relationships with the Pacific community and in fostering collaboration and partnership within that community. The data however, suggests that an increased focus on the management and coordination of the Work Stream would support the achievement of some tangible outcomes. There is also a need to work closer with the other Action

Areas in an advisory capacity to enhance LBD responsiveness to Pacific issues, and with the Pacific Health Team to work more efficiently towards their common goals- this is especially pertinent due to the capacity issues that are currently faced.

### ***Changes over Time***

There was a significant increase in the Work Streams score in organisational development was observed, whereas there were decreases in the collaboration and cohesion variables. Although the project team have established very strong relationships with the LotuMoui programme, which is a key success in and of itself, a need was identified to work more closely with Pacific Health within the DHB, and the various other LBD Action Areas to increase responsiveness within the organisation to Pacific issues. There have also been considerable staff turnover within this Work Stream which may account for some of this variance.

### ***Issues for Consideration***

- Given the capacity issues facing the Pacific workforce within the health sector, it is important to consider developing the capacity of the local community to support the work outlined within the Pacific Work Stream.
- In terms of information sharing, a reliance on the churches to provide feedback on progress every 6 months may be worth reviewing given the gaps in available information. More frequent reporting might also improve the level of responsiveness to any issues or opportunities, as a lot can happen within 6 months.
- Enhancing the relationships between the Pacific Work Stream and the other LBD Action Areas to support responsiveness to Pacific communities.
- Progress towards KPIs for the 08/09 financial year is not fully represented given that reporting is occurring midway through the financial year.

#### ***4.1.4 South Asian Work Stream***

The Asian people in CMDHB are a culturally diverse group with each ethnic group having its own language, customs, traditions and health issues. The Asian community totalled approximately 83,000 people living within Counties Manukau in 2006. This population is expected to grow by more than 90% over the next 20 years.

This particular area focuses on those of South Asian descent as this population has a higher risk of diabetes than other Asian populations.

In 2007/08 LBD began to work with the South Asian community and a leadership group was formed.

During 2008/09 a South Asian Community Action Plan will be developed through consultation with the community. From this plan a number of key initiatives will be developed to improve the prevention, treatment and management of type 2 diabetes for this community.

### South Asian Work Stream Progress for 2007/2008

The South Asian Work Stream commenced work in July 08, therefore no information is presented in relation to progress for the 2007/2008 financial year.

### South Asian Work Stream Progress for 2008/2009

The nature of the KPIs encompassed by each Action Area will impact on the scores on each of the evaluation variables that the Action Area is designated. It is also of note that the initiatives under the South Asian Work Stream were classified as comprising activities involving structural development and collaboration which may be relatively time intensive. This should be taken into account when interpreting the Action Area's progress in achieving these KPIs.

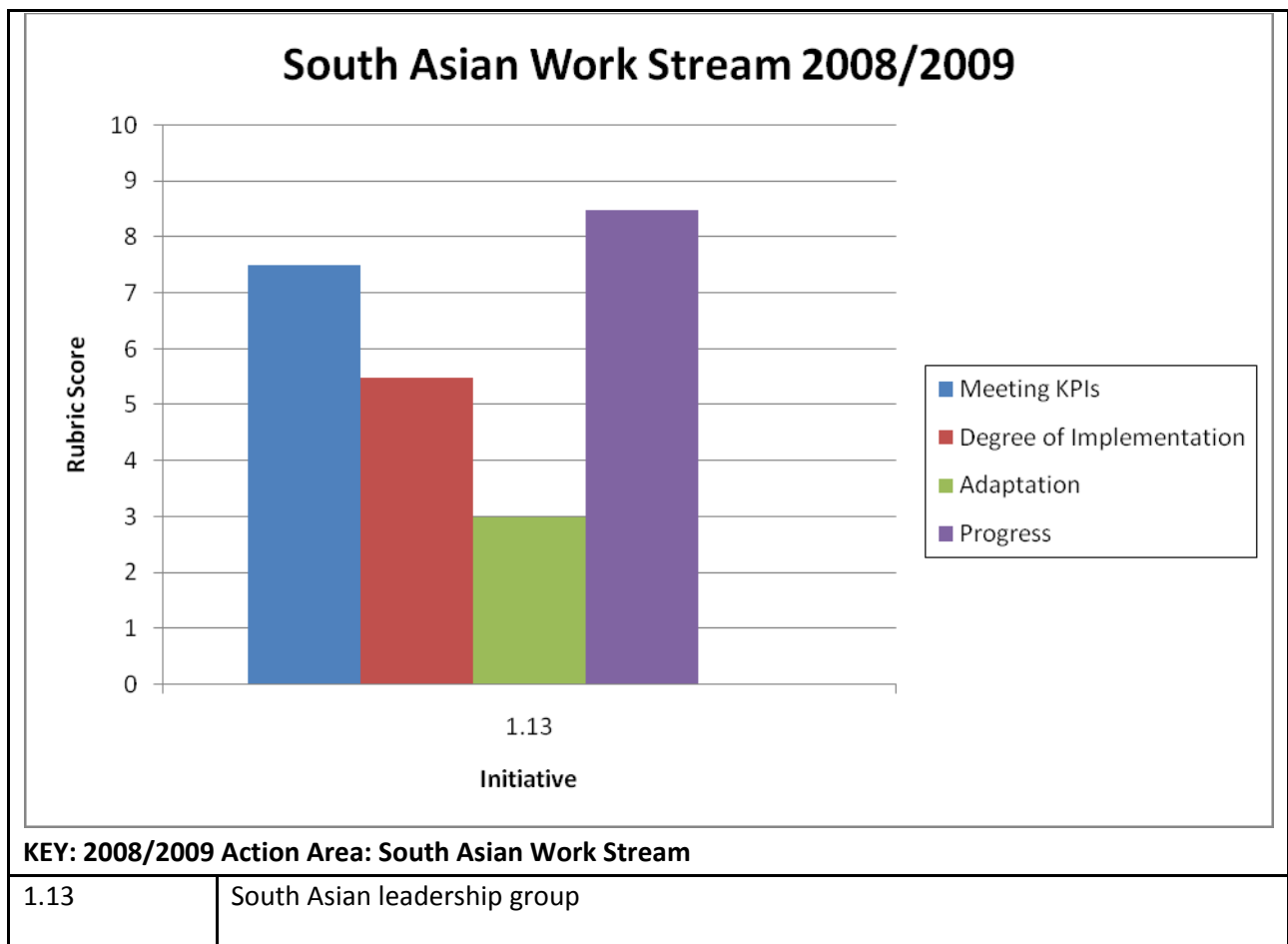


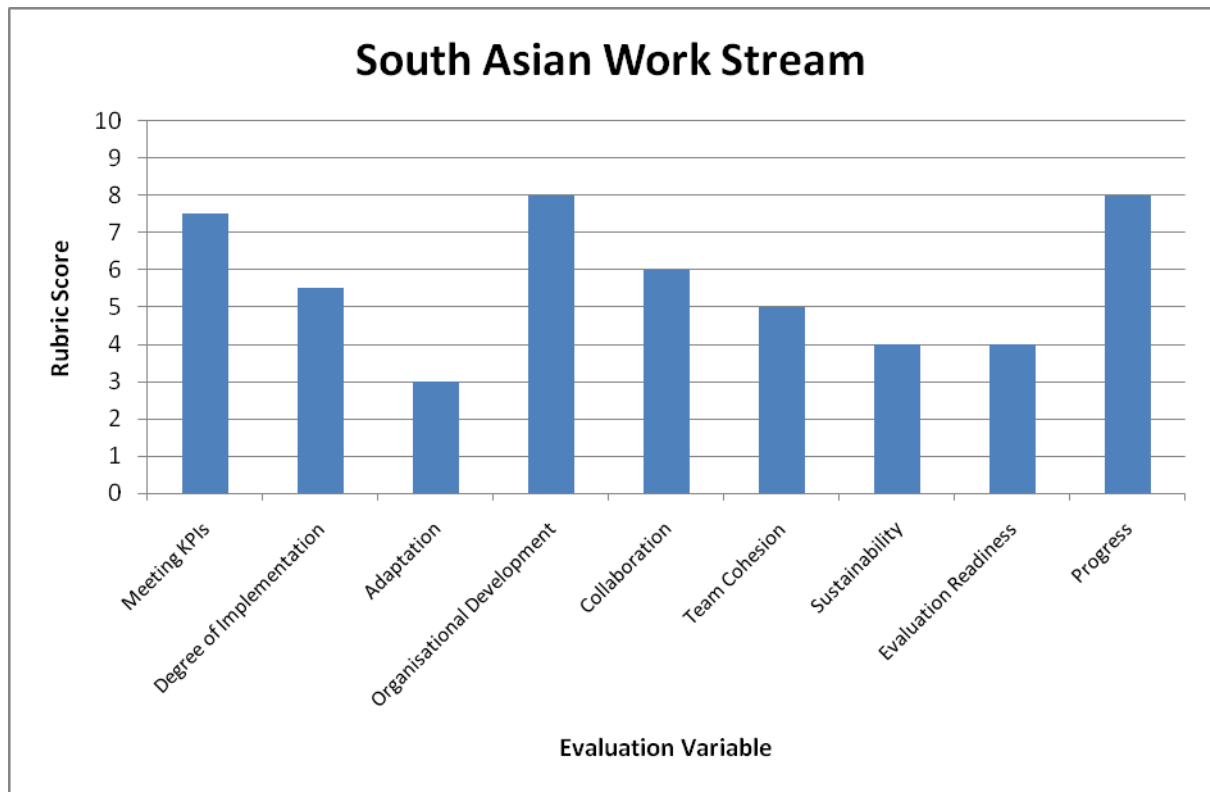
Figure 10: South Asian Work Stream 2008/2009

Initiative 1.13 involves the collaborative development of Community Action Plan. The Work Stream received a high score for meeting KPIs and progress, as there was evidence that the leadership group were meeting regularly, and a significant amount of work was being undertaken towards getting the Action Plan completed. It is envisaged that this plan will be completed by Jan 09 (one month behind timeline). The identification/implementation of two initiatives is on schedule within the development of the Action Plan. This resulted in a somewhat lower score for implementation, although the score was moderate due to the community consultation that had been undertaken in

preparation for the Action Plan. The adaptation score for this initiative was somewhat elevated due to the level of responsiveness to feedback on the Action Plan from various stakeholders.

**Overview of the South Asian Work Stream**

A combined analysis of the 2007/2008 and 2008/2009 data was used to provide an overview of the South Asian Work Stream over this reporting period. In addition, the Action Area was assessed on their collaboration, sustainability, evaluation readiness and team cohesion. Figure 11 illustrates these findings, and the interview data is used to support the overview.



**Figure 11: Overview of the South Asian Work Stream**

***Achievements and Adaptations***

The Work Stream achieved a high level of progress towards meeting KPIs and achieving the desired outcomes for this area. There has been a high level of consultation with the community that has informed the development process for the Action plan, and community organisations and groups are engaged in and committed to this process, which elevated the Work Stream’s score for degree of implementation. It is acknowledged that it is vital to get the approach right from the outset with an initiative of this kind, and there is a strong focus on this process, as well as outcomes.

There was minimal adaptation to the original aims identified in the 2008/2009 Operational Plan; however there was evidence that the leadership group were receptive and responsive to feedback on the Action Plan which necessitated a slightly elevated score for adaptation.

### ***Functioning of the Action Area***

The work being carried out in this Action Area is different to other AA's in that it is foundational work and is focused on developed leadership structures rather than initiatives. A great deal of time and effort has been dedicated to ensuring this foundational work is best practice and undertaken with an appropriate degree of community consultation. This involved developing a literature review and conducting surveys and focus groups with the local South Asian community as well as liaising with other organisation whose interest is with the South Asian community. Taking this into consideration, leadership and governance in this area is functioning well, with a reasonably strong steering group, the members of which have been very involved in the decision-making process throughout the development of the action plan. There is a high level of community consultation occurring. The Steering Group also involves representatives from a variety of community organisations and groups; however a need was identified for a greater level of support from LBD as an organisation, as well as more focus engagement from the steering group with respect to input into the development of the Action Plan. Given that a key component of organisational development is the ability to smoothly and efficiently work in partnership with other organisations, establishing links and building co-operative relationships, the South Asian Work Stream scored highly on this variable.

The Work Stream received a moderate score for collaboration in reflection of the early stage of the initiative; however there is evidence for a concerted effort to involve the community from the outset, and there appears to be a good level of buy-in from the South Asian community. The project manager regularly communicates with other Action Area leaders, and is receptive to sharing ideas at this level, however there is little in the way of joint initiatives given the early stage of the initiative.

The team cohesion variable was difficult to score for this workstream, given that it is managed by one individual; however this score was elevated by the prioritisation of shared decision-making and the engagement of the steering group. It was unclear, however, how the Work Stream is engaged with the rest of LBD, and how the needs of the South Asian community are reflected and responded to across the programme as a whole.

### ***Sustainability***

Sustainability was noted to have been a key consideration in the planning stages of the initiative. The Action Plan is looking ahead, however it was noted that this needs to be continuously revisited to ensure that it is a sustainable plan and is giving the community the right tools and support as needed. Workforce training, both professional and within the community, was seen as critical to the sustainability of the initiative.

### ***Evaluation Readiness***

Evaluation was acknowledged as an important aspect of the life cycle of the initiative, and it is envisaged that this will be incorporated into their Action Plan once priorities have been identified, in early 2009.

### ***Summary of Progress***

The Work Stream is to be commended on the level of progress to date, given that the nature of the initiative required starting from scratch, establishing a strong, cohesive steering group that is

representative of the community they serve, and developing a comprehensive action plan in a limited time frame. It is clear that the Work Stream is putting in a considerable amount of effort to get the process right the first time, even if this has meant less in the way of demonstrable outputs.

### ***Changes over Time***

As this initiative was newly introduced in 2008 this Work Stream could not be analysed with respect to changes over time.

### ***Issues for Consideration***

- The early stage of the initiative.
- Trying to accommodate differing ideas from those involved as to what will work within the community, and balancing these against DHB expectations.
- Barriers related to the cultural diversity of the South Asian community.
- Increasing integration with LBD to ensure responsiveness across other LBD Action Areas and initiatives.
- Progress towards KPIs for the 08/09 financial year is not fully represented given that reporting is occurring midway through the financial year.

#### ***4.1.5 Workplace Work Stream***

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

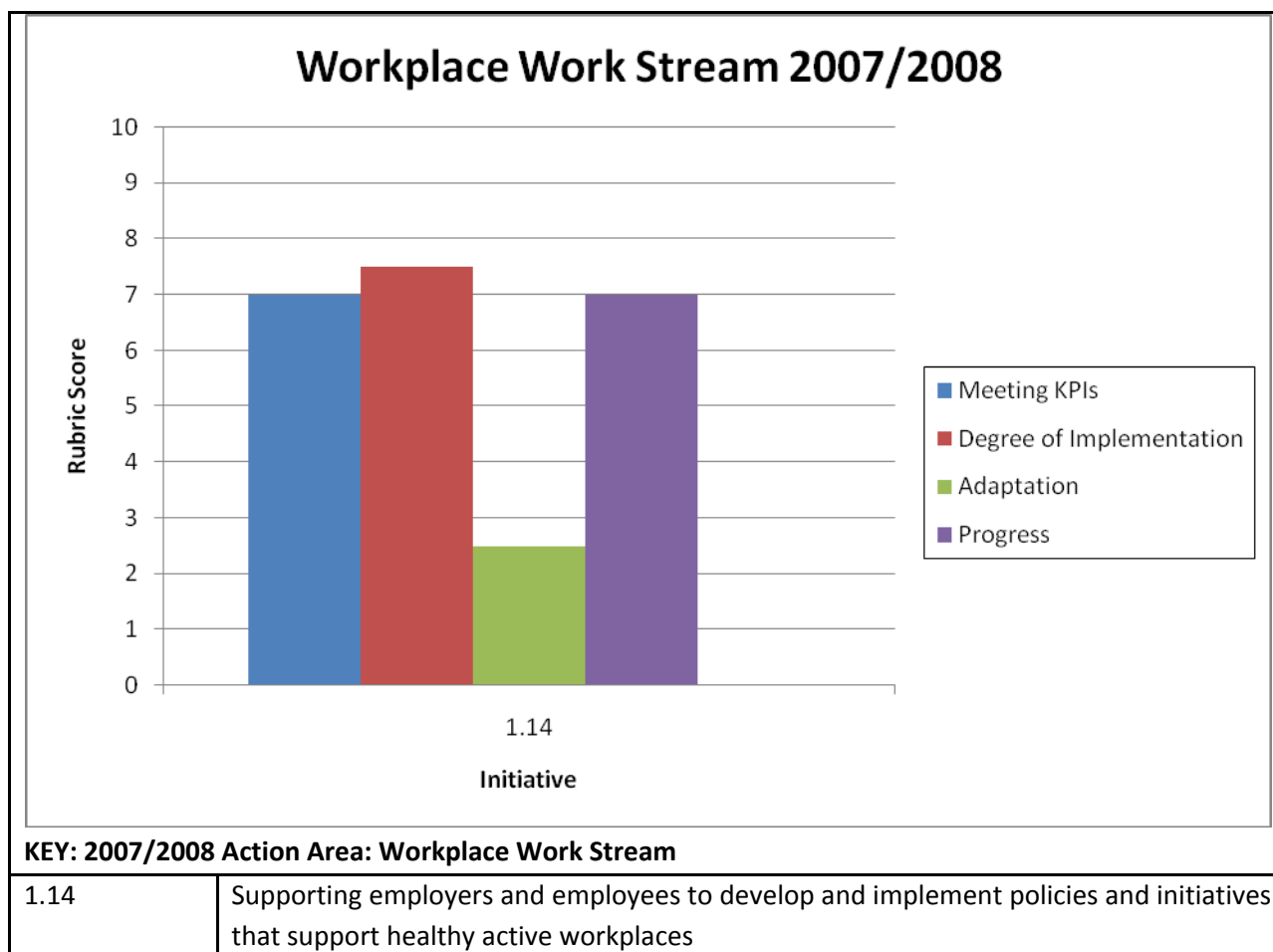
In 2007/2008 the Auckland Regional Public Health Service (ARPHS) led this action area on behalf of LBD. The Heartbeat Challenge (HBC) programme was offered to partner organisations, CMDHB, Housing New Zealand Corporation (HNZC), Ministry of Social Development, Ministry of Pacific Island Affairs (MPIA), Manukau City Council (MCC), Papakura City Council and Franklin District Council to enhance or develop and implement policies and initiatives that support healthy, active workplaces. The programme was successfully implemented by CMDHB and HNZC, with HNZC receiving their HBC in December 2007. Within the CMDHB area the programme continued to be delivered to workplaces especially those employing Maori and/or Pacific Island and/or lower socio-economic workers.

A scoping exercise has been completed on the interest of small to medium enterprises in a workplace health programme. A review of the literature around workplace wellness and SME was conducted in June 2008 and consultation with Auckland based SMEs commenced. The scoping report will be delivered in July 2008. In 2008/2009 the focus was again identified as supporting employers and employees to develop and implement policies and initiatives that support healthy active workplaces

#### ***Workplace Work Stream Progress for 2007/2008***

The nature of the KPIs encompassed by each Action Area will impact on the scores on each of the evaluation variables that the Action Area is designated. The Action Area's progress is commendable given that the number of individual KPIs that were set out for this initiative was high. It is also of note that the initiatives under the Workplace Action Area were classified as comprising activities involving programme development and more specifically intervention targeting prevention; both of

which are relatively labour intensive. This should be taken into account when interpreting the Action Area’s progress in achieving these KPIs.



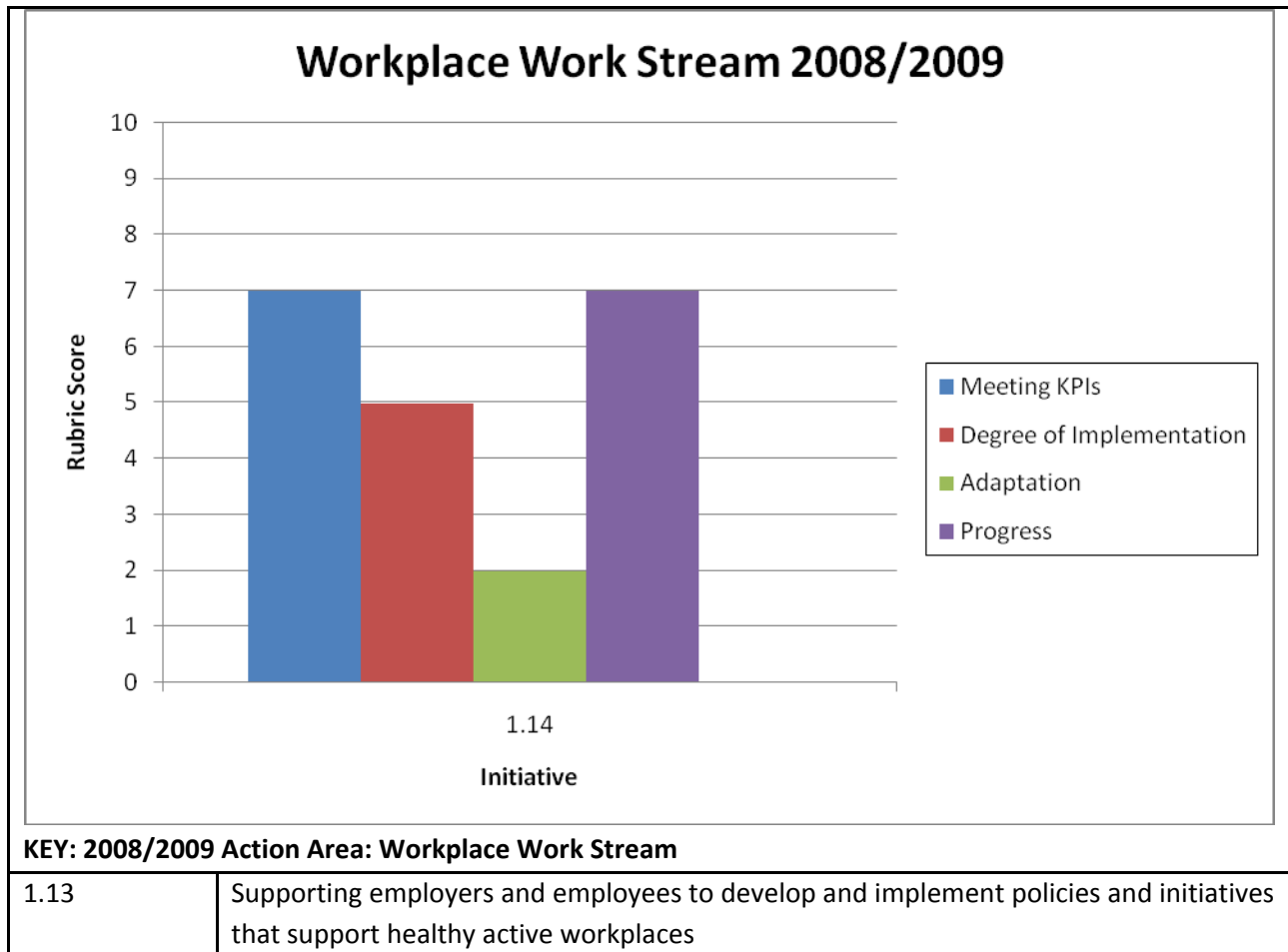
**Figure 12: Workplace Work Stream 2007/2008**

This initiative achieved a high score for the meeting KPIs, degree of implementation and progress variables. The reporting period for this report encompassed sub-initiatives 1.14.1<sup>11</sup> through to 1.14.5<sup>12</sup> only, hence the scores presented in Figure 13 are reflective only of progress towards those KPIs. Existing partners engaged in the HBC programme (Housing New Zealand, Papakura City Council and ARPHS) were working towards awards, and discussions were held around instigating the programme within LBD. The project team was also actively recruiting new workplaces, with a focus on those within the Food Industry, to participate. The reader is referred to the Data Supplement that accompanies this report for a list of workplaces engaged in the HBC. Uptake of the programme was on schedule, and all work was noted to be focussed towards Maori and Pacific work places. The communications plan was finalised, however this was achieved behind timeline, with ARPHS having taken the lead of this initiative. This resulted in a slightly elevated score for the adaptation variable.

<sup>11</sup> Sub-initiative 1.14.1: Engage large LBD partners in the Heartbeat Challenge (HBC) workplace programme

<sup>12</sup> Sub-initiative 1.14.5: Develop a communication plan

**Workplace Work Stream Progress for 2008/2009**



**Figure 13: Workplace Work Stream 2008/2009**

As seen in Figure 13, this initiative achieved moderate scores for the meeting KPIs, degree of implementation and progress variables; this was in part a function of the monitoring report being written halfway through the time period allocated for achieving these KPIs. The KPI also does not meet the SMART (specific, measurable, attainable, realistic and timely) criteria, which complicates measurement and evaluation of progress. Certain sub-initiatives had been achieved or were on track to being achieved within the designated time frames. For example the project team had successfully brokered an agreement to profile success stories on the website and other medium to promote the HBC programme. The vending machine guidelines had been developed and were available on the ARPHS website. The scoping exercise in relation to a wellness programme for small to medium enterprises was completed, as was a literature review around workplace wellness, with the outcome being that this was not feasible at the current time. It was planned to revisit this in the next financial year. Other KPIs were achieved, albeit behind timeline, such as the identification of five workplaces to participate in the HBC. Certain sub-initiatives, however, had not yet started or were still progressing. A workplace to be developed as a case study to promote the HBC had yet to be identified at the time of writing of this report. The communications plan had yet to commence at the time of writing of this report, however the evaluation tool for ‘blue collar’ workplaces was in the

process of being completed. Discussions were being held around re-branding to reflect HBC partnership.

The adaptation score for this initiative was lower, as although there were unanticipated delays in achieving a number of the sub-initiatives, and in particular issues in identifying and recruiting workplaces to fulfil more specific quotas (as in the previous financial year), there was no evidence provided to the evaluation team as to how the project team were revising their work plan to tackle these issues.

### Overview of the Workplace Work Stream

A combined analysis of the 2007/2008 and 2008/2009 data was used to provide an overview of the Workplace Work Stream over this reporting period. In addition, the Action Area was assessed on their collaboration, sustainability, evaluation readiness and team cohesion. Figure 14 illustrates these findings, and the interview data is used to support the overview.

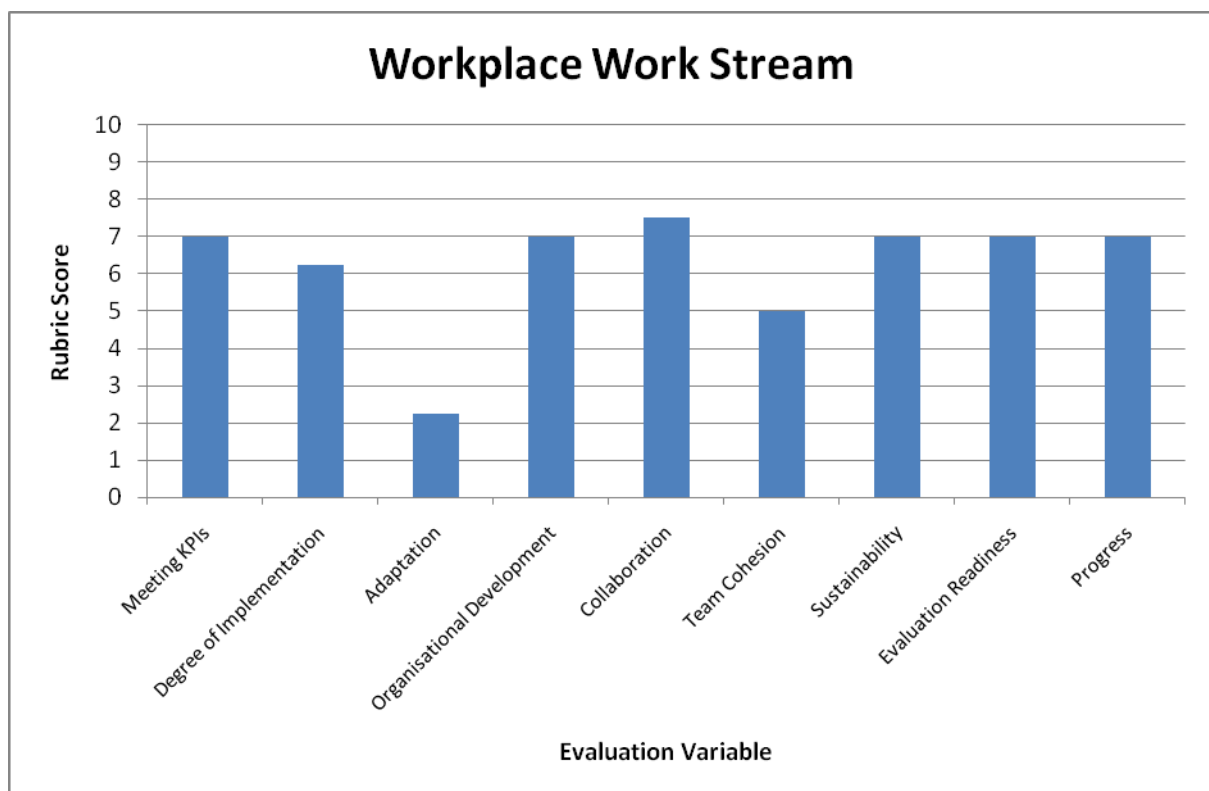


Figure 14: Overview of the Workplace Work Stream

### Achievements and Adaptations

An analysis of the combined 2007/2008 and 2008/2009 data was used to provide an overview of the Work Stream's progress. The Workplace Work Stream involves a number of sub-initiatives, and the breadth of activity occurring under this initiative was often considerable. The Work Stream received moderate scores for meeting KPIs and degree of implementation, however this was in part a function of progress in 08/09 being lower due to the fact that reporting is occurring part way through the financial year. For the most part the Work Stream appeared to be on track towards

meeting its stated objectives, and was undertaking extensive consultation with a variety of workplaces to try to promote the HBC programme.

The evidence provided suggested that minimal adaptation was occurring, and this was supported by the interview data. This may reflect a lack of need for adaptation given the progress that is being made towards meeting KPIs and implementing programmes. Consequently the Work Stream received a low score for this variable.

### ***Functioning of the Action Area***

Organisational development within this Work Stream received a relatively high score, as there appeared to be effective leadership in place, and a good flow of information amongst the workplace team (comprising the Action Area leader, 2.5 FTE health promoters, facilitator/trainer, communications, nutritionists etc.) This also influenced the Work Stream's score on the team cohesion variable; although the team is small there is good communication and information sharing occurring.

Collaboration is inherent in the initiatives this Work Stream is tasked with achieving, and consequently this is occurring with an extensive number of groups and community organisations. In addition to the workplaces that have partnered in the HBC programme, the Work Stream is collaborating with a number of NGO's, including the Heart Foundation, the Cancer Society, Diabetes Auckland, the Arthritis Foundation, Men's Health, and a women's nursing group. In addition, the interviewee noted that the project team has partnered with the Sports Trust, PHOs, the territorial councils, EEO Trust, Department of Labour, and the YMCA.

*We collaborate with a lot of organisations because with the programme we facilitate, so we have the framework for the programme and we facilitate people to come into the workplace... so we have to have a very broad base of organisations that we collaborate with so we can bring people in...*

Although collaboration at the external level is functioning well, very little collaboration was noted to be occurring at an internal level with the other LBD Action Areas, or more generally with LBD as an organisation, although there were discussions around how the partnership between the HBC programme and LBD could be reflected in the re-branding and the communications plan. The interviewee reported that this was largely due to the fact that ARPHS had a number of staff that could be called on, and if additional support were required they were more likely to use ARPHS personnel:

*[Collaboration between Action Areas is] not [occurring] as such...that's not saying that we cant..... but we have our own Maori health promotion, Pacific health promotion, Workforce health promotion and South Asian health promotion teams...if we've got them within ARPHS we tend to use them...but I know they [LBD] are there if we need to collaborate with them...*

However a failure to identify linkages and collaborate with other LBD Action Areas, particularly Maori and Pacific, may limit the potential impact and coverage of the Work Stream in relation to the Counties Manukau population, and this is something that may be addressed in the future.

### **Sustainability**

The Workplace workstream received a high score for the sustainability variable. It was suggested that the nature of the award system promoted this as awards are only valid for two years to ensure that workplaces are motivated to maintain progress. In addition, the workplace health programme is written into the relevant staff member's job description to ensure that the programme doesn't fall over if turnover occurs. The high level of collaboration that is undertaken by the project team is also likely to foster sustainability (see above).

However, it was noted that the sustainability of the initiative within workplaces was dependent to a large extent on the approach that each workplace takes, and the priority that is placed on health within that workplace:

*Health is always at the bottom of the pile, if anything happens at the place, workplace health programme always goes on hold first. So if there is an ACC programme, if there is an accident at the workplace the whole thing goes on hold for about 6 months, because the focus goes to safety...*

Also noted to be relevant to sustainability was the success of the health promoter in terms of providing an appropriate level of support and building the capacity of personnel within the workplace.

### **Evaluation Readiness**

The project manager engages in a high level of monitoring and self-evaluation on a three-monthly cycle; at the culmination of the project teams involvement with a particular workplace, the project team review what worked well, what didn't work so well, and what could be improved upon in the future. They also collect feedback from workplaces via a formal evaluation form, and keep current with trends in the literature.

Further, there is evidence that the project team are also seeking to promote self-evaluation of wellness programmes among the workplaces they are engaged with, having developed a tool that seeks to streamline this process.

The leader of this Work Stream evidenced an extensive understanding of the evaluation being undertaken by the School of Population Health. There was a concern that progress was not always wholly reflected, however the challenges inherent in the evaluation of large, complex programmes such as LBD were acknowledged:

*The impression that I got is that some people are worried that it [the evaluation] is not showing what a great programme it is. But these programmes are very hard to evaluate and you need a long time to see the benefits from it, particularly when there are so many layers and strands coming in and so many things going on in the community as well...*

It is clear that there is good recognition of the value that evaluation can add to a programme in terms of making recommendations and guiding future work, and the project team are well-equipped to engage in self-evaluation as appropriate.

### **Summary of Progress**

Overall, the Workplace Work Stream was making good progress towards its overall goals. The interviewee noted that there had been a 15% increase in registration for workplace health within the Counties Manukau region which was seen as a real achievement. There was some suggestion that capacity limits what they can achieve.

*But...we are halfway I think...we have completed the small to medium enterprise scoping...we have not actively gone out to promote new workplaces because we don't have to because workplaces come to us...and we don't have the capacity...*

### **Changes over Time**

Significant increases were observed in this Work Streams scores on the collaboration, evaluation readiness and cohesion variables. This is reflective of the steady progress of this Work Stream, but is also likely to reflect increased engagement in the evaluation process, which has meant the evaluation team have more information available to them in making judgments about the initiatives progress.

### **Issues for Consideration**

- This Action Area is part of the Auckland Regional Public Health Service programme, rather than purely a LBD project. This appeared to have implications for the collaboration between the workstream and other Action Areas, as the organisation utilised its own resources. This may not be an issue provided learnings and progress are sharing with LBD.
- This Work Stream appears to have a culture of evaluation that could provide useful learnings for the other LBD Action Areas.
- Progress towards KPIs for the 08/09 financial year is not fully represented given that reporting is occurring midway through the financial year.

## **4.2 Social Marketing Action Area**

The role of Social Marketing in Let's Beat Diabetes is to promote behaviour change and facilitate change in the community to achieve the goals of increased awareness of the risk factors for diabetes, improved nutrition and increased physical activity leading to a reduction in obesity and prevention of or delay onset of diabetes.

Social marketing will achieve increased awareness and knowledge, and change to healthier attitudes and behaviours affecting change in the social environment as families and communities support each other.

2007/08 saw a focus on management and the on-going development of the Swap2Win campaign, further analysis and dissemination of key findings from the Benchmark study with LBD stakeholders and the wider community, and integration of learning from the Swap2Win campaign and the Benchmark study to inform strategy and communications plans for the next phase of Swap2Win.

### **Social Marketing Objectives 2008/09**

- Promoting behaviour change.

Implement the "find out" phase of the strategy by identifying motivations to change to healthier behaviours by promoting the facts about overweight and diabetes in CMDHB and

creating demand for healthy behaviours i.e. identifying the “why” and “how” need to change

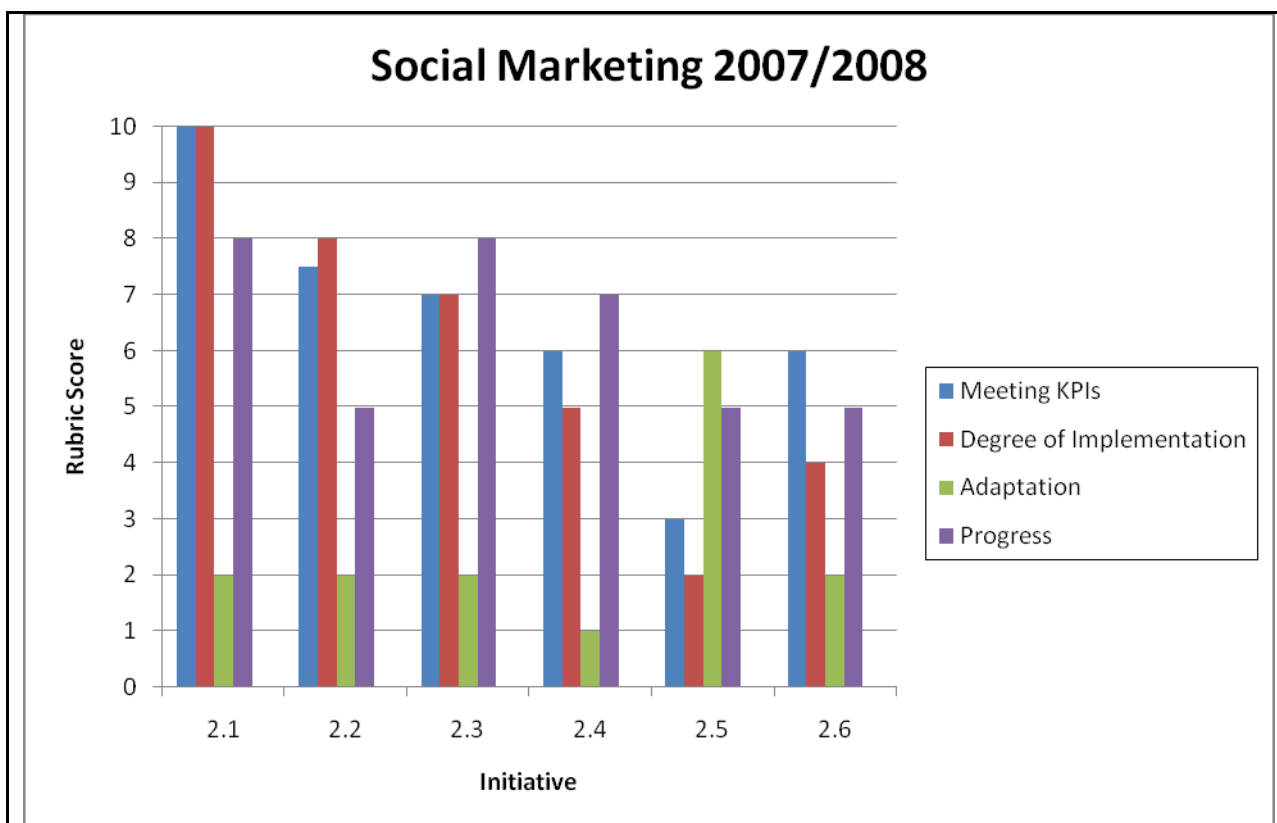
Continue LBD Swap2Win focussed on healthier behaviours so people can be empowered to take responsibility for own health with easy practical solutions to Swap 2 healthier behaviours

Identify ways to help people support others (family, friends, social group) in pursuit of healthier lifestyle e.g. a selecting of healthy foods for the family and social eating, family activities for enjoyable exercise

- Tailored communication by segment i.e. ethnicity and life-stage for more effective uptake and thus impact on KPIs, further developing the LBD Swap2 communication strategy.
- Facilitating behaviour change – making it easier for people to adopt healthier eating and physical activity behaviours by influencing the environment that they live, engage in recreation, and work in.

### **Social Marketing Action Area Progress for 2007/2008**

The nature of the KPIs encompassed by each Action Area will impact on the scores on each of the evaluation variables that the Action Area is designated. It is of note that the majority of the initiatives under the Social Marketing Action Area were classified as comprising activities involving programme development and intervention aimed at prevention. The nature of this type of initiative is relatively labour intensive, which should be taken into account when interpreting the Action Area’s progress in achieving these KPIs.



**KEY: 2007/2008 Action Area: Promoting Behavioural Change through Social Marketing**

2.1	Social Marketing Leadership Hub
2.2	Completion of implementation of Phase 1 of Swap2Win campaign
2.3	Evaluation of Phase 1 of the Swap2Win campaign
2.4	Management and on-going development Phase 2 of the Swap2Win campaign
2.5	Supporting behaviour change re. getting tested for type 2 diabetes
2.6	Maximising value from results from the Baseline Study

**Figure 15: Social Marketing Action Area 2007/2008**

The Social Marketing Action Area achieved varying levels of progress towards meeting KPIs, degree of implementation and overall progress across its initiatives. Initiative 2.1 received a high score for meeting KPIs, implementation and progress. A review of the membership of the leadership hub had been undertaken and the group was meeting on a monthly basis, not bi-monthly as stated in the operational plan, which resulted in a slightly elevated score for adaptation. However no information about attendance, representation on the group and decision-making processes was provided to the evaluation team.

Under initiative 2.2, virtually all of the KPIs specified in the operational plan were achieved, albeit some behind timeline, with the exception of the Maori and Tongan translations. Given that these peoples represent a significant proportion of their target community, and that the project team were specifically tasked with generating translations of the collateral in this part of the financial year, the meeting KPIs, progress and implementation scores for this initiative were slightly lower than may have been anticipated. However, the project team did develop a policy for translations to be shared across the organisation, which accounts for the slightly elevated score for adaptation.

Initiative 2.3 received moderate scores for meeting KPIs, implementation and progress, and a relatively low score for adaptation. Although all the sub-initiatives were completed, they were completed considerably behind timeline. The evaluation report was completed in March 2008, several months behind schedule, and was not signed off and disseminated until October 2008.

Significant activity was being undertaken for initiative 2.4 to develop phase 2 of the Swap2Win campaign however implementation was delayed, which may in part be accounted for by delays in the sign-off on the evaluation report. Consequently progress for this initiative is high, whereas scores for meeting KPIs and implementation are somewhat lower.

Some planning and review had been undertaken to inform initiative 2.5, but it was later decided that Primary Care was to take responsibility for this initiative, which resulted in a high score for adaptation and a relatively low score for meeting KPIs and implementation. Progress was scored as moderate due to the work undertaken to date towards supporting behaviour change, and the collaboration occurring with Primary Care.

The scores for meeting KPIs, implementation and progress were moderate for initiative 2.6, because although the milestones were achieved they were significantly delayed, however no rationale for these delays was provided to the evaluation team. Adaptation was slightly elevated due to some suggestion of troubleshooting, however no specific information was provided.

Social Marketing Action Area Progress for 2008/2009



Figure 16: Social Marketing Action Area 2008/2009

2008/2009 was a busy time for the Social Marketing Action Area with the launch of the second phase of the Swap2Win campaign, and saw a moderate to high level of achievement pretty much across the board in terms of the meeting KPIs, implementation and progress variables. As indicated under initiative 2.1, the Social Marketing Leadership hub was meeting monthly, resulting in a high score for meeting KPIs, and implementation due to the high level of stakeholder involvement. Progress was also high based on the assumption that the group is in fact guiding the development of the social marketing strategy.

There was also a high level of progress under initiative 2.2, with most of the sub-initiatives completed, albeit some slightly behind stated time frames. The adaptation score was slightly elevated to reflect the postponement of the launch date to coincide with the Diwali festival in an

effort to increase uptake of the campaign's messages among the South Asian community, which indicates forward planning and responsiveness to the community they serve.

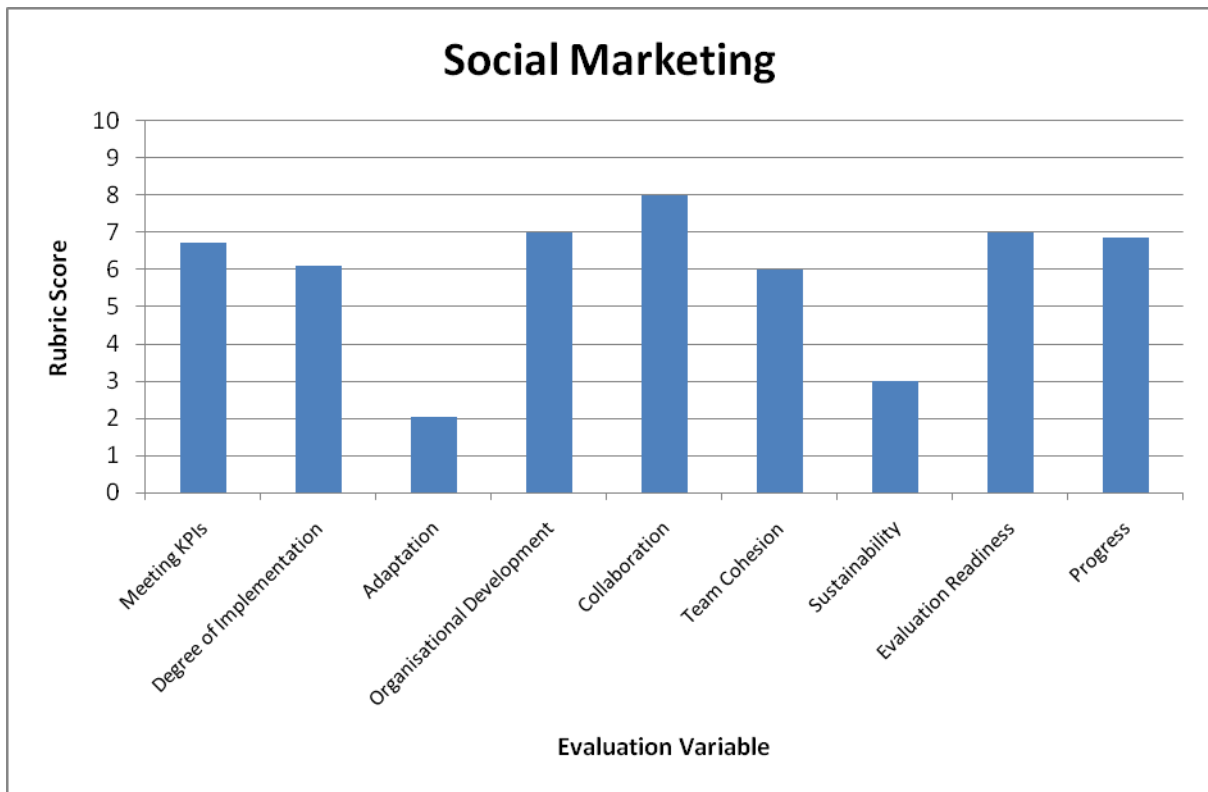
Initiative 2.3 dictates the actions to be taken with respect to the monitoring and evaluation of the campaign. A high level of monitoring was indicated due to the controversy surrounding the campaign, however a provider for evaluation and monitoring services was not appointed until November, 2 months behind timeline, and one month after the campaign launch. In December a monitor model and questionnaire had been developed. This monitor commenced in December, behind timeline due to delays in appointing a provider, and was completed in January 2009 with very positive results reported. Adaptation was somewhat higher due to the prompt development and implementation of the monitor despite these delays.

Progress for initiative 2.4 was scored moderately due to the discussions that were being held around the strategy implications for PHOs/Primary Care. The project team was working collaboratively with Primary Care stakeholders to look at how capacity can be built in this area, and to develop appropriate tools and resources for a screening programme. However the initiative was significantly behind schedule in that there was little evidence of the development and finalising of a specific plan, which is reflected in the lower scores for meeting KPIs and implementation.

There was a high level of achievement in terms of meeting KPIs and progress for initiative 2.5. The project team had selected a preferred provider 6 months ahead of timeline, with projects scoped including a repeat of the 2007 LBD Benchmark Study plus an additional LBD Living with Diabetes Benchmark Study.

### **Overview of the Social Marketing Action Area**

A combined analysis of the 2007/2008 and 2008/2009 data was used to provide an overview of the Social Marketing Action Area over this reporting period. In addition, the Action Area was assessed on their collaboration, sustainability, evaluation readiness and team cohesion. Figure 17 illustrates these findings, and the interview data is used to support the overview.



**Figure 17: Overview of the Social Marketing Action Area**

### ***Achievements and Adaptations***

An analysis of the combined 2007/2008 and 2008/2009 data was used to provide an overview of the Work Stream’s progress. A moderate level of achievement was noted in this area with respect to meeting KPIs, with a great deal of activity occurring in the latter financial year with the launch of Phase 2 of the Swap2Win campaign. There appears to have been a generally positive community response to the campaign, and those who had been opposed to the campaign were for the most part seen to fall outside of the target audience of the campaign:

*We have resonating messages; there has been community support for those messages, but also murmurings from others that don’t like it, who are usually not part of our target audience...*

Implementation scores were generally moderate to high due to the project team’s ongoing commitment to being guided by stakeholders in the community and sharing the evaluation findings with these stakeholders.

Overall there appeared to be little need for adaptation, as reflected in the level of progress towards the Action Area’s stated objectives, except perhaps to develop a process to more effectively counteract set-backs encountered in meeting deadlines; although many of these set-backs were noted to have been outside the project team’s control. It was noted that there had been a shift away from a traditional model of request for proposals to seeking a preferred provider, which had represented a significant change, and had lead to delays in achieving relevant KPIs. There was also evidence of forward planning and responsiveness to the changing environment.

### **Functioning of the Action Area**

The Social Marketing Leadership hub is functioning well, and was seen to provide a degree of structure to the Action Area, as well as a forum for information sharing with partners. This resulted in a high score for organisational development variable. The Action Area leader did at times appear to be working in isolation, where perhaps there may have been greater support from LBD as an organisation, hence a more moderate score for team cohesion. It was noted that the provision of greater administrative support could enhance the organisational development and the functioning of the Action Area in general.

Collaboration was high within this Action Area and was noted to be occurring both externally and internally. The Action Area is collaborating with a number of different agencies and community groups to try to increase uptake of the campaigns messages and resources and to get their input into the campaign. These agencies/groups included the Ministry of Health (Feeding our Futures), the councils, the PHOs, media partners, the Ministry of Education via partners, ARPHS, community collectives, GP practices, Diabetes Auckland, and event organisers for Polyfest. There was a high level of consultation with the community and partners involved in the development of the social marketing strategy, and this was seen as a key achievement and an enabler to the success of the campaign:

*Developing a strategy that can be implemented from grass-roots up, so it's fully community-based, it's centred around consumer needs as a focus rather than top-down organisational needs...that is a key achievement.*

Although greater connectivity with certain Action Area's was desired, the Action Area leader had made a concerted effort to meet with the other project managers to identify linkages and potential opportunities for collaboration to support the work that is undertaken within each action stream, (and particularly with the Community Leadership, Food Industry, Health Promotion, Primary Care, Vulnerable Families, and Service Integration Action Areas):

*Going round all of the Action Areas...actually sitting down with them and going through...what we're doing, why we're doing it...getting their feedback good, bad, ugly, whatever...and then looking at where Social Marketing could enable them to achieve their KPIS, where they could enable Social Marketing to achieve those KPIS...that was a big job...*

### **Sustainability**

The sustainability of the initiatives within this Action Area was seen to be highly dependent on support for the role of the Project manager and the knowledge and commitment of said project manager, as well as the provision of ongoing funding. It was noted to be very hard to track return on investment in this area given the funding that is available for monitoring, particularly as it may take years to see demonstrable change. The interviewee believed that the messages of the campaign will continue to resonate within the community even if funding is withdrawn, but felt that reliance on funding did restrict the potential of the initiative:

*We're really under-funded for the job we have to do and you can only go so far on getting free support. And we can only stretch the money to a certain extent ... the message of this Action Area needs to live on, even if there is a pause in funding...*

### **Evaluation Readiness**

The Action Area leader is aware of the School of Population Health evaluation, and sees this as an important component of the continuous feedback loop. In particular critical, constructive feedback was seen as especially important from a marketing point of view. The interviewee believes the evaluation will be valuable as the evaluation team gives a lot of feedback which can generate robust discussion.

The Action Area has demonstrated a commitment to evaluation. Two contracts have been negotiated for monitoring and evaluation services, and in addition to this the project manager engages in regular self-auditing and record-keeping. However capacity to engage in evaluation was seen as limited by time and resource constraints:

*I certainly have the skills [to engage in evaluation]...do I have the resources? Probably not...*

### **Summary of Progress**

A methodical approach to achieving the objectives set out in the operational plan has led to a consistently moderate to high level of progress towards the overarching goals of the Action Area, particularly as the writing of this report occurred part way through the financial year. In particular the consultation and input from the community and the other LBD Action Areas was seen as a major coup in terms of guiding the social marketing strategy and enhancing the appropriateness and uptake of the campaign's messages:

*It's not one size fits all, it's about tailoring it to the community, and that's what social marketing is all about.*

The focus moving into the next half of the year will be around the ongoing monitoring of response to and uptake of the campaign messages, embarking on the next phase of benchmarking and tracking changes in knowledge, attitudes and behaviours, and working more closely with Primary Care.

### **Changes over Time**

There were no significant changes in the scores for this Action Area on any of the evaluation variables, with the exception of a decrease in team cohesion. This likely due to the fact that the Action Area leader for this initiative is relatively new in the role, and is thus still working to establish relationships with others in the programme.

### **Issues for Consideration**

- Progress towards KPIs for the 08/09 financial year is not fully represented given that reporting is occurring midway through the financial year.
- Greater connection with other Action Areas is desired

### **4.3 Urban Design Action Area**

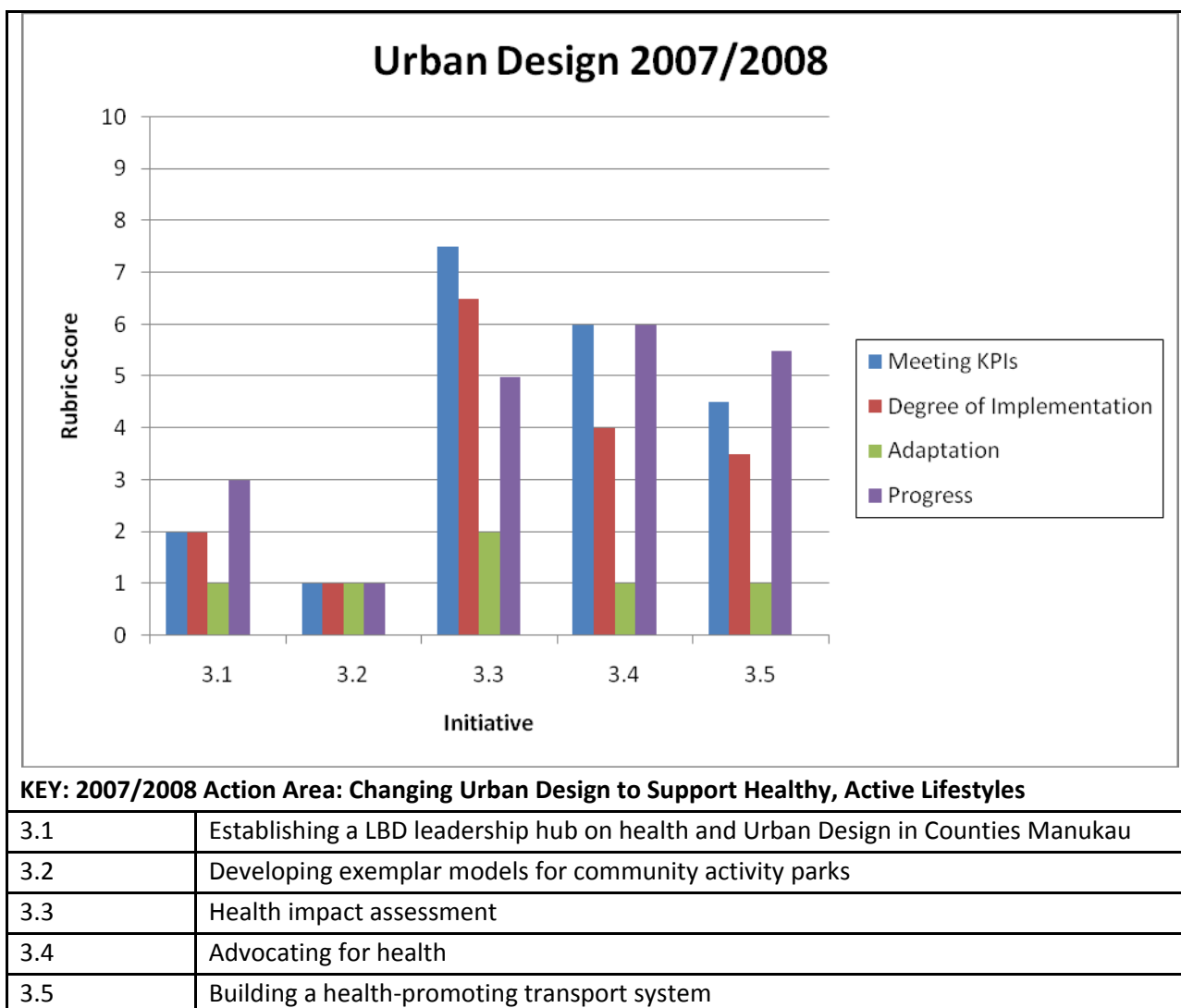
Urban environments impact on our lifestyle choices, and subsequently our health and risk of disease. There are a number of areas LBD wishes to influence within urban design. They include:

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

From 2005 Auckland Regional Public Health Service (ARPHS) and Manukau City Council (MCC) have led this activity in this action area on behalf of LBD. This was to continue in 2008/2009, but to broaden to involve other key stakeholders including Papakura District Council (PDC), Franklin District Council and Housing New Zealand.

#### **Urban Design Action Area Progress for 2007/2008**

The nature of the KPIs encompassed by each Action Area will impact on the scores on each of the evaluation variables that the Action Area is designated. It is of note that the majority of the initiatives under the Urban Design Action Area were classified as comprising activities involving the development and implementation of large scale initiatives that encompassed long-term goals. This poses greater challenges and should be taken into account when interpreting the Action Area's progress in achieving these KPIs.



**Figure 18: Urban Design Action Area 2007/2008**

Scores for meeting KPIs, degree of implementation and progress were generally low across this Action Area in the latter part of the 07/08 financial year, with the exception of initiative 3.3 where a higher level of progress was evident. Adaptation too was typically occurring at a reasonably low level, where a higher level may have been expected due to the limited progress towards achieving the objectives as set out in the LBD operational plan. A leadership hub was not established in 2007/08, as indicated under initiative 3.1, which was reportedly due to constraints on the time and capacity of those people who ought to have been involved. It was not clear from the evidence provided how the Action Area was seeking to counteract this set-back. Informal meetings were reportedly happening sporadically however it was unclear based on the evidence provided when this was occurring and who was in attendance. It was noted that this initiative had been deferred from the 06/07 financial year.

Very limited evidence was provided to the evaluation team as to activity being undertaken to further initiative 3.2. Based on the evidence provided it appeared that little work had been undertaken. It

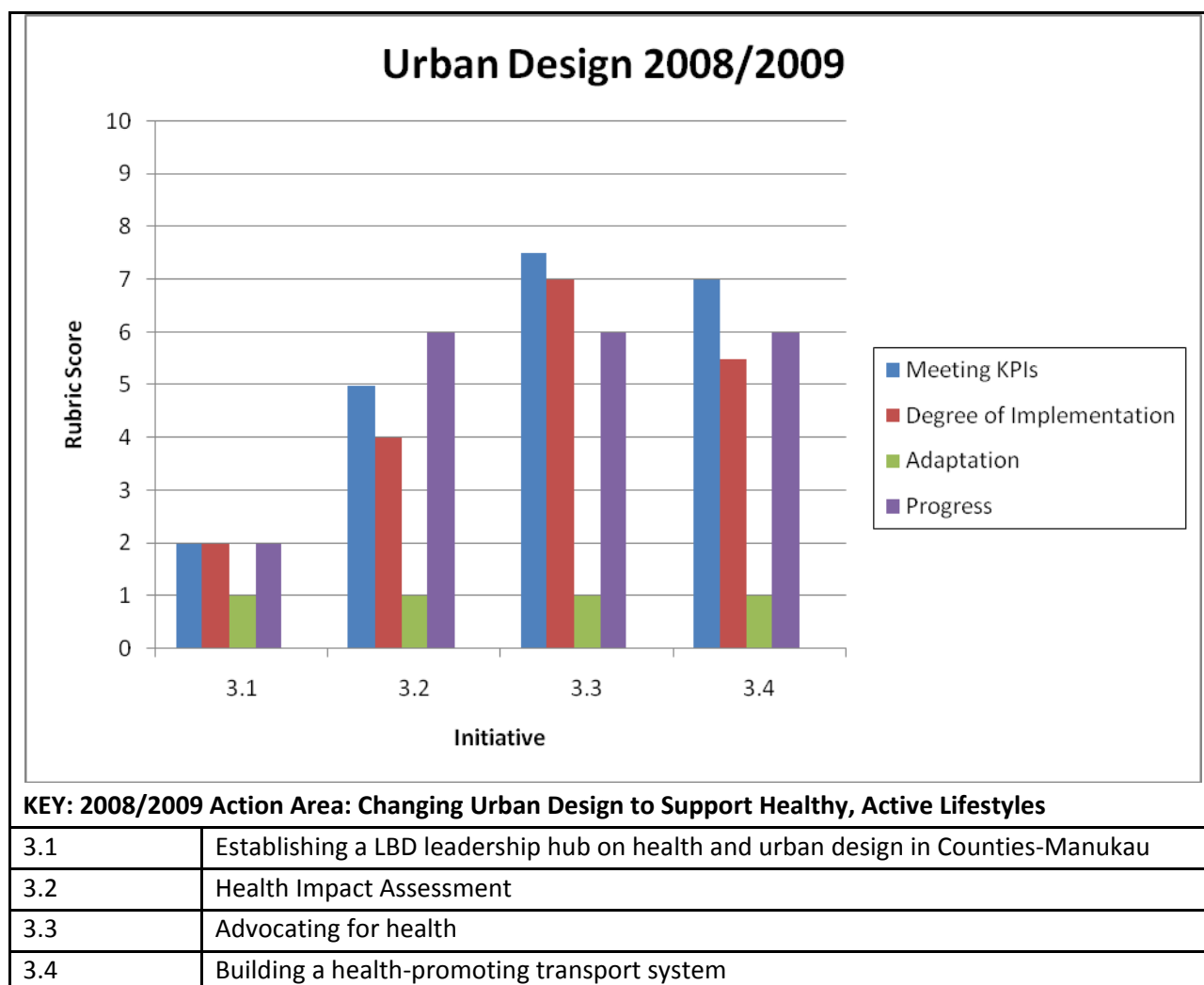
was noted that the upgrade, evaluation and production of a case study booklet would not be undertaken by Manukau City Council; however there was no indication of who would undertake the work in their place. Consequently this initiative received a low score across all of the evaluation variables.

Under initiative 3.3, the Health Impact Assessment for the McLennan Housing Development was completed, whereas the investigation of the implementation and evaluation of the Mangere HIA was delayed, awaiting Housing NZ progress on the Pershore Precinct. The implementation score for this initiative was elevated because they had engaged with key stakeholders and were trying to enhance partnerships, taking into consideration the time- and labour-intensive nature of health impact assessments.

Initiative 3.4 was scored moderately in terms of meeting KPIs, degree of implementation and progress, as participation in planning processes was noted to be ongoing, with submissions prepared on resource consents and plan changes. However no further evidence or detail was provided to the evaluation team.

Limited evidence was provided to the evaluation team as to the work that was being undertaken to further initiative 3.5, which aims to build a health-promoting transport system. It was noted that the project team were active in making submissions, and were actively disseminating health research and information to the regional land Transport Authority with a view to capacity building. Informal links were reportedly being made with transport planners and agencies and the project team were investigating an evaluation of the exemplar model with the School of Population Health and AUT researchers, with implementation deferred until the 08/09 financial year.

## Urban Design Action Area Progress for 2008/2009



**Figure 19: Urban Design Action Area 2008/2009**

Scores for meeting KPIs, degree of implementation and progress were generally moderate across this Action Area in first half of the 08/09 financial year, with the exception of initiative 3.1 where a lower level of progress was evident. At the time of writing of this report, the leadership hub had yet to be established. As in the previous financial year informal meetings were reportedly occurring with various organisations and groups of people, and a hub launch was set for October 2008, however the evidence provided to the evaluation team suggested that this did not eventuate. Workshops were reportedly in the planning stages with a view to broadening the knowledge of stakeholders in relation to: public health issues in urban design, Health Impact Assessment (and Whanau Ora HIA), position statements, the Health and the Resource Management Act, health and planning with particular emphasis on “settings” (including stadia), and Let’s Beat Diabetes and urban design (including priorities for 2009/10), however the majority of these workshops were noted to have fallen behind timeline.

Reasonable progress was noted towards achieving the KPIs set out under initiative 3.2, as at the time of writing of this report, discussions were underway with the Ministry of Health HIA Support Unit,

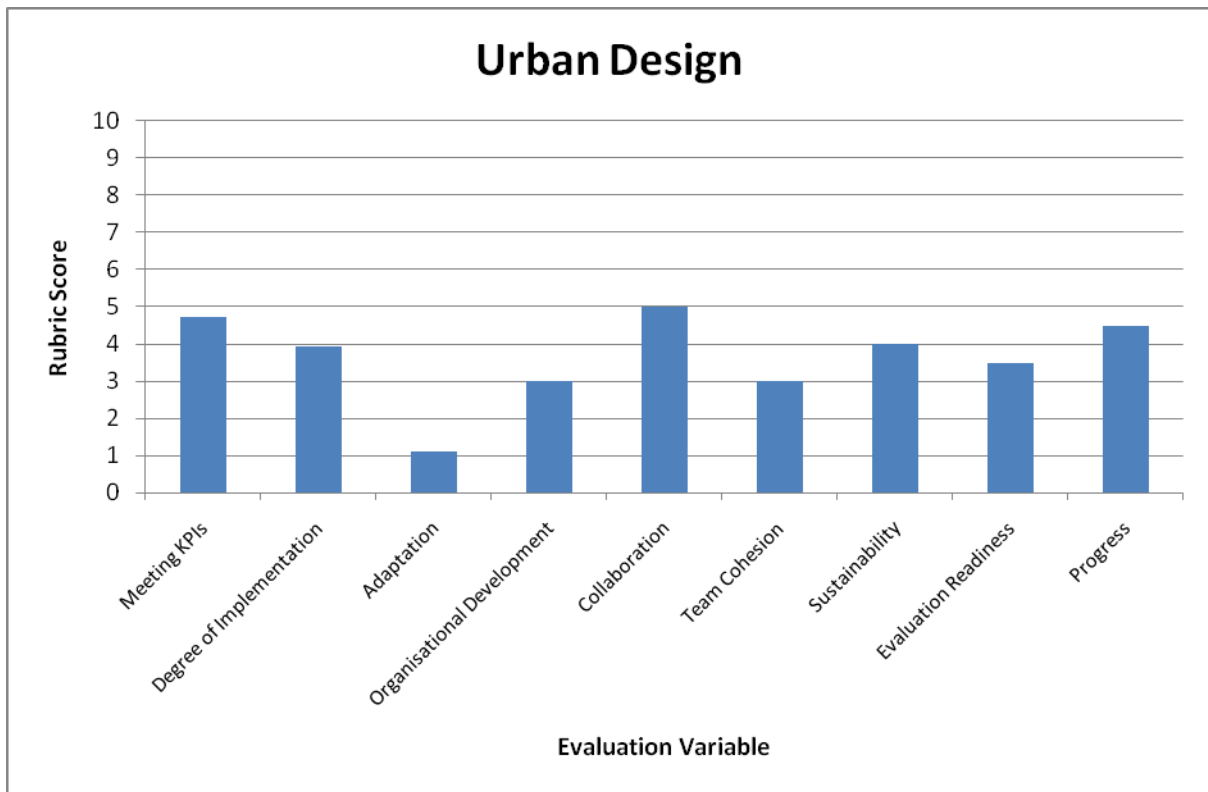
Housing NZ and other key stakeholders with respect to the on-going process of monitoring and review of the recommendations from the Health Impact Assessment on McLennan Housing Development. The 2-day HIA training for health practitioners and advocates was deferred until March 2009 due to constraints on trainer availability. It was noted that the project team were conducting an additional HIA in Papakura, which was outside of their KPIs for this year, which elevated the initiatives score on the adaptation variable.

Again, limited evidence was provided to the evaluation team as to work being undertaken to further initiative 3.3. It appeared that high level submissions were being prepared including input into district plans, regional plans and regional policy statements, although details of these submissions were not provided, which resulted in moderate to high scores for meeting KPIs, implementation and progress for this initiative.

Scores for initiative 3.4 in terms of progress and degree of implementation were moderate, in reflection of the scoping, consultation and planning that was being undertaken to achieve the KPIs set out under this initiative. Timely and active participation in planning processes was reported to be ongoing, with submissions prepared on transport issues and revised following feedback. Capacity building via a Health Impact Assessment on a key transport issue was planned to be undertaken jointly with key agencies in the 2008/09 financial year. With respect to establishing linkages with Walking School Buses, Travel Demand Management and school/work travel plans were scheduled to be investigated, with involvement of key players via workshops and HIAs. The project team were also investigating potential support for Manukau City Council in relation to school travel planning. Further, the project team were meeting with key players to further the exemplar model project.

#### **Overview of the Urban Design Action Area**

A combined analysis of the 2007/2008 and 2008/2009 data was used to provide an overview of the Urban Design Action Area over this reporting period. In addition, the Action Area was assessed on their collaboration, sustainability, evaluation readiness and team cohesion. Figure 20 illustrates these findings, and the interview data is used to support the overview.



**Figure 20: Overview of the Urban Design Action Area**

***Achievements and Adaptations***

The Action Area made moderate progress towards achieving their KPIs. Although there was considerable progress towards the Health Impact Assessment initiative, many of the other initiatives appeared to lack impetus to get beyond the planning stages, and had fallen behind schedule, with several initiatives continuing to roll-over year after year, with no resolution (e.g. the establishment of the Urban Design Leadership Hub). The interviewee was unable to give an indication of milestones that had been met in progressing towards the achievement of the KPIs for this Action Area. It is of note, however, that a somewhat higher level of progress was observed in the first half of the 08/09 financial year, relative to that seen in 07/08.

Very little adaptation was observed, which is somewhat surprising given the lower level of progress towards achieving the stated objectives of the Action Area.

***Functioning of the Action Area***

The Action Area was allocated a low score for organisational development. There appears to be little or no structure to the Action Area, with all of the work falling to one individual, who is very passionate about the work within the area, but is part-time and consequently has numerous competing obligations. The Action Area leader is working to reduce reliance on the one individual by talking to other people about what is happening within the area, and writing it into service obligations and contracts, so that there isn't a loss of knowledge in the instance of staff turnover:

*It's too much on one person, and that's why I'm trying to build it out...You need to make sure others know about it...but you need consistency...you need an identified person to lead it...*

There appears to be a low level of buy-in from stakeholders who have been unable or unwilling to date to commit to ongoing participation on a leadership hub due to constraints on their time:

*In a collaborative approach it shouldn't be just one leader making all the decisions...they have to have a hub behind them, they might coordinate and facilitate but they won't make all the decisions...but to get them all together... to give up their time...they are too busy just to come up and talk about nothing...*

Consequently it was suggested by the current project manager that the hub may not be viable, and that efforts and attention should instead be diverted to sustaining the informal networking and communication happening between key individuals.

Collaboration was scored moderately for this Action Area, although it was noted that once the leadership hub is established this will afford numerous opportunities for collaboration, and there is enthusiasm amongst the stakeholders to work together. It was also noted that much of the work that is undertaken by the Action Area, such as the Health Impact Assessments and the workshops inherently have a strong collaborative focus:

*HIA's are absolutely a collaborative approach, so you develop those relationships...it's often the same people all the way through...it's all about networking and collaboration.*

Further, the identification of an exemplar model for a health-promoting transport system was noted to be a collaborative project being undertaken with the support of the School of Population Health and AUT. CMDHB staff, ARPHS, local government and HNZC were also noted to provide a good level of support with respect to the work that the Action Area is trying to achieve.

At an internal level, the Action Area leader noted that she had met with other Action Area leaders from time to time and that there was regular communication. She felt there was a good level of support from LBD, particularly LBD management, however there was perhaps a lack of knowledge on the part of the other Action Areas as to what happens within the Urban design, and where linkages may lie, and this was something which the interviewee was working to rectify:

*Urban design is the [Action Area] out on the side...I think they probably feel less connected to me.*

The Action Area received a low score for team cohesion due to the reliance on one individual to action much of the work, and the lack of buy-in from individuals who would sit on the leadership group.

### **Sustainability**

The Urban Design Action Area received a moderate score for sustainability. While there are objectives written into the work plan that have a focus on sustainability, such as capacity building and the Health Impact Assessment work, internal restructuring and time and resource constraints have hindered what is able to be achieved:

*It's not lack of funding [that hinders the sustainability of the Action Area]...its lack of staff.*

It was noted by the interviewee that there is now more focus within the Action Area, and some enthusiastic people working on it, so that the sustainability should improve, where it has been lacking in the past.

### **Evaluation Readiness**

The Urban design Action Area received a moderate score for evaluation readiness. Although the Action Area leader saw evaluation as important, she did not engage in any kind of self-evaluation and there were often significant gaps in the information that was provided to the evaluation team. This is likely due to the competing demands on the time of the Action Area leader, who acknowledged that she needs to provide more information to the evaluation team and improve links with the academic world. She also identified a need to produce more formal evidence of the work that they are doing, aside from what is provided in the monthly progress reports, and expressed frustration with respect to the time lag between data collection and dissemination of a final report.

The Action Area leader alluded to difficulties in measuring progress of the work that the Action Area is tasked with, as linking outcomes to changes in the structural environment is inherently difficult:

*I think evaluation of Action Area 3 is going to be difficult, because you plant a seed, an idea, and you can't tell if it's you...you suspect it's you but...trying to measure it...outcome measurement is the most difficult...*

### **Summary of Progress**

Overall progress for the Action Area as a whole was scored as moderate, with certain KPI's progressing well, but a significant number losing momentum in the planning stages and falling behind timeline. A lack of time and staff resource, internal restructuring, and delays in establishing a leadership hub for the area were all seen to have impacted on the progress of the Action Area.

The Action Area leader is passionate about improving urban design to assist in producing healthier outcomes for communities, and although there have been delays in achieving KPIs, work is being undertaken to try to spread the workload and put the onus on to others within the industry also; the leadership hub in particular is seen as an important forum to facilitate this process.

### **Changes over Time**

There was a significant decrease in this Action Areas score on the collaboration variable. This reflects the difficulties that in getting a sufficient level of buy-in from stakeholders to establish a leadership hub, and, further, the challenge of finding mutually beneficial ways of collaborating given that Urban Design is not a traditional health sector initiative.

### **Issues for Consideration**

- Until recently, there has only really been one individual who works on a part-time basis that has been charged with achieving all of the KPIs.
- Challenge of securing health as a priority for those that would sit on the Steering Group.

- Challenges in establishing a leadership hub has had a flow-on effect to delay progress on other initiatives.
- Increasing the integration between Urban Design and the other Action Areas
- Progress towards KPIs for the 08/09 financial year is not fully represented given that reporting is occurring midway through the financial year.

#### **4.4 Food Industry Accord Action Area**

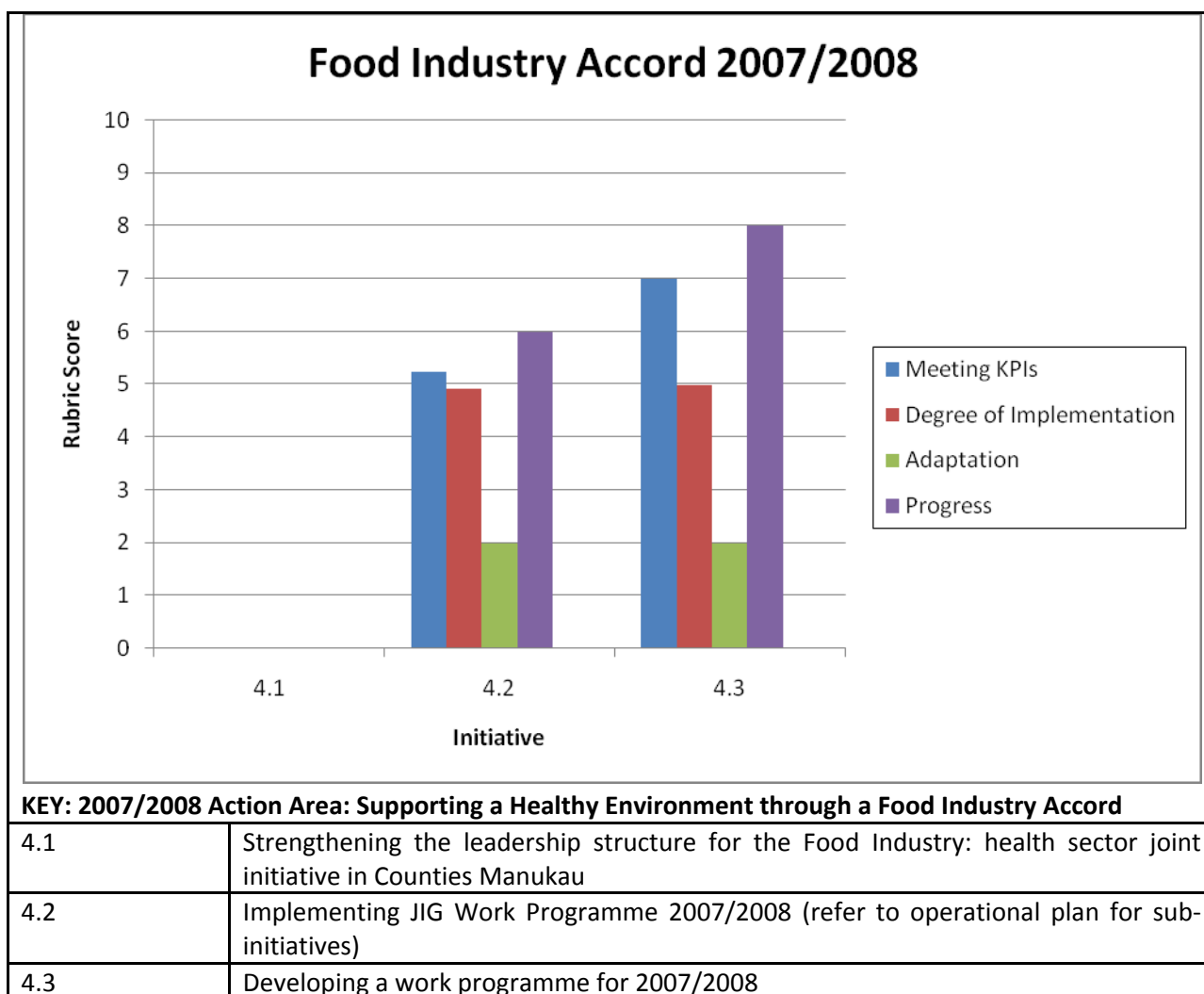
Since May 2005, CMDHB and the Food Industry Group (FIG) have worked collaboratively on a number of innovative projects in Counties Manukau in order to achieve the LBD and the Food Industry Accord's (FIA) joint objectives. These objectives include helping to prevent obesity and creating a healthier with a particular focus on Counties Manukau.

A number of initiatives have been undertaken since 2005. In 2008/2009, both Counties Manukau Lets Beat Diabetes and the FIG have recommitted to continuing and progressing partnership activities.

Historically there has been a focus on working with a wide range of smaller projects; however the time is now right to focus on a smaller number of in-depth projects, which will incorporate to varying degrees other Action Areas in the Lets Beat Diabetes plan

##### **Food Industry Accord Action Area Progress for 2007/2008**

The nature of the KPIs encompassed by each Action Area will impact on the scores on each of the evaluation variables that the Action Area is designated. It is also of note that the majority of the initiatives under the FIA Action Area were classified as comprising activities involving an element of collaboration to develop and implement interventions. This should be taken into account when interpreting the Action Area's progress in achieving these KPIs.



**Figure 21: Food Industry Accord Action Area 2007/2008**

Scores for meeting KPIs, degree of implementation and progress were moderate to high across this Action Area in the latter part of the 07/08 financial year. Initiative 4.1 was not scored, as the only KPI under this initiative was completed in August 2007, which falls outside the reporting period for this report.

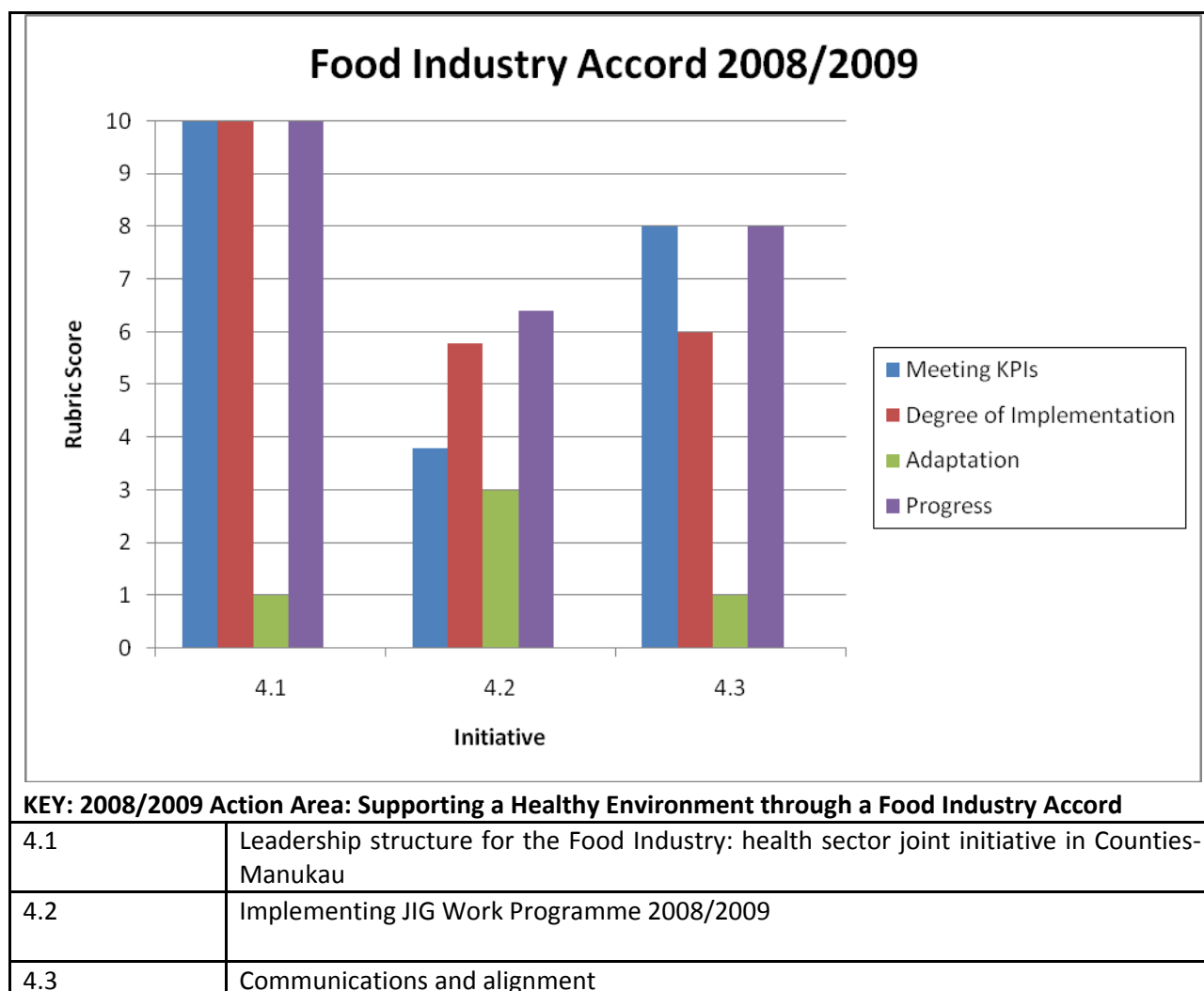
Initiative 4.2 is comprised of twelve sub-initiatives, and the breadth of activity occurring under this initiative was considerable. Progress for each sub-initiative was scored and then these scores were collapsed to generate one overall score for the initiative. Consequently the reader is advised to refer to the data supplement for a more thorough breakdown of progress by sub-initiative. The initiative was allocated a moderate score for the meeting KPIs, implementation and progress variables. A significant amount of work was undertaken to progress the Dairy programme, Fonterra were already in the process of reviewing and reformulating their products to reduce the levels of sugar, fat and salt, and discussions on projects was timely. Goodman Fielder was also scheduled to be approached and discussions took place around their reformulation areas. Collaboration with Foodstuffs on the Fresh for Less campaign and Progressive on the Healthy Recipe Tag was working well, and a significant amount of work was being undertaken by the project team to progress these

programmes. The project team were also active in engaging with new companies within the industry to try to secure their support and raise awareness of LBD's agenda. Moderate progress was noted towards the Soft Drinks, Healthy Food Parcels, and Healthy Active Workplaces programmes. The project team had also secured Food Industry commitment to support the Social Marketing programme where practicable.

Progress towards the White Milk and Breakfast programmes had been postponed as Fonterra, Countdown and Red Cross have taken up this initiative in local schools. The Healthy Tuck-shop Model programme was no longer required due to the introduction of the Food and Beverage Classification System. Support for the Healthy Kai project had not been provided as it was not required. It should be noted that the KPIs for this initiative don't necessarily reflect the work that is being done to progress the sub-initiatives. The absence of certain status reports and meetings, due in part to the over commitment of the project staff, accounted for more moderate scores in this area.

Initiative 4.3 received a high score for the meeting KPIs and progress variables, as a draft action plan had been developed, however the implementation score was somewhat lower as the cancellation of the meeting with JIG meant that the proposed work plan could not be presented until June.

## Food Industry Accord Action Area Progress for 2008/2009



**Figure 22: Food Industry Accord Action Area 2008/2009**

Scores for meeting KPIs, degree of implementation and progress were generally high across this Action Area in the first half of the 08/09 financial year, with the exception of initiative 4.2 where a more moderate level of progress was evident. High scores were allocated for initiative 4.1 as the leadership hub was meeting on a quarterly basis as dictated by the agreement between the Food Industry and Let's Beat Diabetes.

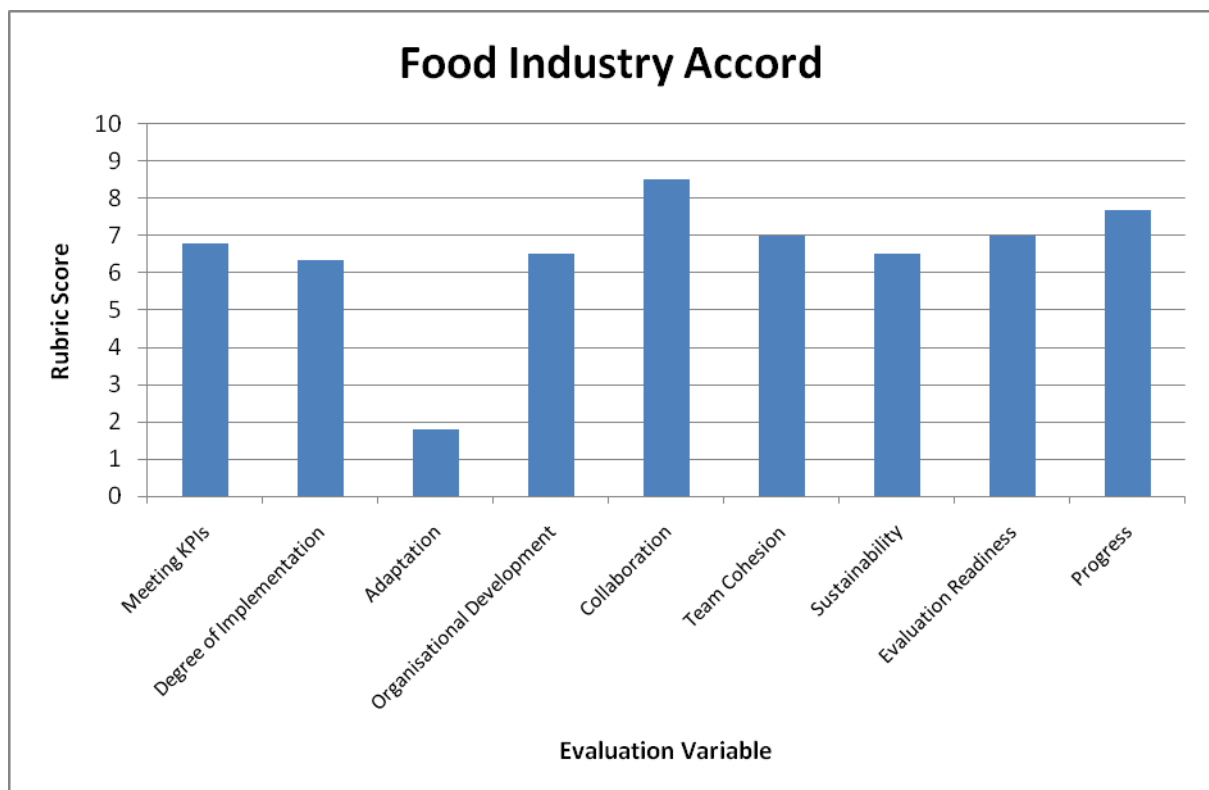
As in the previous financial year, initiative 4.2 is comprised of a number of sub-initiatives (5), and the breadth of activity occurring under this initiative was considerable. Progress for each sub-initiative was scored and then these scores were collapsed to generate one overall score for the initiative. Consequently the reader is advised to refer to the data supplement for a more thorough breakdown of progress by sub-initiative. The initiative was allocated a low score for meeting KPIs, and moderate scores for implementation and progress. The score for the adaptation variable was also elevated. The project team was working with Fonterra, Foodstuffs, Progressive and Goodman Fielder to progress the Milk initiative. The project team was also developing a fruit and vegetable campaign with Foodstuffs to occur in Pack 'n' Save supermarkets, which is scheduled to run from January to

August 2009. The project team was working with Quick Service Restaurants and Coke to progress the Soft Drinks initiative, with a programme set to roll out in early 2009. For sub-initiative 4.2.4<sup>13</sup> there was a focus on working with Dairy owners to promote healthier choices in retail outlets, working with Southern Cross Campus on the Student-led ISLAND initiative and conducting a dairy analysis, however had yet to develop a programme to engage with these retailers. Limited progress was noted for sub-initiative 4.2.5<sup>14</sup>. There was evidence of adaptation in their planning of roll-out for various initiatives, taking into account seasonal trends etc. Again, it should be noted that the KPIs for this initiative don't necessarily reflect the work that is being done to progress the sub-initiatives. The absence of certain status reports and meetings, which in part may be accounted for by a perception that there is over commitment of the project staff, accounted for more moderate scores in this area.

A high score for meeting KPIs and progress was allocated for initiative 4.3. The project team were active in engaging with new companies within the industry to try to secure their support and raise awareness of LBD's agenda. They were also working with the School's Accord on the Healthy School Environment initiative and supporting the Social Marketing programme.

### Overview of the Food Industry Accord Action Area

A combined analysis of the 2007/2008 and 2008/2009 data was used to provide an overview of the Food Industry Accord Action Area over this reporting period. In addition, the Action Area was assessed on their collaboration, sustainability, evaluation readiness and team cohesion. Figure 23 illustrates these findings, and the interview data is used to support the overview.



**Figure 23: Overview of the Food Industry Accord Action Area**

<sup>13</sup> Sub-initiative 4.2.4: Healthier choices through retail outlets

<sup>14</sup> Sub-initiative 4.2.5: Increasing demand for healthier options

### ***Achievements and Adaptations***

The FIA Action Area evidenced a moderate level of progress towards meeting KPIs and implementation. It was noted that a lot of work was being undertaken, particularly in relation to dairy, fruit and vegetables and soft drinks, however this work isn't really reflected in the KPIs which centre on the provision of status reports and attendance at meetings. The interview data suggested that more specific goals are not set, as they need to be able to be flexible and negotiate with the industry as to what is feasible. Adaptation within this area was reasonably high, which reflects this flexible approach, and a willingness to adjust plans based on changes in the environment to optimise uptake.

It was noted that the Progressive Healthy Recipe Tag project and the Fresh for Less campaign had been prioritised, which had led to a lower level of progress for other initiatives.

### ***Functioning of the Action Area***

This Action Area has adopted a partnership approach with the FIA, which was seen to reduce issues of bureaucracy. The leadership group for this Action Area, comprising key individuals from LBD and the Food Industry appeared to be functioning well, which has enabled progress within the area and demonstrates the industry's commitment to support Let's Beat Diabetes, although the interviewee indicated that there could be room for expanded partnerships if more resourcing was available

The current management structure was seen to be appropriate, with an established process to facilitate regular communication and flow of information:

*In terms of process, there are two action area project managers and the other person works off-site so we have a process to work together.*

This commitment to keeping the lines of communication open, and working relationships based on mutual respect was a strong factor in the Action Area's high score on the team cohesion variable.

In terms of collaboration, there was a huge amount of work being undertaken jointly with the Food Industry, including Quick Service Restaurants, Fonterra, Foodstuffs, and Progressive, all of whom were seen to provide a great deal of support to the Action Area. It was suggested by one interviewee that there could be more accountability, in terms of contacts with community groups and companies to track who they are talking with and key issues discussed. This would simplify the process of handover and promote sustainability:

*I think there needs to be some sort of a logging system saying who we are talking with and who we are meeting with and things that were discussed.*

The project team also works with non-profit organisations such as 5+ a day, and consult with community groups such as ProCare and the Diabetes Projects Trust to identify where there are opportunities for collaboration.

At an internal level, the project team are continuously talking with the Maori, Pacific, and South Asian Work Streams, as well as the Social Marketing Action Area to align their messages. The project team is also currently working with the Schools Action Area to look at promoting healthier options in dairies, bakeries and takeaway shops on the perimeter of school grounds. This work is highly collaborative in nature, as it is about trying to build working relationships with the external outlets, understand how their business' run and trying to create a 'win-win'. Collaboration also happens with the Vulnerable Families Action Area for specific projects and initiatives. Interviewees reported feeling connected to the Action Areas in the sense that she understands what they do and what they're trying to achieve, however collaboration was sometimes a challenge as the large proportion of the Action Area project managers are not on site; which meant communication is often complicated and difficult.

### **Sustainability**

The work of the Action Area was seen as highly sustainable, as the project team aimed to only take on projects that are sustainable. It was noted that once a project has been shown to be successful it takes on a life of its own and grows, which makes it sustainable in the long term:

*I think what is great about the Food Industry Action Area is that once you do a project and pilot it and it works well it takes on a life of its own and it sort of evolves bigger than Let's Beat Diabetes, like the Sprite [Zero] example – it's gone huge..*

The interviewees identified the ongoing buy-in and commitment from Food Industry as key to the sustainability of the work. One interviewee also identified a need for a greater level of community involvement, for example in the Fresh for Less campaign, to increase uptake of these programmes.

Funding was also highlighted as a key consideration in relation to sustainability. The projects that are rolled out operate on very tight budgets financial budgets can hinder projects, trying to squeeze out as much as you can out of a set budget, the matter of how much is appropriate to spend on the project to make it sustainable, that kind of thing.

### **Evaluation Readiness**

The interviewee is aware of the evaluation being conducted by the School of Population Health, and noted that the focused evaluation of the Fresh for Less campaign had been highly valuable, and that this year they would like to see an evaluation of the milk project.

The interviewee feels that the evaluation will be valuable in providing feedback on the process of how they are working and whether or not it is effective, and whether there are opportunities to make it more effective. However the interviewee also expressed the concern that evaluation has the potential to interfere with a project, as the 'big picture stuff' cannot always be captured by evaluation, and there may be a shift in focus towards measurable outputs, processes or activities, as expectations about what can be achieved are lowered for fear of coming up short in the evaluation:

*I feel that sometimes people get into a mind frame of evaluation and are so worried about evaluation that sometimes it distorts the project... people have this big way of thinking and want to achieve something big, but because of evaluation [think it] might be a bit difficult, or*

*it can't evaluate our success, so they end up coming to what they can actually achieve and evaluate...*

Monthly reports are submitted as a form of self monitoring and as a means of keeping key stakeholders up to date. The interviewee has also developed a self log in which dates, times of all the meetings and contents of those is recorded, as well as actions to follow this. It was noted that evaluation is always present in the initiatives and projects, but as some of the projects have not yet rolled out it might not be evident at this point in time.

### **Summary of Progress**

Overall, progress for this Action Area was rated as being high, as it was felt that the Action Area was making good progress towards the general aims of the Action Area. The project team's understanding of the Food Industry and the relationship that has been brokered was seen as critical to achieving the aims and objectives of the Action Area:

*I think what is really special about this action area, is that we don't just go out and say that 'this is what we want', we understand what is happening on the other side as well and see what they can do from their perspective; so it is about coming out with a win-win food industry project.*

Furthermore, keeping the companies interested in collaborating with LBD in spite of the economic downturn was seen as a key milestone, which was attributed to the dedication of the Action Area leader and the strength of the relationships established with the Food Industry:

*Something that has been really significant in the last 4 months was getting the industries to agree and interested and committed to working with LBD in the current economic climate...redundancies, and the costs are all factors that the industries are facing at the moment... So getting them interested, and keen, a couple of months down the track is a significant milestone for the Food Industry action area.*

### **Changes over Time**

There was a significant increase in the Action Area's score on the organisational development variable and significant decreases in the team cohesion and evaluation readiness scores. This decrease in the cohesion variable is again likely to reflect a 'settling in' period following staff turnover. The new project team are working together to put systems in place to facilitate communication and information sharing, and are establishing an auditing processes, which is reflected in the increase in the score for organisational development. Whereas last year the project team were very involved in a focussed study with the evaluation team, there is somewhat less engagement in the evaluation process this year, although this might be expected to increase if a focussed study of the milk initiative is undertaken.

### **Issues for Consideration**

- The economic climate; the recession was noted to have affected the Food Industry's ability/willingness to engage with LBD and promote their agenda, as health is not high on their list of priorities.

- Media ‘fear-mongering’ around artificial sweetener Aspartame has hindered progress with the Soft Drinks initiative.
- The Action Area has developed a good relationship with other LBD Action Areas despite the Food Industry being an area that is traditionally outside of the health sector. This process could have some useful learnings for the Action Areas currently feeling disconnected.
- Progress towards KPIs for the 08/09 financial year is not fully represented given that reporting is occurring midway through the financial year.

#### **4.5 Health Promotion Action Area**

Co-ordinated and targeted health promotion is integral to the success of LBD and its aims of preventing diabetes, slowing the disease progression and improving the quality of life for people with diabetes. Significant progress continues to be made in co-ordinating and aligning groups and ideas, understanding barriers to performance and identifying priorities.

In 2007/2008 it was recognised that the time was right to move to a new leadership structure that recognised both the increased role of PHOs in terms of health promotion and the significant role that has and continues to be provided by other organisations across the health sector. A new Health Promotion Steering Group was formed to provide greater opportunities for alignment and for co-ordinated and collaborative activities. In 2008/2009, LBD will work to support the sector by focusing on strengthening health promotion for community settings through this Steering Group with representation from CODA, PHOs, Maori and Pacific providers and other players.

This Action Area and its leadership group is not intended to provide health promotion services to the wider community – this is the function of multiple other LBD Action Areas, however some key initiatives that cross LBD Action Areas are “held” for the purpose of the Operational Plan within this Action Area.

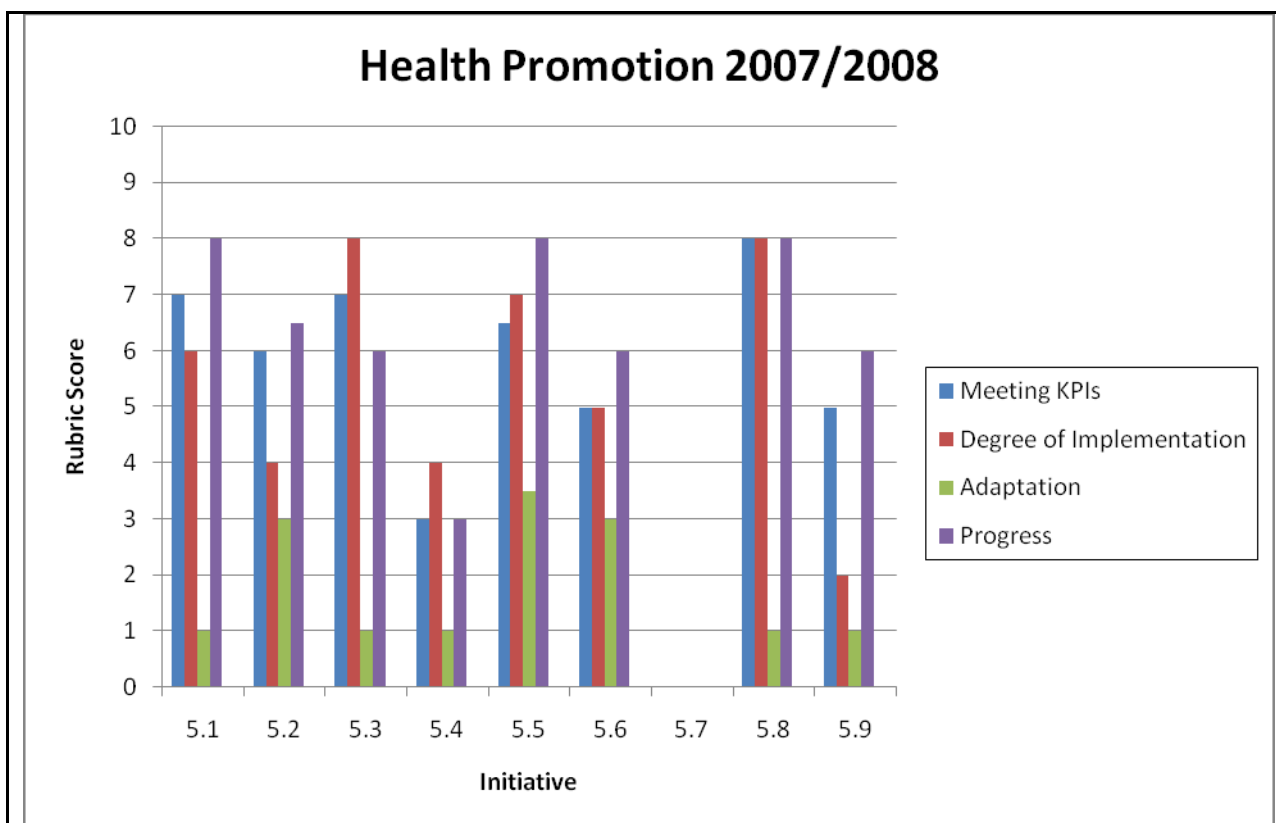
In 2008/09 key activities “held” within this action area include:

- CM Active which will become fully operational in 2008/09
- Gardening and Cooking initiatives which are both in a concept development stage
- Expansion of the Green Prescription Programme
- ASB Polyfest and Outdoor Events.

The conduit for feedback to the wider LBD plan of action will be through the chair person of the Health Promotion Steering Group.

#### **Health Promotion Action Area Progress for 2007/2008**

The nature of the KPIs encompassed by each Action Area will impact on the scores on each of the evaluation variables that the Action Area is designated. It is of note that the majority of the initiatives under the Health Promotion Action Area were classified as comprising activities involving programme development and implementation of large initiatives, as well as collaboration. The Action Area also had a relatively high number of KPIs in comparison to other areas. These factors should be taken into account when interpreting the Action Area’s progress in achieving these KPIs.



**KEY: 2007/2008 Action Area: Strengthening Health Promotion Coordination and Activity**

5.1	Leadership information sharing and planning
5.2	Improving Workforce Capacity
5.3	Training and continuing professional development
5.4	Enhancing Maori training programme and responsiveness
5.5	Improving communications resources within Health Promotion and health education
5.6	Counties Manukau Active (Active Communities)
5.7	Enhance Green Prescription Model
5.8	Active Families (HEHA Innovation Fund)
5.9	Healthy Kai (HEHA Innovation Fund)

**Figure 24: Health Promotion Action Area 2007/2008**

As seen in Figure 25, there was considerable variation in the scores that were allocated to each initiative in terms of meeting KPIs, degree of implementation, adaptation and progress in the latter half of 07/08 financial year for the Health Promotion Action Area. Initiative 5.1 received high scores for meeting KPIs and progress, and a more moderate score for implementation, as all of the stated objectives were achieved, but behind timeline. The delivery of the strategy, co-ordination and planning workshops was delayed such that progress towards these is reported in the 08/09 financial year, which also lowered the implementation score as the meetings were not held by June as specified under 5.1.2<sup>15</sup>. The score for adaptation was low, as although the dates for the workshops were pushed back, there was no indication as to why this was occurring. However progress was high

<sup>15</sup> Sub-initiative 5.1.2: Two strategy, co-ordination and planning workshops for organisations involved in health promotion and health education in Counties Manukau will be delivered

as it was evident that the project team are working towards the high goal of information sharing and coordinated planning.

Initiative 5.2 received moderate scores for meeting KPIs, implementation and progress. Sub-initiative 5.2.1<sup>16</sup> had almost been completed at the time of writing of this report, albeit very late and 5.2.2<sup>17</sup> was withdrawn. 5.2.3<sup>18</sup> and 5.2.4<sup>19</sup> were reported to have been completed, however it was noted that exploring the development of training was moved to Learning and Development within CMDHB as the issues were facing many more community health workers than those engaged on diabetes prevention. In May 2008 it was agreed that MIT would lead the development in health promotion training for community health workers, funded by the Ministry of Health.

The adaptation score for this initiative was somewhat elevated as there was a renewed focus on supporting Maori providers. Progress was higher as there was work being undertaken that ultimately contributes to building workforce capacity in this area.

Initiative 5.3 received a moderate score for progress but high scores for meeting KPIs and implementation. Little information was provided in relation to 5.3.1<sup>20</sup>; up until April this initiative was noted to be behind schedule, but in May it was signalled that the initiative was completed, with no further information provided. As support was supposed to be available throughout 07/08 and not just in May, this lowered the initiatives score for meeting KPIs. The workshops were delivered albeit slightly late; however there was no mention of Maori and Pacific input. The implementation score for this initiative was higher due to the 4 sessions that been held with providers with good attendance. There was limited evidence provided that might have suggested adaptation was occurring.

Very little information was provided in relation to progress towards initiative 5.4. It is important to note the alignment of the initiative with 1.6. Under 1.6, it was noted that 25 people had been trained, albeit behind schedule, and discussions were being held around mentoring, which was supposed to be incorporated and aligned with training, which suggests this sub-initiative was not achieved. No evidence was supplied to the evaluation team except with regards the number of training sessions held, which necessitated a low score for progress and meeting KPIs. There was no evidence for adaptation.

Initiative 5.5 received high scores for implementation and progress, and a moderate score for meeting KPIs. Sub-initiative 5.5.1<sup>21</sup> was achieved, and the project team had contracted providers for the next year, which was taken as evidence of forward planning and lead to an elevated score for adaptation. Resources had been developed however it was unclear whether translations were completed for all the stated languages. The resources that had been developed under sub-initiative

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<sup>16</sup> Sub-initiative 5.2.1: A competency based Performance Management Tool will have been developed and implemented for at least three providers

<sup>17</sup> Sub-initiative 5.2.2: Competencies aligned with NZQA standards

<sup>18</sup> Sub-initiative 5.2.3: Training for managers and supervisors scoped and proposal developed. Funded according to results

<sup>19</sup> Sub-initiative 5.2.4: A proposal for a mentoring service will have been developed. Funding achieved

<sup>20</sup> Sub-initiative 5.3.1: The co-ordinator will be available to act as a resource for information on training

<sup>21</sup> Sub-initiative 5.5.1: ARPMS continues to act as central point for ordering resources

5.5.2<sup>22</sup> couldn't be put on the LBD website, as this was in the process of being redesigned, so these were instead posted on the Diabetes Projects Trust website, which also elevated the initiative's score for adaptation. No information was provided in relation to progress towards sub-initiatives 5.5.4<sup>23</sup>, 5.5.5<sup>24</sup>.

Initiative 5.6 received a moderate score for meeting KPIs, degree of implementation and progress, and a reasonably high score for adaptation. With regards to sub-initiative 5.6.1, by December 2007 SPARC had accepted the proposal for a training package and recruitment of a project manager was to commence immediately. There was ongoing discussion around the implementation of the project, however the contracting processes were lengthy and action was subsequently delayed. Due to the nature of the contracting process between MCC and the banker organisation for all the agencies and SPARC, the employment of the Project Manager (PM) was delayed (5.6.2). Discussions were being held with regards the PM recruitment process and the job description was reviewed. In June 2008 the position for a PM was accepted, and the role was to be commenced in August 2008. Activity around developing a training package was noted to have been delayed (5.6.3).

The start date for initiative 5.7 was postponed such that it was not scheduled to begin until September 2008. Consequently progress towards this initiative is monitored in the 08/09 financial year.

The Active Families initiative (5.8) received a high score for the meeting KPIs, implementation and progress variables, with a low score for adaptation. The contracted number of sessions (40) had been delivered during the school terms, with 53 families enrolled from June 2008 through to February 2009 (please note this reflects programme enrolments, not the number of participants that completed the programme).

Initiative 5.9 requires that further KPIs are developed based on the findings of the evaluation report for Healthy Kai. The final evaluation report was submitted on 21/05/08, and this was signed off on 15/10/08. Although no information was provided in relation to this initiative in monthly progress reports, the KPI in the 08/09 financial year reflects what was highlighted in the report, i.e., increasing community ownership of the programme, which is reflected in the moderate scores for meeting KPIs and progress.

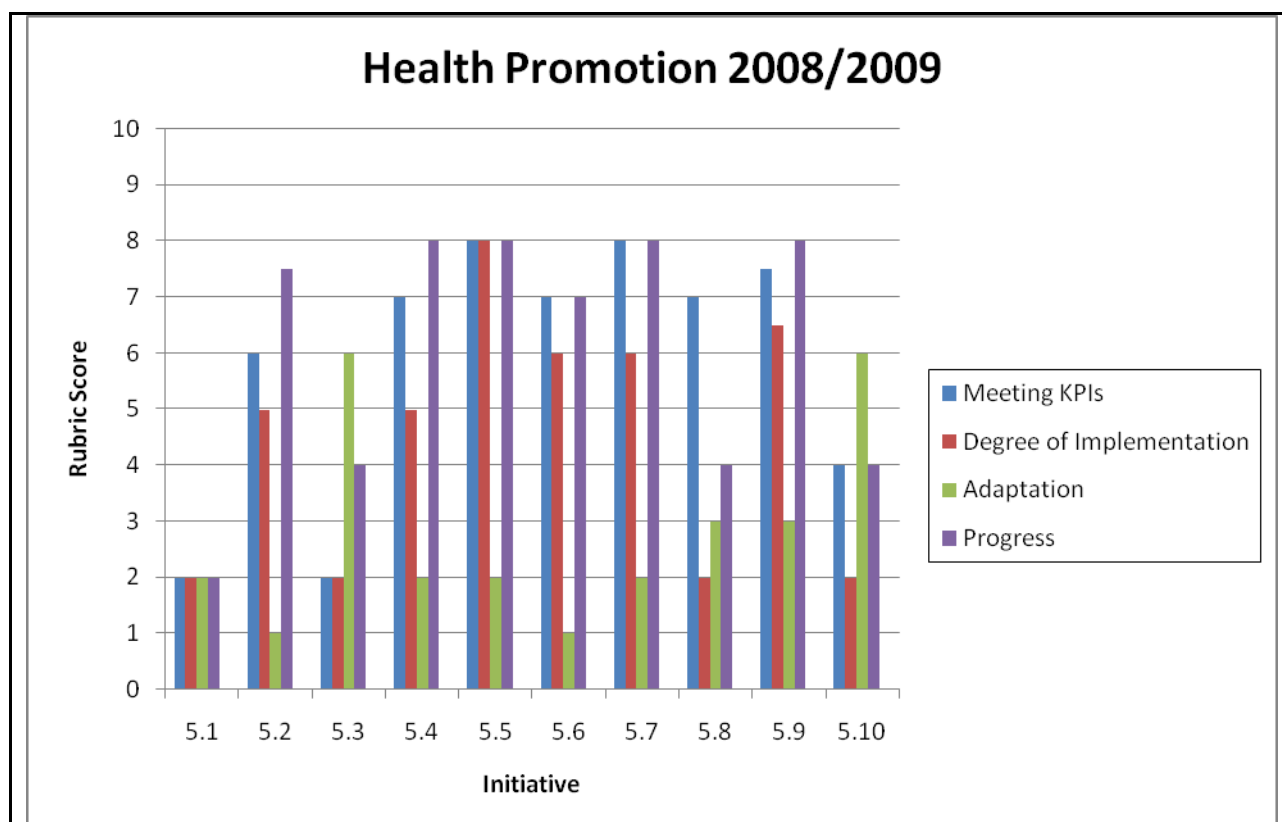
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<sup>22</sup> Sub-initiative 5.5.2: The main resources are made available in at least 3 Asian languages

<sup>23</sup> Sub-initiative 5.5.4: A resource will have been designed and distributed to support the social marketing campaign (in conjunction with the social marketing team)

<sup>24</sup> Sub-initiative 5.5.5: All resources will be put on the LBD website

## Health Promotion Action Area Progress for 2008/2009



### KEY: 2008/2009 Action Area: Strengthening Health Promotion Coordination and Activity

5.1	Leadership information sharing and planning
5.2	Improving workforce capacity
5.3	Improving the provision of communications resources for health promotion and health education
5.4	Counties Manukau Active (Active Communities)
5.5	Enhance Green Prescription Model
5.6	Active Families (HEHA Innovation Fund)
5.7	Health food policy initiatives for ASB Polyfest and outdoor events
5.8	Healthy Kai
5.9	Gardening
5.10	Healthy Cooking

**Figure 25: Health Promotion Action Area 2008/2009**

As in the previous financial year, there was considerable variation in the scores that were allocated to each initiative under the Health Promotion Action Area in terms of meeting KPIs, degree of implementation, adaptation and progress in the first half of the 08/09 financial year. A low level of progress was evident towards all evaluation variables for initiative 5.1, although it was noted that a representative of LBD attended Health Promotion working group meetings, and some members of this group are in attendance at two-weekly LBD Project Manager meetings and PSG. Sub-initiatives

5.1.1<sup>25</sup> and 5.1.2<sup>26</sup> were not met, as their achievement was noted to be dependent on the appointment of a project manager.

Initiative 5.2 received a moderate score for meeting KPIs and implementation and a high score for progress. With regards sub-initiative 5.2.1<sup>27</sup>, the LBD programme director was sitting on the Steering Group of the CMDHB Learning and Development Team, training had been scoped and a proposal developed and initial work with 3 providers (5.2.2<sup>28</sup>) had been undertaken. The KPIs appear to be on track at this point in the contracting year, which is reflected in the high score for progress. There was little evidence for adaptation or alteration to the original work plan.

Initiative 5.3 received a low score for meeting KPIs and implementation, but a high score for adaptation, and a moderate score for progress. The KPIs under this initiative were in regards to conducting a review of the resources, however the project team later learned this had been completed by someone externally. This essentially made the KPIs redundant, and an alternative course of action was decided upon, whereby the project team discussed what had come out of external review (in terms of gaps in resources available). This is reflected in the high adaptation score, and the low score for KPIs, which weren't achieved as this wasn't deemed appropriate in light of the changing context. Further, it was decided that it was neither appropriate nor sustainable for the DHB to develop resources, but rather should be focusing on supporting other organisations to do this work, however no evidence was provided to the evaluation team as to how this support would be enacted.

Initiative 5.4 received a high score for meeting KPIs and progress, and a more moderate score for implementation. Workshops had been planned for mid-December in Otara, Manurewa, Mangere, Franklin, and Papakura; however no evidence was supplied to the evaluation team as to whether these workshops went ahead as scheduled. A project manager was appointed, albeit late, and a provider was identified with contracts with providers to undertake the training anticipated to come in the near future.

A high level of achievement in terms of meeting KPIs, implementation and progress was evident under initiative 5.5. Participation in the expansion of the Green Prescription Model had been achieved, with a link to the GRX website on the LBD website and LBD involvement at a national and local level. Cost comparison documents were completed in 2008 and the LBD programme director sat on the national steering committee. Further a draft response on the regional delivery model was generated through regional collaboration across Auckland, and the project team were actively encouraging graduates to remain involved, securing funding for some to participate in NetFit course.

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<sup>25</sup> Sub-initiative 5.1.1: The Health Promotion Steering Group will meet on a quarterly basis to co-ordinate, collaborate and advise LBD/DHB on strategic matters for health promotion and health education

<sup>26</sup> Sub-initiative 5.1.2: Two strategy, co-ordination and planning workshops for organisations involved in health promotion and health education in Counties Manukau will be delivered

<sup>27</sup> Sub-initiative 5.2.1: Training for managers and supervisors scoped and proposal developed for delivery by CMDHB Learning and Development team

<sup>28</sup> Sub-initiative 5.2.2: Training to support the LBD health promotion competencies will be delivered to the providers of health promotion services

Initiative 5.6 received moderate scores in terms of progress towards meeting KPIs, implementation and progress. The project team were on track to achieving their KPI and delivering the contracted 40 sessions, with 57 families enrolled in the programme from March 2008 through to November 2008 (please note this reflects programme enrolments, not the number of participants that completed the programme).

Initiative 5.7 received a high score for meeting KPIs and progress, but a more moderate score for implementation. Sub-initiative 5.7.1<sup>29</sup> was not completed and 5.7.2<sup>30</sup> and 5.7.3<sup>31</sup> were noted to be complete, and the project team was setting up a culturally appropriate “buddy” system to mentor stall providers. The policy was also to be extended to a Waitangi Day event, in collaboration with Maori Action Area. It was noted that a lot of consultation was occurring in this area.

Although initiative 5.8 received a high score for meeting KPIs, the initiative received a moderate score for progress and a low score for implementation. It was noted that ARPHS was now providing very little support for this initiative as the Ministry of Health had requested more focussed activities, with more responsibility transferred to community partners, although it was noted that this transition could perhaps have been managed better, and the steering group were moving in to support the community to take ownership of the initiative. LBD were to support this process, by meeting with the Ministry and Healthy Kai Steering group with regards to the transition. Healthy Kai sites were to work with ARPHS to develop a transition plan. The elevated adaptation score is a reflection of the adjustments necessary following the decreased support from ARPHS and the shift in ownership of the initiative.

A high level of achievement was noted for initiative 5.9 in terms of meeting KPIs and progress. A business plan had been completed, albeit behind schedule due to delays in appointing a project manager. Work on one gardening initiative was completed, with the Mangere Garden launched in November, and planning was underway for the second initiative. The adaptation score was elevated as it was noted that there was very little structure to the area in the beginning, so extensive consultation with the community and a needs analysis had been conducted to help identify a plan.

A moderate level of achievement was noted for initiative 5.10, and a high level of adaptation was evident, which reflects the project team’s decision that the initiative be linked with 5.9. Funding had been secured from the DHB; and an LBD Dietitian worked on the gardening project. Diabetes Project Trust had been contracted to provide the regional healthy cooking programmes.

### **Overview of the Health Promotion Action Area**

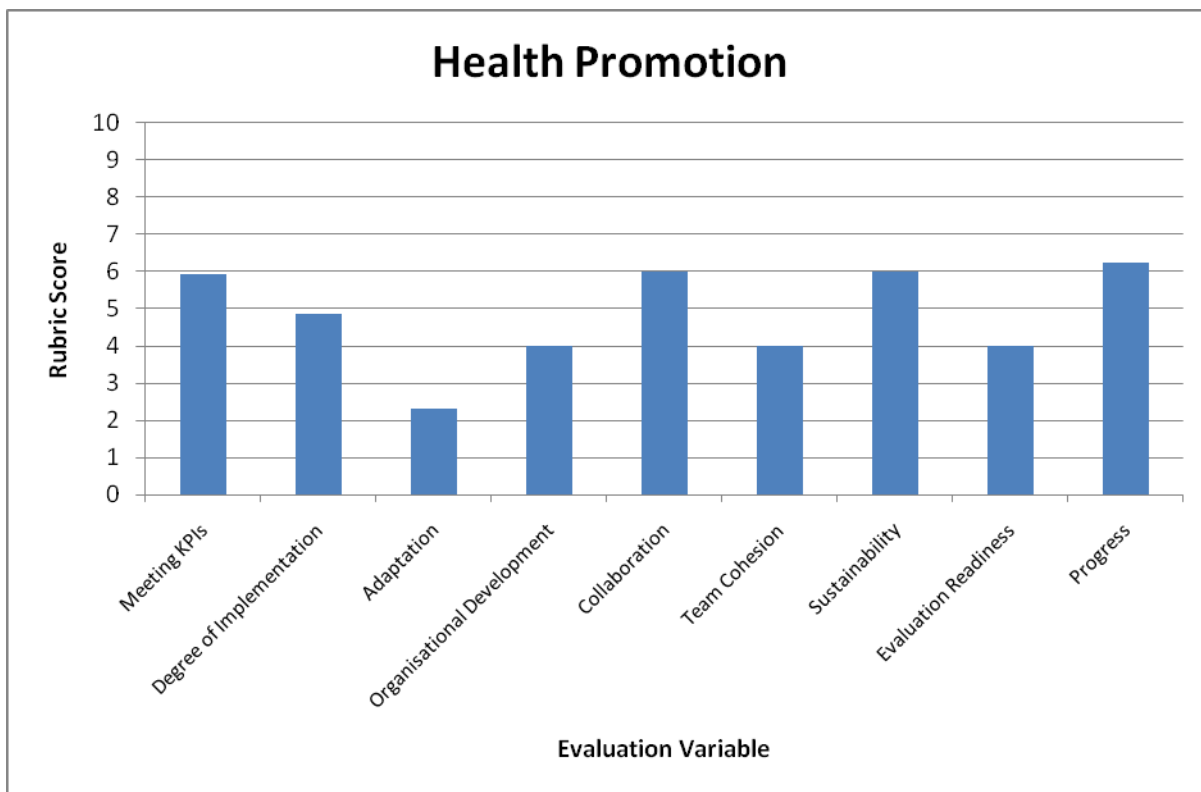
A combined analysis of the 2007/2008 and 2008/2009 data was used to provide an overview of the Health Promotion Action Area over this reporting period. In addition, the Action Area was assessed on their collaboration, sustainability, evaluation readiness and team cohesion. Figure 26 illustrates these findings, and the interview data is used to support the overview.

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<sup>29</sup> Sub-initiative 5.7.1: Agreement to healthy food and beverage policy by the secondary schools principles committee is confirmed

<sup>30</sup> Sub-initiative 5.7.2: Agreement to healthy food and beverage policy process by LBD partner organisations is confirmed

<sup>31</sup> Sub-initiative 5.7.3: Agreement to policy process by cultural Komiti of the Festival is confirmed



**Figure 26: Overview of the Health Promotion Action Area**

### ***Achievements and Adaptations***

Overall, the Health Promotion Action Area received a moderate score for meeting KPIs and implementation. There are a lot of initiatives that fall under this Action Area and a huge breadth of activity which occurs under the Health Promotion umbrella, which was noted to serve as a kind of “holding pen” for initiatives which might not fit elsewhere but are seen to be important nonetheless. The project team are tasked with a lot, and the difficulties noted in recruiting appropriate staff to head some of these initiatives has meant that progress towards certain initiatives has been delayed.

Key achievements within this area were seen as getting some momentum with the Counties Manukau initiative and the regional approach for Green Prescription, as well as the healthy food policy and gardening initiatives which are new to the area in 08/09. In addition a high level of collaboration was noted to be occurring within the Health Promotion Action Area which was seen as a key achievement.

Adaptation was minimal although it was noted that there had been a shift in focus for some of the initiatives:

*...LBD has now decided it's not going to be producing any new resources internally...so we've sort of had a bit of adaptation there...the DHB is not the ideal place to be developing resources...there's a lot of organisations around the country that are doing good quality resources...*

*...the Healthy Cooking is now part...we've done a bit of adaptation and that's been merged into the gardening...so gardening is now the journeys to the plate...*

### **Functioning of the Action Area**

The Action Area received a moderate score for organisational development and team cohesion, largely as there appeared to be limited information sharing between different islets of work and little cohesion as an Action Area. This score is also reflective of the “holding pen” nature of the Action Area. There were also difficulties in appointing a project manager with the appropriate skills and knowledge to lead some of the initiatives within this area, which is reflected in this score. The Action Area leader noted that the purpose of the Action Area is somewhat different to the work that occurs under it:

*...the purpose of the Action Area was coordination, and some activity, but what has ended up being is some of that...which hasn't progressed because we haven't had someone whose been able to undertake that role...but it's also ended up a holding pen for a whole lot of other initiatives that are basically health promotion but not necessarily appropriate to be under the steerage of the Health Promotion Steering Group...*

It was thought that having someone, ideally with a PHO background, to take on an oversight role of the whole Action Area would improve the management and coordination of the Action Area:

*...it's an Action Area but it's a bit different from the others...to improve it we need more focus on leadership, information sharing and planning...*

The Action Area received a moderate score for collaboration, as it was noted that the project team were collaborating well with the community, as a lot of their work is centred around this:

*I think the Health Promotion area has a lot of collaboration, and the more you collaborate the easier it is...so when people see that you're doing something really positive there more likely to get involved with something else... its constructive working together...*

At the external level with CM Active, collaboration was occurring with 3 DHBs, numerous PHOs and SPARC. But there are also links with numerous community organisations and health organisations via the steering group. Collaboration was also occurring with all of the Sports Trusts, other DHBs within the region, the councils, NGOs, the Heart Foundation, and schools.

However collaboration at an internal level was not working as well as at that external level, and a desire was expressed by one member of the project team for greater inter-Action Area collaboration. Current linkages with other Action Areas within LBD included Maori and Pacific, Primary Care, Social Marketing, Education Settings and the Vulnerable Families Action Areas.

### **Sustainability**

The Action Area received a moderate score for sustainability, and was seen as highly sustainable by an interviewee from this Action Area:

*I think this Action Area is probably one of the more sustainable...taking resources out of the picture because that's always going to be an issue from a sustainability perspective...but leadership information sharing and planning should be a standard way of working...*

While it was noted that most of the initiatives are geared towards sustainability (e.g., the work with community gardens), there is a need to support the community further to build workforce capacity. Although the work was seen as dependent on funding to a certain extent, it was noted that there were many different avenues through which funding could be procured to further these initiatives in the future. With respect to specific initiatives, the Green Prescription model is actively seeking ways to be sustainable and improved. The Healthy Food policy was seen to be sustainable as was the gardening initiative. It was noted that Healthy Kai will need to attract funding from other sources to be more sustainable, and the sustainability of the Active Families programme was unclear at this stage.

There is a need for more coordination in terms of health promotion through PHOs as some duplication of efforts was noted, and this has been prioritised by the DHB:

*...the health promotion through PHOs...we'd like to see greater focus...I think there's great opportunity to do that....*

### **Evaluation Readiness**

The Health Promotion Action Area received a moderate score for evaluation readiness which is a reflection in part of the large gaps in the information related to progress that was supplied to the evaluation team. Some commitment to evaluation is evident across the majority of the initiatives under this Action Area. It should be noted however that the Project team have engaged with the evaluation team in a number of focussed studies of initiatives under the Health Promotion Action Area. In addition, monitoring of progress occurs through a combination of monthly reporting and reviewing minutes from the various steering group minutes. The School of Population Health is carrying out several focussed evaluations of various initiatives in this area.

### **Summary of Progress**

Overall a moderate level of progress was evidenced by this Action Area as it was felt that the Action Area was making good progress towards the general aims of the Action Area, with the exception of leadership, information sharing and planning which had been delayed, but was seen as key to the success of the area.

Obstacles to progress cited by an interviewee included finding an individual from a PHO to take on board some responsibility for the Action Area, as well as the restructuring of the DHB, which has shaped their ability to meet milestones.

By contrast, enablers to progress cited by the Action Area leader included regional collaboration, relationships with the PHOs, funding through CM Active, having capable project managers, and getting cooperation from partners to promote the same messages, e.g., health food messages.

### **Changes over Time**

A significant decrease was observed in the Action Area's score on the organisational development variable. This may reflect the changes in this area over the reporting period with respect to leadership and numerous staff changes, as well as seemingly limited information flow among the Area as a whole. There is a need for increased oversight of this Action Areas as a whole.

### ***Issues for Consideration***

- There were often significant gaps in the information that was provided to the evaluation team in relation to progress, which may mean that the level of progress reflected here is not fully representative of the work that has been undertaken
- Delays in appointing a project manager and challenges in securing leadership for the Action Area from outside the DHB.
- Progress towards KPIs for the 08/09 financial year is not fully represented given that reporting is occurring midway through the financial year.

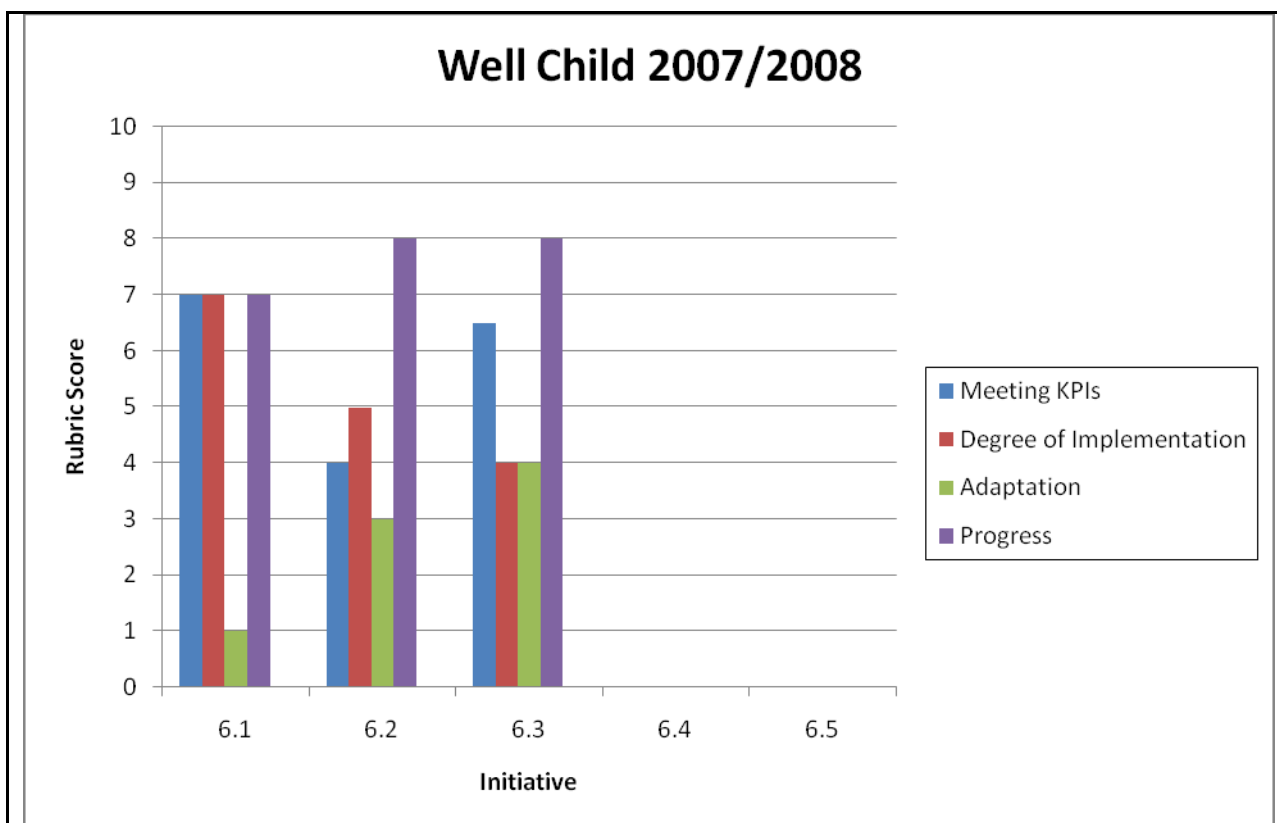
## **4.6 Well Child Action Area**

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

There is a growing awareness of the importance of good nutrition and activity in the early years in order to reduce the onset of obesity, and its long term implications. To support this in 2007/08, consultation with priority population groups and Well Child providers was undertaken, and LBD developed a new set of activity and nutrition messages. These messages are planned to be translated to support Well Child providers to profile the importance of breastfeeding, good nutrition and health activity for children in the early years. There has been mainstream adoption of the evidence that points to increasing risks of diabetes for children, whose mothers who are in a pre-diabetic state and currently dedicated Midwifery services are available to these families. However the major gain in 2007/08 has been to significantly raise the priority of improving breastfeeding rates in our priority population through more successful initiation rates, which has meant planning for active steps to overcome workforce barriers to BFHI accreditation for the Middlemore maternity facility.

### **Well Child Action Area Progress for 2007/2008**

The nature of the KPIs encompassed by each Action Area will impact on the scores on each of the evaluation variables that the Action Area is designated. It is of note that the majority of the initiatives under the Well Child Action Area were classified as comprising activities involving programme development and interventions aimed at prevention and collaboration for the area. The scope of some of the initiatives should be taken into account when interpreting the Action Area's progress in achieving these KPIs.



**KEY: 2007/2008 Action Area: Enhancing Well Child Services to Reduce Childhood Obesity**

6.1	Supporting the existing Well Child forum to be the leadership hub for the Well Child Action Area
6.2	Scoping and development of appropriate nutrition and diabetes resources to support Well Child providers
6.3	Breastfeeding
6.4	Examine obesity pathways for 0-5 years children from the Pacific Island Family long term research study and identify potential interventions
6.5	B4 School Check

**Figure 27: Well Child Action Area 2007/2008**

In 2007/2008 there was some variation in the scores given to each initiative in terms of meeting KPIs, degree of implementation, adaptation and progress, as seen in Figure 28. This variation is likely to be partly a function of the difference in the number, specificity, and difficulty of the KPIs for each initiative. Initiative 6.1 received a high score for meeting KPIs, implementation and progress. The leadership group were meeting on a bi-monthly basis, and the breastfeeding plan and progress had been presented for review. There was a low score allocated for adaptation as there did not appear to be a need to deviate from the set KPIs.

Initiative 6.2 received a moderate score for the meeting KPIs and implementation variables, and a high score for progress. It must be noted that only sub-initiatives from 6.2.4<sup>32</sup> onwards were

<sup>32</sup> Sub-initiative 6.2.4: Undertake focus group reviews of key messages with representative (Maori, Pacific and Asian) parents/ caregivers with children in this age group

encompassed by the reporting period for this report. The project team had held focus groups, albeit significantly behind schedule. The key messages had not been translated, which had delayed other KPIs being achieved, which lowered the initiative's meeting KPIs score. Progress and implementation scores were higher as it was noted that other work was being undertaken in lieu of the translations e.g., scoping costs, photography, design etc. This also resulted in a somewhat elevated score for adaptation.

Initiative 6.3 received moderate scores for meeting KPIs, implementation and adaptation, and a high score for progress. It should be noted that as completion dates for sub-initiatives 6.3.1<sup>33</sup> and 6.3.6<sup>34</sup> fell outside the reporting period, progress towards these are not reported on. Documentation had been developed, adding the Counties Manukau context to relevant breastfeeding policies and an evaluation of the Teen Parent Units had been completed, although both were achieved after timeline. Sub-initiatives 6.3.3<sup>35</sup> and 6.3.4<sup>36</sup> had deliberately been delayed due to the identification of issues that needed to be addressed prior to roll-out of the initiatives, and to allow time to could respond to evaluation feedback, which is reflected in the elevated score for adaptation for this initiative. Although some of the actions had not been completed, and most had been delayed, the initiative received a high score for progress due to the work that been undertaken in preparation for roll-out of the various initiatives. Implementation and meeting KPIs scores for this initiative are lower because the KPIs were late, and they hadn't wholly implemented the plans as dictated by the operational plan.

Initiative 6.4 was not scored as responsibility for this initiative was noted to have been transferred to the Pacific team. Progress towards initiative 6.5 was not reported on as this fell outside the reporting period also, having been completed by October 2007.

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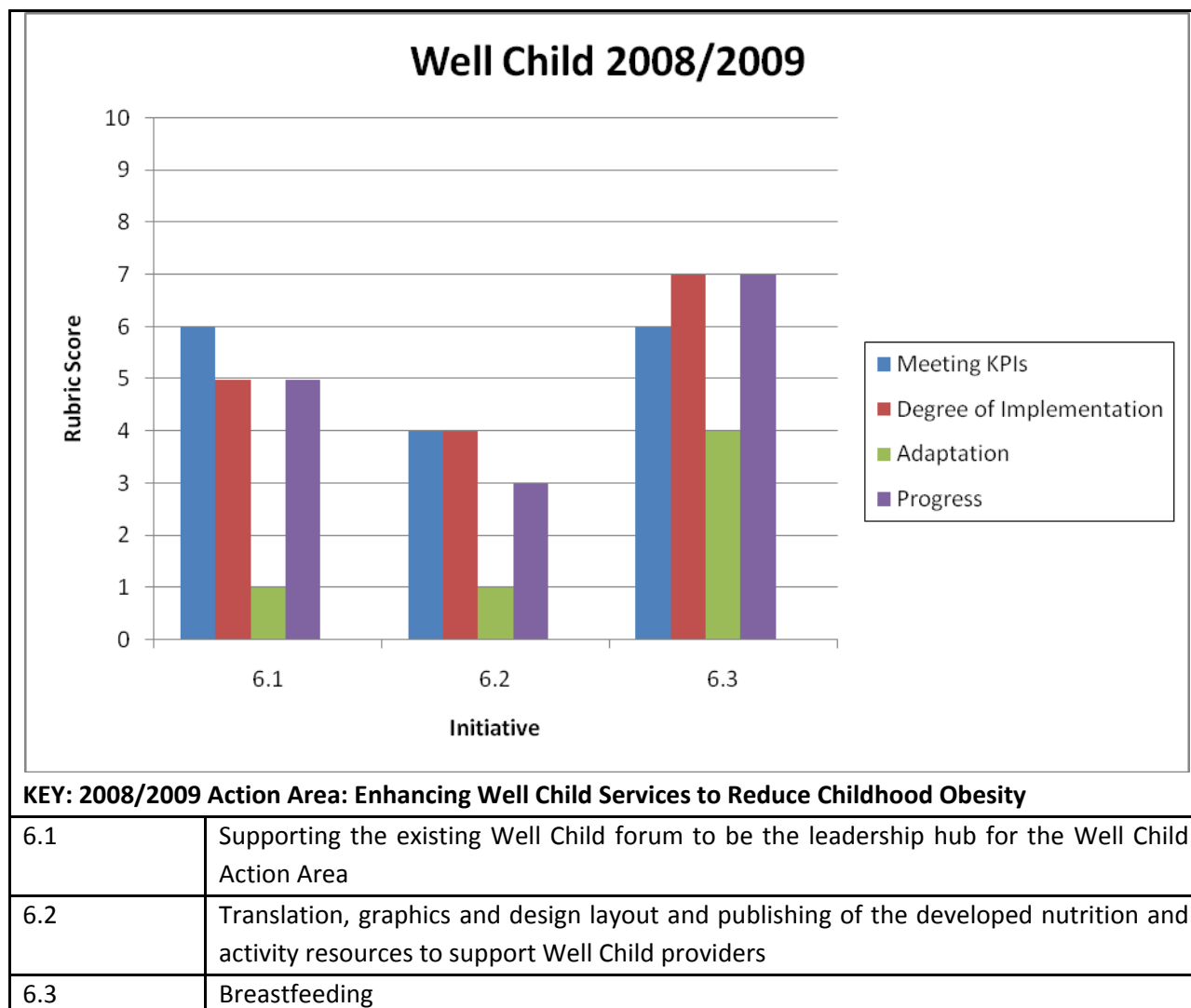
<sup>33</sup> Sub-initiative 6.3.1: Conduct a review of current breastfeeding policies, guidelines, targets, activity and results

<sup>34</sup> Sub-initiative 6.3.6: Develop and refine breastfeeding Policy and Guidelines for Well Newborns, in hospital maternity units

<sup>35</sup> Sub-initiative 6.3.3: Establish and initiate an agreed plan of action to improve breastfeeding outcomes in Counties Manukau

<sup>36</sup> Sub-initiative 6.3.4: Develop a schedule for rollout of the B4Baby programme

**Well Child Action Area Progress for 2008/2009**



**Figure 28: Well Child Action Area 2008/2009**

In 2008/2009 there was more consistency in the scores given to each initiative in terms of meeting KPIs, degree of implementation, adaptation and progress. Initiative 6.1 received moderate scores for meeting KPIs, implementation and progress. The first two sub-initiatives were completed on time; meetings were being held regularly and the group was reviewing plans and progress. Last one was not done at all, no progress being made, so lowers KPIs. No progress was reported for sub-initiative 6.1.3<sup>37</sup> which relates to the development of a scoping paper, which lowered the score for progress. No adaptation to the work plan was evident based on the evidence provided to the evaluation team.

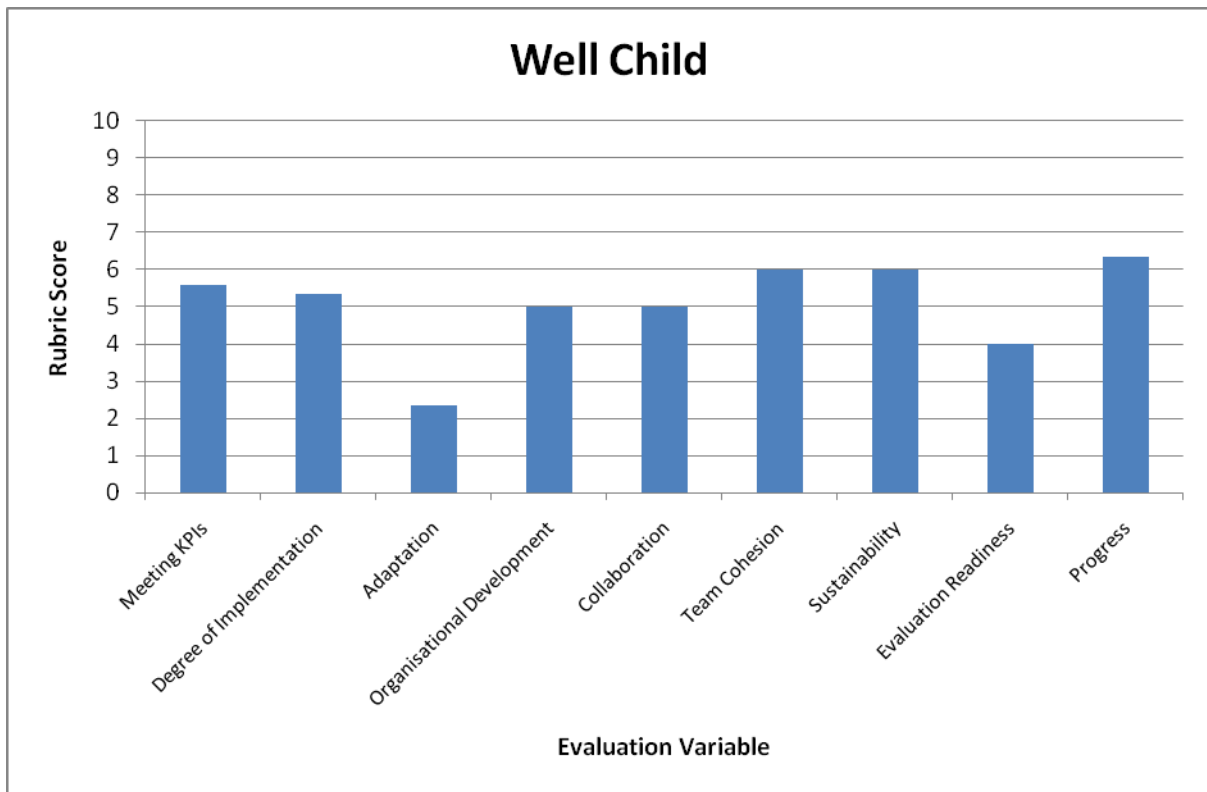
<sup>37</sup> Sub-initiative 6.1.3: Develop a scoping paper to identify available services and perceived gaps in services for children aged less than 5 and their parents where the child has been identified by Well Child providers as being significantly overweight

Very little information was provided to the evaluation team in relation to initiative 6.2. Based on the information that was provided, it appeared that progress had been significantly delayed. In October a new plan and set of timeframes was developed and dissemination of the resources was set to commence in November. This was later deferred to late January 2009. No evidence was provided to the evaluation as to why the initiative was delayed, hence the low score for adaptation.

Initiative 6.3 is comprised of twelve sub-initiatives, and the breadth of activity occurring under this initiative is quite considerable. Progress for each sub-initiative was scored and then these scores were collapsed to generate one overall score for the initiative. Consequently the reader is advised to refer to the data supplement for a more thorough breakdown of progress by sub-initiative. The initiative was allocated a moderate score for meeting KPIs, and a high score for the implementation and progress variables. The first 6 sub-initiatives were scheduled to have been completed; of these three had been achieved, but late, two had not been achieved, and one was a work in progress. A high level of implementation was noted for the initiatives pertaining to e-learning and breastfeeding week; however there was little progress in relation to employing personnel or developing a plan for breastfeeding services. There was little evidence for adaptation across these sub-initiatives. The remaining 6 sub-initiatives appeared to be on track for completion within the specified timeframes. Adaptation was elevated in relation to this set of sub-initiatives as the project team had altered the KPIs such that they were more focussed, which brought up the adaptation score for the initiative as a whole.

#### **Overview of the Well Child Action Area**

A combined analysis of the 2007/2008 and 2008/2009 data was used to provide an overview of the Well Child Action Area over this reporting period. In addition, the Action Area was assessed on their collaboration, sustainability, evaluation readiness and team cohesion. Figure 29 illustrates these findings, and the interview data is used to support the overview.



**Figure 29: Overview of the Well Child Action Area**

***Achievements and Adaptations***

Overall, the Well Child Action Area achieved a moderate score for meeting KPIs and implementation. Whereas the breastfeeding initiative was progressing well, other initiatives appeared to have fallen behind timeline, and some had yet to progress beyond the planning stages. This is perhaps not surprising given that breastfeeding has been identified as a priority area by the Ministry of Health.

***Functioning of the Action Area***

The Well Child leadership hub meets bimonthly, and as this is lead by the DHB, LBD is always on the agenda. The leadership hub was seen to be functioning well, and the two interviewees appreciated the opportunities these meetings afforded for feedback on progress and planning for upcoming activities. It was noted that the DHB lead and control the Action Area; the appropriateness of this was queried by one interviewee given the limit of their understanding of the Well Child programme, and a desire was expressed for a greater degree of community input into the development of work plan priorities:

*...I really question whether they should be leading and driving it so much, because I'm not totally convinced that they have a full understanding of our work out there...*

In addition there is a steering group that was responsible for developing the Breastfeeding Action Plan, and the hospital also has their own steering group.

Difficulties in appointing a project manager were seen to have hindered the functioning and progress of the Action Area, as those individuals currently appointed to progress the LBD Well Child agenda had competing priorities:

*It has been quite challenging, to make time available as this is not my only priority ... that is why it has been key to get the project manager on board and not being able to recruit this person has been difficult ... once we have a project manager on board I think the difference will be huge...*

In terms of collaboration, there was a high level of engagement with the individual Well Child providers (2 Maori providers, 1 Pacific provider, and Plunket), and it was noted that a lot of time and effort had gone into establishing and nurturing those relationships. In addition the Action Area was working with community paediatricians, the Well Child/Tamariki Ora programme, the Ministry of Health, the Breastfeeding Authority, Women's Health Action, and the hospital.

There was less evidence of collaboration at the Action Area level. The Action Area leader was able to provide some specific examples of where there had been input from other Action Areas on the work that was being undertaken by the project team; for example some dietitians on the team had reviewed and provided advice around the resources, and the Maori Action Area leader had provided support with the focus groups. The interviewee appreciated the opportunity afforded by the fortnightly Project Manager meetings to hear what projects others are involved with and would like to see greater opportunity for collaboration with other Action Areas, and identify potential linkages, however to date there appears to have been little collaboration with other Action Areas, perhaps again due to time and resource constraints.

The Action Area received a moderate score for team cohesion; working as part of a team was identified by one of the interviewees as a key achievement, however a failure to appoint a project manager was noted to have placed additional pressures on the project team.

### **Sustainability**

The Action Area received a moderate score for the sustainability variable. The interviewees saw that the work was sustainable, although there was still room for development and improvement. This was seen as achievable given the current level of resourcing provided the project team are able to identify a clear focus. There was, however, a need identified for a project manager (at least 0.5FTE) to further the LBD work specifically. This was seen as dependent on whether or not the DHB sets different (i.e., higher) priorities for child health.

Some of the KPIs within the Action Area appear to have identified a sustainable focus, for example those related to creating a culture around breastfeeding, and training and capacity building. The relationships that had been established with Well Child providers were also seen to enhance the sustainability of the initiatives. It was suggested that there is now a need to focus on under-five year olds that could be overweight. It was noted that there are currently no dietitians that focus solely on this under-five year old group, as they all target school aged children.

The interviewees felt that the DHB was supporting the initiative well, but felt that more of the leadership needs to come from the community in order to maximise the relevance and sustainability of the work undertaken:

*Most of the initiatives are DHB driven and I think some of them really need to be community driven ... we have a lot to offer and some good ideas and they don't always get through and there is a sense of frustration sometimes. I think this is because a lot of it is DHB driven*

### **Evaluation Readiness**

The two interviewees from the Well Child Action Area had a limited understanding of the evaluation being undertaken by the School of Population Health:

*I think they're [SOPH] just looking at the overall how it's going, making any recommendations...I don't always read it...it does get talked about at the PSG meetings from time to time...*

Although it was noted that the evaluation may be valuable at a higher, more strategic level in terms of making decisions about where to direct resources, the interviewees appeared to see the evaluation as less relevant at an Action Area level:

*...[the evaluation] might show whether or not we're making progress...might show up comparative progress in relation to other Action Areas against investment perhaps...might show where our Action Area needs to work more closely with other Action Areas...it might identify a need to put more resource into the Action Area or not...*

There is limited self monitoring or evaluation, and this is informal where it does occur. For example one interviewee noted that they regularly refer back to where they are at in terms of meeting what is set out in their business plan, and they undertake an annual review of the relationships with Well Child providers, but not in any kind of structured way. In terms of the breastfeeding initiative, there is an ongoing peer review process that is facilitated via the steering group. It is of note that there were often gaps in the information that was provided to the evaluation team in relation to progress.

The interviewees saw value in the evaluation in providing an opportunity for the organisation to pause and reflect on how things are going within the Action Area.

### **Summary of Progress**

The Action Area as a whole achieved a high level of progress towards achieving the overarching goal of enhancing Well Child services to reduce childhood obesity. Strong relationships had been formed with the providers and a considerable amount of work had been undertaken to work collaboratively with those in the sector to increase awareness and rates of breastfeeding in the community.

Delays in progress had been attributed by the interviewee to constraints on staff time and resource, where the focus had instead been on building and nurturing relationships with the providers. One interviewee also noted that delays had been experienced in part due to restructuring that had been occurring within the community. The Action Area also desires an increased involvement from the community in terms of the direction of the work undertaken.

### **Changes over Time**

No significant changes were noted in the scores for the evaluation variables for this Action Area.

### ***Issues for Consideration***

- There were often gaps in the information that was provided to the evaluation team in relation to progress, which may mean that the level of progress reflected here is not fully representative of the work that has been undertaken.
- The expressed need to collaborate extensively with Well Child providers.
- Difficulties in appointing a Project Manager.
- Progress towards KPIs for the 08/09 financial year is not fully represented given that reporting is occurring midway through the financial year.

## **4.7 Education Settings Action Area**

Emerging international evidence shows that improved nutrition and physical activity levels in schools and Early Childhood Education Settings support improved behavioural and academic outcomes for children and young people.

Let's Beat Diabetes provides a model for working collaboratively with education sport and recreation and health partners to support the development of innovative and constructive activities and nutrition programmes in our schools.

There are two leadership groups within this action area.

- The Schools' Accord which was re-established in 2006 with strong representation from primary and secondary schools, health, nutrition and activity provider groups.
- The Early Childhood Education Services Advisory Group which was established in October 2007.

During 2007/2008 the following key work was undertaken within this action area:

- Identification of critical success factors for the implementation of initiatives to support schools provides the context for all work. Based on the literature review "The Relationship between Physical Activity, Nutrition and Academic Achievement." This was carried out by researchers from Auckland University
- Distribution of the Physical Activity and Nutrition service directory for schools in Counties Manukau to address the coordination and service provision gaps identified for some schools.
- Pilot of the "Record of Involvement" template and implementation process to address the identified need for improved coordination and working together with schools.
- Provision of support for the implementation of national strategies (Mission On, HEHA) and related local initiatives, with participation in the training workshops for schools and early childhood education settings in Counties Manukau for the Food & Nutrition guidelines and Food & Beverage classification system.
- Development of and advocacy for the Early Childhood Education Services sector to provide advice for the Nutrition Fund, Food and Beverage Classification System, Oral Health and Before School Health Checks
- Support for and allocation of the Nutrition Fund governed by both School, Education and Early Childhood Services representatives.
- Support for the Let's Beat Diabetes social marketing campaign and dissemination and integration of the benchmark survey key findings into all our work.
- The development of best practice guidelines for schools interested in establishing Breakfast clubs
- The provision of support for the youth health hui "living4life". HPS and FIS.

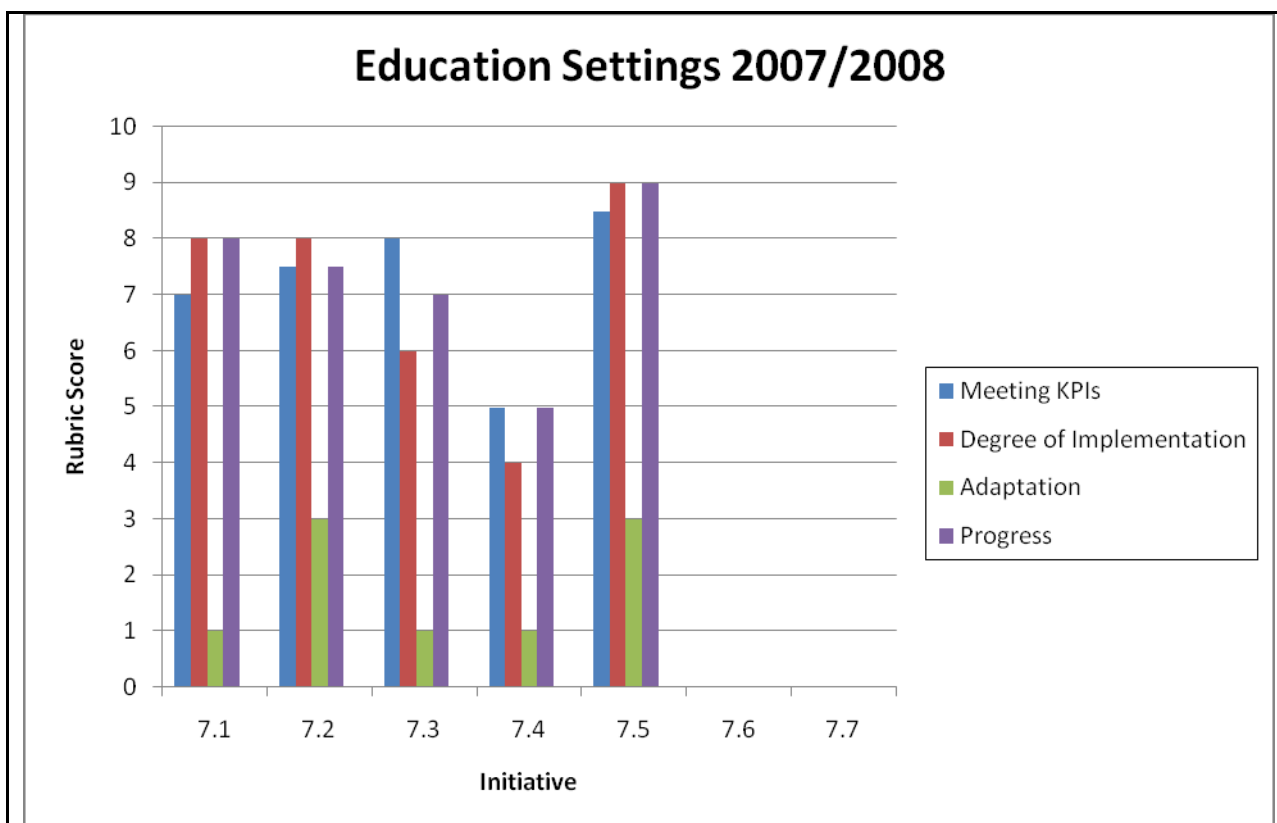
- Participation in a process review by the Auckland University School of Population Health.

In 2008/2009 the focus of activity for this Action Area will be:

- To support schools and early childhood education services with the implementation of the Food and Beverages Classification System ensuring ECEs and Schools in Counties Manukau have access to professional support in terms of nutrition knowledge and expertise and curriculum support for Nutrition.
- To support culturally appropriate initiatives which are designed to enhance the food environments, provide targeted support for schools, Kura Kaupapa, Kohanga reo and Pacific Language Nests which meet their specific needs

#### **Education Settings Action Area Progress for 2007/2008**

The nature of the KPIs encompassed by each Action Area will impact on the scores on each of the evaluation variables that the Action Area is designated. It is of note that although several of the initiatives under the Schools Action Area were classified as comprising activities involving supporting existing and implementing new initiatives. The Action Area also encompassed a number of initiatives designed to sustain the organisational development of the Action Area and foster collaboration. Such initiatives are often time consuming and challenging. This should be taken into account when interpreting the Action Area's progress in achieving these KPIs.



**KEY: 2007/2008 Action Area: Supporting Schools to Ensure Children are ‘Fit, Healthy and Ready to Learn’**

7.1	Strengthening the Counties Manukau Healthy Schools Leadership Hub (Schools Accord)
7.2	Develop and implement a range of projects within the School Accord
7.3	Enhancing and supporting NEW/AIMHI intervention in selected secondary schools
7.4	Enhancing the Implementation of the Healthy Tuckshop model
7.5	Implement the Counties Manukau (HEHA) Nutrition Fund
7.6	Supporting Pacific Language Nests to enhance or develop and implement nutrition and physical activity guidelines and programmes as part of programme delivery
7.7	Supporting kohanga reo and kura kaupapa in nutrition and physical activity

**Figure 30: Education Settings Action Area 2007/2008**

In the latter half of 2007/2008 there was generally a moderate to high level of achievement in terms of meeting KPIs, degree of implementation, and progress across the Education Settings Action Area. The Schools Accord continued to serve as the leadership hub for this Action Area, meeting monthly with representation from the health and education sector. The Schools Accord was providing support in a number of areas under initiative 7.1, particularly in relation to the Breakfast Club guidelines, the service directory, education around the NAG-5s, and the record of involvement. There was limited need for adaptation in relation to this initiative as the Schools Accord was identified as an appropriate group to be taking the lead with Schools for LBD. It was noted that there was representation from Kura via partner networks.

Good progress towards meeting KPIs was evident under initiative 7.2 also, with initiatives achieved albeit behind timeline. The elevated score for adaptation reflects the project team’s responsiveness

to the interest that was expressed in the guidelines by commissioning a second printing run, as well the modification of the Record of Involvement following feedback. It is of note that many of the KPIs fall outside the reporting period (i.e., were completed prior to February 2008) and as such are not encompassed by the current analysis. Overall a high level of progress towards developing and implementing relevant projects was observed.

Initiative 7.3 received a high score for meeting KPIs and progress variables, with a moderate score for implementation, and a low score for adaptation. Progress towards KPIs was generally noted to be good; there was evidence for working cooperatively with other funded programmes to facilitate sharing of best practice, although it was noted that this was most likely facilitated via the Schools Accord.

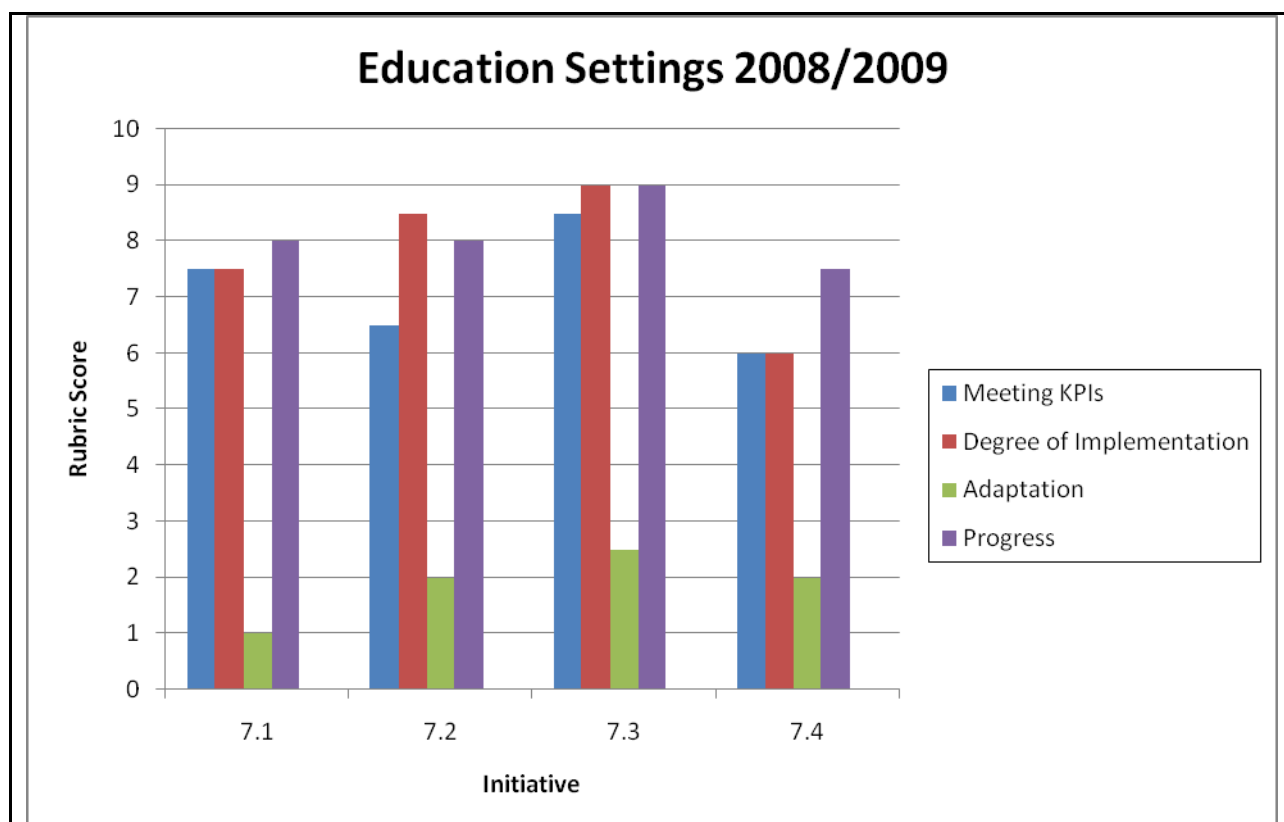
Moderate scores were allocated to initiative 7.4 related to the review and extension of the healthy tuck-shop model. The model was reviewed and revised, albeit some months behind timeline and advice corresponding with this and in alignment with NAGs was posted on the website. The contract for the extension of the model was then taken over by Diabetes Projects Trust with the Ministry of Health, supported by LBD, which accounts for the elevated adaptation score for this initiative.

A high level of progress towards initiative 7.5 was evident, which is reflected in the high scores for meeting KPIs, implementation and progress. There was also an elevated adaptation score as the project manager had gone to considerable efforts to ensure that all of the funds were allocated, supporting failed applicants to rework and resubmit their applications.

It should be noted that responsibility for reporting on initiatives 7.6 and 7.7 fell to initiative leaders outside the Education Settings Action Area. Although there are gaps in reporting here, it should be noted that the Education Settings area was active in seeking representation from Maori and Pacific. Initiative 7.6 was not scored as responsibility for this initiative was noted to have been transferred to the Pacific team, and no information was provided to the evaluation team with regards its progress.

Very little information was provided to the evaluation team in relation to initiative 7.7, which accounted for low scores across the board for this initiative. It was noted however that the Tamaki Makaurau Trust had actively participated on the Nutrition Fund panel, and had supported the HEHA initiative by holding Tamaki Makaurau Te Kohanga Reo Trust-specific food and nutrition workshops, which had been supported by Auckland regional Public health Service.

## Education Settings Action Area Progress for 2008/2009



**KEY: 2008/2009 Action Area: Supporting Schools to Ensure Children are 'Fit, Healthy and Ready to Learn'**

7.1	To build engagement within the health and education settings
7.2	To enhance and maintain the existing work currently being done within our educational settings by developing and implementing a range of projects
7.3	Support for the Food and Nutrition Training Seminars delivered to ECEs and schools
7.4	Support the implementation of the Counties Manukau (HEHA) Nutrition Fund

**Figure 31: Education Settings Action Area 2008/2009**

As in the previous financial year, a moderate to high level of achievement was noted across the board for this Action Area in the first half of the 08/09 financial year with respect to the meeting KPIs, implementation and progress variables. Initiative 7.1 was noted to be progressing well, and was on track to achieve its KPIs, most of which had already been completed, however some were noted to be behind timeline, and sub-initiative 7.1.5<sup>38</sup> had been delayed due to change in staff. Adaptation with respect to this initiative was minimal as, again, there was no need for alteration to the work plan, although a strategic planning day had been held subsequent to the delivery of the evaluation report to guide the Schools Accord overarching 'agenda' for the coming years.

Good progress towards meeting KPIs was noted under initiative 7.2, most of which were ongoing but were on track to be achieved within the specified timeframes. The high score for implementation

<sup>38</sup> Sub-initiative 7.1.5: A minimum of four newsletters will be provided to the schools from the Schools' Accord

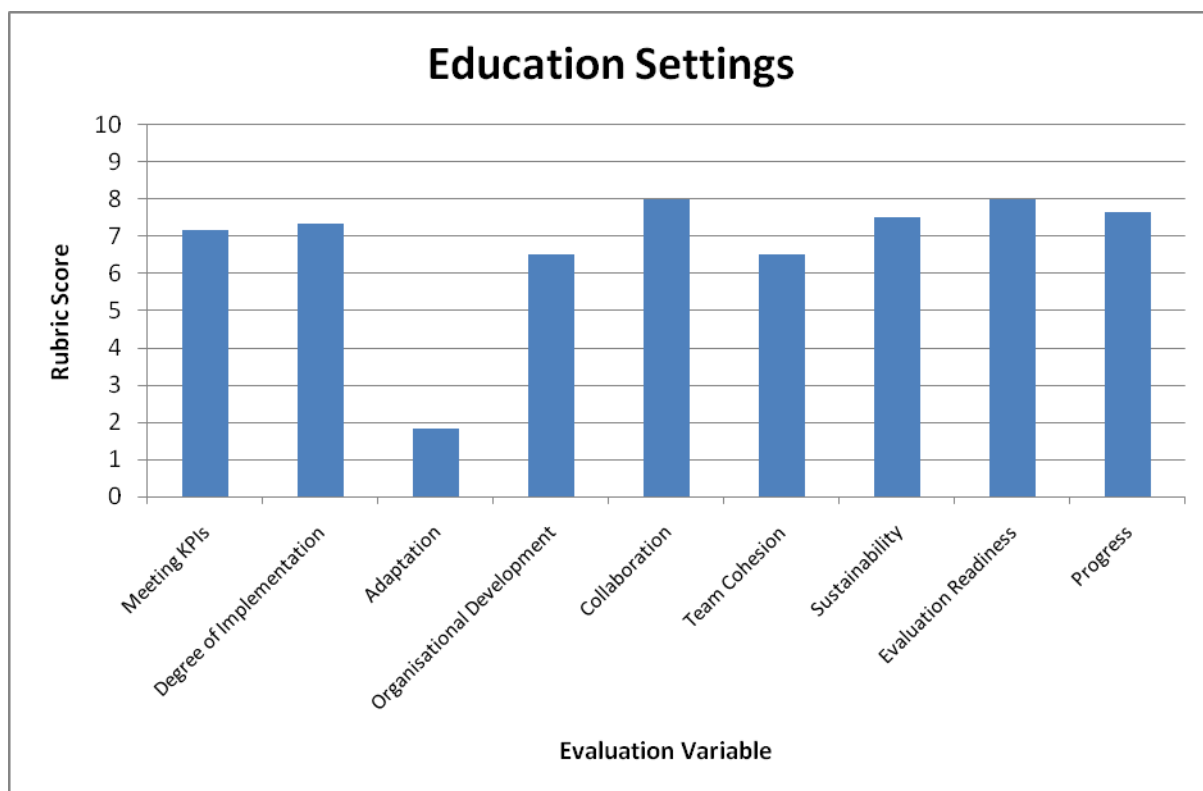
reflects the amount and breadth of activity that was occurring under the initiative. In addition, significant work was being undertaken on the ISLAND project to food supply outlets on school perimeters to improve the food environment. Adaptation was minimal as there was no need identified to alter course, and progress with respect to enhancing and maintain the existing work being done within educational settings by developing via the implementation of projects was high.

A high level of progress towards initiative 7.3 was evidenced in the first half of the 08/09 financial year, which is reflected in the high scores for this initiative in terms of meeting KPIs, implementation and progress. The project manager was noted to be actively advocating for Pacific issues. Further, workshops had been delivered to Pacific language nests (via ARPHS) and Kohanga (via Tamaki Makaurau Te Kohanga Reo Trust). There was ongoing provision of support where needed to ECEs and schools in relation to the Food and Beverage Classification System. Although there was minimal need for adaptation, it was noted that the project team were working to develop a more strategic approach, which is reflected in the elevated score for this variable.

Initiative 7.4 received a moderate score for meeting KPIs. The second funding round for this initiative was underway by November 2008, by which time \$55,050 of the total \$268,469 had been allocated. A review of the initiatives funded had been completed by October, and a review of the Panel had been completed by August. Support to modify the food environment in and around schools was to be managed via the Schools Accord's partner networks. Discussions were being held as to how this process would be managed. Adaptation was also somewhat elevated due to the discussions and planning occurring for a regional School Food Expo. The register of schools with a food policy compliant with FBCS guidelines was yet to progress at the time of writing of this report. However it was noted that a register of schools with a food policy was available via the National Heart Foundation.

### **Overview of the Education Settings Action Area**

A combined analysis of the 2007/2008 and 2008/2009 data was used to provide an overview of the Education Settings Action Area over this reporting period. In addition, the Action Area was assessed on their collaboration, sustainability, evaluation readiness and team cohesion. Figure 32 illustrates these findings, and the interview data is used to support the overview.



**Figure 32: Overview of the Education Settings Action Area**

### ***Achievements and Adaptations***

Overall there was good progress towards all KPI's with most complete or nearing completion, but some ongoing. There was also a high level of implementation across the Action Area. It should also be noted that the lack of information provided in 07/08 in relation to initiatives 7.6 and 7.7 brought down the overall scores for meeting KPIs and degree of implementation.

In particular the work that had been done with the Nutrition Fund was seen to have been a key achievement in supporting the overarching goals of the Action Area:

*We had some children who moved from a primary school that had a big emphasis on organic gardens, so when they moved to intermediate, they wanted a garden ... so we helped to fund an edible garden and it was continuing work they had learnt in primary school, now that's evidence of change...*

Adaptation within the Education Settings Action Area was reasonably low; it was noted that the reporting structure had altered somewhat, however there had been little change to the KPIs. One interviewee suggested however that the KPIs are reasonably broad to allow for a certain amount of flux as required by the changing needs and priorities of the environment, and the strategies used to achieve them and the work that sits underneath them is continuously adapted.

### ***Functioning of the Action Area***

The Action Area's score for organisational development was more moderate, as it was noted that the interface between the three areas with schools (i.e. Early Childhood and Kohanga, Youth and

Kura) could be managed better, with more sharing and collaboration between the project managers. This resulted in the lower score for team cohesion. Although the Schools Accord leadership hub and ECE Advisory group are highly cohesive, one interviewee suggested that the project team may work more efficiently if these areas within the Action Area are more closely linked at the level of information sharing and collaboration. It was noted that appointing someone full-time to oversee the whole of education settings might be a means of achieving this integration:

*The spin-off of what's possible gets lost in that [separation]...*

*...someone working full-time on schools...if someone managed schools, ECEs, Kohanga reo, Kura, the whole of education settings...one full-time person in that position maybe...*

It was also noted that more resource to enable project managers to have time to reflect and be critical, rather than merely responding to imperatives would be appreciated as it was thought that this could improve the quality of the Action Area's inputs.

The Education Settings Action Area received a high score for collaboration as there was evidence of high level of collaboration both with partner organisations and with other Action Areas. The interviewees referred to numerous partners of the Schools Action Area, many of whom sit on the Schools Accord, include: Diabetes Projects Trust, Counties Manukau Sport, various education settings, School of Population Health, Primary Health Care, Otara Health, Walking School Buses, OPIC, public health nurses, Health Promoting Schools, district coordinators for HEHA, Ministry of Health personnel, National Heart Foundation, Team Solutions, Ministry of Education, Auckland Regional Public Health Service, Kindergarten associations, Kohanga Reo trust, various pacific island groups, and KidzFirst.

Collaboration with other Action Area's was often noted to occur, however often this was managed indirectly through community partners than via a direct interface with the leaders of those Areas. In particular links had been established with the Social Marketing, Maori, Pacific, Primary Care, Food Industry and Well Child Action Areas, and the LBD communications advisor. The interviewees were clear that there was potential to work together where needed, but that this was typically managed on an ad hoc basis for specific projects or queries:

*I attend the fortnightly meetings and I know that they are just an email away...if I've got a question, or if there's a specific project I need some advice or help with...*

One interviewee suggested that the collaboration between the Action Areas could be better, and that this would greatly enhance the outputs of the programme as a whole:

*...potentially there's this momentum that could be phenomenal if those areas were connected...*

### **Sustainability**

The Education Settings Action Area received a moderate score for the sustainability variable. The Schools Accord was seen as a vital structure for the DHB to mediate the schools/health interface:

*I think for health and education to work together, it is a priority that the Accord stays, in whatever form that is...if they don't have Schools Accord ... schools will shut down on them [the DHB]...*

It was noted that the group existed prior to LBD and is likely to continue after, however ongoing resourcing for a coordinator and administrative support was seen as important.

Ongoing provision of funding and support was thought to be essential to the sustainability of the work that was being undertaken, and constraints on resource were seen to hinder sustainability:

*You don't get traction and public health change unless you have an investment for a sustained period of time...I would hope this programme goes for a further five years to really embed some of the changes that are required...*

*...What hinders it [the sustainability] hugely is being spread too thinly...*

One interviewee saw a need for more support for the early childhood sector from the DHB to support the sustainability of the work being undertaken in that area.

### **Evaluation Readiness**

The Action Area received a high score for evaluation readiness. The project team are in general highly engaged with the evaluation team, although there are some gaps in the information that is provided to the evaluation team, and are responsive to feedback, as reflected in the Strategic Planning day that was held subsequent to the delivery of the evaluation report.

The interviewees were both well aware of the evaluation of LBD that is being conducted by the School of Population Health. The evaluation was seen to add value, particularly in guiding planning:

*The value in our review was enormous...we [LBD and SoPH] need to work together to inform the direction...*

However one interviewee felt that the LBD team probably wouldn't have the time to engage in self-evaluation if it weren't externally facilitated:

*I think the Action Areas all individually have the capability to do the evaluation... I'm not sure that it would be totally impartial...and secondly I don't think anyone has the capacity...*

There is a certain extent of review and monitoring that occurs, primarily via formal reporting and the submission of reports. One interviewee identified a need for greater support in terms of developing evaluation tools.

One interviewee expressed a desire to see a greater focus on outcomes as opposed to process. Problems with the dissemination of evaluation information within LBD were also highlighted as a concern, as the sharing of those learnings was viewed as important:

*I was delighted that at the last PSG meeting [held in October] the reports [submitted in February] were made available to everybody...*

### ***Summary of Progress***

Overall the Action Area has made a great deal of progress towards achieving its overarching aims and objectives. A number of achievements and significant milestones were listed, all of which were thought to be enhanced by ensuring that the knowledge, expertise, and voice of the schools and ECEs (as housed within the Schools Accord and the Early Childhood Advisory Group) are shared and used to guide the DHB's work within education settings. The separation between the different education settings within the Action Area however, was sometimes considered to hinder progress and the Action Area was particularly keen to see the DHB increase support for early childhood.

### ***Changes over Time***

No significant changes were noted in the scores for the evaluation variables for this Action Area.

### ***Issues for Consideration***

- Dropping profit margins for Canteen Managers.
- Increasing DHB support for early childhood initiatives.
- Developing strategies to facilitate collaboration and information sharing between the different education settings, whilst recognising the autonomy of the independent governing bodies
- Progress towards KPIs for the 08/09 financial year is not fully represented given that reporting is occurring midway through the financial year.

## **4.8 Primary Care Action Area**

Improving primary care based prevention and management of diabetes is a key component of the Let's Beat Diabetes (LBD) project. LBD will build on the foundations of the Chronic Care Management programme (CCM) and the LBD primary care activities commenced in 2005/06.

A number of key milestones were achieved in 2007/08, namely:

- working through the SME Steering Group, established the Diabetes SME programme as a robust effective structured care programme in PHOs
- integrated the learning's from the community nutrition project evaluation and the whanau support project into the SME programme
- developed a business case and secured funding to implement CVD annual reviews within PHOs and developed guidelines for PHOs to implement systematic risk screening for diabetes and CVD; developed a CVD risk prevention strategy after consultation with key stakeholders
- improved access to and performance of the Get Checked programme with 3200 additional diabetes annual reviews undertaken by general practice in 2007 and through the Known Diabetes Project established an accurate database of people with diabetes in CMDHB
- reviewed the training needs of primary care nurses in relation to diabetes and cardiovascular disease, and explored opportunities to develop a workable strategy for the ongoing diabetes education of primary care nurses.

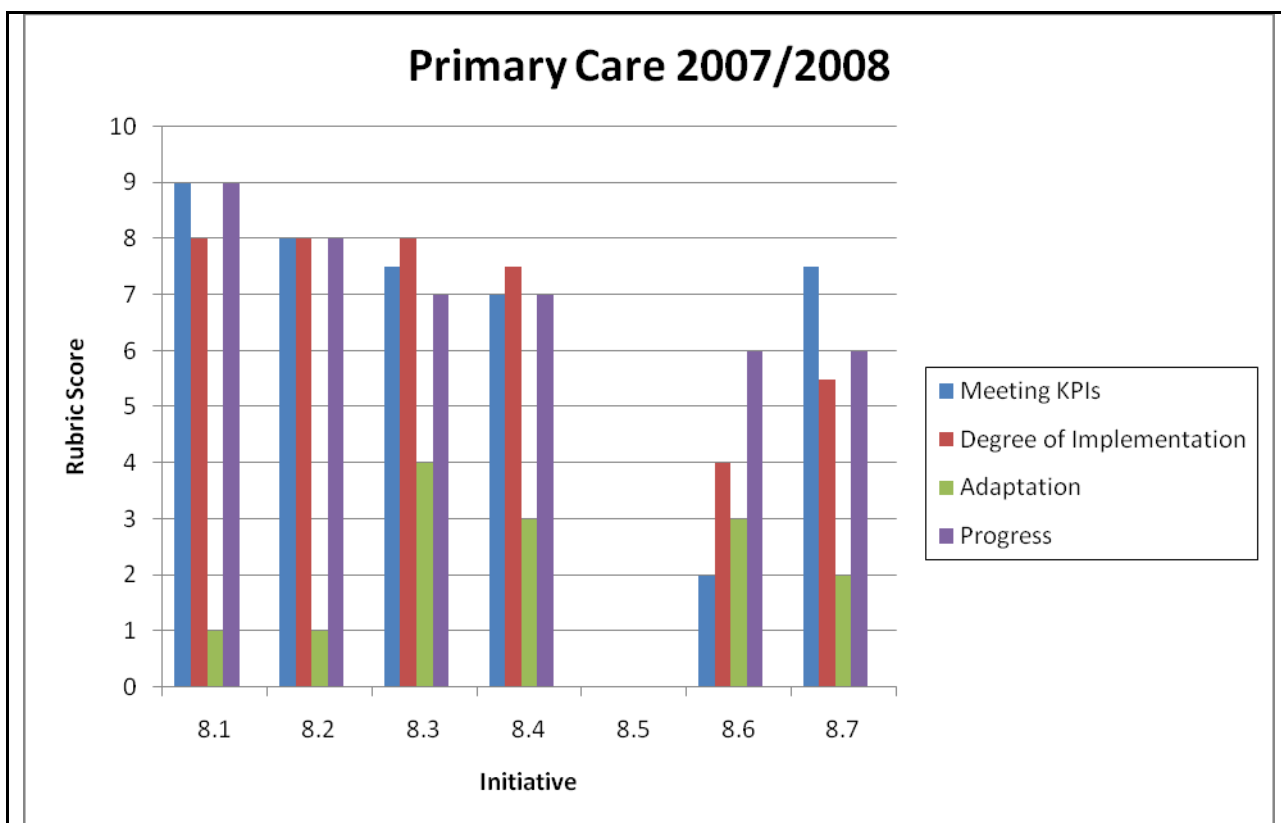
The focus in 2008/09 will be to:

- encourage the establishment of CVD and diabetes risk screening systems within Counties Manukau PHOs
- working through the SME Steering Group expand the self management programme to include other chronic conditions and all PHOs within Counties Manukau
- raise the profile of the Diabetes Get Checked programme through a communications campaign for the public and the primary care sector
- work with the primary care sector to assist general practice better identify at risk patients and find ways to manage their obesity, improve nutrition and physical activity; and
- work with the primary care sector to improve performance in the Get Checked programme in particular managing their HbA1c levels.

Consideration will also be given whether or not to identify and work with high risk individuals (those with IGT/pre-diabetes) to reduce the risk of progression to diabetes.

#### **Primary Care Action Area Progress for 2007/2008**

The nature of the KPIs encompassed by each Action Area will impact on the scores on each of the evaluation variables that the Action Area is designated. It is of note that the majority of the initiatives under the Primary Care Action Area were classified as comprising activities involving the development and implementation of a range of initiatives. The scope of these initiatives should be considered when interpreting the Action Area's progress in achieving these KPIs.



**KEY: 2007/2008 Action Area: Supporting Primary Care-Based Prevention and Early Intervention**

8.1	Leadership Structure
8.2	Diabetes/CVD Education
8.3	Community Nutrition Project
8.4	Self Management Education (SME)
8.5	Whanau Support
8.6	Risk Screening
8.7	Get Checked Programme & GP Quality Improvement Audit

**Figure 33: Primary Care Action Area 2007/2008**

Overall there was a high level of achievement in terms of meeting KPIs, implementation and progress across the Primary Care Action Area in the latter half of 07/08. Good progress towards all KPIs was noted under initiative 8.1, with limited adaptation as there was no need identified for change to the original work plan, as reflected in the high scores for meeting KPIs, implementation and progress. The leadership hub was functioning well and providing good leadership to inform all of the work undertaken by the Action Area. The initiative's implementation score was bolstered by the high level of engagement with the stakeholders within this area.

Good progress was also noted towards KPIs under initiative 8.2, although some were noted to have been achieved behind timeline. It was noted that the foundations of the work under this initiative had largely been laid down in the first half of the financial year, and much of the work was just a

continuation of this. However under sub-initiative 8.2.4<sup>39</sup> there was limited evidence of a linkage with Action Area 5.2. There was little evidence for adaptation under this initiative.

Initiative 8.3 received high scores for meeting KPIs, implementation and progress, with most sub-initiatives completed but somewhat behind timeline. The elevated score for adaptation reflects the project teams delaying of certain activities while capacity was sourced, particularly under sub-initiative 8.3.3<sup>40</sup> in relation to up-skilling SME facilitators.

Again, initiative 8.4 received high scores for meeting KPIs, implementation and progress. They had not completed sub-initiatives 8.4.2<sup>41</sup> and 8.4.3<sup>42</sup> due to the communications advisor leaving, and delays in the implementation of the Stanford model. Consequently the communications plan and quality framework which was set for completion by the end of 2007 had yet to be completed by mid-2008. This is reflected in the higher adaptation score, as the project team recognised that this would be dependent on the implementation of the Stanford model, and had planned for when they would do it. The remainder of the sub-initiatives were being met, with the project team addressing other chronic conditions, implementing improvements, and looking into evaluation. Progress was particularly high for sub-initiative 8.4.9<sup>43</sup>, as the project team had met double of their quota for DSME enrolments by June 2008. The implementation score was high due to the connection with the community and other stakeholders. Progress was also high but was limited somewhat due to the delays in implementing a communications plan.

Initiative 8.5 was not scored as the initiative had been completed by January 2008, and thus fell outside the monitoring period for this report.

Only sub-initiative 8.6.3<sup>44</sup> fell under the monitoring period for this report for initiative 8.6. The score for meeting KPIs and implementation was lower as the initiative was not achieved due to licensing issues with Medtech, however roll-out was anticipated for August 2008. Sub-initiative 8.6.4<sup>45</sup> had been abandoned as this was noted to be dependent on the achievement of 8.6.3.

Sub-initiatives 8.7.1<sup>46</sup> through to 8.7.5<sup>47</sup> only were encompassed by the monitoring period for the current report. Progress towards these KPIs was noted to be good, however it was unclear as to whether any specific actions were being undertaken to increase Maori participation in the Get Checked program. The slightly elevated score for adaptation reflects the project team's responsiveness to outcomes of regional discussions. Progress for this initiative was moderate, as

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<sup>39</sup> Sub-initiative 8.2.4: Align this activity with other relevant CMDHB Workforce projects including linkages with LBD action areas 5.2 and 10.3

<sup>40</sup> Sub-initiative 8.3.3: Link with the self management education programme by up skilling SME facilitators to manage patient related weight issues in a group setting

<sup>41</sup> Sub-initiative 8.4.2: Develop and implement a Communication Plan

<sup>42</sup> Sub-initiative 8.4.3: Develop a quality framework for SME

<sup>43</sup> Sub-initiative 8.4.9: Increase enrolment of DSME patients from 50 to 250

<sup>44</sup> Sub-initiative 8.6.3: Implement a range of strategies as outline in the CVD prevention strategy

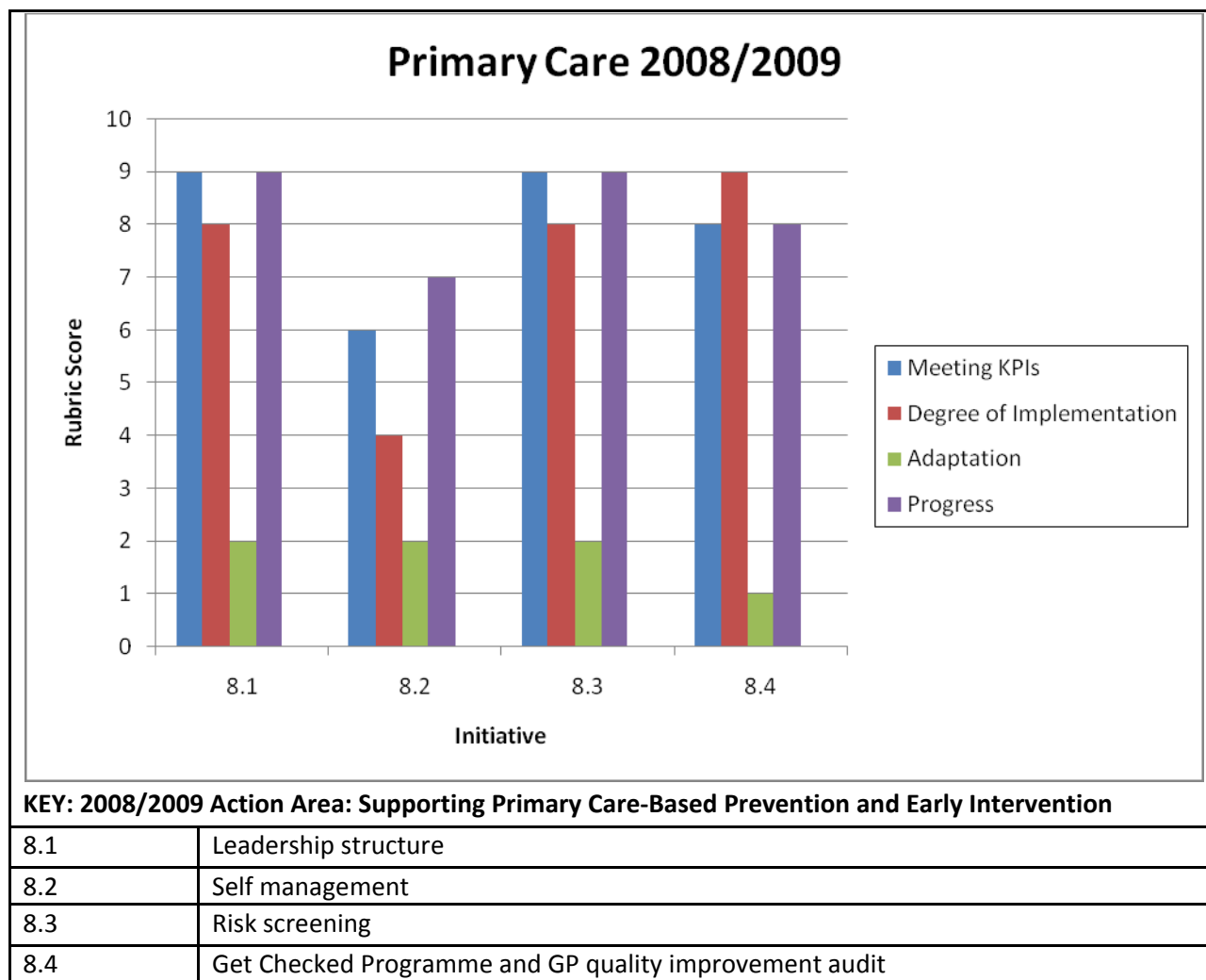
<sup>45</sup> Sub-initiative 8.6.4: Work with comms/social marketing to develop strategies to assist in the implementation and high uptake of these programmes

<sup>46</sup> Sub-initiative 8.7.1: Work closely with the DCAG working group (LDT) to encourage PHOs to improve Maori uptake and overall performance

<sup>47</sup> Sub-initiative 8.7.5: Link with Action Area 10 to improve integration between Get Checked and the Diabetes Retinal Screening database

there was much discussion around the best way forward with these initiatives, but less in the way of directed action.

**Primary Care Action Area Progress for 2008/2009**



**Figure 34: Primary Care Action Area 2008/2009**

As in the previous financial year, a generally high level of achievement in relation to meeting KPIs, implementation and progress was noted across the Primary Care Action Area in the first half of the 08/09 financial year, with most indicatives looking to be on track to achieving their set objectives within the time frames assigned. A similar level of progress for initiative 8.1 was observed as was reported in the previous year. The adaptation score was somewhat elevated due to evidence of forward thinking in the discussions that were held in relation to the future role of the group, and as the meeting schedule was altered such that meetings were to be held bi-monthly.

Initiative 8.2 received moderate scores for the meeting KPIs and implementation variables. This was due to the fact that most of the sub-initiatives were based around implementation, although progress reports indicated a lot of work was being undertaken in terms of development less had

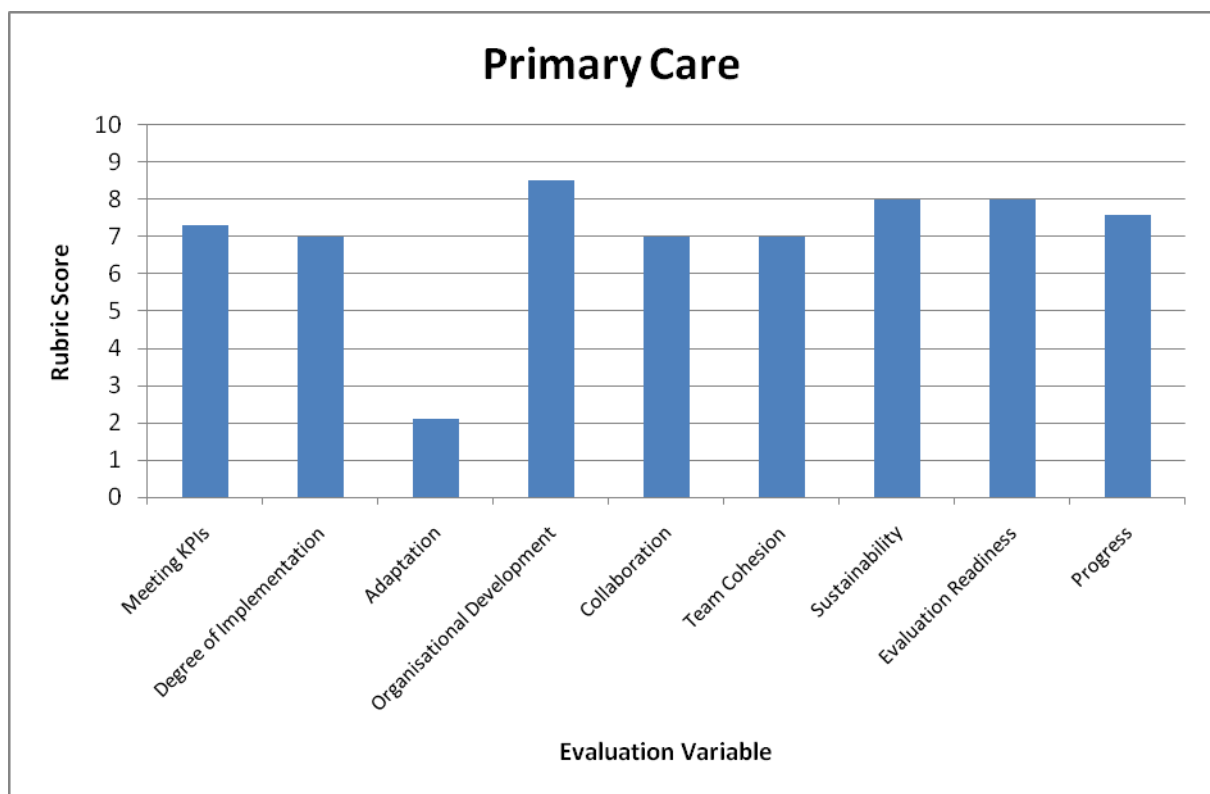
occurred in the way of implementation. However progress was high as the project team appear to be on track to achieving these KPIs within the specified time frame.

A high level of progress was observed towards initiative 8.3, with all KPIs achieved, albeit some behind timeline following on from the pre-emptory work that had been undertaken in the previous financial year. The adaptation score was somewhat elevated due to the project team’s response to resolving the licensing issues.

A high level of achievement was also noted for initiative 8.4. A significant amount of work was undertaken with PHOs and LDT around databases to improve case management within these organisations, as is reflected in the high scores for meeting KPIs, implementation and progress.

**Overview of the Primary Care Action Area**

A combined analysis of the 2007/2008 and 2008/2009 data was used to provide an overview of the Primary Care Action Area over this reporting period. In addition, the Action Area was assessed on their collaboration, sustainability, evaluation readiness and team cohesion. Figure 35 illustrates these findings, and the interview data is used to support the overview.



**Figure 35: Overview of the Primary Care Action Area**

***Achievements and Adaptations***

The Primary Care Action Area received a high score for both the meeting KPIs and implementation variables which is a reflection of the amount of work that has been undertaken in the reporting period, and the focus and commitment of the project managers:

*Most of them [KPIs] are complete...or we're on track to meet them all...*

There was a minimal level of adaptation occurring within this area however the project team were adapting where a need was identified:

*...we were going to do a bit of a Social Marketing campaign to raise the awareness of this new CVD annual review...but talking with the Social Marketing people we've decided because its focusing now...on phase two of the Social Marketing campaign...it's bad timing...so it's been delayed which was a mutual decision...*

It was also noted that where outcomes were less than desirable the project team were actively troubleshooting to try and remedy this:

*...the only one that's failing is our case management rates...the number of people who are managing the HbA1c level is falling, but we've developed a whole lot of strategies to try and get that up and running and working with PHOs to find ways to deal with that.*

### **Functioning of the Action Area**

The Action Area received a high score for organisational development, with the project team prioritising the establishment of integrated systems and structures to enhance information sharing. The Diabetes-CVD Advisory Group was also noted to be functioning well in its role as leadership hub for the area, and the project team reported deriving considerable value from these meetings.

The project team have spent considerable time and effort building relationships with primary care and PHOs as well as relevant NGOs, such as the Diabetes Projects Trust and the Arthritis Foundation.

Within LBD, the project team was collaborating with social marketing and integrated care on a regular basis, and other Action Areas to a lesser extent. The interview data suggested that the project team feels connected to the service integration Action Area as they both focus on people with diabetes while the other Action Area are focus on preventing diabetes, and consequently they are able to share issues and liaise on things on regular basis:

*Apart from Service Integration (Action Area10), I feel closest to that, [as they are] the only other area that focus on people who have already got diabetes, the others are more at the prevention ends doing other activities not necessary dealing with people who have got diabetes.*

The project team reported feeling connected to the Maori and Pacific Action Areas; they saw it as important to work with these areas to enhance their responsiveness, but they are also represented on many of the groups the interviewees sit on. There is also some connection with the Health Promotion Action Area, although not to the level that it has been in the past. Having a shared understanding of how the Primary Care sector operates was seen to enhance opportunities for collaboration.

### **Sustainability**

The Primary Care Action Area received a high score for sustainability, as it was clear from both the interview data, and the work that had been undertaken throughout the monitoring period, that this

was something that was prioritised and built into programmes and processes. The project team was actively building capacity within Primary Care and working to put systems in place that will enhance the sustainability of various initiatives. One of the key achievements was seen as the institution of a sustainable trainer group for the area. Further, the Action Area has access to a separate funding stream that is ongoing in nature:

*It is very sustainable because they have got a separate funding stream...the Get-Checked programme is fully funded by the DHB... and it's a national programme so that will always be funded. Along with other chronic care management programme, that is ongoing and funded...*

The support from the primary care sector was seen to greatly enhance the sustainability of the work undertaken by the project team, whereas a reluctance to engage with the project team due to mind sets around who ought to be undertaking self-management work was seen to hinder progress and sustainability:

*An attitude that only health professionals should be in this stuff...that's quite a barrier and a hindrance.*

### **Evaluation Readiness**

The interview data suggested there is a good level of awareness in relation to the evaluation of the LBD programme being undertaken by the School of Population Health, and had been quite involved in both the generic evaluation as well as two focussed studies (Community Nutrition Project and DSME). It was felt that the generic evaluation had perhaps not wholly captured the successes of the Action Area, due to some gaps in the information that was provided to the evaluation team, and the interview data suggested that there is a willingness to provide more information if it would help the evaluation team to better understand the issues and challenges facing this Action Area.

Process evaluation was seen to be valuable as a tool to improve services, although this was dependent on acting on the findings of an evaluation:

*[Evaluation has value]...in terms of improving services, but only if you take on board what's said...*

Currently progress is monitored via the reports that have to be produced each quarter and on a monthly basis. The project team did not report engaging in any formal self-evaluation, although they did see the value of evaluation as a means of keeping on track towards objectives:

*Its good...it reminds you to keep going back to the original objectives...of what this Action Area is all about and what it was intended to achieve...because often you get bogged down in your little area...and focussed on a small aspect of it...and you forget the big picture and what it all means so evaluation's great to put all that back into perspective*

### **Summary of Progress**

Overall a moderate level of progress was evidenced by this Action Area as it was felt that the Action Area was making good progress towards the general aims of the Action Area. A key vehicle for achieving this progress was identified as the Get Checked programme:

*...were getting better at detecting people with Diabetes or getting people enrolled in the Get-Checked programme...that's really improved...our retinal screening rates have improved...*

*...Primary Care is more responsive to the whole Get-Checked programme...is more aware that it is a viable programme that they should be adhering to...*

This level of progress was seen as particularly commendable given the level of acuity in the Counties Manukau district:

*The level of illness and poor health and poor behaviours...Counties has the highest prevalence rates in NZ...way ahead...our obesity rates are the highest in the country and the all the behaviours that [contribute] to that...*

Having someone from the Primary Care sector being more heavily involved with the LBD programme was identified as a means of improving progress and responsiveness within this Area, as was increasing engagement from the management team with the sector, in some form or other:

*...having LBD leaders go and visit and engage more with Primary Care...keep them better informed... sometimes Primary Care feel a little bit disenfranchised...they think it's just a DHB driven activity and they don't realise its broader with the ten arms...*

### **Changes over Time**

No significant changes were noted in the scores for the evaluation variables for this Action Area.

### **Issues for Consideration**

- Securing confidence in the health sector for the implementation of self-management initiatives by those who are not health professionals.
- Progress towards KPIs for the 08/09 financial year is not fully represented given that reporting is occurring midway through the financial year.

## **4.9 Vulnerable Families Action Area**

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

The Family and Community Services (FACS) service within the Ministry of Social Development (MSD) is working with Lets Beat Diabetes to provide leadership for the development of integrated services that focus on the situation and needs of vulnerable families to reduce the risk of obesity and diabetes and to provide better support and opportunity for those with diabetes and complications.

In 2006/07 the focus was on strengthening a multi-sector leadership hub for this Action Area and creating pathways for closer working relationships between health and social service providers. In 2007/08 the focus was to develop the links between health and social service providers through specific actions.

In 2008/09, the focus will be on enhancing and developing the links between health and social sector and vulnerable families. This includes the links between health and social service providers, promoting and linking the available resources and information to vulnerable families through key partners and extending the links to other government agencies involved with vulnerable families.

**Vulnerable Families Action Area Progress for 2007/2008**

The nature of the KPIs encompassed by each Action Area will impact on the scores on each of the evaluation variables that the Action Area is designated. It is of note that the initiatives under the Vulnerable Families Action Area were classified as comprising activities involving programme development and implementation. The Action Area is also challenged with implementing these initiatives without a consistent leadership structure designed to promote and support population health. This should be taken into account when interpreting the Action Area’s progress in achieving these KPIs.

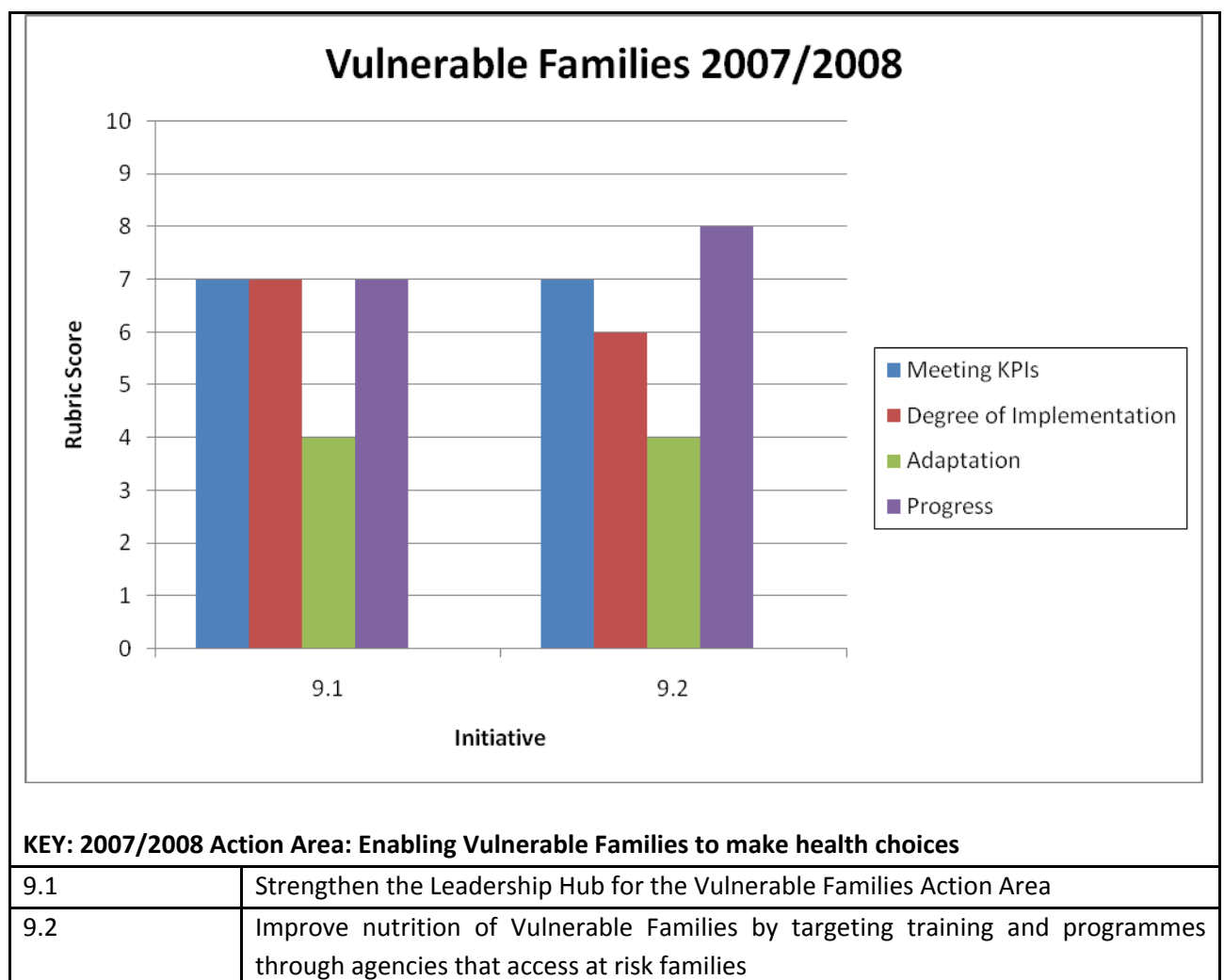


Figure 36: Vulnerable Families Action Area Progress for 2007/2008

In the latter half of 2007/2008 there was generally a high level of achievement in terms of meeting KPIs, degree of implementation, and progress across the Vulnerable Families Action Area. Work towards increasing communications about the LBD plan, the work was profiled in the FACS up until these were noted to no longer be in circulation, after this time the project team were working to share this in regional newsletters, and via presentations to community groups and PHOs. The adaptation score is higher due to the project team's response to changes to the newsletter structure.

Initiative 9.2 is comprised of five sub-initiatives, and the breadth of activity occurring under this initiative was considerable. The initiative was allocated a high score for the meeting KPIs and progress variables, and a moderate score for implementation. The project team appeared to making good progress with most of the KPIs, but had been delayed in the final stages for most of them. For example the workshops for sub-initiatives 9.2.1-9.2.3<sup>48</sup> had all been delayed, despite the fact that they are fully developed and ready to implement. Thus, the implementation score for the initiative is lower, where progress is higher. The Early Years Hubs have been pushed back so that the initiative can be rolled out when the hubs are ready, which elevated the initiative's score for adaptation. The recipe book had not been completed; although there was good progress, again, the KPI was not achieved on time.

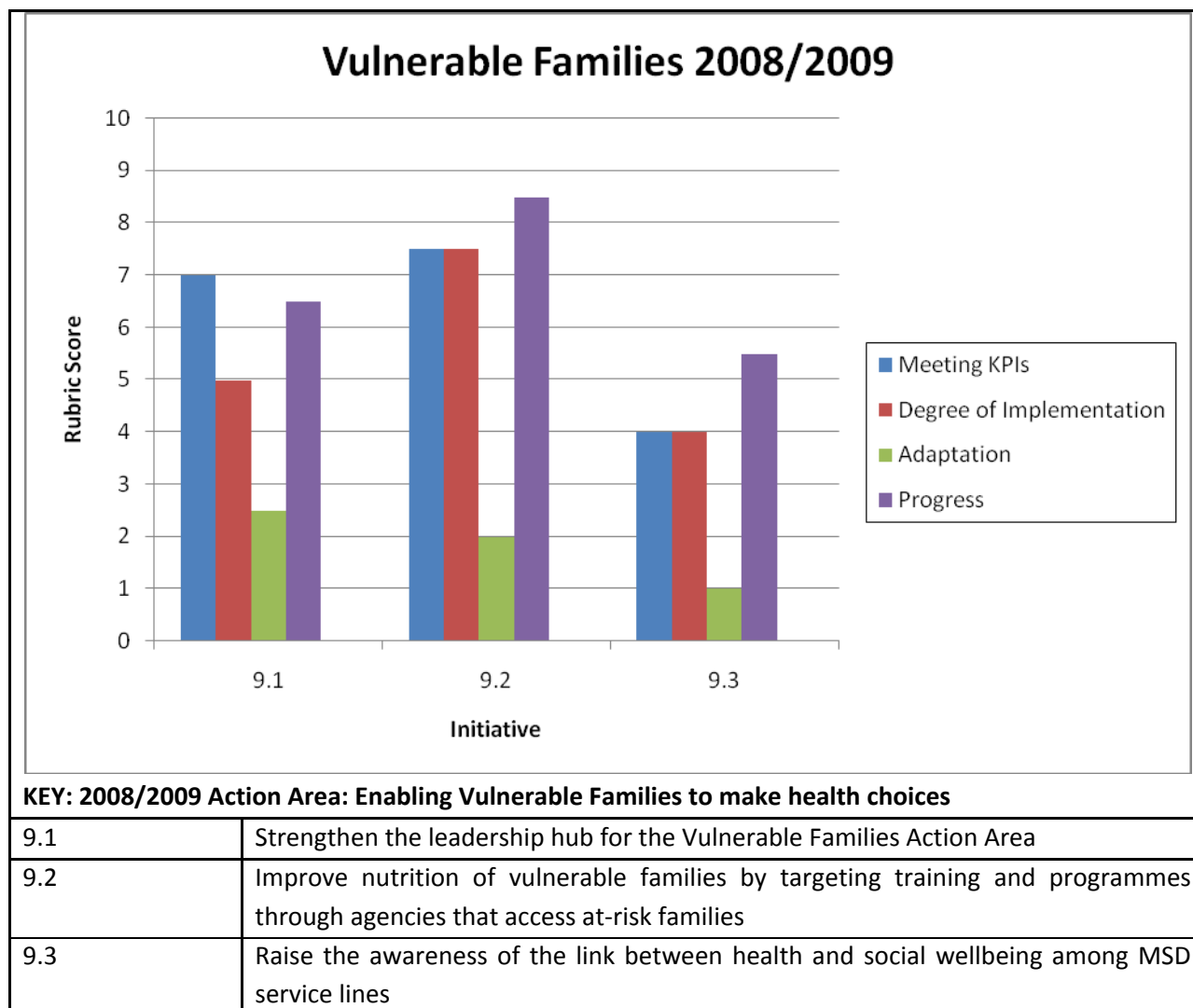
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<sup>48</sup> Sub-initiative 9.2.1: Follow up training for one Family Start provider

Sub-initiative 9.2.2: Negotiate targets with FS providers re referrals to health organisations re diabetes and obesity

Sub-initiative 9.2.3: Run workshops for strengthening Families Co-ordinators and contracted community organisations re nutrition and physical activity

**Vulnerable Families Action Area Progress for 2008/2009**



**Figure 37: Vulnerable Families Action Area Progress for 2008/2009**

In 2008/2009 there was considerable variation in the scores given to each initiative in terms of meeting KPIs, degree of implementation, adaptation and progress, as seen in Figure 38. There was a moderate level of achievement in terms of meeting KPIs, implementation and progress for initiative 9.1. Sub-initiative 9.1.1<sup>49</sup> was complete, with the project team delivering regular progress reports to the leadership hub, and presented to the group before restructuring. Sub-initiative 9.1.2<sup>50</sup> as ongoing, but was delayed by the restructuring of the leadership hub, as was 9.1.3<sup>51</sup> which had not yet commenced at the time of writing of this report. In a more general sense the project team are working with the steering group to keep them up to date and to advocate for the work they are undertaking in relation to health and its link to social well-being. The initiatives score for adaptation

<sup>49</sup> Sub-initiative 9.1.1: Inform the leadership hub of the outcomes from LBD

<sup>50</sup> Sub-initiative 9.1.2: Present to the steering group at least twice to highlight the importance of health and it's link to social wellbeing

<sup>51</sup> Sub-initiative 9.1.3: Identify at least one additional initiative

was somewhat higher as there was evidence that the project team had been looking for people to talk to while the governance group gets developed.

Initiative 9.2 achieved a high level of achievement in terms of meeting KPIs, implementation and progress. The KPIs appeared to be on track for completion within specified timelines, with the exception of 9.2.1<sup>52</sup> which was achieved slightly behind timeline. 9.2.4<sup>53</sup> was an area of strength, as it was clear the project team were engaging with many community groups providing support and/or resources. Initial contact had been made to further sub-initiative 9.2. The initiative's implementation score is high because as the project team were reaching key milestones and have engaged with a lot of key groups and people within the community. Adaptation was limited with the exception of the cookbooks, where the project team had realised that they didn't have enough copies, and responded by creating a waiting list and setting up a PDF. Progress for this initiative was high because they had completed a lot of work at this early stage in the financial year, with many KPIs set to be achieved early.

Initiative 9.3 received moderate scores for meeting KPIs, implementation and progress. The project team were in discussions with Work and Income New Zealand to highlight the impact of health on social circumstances, and were scoping ways in which the two organisations could work together. Although the project team had started undertaking work to raise awareness, there had been no real implementation or follow through at the time of writing of this report, with little work undertaken to further initiatives 9.3.3<sup>54</sup> or 9.3.4<sup>55</sup>. There was no evidence for adaptation to the work plan.

### **Overview of the Vulnerable Families Action Area**

A combined analysis of the 2007/2008 and 2008/2009 data was used to provide an overview of the Vulnerable Families Action Area over this reporting period. In addition, the Action Area was assessed on their collaboration, sustainability, evaluation readiness and team cohesion. Figure 38 illustrates these findings, and the interview data is used to support the overview.

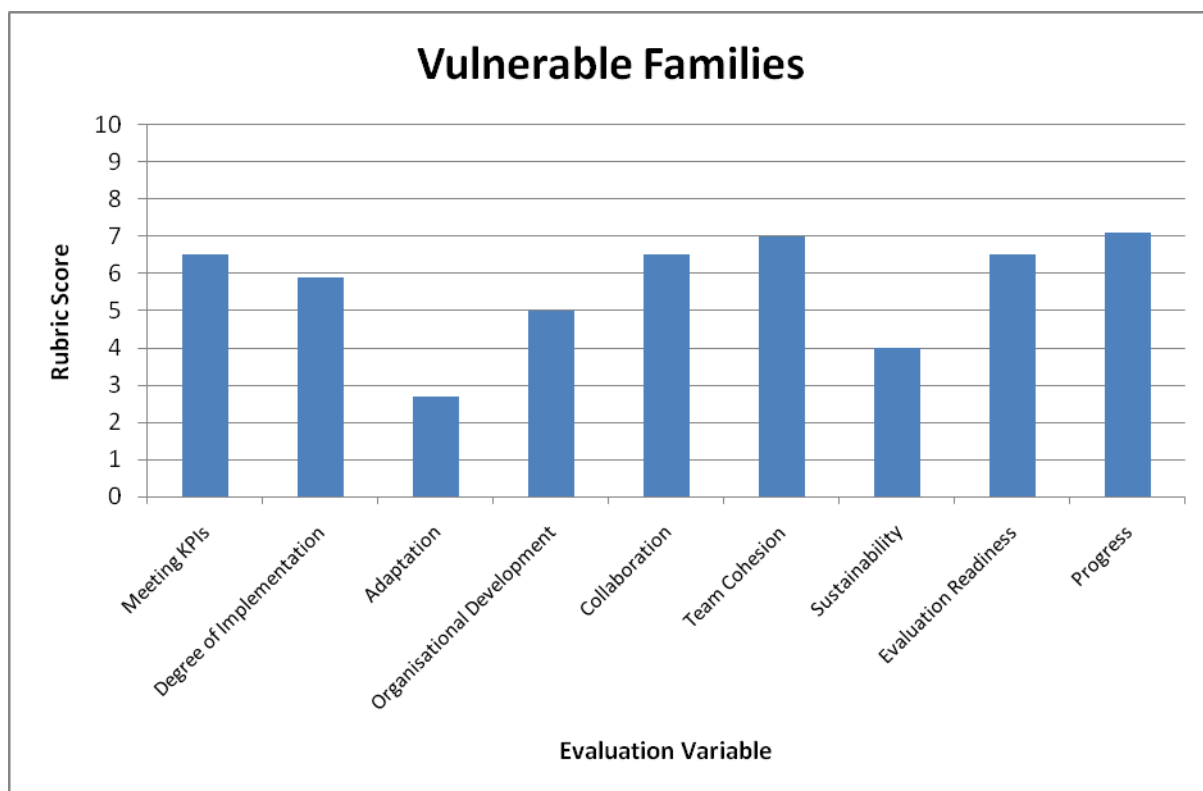
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<sup>52</sup> Sub-initiative 9.2.1: Conduct evaluation of workshop programme for 2007/08

<sup>53</sup> Sub-initiative 9.2.4: Act as the conduit to provide support and available resources (e.g. cookbook developed in 2007/08) to groups who provide life skills training to families, e.g. Manukau Salvation army life skills groups, Otara Boards Forum's Parent network, Early Years hubs and Family start services an SAGES

<sup>54</sup> Sub-initiative 9.3.3: Identify at least one initiative based on the scoping document

<sup>55</sup> Sub-initiative 9.3.4: Offer training to government frontline staff within Counties Manukau about the impact of diabetes and obesity on their clients and what resources/ support are available



**Figure 38: Overview of the Vulnerable Families Action Area**

### ***Achievements and Adaptations***

The Vulnerable Families Action Area received moderate scores overall for meeting KPIs and implementation. This is consistent with the interviewee’s perception that the project team are approximately half way in terms of progress towards KPIs. The production of a cookbook and the workshops that were held for people working in the social services sector were seen as the key outputs for the monitoring period.

There was a higher level of adaptation in this Action Area due primarily to the fact that 12 months of work had to be accomplished in four months due to the delays in appointing a project manager at the end of 2007. There are also specific examples of adaptation, for example the alteration in the delivery of the annual workshop such that this is Auckland-wide rather than more locally, with the project team contracting and working with another organisation to go wider.

### ***Functioning of the Action Area***

The Vulnerable Families Action Area received a low score for organisational development. The restructuring of the leadership hub has caused some problems, and there appears to be some confusion around what the structure is and what its future role will be. There was some suggestion that with the new overarching group with smaller sub-groups underneath it takes longer to get momentum with initiatives. Time and resource constraints were also seen to hinder organisational development within this area. The Action Area leader only works twenty hours a week and has a lot to do in that time; a desire for more time for project management was expressed to be able to develop the initiative further:

*There is so much that can be done, but I have to limit it down...*

The Action Area leader manages the area in conjunction with the project manager from the Ministry of Social Development. This project team meet regularly, to track progress towards KPIs, which is reflected in the high score for team cohesion was high as the two seem to work well together as a team and are in regular communication. The Action Area leader is also in contact fortnightly with the LBD programme manager to discuss progress towards initiatives and potential new initiatives. Although the interviewee felt that the coordination of the area was generally appropriate, there was a desire for more support of this kind from LBD:

*More guidance, support and advice about how to progress with projects would be useful. Also, helping us to link in more with other Action Areas...sometimes we feel a bit like we are doing things on our own...a lot of the time we have to identify what is going on [in other Action Areas]...*

The Vulnerable Families Action Area received a moderate score for collaboration. Whereas strong relationships had been established with external partners and community groups, collaboration across Action Areas was not as strong, and where this was occurring it was typically quite one-way, with other project managers approaching the Action Area for support.

*Because I am a dietitian and people want my input into their Action Areas...*

It was noted that there is a need for a system that will help to identify linkages between the Action Areas to facilitate closer working relationships and collaboration between the Action Areas and reduce the duplication of efforts within LBD:

*It's really good that they've got the 10 Action Areas to it, my concern is that is another layer of silos and that they work in isolation ... although it's good to have a focus in those areas, it's created silos ... a lot of the stuff we're doing has been duplicated...*

*I think we need more time to develop the KPIs in discussion with the other Action Areas so that we they can all link together better...I think at the moment they're all too separate.. working together could help improve coordination of the initiatives...*

Instances where collaboration had been strong that were highlighted by the interviewees included the work with the Salvation Army and other organisations such as Diabetes Projects Trust around the cookbook. The collaboration with the Ministry of Social Development was also highlighted as a strong partnership, and the project team were appreciative of the support provided to them via this organisation.

At an internal level, there was some sharing of resources with the Social Marketing Action Area. The project team has also worked with the Food Industry Accord Action Area to help guide their programmes and initiatives, and make sure they are targeting the vulnerable families and the low income groups. The Action Area leader has also done some work with the nutrition fund panel, and will in the future be helping to develop workshops with the Gardening project manager to teach people how to use produce from the garden.

### **Sustainability**

The Action area received a moderate score for sustainability. One interviewee saw that the Action Area is not sustainable as there is no top-down management support, and there are unrealistic expectations in terms of workload. It was felt that the personnel working within this Area are stretched too thin and that there is a need to be more realistic in setting the action plan for the next financial year. The future of the Action Area was seen as tenuous, and very dependent on the ongoing commitment of the project team:

*...It [the Vulnerable Families Action Area] so easily can drop-off [from LBD]...*

Because the workshops are about capacity building, the staff within the organisations they target should retain the skills and knowledge and continue the work in the community even if the workshops are discontinued, and in that sense the work is sustainable. In addition to this, the cookbooks are publicly available and are being used by many individuals throughout the community, independent of the Action Area or the LBD programme of action. By contrast some of the workshops that are delivered directly to the community are not seen as sustainable, however it was noted that for the most part enhancing the sustainability of the initiatives was a foremost consideration:

*Most of them are sustainable and [we] try to incorporate that into the plans...*

Having ongoing funding and people within the NGOs who are interested and see the benefits of good nutrition was seen to support the sustainability of the work that the Action Area undertakes, in that they may be more likely to take the information and knowledge and use it in a practical ways. By contrast, resource constraints and a lack of interest from those at higher levels within the social and health sectors was seen to hinder the sustainability of the Action Area

### **Evaluation Readiness**

The evaluation that is being undertaken by the School of Population Health was seen by the interviewees as being a means of evaluating how the multi-agency, collaborative approach that LBD has adopted is working, and informing best-practice processes. The interviewees both saw value in conducting evaluation:

*I think it's really important to see if it's working...whether what we're doing is actually making a difference...and that its sustainable and makes a long term difference...as well as looking at the way that were working and seeing if we can improve on that...*

However one interviewee suggested that perhaps the evaluation does not capture the big picture, or important contextual factors that may impact on progress:

*...sometimes the whole story isn't there...*

The Action Area had been involved in some rudimentary evaluation. The project team routinely conducts evaluation of satisfaction in relation to the workshops, as well as collecting pre- and post-knowledge measures, and assessing how this knowledge has been used 3 months down the track. The project team has also completed an evaluation of the cookbook that was produced. Results

from the evaluations conducted for the cookbook and the workshops have been incorporated into future projects.

The Action Area leader has some skills in relation to evaluation, but no formal training and noted that perhaps the evaluation process could be improved to get more information and feedback. Another interviewee noted that they would like to learn more evaluation skills, and thought that more evaluation was required to enhance the impact and appropriateness of initiatives:

*More evaluation is probably needed to look at the outcomes and whether individual initiatives are working...and possibly looking more at research-based programmes and using focus groups more to make sure that programmes are aimed at the population that its targeted towards...these things are happening but need to be increased I think...*

### **Summary of Progress**

Overall there was a high level of progress within this Action Area; it was felt that the Action Area was making good progress towards the general aims of the Action Area, in promoting awareness of the relationship between health and social wellbeing to those within the social services sector, and ultimately enabling lower income families to make healthier choices.

Time and lack of resources were cited as key obstacles that limit the impact of the Action Area. The restructuring of the leadership hub, has meant that for the most part of the reporting period there was no leadership structure for the Vulnerable Families Action Area. Consequently, the project team has had to develop initiatives without much support from the Ministry of Social Development and the people that actually work with lower income families, as it is not part of their core work and budget spend. It was noted however that support had been provided in the way of the work time of one of the initiative leaders (up to 0.5FTE at times) whose organisation is the Ministry of Social Development. Both project managers working to further the work of the Action Area are employed on a part-time basis and have limited time to put in the project, and limited knowledge of health promotion and public health. Given this the project team should be commended on the progress that has been made to date.

### **Changes over Time**

Significant increases in the scores the Action Area received were noted for the following variables: meeting KPIs, implementation, progress, collaboration, sustainability, evaluation readiness and cohesion. A significant decrease was noted in the Action Area's score for adaptation, which is perhaps not surprising given the improvement in functioning with respect to the other evaluation variables.

### **Issues for Consideration**

- The restructuring of the Vulnerable Families leadership hub
- Increased support for the Action Area in terms of project development and future work.
- Supporting collaboration with the other Action Areas that develops the work of the Vulnerable Families Action Area.
- Progress towards KPIs for the 08/09 financial year is not fully represented given that reporting is occurring midway through the financial year.

#### **4.10 Integrated Care Action Area**

While strategic effort toward the prevention of diabetes is pivotal, LBD also recognises the importance of improving care for people who already have advanced diabetes, as the disease will present challenging complications throughout the rest of life. Due to the diversity of complications associated with diabetes, our patients demand comprehensive and cohesive delivery of care from a variety of relevant (and sometimes discrete) health services throughout the continuum. To that end, this Action Area focuses on improving the quality of care for people living with diabetes, with an emphasis on integration amongst associated health services.

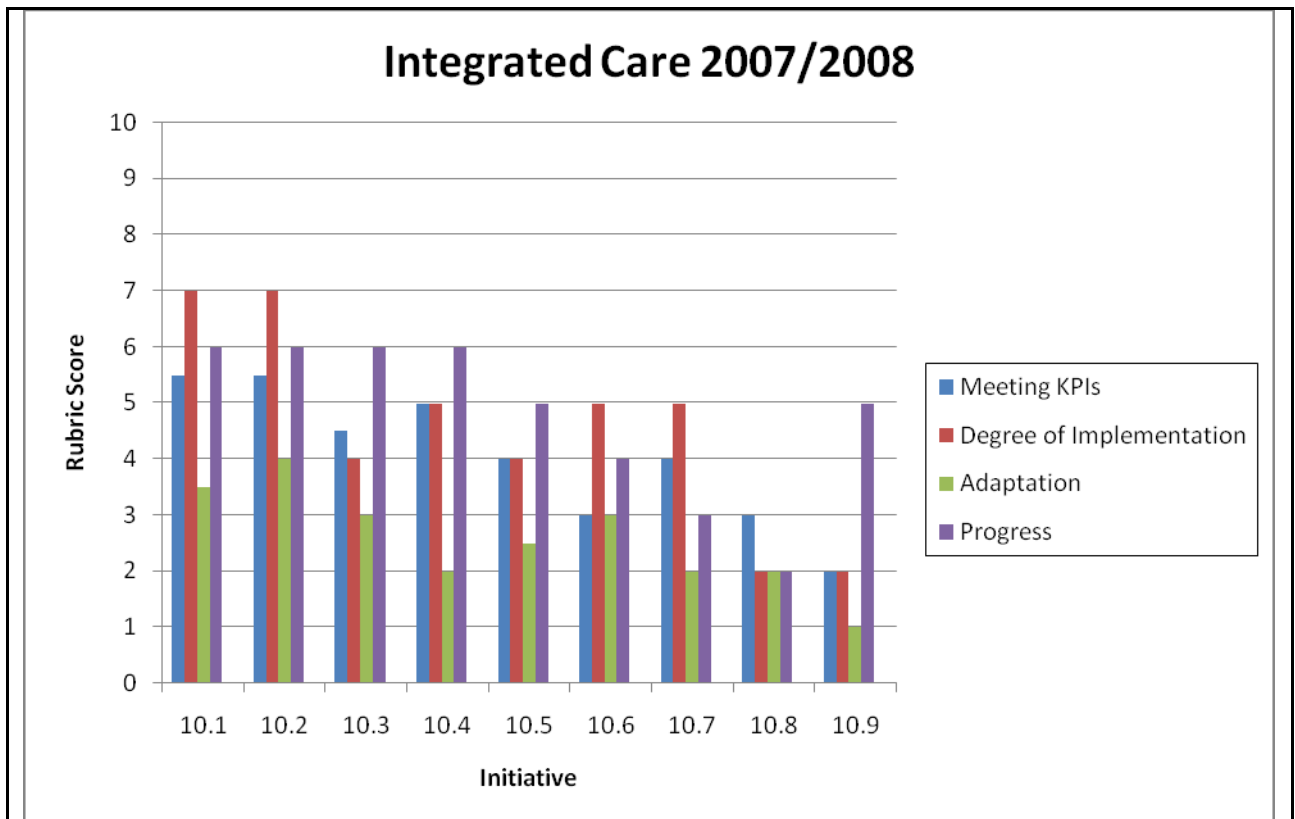
A number of key milestones in were achieved in 2007/08 namely:

- Visit to The Royal Melbourne Hospital Diabetic Foot Unit to improve clinical treatment of diabetic foot disorders, build a business case for foot beds, and observe alternative information systems and models of care.
- Successful launch and completion of CVDIS pilot in Module 5, Manukau Super Clinic – sets the stage for evaluation, modification, and potential implementation of the system across other sites.
- After some lapse in the Diabetes & Pregnancy Work Stream (due to staff turnover), multidisciplinary working parties have been reconvened and progress has resumed.
- Document defining entry and exit criteria for referrals from primary care was developed, endorsed by DCAG, and circulated amongst all PHO's.
- Adolescent Diabetes clinic was established and continues to run successfully.
- A paper describing a model for training internships in secondary care was well-received by DCAG, and will require further scoping.
- Three navigational tools for people accessing diabetes services have been updated and posted to the Health Point website.

In 2008/09 this Action Area will focus on: the development and execution of a survey of people living with Type 2 diabetes; continued evaluation and potential implementation of the CVDIS; integrated solutions to the Diabetes & Pregnancy model; and hosting a therapeutics workshop to support best practice utilisation of medicines.

#### **Integrated Care Action Area Progress for 2007/2008**

The nature of the KPIs encompassed by each Action Area will impact on the scores on each of the evaluation variables that the Action Area is designated. It is of note that the number of individual KPIs that were set out for each initiative was typically high, as was the degree of difficulty and reach of several of these activities. It is also useful to note that the majority of the initiatives under the Integrated Care Action Area were classified as comprising activities involving programme development. These factors should be taken into account when interpreting the Action Area's progress in achieving these KPIs.



**KEY: 2007/2008 Action Area: Improving Service Integration and Care for Advanced Disease**

10.1	Strengthening the Leadership Hub for In-Hospital Service Integration
10.2	Developing Whitiora Diabetes Service's role as clinical centre of excellence and supporter of system-wide capacity development. Activity will be focusing on improving health outcomes for Maori and Pacific people
10.3	Ensuring diabetes management activities across Primary and Secondary are implemented in consistent manner in partnership with DCAG, Integrated Medicine, School of Population Health, Whitiora and other secondary services
10.4	Improving Clinical Data/Ethnicity Data and Reporting
10.5	Supporting Diabetes in Pregnancy
10.6	Supporting Diabetic Eye Disease
10.7	Diabetes and Mental Health
10.8	Supporting Therapeutics
10.9	Survey those with Type 2 Diabetes in CMDHB area

**Figure 39: Integrated Care Action Area 2007/2008**

In the latter half of 2007/2008 there was generally a moderate level of achievement in terms of meeting KPIs, degree of implementation, and progress across the Integrated Care Action Area. It is also of note that the adaptation scores were generally elevated across this Action Area. The Action Area had abandoned the plan under initiative 10.1 to have a leadership forum, as it was felt that there was a need for greater buy-in from clinical leaders. Instead, the KPI was modified for 08/09 to

have a work plan instead, which is reflected in the higher score for this initiative for adaptation. Sub-initiative 10.1.2<sup>56</sup> had been completed.

Moderate progress in terms of meeting KPIs and progress towards the overall goals of the Action Area was noted for initiative 10.2, however a high score was allocated for implementation in reflection of the work that was undertaken with the CVDIS pilot. It should be noted that there is a large number of sub-initiatives encompassed by this initiative, and the breadth of activity occurring is substantial. Sub-initiatives 10.2.1<sup>57</sup>, 10.2.2<sup>58</sup> and 10.2.3<sup>59</sup> had not been completed, but were ongoing. The project team had presented an initial paper under 10.2.4<sup>60</sup> had but had then shifted the initiative such that it was to be tracked under 10.3. The CVDIS pilot was completed and the project team were working with PHOs, however 10.2.8<sup>61</sup> had not been undertaken, and 10.2.10<sup>62</sup> and 10.2.11<sup>63</sup> were ongoing. The adaptation score for this initiative was reasonable, as the project team appeared to be realising what KPIs are redundant or irrelevant and trying to sort these such that the work plan is more coherent.

Progress towards all KPIs were noted under initiative 10.3, however none had been achieved, with the exception of attendance at meetings. Work around the auditing process was progressing but had yet to be implemented, and the last two KPIs appeared to have been abandoned. So while progress is being made, the majority of the sub-initiatives which were due to be completed prior to reporting period had not been achieved, which resulted in a lower score for meeting KPIs and implementation.

Of the four sub-initiatives encompassed by initiative 10.4, two had been partially completed and the remaining two had not been completed as they were noted to be dependent on completion of the first two. This resulted in a moderate score for meeting KPIs. There had been delays in the evaluation related to the vendor, which meant the feasibility study and the ICD coding had been pushed back. This lowered the initiative's score for implementation. There was limited evidence for adaptation even though KPIs were not being met.

Of the five KPIs under initiative 10.5 encompassed by this monitoring period, three had been written off or not yet started. For initiatives 10.5.4<sup>64</sup> and 10.5.5<sup>65</sup> revised approach was being taken, which is reflected in the higher score for adaptation. Further, the project team had been trying to make the working parties function better, and had adapted their approach accordingly. In general, however, the project team were did not appear to be making much progress towards achieving the set KPIs, which is reflected in both the lower score for meeting KPIs, implementation and progress, as all were due to be completed by October 2007.

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<sup>56</sup> Sub-initiative 10.1.2: Provision of an updated and maintained navigational tool for consumers

<sup>57</sup> Sub-initiative 10.2.1: Linking with 8.2 (diabetes education in primary care activities in 2007/08)

<sup>58</sup> Sub-initiative 10.2.2: Whitiara Team

<sup>59</sup> Sub-initiative 10.2.3: Complete audit DKA

<sup>60</sup> Sub-initiative 10.2.4: Develop a paper describing a model involving a training role in primary care

<sup>61</sup> Sub-initiative 10.2.8: Develop an audit tool to enable assessment of integrated clinics

<sup>62</sup> Sub-initiative 10.2.10: Develop business case for foot beds

<sup>63</sup> Sub-initiative 10.2.11: Review the number of visits to secondary diabetes services per patient

<sup>64</sup> Sub-initiative 10.5.4: Develop communication plans for all services

<sup>65</sup> Sub-initiative 10.5.5: Develop risk registers for all services

Low to moderate progress was noted towards initiative 10.6 in the latter part of the 07/08 financial year. While it was noted that consistency in waiting times from 2007 had been achieved (10.6.1<sup>66</sup>), initiatives 10.6.2<sup>67</sup>, 10.6.4<sup>68</sup> and 10.6.5<sup>69</sup> had been assigned to Health Alliance for completion. Little evidence was provided to the evaluation team as to how the project team were collaborating with Health Alliance or working in a support role. The implementation score for this initiative was higher due to the work undertaken to improve access to services diabetic eye disease, but progress appeared to be limited in terms of achieving the objectives as set out in the operational plan.

Little evidence of progress was provided to inform the evaluation of initiative 10.7. The guidelines were published in 2006; however there is little or no evidence that the project team are working with Mental Health to implement these guidelines. The project team were providing support and information where needed (10.7.2<sup>70</sup>), but there was little information about how this was occurring, as the project team only reported meeting the Mental Health team once annually.

Again, limited evidence was provided in relation to progress towards initiative 10.8. A research fellow in place, however the revision data for the guidelines had not been set (10.8.3<sup>71</sup>), and all other KPIs had been written off; sub-initiatives 10.8.5<sup>72</sup> through to 10.8.7<sup>73</sup> were reportedly to be included in the symposium under 10.4, however this symposium was also written off, as it was said to be encompassed by Health Alliance work. Consequently the initiative received low scores for meeting KPIs, implementation and progress as little had been achieved by the project team.

Preliminary meetings had been held at the start of 2008 to further progress under initiative 10.9, however at the time of writing of this report the design was not completed and survey had not been conducted. Thus scores for meeting KPIs and implementation for this initiative were low. Progress was higher however due to the work that was being undertaken with respect to developing the survey.

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<sup>66</sup> Sub-initiative 10.6.1: Ensure consistency in access to retinal screening for patients

<sup>67</sup> Sub-initiative 10.6.2: Houston VIP upgrade replace existing version, containing new national grading classifications

<sup>68</sup> Sub-initiative 10.6.4: Ensure patients who require Ophthalmology treatment of monitoring have access to this according to National Diabetes Retinal Screening Grading system and referral recommendations

<sup>69</sup> Sub-initiative 10.6.5: Houston VIP will link with Via Health Events summary enabling improved information sharing between services involved in care of the patient

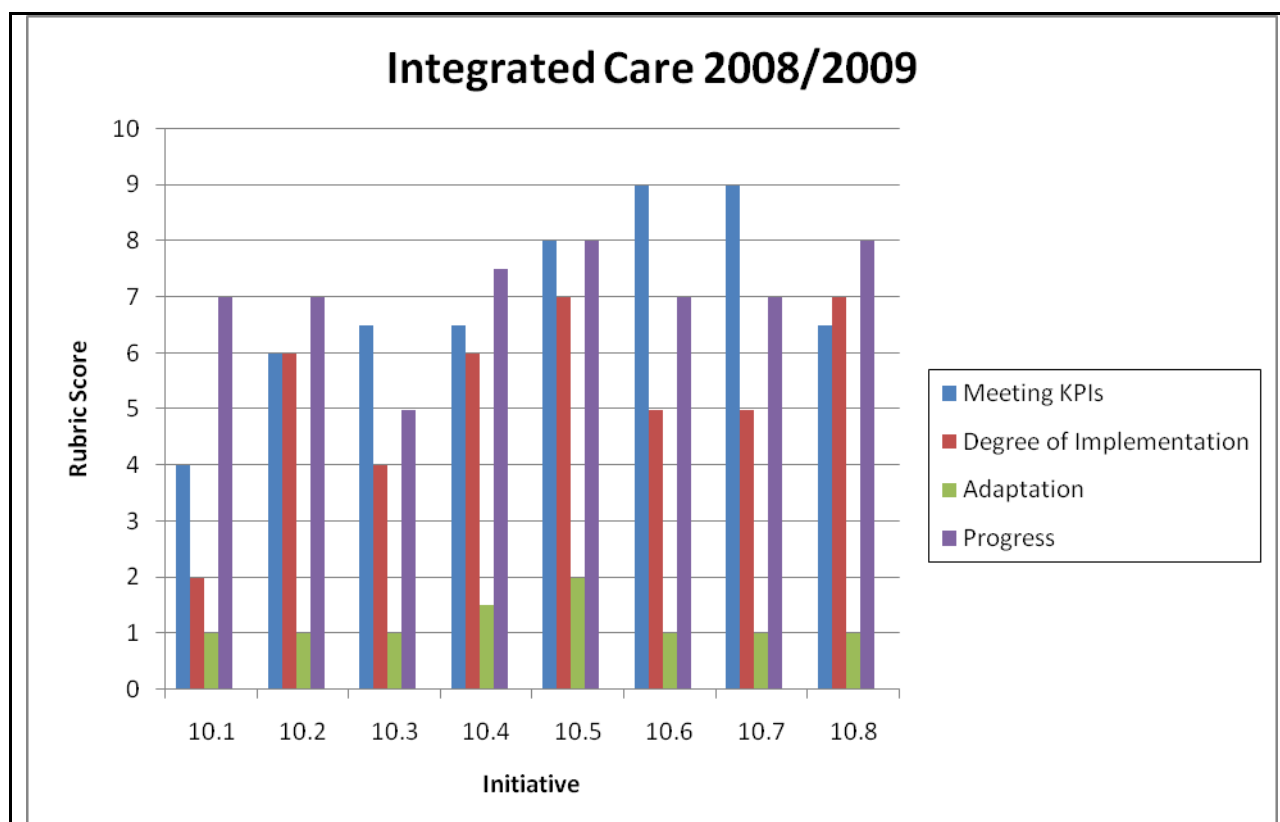
<sup>70</sup> Sub-initiative 10.7.2: Develop information relating to appropriate physical exercise and diet for people accessing mental health services

<sup>71</sup> Sub-initiative 10.8.3: Representation in Type 2 Diabetes Guidelines – next revision date (pending)

<sup>72</sup> Sub-initiative 10.8.5: Develop recommendations to encourage the effective utilisation of evidence based medications

<sup>73</sup> Sub-initiative 10.8.7: Identify ways to minimise barriers (cost, convenience, access, side effects) to effective medication

## Integrated Care Action Area Progress for 2008/2009



**KEY: 2008/2009 Action Area: Improving Service Integration and Care for Advanced Disease**

10.1	Strengthening the leadership hub for in-hospital service integration
10.2	Developing Whitiora Diabetes Service as a Clinical Centre of Excellence and supporter of system-wide capacity development
10.3	Ensuring diabetes management activities are implemented consistently, across primary and secondary care
10.4	Improving clinical data/ethnicity data and reporting
10.5	Diabetes in pregnancy
10.6	Diabetic eye disease
10.7	Diabetes and mental health
10.8	Survey of those with Type II Diabetes in CMDHB area

**Figure 40: Integrated Care Action Area 2008/2009**

Scores for meeting KPIs, degree of implementation and progress were generally moderate to high across this Action Area in the first half of the 08/08 financial year, a marked improvement from progress evidenced in the previous financial year. Although the project team were working on the work plan, following the decision to postpone the establishment of a leadership group, this was yet to be finalised, which delayed the achievement of sub-initiative 10.1.2<sup>74</sup> also, thus the moderate

<sup>74</sup> Sub-initiative 10.1.2: Act on EMT's recommendations (following review of work plan) as they pertain to Secondary Care services

score for meeting KPIs and the low score for implementation for this initiative. Progress was higher, however, because the project team were having meetings and discussions around the work plan to further this initiative in the remainder of the financial year.

Under initiative 10.2, sub-initiatives 10.2.1<sup>75</sup> and 10.2.2<sup>76</sup> were only half complete. 10.2.3<sup>77</sup> was not complete although this work was not due to be completed until May 2009. Sub-initiative 10.2.4<sup>78</sup> was achieved, and it was noted that a significant amount of work had been undertaken to develop the web portal, trial it, and incorporate feedback to improve the tool, and this was reflected in the initiatives score for both implementation and progress variables. The project team had completed the quality framework; however the audit of adherence to guidelines had not been completed, nor had the review of patient numbers at the time of writing of this report. Adaptation was noted to be minimal in this area.

In relation to work undertaken to progress initiative 10.3, the project team were working with the School of Population Health on an integrated care model and were participating in DCAG meetings, however there was no evidence for any further work on the paper since February 2008. The implementation score for this initiative was lower as although discussions were being held and stakeholders are engaged, no work appears to be happening at the grass-roots level. Progress was also lower as it appeared that little work had been undertaken to progress sub-initiative 10.3.2<sup>79</sup> for a substantial period of time.

A moderate to high level of achievement was evidenced under initiative 10.4. The evaluation that was to be undertaken had been delayed as the project team were experiencing difficulties in getting everyone to meet, however they were making progress, as the report was being finalised, and recommendations developed at the time of writing of this report. Progress towards sub-initiative 10.4.2<sup>80</sup> was noted to be dependent on the achievement of 10.4.1<sup>81</sup>, and work towards this was ongoing. Sub-initiative 10.4.3<sup>82</sup> had been achieved albeit behind timeline. Progress and implementation scores are reflective of the variable progress towards KPIs, taking into account the project teams position in terms of the contracting year. The initiative's score for adaptation was somewhat higher as the team had to work around constant change in deadlines and meetings.

A high level of progress was noted for initiative 10.5. Working groups were meeting, trials had been completed and implemented, and decision- making processes were working well, and the project team appear to be on track for achieving all of the KPIs within their specified time frames. This is reflected in the high scores for meeting KPIs, implementation and progress for this initiative. Adaptation was minimal, mainly as a result of the progress towards goals, although the project team

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<sup>75</sup> Sub-initiative 10.2.1: Publish stock take report of services

<sup>76</sup> Sub-initiative 10.2.2: Develop a business case for foot beds and implement the results – Discrete KPI's to be developed

<sup>77</sup> Sub-initiative 10.2.3: Presentation of 2 to 3 research papers to NZ Society Study of Diabetes

<sup>78</sup> Sub-initiative 10.2.4: Complete development of new Whitiara web portal and update/ maintenance throughout 2008/09

<sup>79</sup> Sub-initiative 10.3.2: Further detail paper for training role model in primary care and develop that model in cooperation with DCAG, primary care, GPHO

<sup>80</sup> Sub-initiative 10.4.2: Implementation of pilot evaluation recommendations

<sup>81</sup> Sub-initiative 10.4.1: Review of CVDIS pilot evaluation report and development of recommendations

<sup>82</sup> Sub-initiative 10.4.3: ICD 10 coding will be implemented across the Diabetes Service

were trying new approaches at meetings in hopes of 'breaking new ground', and the Women's Health Service Coordinator had resolved to fix a number of internal issues.

Initiative 10.6 and 10.7 both received a high score for meeting KPIs and progress, largely due to the limited scope of these KPIs. The project team had, as specified, met with key leaders from both Diabetic Retinal Screening and Ophthalmology services and Mental Health services, although they had planned to meet again and this had yet to happen at the writing of this report. Implementation was lower as it was unclear based on the evidence provided what the outcome of that meeting was.

A moderate to high level of progress was noted towards initiative 10.8. A meeting had been held in late 2008, in which decisions were made as to what the survey would tell the project team, what the outcomes would be, and how this information would be used. The contract was scheduled to be finalised in late December and the design completed and submitted to ethics by late January, however it was unclear based on the evidence supplied to the evaluation team whether this was achieved. Working groups had met as specified under 10.8.2<sup>83</sup>, however the survey had yet to be conducted, and consequently 10.8.3<sup>84</sup> and 10.8.4<sup>85</sup> had not been achieved, although it was noted that these were not scheduled to be complete until the end of the 08/09 financial year, which is reflected in the higher score for progress relative to meeting KPIs.

### **Overview of the Integrated Care Action Area**

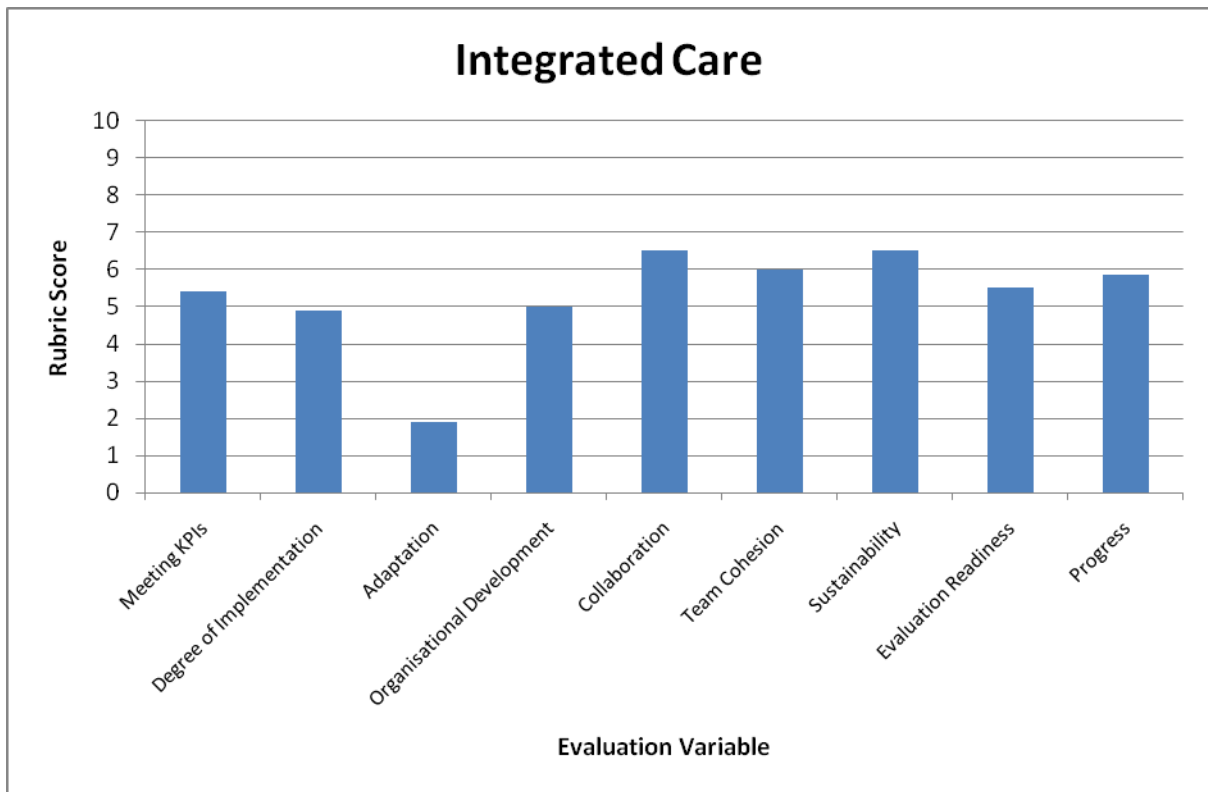
A combined analysis of the 2007/2008 and 2008/2009 data was used to provide an overview of the Integrated Care Action Area over this reporting period. In addition, the Action Area was assessed on their collaboration, sustainability, evaluation readiness and team cohesion. Figure 41 illustrates these findings, and the interview data is used to support the overview.

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<sup>83</sup> Sub-initiative 10.8.2: Convene multiple discrete working groups to facilitate development of survey design

<sup>84</sup> Sub-initiative 10.8.3: Conduct a survey of those with type 2 diabetes living in Counties Manukau – analyse and disseminate results

<sup>85</sup> Sub-initiative 10.8.4: Formulated development of recommendations, following survey outcomes in 2008/09



**Figure 41: Overview of the Integrated Care Action Area**

***Achievements and Adaptations***

Overall the Integrated Care Action Area received moderate scores for meeting KPIs and implementation; however this was in part an artefact of the area achieving lower scores in the 07/08 financial year, and higher scores in the 08/09 financial year. The interviewee also commented on the contrast in the progress that had been made in the 08/09 financial year and in previous years:

*I've been told from time to time that we are way ahead of where we use to be...I think we are doing well.*

The most significant output of the Action Area was identified as the Diabetes and Pregnancy initiative, and in particular the pilot of the collaborative doctor-nurse approach to meeting with patients who were pregnant with diabetes, which was seen to be making the most significant collaborative change. It was noted by the interviewee that the KPIs for the Action Area were deliberately challenging to promote traction with the initiatives:

*With some of these initiatives its really kind of nebulous stuff in my opinion...everything really needs to hard and sharp and you need to be able to quantify it...in defining those KPIs I've tried to make those as hard as possible...*

The Action Area did received some reasonably high scores for adaptation, mainly in the 07/08 financial year, however this mostly reflects delays or changes/restructuring as to who is responsible for KPIs, and the incorporation of certain KPIs into other areas. It was noted that a lot of the time

KPIs are not met within the specified timeline, yet there appears to be no process in place to initiate an appropriate response to set-backs.

### **Functioning of the Action Area**

The Integrated Care Action Area received a moderate score for organisational development. The KPIs related to leadership were not achieved; the concept of the hub was abandoned due to an insufficient level of buy-in from those that would sit on the group, and the work plan which was to replace the hub was not completed. The LBD programme director and programme manager currently provide oversight for the area. There is a strong feeling amongst the project team that there is a lack of support from stakeholders, in part due to constraints on their time, which was seen to limit the impact of the Action Area:

*What I find really challenging sometimes, is not only trying to get folks together who don't see it as their number one priority, but also folks who are really busy ... they don't have an inch of time ...*

The Action Area received a moderate score for collaboration. There is some feeling from KPIs that were abandoned that perhaps collaboration was not prioritised, as it appeared that initiatives were given over to other community groups entirely, rather than the project team working with those groups to support or facilitate their work. Otherwise the project team appeared to be engaging fairly well with PHOs, the School of Population Health and other players. A lot of collaboration had been undertaken with the WDH in piloting the CVDIS, which was seen as important in ensuring regional alignment and learning from those that have gone before. There were also strong links noted with the Whitiora Diabetes Service. There was no evidence to suggest that collaboration was occurring with other Action Areas within LBD.

The Action Area received a moderate score for team cohesion. The project manager noted that there is a lot of support available from the Action Area leader, which is seen as particularly valuable given this individual's understanding of the clinical side of things. While ownership of the Action Area historically falls to the Action Area leader, there appears to be some fluidity in terms of management, and the project manager is able to support the Action Area leader where necessary. The interviewee noted that over time the project team have come to understand which persons are ideally suited, and thereby responsible for, different pieces of work.

### **Sustainability**

The Action Area received a moderate score for sustainability. The work that is undertaken under the Integrated Care umbrella is often inherently sustainable, e.g., updating systems and structures, trying to get guidelines in place, developing new evaluation systems. Indeed the interviewee suggested that sustainability is a key consideration for the Action Area in any work that is undertaken:

*That's one of the biggest drivers or goals of LBD...this stuff is meant to be sustainable beyond LBD...will these programmes be able to continue on and excel and enhance grow...just thinking about...diabetes and pregnancy...it's certainly designed this way so that the work we've done could continue without us...we've put the pieces in place*

It is not clear, however, if the relationships or the collaboration is sustainable, or if buy-in from key stakeholders will continue post-LBD, although there is evidence that the DHB is trying to secure and sustain community input in the work of this Action Area. It should be noted however that in general Chronic Care Management is high on the list of priorities in Counties Manukau, and therefore there is likely to be ongoing access to adequate resource and funding for these kinds of initiatives.

### **Evaluation Readiness**

The Integrated Care Action Area received a moderate score for evaluation readiness. A lot of the KPIs within this area are related to auditing and evaluation, and the project team do appear to be responsive to feedback – although this feedback does not always receive follow up.

The interviewee is aware and has an understanding of the LBD evaluation currently undertaken by the School of Population Health. The project team are willing and engaged participants in the evaluation process, being mindful of the need to forward all relevant documentation on to the evaluation team. The Action Area is currently undertaking a focused study with the School of Population Health. The interviewee noted that there was at times some frustration from those working within the various Action Areas who felt their progress had not been accurately captured and signalled in the evaluation report, and acknowledged the importance of providing sufficient information to the evaluation team:

*It seemed like people around here got understandingly perturbed...that maybe their successes weren't represented in the evaluation...and what I got out of it was that the School of Population Health could only evaluate as much as LBD fed back to them...*

The interviewee noted that that DHB conducts their own in-house auditing, that occurs via the submission of monthly reports; which provide feedback on the KPIs that have been achieved, and those still progressing. The interviewee strongly believes that this process adds value to the work of the Action Area.

### **Summary of Progress**

Overall a moderate level of progress was noted for the Integrated Care Action Area, with progress noted to be markedly improved in the 08/09 financial year.

Things have really got moving in this latter financial year and the Action Area appears to have matured and created a division of labour that works for all those involved. However, support from key stakeholders remains a challenge, partly due to the capacity of people supporting this initiative from outside the Action Area. To improve the impact of the initiatives, the interviewee saw a need for higher level buy-in, to really drive it and help initiatives gain more momentum. Although not all of the KPIs for this area had been achieved, there was good evidence of progress towards the overarching goals of the Action Area.

### ***Changes over Time***

There was a significant decrease in the Action Area's score for adaptation, which is likely a reflection of the improvements in programme fidelity, for example, there was a significantly lower rate of abandonment of KPIs than was evident in the previous reporting year.

### ***Issues for Consideration***

- Lack of buy-in and support from key stakeholders.
- Action Area also appears to be working in isolation from the other LBD Action Areas.
- Discuss strategies for engaging key stakeholders in the Action Area.
- Action Area has had some success with engaging the community and key stakeholders to support the sustainability of initiatives; this is a learning that may bring benefit if shared with the other Action Areas.
- Progress towards KPIs for the 08/09 financial year is not fully represented given that reporting is occurring midway through the financial year.

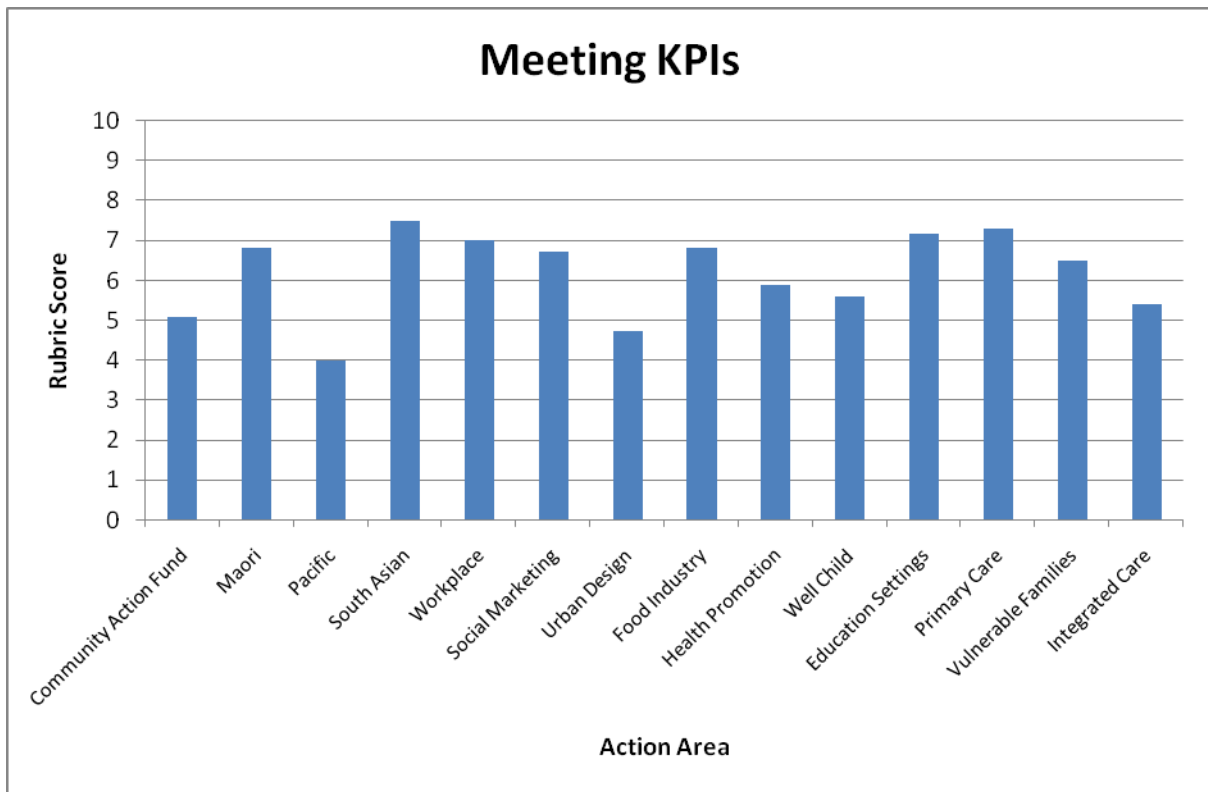
## **5. Overall LBD Programme Progress**

This section uses means analyses to provide an overview of the LBD programme between February 2008 and January 2009. Graphs will be presented to compare the key Work Streams and Action Areas on the eight evaluation variables: meeting KPIs, adaptation, degree of implementation, organisational development, progress, collaboration, sustainability, and evaluation readiness. Graphs will be presented first and then a summary of the LBD programme will be provided. Finally, the report will conclude with the identification of key learnings.

### **5.1 LBD Programme Progress**

#### ***Meeting KPIs***

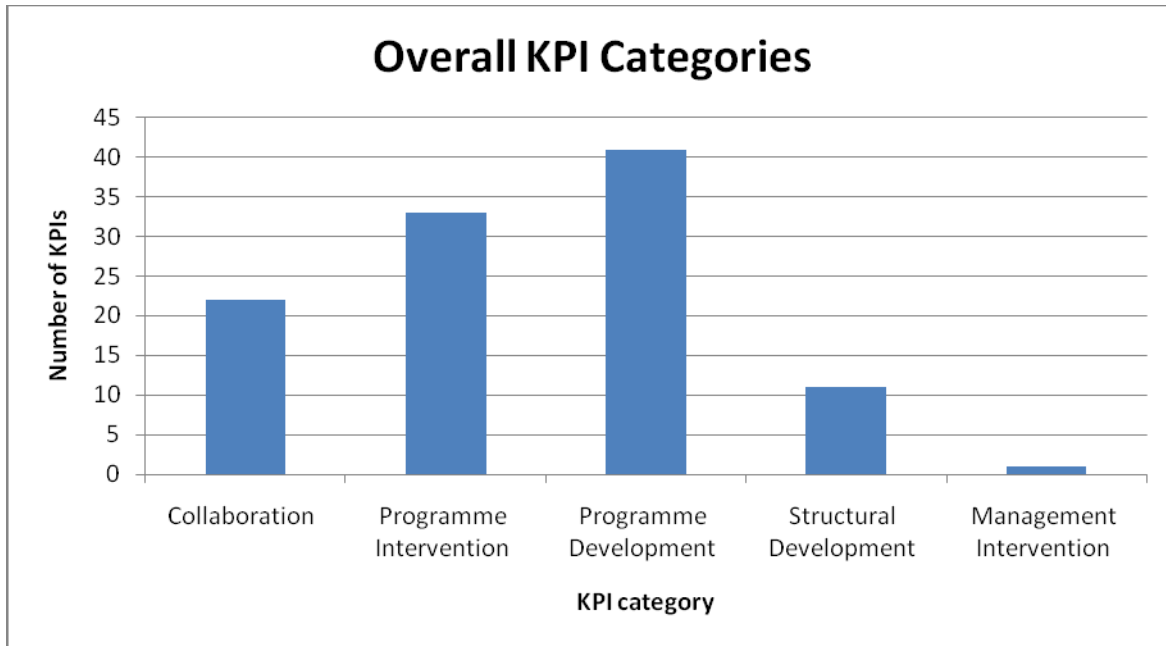
Figure 42 illustrates the progress each Action Area made towards achieving its stated KPIs. There was some variation in the scores achieved by different Action Areas in terms of meeting KPIs. It is important to note that there are large variations in the type, number and difficulty of KPIs between the different Action Areas, and where these differences were marked this has been signalled in the report. It is also important to take into account that lower 08/09 KPIs scores would be expected as this report is written half way through this financial year, and as such, progress for many of the initiatives is ongoing. As the scores depicted in Figure 42 represent the mean total for both 07/08 and 08/09 financial years, the actual level of progress may be higher.



**Figure 42: Meeting KPIs**

There was generally a moderate level of achievement in terms of meeting KPIs across the Action Areas including Maori, Social Marketing, Food Industry and Vulnerable Families Work Stream. The Education Settings, Primary Care and South Asian Work Streams achieved a higher level of achievement. It is important to note however that the South Asian Action Area are tasked with only one initiative, and the score is representative of only one contracting year. The score for Integrated Care was brought down by a low 07/08 score, although there was a significantly higher level of achievement in the 08/09 financial year. It should also be noted that the Pacific Action Area has not achieved many KPIs as the project team’s efforts were focused primarily on the LotuMoui Games.

In an attempt to account for these differences in scores a subsequent analysis was carried out whereby KPIs were coded using the following codes: collaboration, prevention intervention, programme development, structural development and management intervention. There were instances where the KPIs were coded in more than one category.

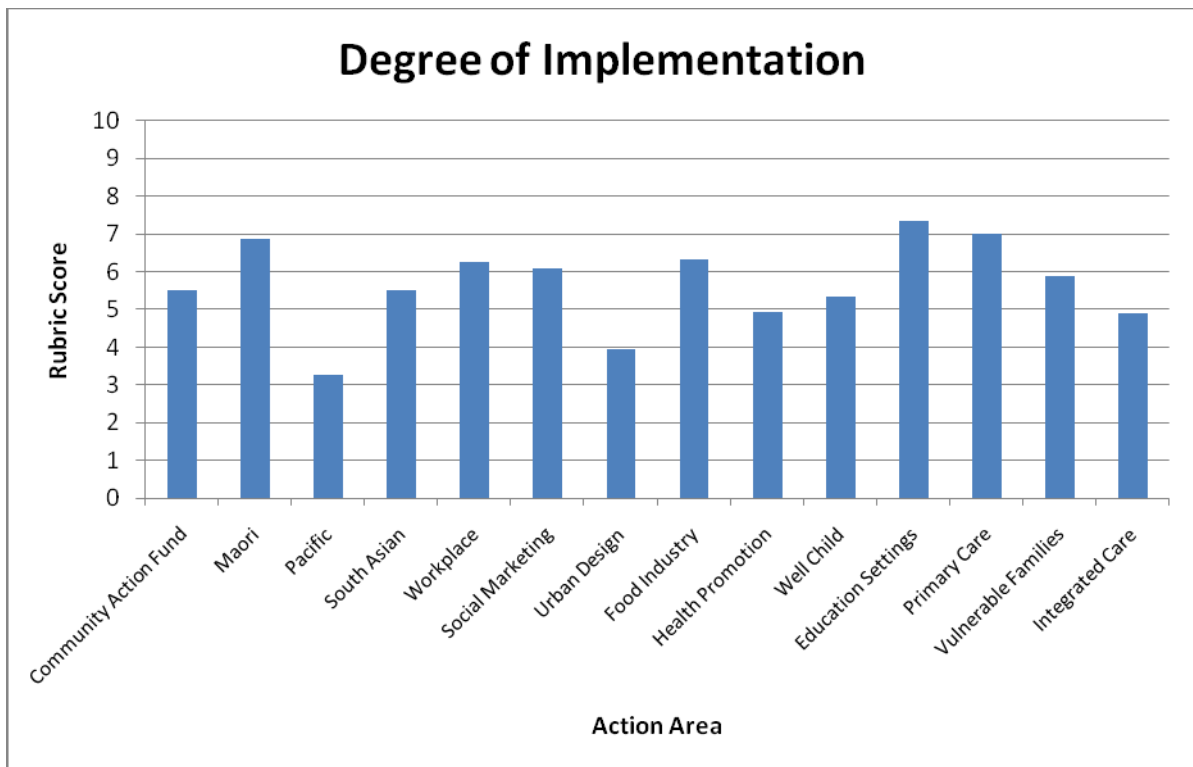


**Figure 43: Number of KPI's in each of the KPI categories**

Figure 43 illustrates that overall there were more KPIs coded as programme development. This was closely followed by KPIs involving prevention intervention, and collaboration. There were few KPIs that involved structural development or interventions directed at management. No significant differences emerged in the mean score for meeting KPIs as a function of these categories.

***Degree of Implementation***

Figure 44 illustrates the degree to which the goals of the programme or each Action Area have been implemented between 2007 and 2008. This score takes into account achievement of proposed actions by key completion dates, the level of stakeholder participation and target audiences reached, or more generally, how much intervention has occurred. The nature of the Action Areas' KPIs did influence scores on the implementation variable to a certain extent, for example if KPIs were complex or lengthy, or if they were not really related to implementation as such, e.g., those involving scoping and collaboration.

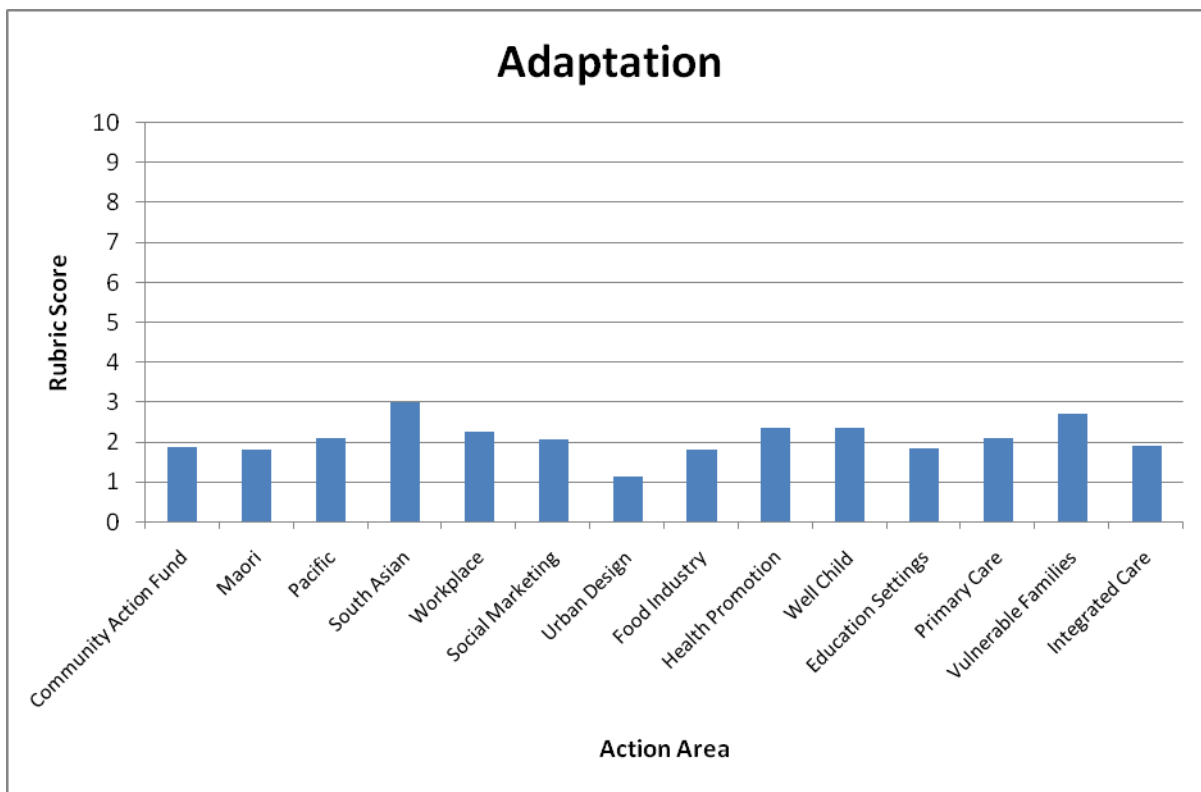


**Figure 44: Degree of Implementation**

As seen in Figure 44, the majority of Action Areas are engaged in a moderate degree of implementation, with the exception of Primary Care and Education Settings and Maori Work Streams, which are relatively higher due to the more direct focus of these Action Areas. Urban Design had lower levels of implementation due to the complex nature of the Action Area KPIs, and the issues highlighted for consideration under section 4.4, while Pacific again evidenced a lower level of implementation due to the focus on the LotuMoui Games.

**Adaptation**

Figure 45 illustrates the degree of adaptation each Action Area made to their original goals or work plans. Alterations to goals or plans were classified as adaptation only if there was a clear rationale as to how the changes were more appropriate given the (changing) needs and priorities of the community or environment which they serve. It is important to note that the interpretation of the scale for this evaluation variable was somewhat different relative to the other variables. A score of 0-1 is equivalent to little or no adaptation, a score of 2-3 is equivalent to a moderate level of adaptation, and a score of 4 upwards is equivalent of a high score for this variable, as a huge amount of adaptation would not be expected to occur within a programme without compromising the reliability and dependability of the programme.

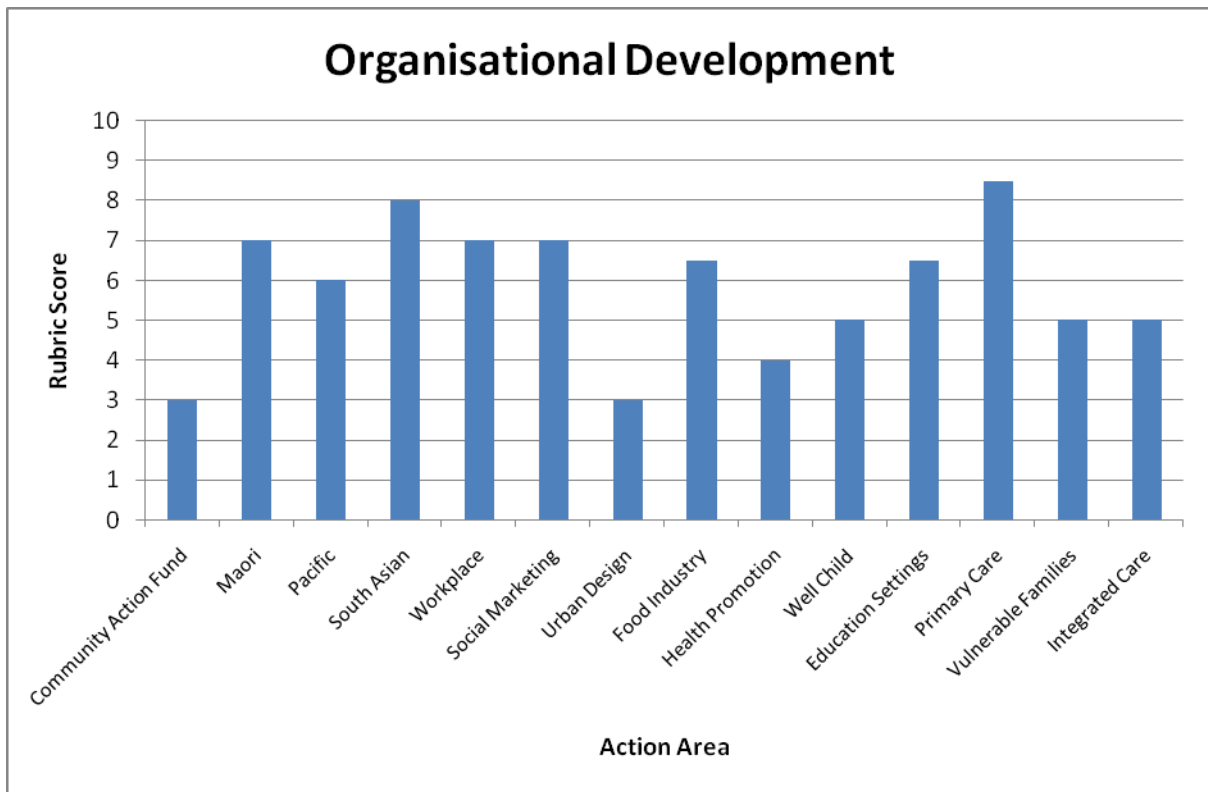


**Figure 45: Adaptation**

As anticipated with any programme, all Action Areas evidenced some degree of adaptation. The level of adaptation was fairly moderate across the Action Areas, although there was a lower level evident for the Urban Design Action, and a relatively higher level of adaptation occurring within the South Asian Work Stream, which was largely accounted for by the level of responsiveness to feedback around the Action Plan for this initiative. More moderate scores for most Areas were due to the fact that there was a not a significant demand for adaptation because their KPIs were reasonably specific and remained relevant over the course of the year, which is also reflected in the moderate to high scores across the Action Areas for the meeting KPIs variable. In other areas however, this was reflective of a failure to respond appropriately or in a timely manner to set-backs and delays.

***Organisational Development***

Figure 46 illustrates the degree to which Action Areas have organisational structures to support goals and objectives. In scoring the different Action Areas for this variable many factors were taken into consideration including: governance structures, decision making and information flow processes, strategies for improvement and member roles, goal formation, leadership engagement, reflective activities, communication and coordination within the Action Area. The Action Areas connection to LBD as an organisation was also taken into account.

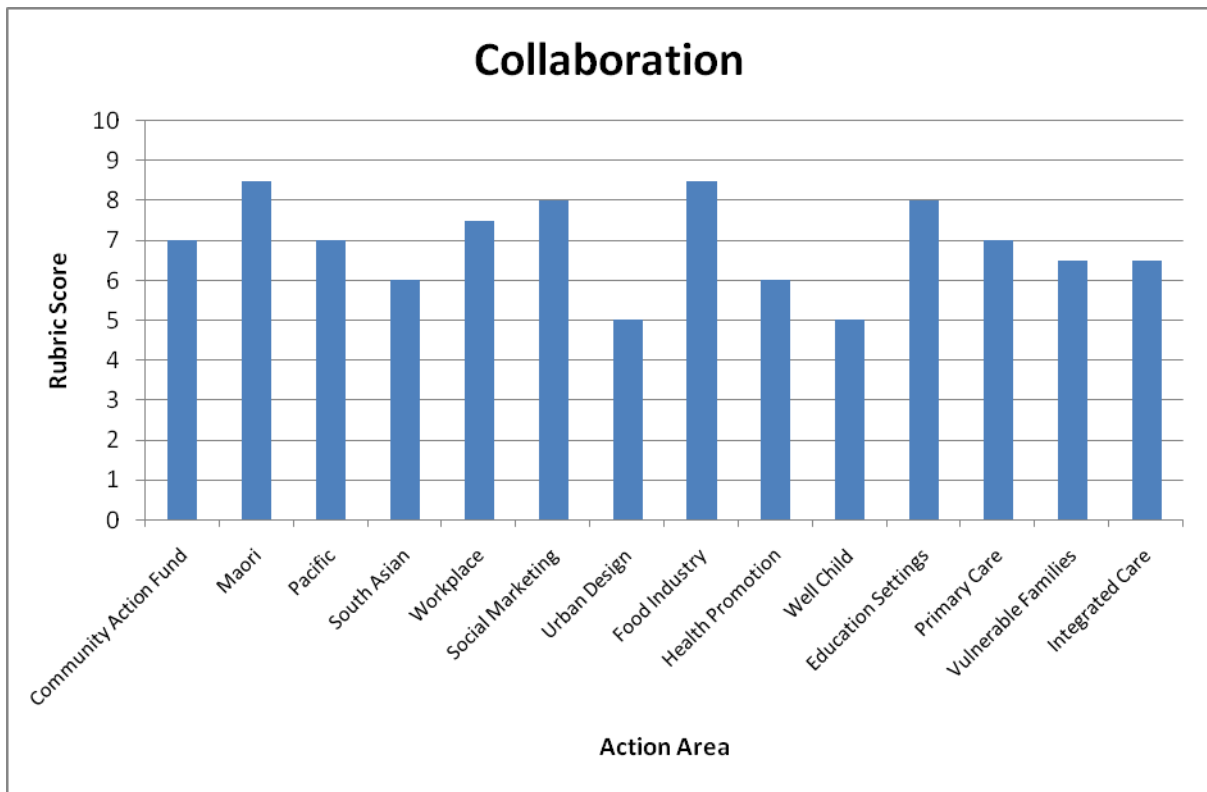


**Figure 46: Organisational Development**

In general, structures and systems appeared to be moderately developed, a high level of organisational development was noted for the Primary Care Action Area where leadership structures were well developed and there was evidence of collaborative decision making and information sharing. In addition to this, the South Asian Action Area also received a high score due to the nature of the foundational work being carried out which focuses on developed leadership structures rather than initiatives. The Community Action Fund, Urban Design and Vulnerable Families Action Areas received lower scores for organisational development. For Community Action Fund this was an artefact of there being only one individual working in the Action Area, and the lack of systems and structures in place to support leadership and communication. For Urban Design this was primarily reflective of the difficulties that had been experienced in getting buy-in from stakeholders to establish a leadership structure. For Vulnerable Families this lower score was a reflection of capacity issues, the restructuring of the leadership hub for this Area, and the lack of connection to LBD in general.

**Collaboration**

Figure 47 illustrates the degree to which the Action Areas are working in partnership with external providers and the other LBD Action Areas.

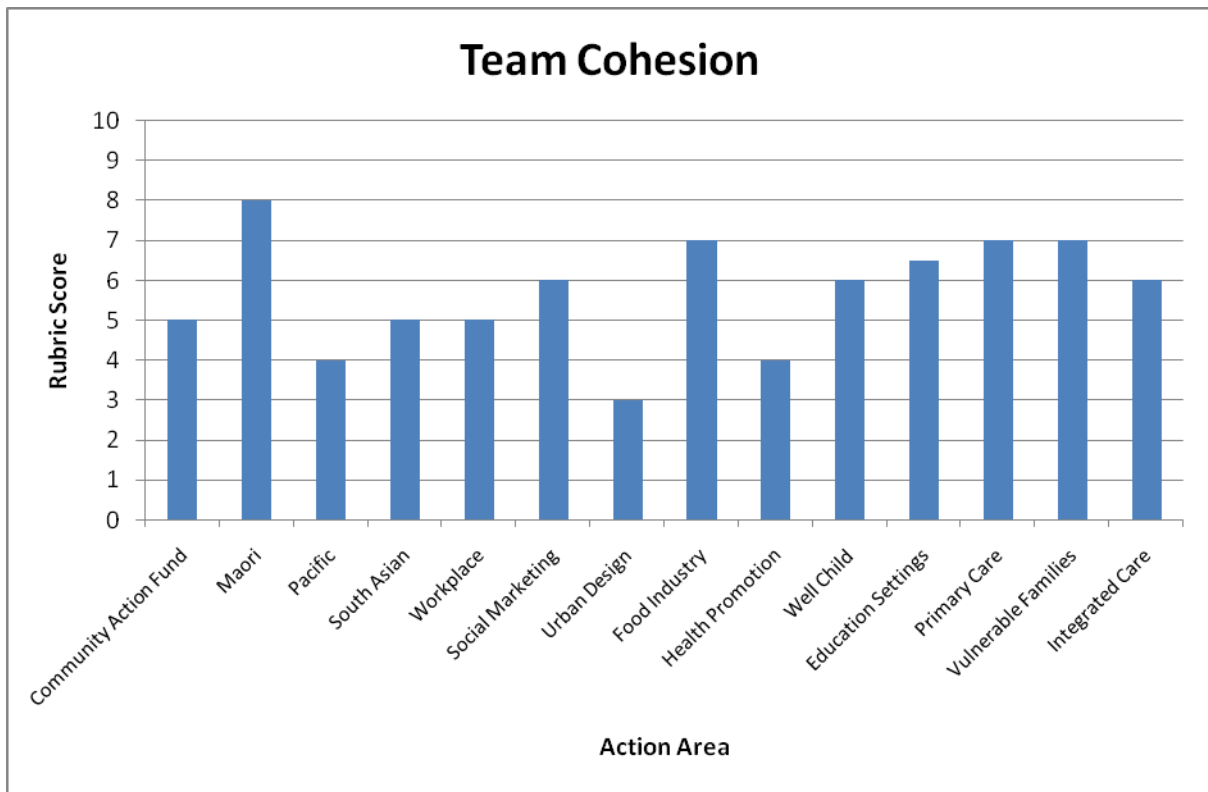


**Figure 47: Collaboration**

As seen in Figure 47, there was a moderate to high level of collaboration across all Action Areas, and all Areas were engaging with key stakeholders. This collaboration tended to be with external organisations including PHO's, NGOs and the Ministry of Health. With respect to internal collaboration, the Maori Action Area was most often cited, who were working with almost every Action Area to increase Maori responsiveness across LBD. However, across the board the level of collaboration with other Action Areas was generally lower than with external organisations. While most Action Areas noted other Action Areas they were collaborating with, over half the interviewees felt that collaboration with other Action Areas could be improved. Food Industry received a high score because they were engaging with big players within the Food Industry, a form of collaboration deemed more difficult than some other partnerships, and were also collaborating with a number of different Action Areas within LBD.

### **Team Cohesion**

Figure 48 illustrates the cohesiveness of the various Action Areas as a team. Cohesion was scored as a function within Action Areas, rather than within LBD as a whole; however, where there was an especially high or low level of connectedness to LBD, this was factored into the scoring for this variable. Other factors considered during the scoring process included: the level of team spirit or morale, perceived efficacy as a team, availability of social support, communication between team members, workload and decision-making processes, and the level of cooperation among team members.

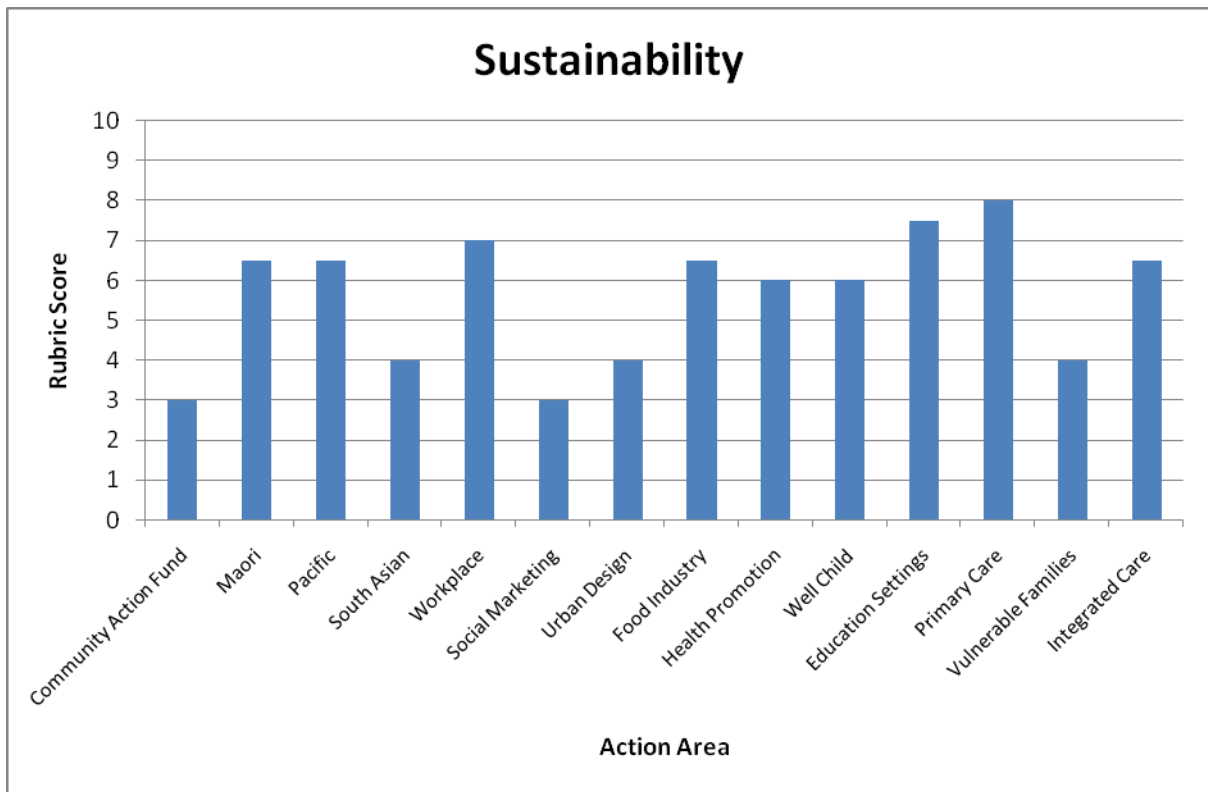


**Figure 48: Team Cohesion**

The scores for team cohesion varied considerably across Action Areas. Some of this variation can be accounted for by factors such as lack of information made available to the evaluation team, and lack of Action Area personnel; however most of the variation in the scores is reflective of differences between the Areas in the aforementioned factors which are noted to contribute to cohesion.

***Sustainability***

Figure 49 illustrates the likelihood of sustainability or the degree to which the Action Area has a set of durable activities and resources to support their initiatives. Higher scores were allocated for this variable if the intended benefits of the programme had the potential to continue even in the absence of the provision of funding, if there was evidence of capacity building and sustainable partnerships, or if systems were being implemented that would outlast LBD. Lower scores were allocated where sustainability was constrained by factors such as resource, funding, and capacity.

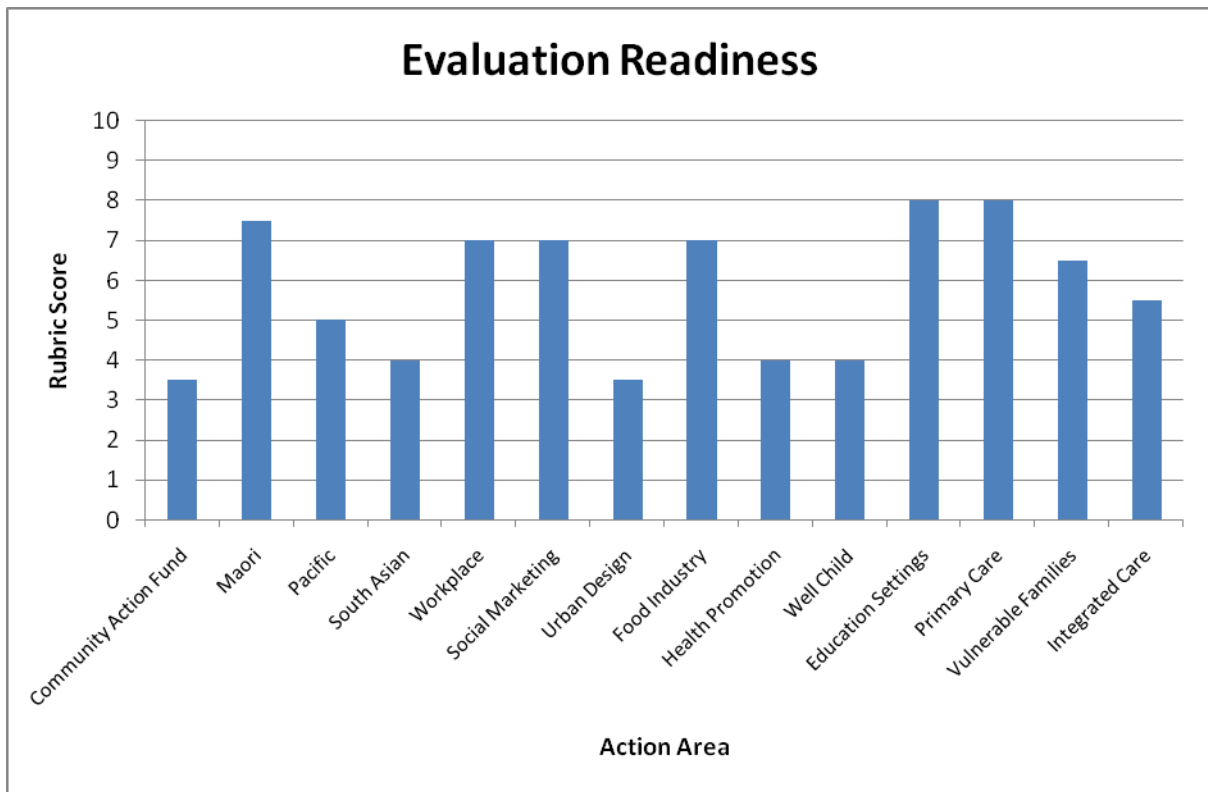


**Figure 49: Sustainability**

As seen in Figure 49, across most of the Action Areas there appears to be moderate to high likelihood of sustainability, with the exception of the Community Action Fund and Social Marketing initiatives, which are highly dependent on the provision of funding, and as such are not necessarily designed to be sustainable in and of themselves. Many of the Action Areas were seen as sustainable, with the potential to continue to deliver intended benefits after the initial impetus from LBD is withdrawn, although it was noted that this was frequently dependent on the continued involvement and commitment of key personnel at some level.

***Evaluation Readiness***

The preparedness of the Action Area to begin evaluation is illustrated in Figure 50, based on the capacity of the Action Area to carry out the evaluation tasks and to engage in evaluation. These scores represent both the willingness of the members of the Action Area to engage in the external evaluation of the overall LBD programme, as well as the level of engagement in self-evaluation practices.

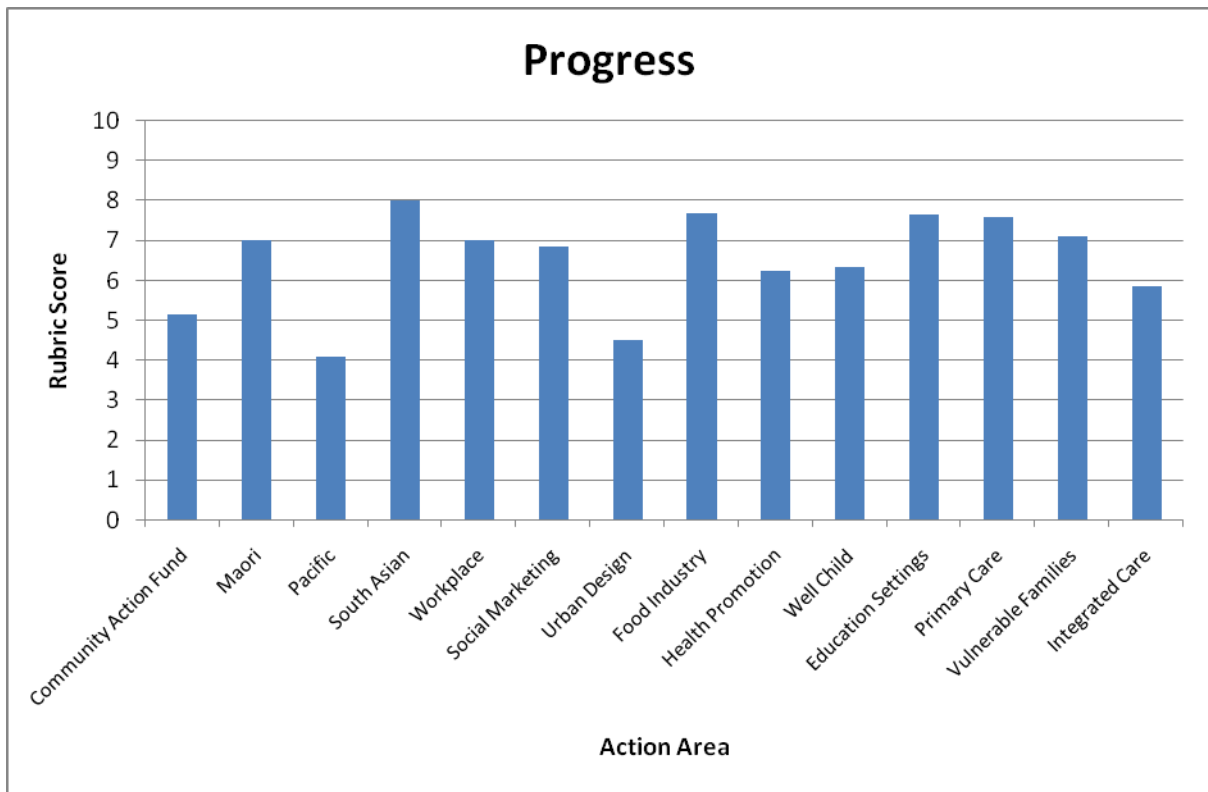


**Figure 50: Evaluation Readiness**

As seen in Figure 50, there was a large degree of variation in the evaluation readiness scores across Action Areas, with the Maori, Education Settings and Primary Care achieving a high level of evaluation readiness, and Well Child, Urban Design and Community Action Fund Action Areas evidencing lower progress in relation to this variable. In general, the Action Areas that had been involved in focussed studies appear to be more aware of evaluation and the importance of sharing information. Further, Action Areas with KPIs related to evaluation tended to be more engaged in this process, and more responsive to evaluation feedback. Where there were substantial gaps in the information that was supplied to the evaluation team these Areas received lower scores on this variable.

***Progress***

The overall progress each Action Area made towards their overarching goals over the 2007/2008 and 2008/2009 financial years is illustrated in Figure 51.

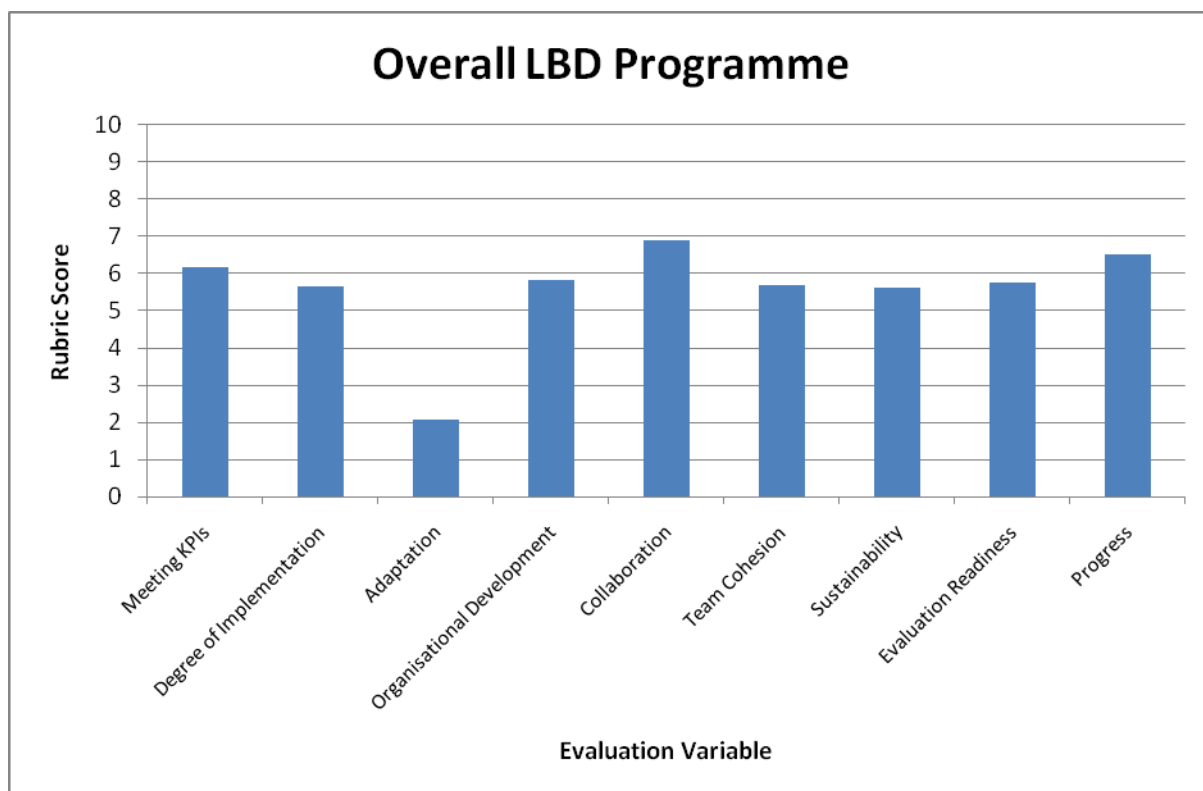


**Figure 51: Progress**

Overall there was a moderate to high level of progress across Action Areas towards the overall goals and objectives of the various initiatives. Although not all KPIs were met within individual Action Areas, most Action Areas were making some progress towards the overall aims of the Action Area; as such, higher scores for overall progress were given to Action Areas that demonstrated a high level of output, even if this output was not specifically related to individual KPIs.

## 5.2 Overview of the LBD Programme

Figure 52 is based on a means analysis of all the LBD Action Areas and Work Streams. This graph provides an overview of the current status of the LBD programme based on the information and data collected by the evaluation team.



**Figure 52: Overall LBD Programme Progress**

### ***Achievements and Adaptations***

Overall the LBD programme made good progress towards meeting its stated KPIs across the Action Areas. Consistent with this, the degree of implementation across the programme was moderate and adaptation to programme plans was low. Implementation scores varied according to the nature of the KPIs; many were not focussed on implementation as such, hence why this score was lower.

Nine Action Areas/Work Streams achieved a higher level of progress towards meeting KPIs, one was newly established (South Asian), two remained the same (Urban Design and Primary Care), and two achieved a lower score (Social Marketing and CAF). The achievement of goals and KPIs also appeared to be bolstered by support from national initiatives, such as the Ministry of Health breastfeeding initiative, the Nutrition Fund and Mission On through HEHA.

Adaptation was slightly lower than in the previous year; however, this is due to ensuring that the adaptation score only reflected a change in plans or implementation, as these scores were inflated last year due to delays in achieving KPIs rather than changes to the overall plan. In general adaptation was low as a consequence of the fixed nature of most of the KPIs, and a lack of processes to counter set-backs. Some of the Action Areas also felt that the demands on their time offered little opportunity for reflection. This also fits with the comments relating to the challenges with responding to evaluation.

### ***Functioning of the Action Areas***

Overall, organisational development had increased slightly for LBD as a whole. For some Action Areas, however, their organisational development scores had decreased. These lower scores tended to relate to the perceptions around limited communication and information flow, despite the meetings that occur, as well as confusion around roles and how these fit within LBD. Staff turnover remains an issue for LBD and its partner organisations, along with the rest of the health sector. The difficulties in appointing a replacement and the lack of formal induction procedures posed additional challenges for the new appointees in terms of getting up to speed with the LBD plan. Capacity was also consistently identified as a barrier to progress, both within the LBD, its partners and other key stakeholders.

Collaboration scores were slightly lower this year, although the scores remained moderately high. Interestingly, collaboration tended to involve external stakeholders and organisations rather than other LBD Action Areas. When describing internal collaboration, however, Maori was the most commonly cited Action Area. This is a positive finding for LBD given its aims and objectives. The Action Areas however, called for greater integration across LBD. Some Action Areas, particularly those outside of the health sector, found it difficult to identify areas for collaboration and appeared to be working in silos. While the regular staff meeting was useful for sharing information, this did not appear to specifically identify areas for collaboration across LBD. When collaboration was happening internally, however, all Action Areas identified this as a success. Education Settings, Maori and Gardening initiatives are all excellent examples of how collaboration within LBD can work and should be shared across the organisation.

The lack of integration across the Action Areas is reflected in the low scores for Team Cohesion. The Action Areas do not appear to feel part of a cohesive whole and are perhaps not working as closely as they could be. This is likely to be a consequence of time and capacity, as well as challenges in understanding one another's work and identifying areas for collaboration. The Action Areas suggested that they would welcome support to identify initiatives where they support one another. This should also increase the connectedness of some of the Action Areas to LBD, particularly those sitting outside of the District Health Board.

### ***Sustainability***

The sustainability scores were slightly lower this year, although overall sustainability reached a score of 6. When discussing sustainability the Action Areas placed great emphasis on funding. While this makes sense, some Action Areas had really taken on board the notion of sustainability through community involvement and ownership. For example, Integrated Care and the Diabetes and Pregnancy initiative had enhanced their sustainability through involving general practitioners and nurses throughout each stage of the process. This approach holds some useful insights into how LBD can enhance the sustainability of its initiatives. Inevitably the size and scope of a plan such as the LBD plan poses challenges for sustainability; these are also exacerbated by staff turnover and capacity issues. Some of the Action Areas' suggestions for increasing community involvement and capacity may be important here.

### ***Evaluation Readiness***

The evaluation readiness score increased this year for LBD. Overall, the Action Areas had a really positive attitude towards evaluation. Some, however, suggested that the evaluation was not always

responded to and this was partly due to the format of the School of Population Health evaluation reports, as well as capacity for reflection and change. The challenge of finding an appropriate format for sharing the huge amount of work undertaken within LBD was also often noted. For example, while some valued understanding process to enhance implementation and ultimately outcomes, others were more comfortable with harder outcomes that are more traditionally used to gauge success within the health sector. The enthusiasm to engage in and learn from evaluation however, resonated throughout LBD. Yet, the ability to engage in formal evaluation was often hindered by time and capability.

### ***Summary of Progress***

- Great progress appears to have been made across the majority of LBD in terms of getting out there and getting things done. This has been supported by the development and maturation of some Action Areas, as well as the appointment of appropriate personnel.
- Success appears to be heightened when supported by national initiatives.
- Capacity sometimes hinders progress and remains an issue both within LBD and within the community.
- Adaptation scores were moderate, suggesting that plans are adhered to, although some stakeholders suggested that this was more a consequence of difficulties in changing the aims and objectives.
- Organisational development was an issue for some Action Areas and this also appeared to be linked to difficulties in engaging key stakeholders in leadership hubs.
- Generally, collaboration was working well with external stakeholders but, apart from a few notable exceptions, appeared to be more challenging between the LBD Action Areas. While the Action Areas reported meeting fortnightly this did not appear to result in extensive collaborative action.
- The whole systems approach adopted by LBD also tended to make it difficult for some Action Areas to identify similarities with one another, as many are focused on prevention as opposed to treatment.
- Maori and Pacific were the most commonly cited Action Areas when discussing internal collaboration, although this challenged the capacity of these Action Areas.
- The limited integration between the Action Areas also resulted in lower team cohesion scores, with many Action Areas feeling like they are working in isolation.
- Some Action Areas have bought into the notion of sustainability through collaboration more than others. For many an over-reliance on funding appears to remain.
- Generally, the Action Areas provided greater information on progress to the evaluation. There were, however, some gaps in information for some key areas.
- The Action Areas had an extremely positive attitude towards evaluation, although it was noted that the size and scope of the evaluation reports sometimes made it difficult for LBD to engage.

### ***Issues for Consideration***

- Identify strategies to support the ongoing challenge of capacity and staff turnover.
- Provide increased opportunities for community engagement in LBD.
- Increase internal collaboration and integration across the Action Areas.

- Increase cross-sector links and connections both within the LBD Action Areas and its partner organisations.
- Support Action Areas to identify strategies and processes to support sustainability.
- Learn from the utilisation of evaluation within the individual Action Areas to support the utilisation of evaluation across LBD.
- Work with the evaluation team to develop a more useable format for the evaluation reports through increasing Action Area engagement in the evaluation.