Working together

HealthShare
He Rourou Takitahi
Midland district health boards' shared services agency

This quarterly newsletter is produced by HealthShare Ltd.

HealthShare Ltd supports and enables the Midland District Health Boards as its shared services agency - working in collaborative partnerships, leading and facilitating change, building a future focused organisation.

About
our midland region

DHB	PHO
Bay of Plenty	Eastern Bay Primary Health Alliance Nga Mataapuna Oranga Ltd Western Bay of Plenty Primary Health Organisation Ltd
Lakes	Pinnacle Midlands Health Network - Lakes Rotorua Area Primary Health Services Ltd
Hauora Tairāwhiti	Pinnacle Midlands Health Network - Tairāwhiti Ngati Porou Hauora Charitable Trust
Taranaki	Pinnacle Midlands Health Network - Taranaki
Waikato	Hauraki PHO Pinnacle Midlands Health Network - Waikato *National Hauora Coalition

MOH categorises Counties Manukau DHB as the lead DHB for the National Hauora Coalition (NHC), which excludes NHC from the Midland DHB list, however NHC figures have been added into the above table for Waikato DHB - where NHC provides a locally based service.

21%

The Midland region covers an area of 56,728 km², or 21% of New Zealand's land mass.

Stretches from Cape Egmont in the West to East Cape and is located in the middle of the North Island.

5 DHBs

Five District Health Boards: Bay of Plenty, Lakes, Hauora Tairāwhiti, Taranaki, and Waikato.

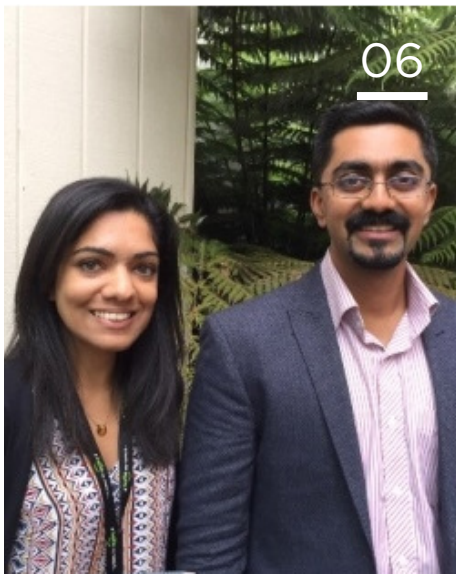
Includes major population centres of Tauranga, Rotorua, Gisborne, New Plymouth and Hamilton.

924,165 people (2017/18 population projections), including 237,020 Māori (26%) and 43 local iwi groups.

Our six regional objectives

- Health equity for Māori
- Integrate across continuums of care
- Improve quality across all regional services
- Build the workforce
- Improve clinical information systems
- Efficiently allocate public health system resources

In this issue



A word from the HealthShare CEO

HealthShare
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...continuing our journey together towards 'one team'

Andrew Campbell-Stokes
CEO, HealthShare

Midland District Health Boards' shared services agency

Over the past 18 months HealthShare has been on a journey together – revitalising our Vision, Mission and Values, as we continue to support the delivery of health services in the Midland region. All staff from across our teams have contributed to the emergent statements that they feel best describes HealthShare's essence, ie the 'what, why, and way we work'.

I am delighted to share that HealthShare's Board of Directors (the Midland DHB Chief Executives) have considered and endorsed our revitalised Vision, Mission and Values. In essence our mission statement hasn't changed. Our vision and values now aligns with our shareholders (Midland DHBs) and partners in health.

My acknowledgement and personal thanks to Matua Hemi Curtis, Te Puna Oranga (Waikato DHB Māori Health Service) who has been guiding our organisation's journey of learning, discovering and expressing of our intent – particularly our whakatauki and values. Also Ron Dunham, HealthShare Board Chairman, who facilitated our discussions.

Our Vision Hei oranga he hapori, kia oranga te whānau - When communities are well, whānau will thrive

Our Mission To support Midland DHBs by working in collaborative partnerships, leading and facilitating change, building a future focused organisation.

Our Values

- Focus on people	- Kia haangai te iwi
- Do the right thing well	- Whaia te mea tika
- Act with integrity	- Mana tangata, ngaakau pono
- Be courageous	- Kia maia, kia manawanui

This is an important milestone, and one which prompts follow-up questions for each of us, such as; "what's next?", "what do they mean for me?", "how do I live these?" Whilst activities will be organised to assist our ongoing discussions, I encourage you to have a conversation with someone else about what this means.

"What I regard as being special and significant is that these statements are what we have chosen to reflect us.

We have taken content and moulded it to reflect what our vision is, who we believe we are – and are increasingly becoming – and how we seek to go about achieving this."

Find out more about HealthShare
Andrew Campbell-Stokes | CEO, HealthShare Ltd
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eSPACE

UPDATE FROM THE eSPACE TEAM

David Page is the eSPACE Programme Director and has been leading the team since December 2015. David has been involved with health transformation programmes in New Zealand for the last seven years. His role is to shape and deliver the strategic direction of the eSPACE programme.

Our focus as a team is to begin the transition of DHBs off legacy systems on or before 1 July 2019, while continuing to develop specific functionality within the Midland Clinical Portal (MCP).

We launched the MCP foundation in an initial read-only capability in July 2017. Since then, an ever-increasing number of clinicians (c.3000 in June 2018) from all five DHBs now have access to more than 3 million patient events and 2.2 million patient documents across the region. From a clinical perspective, as we move away from DHB clinical workstation systems (such asHealthviews, Concerto, and CHIP) to MCP, the question "What am I getting next?", is one we are often asked.

The scope of the eSPACE Programme is large, varied and complex, but at a high level includes the following areas which, overall take the current MCP system from a read-only capability, to one that provides full interaction (read/write) and built-in 'smarts' to assist clinical decision-making:

1. Clinical Portal (demographics, in-patient / out-patient / emergency department events, some current electronic form data, national and local DHB alerts and allergies) – delivered in July 2017 and providing read-only access to patient information across the Midland region.
2. Forms and Workflows (discharge/transfer of care, progress notes, pre-anaesthetic assessment, general assessment, mental health and addictions solution, other forms).
3. Results and Ordering (the ordering, reporting and acknowledgement oflaboratory and radiologyresults).
4. Imaging and Linked Systems (visibility of knowledge based links, visibility of diagnostic imaging acquired in the Midlands DHBs).
5. Community Access (the two-way sharing of DHB, PHO and community based care providers' patient data – where possible).
6. Medicines Management (prescribing, dispensing – including NZePS/hospital and community data – reconciliation and administration).
7. Whiteboard (provision of an interactive electronic 'Whiteboard' to provide at-a-glance views of data).
8. Referrals (Inter-DHB, intra-DHB to the Midland region, external referrals to primary care organisations, and out of the Midland region patient referrals).
9. Integration with other regions (Starship / Northern region, Central TAS and the South Island).
10. Access to historic data (to enable decommissioning of local systems).

The scope of the Programme is obviously too large to implement all at once. Therefore the plan for delivery to build on the MCP foundation that is already in place will be phased in over several years, but within the timeframe of our regionally approved business case.

Our vision of 'One Patient, One Record' for a region home to approximately one quarter of New Zealand's population is a bold one, and to help us to progress efficiently, we have adopted a framework that should lead to a more successful implementation of MCP:

1. **Transformational**. eSPACE is a change programme, not a technical implementation. This will require the Programme to collaborate with DHBs to implement effective change and learning strategies. We are introducing new technology and, with regional agreement, many processes will become standardised / regionalised.
2. **Well designed**. We are taking our directions as we build MCP from clinicians across the region to ensure access to clinical information and functionality is intuitive, clean and as seamless as possible. Orion software lies at the core of MCP, but to ensure we can continue to develop and grow capability well into the future, we need to ensure:
    a. System wide interoperability (with other software)
    b. Speed (response times)
    c. Accessibility (mobility of applications and devices)
    d. Safety (of patients and their data and of the information that is presented to clinicians)
3. **Not like for like**. eSPACE will not deliver like for like replacement of legacy clinical work station functionality in MCP.
4. **Regional**. MCP is a regional system and as such we have sought and will continue to seek regional agreement on its requirements from all DHBs.
5. **Tactical**. We are not aiming for perfection on day one – good is good enough – and so we will use a mix of tactical and strategic deployments to deliver rich functionality that might change over time.
6. **Standards based**. Well structured master data using available standards.
7. **Leveraged solutions**. We will seek to use software configurations from elsewhere in New Zealand or Europe, rather than embarking on significant and bespoke development, preferring to change our processes over changing the software itself.
8. **Not Big Bang**. We are seeking incremental functionality releases so that DHBs can enter an agreed, safe and orderly transition pathway. The functionality that becomes available to one DHB at the commencement of this process will, technically, be available to all should they be ready to receive it, but each DHB will move to adopt functionality at an appropriate and absorbable pace.

We are presently undertaking detailed due diligence of current state functionality for each of the five legacy clinical work stations across the region. This work is critical to help us determine the minimum viable functionality that is required for each DHB to commence transition to MCP.

As of June 2018, we are in advanced discussions with Bay of Plenty DHB and Hauora Tairāwhiti. Discussions with Lakes DHB and Waikato DHB have commenced and preliminary discussions with Taranaki DHB are yet to be confirmed over the next few weeks.

While the sequencing of DHBs switching over to MCP is yet to be decided, we are confident that within the window of June to October 2019, the technology will be made ready to offer the region functionality that includes (but is not limited to) a discharge summary, progress note, general assessment form and a pre-anaesthetic assessment form. In addition there will be an interim Results capability and an interim Mental Health and Addictions solution.

There is much to do between now and then. Critically, there are many areas that require regional decisions and significant, broad and deep clinical engagement. We would therefore welcome anyone who is interested in providing their input and/or leading specific pieces of work, to get in touch. Feel free to contact your local Clinical Information Reference Group (CIRG) Chair, eSPACE Clinical Authority Chair Dr Ian Martin, (Ian.Martin@waikatodhb.health.nz) or myself, David Page (david.page@healthshare.co.nz) to discuss where you can add value and assist the region.

Midland Cancer Network update

Midland Bowel Screening Regional Centre

Lakes DHB National Bowel Screening Programme consumer hui

The Midland Bowel Screening Regional Centre recently assisted Lakes DHB to facilitate a National Bowel Screening Programme consumer hui.

The aim of the hui was to hear from Lakes DHB consumers around what strategies could be used to increase Māori participation in the Lakes DHB bowel screening programme, due to be rolled out in September 2018.

The hui was an opportunity for the consumer group to share personal experiences, journeys and learnings and provided the regional bowel screening team with numerous ideas to explore further including:

- Kanohi ki te kanohi (face to face) hui with local Marae committees, Iwi Trusts and land incorporations work best for Māori as well as the availability of information about the bowel screening programme
- Social blogging could be utilised for awareness and participation with the right personality leading it. Talei Morrison's latest influential 'Smear your mea' campaign was continually referred to throughout the hui.
- Use of local personalities on posters with appropriate key messaging
- Essential to include prevention as part of the journey as well as demonstrating lifestyle changes
- School health literacy plan targeted at younger generations to encourage whānau participation.

All seven consumers agreed to become local community champions within the areas of the Lakes region.

It is anticipated that a further hui will take place in end of July to consolidate initial plans prior to the Lakes DHB bowel screening programme going live 11 September 2018.

Cancer services closer to home

Dr Pragya Attri and Dr Prashanth Hari Dass (left to right)

Welcome to the new resident Medical Oncologist, Dr Prashanth Hari Dass and his Registrar Dr Pragya Attri.

Their appointments are the result of a project that reviewed cancer volumes and the increasing demand for medical oncology cancer services at Lakes DHB.

Prior to the commencement of the new service, patients were required to travel to Waikato DHB for all first specialist appointments (FSA). The new service will provide medical oncology FSA services closer to home for the patients of Lakes DHB, in line with other Midland DHBs and the New Zealand Health Strategy.

Midland cancer patient information project

Online patient information resources

The Midland Region Cancer Clinical Nurse Specialists and Cancer Nurse Co-ordinators have revised and produced a number of information resources for Midland cancer patients

The patient information leaflets will be available on the new Midland Cancer Network website and from the local Cancer Clinical Nurse Specialists and/or Cancer Clinical Nurse Co-ordinators.

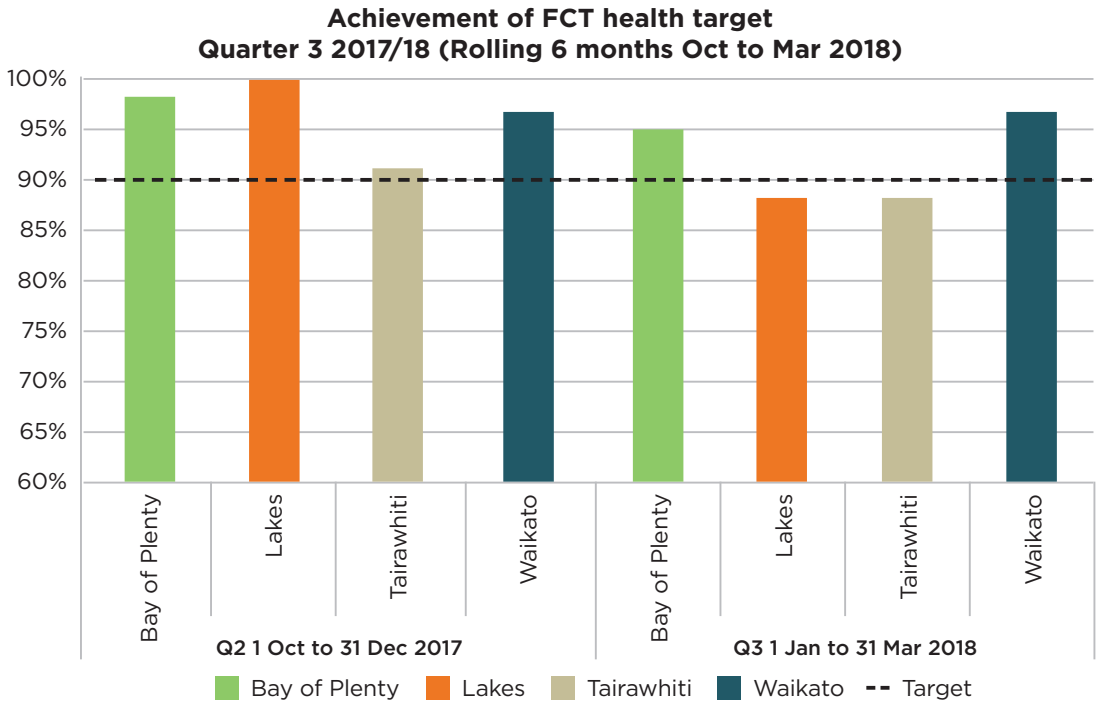
The Midland Region Cancer Clinical Nurse Specialists and Cancer Nurse Co-ordinators will continue to work on developing further resources for Midland region cancer patients.

Midland Cancer Network web-based reports

Midland Cancer Network is working towards making key cancer data for the region available through web-based reporting. Reports that are currently available are cancer registration numbers for the Midland DHBs and Faster Cancer Treatment (FCT) reports. No NHI level identifiers are included in these reports.

The FCT reports show quarterly performance of the individual Midland DHBs and the MCN DHBs as a whole, in achieving the 62 day FCT health target (from referral - triaged as high suspicion of cancer triaged to be seen in 2 weeks, to first treatment) and the 31 day target (from decision to treat to first treatment). Further details of each indicator are available by ethnicity, tumour stream, treatment type, cohort and delay analysis.

Areas identified for future report development include oncology and haematology service volumes by purchase units, PET-CT volumes, and cancer mortality data. Access to the web-based reports are only available to authorised users, and each Midland DHB will have an authorised user or users.



Reporting Quarter		B.O.P	Lakes	Tairawhiti	Waikato	Midland
Q2 2017/18	Number in health target	54	11	23	87	175
	Number met target	53	11	21	84	169
	% Met target	98%	100%	91%	97%	97%
Q3 2017/18	Number in health target	39	16	17	61	133
	Number met target	37	14	15	59	125
	% Met target	95%	88%	88%	97%	94%

For more information contact:
Jan Smith | Manager, Midland Cancer Network | HealthShare
jan.smith@healthshare.co.nz | www.healthshare.co.nz | www.midlandcancernetwork.org.nz

Regional Pathways of Care

Midland Regional Community HealthPathways is here

On 2 July 2018, we launched the Midland Regional Community HealthPathways for the region's five DHBs, eight PHOs and approximately 200 general practices. This has been a rapid transition due to the Map of Medicine UK decommissioning their tool as of 30 June 2018, and learning of this outcome in November 2017.

After receiving approval and support in April 2018 from the region's CEs, with the Midland United Regional Integrated Alliance Leadership team, it was agreed the region would move to the Community HealthPathways tool.

HealthPathways Community

The HealthPathways tool will connect us with a large collaborative community[1] throughout New Zealand, Australia and the UK, where we can collaborate, share knowledge, service configurations, and transform pathways of care for the people of the Midland region. This collaborative community has been growing over the past 10 years and the pathways tool is being increasingly enhanced and improved. Feedback from the Midland region PHOs has been very positive about the change. The pathways of care team are excited to move into a new phase in the Regional Pathways of Care Programme.

Christine Scott
Project Manager

Jo Hollobon
Regional Lead Editor

MIDLAND REGION
Community HealthPathways

Translation

The region's primary and secondary clinicians with support from the pathways of care team, under the governance of the Regional Pathways of Care Group, have been in the process of translating the 126 localised (Midland region) pathways. This translation process involves moving the information held in the Midland Region Map of Medicine and Bay Navigator over to the HealthPathways format. We have achieved three published pathways and their respective request (referral) pages and all the other pathways will be accessible to the region's clinicians in the new tool through links until they have been translated into the HealthPathways format in the months following.

Integrations

The current integrations with the BPAC patient prompt and eReferrals will be replicated in the HealthPathways tool. The team are also working with PHOs, DHBs and vendors of other clinical systems in the region to integrate the new Midland Region Community HealthPathways into clinician workflow.

Pathway work

The Regional Pathways of Care Governance Group will work with the region to determine the priority of the publication of new pathways onto the Midland Region Community HealthPathways tool.

If you wish to access the Midland Region Community HealthPathways and you do not have access via your clinical system you can use the following link: https://midland.communityhealthpathways.org.

To receive the user login details or for any further enquiries please email healthpathways@healthshare.co.nz.

For more information contact:

Damian Tomic | Chair - Regional Pathways of Care Governance Group | damian.tomic@waikatodhb.health.nz
Christine Scott | Project Manager | christine.scott@healthshare.co.nz
Jo Hollobon | Regional Lead Editor | jo.hollobon@healthshare.co.nz

1. www.healthpathwayscommunity.org

Motorcycle Related Trauma in the Midland Region

A novel collaborative study between the NZTA (NZ Transport Agency) and MTS (Midland Trauma System) has identified on road motorcycle crash injuries as an area of particular interest. During 2012-2016, the NZTA 'Crash Analysis System' (CAS) recorded a total of 1,331 motorcylce casualties on roads within the Midland Region (as colllected by NZ Police). During the same time, the MTS Trauma Registry recorded 689 persons admitted to hospital due to on-road motorcycle crashes within the same geographic area.

Motorcycle casualties, occuring in Midlands*, were reported to police during 2012-2016 **1331**

386 26% of those reported to police were also admitted to hospital as trauma patients

Additional on-road motorcycle casualties were admitted to hospital who were not amoung police records **303**

689 Total amount of motorcycle crash casualties were admitted to hospital (Police records underestimated on-road casualties by 18.5%

Police reports only captured 56% of on-road motorcycle casualties who were admitted to hospital **56%**

**Excluding Tairāwhiti DHB due to incomplete dataset*

Merging police (CAS-NZTA) and MTS trauma registry data is providing new insight into the true extent and nature of motorcycle crashes resulting in hospital admission within the Midland Region. Future studies will examine crash locations, the direct in-hospital and wider social costs of motorcycle trauma, as well as contributing factors and behaviours of those admitted to hospital following a motorcycle crash.

For more information contact:
Grant Christey | Clinical Director, Midland Trauma System | grant.christey@waikatodnb.health.nz
www.midlandtrauma.nz

New Midland region child health data tool

Now available

Over the past year the Child Health Action Group (CHAG) has been fine-tuning a data tool which utilises publically-available results and presents in some creative ways. The tool was at a point where it was ready to share widely so we undertook a series of roadshows last month to release it and explain how it can be utilised to its full potential for service planning and monitoring progress.

Honor Lymburn, HealthShare's 'data stylist' has developed a unique technique to present equity results. Put simply it has a memorable 'bat and picket fence' system making the results in terms of the absolute and relative equity gaps easily identifiable. A key point for users of the tool is to remember that the equity results should be considered along with the target and trend to fully understand the status of a key result area.

There was great attendance at the sessions including three District Health Board Chief Executives along with over 120 staff, including psychiatrists, paediatricians, community providers, Māori health, public health analysts, planning and funding, researchers, and child and women's health clinicians. We were also delighted to have CHAG's Chair, Dr Dave Graham, support discussions at Lakes, Bay of Plenty and Waikato. The enthusiasm across the region was evident and the presentation generated some interesting discussions.

The report will be distributed to interested parties on a quarterly basis and for ease of access DHBs may wish to link to their intranets in the future. CHAG is interested in hearing the stories behind the data which can be fed back through your Child Health Action Group member.

Midland Child Health Action Group Members

Waikato DHB	Dr David Graham (Chair)
Lakes DHB	Dr Stephen Bradley (Deputy Chair)
Taranaki DHB	Dr John Doran
Hauora Tairāwhiti	Dr Margot McLean
BOP DHB	Dr Justin Wilde
CEO representative	Ron Dunham (Lakes DHB)
COO representative	Michelle Sutherland (Waikato DHB)
DoN representative	Gary Lees (Lakes DHB)
GMs P&F representative	Becky Jenkins (Taranaki DHB)
Child Health Portfolio Manager	Marnie Reinfelds (Taranaki DHB)
Management representative	Karen Smith (BOP DHB)
Māori Health	Dr Nina Scott (Waikato DHB)
Public Health representatives:	Lindsay Lowe (Toi Te Ora)
	Dr Richard Vipond (Waikato DHB)
Paediatric Society:	Mollie Wilson/Karyn Sanson NZ Child & Youth Clinical Network Programme
Primary Sector:	Dr Jo Scott-Jones, Tracy Jackson (Pinnacle PHO)
	Debi Whitham (Hauraki PHO)
	Dr Neil Poskitt/Dr Sharon Lovegrove (RAPHS)
Allied Health	Arish Naresh (Hauora Tairāwhiti)
Plunket	Viv Edwards
Ministry of Health	Dr Pat Tuohy
HealthShare:	Anna-Maree Harris, Project Manager
	Honor Lymburn, Senior Data Analyst

For more information contact:

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Honor Lymburn | Senior Data Analyst, Regional Health Integration Team | HealthShare
honor.lymburn@healthshare.co.nz | www.healthshare.co.nz

Introducing...

Karen Woortman, Anne Paterson and Louise Cohen

Auditors, Regional Internal Audit Service, HealthShare

Internal Audit is a team of five auditors providing support, advice and assurance to four of the Midland DHBs (Lakes, Tairāwhiti, Taranaki and Waikato) on the status of internal controls being used to meet the objectives of the DHB. The team is supported by Jackie Clayton, Business Support Coordinator who has recently co-located with the Waikato Hospital campus internal audit team members, and Mukhlis Ismail who has recently joined the team supporting Taranaki DHB. Ian Cowley, Regional Internal Audit Manager, oversees the synergy with DHB management and guides the team.

Karen Woortman is based at Waikato Hospital campus and provides the internal audit function for Waikato DHB and the other regional DHBs from time to time. Karen has collectively been with Waikato DHB and HealthShare for 11 years. (left)

Anne Paterson is based at Lakes DHB and supports Lakes DHB and Hauora Tairāwhiti. Anne has been with HealthShare for five years, however, Anne has 40 years of health experience across various public and private health entities. (centre)

Louise Cohen is based at Waikato Hospital campus and provides the internal audit function for Waikato DHB. Louise has collectively been with Waikato DHB and HealthShare for 10 years. (right)

What does your job involve?

The purpose of our work is to provide independent assurance and consulting services to support and monitor the Midland DHBs' risk management, internal control and governance processes that have been implemented by management to effectively govern the DHBs. In providing these services, the Internal Audit function aims to assist in improving the DHBs' operations and achievement of the DHBs' objectives through our independence.

Our work involves completing internal audits on our approved annual Internal Audit Plan for each DHB. In addition to the agreed audits, we perform ad hoc audits as requested by management, in addition to enquiries/investigations at the request of management or that are received via the Ministry of Health's Health Integrity Line.

For each audit assignment the following is required to be completed:

- terms of reference
- audit approach / programme
- work papers outlining and supporting our audit tests, observations/findings and conclusions
- audit report outlining our findings and recommendations.

We attend our respective DHB Audit Committees which are held monthly or quarterly and provide feedback on recently completed audits and other matters which should be brought to their attention.

Not only are we to comply with internal DHB policies, procedures and guidelines; as internal auditors we

must also comply with the International Professional Practices Framework of the Institute of Internal Auditors.

We network with internal audit functions supporting DHBs outside the Midland region and with internal auditors that are members of our professional association.

Why did you choose to work in this field?

Karen – Internal Audit is a module of accounting and provides a pathway that is professionally challenging and at the same time rewarding to see positive changes within the health sector.

Anne - Internal audit is about contributing to the health world by validating best practice and/or providing critique and advice, to attain it within a continuous quality improvement (CQI) environment. This challenge of reviewing ever changing familiar and unfamiliar areas to audit and offer practical counsel provides me with job satisfaction.

Louise - I could never imagine myself doing a routine day-to-day job and as I already enjoyed accounting at school and university, it seemed to be an interesting alternative.

What do you like about it?

Karen – No two days are the same. Through my work as an internal auditor I have the opportunity to view the DHB through a different lens and to effect real change that benefits all DHB stakeholders.

Anne – My work can range from considering high level governance and risk management policies and processes, to the front line practices and internal controls that minimise individual risk points. Also, after years of shifts, and on-call, sometimes 24/7, for the first time in my career, I have a Monday – Friday office hours job and a much better work-life balance.

Louise – I enjoy the diversity of the work, getting to know different people from all levels in the organisation and getting a broad understanding of how all the functions work in the organisation.

What are the challenges of your job?

Karen – Our work requires us to listen actively to people and build good work relationships with management, staff and our Audit Committees. The challenge in this is learning to deal with different personalities, work and management styles and maintaining our professionalism and independence at all times. Challenges also include understanding and keeping up to date with activities and changes in our DHBs and the health sector in general that impact on our work.

Anne – Learning about a new area quickly where staff are uncomfortable with their perceived intrusion of both a non-expert and an auditor. Obstructions may be overt such as not providing access to information or more covert such as telling the truth but not the whole truth.

Louise – Getting people to understand that you are not there to look for mistakes/errors/faults but rather that these are indicators of where process is lacking or is not being complied with. As an auditor you have to learn to keep an open mind, be objective and independent in your work, and this means you have to separate yourself from your own personal opinions. The job teaches you that there are always two sides to a story and not to draw conclusions without appropriate evidence behind it. As the work can be quite diverse it means spending a lot of time getting a reasonable understanding of your subject matter, etc.

What do you do when you are not at work?

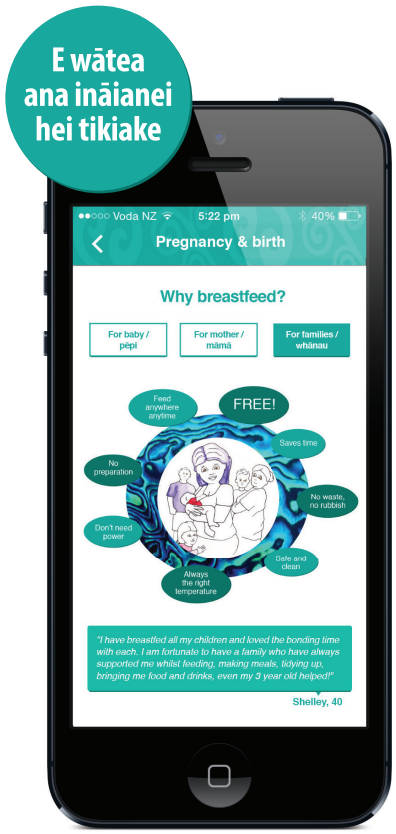
Karen – my personal time currently includes wine sampling, menu planning, looking at colour swatches and white dresses, shoe shopping (not really a chore!!), floral arrangements, table decorations and negotiating with my 'groomzilla' on the many details that are required to ensure our wedding day fulfils our dreams and wishes.

Anne – family and farm activities and support services; knitting; reading; special event planning and surprises. Currently our elder son and his family are living with us while they build a new house. Having a 5 and 7 year old in the house again full-time is giving us a noisier and much more untidy house with lots of re-awakened joys of experiencing life with them and through their eyes. Our elder grand-daughter and grandson are learning about life on a farm as opposed to life in Auckland shopping malls and cafés. The highlight is motorbike rides while shifting the deer and sheep. Roll-on lamb, calf and chicken day at Kaharoa School!

Louise – when I am not at work I can be found undertaking any of the following activities:

- spending time with family, friends and my dog
- enjoying occasional day trips to the beach
- taking the dog for a walk
- going to the gym
- reading
- watching a movie.

Tīkina tō Taupānga Whāngai Ū KOREUTU



Ngā kōrero - ina hiahia ana koe, i te wā e hiahia ana koe, ki te āhua e hiahia ana koe

Tikiake i te taupānga **BreastFedNZ** mō te koreutu hei kimi i ngā āwhina, ngā kōrero, tautoko hoki mō te whāngai ū.

Rapua ngā pātaka GooglePlay, iTunes rānei mō **BreastFedNZ**

www.breastfednz.co.nz BreastFedNZ

Midland District Health Boards
www.midlanddhbs.health.nz

From classroom to Cambodian villages

– Suzanne Andrew, Manager, Regional Services Plan & Executive Projects

I took the opportunity to attend a three day 'Outcome Mapping Learning & Exchange' in late April 2018, organised by the Outcome Mapping Learning Community (OMLC) and ably facilitated by three of its Stewards: Simon Hearn from the United Kingdom, Jeph Mathias from India, and Mariam Smith from Sweden.

Participants from around the globe attended; representing several government aid sectors, international Non-Governmental Organisations (NGOs) and private consultants. The Center for People and Forests (RECOFTC) – based at Kasetsart University, Bangkok – hosted the workshop. Its modern, spacious conference facilities supported the participatory-style format.

The topics covered Outcome Mapping (OM) theory, its advantages and challenges, supporting social change in complex settings, the 12-step system to designing projects, monitoring and evaluation, and Outcome Harvesting (OH).

Participants could choose a 'market place' to explore some of the practical applications of OM, and also take up the offer of a 1:1 clinic with a Steward.

The bare walls on Day 1 were transformed into a mass of colour notes and flip chart ponderings by the close of Day 3.

Outcome Mapping (OM) is a methodology for planning, monitoring and evaluating development initiatives in order to bring about sustainable social change.

Jeph started us off with an unexpected letter...

> **"Dear God... We want to design a monitoring and evaluation tool that works in complexity... please make a tool that has these features..."**

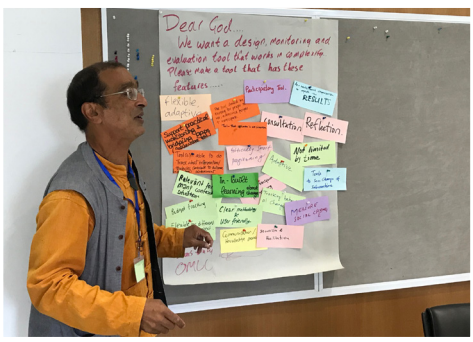
At the close of the workshop we revisited our many suggestions for a monitoring and evaluation tool and pared these down to:

> **"...exciting for people and Donors to use; supporting people to participate; being flexible and adaptive; making the process of change visible"**

Emily Balls, a fellow participant and an experienced OM practitioner, shared the value she found in attending the Learning Exchange;

"The element of the training that I found most useful was hearing examples and stories from facilitators and participants about projects that had applied Outcome Mapping and Outcome Harvesting principles.

I'm taking away lots of new ideas and inspiration to inform my own practice."



The OMLC Learning & Exchange in Bangkok gave me the opportunity to meet development practitioners and to fast-track my understanding of OM theory. It also provided me with some practical OH monitoring and evaluation tools.

Cambodia - counting what you find... finding what counts

The next step of my adventure would see my classroom theory turned into practice, with an outcome harvest in neighboring Cambodia.

I would need to listen for changes in behaviors, attitudes, relationships and policies.

As a Master of International Development student with Massey University, New Zealand I was invited to join Jeph Mathias in a mid-term review of a Cambodian NGO in May 2018. The NGO's programme was using outcome mapping in its programme design and delivery.

Outcome Harvesting (OH) focuses on outcomes – changes in behaviour attitude relationship or policy of people or groups of people. In short OH asks deep questions, not only of what has changed for people but also why, and makes clear the dynamics of complex systems 'from the inside'.

The mid-term review began with five evaluation questions to be answered, using OH techniques, in three southern Cambodian provinces (Kampong Trach, Kampong Speu and Prey Veng). During the two week evaluation three emergent 'baskets' also came to light; new social dynamics, significant changes since 2016, and key stories (good and not so good).

The NGO's programme is focused on seeing positive changes in the lives of community members by working directly with their chosen five Boundary Partners.
These Boundary Partners are at the village, community and district level and involve village leaders, village and community development associations, school committees and commune councils.

During the two week evaluation 140 'stories' were collected from interviews with Boundary Partners and villagers across the three provinces. Two teams of NGO field workers assisted and enriched the evaluation with their dedication - working long hours, travelling and eating together, sleeping on hard wooden floors, and never complaining.

We identified where Boundary Partners had changed their behaviours, attitudes, relationships and policies, and verified these changes with villagers' experiences.

The collected stories were re-told in Khmer, translated into English by Samnang (our interpreter and cultural advisor), typed and uploaded to Dedoose (a cloud based qualitative/ quantitative software tool), thematically coded and slotted into a pre-made code tree that was shaped to the evaluation questions.

As we coded, our code tree grew some branches of its own, which became very important in the process. Although we had started with 140 stories, after coding we had a database of 1,265 excerpts, each one containing a change of behaviour, attitude, relationship or policy.

The original five evaluation questions were answered by the 1,265 data-points and the results presented back to the NGO and Donors in Phnom Penh.

Personally, it felt like we were visiting from another time and place. It was a full-on experience – lots of thinking deeply, laughter, tears, and excitement at the positive changes occurring, but also the weighted responsibility to re-tell the unexpected and dismaying stories uncovered in Cambodia's remote rural villages.

While we sat and talked to rural farmers about their lives and changes, progress was constantly rumbling past in the form of heavy trucks and a steady stream of vehicles. Traditional livelihoods from rice-growing were now dependent on fertilisers, chemicals, labour, money, and the promise of big companies selling them water (from their own dams).

Rural women and girls as young as 15 years old are trucked out at 4:30am six days a week to work long days in mega-factories in the city, returning at 7pm. During the day the villages are largely silent as the elderly (and those whom the factories no longer need) spend their time bringing up young children and waiting for family members to return from the city construction sites, truck driving depots and factories.

It is vital to make the time to step back from our daily activities and look up strategically at the larger landscape in front of us.

We heard inspiring stories from villagers – women running savings groups, lending money to start up businesses, caring for the poor, and sharing dreams for their children to finish school and go to university. There were women with no education excited to receive training on advocacy, human rights and domestic violence, who are looking forward to leading training with small groups of women.

Going forward, the NGO and its Donors will look at a strategic re-visioning and redesign to inform their next programme cycle, taking in the broader and complex changes in Cambodia.

Yes, we counted what we found … we also found 'what counted' for Cambodian villagers and for the NGO working with them.

With thanks to:

Outcome Mapping Learning Community (OMLC) – a global, informal, open membership network for sharing information and facilitating learning on using Outcome Mapping for planning, monitoring and evaluating complex interventions www.outcomemapping.ca

Dr Jeph Mathias – an Indian/New Zealander who lives in the Indian Himalayas. Jeph consults independently with innovative social and environmental projects across South Asia and is a Development Studies research fellow at Massey University. The constant undercurrent in social and environmental issues for Jeph is how people think, act and relate so for him OM 'goes for the jugular' of this wonderfully, complex, unpredictable planet. www.unpredictable.co

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