LET'S BEAT DIABETES

A Five Year Plan
to Prevent and Manage Type 2 Diabetes
in Counties Manukau

FINAL PLAN
Endorsed by the Board of Counties Manukau District Health Board
02 February 2005

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Please note: the diabetes referred to in this document is Type 2 Diabetes.

Part I

Introduction & Overview

Executive Summary

Counties Manukau is experiencing a growing epidemic of Type 2 Diabetes ("*diabetes*"). Currently there are more than 12,000 people in Counties Manukau diagnosed with diabetes. Almost double this number remains undiagnosed. It is estimated that the number of people with diabetes will more than double over the next 20 years, given population growth, the ethnic, youthful and generally low socio-economic make up of our population.

A major change to the health sector and our broader society is required to stop the diabetes epidemic.

Let's Beat Diabetes, commissioned by Counties Manukau District Health Board (CMDHB), is a five year plan aimed at long-term structural changes to prevent and/or delay the onset of diabetes, slow disease progression, and increase the quality of life for people with diabetes. It recognises the significant activity that already exists to prevent and mange diabetes, and creates a long-term vision to align existing activity and a context for new investment, based on evidence and best practice.

Let's Beat Diabetes is a district-owned plan developed by Counties Manukau for Counties Manukau.

After extensive consultation, Ten Action Areas have been defined:

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

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

The plan will be supported with committed funds and a governance structure that reflects the broad societal support required for successful implementation.

The plan will be presented to the Board of CMDHB and other key stakeholder representative groups in early 2005 for endorsement and sustained funding. Developmental work and preparations will continue early 2005, with full implementation from 01 July 2005.

This Document

This document provides a context for a whole society response to diabetes, a framework for action and an implementation plan.

The intention is to provide a vision and shape for community partnerships over the next five years.

The planning process during 2005 will involve detailed programme development by community partners in each of the Ten Action Areas. One of the outcomes of this more detailed work will be to refine the goals, targets and key performance indicators for each of the Action Areas, as well as setting overall goals for the plan. The plan will continue to be updated as developmental work progresses.

Currently this plan does not include inpatient secondary and tertiary services or morbid obesity.

This document does not provide a detailed analysis of diabetes in Counties Manukau - this was covered in an earlier document: *Diabetes in Counties Manukau – A Call to Action.* This document is also not a business case and does not discuss funding issues. This is addressed in a separate document.

The intended audience for the plan is the Counties Manukau community and district organisations and individuals who will take up leadership roles in the campaign to beat diabetes.

A Letter From 2020

It is the year 2020. Type 2 Diabetes is still a major health problem in Counties Manukau - the number of people diagnosed with diabetes is greater than it was in 2010 - but positive trends are emerging that show diabetes rates and numbers will decrease over the next decade. We are beating diabetes!

The turning point in the battle against diabetes came in 2010, when the growth in population obesity stabilised, and from 2012 when average weights began to decrease. Many experts have commented on the rapid reduction in the number of obese children since 2015, with a new wave of well nourished, fit children now flowing through the primary schools.

How did we get to this point, when back in the early years of the century it seemed nothing could stop the growth in diabetes? The simple answer is that it has been the collective efforts of many strategies applied over decades and a commitment from all parts of society to a shared vision and goal – much like the smoking epidemic of 50 years earlier.

While the big gains in health have been made in the past five year (2015 – 2020), the real changes came in the 2005 - 2010 period. Those years are remembered as the 'hard yards', when there was a lot of effort for little change in outcome. But they put in place many of the strategies that continue to guide us today, and most importantly, galvanised commitment and action across society.

It was during those years that the renaissance in Maori and Pacific health began, with community leadership, through marae and Pacific churches, taking up the challenge of improving the health of their people, especially the young ones. The change in community attitude and behaviour towards nutrition and physical activity seemed to reach a tipping point in 2009 - adult and child obesity levels in Maori and Pacific populations began to decrease significantly faster than those of the general population.

The general change in community attitude had its roots in community leadership but was further supported by a comprehensive social marketing programme that began in 2005 and is now part of our cultural landscape. In fact, the partnerships between health sector, local government, and the food and physical activity industries, which characterises the national social marketing programme of today, was forged in Counties Manukau 15 years ago.

The fast food industry is now competing on product 'health/goodness'. And while the trends towards eating out and consuming pre-prepared food have continued, the population diet has significantly improved. Children cringe when they are shown some of the meals their parents used to eat.

For more than a decade, schools have taken explicit accountability for the physical health of children while they're at school. This has meant ensuring students get at least 30 minutes of physical activity every day. All schools in Counties Manukau actively support good nutrition. The number of children walking or cycling to school has doubled since 2010, thanks to efforts by schools, working with communities, local government, and activity organisations. Many educationalists have noted that the improved health of students has also contributed to improved academic performance in Counties Manukau.

The Flat Bush development, which was identified as the pilot for the 'healthy by design' planning initiative, is now seen across New Zealand as a watershed in urban design, with its focus on healthy, active and socially cohesive communities. The lessons from Flat Bush have already been applied to urban developments and redevelopments across the country.

Child health has been a substantial success story, attributed to improved services and changes in attitudes towards health in the first years of life. Well Child Services are now broad in scope and include a focus on good nutrition and chronic disease prevention, through pregnancy and from birth. There is a significant investment in parental education and sophisticated techniques

for identifying vulnerable families and children. Multi-sectoral support is available for vulnerable families, with information systems helping co-ordinated service delivery across agencies. The Well Teen pilot for a structured health assessment of 13 year olds has now become a national programme.

Primary care has evolved (despite continual government restructuring … some things don't change) to have a far greater focus on disease prevention.

Primary Health Organisations (PHOs) have become sophisticated organisations, with a strong community and civic presence. GP surgeries have in general been consolidated into fewer larger centres, with the development of nurse-led healthy living and disease management teams

The primary-care based in-clinic and outreach teams have become expert at processes of family and group-based behaviour modification, which, coupled with early diagnosis, has led to a measurable slowing in disease progression and a reduction in expensive hospital-based care. Supporting the re-orientation of primary care is the continuous development of a world-leading IT system that provides best practice advice to GP teams and to the health consumer.

Health promotion is often described as the glue in the system. A set of strong organisations effectively link the community development, social marketing and primary care strategies at an operational level, and provide a source of community-based innovations to service design. One of the most remarkable and enduring changes during the 2005 - 2010 period was the development of the health alliances –self-organising groupings of community, health and social service providers - which developed long term place-based strategies to identify and support the most vulnerable families.

One of the key features of Counties Manukau's efforts to beat diabetes has been an extremely stable governance and leadership structure. Representatives from many organisations and communities still form the core governance structure to beat diabetes, and the group has become something of a Counties Manukau institution. This stability has been at the heart of the persistent year-on-year progress.

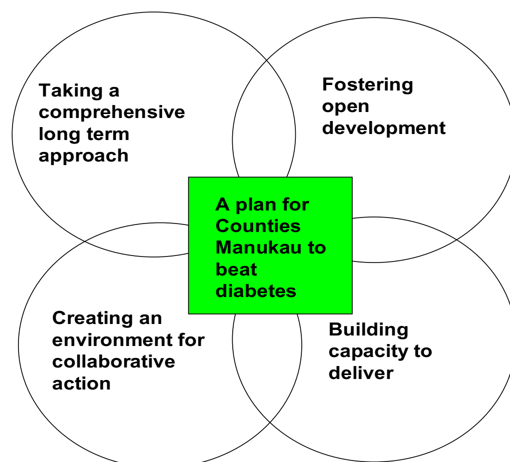
Another key feature that has been emphasised in academic reviews is the 'success model' of learning and service development that has been adopted across many health providers. Some have likened it to 'action research on a massive scale' or a continuous quality improvement strategy. But the result has been the rapid uptake of innovations in practice across providers. The ability to learn from each other is one of the defining features of the 'Counties Manukau way'.

The final success factor was the decision by the District Health Board to invest 'upstream' and commit effort and money to support strategies that reduced risk and identified vulnerable people at an early stage in their disease. It is these strategies that are providing payback now in terms of health sector costs and community vitality.

The Planning Process

The required outcomes of the planning process have been to develop a plan for the Counties Manukau district as a whole (not just the health sector) and to build community momentum in support of the plan. Achieving these outcomes has required taking a highly participative approach, creating the foundations for long-term relationships, collaborative partnerships and networks.

A steering group made up of community, professional and cross-sector representatives has guided the development of the plan. The planning process has been open and transparent at every stage. All key planning documents developed during the year and the minutes of all the working shops and group activities have been posted on the *Let's Beat Diabetes* website (www.cmdhb.org.nz) to provide a fully public view of the ideas and participants guiding the planning process. Graphic 1 below shows an outline of the planning process.



Key Planning Concepts

Six concepts have influenced the planning approach:

1. Guiding principles of the World Health Organisation's (WHO) *Global Strategy on Diet, Physical Activity and Healt*h (2004)

Whilst the global strategy is aimed at the international community and national-level strategies, it contains a discussion of principles to guide action and recommended areas of activity. The strategy provides an excellent starting point for developing a long-term change programme. Key principles taken from the global strategy include:

- Evidence-based strategies
- Multi-sectoral action
- Long-term approach
- Life course approach
- Broad, comprehensive efforts
- Priority on most vulnerable groups
- All parties accountable for policies and programmes

- Culturally-appropriate, and challenge cultural influences

2. Evidence of need and effective action

The plan development has been based on needs analysis, and evidence of effective interventions, whether it be international or local evidence. There are, however, some areas where there is a clear need for action but a lack of strong evidence for effective programmes. In these situations, it is critical that thorough evaluation is undertaken to develop new evidence – a good example of this issue is in the schools programme. The plan structure and approach taken by *Let's Beat Diabetes* closely aligns with international best practice and is reflected in many recent national and state strategies; examples include: The *New South Wales Chronic Disease Prevention Strategy 2003-2007*, the Australian National Public Health Partnership *Prevention Chronic Disease a Strategic Framework (*2001) and the US Centres for Disease Control *Promising Practices in Chronic Disease Prevention and Control (2003*).

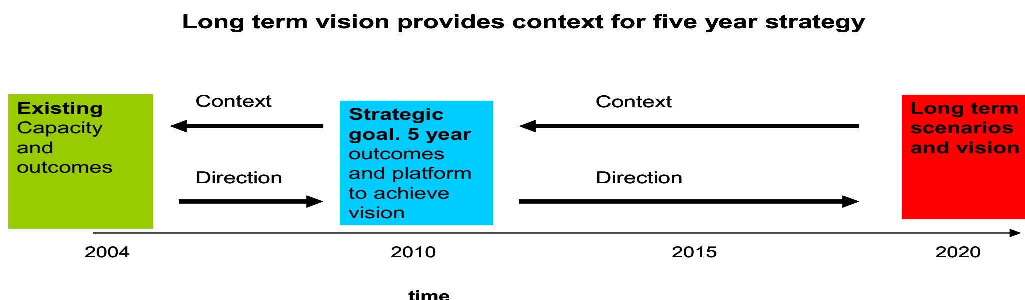
3. Sector capacity and community motivation

The plan has identified where need, evidence and good ideas intersect with the local capacity and motivation for action. There is little point in proposing strategies where the community and organisations are not ready and/or willing to take up the call. Examples of finding fertile ground for action include the food industry being strongly motivated to develop tangible outcomes following the signing of the National Food Industry Accord; the new Family and Community Services division of the Ministry of Social Development wanting to work with the health sector in the area of vulnerable families; and Pacific church leaders wanting to be more involved in supporting the physical health of their communities.

4. Long term approach

The fourth key concept has been to think about the long-term implications of actions. It took decades to make real inroads into the threat of smoking on health. The obesity issue is far more complex and will require broad changes to our environment, societal norms and health sector capabilities before substantial positive changes and outcomes are achieved. The emphasis has been on identifying areas where actions over the next five years will deliver positive benefit and align with a 15-year vision. Graphic 2 below shows how the long-term vision creates a context for the five year plan.

Long term vision provides context for five year strategy



5. Alignment with national and CMDHB overarching strategies

Key documents such as Counties Manukau District Health Board's Strategic Plan (CMDHB 2002), *Healthy Eating Healthy Action Framework (*Ministry of Health, 2003), *He Korowai Oranga* – Maori Health Strategy (Ministry of Health, 2002) the *Pacific Health and Disability Action Plan* (Ministry of Health, 2002), and emerging Ministry of Health frameworks for chronic disease management such as Leading for Outcomes, have influenced the planning approach and processes.

6. Building on lessons from past strategies and services

Counties Manukau has a long history of strategic planning and service innovations relating to diabetes, including the work undertaken by Dr David Simmons during the 1990s and the *South Auckland Diabetes Report* prepared in 2000. In many areas, Counties Manukau service providers have developed innovative services, some of which have been sustained. One of the challenges for *Let's Beat Diabetes* has been to learn from this rich background and to create the systematic conditions that support sustainable programmes.

7. Building on existing strengths

Let's Beat Diabetes starts from a strong base. CMDHB has for the past five years invested in improved chronic care management in the primary care sector. The Chronic Care Management (CCM) programme is well advanced and involves primary care being supported by training, information technology (IT) and decision support tools to provide structured care in the community for people with advanced diabetes. CCM is supported by Whitiora, the Middlemore Hospital Diabetes Service. Whitiora provides training for practice teams and outreach education for patients as well as clinical services.

Primary Health Organisations (PHOs) are increasingly developing new health promotion and disease prevention services. Maori and Pacific providers deliver specific services and programmes to their respective communities. Niche providers such as the Diabetes Projects Trust also provide community-based health promotion and education activities. Counties Manukau has a history of health leadership from Manukau City Council with the Te Ora O Manukau/Manukau the Health City and more recently the Tomorrow's Manukau Health and Wellbeing Outcome Group. The Auckland Regional Public Health Service (ARPHS), which has an office in Manukau City, provides services aimed at improving lifestyle and environmental risk factors.

Obesity & Diabetes - Global Epidemics

The world is currently experiencing an unprecedented growth in obesity. Obesity is a major risk factor for Type 2 Diabetes.

In 1995, there were an estimated 200 million obese adults world-wide. By 2000, the number of obese adults had increased to over 300 million.

The situation in New Zealand is no different. Approximately 59.5 percent of all New Zealand adult males and 48.6 percent of all New Zealand adult females are overweight. These figures are more marked for Maori and Pacific adult populations, where 68.5 percent of Maori males, 59.2 percent of Maori females, 80.9 percent of Pacific males and 82 percent of Pacific females are overweight (Ministry of Health, 2003).

The figures for children are of particular concern with 31 percent of all children overweight, 62 percent of Pacific children overweight, and 41 percent of Maori children overweight.

The prevalence of obesity is increasing. Between 1989 and 1997 adult obesity increased by 55 percent. From 1997 to 2011 obesity is expected to increase by a further 70 percent. It has also been estimated that by 2011 approximately 29 percent of the adult population may be obese (Ministry of Health, 2002).

Diabetes – A Disease of Inequalities

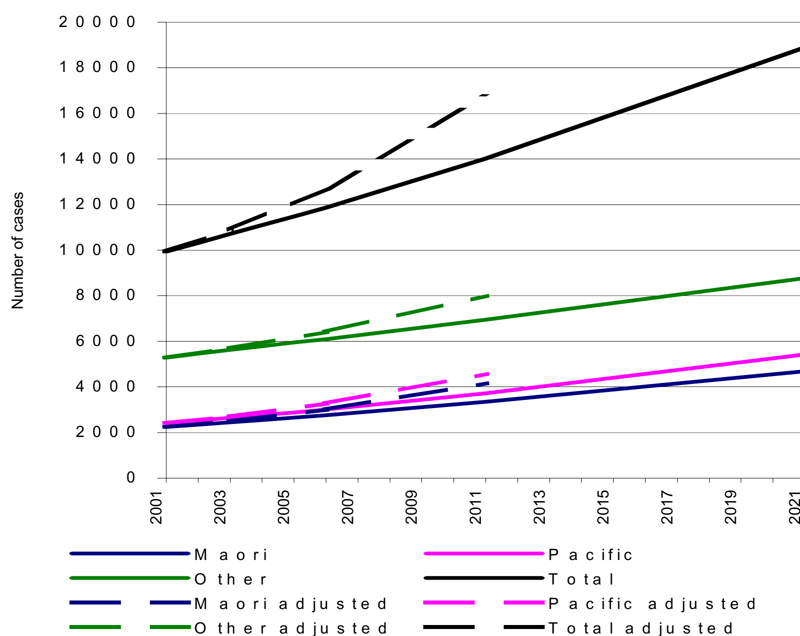
Diabetes is a serious chronic disease that leads to serious complications such as heart disease, kidney failure, stroke, and blindness. People with diabetes have a reduced life expectancy. Currently, one in 12 adults over 45 years in New Zealand have been diagnosed with diabetes.

Diabetes is a disease of inequalities, with Maori and Pacific peoples at greater risk of diabetes than other New Zealanders:

- 21 percent of Maori males over 45 years have diabetes compared to 8.5 percent of non-Maori
- 20 percent of all Maori and 17 percent of all Pacific deaths are due to diabetes – compared to 4 percent of deaths amongst European New Zealanders
- The lifetime risk of being diagnosed for diabetes is one-in-four for Pacific peoples and one-in-three for Maori – compared to one-in-ten for European New Zealanders
- Approximately 8 percent of Maori and Pacific adults have diabetes compared to 3 to 4 percent for European New Zealanders
- Estimates are that from 1996 to 2011 the total number of adults with diabetes in New Zealand will increase by 78 percent, but the relative increase for Maori and Pacific peoples will be 130 to 150 percent (Ministry of Health, 2002).

Diabetes in Counties Manukau

Counties Manukau is experiencing a growing epidemic of Type 2 Diabetes. Currently there are more than 12,000 people in Counties Manukau diagnosed with diabetes. Almost double this number remains undiagnosed. It is estimated that the number of people with diabetes could more than double over the next 20 years, given population growth, the ethnic, youthful and generally low socio-economic make up of our population. In the graphic below the top dotted line shows the expected growth in diabetes if the prevalence of obesity goes on increasing – which is exactly what it is doing.

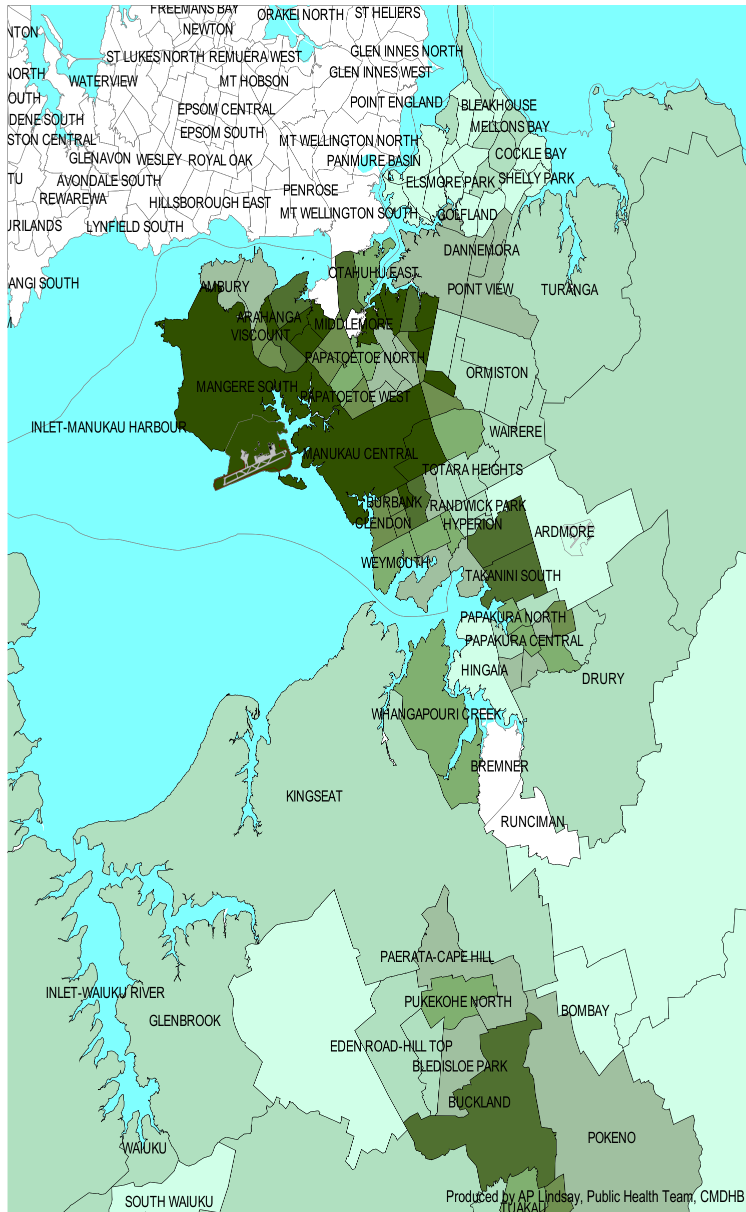


(Lindsay A, 2003)

A disturbing feature of this epidemic is that it is no longer 'contained' to people aged between 40 and 64 years of age. The number of young people being diagnosed with Type 2 diabetes, while still small, is increasing. Children as young as 6 years old are now being diagnosed with Type 2 Diabetes.

Mothers with gestational diabetes or pre-diabetic conditions may be passing on an increased risk of diabetes to the unborn child. With more women in the childbearing age group at risk of diabetes, the risk to future generations is increasing.

People living in low decile areas of Counties Manukau are more likely to suffer from diabetes. The map below shows where these areas are – which are also where there are high rates of diabetes (dark shading).



Rate per 100,000

Based on hospital admission data only, for individual CM residents hospitalised anywhere in New Zealand

- 2,400 to 6,550 (13)
- 2,000 to 2,400 (8)
- 1,600 to 2,000 (12)
- 1,200 to 1,600 (13)
- 800 to 1,200 (21)
- 400 to 800 (33)
- 1 to 400 (25)

(Lindsay A 2003)

The Cost of Diabetes

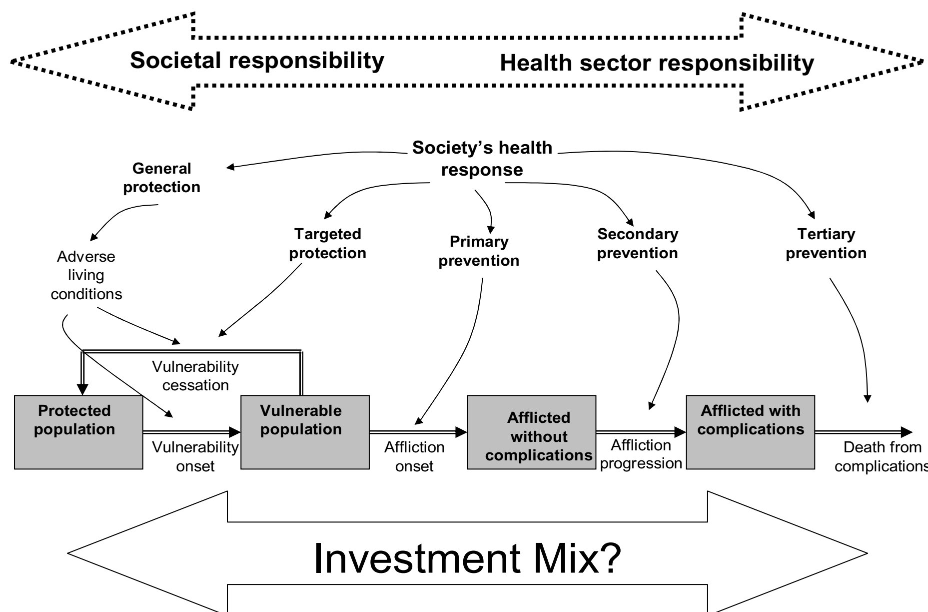
Diabetes is a major driver of health sector costs within both primary and secondary care, with increased cardiovascular disease, kidney disease, stroke, lower limb ulcers and retinal damage. Diabetes has explicit social costs through loss of work and support payments and implicit costs through the impact of chronic disease on family and community life.

Growth in diabetes leads to a huge increase in hospital costs, social support costs and loss of economic contributions. It is estimated that a person with diabetes generates hospital costs on average 2.5 times as much as someone without diabetes – and that the indirect costs are as much again (PriceWaterhouseCoopers, 2001). It is also estimated that as the number of patients with kidney failure grows (primarily due to the increasing number of diabetics and an ageing population), the need for new dialysis stations will grow at a level that within five years, a new satellite clinic with 20 dialysis stations would be required every year to keep up with demand (Ratanjee, 2004).

The cost of diabetes to the family and community is significant and immeasurable. Diabetes robs us of our elders and the cultural richness and wisdom they bring to our society. With the increasing prevalence of diabetes moving down the age-spectrum, it is beginning to rob us of our future.

Whole Society, Whole Life Course, Whole Family Approach

International research and evidence emphatically support a 'whole society, whole life course, whole family' approach to beat diabetes. The graphic below, adapted from a diabetes model developed by the US Centre for Disease Control, shows the challenge for a whole-system strategy.



Adapted from (Homer J 2004)

A life course approach works across all areas from universal protection of the whole population to tertiary prevention for people already with diabetes.

The 'afflicted with complications' area is where most of health expenditure on diabetes occurs at present. A life course approach supports analysis of the whole system, including public health, primary care and hospital services, and encourages explicit thinking about where to invest in the progression of risk and disease.

Investment decisions need to be based on evidence of effectiveness and also on an understanding on how programmes impact on disease progression and health sector costs. For example, reducing complications of someone with advanced diabetes may have an immediate payback in reduced hospital costs, while an investment in targeted protection, like improving the schools environment, might not provide benefits to health system costs for many years, in fact decades but may have a big impact on improved lifelong health for many people.

Let's Beat Diabetes

The approach taken in this plan is that well constructed strategies across the life course should work in synergy. For example, a person with diabetes may be better at self management with a supportive church environment, encouraging social marketing,

a family that understands their problem, healthier food options and a practice team that is proactive and motivational. Schools are more likely to take up a fit and healthy policy if the food industry is supportive, community leaders are backing them, vulnerable families are identified and helped with food choices and support services make it easy for schools to schedule regular physical activity sessions.

Part II

Let's Beat Diabetes

A Five Year Plan to Prevent and Manage Type 2 Diabetes in Counties Manukau

Let's Beat Diabetes

Aim

The aim of the *Let's Beat Diabetes* plan is to stop people getting diabetes, slow the disease progression, and increase the quality of life for people with diabetes.

Strategic Approach

A range of strategies are proposed, guided by the basic concept that a 'whole society, whole life course, whole family/whanau' approach is required to beat diabetes, and that focused effort will need to be sustained over decades.

- *Whole society* – Acknowledgment that we cannot beat diabetes without the motivation and support of the communities, institutions and businesses that make up the social fabric of Counties Manukau.
- *Whole life course* – A focus on supporting health and preventing and managing diabetes at all stages of disease progression.
- *Whole family/whanau* – Acknowledgment that an individual is part of a family/whanau (or household) which has a direct influence on environmental risks, choices and decisions. Wherever possible, working with families is central to the plan.

Guiding Principles

The principles of *Partnership, Participation and Protection* form the constitutional foundations of New Zealand through the Treaty of Waitangi. These principles are also fundamental to the practice of modern public health.

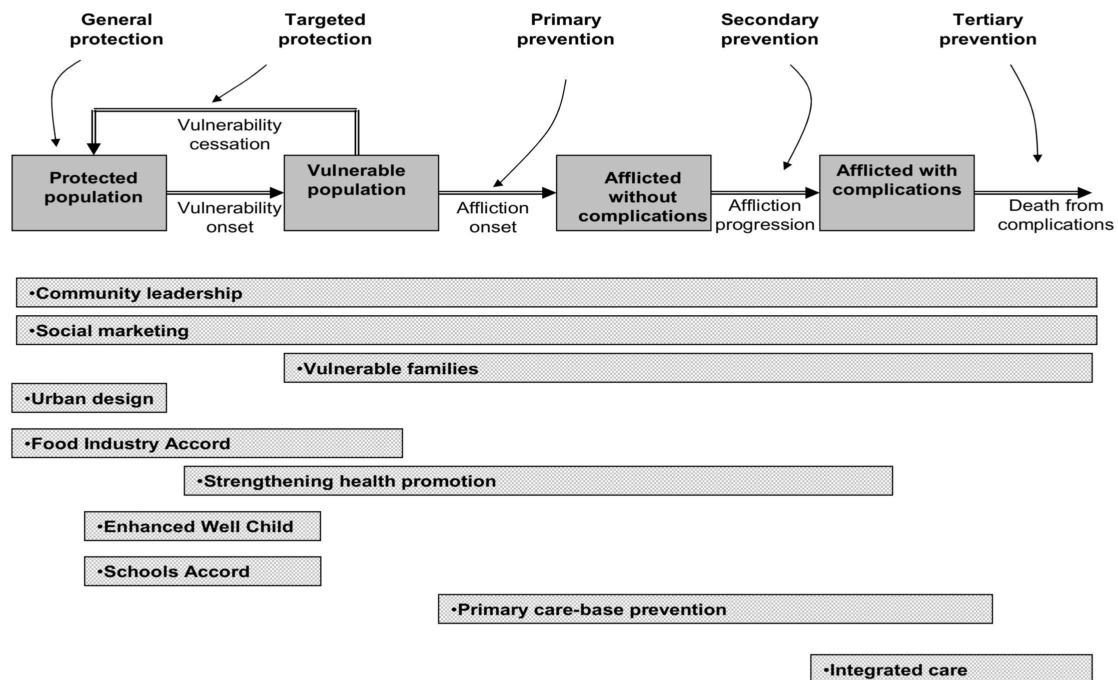
- *Partnership* – Institutions, organisations, communities, families and individuals must work together to beat diabetes. The scale of social response required for diabetes means that formal partnerships based on aligned goals and civic responsibilities will need to be developed and actively sustained.
- *Participation* – The prevention and control of chronic disease is enabled through self management and via the ongoing participation of family, community and health professionals in the lives of people with diabetes. Also, for strategies to be successful, families and communities must be able to participate in service design, development and governance.
- *Protection* – The current diabetes epidemic has been created by a new environment of obesity. The 'obesogenic environment' is a threat to the health and wellbeing of our children and families. There is an obligation on behalf of government, business and community leadership to protect citizens from this environmental hazard.

Ten Action Areas

The *Let's Beat Diabetes* plan is complex and wide ranging. In order for it to be understood by, and motivational to our diverse communities, activity has been set out under ten key action areas. They are as follows:

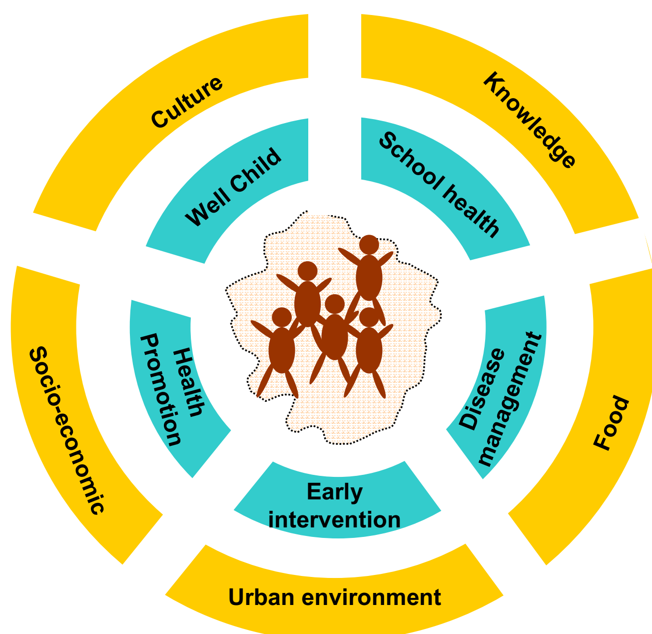
1. Supporting **Community Leadership and Action**
2. Promoting Behaviour Change Through **Social Marketing**
3. Changing **Urban Design** to Support Healthy, Active Lifestyles
4. Supporting a Healthy Environment Through a **Food Industry Accord**
5. Strengthening **Health Promotion** Co-ordination and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

The Ten Action Areas reflect a range of intervention strategies, including general and targeted protection, and primary, secondary and tertiary prevention. They are designed to fit together to form an overall strategy that reduces risk factors for diabetes and slows disease progression, while building capacity in the health sector and a sustainable whole society approach. Graphic 3 below shows the zones each action area is designed to influence.



Another way of looking at the Ten Action Areas is from the perspective of the family. As shown below in Graphic 4, the family is in the centre surrounded by rings of support. The outer ring is that of the social and environmental determinants of health, which affect everyone. The social determinants are the responsibility of society. The inner ring is that of the more direct health environment and services environment. The services environment is mostly about the relationship between individuals (and families) and government funded services. These are the services that the health

sector has more control over. Strength in both circles and strength within the family is required to reduce diabetes risk factors and control disease.



Enablers

The Ten Action Areas describe the content of activities needed to beat diabetes, but there is also a set of support activities that must be managed in order to implement the plan in a sustainable manner. These support areas or 'enablers' are outlined below:

1. *Consumer involvement*

An effective consumer forum needs to be developed, or an existing forum enhanced and actively involved in the development of new programmes and evaluation design.

2. *Maori*

A Maori advisory forum will be developed, or an existing forum enhanced, to ensure all new programmes and evaluation design are culturally responsive to Maori.

3. *Pacific peoples*

A Pacific advisory forum will be developed, or an existing forum enhanced, to ensure all new programmes and evaluation design are culturally responsive to Pacific peoples.

4. *Funding environment*

The funding environment is modified and aligned to support the Ten Action Areas.

5. Learning environment

Evaluation and learning systems are explicitly supported as part of the overall investment.

6. *Sustainable governance*

Governance and leadership for the whole plan and for each of the Ten Action Areas is developed and supported.

7. *Organisational development*

Investment in workforce, particularly in primary care, will be required as will the development of an ongoing centre of excellence for whole system diabetes prevention and management in Counties Manukau.

8. *Information systems*

The many disconnected systems and programmes used for supporting diabetes management need to be brought together over time to align with the whole system approach outlined in the *Let's Beat Diabetes* plan.

Let's Beat Diabetes

Action Areas & Enablers

1. Supporting Community Leadership and Action

Context

The *Let's Beat Diabetes* plan seeks to lay down the foundations for the long term reduction of Type 2 Diabetes in our community. These foundations are built on the understanding that real, sustainable change will require support from our whole society – from individuals, families, organisations, cultures, systems, policies and the myriad dimensions that make up our communities. Creating societal support for change requires a proactive process of developing community leadership. Without community leadership, the *Let's Beat Diabetes* plan will fail. It is individuals, within families, within communities, who make the decisions about their lives. Empowered communities change their environments through action, advocacy, local democracy and consumer choice. Our plan must work with communities in order to succeed.

The call for the community to lead and champion the fight against diabetes has been voiced by Maori and Pacific communities, who are most at risk from the diabetes epidemic. From our workshops, hui and fono on how to this support community leadership and change, a number of core concepts have emerged:

- For Maori, it has been the need to work with the roots of culture and cultural norms in order to change behaviours that are causing diabetes. As one participant put it 'we need to change the lore' as it applies to culture. This means working through traditional cultural institutions such as marae and contemporary institutions like kura kaupapa so tamariki learn and grow up in an environment where healthy eating and active living is the 'lore'.
- For Pacific peoples, it is about rediscovering, strengthening and practising the positive aspects of their cultures and cultural practices around food and physical activity, and exploring opportunities for Pacific churches to be vehicles for physical health promotion.
- The Asian and new settlor community is diverse in its community structures and leadership. Ethnic-specific strategies will be required.
- For the general population, the workplace has emerged as a place where institutions can have a tremendous positive influence on health and where there is great opportunity for improvement.
- The community empowerment model, which seeks to build community connections, strength and self determination, and seeks community-based solutions to problems, has also emerged.

Programme Design

The programme design to support this Action Area is consistent with the community empowerment model:

- The strategies were developed through workshops, hui and fono, and 'by Maori for Maori' and 'by Pacific for Pacific' (please note: priority has been placed on supporting activities for the Maori and Pacific communities, given the heightened risk these communities face from diabetes).
- *Let's Beat Diabetes* will support a broad range of ideas that encourage community empowerment, and utilise the strength of culture and cultural institutions to bring

about change to lifestyles and/or environments which reduce obesity or slow the progression of diabetes.

To facilitate this, Counties Manukau District Health Board (CMDHB) is proposing to set up a Community Action Fund (CAF) to support and assist initiatives that are aligned with the action plan. This funding will be available to a range of community organisations, ccessed via funding proposals.

The programme design also looks to the membership of Tomorrow's Manukau Te Ora O Manukau/Manukau the Healthy City Outcome Group to role model healthy workplace policies. This group is comprised of key central and local government agencies and organisations in the district.

Action Plans

Maori

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

Long-term goals and targets	Actions	Action Leaders
Goal: Tikanga are developed and implemented to reduce at risk diabetes behaviour. **Target: 'Healthy eating active living' are values adopted as an accepted part of custom and practice.**	Whanau, hapu, iwi and Maori communities of interest develop 'healthy eating active living' guidelines in conjunction with health organisations. Resources which convert 'healthy eating active living' rules/ guidelines into practical applicators are developed (e.g. Billy T handbooks). Resources need to be targeted at Maori environment in both languages. 'Healthy eating' Tikanga are developed by Marae, Kohanga Reo and Maori organisations in all sectors. 'Health eating active living' awards are awarded annually at an event to celebrate 'whanau ora' lifestyles.	Whanau, hapu, Iwi, Maori communities of interest (e.g. education providers, sport teams) ARPHS, Maori health providers, health promotion sector Maori organisations, Maori health providers, Maori Health, CMDHB
Goal: To identify opportunities (people and events) within the community to champion Maori approaches to reducing Diabetes. **Target: A calendar of 'Patua i te mate huka' events is adopted each year. Calendar to be developed with the community.**	Wananga Mate Huka are hosted to discuss Maori approaches to beat diabetes, and the kaiwhakahaere (champion) roles to be played by whanau hapu and iwi. The Wananga include Manawhenua, kuia/ kaumatua, consumers, rangatahi, takataapui and other 'at risk' Maori groups. Formal development of kaiwhakahaere roles and responsibilities to drive 'Patua i te mate huka' are undertaken. Relationships with current Maori leaders to promote positive Maori diabetes messages are established. These leaders could include Te Atairangi Kahu, MHAC members, Stacey Jones and Veeshane Armstrong.	CMDHB, Maori health providers, Maori, Maori Health, Manawhenua, Counties Manukau Sport
Goal: Ensure all Maori understand diabetes and the risk behaviours which increase the chances for getting diabetes. **Target: Opportunities are made available for Maori to access health promotion resources and information on diabetes.**	On-going development of health promotion resources are clearly targeted at Maori, across the age spectrum. Recognised training and education packages for delivery to Maori in the community are developed. These training packages are aimed at specific groups, across the age spectrum. A regular timetable of Wananga Whanau Ora for Maori to discuss diabetes is	ARPHS, Maori public health, health promotion sector ARPHS, Maori public health, health promotion sector ARPHS, Maori public health, health

	put together. Where possible these hui will link in with existing hui (e.g. Poukai, Kapa Haka competitions etc). Utilise Maori events calendar to promote key 'health eating active living' messages.	promotion sector
Goal: Make physical activity a fun, natural part of a person's day. **Target: Maori of all ages engage in physical activity as a part of their normal day.**	A survey to identify the range of physical activity activities currently carried out in the Counties Manukau area by Maori is undertaken. Include all forms of activity including dance, elderly walking classes etc.	CMDHB, SPARC, Counties Manukau Sport
	Work with regional and national bodies to identify physical activity initiatives currently under development, for piloting/ launching within the local area. Ensure there is local input to make the initiative Manukau–centric.	CMDHB, SPARC, Counties Manukau sport
	Work with the community to identify natural fit of activities currently offered and community leader(s) for this activity (development process).	CMDHB, Counties Manukau Sport
	Promote the development of fun, community-oriented active living initiatives, to be lead by community (e.g.Take Nan/ Pop for a walk).	Community leaders, CMDHB, Counties Manukau Sport
Goal: Make health eating a fun, natural part of a person's day. **Target: Maori of all ages engage in physical activity as a part of their normal day.**	A survey to identify the range of healthy eating initiatives and resources available in the Counties Manukau area is undertaken. Include areas where Maori communities act en mass (e.g. Secondary schools festival, markets, sports occasions, etc.) This should include what is healthy food, and how do you cook healthy food in a healthy way.	CMDHB, Maori Public Health
	A 'healthy eating' toolkit (rourou) is developed to be used as the basis for education/ health promotion sessions for delivery in all Marae/ Maori organisations in the district.	CMDHB, ARPHS, Maori Public Health Provider
	'Health eating active living' marae awards which acknowledge the work carried out in Marae to change the dietary habits of tangata whenua and their manuhiri are developed.	CMDHB, Maori
Goal: Rangatahi develop a Tikanga/culture where they are able to make informed nutrition and physical activity choices. **Target: Rangatahi are able to define what healthy eating and active living means for them as examples to everyone.**	A rangatahi council to discuss diabetes is convened. Main aim of the forum is to engage Rangatahi into Health forums, with a purpose.	CMDHB, Maori Health
	Work with youth to identify barriers to healthy living and active lifestyles including: Who are their role models? The people you look up to? Who are they more likely to take information on board from? Who will make a difference? What things make it difficult to live healthy, active lifestyles?	CMDHB, Maori Health

	Rangatahi-focused 'healthy eating active living' resources are developed and distributed throughout the community.	Maori public health, health promotion sector

Pacific peoples

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

A Tongan-led diabetes workforce, resourced to work together with the Counties Manukau community to serve our families.
Our aims: (1) Ke haofaki'i hotau ngaahi famili mei he suka and (2) Ke leva'i lelei e suka 'i he famili.

Tamate i te toto vene.

Omai ke kau fakalataha ke tuku hifo e gagao suka ki lalo.

Long-term goals and targets	Actions	Action Leaders
Goal: Leadership **Pacific peoples leadership groups work with the health sector to lead Pacific communities' fight against diabetes.** **Target: Groups established by April 2005.**	Ethnic-specific leadership groups established to lead the Pacific component of the 'Community Leadership and Action' activity area of the *Let's Beat Diabetes* plan. Pacific churches as partners and champions for health promotion will be supported to provide community settings for service provision. Representatives from the ethnic-specific groups appointed to the *Let's Beat Diabetes* Governance Group. The ethnic-specific leadership groups, supported by the health promotion sector, champion, promote and encourage healthy eating and physical activity to their various community groups and organisations. Key groups include: ▪ Churches and church groups ▪ Homes ▪ Early childhood centres and pre-schools ▪ Workplaces ▪ Village meetings ▪ Ex-Students Associations	Pacific communities, CMDHB, ethnic-specific leadership groups, health promotion sector

Goal: Partnerships & Collaboration **Pacific communities, the health sector and other key agencies work effectively together to promote and support health and wellbeing to Pacific communities.** **Target: *Let's Beat Diabetes* plan aligns with the Healthy City Charter**	Specific diabetes prevention objectives included as part of the Tomorrow's Manukau Te Ora O Manukau/Manukau the Healthy City Outcome Group review of the Healthy Cities Charter. Annual action plans developed which focus on diabetes and how every health provider will endorse and implement the identified actions. Database of all providers and groups working in the diabetes field accessible to community groups as a means of networking and developing working partnerships. Pacific providers and partners included in web-based information linked to *Let's Beat Diabetes* website. Protocol for information sharing developed to ensure that both primary and secondary care providers have access to relevant information. Pacific churches and health promotion explore opportunities to work together to promote and deliver health and physical activity programmes to the communities, with the view to becoming a key setting for service provision.	Tomorrow's Manukau Te Ora O Manukau/Manukau the Healthy City Outcome Group, CMDHB, providers
Goal: Education & Empowerment **Pacific communities are knowledgeable and informed about diabetes, its risk factors, how to prevent it, and how to manage it.** **Target: By 2008 a measurable increase in prevention knowledge in children, adults and older adults.**	Community-wide, culturally appropriate diabetes awareness and education programmes facilitated community wide. ▪ Churches and church groups ▪ Homes ▪ Pre-schools and early childhood centres ▪ Workplaces ▪ Village meetings ▪ Ex-Students Associations Ethnic-specific spokespersons work with the health promotion sector and Auckland Public Health Resource Service (ARPHS) to educate and inform	Health promotion sector, ethnic-specific spokespersons, health promotion sector, ARPHS, Ministry of Pacific Islands Affairs (MPIA), Ministry of Health (MoH), Churches, CMDHB, health providers

	Pacific communities on diabetes and on a regular basis via Pacific radio and newspapers. Positive diabetes role models and stories are collated and distributed as part of education and empowerment. Diabetes and diabetes-related information reviewed and translated into the different Pacific languages, and distributed through Pacific networks Ethnic-specific guidelines for managing diabetes for Pacific peoples developed. They include: ▪ A diabetes focused clinic ▪ Health promotion ▪ Training manuals ▪ Recognised training providers Pacific churches and health promotion explore opportunities to work together to promote and deliver health and physical activity programmes to the communities, with the view to becoming a key setting for service provision.	
Goal: Healthy, Active Communities **Pacific communities are healthy, active and vibrant communities.** **Target: By 2008 a measurable increase in healthy eating and active lifestyles by Pacific peoples in Counties Manukau.**	Pacific community organisations and groups work with ARPHS to develop and implement culturally appropriate nutrition guidelines that promote and support healthy eating. These organisations and groups include: ▪ Churches and church groups ▪ Homes ▪ Pre-school and early childhood education centres ▪ Workplaces ▪ Village meetings ▪ Ex-Students Associations Community organisations and groups supported by health promotion sector to develop and implement physical activity programmes that are culturally appropriate and age-specific.	ARPHS, Pacific communities, health promotion sector
Goal: Workforce Development **'By Pacific for Pacific' workforce development. Pacific communities and**	CMDHB supports and resources the development and ongoing development of qualified Pacific workers in the diabetes field, including nurses, doctors,	CMDHB, providers, Manukau Institute of Technology (MIT)

CMDHB work to increase the number of qualified workers in the diabetes field to deliver to Pacific communities. **Target: The number of Pacific nurses, doctors and community workers working in Counties Manukau doubles by 2010.**	dieticians, community workers and other necessary professions.	
Goal: Evaluation **Evaluation identifies successful strategies and supports a learning framework that supports functional and effective partnerships and activities.** **Target: Evaluation framework set up by July 2005**	Pacific communities, Manukau City Council (MCC) and CMDHB work with the School of Population Health (UoA–SoPH) to develop a framework for process and outcomes evaluation of the agreed action plans, with the key objective being to support a learning framework and effective sustainable partnerships.	Pacific communities, MCC, CMDHB, UoA-SoPH

The Workplace

Healthy, Active Workplaces.

Long-term goals and targets	Actions	Action Leaders
Goal: Partnerships **Tomorrow's Manukau/Te Ora O Manukau/Manukau the Healthy City Outcome Group, with support from CMDHB and ARPHS work effectively together to advocate for initiatives within their own workplaces that promote and support healthy, active lifestyles.** **Target: By December 2004 support in principle from Tomorrow's Manukau/Te Ora O Manukau/Manukau the Healthy City Outcome Group.**	Tomorrow's Manukau Te Ora O Manukau/Manukau the Healthy City Outcome Group and ARPHS formally agree to work together to advocate for initiatives within their own workplace that promote and support healthy, active lifestyles.	Tomorrow's Manukau/Te Ora O Manukau/Manukau the Healthy City Outcome Group, CMDHB, ARPHS

Goal: Healthy, Active Workplaces **Tomorrow's Manukau/Te Ora O Manukau/Manukau the Healthy City Outcome Group members implement initiatives within the workplace that promote and support healthy, active lifestyles.** **Target: By July 2005 formal agreement by individual members of Tomorrow's Manukau/Te Ora O Manukau/Manukau the Healthy City to introduce healthy workplace policies, where they do not already exist.**	Tomorrow's Manukau/Te Ora O Manukau/Manukau the Healthy City Outcome Group, with support from CMDHB and ARPHS work together to introduce initiatives within their own workplaces that promote and support healthy, active lifestyles. This initiative is rolled out to similar intersectoral working groups in the Papakura and Franklin Districts, and all central and local government agencies in Counties Manukau. In collaboration with the Food industry Accord Action Area, the food industry is encouraged and supported to introduce healthy eating active living policies into its workplaces.	Tomorrow's Manukau Te Ora O Manukau/Manukau the Healthy City Outcome Group, ARPHS
Goal: Evaluation **Evaluation of the activity will be undertaken with the objective of identifying successful healthy workplace practices and supporting learning across organisations.** **Target: By July 2005 an evaluation framework is in place which will support process and outcome evaluation.**	Tomorrow's Manukau/Te Ora O Manukau/Manukau the Healthy City Outcome Group, CMDHB and APHRS, works with the University of Auckland School of Population Health (UoA – SoPH) to develop a framework for process and outcomes evaluation of the agreed action plans, with the objective of support a learning framework and an effective sustainable partnership.	Tomorrow's Manukau/Te Ora O Manukau/Manukau the Healthy City Outcome Group, CMDHB, ARPHS, UoA-SoPH

2. Promoting Behaviour Change Through Social Marketing

Context

Beating obesity and diabetes will require a change in norms – of government, industry, community, family and individuals. Changing norms means changing environments and behaviour. The scale of change required will not occur without a substantial investment in the information and knowledge environment for all people in Counties Manukau.

Effective social marketing involves consistent messages reinforced in different ways and received from multiple trusted sources. In Counties Manukau that could mean messages from sources such as kaumatua, church leaders, doctors, health workers, the local council and the media. The changes being promoted must also be relevant, practical, and achievable and deliver value when accomplished.

New Zealand experience shows that well constructed social marketing programmes are an effective and critical part of broad public health programmes. Examples include the stop smoking campaigns, seatbelts, drink driving, and mental health destigmatisation. However, the obesity and diabetes message is far more complex than these examples, and the difficulties are amplified by those most at risk being hard to reach through traditional social marketing avenues. The social marketing strategy for *Let's Beat Diabetes* will need to recognise these complexities and need to have suitable messages for different audiences and communities of interest. Ongoing evaluation of social marketing is required to assess whether it is being effective in changing knowledge, attitudes and behaviour.

A number of organisations have indicated their interest in supporting a broader social marketing strategy, including Manukau City Council (MCC) and the Food Group. There are also existing social marketing programmes by Sport and Recreation New Zealand (SPARC), the Heart Foundation and the Auckland Regional Public Health Service (ARPHS) which support healthy eating and/or active living. A marketing strategy to support the national *Healthy Eating Healthy Action Framework* is also being developed. It is prudent that Counties Manukau's *Let's Beat Diabetes* plan's social marketing programme aligns with existing programmes.

Marketing is not just about selling an idea or service, effective marketing is based on developing an intimate understanding of and relationship with, the customer so that the design of products and services meet customer needs and wants – and deliver value.

Programme Design

The social marketing programme design has a number of components to it:

1. *The branding*: The publicising and positioning the *Let's Beat Diabetes* plan itself. The plan must develop a profile and be understood by community and health sector leaders. We can not expect a broader audience to understand the detail of the plan, but the core concepts and key action strands should be known. The plan also needs to develop an emotional response and to represent hope and the 'can-do' Counties Manukau attitude. In response to these needs, it is proposed to develop an identity and profile for the plan that resonates with the Counties Manukau community.

2. *The social marketing programme:* A comprehensive and integrated programme that runs for five years with the objective of changing knowledge, attitudes and behaviour towards nutrition and physical activity.

The plan will require support from market research to better understand the profile and issues for the Counties Manukau population. A professionally designed and executed marketing/information strategy will developed with alignment to activity by Health Promotion, Primary Care-based Prevention, Schools, Well Child and support from other sectors such as industry and local government.

A programme of evaluation is required to identify the impact of the strategy and provide direction for future developments.

The social marketing strategy must also fulfil the function of understanding the needs and wants of the people of Counties Manukau so that substantive issues such as health service design and access can be based on what the people want. This feedback process will guide service developments across all action areas of the *Let's Beat Diabetes* plan.

Action Plan

A whole system communications programme changes people's behaviour.

Long-term goals and targets	Actions	Action Leader
Goal: The *Let's Beat Diabetes* plan becomes a motivational call to action for communities and organisations in Counties Manukau. **Target: February – July 2005 the plan is marketed across our communities.**	An identity and marketing plan for the *Let's Beat Diabetes* plan itself is developed and implemented. Summary versions of the plan are developed and distributed, along with presentations and supportive media to develop good understanding and support for the plan from leaders inside Counties Manukau and at a national level. The plan identity and presentation must be relevant to and motivational for Maori and Pacific peoples.	Counties Manukau District Health Board (CMDHB)
Goal: A well developed social marketing strategy is sustained over five years and integrated with wider plan objectives. **Knowledge, attitudes and behaviour changes as a result of a five-year comprehensive social marketing programme.** **Targets: Second half 2005 the media aspect of the social marketing programme begins.** **Measurable change in knowledge attitudes and behaviour (actual measures yet to be developed).**	A governance group is set up to guide the development of a social marketing programme that is linked with the broader strategies of *the Let's Beat Diabetes* plan, is responsive to needs of Maori and Pacific peoples and aligns with the national *Healthy Eating Healthy Action* strategies. The governance group develops a commercial relationship with survey/evaluation and communication professionals to devise, develop, implement and evaluate a comprehensive five-year social marketing strategy. The strategy includes the following components: ▪ Surveys to create a baseline and to inform the development of a five year social marketing strategy. ▪ Strategy implemented with support from multiple organisations and which is integrated with other components of the broader plan. ▪ Ongoing evaluation undertaken to inform and improve programme design.	CMDHB, MCC, Ministry of Health (MoH), SPARC, PHARMAC, Food group, Primary Health Organisations (PHOs), Non-Government Organisations (NGOs)
Goal: Health services improve their performance through having better knowledge of patient needs and issues. **Target: By October 2006 initial survey completed.**	Survey on social marketing issues also seek an understanding of wider health service issues and are used to inform decisions on service design across the Ten Action areas of the *Let's Beat Diabetes* plan.	Social marketing provider, CMDHB

3. Changing Urban Design to Support Healthy, Active Lifestyles

Context

Urban design influences the physical environment (such as road and parks), the service environment (such as shops and public transport) and the social environment (such as social cohesion and community safety) (Kawachi I, 2003). Urban environments also impact on our lifestyle choices and decisions, and subsequently our health and risk of disease. A key issue for the health sector is to ensure urban design in Counties Manukau encourages and supports physical activity, and provides access to medical facilities.

In recent decades, the predominant urban residential design globally, as well as in Counties Manukau has been towards suburban, car-based living. This suburban lifestyle brought larger sections and low density living which has been considered desirable. There have also been downsides with traffic jams, social isolation, poor public transport, community safety concerns, poor access to many service amenities (except by car) and less opportunity for daily physical activity.

There is good evidence to show that good urban design can increase physical activity. Germany and the Netherlands have implemented a wide range of policies over the past two decades that have simultaneously encouraged walking and cycling while dramatically lowering pedestrian and bicyclist fatalities and injuries and keeping auto use at only half the American level (Pucher J, 2003). Urban environments also impact on community life, which influences perceptions of safety, leading to concerns over children walking to school or walking and jogging for exercise.

Changing urban design is difficult because of the expensive and permanent nature of basic infrastructure. It is also very slow.

A number of initiatives are already under way. Manukau City Council (MCC) and other stakeholders are supportive of the priorities identified in the Auckland Regional Growth Strategy and the Urban Design Protocols which will address active transport provision, injury prevention measures and availability of public transport in city and urban design. Healthy urban design concepts also encourage 'liveable cities that support social wellbeing, quality of life and cultural identities', which is one of the key government outcomes in the sustainable cities component of the national Sustainable Development Programme of Action. Manukau City along with Infrastructure Auckland has invested in the development of cycle-ways across the district as part of the cycling/walking strategy.

Programme Design

MCC is demonstrating healthy urban design concepts in the Flat Bush development. Flat Bush will be a new town of more than 40,000 people. The development will not be another sprawling suburb, but is being designed to be a 'town', with a town centre, extensive parkland, cycle ways, local shopping centres and green fingers of protected stream-ways running through the residential areas. MCC also intends to introduce urban design concepts that support more active, connected and healthy communities as it redevelops the various urban hubs and town centres in the district. Introducing these new concepts in the urban hubs represents new

design priorities for MCC and reflects their commitments to healthy city and sustainable city ideals.

CMDHB and Auckland Regional Public Health Service (ARPHS) will work in partnership with MCC, providing health advice and expertise, where required for urban design planning.

Action Plan

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

Long-term goals and targets	Actions	Action Leader
Goal: Sustainable approaches to supporting healthy urban design are developed and implemented in partnership with Manukau City Council (MCC), Papakura District Council (PDC) and Franklin Distrcit Council (FDC). **Target: By 2005 CMDHB and MCC sign the Ministry for the Environment sponsored Urban Design protocol, which is a component of the Sustainable Cities national strategic initiative.**	MCC and CMDHB sign the Ministry for the Environment sponsored urban design protocol, which is component of the Sustainable Cities initiative. CMDHB supports MCC, FDC and PDC in analysis and planning processes to implement urban design which promotes healthy lifestyles and accessible health services.	MCC, CMDHB, ARPHS, PDC, FDC
Goal: Flat Bush development with improved healthy design concepts contributes to increased physical activity of residents. **Target Enhanced safe walking and cycling opportunities are introduced into Flat Bush development.**	MCC develops overall design concepts and provides public amenities which support healthy urban design in Flat Bush. MCC develops specifications for private developers which ensure that the healthy urban design concepts are taken up in commercial developments throughout the Flat Bush area. CMDHB provides MCC, PDC and FDC with a review of the international literature as it relates to healthy urban environments. CMDHB works with MCC to develop a plan for the health facility and service infrastructure for the Flat Bush development.	MCC, ARPHS, CMDHB, PDC, FDC
Goal: Increased physical activity levels and social cohesion are supported by the redevelopment of existing urban hubs and town centres. **Target: Detailed review and redevelopment plans for at least one urban hub in a low socio-**	As Councils undertake redevelopment activities for existing urban infrastructure, the approach will be guided by new priorities for urban designs which increase physical activity and social cohesion. CMDHB will advocate to MCC, PDC and FDC on a case by case basis to provide evidence and analysis that will support healthy urban design, which includes adequate and accessible community health	MCC, FDC, PDC, CMDHB, ARPHS

economic area.	facilities, public open space and community facilities, safety and increased opportunities for physical activity.	
Goal: MCC and CMDHB support healthy urban design through planning, implementation and evaluation partnerships in Flat Bush development. **Target: By July 2005 there is agreement for evaluation for the Flat Bush development with the University of Auckland School of Population Health (UoA-SoPH)**	CMDHB, MCC and the University of Auckland School of Population Health (UoA–SoPH) work to develop an evaluation framework for the Flat Bush development and ongoing urban redesign initiatives.	MCC, FDC, PDC, CMDHB, ARPHS, UoA SoPH

4. Supporting a Healthy Environment Through a Food Industry Accord

Context

Changes to the food environment have been a major contributor to the current obesity epidemic (Critser G, 2003) The food environment during pregnancy, childhood, adolescence and adult life all contributes to health and can cause disease. The food environment also amplifies the issues of disparity in diabetes rates in our society. Generally, people who have high incomes eat food that is higher in nutrients and lower in fats and carbohydrates. People who have low incomes tend to eat low-cost high-fat/high-sugar/high-salt take-away foods more often than is considered 'healthy'. Children from families with lower incomes are also less likely to eat a proper breakfast at home and a nutritious lunch at school (FAO/WHO Expert Consultation, 2003; Barnfather D, 2004; Ministry of Health, 2003).

The current 'obesogenic' food environment is a global issue, with governments from many countries and international agencies like the World Health Organisation looking at how to make changes to protect populations from poor diets. Strategies being investigated include regulation of aspects of food industry behaviour and more collaborative approaches with industry seeking voluntary changes to commercial behaviour.

Industry itself has identified that its customers are seeking healthier food and that there is an obligation for responsible corporates to work with health agencies to develop an overall healthier food environment to reduce population obesity and subsequent disease.

Representatives of major food producers and retailers in New Zealand signed the Food Industry Accord in September 2004, which commits the signatories to supporting the Ministry of Health's *Healthy Eating Healthy Action Framework*, and recommends that a pilot of the Accord's activities is instigated in the Auckland Region (New Zealand Food Industry Accord 2004). Counties Manukau Distrcit Health Board (CMDHB) and representatives of the food industry have agreed to collaborate to undertake a 'demonstration pilot' of the Food Industry Accord in Counties Manukau.

Programme Design

The Counties Manukau food industry 'demonstration pilot' represents a number of major food organisations working together with the health sector for a common health objective.

The initial component of programme design is to develop a set of trusting and functional relationships, which acknowledge the unique nature of the collaboration and identify ways to deliver real improvements to the food environment.

A collaborative working group will be set up which includes representatives from industry, CMDHB, the Auckland Regional Public Health Service (ARPHS) and Manukau City Council (MCC) in the first instance. Others groups may join at a later date.

The food industry has identified a number of Action Areas it is interested in supporting, namely: Community Leadership and Action; Social Marketing; Food Accord; Schools; and Vulnerable Families

Specific practical activities will be developed in each of these areas. As the relationships and programmes mature, it would be expected that a wider range of food industry partners would join the collaborative group.

It is proposed that the food industry group be represented on the wider governance group for the *Let's Beat Diabetes* plan.

Evaluation of the strategies will need to be undertaken for process and outcomes to ensure that all parties are informed of performance and value issues associated with the collaboration. The objective is to develop a learning environment which supports continuous quality improvement methodology and measures the effectiveness of this new partnership.

Action Plan

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

Long-term goals and targets	Actions	Action Leader
Goal: The food industry and communities of interest work effectively together to design and deliver obesity-reducing strategies. **Target: By 2007 the Food Group will have shown that effective collaborative activities can occur and other District Health Boards will seek to join the Food Industry Accord initiatives.**	CMDHB, ARPHS, MCC and the Food Group form a working group that will lead the 'Food Industry' activity area of *the Let's Beat Diabetes* plan. Food industry representation is included on the *Let's Beat Diabetes* Governance Group.	CMDHB, Food Group, ARPHS, MCC
Goal: The average per capita energy intake of the Counties Manukau population decreases as a result of the Food Industry Accord initiatives. **Target: By July 2005 specific strategies to be developed in each of the five identified action areas (target to be updated at that stage).**	The food working group implements practical strategies in the areas of: ▪ Community Leadership ▪ Social Marketing ▪ Food Accord ▪ Schools ▪ Vulnerable Families These strategies are to be developed and implemented in a collaborative manner. At the time of writing the development of the specific strategies is at a very early stage and will be completed during the first six months of 2005.	Food Group, MCC, CMDHB, ARPHS,
Goal: Evaluation of the food industry relationship and activity develops and environment of trust and ongoing evidence-based activities to improve the food environment. **Target: By July 2005 an evaluation framework is in place which will support process and outcome evaluation.**	The food working group works with the University of Auckland School of Population Health (UoA – SoPH) to develop a framework for process and outcome evaluation of the agreed action plans with the objective of supporting a learning framework and an effective sustainable relationship.	CMDHB, Food Group, UoA - SoPH

5. Strengthening Health Promotion Co-ordination and Activity

Context

Health promotion in Counties Manukau is a small sector with many providers and multiple funders. The diversity of providers is a strength, with organisations establishing strong relationships with their local communities to deliver well targeted programmes. Many providers deliver population based services as well as personal health services such as health education.

The health promotion environment is also somewhat fragmented, with low levels of communication between funders leading to poor alignment of funding streams and strategic objectives. Health promotion funders include Ministry of Health (MoH), Counties Manukau District Health Board (CMDHB), Manukau City Council (MCC) and Primary Health Organisations (PHOs). Providers operate in an environment where there is often limited knowledge of each other's activities and there is not a long term view about capacity development across the sector.

There is a history of broad collaboration associated with Te Ora O Manukau/Manukau the Health City and more recently the Tomorrow's Manukau Health and Wellbeing Outcome Group, which provides an umbrella forum for health and social service organisations. At a more specific level, CODA (Community Organisations working together) has acted as a network for health promotion organisations with an interest in diabetes.

Recently PHOs have begun to receive funding for health promotion and the Counties Manukau PHOs have agreed to a charter that will see coordination of health promotion activity across PHOs.

Maori and Pacific communities would like to see the strengthening of health promotion providers and programmes that work within a cultural framework of 'by Maori for Maori' and 'by Pacific for Pacific'. The Pacific communities also support ethnic-specific programmes within the broader Pacific community, especially church-based programmes.

The development of effective health promotion programmes for Asian and new settler communities is a challenge given the range of languages, cultures and community structures health promoters must work within.

The overall health sector expenditure in health promotion is low despite good evidence from multiple sources that investment in effective health promotion delivers good returns compared to other parts of the health sector.

Programme Design

The programme design is a direct response to the issues raised by health promotion providers and community leaders at a series of workshops, hui and fono held in Counties Manukau. They include:

- *Funder Alignment:* the need to ensure there is communication and strategic alignment between funders as it applies to programme priorities and design, and also to long-term views about building the capacity of the health promotion sector.

- *Workforce Capacity*: the need to identify the workforce development requirements for health promotion providers, and put in place a sustainable system to develop a new heath promotion workforce and grow the skills in the existing workforce.
- *Communications & Resources:* the need to review the quality, accessibility and suitability of resources being used by health promotion providers as they relate to diabetes prevention and management; and to develop new resources as required, and ensure all providers are aware of existing resources.
- *Networking & Aligned Activity:* the need to develop an effective process for networking health promotion providers so there is a forum for raising and resolving common issues, aligning programmes and communicating with one voice to funders. It is important to maintain communication between the PHO services and other health promotion providers.

Health promotion needs to fulfill a role of being the glue that holds many parts of the plan together, which can only be achieved through improved provider capacity and whole system coordination. *Let's Beat Diabetes* will strengthen health promotion providers, support existing partnerships and create new ones to encourage more effective cross sector activity.

The sector acknowledges that all actions must be culturally responsive to the needs and aspirations of Maori, Pacific peoples, Asians and other ethnic groups. To this end ethnic groups and communities of interest will be involved in all aspects of design, development, implementation and evaluation, including strengthening of programmes that work within a cultural framework of 'by Maori for Maori' and 'by Pacific for Pacific'.

Action Plan

A vibrant, skilled and co-operative health promotion sector that works effectively with all groups and in all settings to reduce the incidence and impact of diabetes and health inequalities.

All actions must be culturally responsive to the needs and aspirations of Maori, Pacific peoples, Asians and other ethnic groups. To this end, Maori, Pacific peoples, Asians and other ethnics groups will be involved in all facets of design, development and implementation.

Long-term goals and targets	Actions	Action Leaders
Goal: Funder Alignment		
A more productive and sustainable environment for effective health promotion is created through better collaboration between funding agencies.	Health Promotion funders and other relevant organisations meet at least twice a year as a group to discuss issues, performance, strategies, programme design and funding allocations in order to develop an aligned and efficient funding framework for all health promotion providers in Counties Manukau.	CMDHB, MoH, SPARC, MCC, PHOs
Target: Funder agreement on *Let's Beat diabetes* funding initiatives for health promotion by May 2005.	CMDHB develops its funding strategies for *Let's Beat Diabetes* in collaboration with other funders to identify synergies, reduce overlap and ensure funds are used efficiently.	
	A cross funder plan is developed for *Let's Beat Diabetes* that includes budgets and service objectives.	
Goal: Partnerships		
CODA and the PHO Health Promotion Working Group work effectively together to oversee to implementation of this plan of action in collaboration with MCC and Tomorrow's Manukau/Te Ora O Manukau/Manukau the Healthy City Outcome Group.	The CODA health promotion forum and PHO HPWG work together to oversee the successful implementation of this plan of action, in collaboration with Tomorrow's Manukau/Te Ora O Manukau/Manukau the Healthy City Outcome Group,	Diabetes Projects Trust, CODA, PHO HPWG, Tomorrow's Manukau/Te Ora O Manukau/Manukau the Healthy City Outcome Group, ARPHS
	CMDHB explores opportunities for a health promotion provider to take a more active role to support the networking and administration required for the partnership approach and the capacity building aspects of the plan.	CMDHB
Target: Contract to support health promotion capacity in place by June 2005.	A representative from the health promotion partnership group sits on the *Let's Beat Diabetes* Governance Group.	
Goal: Workforce Capacity		
Health Promotion workforce is diverse and highly skilled, and provides effective,	Consultation and needs assessment – identify a number of roles that people perform in health promotion and establish what type of skills these roles need and	Diabetes Projects Trust, CODA, PHO HPWG, Tomorrow's Manukau/Te Ora O

culturally responsive health promotion to people from all ethnic groups. **Target: Contract to support health promotion capacity in place by June 2005.**	whether people have or can easily gain these skills. Curriculum – identify or develop a curriculum for each of these roles. Training – source training for each of these roles including training that allows people to move between roles of different skill levels and training to maintain skills. Advocate to ensure that funding is available for people to attend training. Develop existing health promotion education programmes to accommodate *Let's Beat Diabetes* workforce competencies. Recognition – ensure that people who undertake training receive recognition of this training from employers such as DHBs, PHOs and NGOs Specialist skills – recognise that most organisations will not be able to employ people with all specialist skills. Ensure people with special skills are known about and available to provide advice. Specialist skills may include cultural skills for working with Maori, Pacific peoples and other ethnic groups, evaluation, IT, and media skills etc.	Manukau/Manukau the Healthy City Outcome Group, ARPHS, CMDHB
Goal: Networking & Alignment **Health Promotion environment and activity is co-ordinated and focused, working towards a shared vision.** **Target: Contract to support health promotion capacity in place by June 2005.**	Website – develop and maintain a website where groups can share information on activities and events, training opportunities, human and physical resources, research information etc. Link to Tomorrow's Manukau and other agencies web sites where appropriate. Meetings – establish a minimum number of forums that meet the needs of organisations (quality forums, information sharing) working in the field and ensure that they are run effectively and their decisions are disseminated to all interested parties. Building trust between organisations – foster co-operation between organisations by ensuring individuals can meet and work together and developing a set of mutually agreed ground rules. Key coordinators – identify a number of individuals who can act as key people for holding and sharing information in specific topic areas (e.g. schools/youth, Marae, physical activity, GP, etc).	Diabetes Projects Trust, CODA, PHO HPWG, Tomorrow's Manukau/Te Ora O Manukau/Manukau the Healthy City Outcome Group, ARPHS, Health providers, CMDHB

Goal: Communication & Resources		
Key messages around diabetes prevention to be evidence based and effectively and consistently disseminated. **Target**: **Contract to support health promotion capacity in place by June 2005.**	Key messages – develop a group that can identify and update key messages for diabetes related health promotion for the region. Ensure that these messages are disseminated to those who will use them. Resources – identify or fund and develop a range of appropriate (preferably locally developed or evaluated) resources that include the key messages. Ensure these resources are used by effective dissemination and having a register of resources. Other sectors – ensure that the strategies and activity of the health promotion sector is communicated to other areas of the health sector (primary and secondary care) and other relevant sectors through key identified contacts.	CMDHB, Specialists, PHOs, Non-Government Organisations (NGOs), MoH, CODA, ARPHS, Diabetes Auckland

6. Enhancing Well Child Services to Reduce Childhood Obesity

Context

'*A life-course perspective is essential for the prevention and control of non-communicable diseases. This approach starts with maternal health and prenatal nutrition, pregnancy outcomes, exclusive breastfeeding for six months, and child and adolescent health; reaches children at schools, adults at worksites and other settings, and the elderly; and encourages a healthy diet and regular physical activity from youth into old age*' (WHO, 2004).

The World Health Organisation's (WHO) *Global Strategy on Diet, Physical Activity and Health* acknowledges the importance of a life course approach in beating chronic diseases like diabetes. A life course approach starts with maternal health and the critical early years of life. An increasing body of evidence now supports the impact maternal nutrition and child nutrition and physical activity have on a person's health throughout life (Barnfather D, 2004).

The importance of the health of our young children has been echoed in hui and fono undertaken as part of the *Let's Beat Diabetes* planning process. Maori and Pacific peoples have given clear guidance that the strategy must focus strongly on the new generation and place more effort on protecting children from obesity and subsequent disease. Recent statistics show that 31 percent of New Zealand children are overweight or obese; 62 percent of Pacific children overweight or obese; and 41 percent of Maori children overweight or obese. Childhood obesity can lead to early onset of diabetes and is a strong predictor of adult obesity.

While international and local communities call for health services to address chronic disease throughout the life course, there is little national policy or service provision targeting good nutrition and physical activity in the early years - breastfeeding being the exception. There is also a need to improve identification and management of gestational diabetes.

The *Let's Beat Diabetes* consultation process has also identified community concerns about how best to support 'at-risk' families. Many of these families have multiple problems, and providing appropriate nutrition for their children is beyond their reach. Health services on their own are limited in what they can do to support children in situations where the family is dysfunctional or has very limited resources.

Programme Design

The objective of this action area is to develop an environment in which parents have the knowledge and opportunity to provide appropriate nutrition and physical activity for their young children. There is an opportunity to enhance the current maternity and Well Child frameworks to support a life course approach to diabetes prevention. There is also an opportunity to forge new partnerships with the Ministry of Social Development to better identify and support vulnerable families.

To achieve the desired changes in service provision, it is proposed that a district-wide national pilot programme is developed which, due to its broad and cross-sectoral implications, includes the Ministry of Health (MoH), Ministry of Social Development (MSD), Counties Manukau District Health Board (CMDHB) and service providers in the

planning and development phases. The pilot would seek to achieve four key outcomes:

- Enhancement of Maternity and Well Child frameworks to facilitate greater family uptake of appropriate nutrition and physical activity in the early years, and throughout childhood.
- Improved capabilities of Well Child services to assess children with developing obesity risks, and provide more intensive support or referral were required.
- Develop a cross-sectoral approach to identification of, and support for, vulnerable families. Increase the ability of maternity and Well Child providers to identify vulnerable families and refer for support services.
- Develop a broader strategic framework for reducing childhood obesity, which may include an extension of Well Child support systems into the school environment.

Implementation of the proposed service enhancements would not take place until the roll out of the current update to the Well Child service framework is completed, which is expected in late 2005. Implementation of the enhanced Well Child framework may require greater CMDHB control over the Well Child funding stream than is currently the case.

Action Plan

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

Long-term goals and targets	Actions	Action Leader
Goal: Sustainable structures are set up to support new early year's services. **Target: By 2005 agreement for detailed pilot structure and outcomes.**	Develop an agreement between CMDHB, MoH, and MSD to trial enhanced Maternity and Well Child frameworks in Counties Manukau in a district-level pilot. Develop a governance structure for the pilot programme.	CMDHB, MoH, MSD
Goal: Obesity in young children reduces due to improved nutrition and physical activity. **Target: By 2006 enhanced education operational.** **By 2010 the rise in child obesity will have stopped.**	Develop a set of learning objectives and a curriculum to cover both antenatal and early years activities that goes beyond the current support for breast feeding. Curriculum covers knowledge and behaviour change techniques to support changed attitudes to childhood obesity. Introduce the learning objectives and curriculum into the service specifications of maternity and Well Child providers. Develop supporting resources. Train service providers in the new curriculum and deliver enhanced services.	CMDHB, Well Child providers, Manukau Institute of Technology (MIT), MoH
Goal: Vulnerable families will be able to bring up healthy children. **Target: By 2006 new referral mechanisms in place.**	Support training and development processes to enable maternity and Well Child providers to accurately assess and identify families in vulnerable situations, who are unable to provide an appropriate nutrition environment for their children. Develop explicit processes for maternity and Well Child providers to refer vulnerable families to MSD-linked services for support and recovery. Maintain collaborative health/welfare support for family resiliency and Child Health outcomes.	CMDHB, Well Child providers, MIT, MoH
Goal: Child obesity is identified and responded to in an evidence-based manner. **Target: All obese children pre five are identified and parents provided with advice on appropriate response.**	Support training and development processes to enable Well Child providers to accurately assess and identify children at risk of obesity or who are already obese and whose health may be compromised. Develop specialist support and referral services to enable Well Child providers to provide more intensive support for high risk children and referral to specialist services if necessary.	CMDHB, Well Child providers, MIT, MoH
Goal: Service continuity is developed	Develop a more strategic conceptual view of Well Child services for Counties	CMDHB, MoH, MSD, Ministry of

between Well Child and 'healthy school' services. **Target: By July 2005 scoping review complete with recommendations for further action.**	Manukau in the future, which sees the structured process of Well Child activity flow through into primary school Health Promoting Schools frameworks and on into a Well Teen concept that could emerge from the current Year 9 assessments and 'Nutrition Exercise and Weight' programme within the Aim Hi cluster of low decile secondary schools. This more strategic view of a 'Well Child to Well Teen' framework could be developed as a pilot in partnership with the Ministry of Education and MSD to meet the policy objectives of health, welfare and education.	Education
Goal: A continuous learning and quality improvement environment encourage improved provider effectiveness. **Target: Evaluation framework developed by July 2005.**	Work with the University of Auckland School of Population Health (UoA-SoPH) to develop a framework for evaluation of the Well Child initiative. Ongoing process and outcome evaluation undertaken, designed to foster quality improvement cycles.	UoA-SOPH, CMDHB, Well Child providers, MIT, MoH

7. Developing a Schools Accord to Ensure Children Are 'Fit, Healthy and Ready to Learn'

Context

The school environment is important for the health of our growing children. Children spend up to thirteen years in school. What they learn during these formative years will influence their choices and decisions in later life. Also, the nutrition and physical activity environment at school directly affects children's health and predisposition for chronic diseases, like diabetes, later in life. Children's levels of physical activity during school years are dropping and children are eating more energy dense foods, leading to obesity (Barnfather D, 2004). In 2002, 30 percent of all New Zealand children were overweight or obese. A recent survey of Year 9 pupils in AIMHI secondary schools in Counties Manukau showed that in excess of 30 percent are already obese.

Many schools within Counties Manukau have challenging educational environments and relatively low levels of financial support from their communities. Schools are under pressure to meet academic outcomes. A number of observers have noted that schools place less emphasis on physical activity now than they have in the past in order to devote more time to academic learning.

The benefits of improving the health environment in schools are not only health-related. There is an emerging body of evidence linking physical activity and good nutrition with educational attainment, the most recent being *The Learning Connection: The Value of Improving Nutrition and Physical Activity in Our Schools* report. The report documents that the rise in poor nutrition and inactivity is adversely affecting academic achievement and increasing financial pressures on schools. It is in the school's interest to support a health promoting environment.

The importance of health in schools has recently been noted by a new Government policy that primary schools will be expected to provide students with one hour of physical activity a week.

Many schools will require increased levels of support if they are to reorient themselves to address the obesity epidemic and actively create healthy environments, including skills, programmes, resources and community support. Many schools have said they prefer to operate comprehensive or integrated programmes which have a whole-school approach, reflect each school's unique situation and look at student health in a holistic manner.

Currently there are a number of organisations and providers that support healthy schools but in general they work in only a small number of schools and lack sector-wide coordination or long term goals. There are a number of advice-only programmes, where-as schools have indicated they want on-the-ground practical help. The KidsFirst public nursing service is one of the few health-based services delivered across all primary schools. A comprehensive approach to school health is being supported in a small number of high needs secondary schools through the Nutrition Exercise and Weight (NEW) programme.

Despite the issues with fragmented providers, there is a platform of skills and programmes that can grow to provide more substantial support for schools. Primary Health Organisation (PHO)-based health promotion services have recognised that they may have a role in the schools environment. The Food Group has indicated its interest

in activities associated with the schools environment. Schools themselves are taking a stronger interest in their health promoting role.

Consistent approaches to achieving best practice in schools are required, as well as better feedback on which programmes are achieving the desired outcomes.

Programme Design

The fundamental requirement of programme design is to create a vision and a framework that enables schools and service providers to work in a more coordinated and effective way. The programme design seeks to develop a collaborative approach that includes teachers, principals, trustees and the health and physical activity sectors. A sustainable governance structure is required that can provide a direction that all parties own.

A set of realistic goals need to be developed that contribute to reducing the obesity epidemic but are also achievable. Some proposed goals are outlined in this paper. A number of these actions can be started immediately with existing services and resources.

In order to achieve a far reaching change in school environments the existing level of support and general activity may not be enough. A more thorough review of the programmes and resources required to achieve the fit and healthy schools goals may be needed.

Existing service providers should be encouraged and supported where their programmes are well accepted and effective. It is proposed that the various services on offer are presented to trustees and principals as a consolidated menu of services, which schools can choose from to help them meet their objectives.

Early childhood education, primary schools and secondary schools have different needs and dynamics. Strategies need to look at each of these sectors separately.

Action Plans

Early Childhood Education

Schools are an environment that protects against obesity.

Long-term goals and targets	Actions	Action Leader
Goal: By 2010 Counties Manukau early childhood education leads the country in their commitment to supporting healthy eating and active living. **Target: By 2010 100% of early learning environments have audited effective healthy eating active living policies.**	A district governance group is established that includes early childhood education staff, parents and health sector to guide work assessing needs for early childhood, five year goals and recommended programmes. A representative from the group sits on the *Let's Beat Diabetes* Governance Group.	Counties Manukau District Health Board (CMDHB), Ministry of Education (MoE), Manukau City Council (MCC), Early Childhood Centres (ECE), Kohanga Reo
Goal: Physical activity **By 2010 obesity growth in children has stopped and is reducing.** **Target: By 2010 100% of early learning environments have audited effective healthy eating active living policies.**	Sport and Recreation New Zealand (SPARC), supported by the education and health sectors, implements its Kiwi baby, Kiwi toddler and Kiwi pre-school programmes in ECEs in Counties Manukau. This includes Kohanga Reo and Pacific ECEs. Strategies are investigated that leverage cultural knowledge and practice in Kohanga Reo and Pacific ECEs to support healthy approaches to physical activity.	SPARC, health sector, ECEs, Non-Government Organisations (NGOs)
Goal: Nutrition **By 2010 obesity growth in children has stopped and is reducing.** **Target: By 2010 100% of early learning environments have audited effective healthy eating active living policies.**	Auckland Regional Public Health Service (ARPHS) supports SPARC's efforts by providing nutritional information and support to the ECEs in Counties Manukau. This includes Kohanga Reo and Pacific ECEs. Strategies are investigated that leverage cultural knowledge and practice in Kohanga Reo and Pacific ECEs to support healthy approaches to nutrition.	ARPHS, NGOs, SPARC
Goal: Evaluation **Evaluation supports a learning framework and supports establishment of best practice in early learning centres.**	SPARC evaluates its programmes.	SPARC, CMDHB, UoA-SoPH

Target: Evaluation framework set up by July 2005.	SPARC works with CMDHB and the University of Auckland-School of Population Health (UoA–SoPH) to develop a framework for process and outcomes evaluation of the agreed action plans.	

Primary Schools

Primary schools are an environment that protects against obesity.

Long-term goals and targets	Actions	Action Leader
Goal: By 2010 Counties Manukau schools lead the country in their commitment to supporting healthy eating and active living. **Suggested targets:** **By 2008:** ▪ **100% of primary schools provide 1 hour exercise per week.** **By 2010:** ▪ **90% of primary schools provide 30 minutes exercise a day.** ▪ **100% of schools have audited healthy menu canteens.**	A representative governance group is established (includes students, teachers, principals, trustees and health/ activity providers) to guide assessment of need in primary schools, identify the five year goals and recommend programmes. A representative from the group sits on the *Let's Beat Diabetes* Governance Group.	Kidz First, CMDHB, Schools, NGOs, MOE, ARPHS, MCC
Goal: Resources are available to achieve goals. **Target: By July 2005, review completed.**	A review is undertaken looking at what levels of input, programme designs and resources will be required to achieve the identified goals. The report will guide the action plan.	Schools governance group, CMDHB
Goals: Schools are supported to develop healthy environments. **Target: All schools are personally contacted and services on offer presented during 2005.**	There is improved co-ordination of programmes amongst providers to make it easier for principals to understand what support services are available to assist them to achieve the identified goals. Principals are informed about the support services and resources available. There is proactive communication with all schools about the need to	CMDHB, SPARC, PHOs, Ministry of Health (MoH), NGOs

	address obesity and the support services on offer.	
Goal: Evaluation **Goal: Evaluation supports a learning framework and supports establishment of best practice in primary schools.** **Target: Evaluation framework set up by July 2005.**	Schools governance group, SPARC and CMDHB work with the University of Auckland-School of Population Health (UoA–SoPH) to develop a framework for process and outcomes evaluation of the agreed action plans, with the key objective being to support a learning framework and effective sustainable partnerships.	Schools governance group, UoA-SoPH, CMDHB, SPARC

Secondary Schools

Secondary schools are an environment that protects against obesity.

Long-term goals and targets	Actions	Action Leader
Goal: By 2010 Counties Manukau secondary schools lead the country in their commitment to healthy eating and active living. **Suggested targets:** **By 2010:** ▪ **80% of secondary schools provide 30 minutes exercise a day.** ▪ **100% of schools have audited healthy menu canteens.**	A representative governance group is established (includes students, teachers, principals, trustees and health/ activity providers) to guide assessment of need in primary schools, identify the five year goals and recommend programmes. A representative from the group sits on the *Let's Beat Diabetes* Governance Group.	CMDHB, schools, MoE, ARPHS, NGOs
Goal: Resources are available to achieve goals. **Target: By July 2005, review completed.**	A review is undertaken looking at what levels of input, programme designs and resources will be required to achieve the identified goals. The report will guide the action plan.	Schools group, CMDHB
Goals: Schools are supported to develop healthy environments. **Target: All schools are personally contacted and services on offer presented during 2005.**	There is improved co-ordination of programmes amongst providers to make it easier for principals to understand what support services are available to assist them to achieve the identified goals. Principals are informed about the support services and resources available.	CMDHB, SPARC, PHOs, MoH, NGOs

	There is proactive communication with all schools about the need to address obesity and the support services on offer.	
Goal: Schools serve only diet drinks and water. **Target: By 2006, 90% diet drinks and water target achieved.**	Schools are encouraged to reduce the availability of high carbohydrate drinks on school grounds.	Schools, ARPHS, Food Group, CMDHB
Goal: Students take up leadership roles within their schools to support healthy eating active living. **Target: Student-led activism begins during 2006.**	Student-led activism in the area of fit and healthy schools is encouraged and resources are made available to support appropriate student activities.	Schools governance group
Goal: Evaluation of interventions at the AIMHI schools provides guidance for ongoing high school strategies. **Target: Preliminary results of NEW evaluation completed by end of 2006, with decisions made about ongoing programme design.** **A further evaluation of schools interventions will be undertaken by UoA-SoPH, which with results available in 2007/08.**	The existing NEW programme, a component of the AIMHI Healthy Community Schools initiative, delivered in association with the Diabetes Projects Trust, is supported as a pilot programme - with its own evaluation component. The University of Auckland School of Population Health (UoA-SoPH) secondary school intervention and evaluation is also supported and synergies developed between the two programmes. Both sets of evaluation results would be used to guide ongoing programme design, implementation and investment in secondary school-based programmes.	AIMHI schools, Diabetes Projects Trust, UoA-SoPH, CMDHB, MoE

8. Supporting Primary Care-Based Prevention and Early Intervention

Context

A large number of government policies call on primary health care to make a greater contribution to the health of populations, to work with families, and to focus on chronic disease prevention and management (*NZ Health Strategy, NZ Primary Health Care Strategy, He Korowai Oranga, The Pacific Health* and *Disability Action Plan*). (Ministry of Health 2000; 2001; 2002).

Primary Health Organisations (PHOs) have been set up and new funding streams are now available to support chronic disease prevention and management. However, there is also a lack of clear evidence about exactly how PHOs and General Practitioner (GP) teams can go about preventing disease in a cost effective way. Prevention and disease management programmes challenge the primary care sector to define new relationships with patients and new roles and responsibilities within primary care teams.

Counties Manukau District Health Board (CMDHB) and the primary care sector have invested considerable resources over the past five years developing the Chronic Care Management programme (CCM), which supports community-based structured management of people with advanced and complicated diabetes. The CCM project involves collaborations between CMDHB and PHOs. CCM delivers training programmes for GP teams, information technology support and incentive payments to GPs. It is one of New Zealand's most sophisticated disease management initiatives, and provides a strong platform for further collaborative activities between CMDHB and the PHOs.

Developing primary care initiatives that focus on disease prevention and management will need sound evidence and be achievable in the busy practice environment. The CCM experience has identified that significant training, support and strong project management is required to bring about changes in the general practice environment and that even small changes can take considerable time to introduce. PHOs have shown a willingness to become more involved in disease prevention activities.

Primary care involvement in, and support for, broader social marketing programmes is essential to change population behaviour. There is an increasing body of evidence about the role for primary care in providing brief intervention advice on behaviour change and support for improved education to support the "expert patient" and improved self management. General practice is the key environment for the early identification of risk factors and screening to identify diabetes. New Zealand has published national guidelines for the screening for and management of diabetes. The fact that the major health sector costs from complications of diabetes are heart disease, especially in the early stages of disease progression, suggests that people with diabetes should also be proactively managed in terms of their cardiovascular risk.
PHO funding streams allow for significant flexibility for primary care based health promotion and disease prevention activities – especially targeting high risk groups.

Programme Design

The following four initiatives have been identified in collaboration with the primary care sector. They are based on supporting evidence that they will have a positive impact,

they are achievable, they fit together to support improved overall system capacity in primary care, and they link into the broader *Let's Beat Diabetes* plan:

- To provide consistent and persuasive information to 'at risk' people to support lifestyle change;
- To improve identification of people who have diabetes at an earlier stage of their disease progression; (New Zealand Guidelines Group 2003)
- To improve the level of education given to newly-diagnosed diabetics to support improved self management of diabetes and of their cardiovascular risk; and
- To trial a new approach to disease management in which the primary care team works with the whole family of a person with diabetes, to support better health for the whole family/whole whanau approach (links with He Korowai Oranga).

These programmes will require collaborative leadership across CMDHB and PHOs. They will also require investment in training and development of primary care teams and in the community outreach medical and nursing specialist service at Middlemore Hospital.

Information Technology (IT) infrastructure will be required to support activities. The projects will require CMDHB project management and clinical expertise and well as PHO-led operational management. Evaluation will also be a key component of the activity, and will inform how the programmes develop, particularly the family group practice trial.

Action Plan

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

Long-term goals and targets	Actions	Action Leader
Goal: Patients attending GP teams proactively receive information and counselling to support healthy eating and active living. **Target: 70% of at risk patients attending GPs receive a 'dose' of practical health information about lifestyle which aligns with the social marketing strategy.**	GP teams are trained in evidence-based approaches to effective brief intervention counselling. GP teams are involved in and informed of the social marketing programme and are aware of their role in support of the desired behaviour change outcomes. GP teams are provided with resources and tools (e.g. computer-based advice/prompts and patient resources) to undertake brief interventions. Funding systems are developed to support GP team ability to deliver brief intervention counselling. Programmes rolled out with a best practice framework.	PHOs, CMDHB, hospital services, RNZCGP
Goal: People at risk of diabetes are screened in a timely manner in accordance with New Zealand guidelines. **Target: By 2010 80% of practices are effectively and systematically screening for diabetes as described in the New Zealand Guideline for the Assessment and Management of Cardiovascular Risk.**	CMDHB works with PHOs to assist uptake of IT based decision support tools and management protocols, which would facilitate accurate, evidence-based screening and follow up activities. Roll out of screening is aligned with broader system review to ensure there is capacity to provide effective follow up activities.	CMDHB, PHOs, Health Alliance
Goal: All newly diagnosed people with diabetes participate in quality education and learning to support effective self management of the condition. **Target: By 2010 80% of people diagnosed with diabetes receive an enhanced education from a health professional who has received accredited training.**	Develop accredited training programmes for primary care teams for diabetes education and support for self management. It is likely such a programme could be provided by MIT, resulting in a formal qualification. Support GP teams to undertake training and development (there will be a need for consistency across the training but different team members will require different training modules). Collaborate with Waitemata District Health Board in the development of	PHOs, MIT, CMDHB, Whitiora Diabetes Service, Waitemata District Health Board

	resources and best practice models for self management Introduce ‘accredited’ education/self learning process into normal GP-team activity. Roll out training programmes across GP teams.	
Goal: GP teams work with whole families to better support people with diabetes and to help families stay healthy. **Target: By 2008 the trial of new ‘family group’ approach completed and evaluated.**	Develop detailed evidence and programme design for a second Phase of the Chronic Care Management programme, which supports GP teams working more closely with the families of people with diabetes. The programme would involve a trail with a limited number of GP practices becoming involved in the new programme, with formal evaluation. While primary care based, the trial may have links to the ‘families’ action area of *Let’s Beat Diabetes*, which aims to support vulnerable families to make healthy choices. The programme design would involve two stages of activity; firstly to determine whether the approach is effective, and secondly to test if it is effective in an average general practice situation. The trial objectives are to improve disease management for the person with diabetes and also to identify and reduce risk factors for the family members.	PHOs, RNZCGP, CCREP, CMDHB

9. Enabling Vulnerable Families to Make Healthy Choices

Context

Many families in Counties Manukau find it very difficult to live healthy lives.

Some families are able to change their behaviour to support a family member who has diabetes or to reduce the risk of getting diabetes, but for some families there are so many other difficulties in their lives, making healthy choices is not an option.

Counties Manukau has a high proportion of families that are in difficulty or are ‘vulnerable’ and may not be far from a crisis. 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. Disease then adds to their difficulties. It is a vicious circle.

Many of the strategies in the *Let’s Beat Diabetes* plan make it easier for families to make healthy choices (Community Leadership, Well Child, Schools, Social Marketing, Health Promotion, Primary Care-based Prevention), but these strategies on their own are unlikely to work for vulnerable families. Action is required to help those families most ‘at risk’. Many organisations and agencies support vulnerable families but more focus is needed on how they work together to support healthy living and self management of disease. A new level of collaboration is required across government agencies at policy and funding levels and across providers at operational levels to provide well targeted support for families.

Over the past year, there has been a major government focus on improved support for vulnerable families. This has been reflected in a number of budget initiatives through the Ministry of Social Development (MSD), including:

- *Working for families package* – increased number of social support entitlements for working families, such as childcare subsidies, accommodation supplements and return to work support.
- *Family Start expansion* – expansion of service aimed at families with very young children who have the greatest needs. It provides early help to improve outcomes for children by providing intensive cross-government support to parents (coming in to Manukau in 2005).
- *Pacific family violence* – funding has been made available to begin implementation of education and awareness programmes as part of the Framework for Preventing Family Violence in Pacific Communities.
- *Social workers in schools expansion* – social workers in schools support participating families to achieve improvements in their children’s educational, health and social outcomes as well as improvements in parenting and management of household resources.

There are also many existing family focused programmes supported by MSD, including: Strengthening Families, Heartlands, Youth Interagency Project, Teenage Parents Project, Enhanced case management for people on a sickness benefit and invalids benefit and Youth Transitions.

MSD has also set up a new service called Family and Community Services (FACS). The FACS's role is to support government and non government organisations in working collaboratively to strengthen family support services and make them more effective for families. There is a strong focus on prevention and early intervention. Some of the action areas for FACS include:

- The development of a detailed web-based national social services directory that enables social agencies to accurately refer to other support organisations
- The Strategies for Kids/Information for Parents (SKIP) programme which aims to provide positive patenting skills and resources for parents and caregivers of children aged from one to five
- A number of programmes which aim at prevention and early intervention of family violence
- Local services mapping – a framework for determining how services provided by central government, local government and local agencies can be managed to better meet local needs

There are opportunities for the health sector to more effectively interface with the MSD suite of services to enable families to live healthier lives and better manage disease.

Programme Design

It is proposed MSD take the lead in the development of activities to support families to make healthy choices. MSD has responsibility for Government policy and service delivery in many areas of social support, such as Work and Income and FACS. It also has links with many other organisations and a history of working closely with the health sector and local government in Counties Manukau. As noted above, there are a number of new service initiatives and funding streams based in MSD, which can directly support vulnerable families.

The approach will need to create a sustainable collaboration between health and welfare at a policy and design level and also at the level of implementation, which would be accomplished through the development of an MSD-led working group. This working group could emerge from one of the existing interagency groups, such as Strengthening Families.

The broad aim is to develop the health sector's ability to identify vulnerable families and to refer those families to the most appropriate point for ongoing support, and then to work with those support organisations in a co-coordinated manner. For MSD services, there is an opportunity to be involved with families at a point of vulnerability - as opposed to crisis – where families may be more amenable to early intervention. There is also opportunity for MSD to better achieve its policy goals such as return-to-work, reduction in disparities and reduction in family violence if it is working with the health sector.

A number of the programmes will emerge once the working group has been established, however, some areas that have been identified where collaborative programmes should be developed.

- Aligning an enhanced Well Child programme (the focuses more strongly on childhood nutrition) with Strengthening Families and the expanded Family Start

programme to provide improved assessment and referral processes for vulnerable families

- Strengthening vulnerable families, within the context of their community, to make healthy choices for themselves and their children
- Alignment of the primary care family group intervention trial with family group focused welfare support
- Supporting accurate and appropriate referral from health services to welfare support agencies.
- Ensuring the local area mapping service programme is undertaken in relation to the health welfare interface and the needs of chronic disease prevention and management.

Action Plan

Vulnerable families are able to make healthy choices.

Long-term goals and targets	Actions	Action Leader
Goal: A governance structure supports collaboration between health and welfare sectors to better support vulnerable families. **Target: By April 2005 working group is functioning effectively.**	MSD becomes a member of the overall governance group of the *Let's Beat Diabetes* plan. A working group is set up under MSD guidance that becomes a leadership hub for integrating health and welfare activities to better address the health needs of vulnerable families as they relate to chronic disease. It is likely this group will be an extension of the current Strengthening Families interagency group. The group will need to identify where there are opportunities for application of recent budget and service initiatives to support the family focused approach to obesity prevention and disease management.	MSD, Counties Manukau District Health Board (CMDHB)
Goal: All children receive adequate and appropriate nutrition during the critical early years of life. **Target: By July 2006 Enhanced Well Child and accompanying welfare supports are implemented.**	Well Child providers receive training/capacity development to enable improved identification of family vulnerability, when there is evidence of poor nutrition in 0-5 year olds (this includes obesity as well as under nutrition). Clearly defined referral pathways to social support agencies and ongoing processes of collaborative support are identified and developed with the Strengthening Families interagency group.	CMDHB
Goal: Families are able to make healthy nutrition choices for themselves and their children. **Target: The percentage of children not eating breakfast at home before school reduces by 50% by 2010.**	MSD-linked services join with health providers to support improved education of parents on appropriate nutrition for adults and children. There is more use made of entitlement reviews where it appears that healthy choices are not being made due to financial constraints. There is support for a broad strategy that encourages children to eat breakfast at home before school. There is a review of the Food in Schools programme in Counties Manukau as a component of the broader child nutrition strategic approach.	MSD

Goal: Improved whole system approaches to prevention and early intervention are developed. **Target: By 2008 Health and welfare family group intervention trial completed.**	The primary care based trial of family group interventions also includes explicit linkage with whole family based approaches from welfare agencies. The trial will be able to identify the value of this cross agency whole family approach for working with high risk families. Welfare agencies need to be involved in development of the trial design.	CMDHB
Goal: Increase effective support for families through appropriate referral between health and welfare agencies. **Target: By July 2005 national directory is updated and marketed to health services.**	Review the applicability of the Family and Community Services web based national services directory as a core tool for use in supporting appropriate referral between health and welfare agencies. Enhancements could improve the usefulness of the directory for health providers. Market use of the national directory to health services.	MSD
Goal: There is a clear long term strategy identified for service structures that will most appropriately meet the needs of the Counties Manukau population. **Target: Papakura service mapping complete by the end of 2005.**	The Local Services mapping initiative by FACS will explicitly focus on the needs of the health/welfare/education interface in relation to vulnerable families and develop a long term strategy for service development.	MSD

10. Improving Service Integration and Care for Advanced Disease

Context

The *Let's Beat Diabetes* plan has a strong focus on stopping diabetes through whole-society strategies. It also supports primary care to have a greater capacity to prevent diabetes, identify diabetes early, and support lifestyle change to slow or stop disease progression. However, many people already have advanced diabetes and will continue to get serious complications from diabetes despite better prevention.

For most people with diabetes, the disease gets steadily worse over time. The average time from diagnosis to death for diabetes for Europeans is approximately 22 years, Pacific peoples approximately 20 years, and Maori approximately 18 years (Ministry of Health, 2002). The complications from diabetes include heart disease, kidney failure, stroke, blindness and ulceration/amputation of lower limbs. The disease leads to suffering for the patient and also cost for the health sector. In 2003, diabetes-related cost for the top 20 diabetes patients at Counties Manukau District Health Board's (CMDHB) inpatient and outpatient service was $77,000 to $170,000 per patient (Thomas E, 2004). The average cost of clinic-based haemodialysis is $45,000 a year.

There is very good evidence that best practice health interventions and lifestyle change can make a significant difference to the outcomes of people who have diabetes, including people with advanced diabetes with serious complications (UKPDS, 1975 - 204).

A number of initiatives have been introduced at a national, regional and district level to support more effective care and treatment for people with diabetes, including:

<u>National level</u>

- *Get Checked* - a national programme, where General Practitioners (GPs) are paid $40 to provide a recall and check-up for people with diabetes – and to provide data for a national database. (There is currently a review of the electronic support for the *Get Checked* programme).
- *Care Plus* - a national funding initiative that provides GP teams with $200 a year to provide extra care for people with chronic disease. It can be applied to support structured care for people with diabetes.
- *National Diabetes* Guidelines – The New Zealand Guidelines Group published evidence based best practice guidelines for the management of Type 2 Diabetes in December 2003, including a view on Maori and Pacific perspectives on management.
- *Electronic decision support tools* – the Ministry of Health has funded the publishing of the guidelines within an electronic decision support environment. The guidelines will be embedded in the Predict decision support tool and are expected to be released in early 2005.

<u>Regional level</u>

- *Dialysis review* – a regional review of dialysis services, access criteria and demand management strategies is currently underway in collaboration between the Waitemata, Auckland and Counties Manukau District Health Boards (DHBs).

- *Chronic disease strategy review* – there is currently an analysis of the approaches to chronic disease management being taken by the four northern DHBs, looking at areas of convergence and divergence in approaches and at the risks and opportunities associated with the current approaches, with a view to developing more effective regional collaboration.

Activities of other DHBs – Auckland DHB is working with Primary Health Organisations (PHOs) to provide enhanced primary-care-based services for people with advanced diabetes, similar to services provided under the Chronic Care Management (CCM) programme. Waitemata DHB is focusing on improving PHO-based retinal screening and intensive education post diagnosis to support improved self management. Waitemata has also introduced a practice based quality and learning cycle – based broadly on the Institute of Healthcare Improvement's 'Collaborative Model for Achieving Breakthrough Improvement.' The learning programme is delivered in partnership with the Royal New Zealand College of General Practice (RNZCGP). Across the three Auckland DHBs, similar frameworks to diabetes management are emerging, all involving defined levels of care intensity, with associated expectation of service response.

District level

- *Chronic Care management* - Counties Manukau has for the past five years been developing and implementing the CCM programme, which aims to provide quality management of diabetes within the primary care environment. CCM involves training and development for practice teams, increased levels of nurse-based support, structured care and an Information Technology (IT) system that supports GP decisions and provides reports on how patients are responding. CCM also provides GPs with extra funding to carry out the structured care activities and it reduces the financial barriers for people to access GPs.

- *Retinal Screening* – In 2003 the Counties Manukau Diabetes Advisory Group (CMDAG) commissioned a review was undertake to develop improved co-ordination, clinical pathways and capacity development for diabetes retinal screening services. The recommendations of that review are now being implemented.

- *Gestational diabetes* – A project is currently under way to provide better integration between hospital and primary care services to support women with diabetes to have healthy babies and to provide better follow up of women with gestational diabetes.

- *Community pharmacy* – a strategy is being developed to improve the contribution pharmacists make to the management of chronic disease through providing advice to practice teams and through enhanced counseling services for patients on correct use of medicines and improving adherence to medication regimes.

As the above list of existing and emerging activities show, there is no shortage of new programmes and review processes in the treatment and management of diabetes. The major issue for improving diabetes outcomes is the effective uptake of best practice processes in the general practice environment and the co-ordination of services across primary and secondary care. There are few practices which are currently working at the level of identifying and managing diabetes in a manner which meets the national guidelines.

The CCM programme has recently released information which shows that whilst the early adopter practices were making a significant change in outcomes due to taking up the CCM structured care approach, late adopter practices are not making the same

impact, despite financial incentives and considerable IT support. This outcome illustrates the difficulties in introducing chronic disease based programmes that require culture and systems change into the general practice environment. In other words, some of the major impacts on patient outcomes for diabetes are not patient characteristics or programme design but provider characteristics and capacity.

Progress is not being held back by a lack of ideas, but the need for effective implementation.

Programme Design

The objective of the programme design is to develop robust and sustainable systems that support broad primary care uptake of best practice care and improved integration with secondary care. Achieving this improved uptake of innovations requires a multifaceted change management programme, with strong governance, management (including knowledge management) and clinical leadership, as well as investment in workforce capacity and the use of innovative funding mechanisms.

The proposals outlined below are wide ranging and will challenge existing roles and relationships, however, this type of systems approach is required if the sector is to take on the changes required to effectively manage diabetes and other chronic diseases. The programme design supports:

- Developing an improved framework for delivering care and organising integration
- Creating an improved governance and management framework for diabetes care
- Developing improved medical and nursing clinical leadership and a centre of excellence for whole system diabetes management
- Creating an explicit learning collaboration to support innovation adoption, which includes general practice and secondary care
- Building a sustainable and professionalised education courses/qualifications for the educational aspects of chronic disease management
- Bringing various IT developments together to create a unified system
- Defining a funding structure that incentivises outcomes as well as inputs
- Building process and outcome evaluation to support whole system learning.

Action Plan

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

Long-term goals and targets	Actions	Action Leader
Goal: Diabetes management activities are implemented effectively in a consistent framework across primary and secondary care. **Target: By 2005 framework for care agreed.**	An organising framework for diabetes cross-sector management is developed and endorsed that links to the NZ Guidelines, is supported by funding frameworks and is congruent with other DHBs in the Auckland region. Align with retinal screening project, dialysis review, gestational diabetes review, national developments. An outline of core activities to be undertaken is developed (with useful reference to Waitemata DHB work) in partnership between DHB and PHOs. Roles and responsibilities of various sector partners are clarified. Funding and support mechanisms are developed, with programme of implementation.	CMDHB, PHOs, Whitiora, WDHB
Goal: Diabetes governance structures support a whole system view and management. **Target: New governance structure in place by July 2005.**	The current structure and terms of reference of the Diabetes Advisory Group and the Chronic Care Management Governance Groups are reviewed with an objective of ensuring there is effective cross sector governance of issues and programmes across all levels of diabetes management, including outpatient services. Governance and associated management roles and relationships across PHOs and DHB are defined and implemented.	CMDHB, PHOs
Goal: A sustainable learning environment is created which supports uptake of service innovations in primary and secondary care. **Target: Initial learning collaborative begins July 2005, runs for six months.** **30% of GPs have participated in a learning collaboration by 2010.**	CMDHB, PHOs and the RNZCGP set up an approach to learning amongst practice teams based on the learning and action cycles described in the Collaborative Approach to Breakthrough Improvements literature. The objective of the project is to move averagely performing mainstream practices towards best practice activity and achieving the performance standards set by existing leading practices. Set learning objectives, choose collaborating partners, design structure of learning/acting cycles, provide funding to support practice team release time for learning cycles. Implement initial Breakthrough Collaboration, with collaborative groups expanding over five years to include increasing number of practices.	CMDHB, PHOs, Whitiora, RNZCGP
Goal: There is effective clinical leadership for the delivery of integrated diabetes management strategies.	Recognise and enhance the role of the Whitiora Middlemore Diabetes Service as the district centre of excellence for whole system clinical design, providing sector wide medical, nursing and disease psychology expertise, programme content leadership and capacity development for the wider sector.	Whitiora, CMDHB

Target: Review of Whitiora role complete April 2005.	Allocate more specialist time for non clinical activities for development of broader programme design and quality review, along with training and development for primary care. Ensure Whitiora team has developmental support to build and maintain centre of excellence status.	
Goal: The primary care workforce has the skills and knowledge to support self management and adherence strategies. **Target: There is a formal course/qualification for upskilling practice nurses in self management education for the 2006 year.** **30% of practice nurses have been through the course by 2010.**	Develop a strategic relationship with Manukau Institute of Technology (MIT). Support sustainable courses to provide new graduates with in-demand skills, such as community health worker and practice nurse, and provide upskilling courses for existing primary care practitioners in patient education and self management techniques. Existing practitioners will receive recognised qualifications for the course they undertake. Agree on courses to be offered. Develop course content. Enrol. Teach. Align the community pharmacy strategy to upgrade GP prescribing and adherence management skills and to enable joint GP/pharmacy activities for increasing medication compliance rates.	CMDHB, MIT, Whitiora, PHOs
Goal: The information environment supports efficient best practice management of diabetes. **Target: Integrated primary /secondary diabetes IT system operational by July 2006.**	The existing strategy of completing Version II of the CCM software is supported along with sustained roll out of the programme. The proposal to redevelop the CCM software components to support management of Care Plus patients is supported, allowing GPs not enrolled in CCM to gain benefits of using IT tools that encourage a structured care environment. Implementation of the national diabetes guidelines within an electronic decision support format is supported, and integrated with the CCM programme. There is a review of the opportunities associated with the MOH desire to update the Get Checked database design to see whether it could align with existing CCM data management processes and support integration with retinal screening databases. There is support for the WDHB-funded development of a secondary care cardio vascular/diabetes disease management/database that would eventually align with the primary care based CCM database to create a full management system.	CMDHB, PHOs, Whitiora, MOH, WDHB, ADHB
Goal: Diabetes funding supports real changes in patient outcomes. **Target: The balanced funding trial is completed by December by 2007.**	The funding environment for primary care activity in diabetes management is reformed to provide a balance of funds for input activity and to incentivise outcomes, such as sustainable changes in biological indicators (e.g. HbA1c) A trial is undertaken where the current situation of funding based on inputs is	CMDHB, PHOs

	compared with a balanced funding strategy where there is a split of incentives across inputs and outcomes.	
Goal: Evaluation provides evidence of effectiveness of investment in system capacity	The Centre for Clinical Research and Effective Practice (CCREP) develops a process and outcome evaluation framework for the above strategies and links with the RNZCGP in supporting a plan-do-study-act quality cycle amongst general practice.	CCREP, RNZCGP, CMDHB, SoPH

Enablers

Let's Beat Diabetes is not only about diabetes prevention and management, but about the types of changes society and the health sector need to make to better prevent and manage a number of chronic diseases, most obviously heart disease.

The change required challenges how the many different parts of the health sector operate, particularly the role of the District Health Board. The plan is divided into the Ten Action Areas. However, there are many cross cutting themes, capacity and systems issues that require proactive management to create an environment that in conducive to change. Some of these will require DHB management; others will emerge as the plan's development process continues.

1. Consumer involvement

There is currently no well supported consumer forum to support consumer consultation about issues of service design and quality. There are some existing consumer groups, one of these could be supported and expanded or a new group developed. The consumer group should include people from various ethnicities and stages of diabetes progression. The group should also receive training and development in effective advocacy. There may be an opportunity to more effectively use existing community vehicles and networks, such as community boards, to support consumer involvement.

2. Maori and Pacific peoples

The priority placed on Maori and Pacific diabetes outcomes means that there needs to be a special focus through the plan to ensure that Maori and Pacific health needs are being met in all Ten Action Areas. There needs to be separate stand-alone plans for Maori and Pacific peoples that pull together all aspects of the broader *Let's Beat Diabetes* plan into one document to provide focused communication about the plan for Maori and Pacific communities. The strategies designed to assist Maori and Pacific peoples are outlined below:

- *Community Action Fund:* This fund will enable Maori and Pacific community organisations, marae and churches to apply for funding to support activities which prevent diabetes and support people with diabetes.
- *Focus on marae/kura:* The Maori leadership strategy supports the development of marae and kura as health promoting environments through knowledge, cultural lore and activities.
- *Focus on churches:* The Pacific leadership strategy supports the development of multi-ethnic strategy that is responsive to each of the Pacific peoples and enables Pacific churches to support the physical as well as spiritual health of their congregation.
- *Cultural training (professionalise in primary care):* The professionalisation of upgrading skills within primary care will enable greater uptake of training in cultural issues and safety.
- *Health Promotion capacity:* Maori and Pacific health promotion providers will receive more support for capacity development and more opportunity for programme developments, plus more effective links with mainstream providers.
- *Family/whanau focus to work:* The core family focus to the strategy aligns with the national *He Korowai Oranga (Maori Health Strategy)* and *Pacific Health and*

Disability Action plan. The family focus is illustrated in the Vulnerable Families strategy and in the 'family group' trial of the Prevention Focused Primary Care strategy.

- *Targeted social marketing*: The social marketing programme will target Maori and Pacific peoples in an encouraging environment and provide practical information on lifestyle change.

- *Evaluation of outcomes for Maori and Pacific peoples:* The evaluation framework will develop special considerations for process and outcomes issues for Maori and Pacific peoples, utilise Maori and Pacific researchers and include communities in process.

3. Funding Environment

One of the key functions of CMDHB in creating a supportive environment for *Let's Beat Diabetes* is to provide resources for action and to realign existing resources under its control and influence resources under the control of other organisations. Funding activities required to support the plan include:

- *Aligned Health Promotion Funding*: CMDHB will work with other funding organisations in the health promotion area to gain greater synergy between fund allocation in terms of programme design, target group and capacity building in the sector.

- *Sustained upstream funding:* CMDHB will provide an estimate about a level of funding that will be allocated to the *Let's Beat Diabetes* strategy for a period of five years, so that there is security from the health sector and confidence from non-health partners that diabetes is a priority area and CMDHB is committed to sustained action for the five years of the plan.

- *Balanced primary care input/outcome incentives:* The funding for activities within the primary care environment will be reviewed to see if improved outcomes can be achieved by a balanced funding strategy across inputs and outcomes – as opposed to purely funding inputs as is currently the case.

- *Allocation to evaluation:* A proportion of the overall investment in *Let's Beat Diabetes* will be set aside for evaluation.

- *Seeking matched funding with other agencies:* Where possible CMDHB will seek matched funding or resource input from other agencies in new areas of activity where there is cross agency jurisdiction and interest in order to maximise societal investment in diabetes prevention. This may include sponsorship in some areas.

- *Support for specific strategies and the Community Action Fund:* Funds will be allocated to support specific strategies outlined in the *Let's Beat Diabetes* plan and there will also be a general fund which will allocate small grants to community organisations to support diabetes prevention programmes that work within a paradigm of cultural strength and community empowerment.

4. Learning Environment

Let's Beat Diabetes proposes strategies that expand health sector activity and society efforts into challenging new areas of activity. The plan will not succeed unless there are strong evaluation and learning frameworks to support continual reassessment and fine turning of activities and to know whether the plan is having the desired impact.

- *Overall evaluation – continuous quality improvement:* It is proposed that CMDHB develop a partnership with the University of Auckland School of Population Health

(UoA-SoPH) and Counties Manukau communities to develop an evaluation framework that sits across the entire 10 strands of the plan and the governance process. The evaluation would be designed to measure outcomes but to also support a process of learning through a continuous quality improvement cycle.

- *PDSA cycle – Breakthrough Collaboration:* Approaches will be made to GPs, PHOs and the Royal New Zealand College of General Practice to implement a series of action learning cycles (based loosely on the IHI Breakthrough Collaborations) to support uptake of innovations by GPs and to better understand the blockages to innovation adoption.

- *Workforce development – education and self management:* A major issue for primary care and to some extend in secondary care is the need for there to be improved expertise in patient education, motivational interviewing and support for self management. This requirement applies to all chronic disease, not just diabetes. There needs to be a move to a proper professionalised course based in an education institute that can access education funding streams, provide new skills to a wider range of health professionals, deliver a recognised qualification and create a common language and approach to help foster a new paradigm in the management of chronic disease. There is also a need to enhance training opportunities for a broad range of community workers so they are better able to contribute to community wellness and chronic disease management.

- *Mangere schools evaluation:* The UoA research project into the impact of health interventions at secondary schools should be supported as it provides an opportunity to accurately quantify the impact and outcomes of such interventions and build an evidence base for ongoing investment in schools programmes.

5. Sustainable Governance

The development of a sustainable governance structure will require a strong and inclusive initial structure, powerful links to the action areas, the delivery of value for participating organisations and individuals and good administration support:

- *Overarching governance model:* The overarching governance group for *Let's Beat Diabetes* will guide the plan implementation. The group will have representation from all Ten Action Areas, plus key partnership organisations, community leaders, clinical experts and consumers.

- *Links to Tomorrow's Manukau:* The governance group will link with the Health and Wellbeing sub committee of the Tomorrow's Manukau group to ensure that the partnership and information flow with Manukau City Council (MCC) and other key government agencies is maintained.

- *Leadership Hubs for each area:* Each of the Ten Action Areas will have its own leadership hub or group. The make-up of each hub will differ as each will have different requirements. For example, the Food Group will differ from the Well Child group. Different organisations will lead each area. For example, Ministry of Social Development will lead the Vulnerable Families area, whereas Manukau City Council will lead the Urban Design area. The 'action leader' approach is similar to that used in the Tomorrow's Manukau plan.

- *Administration support:* CMDHB will support resources and networks to provide overall administrative co-ordination of the various work streams.

6. Organisational Development

The development of appropriate and trained workforce may be the single most important factor for enabling primary care to meet the challenge of improved chronic disease management. Workforce development must be a priority. Health programmes also require strong professional leadership. It is proposed that the Whitiora Diabetes Service is supported to maintain a centre of excellence status with regards to whole system diabetes management. CMDHB will also have to look to its own capacity in order to support *Let's Beat Diabetes.* It is proposed that enabling cross-sector learning could be a central pillar to the DHB role:

- *Workforce – new workforce and training in primary care:* Modeling has shown that there is likely to be a substantial demand for practice nurses and community health workers as primary care changes to support improvements in chronic disease management. There will also be requirements for proportionally more dieticians, psychologists, nurse practitioners, nurse specialists, social workers, pharmacists as part of the primary care team but these are likely to be provided by existing marketplace mechanisms. Indications are that there will be shortages in practice nurses and community workers unless proactive activity is undertaken to develop an increased workforce.

  There is also a need to professionalise the upskilling of the existing primary care teams (discussed under the 'Learning Environment' heading).

- *Workforce – constraints within secondary care:* If the current increase in dialysis continues there is a high likelihood that the existing global shortage of nephrologists will become an acute issue in terms of quality and capacity. Forward planning is required across the entire area of demand and service capacity for dialysis.

- *Whitiora centre of excellence – clinical leadership*: Middlemore Whitiora Diabetes Service currently provides the clinical base and centre of excellence that has driven much of the capacity increase across primary care, through training, advice and support for nursing and medical practitioners. The Whitiora team is under considerable pressure from clinical workloads and needs to be able to retain a strong strategic role in broad guidance across clinical issues and whole system capacity and processes as they relate to best practice care for people with diabetes.

  Let's Beat Diabetes creates greater demand for centre-of-excellence medical, nursing and health psychologist leadership. Investment in increased medical specialist time devoted to system-wide clinical leadership and ongoing development of nursing staff in their nurse specialist roles is required to implement the system improvements outlined in the plan.

- *DHB co-ordination and system change model: Let's Beat Diabetes* challenges the role of the DHB in system change. How much is CMDHB a hands-off policy/funding organisation and to what extent does it become involved in the management of programmes and change processes? CMDHB is already involved at quite a detailed level with broad whole system processes, like the CCM programme. While there will be leadership from many organisations and communities with the plan implementation, there will still have to be a core administrative heart across the wider process – and this role legitimately falls to the DHB as it has the requisite administrative, management, policy and strategic skills and the governance mandate.

It is suggested that CMDHB focus its attention strong on the whole system learning requirements of the plan. The plan will not work with a purely top down command and

control structure. A network based learning environment will need to be encouraged which is supported with robust proven, learning processes and with regular performance information from the evaluation process.

In this manner, CMDHB will develop a core competency in directing and encouraging learning and innovation adoption within the health environment, which will be important to its ongoing effectiveness as a leadership organisation.

7. Information Systems

There are many powerful information systems tools to support clinical decisions, patient administration and performance measurement. At present there are a number of unlinked systems that have the potential to become better aligned/linked/integrated to form a complete system of clinical management support for people with diabetes:

- *CCM Version II/CCM Care Plus/ Ministry guidelines in Predict:* Complete the development of the CCM Version II plan to make the CCM tools more useful and user friendly, update the CCM tools to support the clinical and administrative tasks associated with the Care Plus disease management activities and include the new guideline-based decision support tools in the CCM suite of tools.
- *Screening – CV/diabetes:* Provide general practice with the ability to undertake decision-support-assisted screening for CV risk and diabetes according to the New Zealand guidelines. There may have to be a dual approach. The preferred approach of embedding the screening tools and activity within the CCM suite of tools, and the contingency plan for those GPs who appear unlikely to take up CCM of supporting web based screening and risk assessment decision support tools. The objective is to maximise the penetration of screening and introduce general practice to the use of decision support tools to assist clinical activities.
- *Get Checked – annual check database*: The national data system that supports the *Diabetes Get Checked* programme should be aligned, or at least linked, with the CCM system to allow for simplified user data entry and reporting.
- *WDHB secondary care module:* Waitemata District Health Board is investing in the development of a secondary care based clinical support system and database for diabetes and cardiovascular disease. This system is being designed to fit with the CCM system to create a wider whole clinical system for primary and secondary care management of CV and diabetes. Counties Manukau needs to maintain close links with the development of the Waitemata system to see where the synergies lie with Counties Manukau secondary care needs and that issues of integration with the existing CCM system are managed from the user perspective.
- *Advice only support for brief interventions and self management counseling and resources on line:* A scoping study should be undertaken as to the practicality and value of the CCM platform being used to support brief intervention counseling and patient education via on-line evidence-based advice for practice staff and the provision of online education resources.

Part III

Implementation

Executive Summary

Let's Beat Diabetes presents an implementation challenge due to its breadth, complexity and cross sectoral approach. The need to reduce the risk factors for diabetes, slow disease progression and increase the quality of life for people with diabetes requires a response that encompasses whole-society action across the life course.

The implementation process must develop a community partnership that can create an 'atmosphere of leadership' that permeates local government, industry, the health sector and the population itself. The 'newness' of this project means implementation must support an explicit learning framework and strong feedback loops.

A governance structure is proposed that includes a broad stakeholder governance group that meets as a forum twice a year to provide overall guidance for the project and feedback from the broader society, a steering group made up of key action leaders that meets monthly and leadership hubs for each of the Ten Action Areas.

Counties Manukau District Health Board (CMDHB) will provide support for a project management team that coordinates the overall implementation process through the governance and steering groups and provides links across the various health sector actions.

The project management team will need to work closely with each of the partner organisations to ensure *Let's Beat Diabetes* is aligned to their strategic objectives and that the plan and implementation continue to deliver value to stakeholders and thereby maintains their commitment.

The implementation process includes an establishment phase for the first six months of 2005 when the governance and management structures are set up, detailed programmes designed in each of the Ten Action Areas, targets and key performance indicators set, reporting and evaluation mechanisms set up, and funding committed.

Implementation will be phased with most programme activity beginning from July 2005, but with some programmes scheduled to begin a year later to enable more detailed design and to manage the workload and complexity of the project, and a small number of programmes beginning earlier to ensure momentum is maintained from the planning during 2004.

There are a number of significant risks with the project associated with its breadth and complexity and the need for effective community and organisational partnership processes. These risks are mitigated to some extent by the community commitment shown to date, the strong interagency relationships in Counties Manukau, and the skills CMDHB, Manukau City Council (MCC), and other agencies have developed in implementing community based programmes.

It is noted that the implementation plan does not include a discussion on funding issues. These will be included in a separate 'business case' document.

Scoping the task

The Challenge

Implementing *Let's Beat Diabetes* represents a huge challenge for the health sector and for the wider Counties Manukau society. Reducing the risk factors for diabetes requires us to change some of the core components of our modern environment and lifestyle. Treating diabetes effectively needs health sector reorientation from its historic acute care model to a chronic care model, which requires a paradigm shift in roles, relationships and skill sets.

As the WHO has noted: *'In developed countries, the epidemiological shift in disease burden from acute to chronic diseases over the past 50 years has rendered acute care models of health service delivery inadequate to address the health needs of the population' (WHO, 2003)*

Our immediate challenge is diabetes - but to beat diabetes we must address head-on the current inability of society and our health sector to respond effectively to chronic disease.

These deep structural issues must be manifest in both programme design and in implementation.

Implementation challenges inherent in the programme design

- *Let's Beat Diabetes* describes a set of Ten Action Areas that, when implemented, will have a material impact on obesity, diabetes and other chronic diseases, such as cardiovascular disease. The 10 areas are wide in scope and emphasise a whole society approach and the need for sustained commitment over time by government agencies, industry and communities.
- *Let's Beat Diabetes* is committed to the principles of partnership, participation and protection permeating all aspects of design and delivery, specifically in its relationship with Maori and more generally as a guiding philosophy for meaningful civic leadership.
- *Let's Beat Diabetes* notes the importance of community ownership and the use of culture to embed sustainable change in our society.
- *Let's Beat Diabetes* is a plan for the Counties Manukau district (not just a health plan) and as such has a different and far more complex dynamic in terms of governance and operational management than a normal sector-specific strategic plan.
- *Let's Beat Diabetes* is new. It is moving into new ground for a district health board in New Zealand, forging new partnerships and designing and implementing new programmes. Some programmes are being developed in areas where there is not conclusive evidence of effectiveness, therefore a strong learning and evaluation framework is required.
- In some areas *Let's Beat Diabetes* programmes cannot be implemented without a fundamental change to the traditional skill sets, organisational capacity and accountabilities of parts of the health sector.

- *Let's Beat Diabetes* will require significant financial investment from multiple funders.
- *Let's Beat Diabetes* is aiming for integration of campaigns at the district level, with consistent branding, messages and resources. Achieving this will require influence over the focus of national agencies,

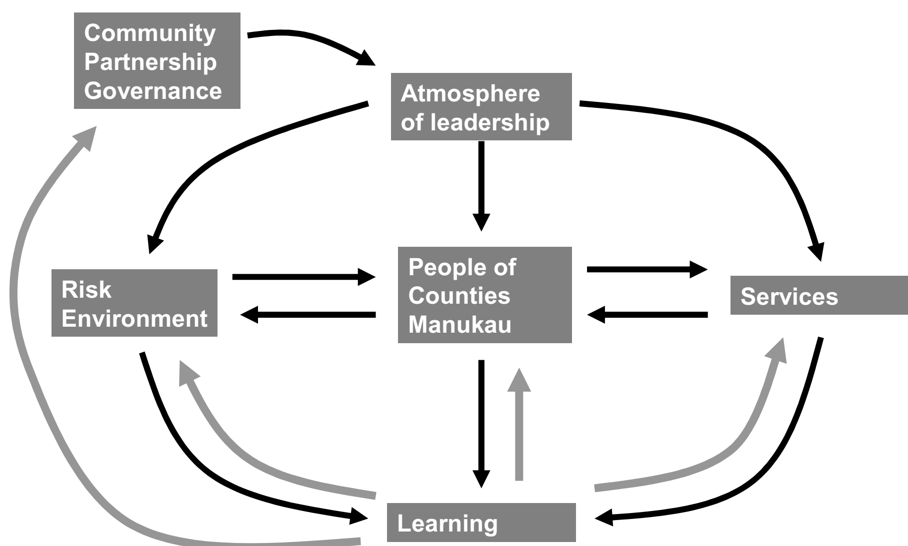
Required outcomes

Let's Beat Diabetes must stop people getting diabetes, slow the disease progression and increase the quality of life for people with diabetes.

Achieving this vision will require:

- Changes to the environment and behaviour at all stages in a person's life
- A reduction in the proportion and number of people who are overweight and obese
- Early identification of disease
- Best practice approaches to disease management
- Improved self management and adherence to treatment
- A more supportive family and community environment for people with diabetes.

Necessary system characteristics



The graphic above is an attempt to provide a fundamental picture of the system characteristics required to meet the outcomes of *Let's Beat Diabetes.*

To achieve real change requires a groundswell of understanding and commitment – and a common direction. This is described as an 'atmosphere of leadership' in the graphic. The atmosphere of leadership and an understanding of direction should permeate health service providers, communities, industry and local government.

The atmosphere of leadership will take on a life of its own, as all successful societal changes do, but in the early stages it will require spark and fuel – and this is the role of the community partnership governance.

Activities to change the risk environment (both behavioural and environmental risk) and the service environment will be more effective if the population is not a passive recipient, but an active participant in shaping the sorts of changes required.

Finally, there are no 'off-the-shelf' models for beating diabetes. There is evidence from multiple sources to help plan the journey, but central to success will be the ability of all parties to learn fast about what is working and what is not. This new knowledge needs to be shared at a local level and also to be fed back to the community partnership leadership in order to shape the overall plan.

The implementation plan attempts to influence all of the necessary system characteristics.

Implementation structure and process

Programme shape and implementation phasing

ID	Task Name	2005				2006				2007				2008				2009			
		Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
1	Governance structure and project team development																				
2	Programme design and establishment (Phase I)																				
3	Phase I implementation																				
4	Programme design and establishment Phase II)																				
5	Phase II implementation																				
6	Major evaluation report																				
7	Planning for second five year plan																				

The Gantt chart above describes the basic shape of the *Let's Beat Diabetes* plan. The first six months of 2005 are an establishment phase in which district governance structures are put in place and the project team set up. There is intensive detailed programme design. A small number of CMDHB-funded initiatives begin in order to maintain momentum from 2004 planning.

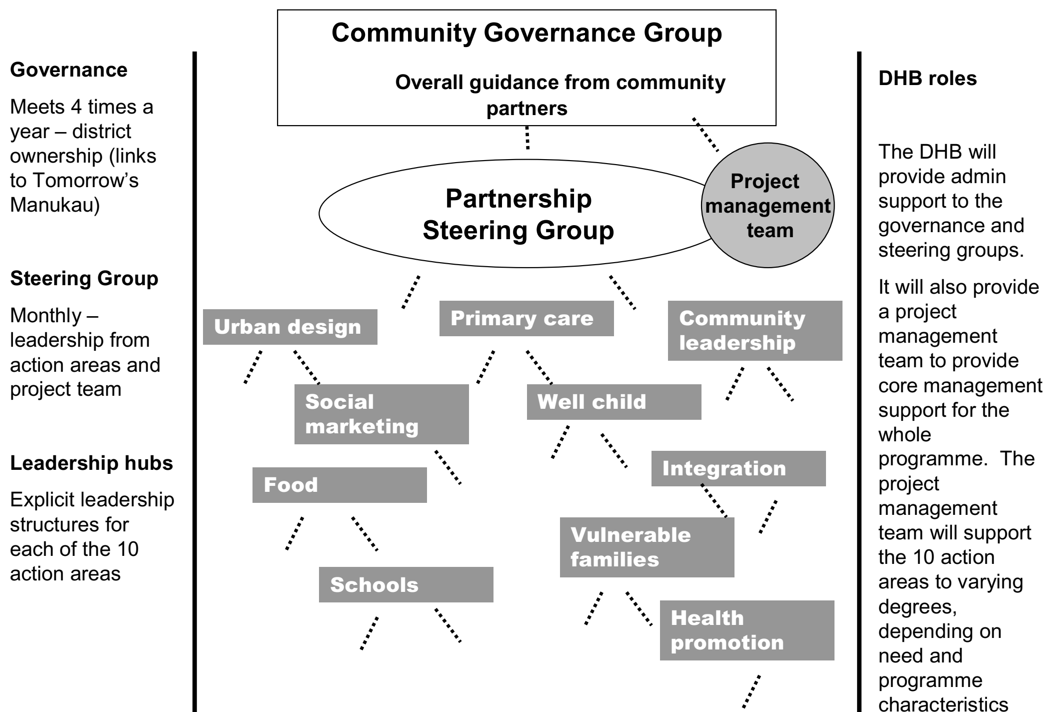
From 01 July 2005, sustainable funding becomes available for the programme. The second half of 2005 sees a number of programmes (Phase I programmes) implemented with programme design work continuing for Phase II programmes.

The programme design and implementation is divided into two phases to manage the workload, complexity and to align with other external programmes and activity. The first wave of programmes will create a more conducive environment for those that follow later in the year.

The evaluation process will be ongoing from mid 2005, supporting a continuous quality improvement process and rich learning environment, however, it is proposed that there is a major milestone report at the end of year three to review progress and support any adjustments that are required over the final two years of the project.

It is proposed that a substantive planning process is undertaken in year five to develop strategic directions for the next five years.

Developing community partnership governance



The graphic above describes the overall governance and leadership structure for *Let's Beat Diabetes*. There has been much discussion and debate over the most effective format for community partnership governance. There is a tension between having an effective and focused leadership group to drive the project forward and the need for broad community membership and guidance for the project.

There is also a tension between wanting community governance to retain guidance for the plan as a 'whole' but also to maximise the ability of the various parts to be action orientated, not held back by bureaucracy and to learn from each other without a hierarchical system of control. Conversely, if governance groups do not have any power or influence, participants soon lose commitment to the process.

Underlying the governance structure is a commitment to open governance and community empowerment, with documentation from meetings available on the *Let's Beat Diabetes* website.

The proposed governance structure is an attempt to navigate through these issues.

The structure has three key levels.

i. *Community Governance Group*: This group will own the plan and provide overall high level leadership and guidance for its implementation. The group will represent the key organisational and community stakeholders. It will be quite large (e.g. 30 members) and would meet in a forum situation twice a year (or more often if required) to receive reports on progress, provide feedback from the community and partner organizations, and provide guidance on issues.

ii. *Partnership Steering Group*: The Partnership Steering Group provides operational leadership and co-ordination for the plan implementation. The group will be made up of leaders from the action areas, CMDHB project team members, and identified enthusiasts and experts. Consumer representatives may also with to participate in the steering group on particular issues. It is anticipated the steering group will meet monthly. The steering group will also develop reports for Tomorrow's Manukau Te Ora O Manukau/Manukau the Healthy City Outcome Group to ensure that the partnership and information flow with Manukau City Council (MCC) and other key district organisations is maintained.

iii. *Leadership hubs*: Leadership hubs will be established for each of the ten action areas. The hubs will vary considerably from area to area. In some cases it may be a specific new working group, in others it may be a new accountability for an existing group. Composition will differ to fit the functional needs of the programmes. Efforts will be made to develop stable individual leadership within each action area so that a consistent team develops at the steering group level. Efforts will be made to support non-DHB leadership in many of the action areas to reflect the whole society approach. Functional networking across the action areas will be encouraged.

Supporting effective project management

The governance structure must be supported by effective project management. The breadth and complexity of *Let's Beat Diabetes* creates new challenges and accountabilities across the societal response and across the health sector.

It is proposed that a dedicated project support team is located in CMDHB and would be funded by CMDHB.

The role of the project support team would be to provide administrative and project support for the governance, steering and action areas. It would also deliver expertise and programme design skills for the overall project and to lead and co-ordinate CMDHB's commitment to the project. The project team would also be responsible for overall performance reporting and would provide links back into CMDHB funder and provider operations.

The project team will require management and clinical leadership, with support for the complex co-ordination task.

Alignment and commitment

A critical success factor in creating the 'atmosphere of leadership' necessary to beat diabetes is the ongoing commitment from multiple organisations. CMDHB acknowledges that it will provide the greatest component of resource and administrative support for the programme but other organisations must also commit or the plan will fail.

In order for organisations to commit, the plan must align with their directions and deliver strategic and operational value. If *Let's Beat Diabetes* ceases to deliver perceived value to stakeholders, they will disengage. All organisations have a different view of what constitutes value, and sustainable partnerships will require continually assessing what value is being delivered for all stakeholders and modifying activity where necessary.

The CDHB project team must develop a set of relationships which are not 'one size fits all' but which encompass an in-depth understanding of the needs of key partners in terms of their requirements of partnership, their ability to participate, outcomes that are valuable and meaningful for them, and effective means of communication for their organisation.

A key early point for alignment and commitment will be in constituting the make-up of the partnership steering group, leadership groups for each of the Ten Action Areas, and in the detailed programme design and resource commitment.

Outlined below are the Ten Action Areas and the Enablers and some indications of potential organisations involved in each of the areas. The CMDHB project team will offer administrative and project support for all Ten Action Areas, but the level and type of support will vary considerably depending on need and function. A number of the action areas may be provided administrative and project support by partner organisations.

Action Area	Organisational leadership
1. Community Leadership & Action	Church and marae Community organisations Tomorrow's Manukau organisations CMDHB, ARPHS, PHOs
2. Social Marketing	CMDHB, SPARC, Pharmac, MCC, ARPHS, MOH, NGOs
3. Urban Design	MCC, CMDHB, ARPHS, Housing
4. Food Industry	Food industry, CMDHB, ARPHS
5. Health Promotion	CODA group, CMDHB, Diabetes Projects Trust, NGOs, PHOs, ARPHS, DPT
6. Well-Child	CMDHB, Plunket, MOH, NGOs, Kidz First, PHOs
7. Schools	CMDHB, MOE, MCC, Trustees, Principals, SPARC, NGOs, food industry, Kidz First
8. Primary Care (Chronic Care Management)	CMDHB, PHOs, RNZCGP, Whitiora, NGOs
9. Vulnerable Families	MSD (Work and Income, Family and Community Services), NGOs, CMDHB, Plunket,
10.Service integration	CMDHB, Chronic Care Management, Whitiora, PHOs
Enablers	
Consumer	Consumers, NGOs
Maori	Marae, Kura, NGOs, CMDHB, PHOs
Pacific peoples	Churches, NGOs, ethnic leadership groups, CMDHB, PHOs
Funding Environment	CMDHB, MOH, SPARC, MCC, PHOs, Pharmac, MOE, UoA
Learning Environment	CMDHB, UoA, RNZCGP, CCREP, MIT, other DHBs
Governance	CMDHB funder and provider, local govt (x3), reps of 10 action areas, Maori, Pacific, Asian communities, consumers, national agencies, evaluation, clinical reps
Organisational Development	CMDHB, MIT, NGOs, Whitiora, PHOs, Kidz first
Information Technology	CMDHB, PHOs, MOH, other DHBs, IT providers

Design, performance and learning

Programme design work during 2005 will require detailed development of each of the Ten Action Areas, many of which require cross organisational planning.

Some of the projects are relatively straight forward. Others will require significant detailed technical design. The CMDHB *Let's Beat Diabetes* project team will need to

provide technical support and guidance for programme design in a number of areas, with specialist skills being seconded into support roles as required.

The development of the programmes should link closely to the learning systems and performance measures for *Let's Beat Diabetes.*

It is important that the leadership groups for each of the Ten Action Areas develop their own targets and performance measures. Top down goals and measures may work in a single organisational structure, but since *Let's Beat Diabetes* works with cross organisational collaborations, goals and measures must be owned by all parties.

The leadership groups for each of the Ten Action Areas will be expected to provide a set of goals and Key Performance Indicators by April 2005 and these will be consolidated into a document that outlines goals and measures for the entire *Let's Beat Diabetes* programme.

The evaluation process can help to develop ways of measuring whether processes are effective and outcomes are being achieved. It is much more effective to develop these evaluation measures at the point of design, rather than add them on later. The evaluation plan is expected to be completed by May 2005. The evaluation approach is that of supporting Continuous Quality Improvement across the *Let's Beat Diabetes* Action Areas. The evaluators will have to be familiar with each of the Ten Action Areas to determine how they can best add value and learning outcomes for each area as well as for the wider plan.

The enabler areas will be supported through the CMDHB project team and through some existing support structures within the CMDHB environment (e.g. workforce development, information systems, Maori and Pacific services).

Branding and developing the plan as an entity

One of the core aspects of the atmosphere of leadership is to develop the *Let's Beat Diabetes* plan as part of the Counties Manukau cultural landscape. The plan itself needs a positioning and marketing strategy – which is a different issue to the social marketing strategy about diabetes.

One of the early tasks in the implementation process will be to develop a branding and marketing strategy for the plan.

The plan needs to have a recognisable image and identify and to represent a set of goals that all parts of Counties Manukau wish to contribute to. It must be set up for longevity and to be around in a recognisable form in five years time.

The branding strategy will need to appeal to key communities, such as Maori and Pacific people, as well as to industry and other government agencies. It will also need to be able to align with government strategies, such as the national *Healthy Eating Healthy Action Framework.*

Risk management

There are risks inherent in the *Let's Beat Diabetes* programme design and implementation.

The programme design is broad, complex and ambitious, and relies to a considerable extent on the motivation and goodwill of partner organisations and communities to join the health sector in fighting obesity and diabetes. The implementation of a plan of this nature has not been tried by a DHB before. In many ways CMDHB is running ahead of government policy and MOH guidelines in the scale and scope of the *Let's Beat Diabetes* plan, and hence there may not be a great deal of guidance and supportive processes at a national level.

The positive balance to the inherent risk is that the response to date to the *Let's Beat Diabetes* planning process has shown the depth of commitment in Counties Manukau to beat diabetes and the strong history of functional interagency relationships provides a platform to build from. The timing feels 'right' in terms of a conducive Counties Manukau environment.

CMDHB has excellent skills in community partnering and project management and has indicated that it will provide sustained resources to support *Let's Beat Diabetes* over a five year period. Given the trends in obesity and diabetes, it is likely that the government will provide support to the programme and will highlight it as an exemplar for other DHBs to follow.

Further details of risks and mitigating strategies are outlined below.

Risks	Descriptions	Mitigation
Poor external ownership	Failure of organisational commitment to governance structure and action area leadership	Significant effort has gone into planning phase to align organisations (commitment through summit) This will be firmed up into specific commitment during Q1&2 of 2005
Poor internal ownership	Failure of internal support, alignment within DHB funder and provider arms (other priorities)	High level support from EMT and the Board, and alignment of goals across diabetes plan and broader system and clinical outcomes
Swamped by complexity	Project team is unable to deliver on time due to size and scope of project, design complexity and operational complexity	Maintain high skill level in core team, fund access to specific experts when required, phase activity, review regularly
Evaporation of interest	Internal and external interest evaporates at multiple levels (governance and operational)	Maintain pace of change, include strong learning framework in programme design and evaluation, highlight achievements (and achievers) and provide positive feedback across the broader change programme (a sense of campaign)
Slow wins	Lack of tangible results leads to loss of momentum.	Structure programmes with explicit early wins, identify and publicise KPIs, and celebrate process as well as outcome

		achievements
Capacity and skill lack	Change management, programme design and implementation skills lacking leads to stalled programmes. Risk especially in primary care sector given extent of change	Early identification of skill/capacity lack and investment is skill development. Present and reinforce as top priority
Inconsistent funding environment	Funding environment changes from year to year leading to sector uncertainty about commitment	CMDHB Board agrees to committed and stable funding stream. CMDHB funds supported by resources from other sources. Ongoing engagement of key funders

Establishment phase and developmental phase activities

The set of graphics below outline the key tasks for the establishment phase (first six months of 2005) and the developmental phase (July 2005 – June 2006) of *Let's Beat Diabetes*.

The set of tasks is broken up into governance and management tasks and the activity areas themselves.

Governance, project support and establishment

ID	Task Name
1	**Governance**
2	Identify key partners and set up Stakeholder Governance Group
3	Develop leadership structures for each of the 10 action areas
4	Build operational steering group from key leaders form 10 areas
5	Review existing governance structures and align with LBD structures
6	**Project support**
7	Appoint staff to LBD project team within CMDHB
8	Clarify roles and accountabilities with existing DHB structures
9	**Programme design and performance**
10	Identify targets and KPIs with 10 action areas
11	Ensure targets and KPIs are reflected in partner organisation strategic and operational plans
12	Develop detailed programme design for 10 action areas to inform phasing issues for project management and funding requirements.
13	**Communications and relationships**
14	Presentation of diabetes plan to key partner organisations
15	**Evaluation and learning**
16	Maintain open process of communication and learning through Let's Beat Diabetes web site, which will include core information about all projects and evaluation
17	Develop overarching evaluation framework, aligned to CQI learning process and identified key performance indicators
18	Implement evaluation

Action Area tasks

ID	Task Name	Q1 05			Q2 05			Q3 05			Q4 05			Q1 06			Q2 06			
		Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul
1	**Community leadership**																			
2	Set up community fund and develop workforce programmes for Tomorrow's Manukau organisations																			
3	Community fund operational and organisations implementing health workforce plans																			
4	**Social marketing**																			
5	Launch Let's Beat Diabetes, communicate plan to district, develop contract relationship with professional partner to deliver social marketing programme																			
6	Begin social marketing programme																			
7	**Urban design**																			
8	CMDHB to work with Manukau City to support healthy urban design in Flat Bush and redevelopments of existing urban hubs																			
9	**Integrated Health Promotion**																			
10	Revitalise district health promotion co-ordination through improved support for CODA group and links to HPOs. Develop plan of action.																			
11	Implement contracts for capacity building, co-ordination and resource development for health promotion																			
12	Develop enhanced programmes to achieve targets and implement																			

ID	Task Name
1	**Healthier food supply**
2	Develop and implement strategies to improve food supply with food industry partners
3	**Enhancing Well Child Services**
4	Undertake training and develop resources
5	Implement new programmes
6	**Healthy schools**
7	Development of governance structure and set of agreed targets for schools and support providers. Identify resource requirements to meet targets.
8	Support expansion of NEW programme to align with UoA health schools research
9	Improve co-ordination and marketing of existing programmes to preschools, Kura and primary schools
10	Develop enhanced programmes to achieve targets and implement
11	**Primary care based prevention**
12	Programme design activity around brief interventions, post diagnosis education and family intervention trial.
13	Workforce development programmes implemented
14	Implement enhanced brief intervention programme (linked to social marketing), improved post diagnosis patient education (expert patient) and family group intervention trial.
15	Encourage primary care based diabetes screening as per the NZ guidelines

Q1 05: Jan Feb Mar | Q2 05: Apr May Jun | Q3 05: Jul Aug Sep | Q4 05: Oct Nov Dec | Q1 06: Jan Feb Mar | Q2 06: Apr May Jun | Jul

ID	Task Name
1	**Integrated care for advanced diabetes**
2	Build whole disease management centre of excellence at Whitiora Middlemore Diabetes Centre
3	Work with PHOs to define clear expectations of diabetes management from point of diagnosis and required support systems
4	Improve co-ordination of quality enhancement programmes such as retinal screening, gestational diabetes, foot care, dialysis review, Get Checked for strategic guidance of programme development
5	Support development of enhanced primary care capacity through increased access to community pharmacy, dietitian, psychologist, social worker and community worker expertise in primary and secondary care.
6	Improve linkages to social services for people with diabetes to ensure they are receiving correct entitlements and support for remaining in employment
7	Work with MIT to develop recognised education courses that provide support the new skill sets – in both new graduates and upgrading existing workforce – for chronic disease management
8	Work with RNZCGP to develop collaborative learning process for innovation adoption amongst GPs

Q1 05: Jan Feb Mar; Q2 05: Apr May Jun; Q3 05: Jul Aug Sep; Q4 05: Oct Nov Dec; Q1 06: Jan Feb Mar; Q2 06: Apr May Jun; Jul

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