



CENTRE FOR HEALTH SERVICES
RESEARCH AND POLICY

An Evaluation of the Let's Beat Diabetes - Diabetes and Pregnancy Work Stream

Final Report

June 2009

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Acknowledgments

The School of Population Health would like to acknowledge the Let's Beat Diabetes team for their continued support and collaboration with the evaluation. We would also like to recognise the support of the Diabetes and Pregnancy Work Stream Project Manager and the Community Liaison Coordinator. The evaluation team would also like to thank the steering group members and other stakeholders who gave their time to be interviewed.

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Abbreviations

DHB	District Health Board
CIPP	Context Input Process Product
CMDHB	Counties Manukau District Health Board
CME	Continuing Medical Education
GDM	Gestational Diabetes Mellitus
GE	Group Education
GM	General Manager
GTT	Glucose Tolerance Test
HEHA	Health Eating Health Action
IS	Information System
LBD	Let's Beat Diabetes Programme
MOC	Model of Care
MSG	Multidisciplinary Steering Group
SOPH	School of Population Health
TOR	Terms of Reference
WD	Workforce Development
WG	Working Group

Executive Summary

The Diabetes in pregnancy programme evaluation is detailed in this report. The main objectives of the evaluation were:

- To collaborate with the Diabetes and Pregnancy Work Stream to develop and conduct a process evaluation that meets the needs of the programme providers and key stakeholders, as well as the overall LBD programme.
- To describe and evaluate the implementation of the Diabetes and Pregnancy initiative.
- To describe the outputs of the Diabetes and Pregnancy initiative.
- To support the Diabetes and Pregnancy initiative and incorporate lessons learned.

In order to achieve the objectives, the evaluation utilised a mixed method inquiry, which included two key methods of data collection: documentary analysis and key stakeholder interviews.

Methods

Documents included in the analysis were meeting minutes, project plans and background reports. Meeting minutes were used to determine attendance of the key stakeholders. The topics of discussion from the meeting minutes were used to examine the activities undertaken towards the short term outcomes of the initiative. Thematic analysis of the fifteen key stakeholder interviews was used to identify their perceptions regarding the background and development of the project, achievements to date, collaboration of the stakeholders, and the future of the project.

Results

Document Analysis

The MOC and IS working groups successfully developed their TOR, but there was no known TOR from the WD group. An integrated diabetes information system was developed, and “live” in Healthware at the time of reporting, although doctors and midwives had reported difficulties in using it due to lack of time and unfamiliarity with it. There was an agreement to facilitate initial data entry by allowing doctors to complete a paper version to begin with.

The midwife specialist role was discussed by the Steering Group, MOC and WD working groups, however, it appeared that progress on this issue was hindered by the lack of resolute MOC change required, dependence upon MOC development, and lack of input from key Steering Group members. CME presentation topics were discussed by the MOC working group, a March 2009 session tentatively booked, and two members elected to present the session. The goal of an evaluation of the GDM Group Education was achieved, with a report published from this.

Stakeholder Interviews

According to comments made by the stakeholders, the project lacked common and clear understandings of the purposes of each of the groups, including the Work Stream itself. Stakeholders instead shared a view that, despite attempts made, little progress had been made from the project meetings as yet. Key barriers mentioned by stakeholders included the difficulty of collaboration between fragmented services and departments, and a lack of buy-in related to ownership of the project. Barriers relating to the meetings included that meetings were not resulting

in agreements or outcomes, that meeting attendance was unsatisfactory, and that the meetings were not always a priority for all involved. Further barriers mentioned were a lack of clinical management leadership in regards to this project, and lack of open-mindedness. The overall impression was that collaboration achieved was in the lower spectrum, being mostly participative, when involving people from more than one department or sector.

Stakeholders reported that key achievements of this project included the creation of a forum which has facilitated open discussion between the different departments and disciplines, the development of an IS diabetes component that will enable data entry and collection, and the group education trial that was assisted through LBD support. Overall, stakeholders were positive about the visions and goals of the project and hoped to see it progress into the future. Stakeholders identified steps that they felt were needed to be taken in order to continue the work of the project into the future. The steps included; identification of a clinical champion, revisiting the objectives and re-approaching the project, setting specific deadlines for decision-making, and formalising decisions made in the meetings.

Issues to Consider

Based on the analysis of the data collected, the following issues are proposed for consideration.

Appointment of clinical leader /clinical champion closely related to the service

Work stream members must consider the most appropriate way to engage in a discussion to decide where the leadership for this Work Stream should lie. Due to the original misgivings regarding perceived lack of consultation with key people involved directly in the diabetes and pregnancy clinic, some stakeholders perceive that that leadership for the Work Stream should sit with someone closely related to this service. The sense of urgency for clear leadership is evident.

Clarify objectives and achievable targets to gather momentum

Although there is evidence of a shared vision, the Diabetes and Pregnancy Work Stream must consider further developing objectives that are specific, measurable, and achievable within a specified timeframe. The programme logic is an excellent starting point to review the vision of the Work Stream as well as what are the desired outcomes and by what means these will be achieved. The evaluation team will facilitate the validation of the programme logic as a starting point for this process to occur.

Review membership and re-assess stakeholder commitment

The Work Stream stakeholders must consider how participating in this Work Stream fits within their priorities and assess their level of involvement and commitment. Steering group and working group membership can be reassessed to establish whether it is appropriate for all members to participate in all levels of Work Stream organisation.

1. Introduction

The relationship between diabetes in pregnancy and the health services required is complex and requires the establishment of a collaborative framework in order to identify best practice and to secure a care pathway for women with diabetes in pregnancy. Due to the importance of collaboration between key stakeholders across primary and secondary care in ensuring a comprehensive and cohesive delivery of care; a key theme of this evaluation is the collaboration between the key stakeholders. This section provides a definition of diabetes in pregnancy as well as outlining key literature around collaboration; the aims of objectives of the evaluation are also outlined.

1.1 Literature summary

1.1.1 Diabetes in pregnancy

Gestational Diabetes Mellitus (GDM) can be defined as 'glucose intolerance that is first detected during pregnancy' (Kjos & Buchanan, 1999) and is associated with a number of serious health conditions for both mother and baby (Simmons, Rowan, Reid, & Campbell, 2008). Complications for the mother include pre-eclampsia and caesarean section while complications for the baby include stillbirth, birth injuries, hypoglycaemia, respiratory distress, and jaundice. Rates of GDM are increasing and diagnosed GDM is associated with an increased risk of Type 2 diabetes later in life for both mother and baby.

GDM can only be diagnosed in pregnancy and it is important that this opportunity is taken to implement strategies to reduce the risk of developing Type 2 diabetes in the future and to improve the pregnancy. There is no global consensus on criteria for diagnosing GDM partly due to glucose concentration variability between people.

It is likely that demand on diabetes in pregnancy services will increase; this has implications for the model of care, workforce and other organisational factors. The Diabetes in Pregnancy Work Stream is charged with facilitating the development of a comprehensive and cohesive delivery of care for women with diabetes in pregnancy. This requires strong, multi-disciplinary collaboration; key concepts related to this are discussed in more depth in the next section.

1.1.2 Collaboration

Definitions of collaboration vary according to discipline and the term collaboration can be used interchangeably with other words such as 'networking' and 'cooperation'. For the purposes of this proposal, collaboration can be defined as:

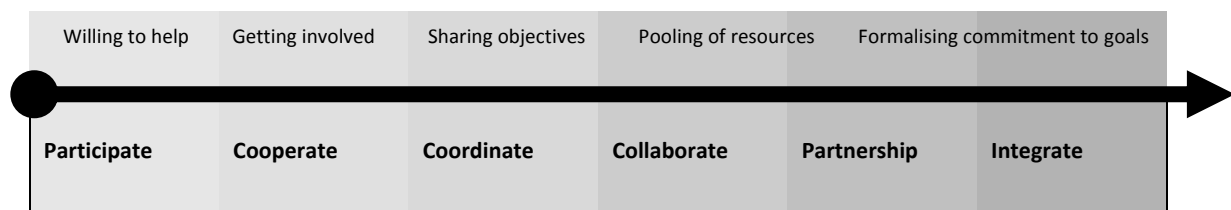
"a process in which autonomous or semi-autonomous actors interact through formal and informal negotiation, jointly creating rules and structures governing their relationships and ways to act or decide on the issues that brought them together, it is a process involving shared norms and mutually beneficial interactions".(Thomson, Perry, & Miller, 2007)

This definition of the collaboration process takes into consideration five dimensions:

- Governance (understanding how to jointly make decisions about rules that will govern their behaviour and relationships).
- Administration (administrative structures that moves from governance to action)
- Organisational autonomy (partners share a dual identity; distinct identities and collaborative identities)
- Mutuality (experiencing mutually beneficial interdependencies based either on differing interests or on shared interests)
- Norms (moving from reciprocity to a mutual trust)

Collaboration can involve much time and commitment, and both the willingness and depth to which an organisation takes part will depend on the purpose(s) for collaboration. Reasons for collaboration include; resource maximisation, development of policy/systems, social or community development, or the creation/modification of a service or programme (Taylor-Powell, Rossing & Gerran, 1998). Because of the novelty of the LBD programme, research into organisational processes is important for the success of the programme, and in learning for the benefit of similar initiatives.

Contemporary management discourse includes ‘networking’, ‘cooperation’, ‘collaboration’, and similar terms. While these words are often used interchangeably, it is useful to distinguish between them. Collaboration in health can be seen within a continuum of working together. At one extreme, people are willing to help one another while at the other, they formally commit to doing so. See Figure 1 below.



Source : McKee K.- Unpublished MPH thesis

Figure 1: Collaboration within a continuum

This continuum will be used to help explain the level of collaboration experienced within each of the working groups for the Diabetes in Pregnancy Work Stream. Furthermore, it is critical to understand the factors that are essential for successful collaboration, these include:

- **Environmental:** including a political favourable and cooperative community
- **Membership Characteristics:** including mutual respect, cross section of skilled members
- **Process/Structure:** flexibility, clear policy goals.
- **Communication:** open, frequent, formal and informal
- **Purpose:** clearly defined and agreed on
- **Resources: consistently sufficient** (Mattessich & Monsey, 1992)

The occurrence of communication between parties can be described as the beginning point of collaboration, which can be further developed through mutual exchanges, obligation and/or trust into a contributory relationship. Medium-level collaboration, which requires a more deliberate and planned approach, can be signified by the presence of a matching and coordinating of needs, resources and activities, in the building of efficiency. Further to this is the sharing of joint goals, linkage of resources, and development of trust through cooperative action. The fullest form of

collaboration is shown through a shared vision, shared resources, and the development of interdependency (Taylor-Powell et al, 1998).

In some cases collaborative partners may be able to provide accountability checks for each other's contributions to the project, thereby integrating an aspect of evaluation into the collaborative process, with provisions for change as necessary (Koopanjan, 2008). An important consideration in the undertaking and evaluation of collaboration is that organisations can differ in their readiness for collaboration, and can also choose to limit collaboration to specific issues or projects, and that both of these are likely to change over the course of the project or evaluation (Taylor-Powell, 1998). In the undertaking of collaboration for a specific project or goal, even if there are clearly defined and agreed-upon goals, the success of collaboration should not be measured solely upon achievement of preset goals. The process of collaboration should be valued equally as the intended result of the collaboration, as it is critical to the effectiveness (Koopanjan, 2008).

1.2 Let's Beat Diabetes

Let's Beat Diabetes (LBD) aims to make long-term sustainable change to prevent or delay the onset of Type II diabetes, slow disease progression and increase the quality of life for people with Type II diabetes in Counties Manukau. Fundamental to the plan is its 'whole society, whole life course, whole family/whanau' approach to preventing and managing diabetes. Within the LBD programme are 10 distinct but inter-related Action Areas for activity. One of these Action Areas focuses on 'improving service integration and care for advanced disease' (Action Area 10), which works on a number of levels to support the LBD strategy within CMDHB. One work stream is designed to develop service integration for the comprehensive care of women with diabetes and pregnancy and enable CMDHB to respond effectively to a continued increase in demand for care [LBD Operational Plan 2008/2009]. The process of integration of the diabetes and pregnancy services is the focus of this evaluation.

1.3 Alignment to HEHA Strategy

Healthy Eating Healthy Action (HEHA) is a national policy framework to bring about changes in the environment in which New Zealanders live, work and play as this relates to nutrition, physical activity and obesity. HEHA reflects the Government's plans to improve nutrition, increase physical activity and reduce obesity throughout New Zealand (Ministry of Health, 2004). LBD shares the HEHA aims and objectives and acts as a vehicle for supporting and implementing the HEHA strategy in Counties Manukau.

The primary goal of LBD is to promote long-term sustainable changes to prevent or delay the onset of Type 2 diabetes, slow disease progression, and increase the quality of life of those individuals diagnosed with diabetes. As a consequence one of the LBD intervention areas aims to promote and facilitate service integration in order to better serve those patients with a diagnosis of diabetes. The Diabetes and Pregnancy Work Stream is designed to examine and improve the service integration between the clinical departments involved in the care of pregnant women with diabetes. As part of managing their diabetes through this service integration, women are encouraged to consider their nutrition, and to become more physically active to the extent allowed by their pregnancy (HEHA outcome 5). Women are also encouraged to consider how nutrition and physical activity affects

their family's risk of diabetes; these aspects of the initiative align it to the LBD programme and HEHA framework.

1.4 Aims and objectives of the evaluation

The evaluation aims to promote a learning environment, whereby a process of review and reflection is encouraged in order to facilitate the development of the initiative.

To achieve this aim, the specific objectives are to:

- To collaborate with the Diabetes and Pregnancy Work Stream to develop and conduct a process evaluation that meets the needs of the programme providers and key stakeholders, as well as the overall LBD programme.
- To describe and evaluate the implementation of the Diabetes and Pregnancy initiative.
- To describe the outputs of the Diabetes and Pregnancy initiative.
- To support the Diabetes and Pregnancy initiative and incorporate lessons learned.

1.5 Structure of the report

This report was prepared by the Centre for Health Services Research and Policy at the University of Auckland, and was commissioned by LBD. It presents the evaluation of the Diabetes and Pregnancy Work Stream, an initiative supported by LBD. The previous section provides the context in which the initiative was carried out and the aims and objectives of the evaluation. The following section presents the background and objectives of the Diabetes and Pregnancy Work Stream. In the third section, the evaluation methodology is explained. The fourth section details the results of the evaluation and the report concludes with a discussion of the results with some issues to be considered.

2. Diabetes and Pregnancy Work Stream

This section presents the background and objectives of the work stream.

2.1 Work stream background

The Diabetes and Pregnancy Work Stream is part of the Service Integration action area of the Let's Beat Diabetes plan. Action Area 10 focuses on improving service integration and care for advanced disease. There are a number of negative health outcomes as a result of diabetes and pregnancy. For women with diabetes who then become pregnant there can be negative health outcomes for the child; for women who are pregnant and are then diagnosed with gestational diabetes there can be negative health outcomes for both the child and the mother. Due to the complex nature of diabetes and pregnancy, women require comprehensive and cohesive delivery of care from a range of health services.

In April of 2007 a multidisciplinary group was organised; the meeting consisted of a presentation of the review of diabetes and pregnancy in CMDHB, discussion around clinical quality and risk, as well as communication exercises. From this meeting, a vision for comprehensive care for diabetes and pregnancy was developed and four working groups were established. After a lapse in work in the Diabetes and Pregnancy Work Stream due to staff turnover, the working groups reconvened in 2008. Initially four working groups (WGs) were suggested including Information Systems (IS), Models of Care (MOC), Workforce Development (WD) and Effective Interface. However upon reflection, stakeholders determined that the components of Effective Interface could be discussed in the Models of Care and Information Systems Working Groups. Therefore existing working groups include:

- Information Systems working group
- Models of Care working group
- Workforce Development working group

Additionally, a Multidisciplinary Steering Group (MSG) was created to help identify issues for the Working Groups and to action the decisions at higher levels.

Due to the complex nature of diabetes and pregnancy and the health services required, the current focus of the work stream is to establish a collaborative framework to identify best practice and to secure a pathway for women with diabetes and pregnancy. Of particular importance is establishing a means of collaboration between primary and secondary care.

2.2 Work stream objectives

The work stream objectives include¹:

1. Collaboration amongst services/providers for optimal management of Diabetes and Pregnancy.
2. Development of sustainable model of care, with specific focus on transitional care (as patient moves from one service/provider to another).
3. Development of workforce and capacity to support the model and burden of disease.

¹ As stated on the November 2008 Project Brief

3. Evaluation Methodology

Programme evaluation is designed to support programme development through evaluating different components of a programme. Evaluation is useful for finding out whether a programme is being implemented as intended and whether what is being done works. Evaluation is also important for maximising the potential of a programme and, ultimately, the benefits to the community.

The Diabetes and pregnancy initiative evaluation is based on the Centres for Disease Control and Prevention (CDC) framework for the evaluation of public health programmes. A mixed methodology was proposed as the most appropriate means of successfully implementing the evaluation. Mixed methods inquiry deliberately pulls together different research methods designed to collect different kinds of information, thus, utilising both qualitative and quantitative methods of data collection and analysis in parallel (Greene & Caracelli, 1997).

Guiding the evaluation will be the CIPP (Context, Input, Process, Product) Evaluation model (Stufflebeam, 1983) which will provide a valuable structure for the evaluation. The core parts of the CIPP model are context, input, process, and product evaluation of the programme (see Figure 2) which assists the decision making process within the programme.

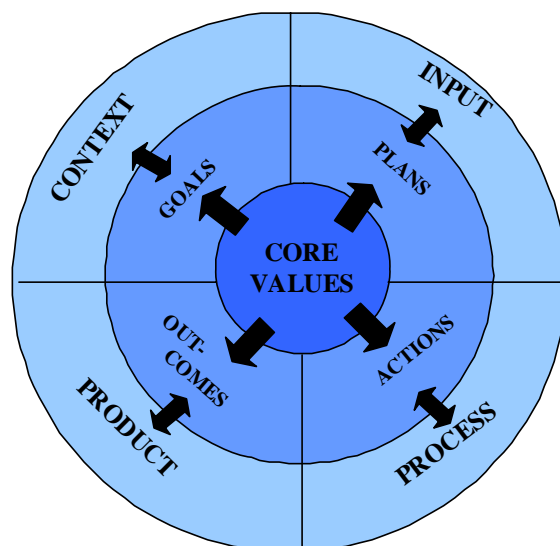


Figure 2: The CIPP Model

(The CIPP model is adapted from Stufflebeam, 2003)

The four parts of the model assist decision-makers in answering these four general questions:

1. What needs to be done? [Context]
2. How should it be done? [Input]
3. Is it being done? [Process]
4. Did it succeed? [Product]

In order to achieve the objectives set out in Section 1.4, the evaluation will utilise two key methods of data collection: a documentary analysis and key stakeholder interviews. These methods are described in more detail below.

3.1 Evaluation Questions

In order to guide the evaluation, evaluation questions were developed in collaboration with the key stakeholders. These are structured using the CIPP model components:

Context

1. How was the initiative developed?
2. What are the key goals and target groups and how were these determined?
3. What was the intended programme logic?

Input

4. Determine what the key programme resources are and how they were intended to be used.

Process

5. What are the factors that influence stakeholder engagement?
6. What are the barriers and enablers to stakeholder engagement?
7. What is the process and level of collaboration for stakeholders within each of the working groups?
8. What is the process and level of collaboration for stakeholders in the steering group?
9. Describe the activities that are a result of the Diabetes in Pregnancy Work Stream.
10. Investigate what factors of the organisational process are likely to help or interfere with the initiative's progress.

Outputs

11. Describe stakeholders' perceptions of results obtained thus far.

3.2 Data collection

This section outlines the methods that were used to collect data for the evaluation. The two methods included documentary analysis and key stakeholder interviews. These are presented in more detail below.

3.2.1 Documentary analysis

Documentary analysis is a systematic process that can identify the individuals and activities involved in a programme or intervention (Garman, 1982). The documents provided to the evaluation team by the Diabetes and Pregnancy Work Stream were analysed to:

- Identify who is involved in the programme
- Provide information about the implementation of the programme.
- Assist in the determination of key achievements to date
- Identify programme inputs and resources to facilitate creation of the Programme Logic

Documentary analyses were conducted using a range of documents provided by the Diabetes and Pregnancy Project Manager. Documents included meeting minutes, project plans and background reports. See Appendix A for a full list of documents.

Meeting minutes were used to determine attendance of the key stakeholders, by assessing the number of attendees and apologies at each meeting. The topics of discussion from the meeting minutes were used to examine the activities undertaken to achieve the short term outcomes of the initiative.

3.2.2 Key stakeholder interviews

Fifteen key stakeholder interviews were conducted to provide insight into the experiences of those involved in the Diabetes and Pregnancy Work Stream from a key stakeholder perspective. This information is important to gain an understanding of the project development, any key achievements, identify any barriers to achieving the project aims, assess the levels of stakeholder collaboration and determine perspectives regarding the future of the project. The interviews lasted no more than one hour and were conducted face-to-face at a location chosen by the stakeholder. Refer to Appendix B for the Interview Guide.

3.3 Data analysis

Existing documentation provided to the evaluation team outlining the development of the Diabetes and Pregnancy Work Stream, its progress, implementation, and outcomes were analysed by way of documentary analysis. To assess participation at the meetings, information from the meeting minutes was used to determine which members were invited to a meeting and whether they attended. Members in attendance at the meetings and apologies that were noted were taken as the total number of invited members. Rates of attendance were then assessed by calculating the percentage of invited members who attended the meetings.

The meeting minutes of the MSG and working groups were also examined to gain insight into the activity towards achieving short-term outcomes. In doing so, the discussions around issues and actions for each outcome were noted and followed through all appropriate meeting minutes.

Thematic analysis of the key stakeholder interviews was used to identify their perceptions regarding the background and development of the project, achievements to date, collaboration of the stakeholders, and the future of the project. Comparisons of responses ensured that the findings reflected the sometimes divergent views of key stakeholders while also allowing for any interesting or unexpected data to be shared. The interview findings were discussed with the interviewers and evaluation team to ensure inter-rater reliability.

4. Results

This section outlines the results from the documentary analysis and key stakeholder interviews.

4.1 Documentary analysis

This section presents data from the documentary analysis, conducted to determine activity towards project objectives, attendance at meetings in the work stream, and to facilitate the development of the programme logic.

4.1.1 Programme Logic

Below is a diagram of the programme logic for the Diabetes and Pregnancy Work Stream (Figure 3). The programme logic illustrates the links between programme inputs, activities, expected outputs and outcomes. This diagram represents the evaluation team's understanding of what the work stream intended to achieve and the means by which it would achieve those goals.

The goal of the project is to create a collaborative environment addressing the increasingly complex management of diabetes and pregnancy and to facilitate the development and implementation of appropriate solutions to improve health outcomes for mothers and babies. Inputs associated with the Diabetes and Pregnancy project included funding, human resources, support from LBD and CMDHB, background documents, and multidisciplinary key stakeholders. The main activities of the initiative were to create and facilitate a multidisciplinary steering group and multidisciplinary working groups. Creation and facilitation of these groups were to lead to establishment of terms of references for each group, an established meeting schedule and regular meeting attendance by key stakeholders. New communication channels to facilitate transparent information sharing and interdisciplinary collaboration were to occur through regular meeting attendance and other efforts of the key stakeholders.

Expected short-term outcomes include: development and implementation of an integrated diabetes information system, identification of workforce deficit and the workforce needed to address the shortage, review and development of the midwifery role, development of a GDM care pathway to address transition protocols, the creation of a communication plan, presentations to community education groups for General Practitioners, advocacy of the decisions made by MSG at higher levels, and the facilitation of the evaluation of GDM Group Education trial. The anticipated medium-term outcomes following from the short-term outcomes include: expansion of the diabetes information system (IS) to enable sharing with primary care and a regional alignment, meeting of the GDM clinical workforce needs, implementation of a culturally considerate, engaging model that facilitates trust partnerships with women, and publication of the GDM Group Education trial evaluation report. It was expected that the combination of these medium and short term outcomes would lead to the development of a culturally appropriate workforce with the capacity to support the model and burden of disease, comprehensive care of diabetes and pregnancy consumers throughout the continuum (preconception through rest of life), and the routine collaboration among service/providers for optimal management of diabetes and pregnancy.

The underlying assumption was that stakeholders have a mutual interest in improving the state of diabetes and pregnancy management, now and into the future. This mutual interest would serve as motivation and enable stakeholders to cooperate and work together to achieve the products and outcomes listed above. Barriers to achieving the objectives include the choice of individual services to remain in silos and an IT system that doesn't support the introduction of a database.

It is important to notice the arrows in the diagram, which indicate causal relationships between factors identified. During the evaluation process, if products or outcomes are not as expected, it is important to assess whether the assumptions made while constructing the programme logic are flawed or incomplete. This will be further discussed in Section 5.

Project Goal: To create a collaborative environment addressing the increasingly complex management of diabetes & pregnancy and to facilitate the development and implementation of appropriate solutions to improve health outcomes for mothers and babies.

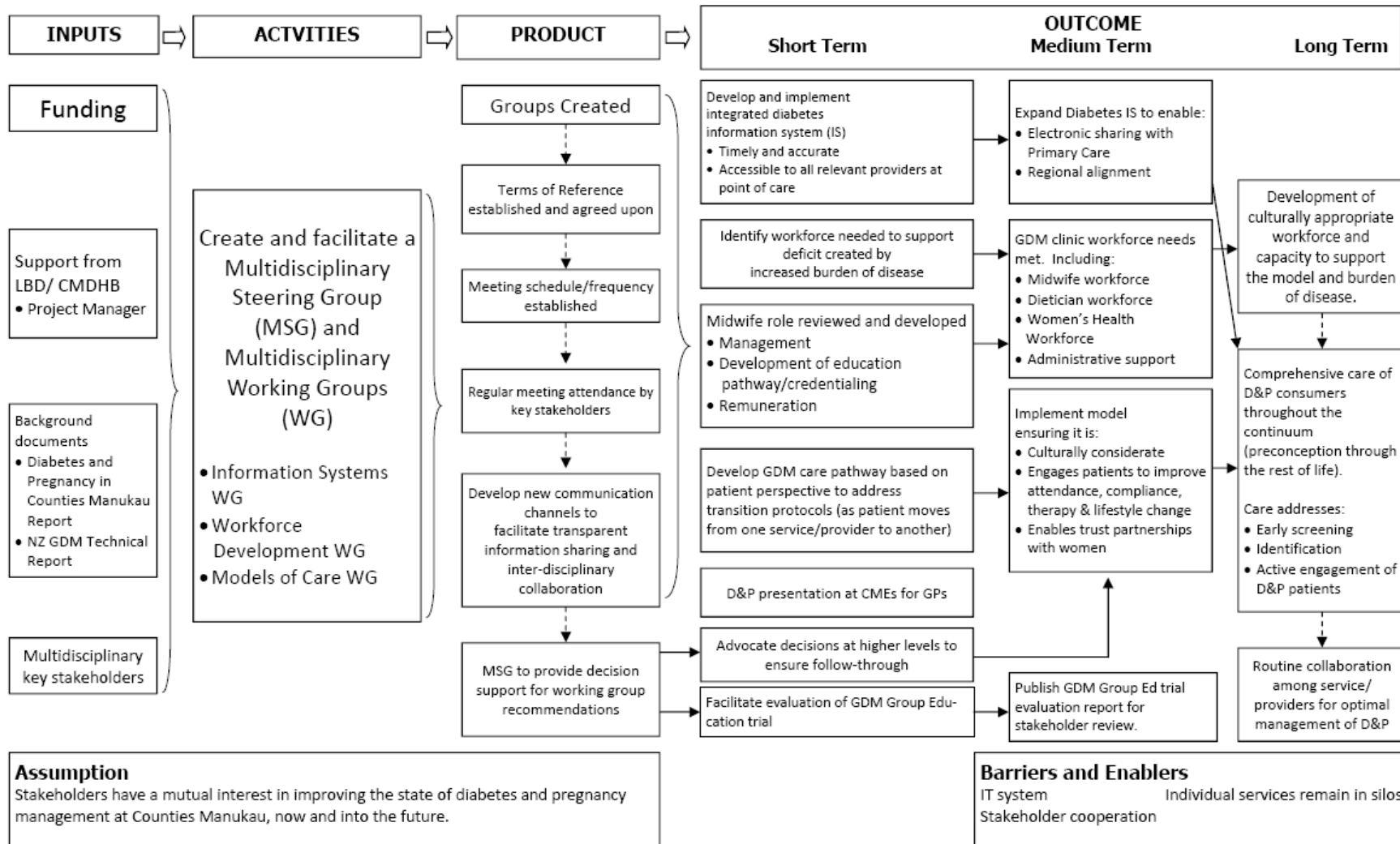


Figure 3: Diabetes and Pregnancy Work Stream Programme Logic

4.1.2 Activity within the Diabetes in Pregnancy Work Stream

This section describes the documented activity towards a number of objectives within the Work Stream based on the meeting minutes provided to the evaluation team. Objectives stated here are based on short-term outcomes outlined in the programme logic, which has been developed in collaboration with other Diabetes in Pregnancy Work Stream partners, but has yet to be validated². It should be noted that while some of the objectives have been defined by Work Stream documents made available to the evaluation team, the objectives described here are yet to be confirmed by key stakeholders. There are a number of outcomes that have no recorded activity against them; these are outlined at the end of this section.

Objective: Terms of Reference established and agreed upon

Outcomes:

- Information system (IS) Working Group has TOR dated June 2007.
- Models of Care (MOC) Working Group has TOR dated June 2008.
- Workforce Development (WD) has no known TOR to date.

The IS Working Group developed their TOR before the Steering group requested them in May 2008. After this request was made, the MOC Working group developed their TOR within the specified timeframe, but it is not certain from the documentation if it was circulated. No mention of TORs could be found in the documentation of the WD Working Group or whether they were presented to the Steering Group.

Objective: Develop and implement integrated diabetes information system (IS)

Outcomes:

- At the time of reporting, the diabetes module was 'live' in Healthware.
- It was noted that doctors and midwives were finding the transition period difficult because of time restrictions and unfamiliarity with the new module.
- It was agreed that initially doctors could complete data on paper as the workforce had the capacity to facilitate this data entry.

At June 2007 it was noted that an upgrade for Healthware had been ongoing for five years. In August 2007 a test environment was developed for the upgrade to include a diabetes dataset, but feedback from Women's Health and clinicians was still being awaited by August 2008. By this time the test version had been dropped due to six months of inactivity. The IS Working Group decided in September 2007 to re-initiate the testing and to actively involve the clinicians. By March 2009 the diabetes module was noted to be "live" in Healthware but not being used adequately by doctors and midwives. As a separate project, one member had been looking at a stand-alone system as a means for GPs to share information with Midwife service during 2008. It is unclear from the information provided what became of this project.

² The programme logic will be validated with key stakeholders after the draft evaluation report has been disseminated.

Objective: Midwife role reviewed and developed (Management; Development of education pathway/credentialing; Remuneration)

Outcomes:

- These issues have been discussed at the Steering Group, the MOC working group and the WD working group meetings, however these discussions have been circular in nature with limited outcomes.
- While the issue of diabetes midwives' lack of career and education progression was acknowledged in the WD working group meetings and the Steering Group meetings, progress in the area was hindered as it relied on having a resolute MOC change first.
- The issue from 2007 regarding recruiting a Maori midwife was not resolved as it was dependent on MOC development.
- Options document was circulated with several MOC options (directly relates to issues around the midwife role).

It was noted that regardless of the MOC change, any training would be beneficial. The Wednesday morning Whitiara training/service meetings were proposed in the July WD working group meeting, but it was mentioned in the Steering Group meeting that midwives who had tried to attend those sessions in the past found that they had no time to do so. The Steering Group suggested that three midwives attend the meetings on rotation. It is not known whether this in fact happened. It was at the November WD working group meeting that the idea was raised for drafting a document containing several MOC options for the Steering Group to review/approve. The subsequent discussion of the "options" document at the December Steering Group meeting was fairly circular, presumably due to key members not being present. It was noted that before proposing a solution like recruiting additional midwives, the input of several key members who were not present was needed first to better define the role, its management and career pathway. At the December 2008 Steering Group meeting there was also discussion of developing a diabetes education role in an effort to decrease midwives' workload. It is not known if this suggestion was taken any further. But by the following Steering group meeting in March 2009, a document had been created and circulated proposing solutions to the workforce issues via the development of a new Diabetes Midwife Specialist role. It had already received positive feedback and Women's Health General Manager (GM) had approved the funding. The process by which this happened is unclear from the documentation.

Objective: Diabetes in Pregnancy presentation at CMEs for GPs

Outcome:

- At the time of reporting, two members of the group had been elected to present at a Continuing Medical Education (CME) meeting for GPs regarding referral process, medicines and informing regarding the Diabetes in Pregnancy steering group.
- The tentative date was set for March 09, but it is not known whether this occurred.

During the June 2008 MOC Working Group meeting, it was noted that there was often a lag in the shared care pathway when a GP ordered a Glucose Tolerance Test (GTT) but then did not look up the test results. It was suggested that more CMEs with GPs would be helpful. At the following MOC Working Group meeting in September 2008, the group was informed that a CME session had been tentatively reserved through Dr. Smart (GP audience) for March 2009, but a firm idea was needed

from the group on what topics they wished to present. The group suggested that they would like to address referral processes, medicines (what to stop) as well as informing GPs of who the group themselves were.

Objective: Facilitate evaluation of GDM Group Education trial

Outcome:

- The draft evaluation report was intended to be presented at the July 2008 Group Education meeting.
- By August 2008, it was noted in the Steering Group meeting that the evaluation report had been published.
- The Steering Group was requested to provide a recommendation for the Group education in the GDM Clinic.
- The group agreed on the success of the system and provided directive to continue.

Other objectives

Objectives that underpin other work being done in the work stream include:

- Identify workforce needed to support deficit created by increased burden of disease
- Advocate decisions at higher levels to ensure follow-through

Specific activity against these objectives is difficult to identify due to their overarching nature.

An objective that had limited or no information relating to activity was:

- Developing GDM care pathway based on patient perspective

According to documentation received, five objectives were being addressed through the meetings. Two working groups successfully developed their TOR, an IS was developed, and a midwife specialist role was being reviewed, as per the short term objective outcomes. Additionally, CME presentation topics were discussed and a session tentatively booked, and an evaluation of GDM Group Education was undertaken, with a report published from this.

4.1.3 Meeting attendance

The results from the documentary analysis of meeting minutes outline the attendance at meetings for the Diabetes in Pregnancy Work Stream.

Multidisciplinary Steering Group:

- Five meetings were documented at approximately two-monthly intervals from May 2008 to March 2009.
- Of those invited to the meetings, attendance of those invited, at each meeting ranged from 45% to 64%, with an average attendance rate of 54% over all the meetings.
- Approximately half (n=16) of the 30 members attended at least 50% of the meetings that they were invited to over the 10 month period.
- More than one third of the members (n=11) did not attend any of the meetings that they were invited to.

Information Systems Working Group

- Four meetings were documented, two of which were held around mid-2007 and two in late-2008.
- Apologies were not noted for the first 2 meetings, but attendance numbers were 7 and 8 respectively.
- Attendance of those invited, for the following two meetings were 50% (n= 5) and 80% (n=8).
- Four people attended all of the meetings that they had been invited to.

Models of Care Working Group

- Two meetings were documented and were held in June 2008 and September 2008.
- Five members attended both of the meetings.
- Attendance of those invited was 50% (n=7) for the first meeting and 73% (n=11) for the second.
- The overall rate of attendance was 62%

Workforce Development Working Group

- Two meetings were documented, one in July 2008 and the other in November 2008.
- Of the 10 members invited at each meeting, only 3 attended the first meeting, and 4 attended the second.
- Six of the 10 members did not attend either of the two meetings.

Group Education Working Group³

- Three meetings were documented taking place each month from April 2008 to June 2008.
- Apologies were not noted for the first meeting on 30 April, but 7 people attended. This was the highest number of people attending the documented meetings. The following meetings had five (36% of those invited) and four attendees (25% of those invited) respectively.
- Only 3 members attended all of the scheduled meetings.

Documentation of meeting attendance revealed that many meetings had low attendance. This was especially so for the WD working group. The highest attendance numbers were recorded from IS working group meetings, and the second MOC working group meeting.

4.2 Key stakeholder interviews

This section presents data from interviews held with steering group members and other key stakeholders involved in the project. The key stakeholders were asked a range of questions in relation to various aspects of the Diabetes and Pregnancy Work Stream.

Topics of discussion included:

- Project development and background
- Key project achievements
- Barriers to achieving the project aims
- Levels of stakeholder collaboration
- The future of the project

³ It should be noted that the Group Education Working Group is an unofficial short-term working group of the Diabetes in Pregnancy Work Stream.

The following section presents the findings from these interviews and is structured under the key themes identified through the analysis of the interview transcriptions.

4.2.1 Project Organisation

Stakeholders offered their perspectives on various aspects of the organisation of the project, including insights into the background of the project, the purpose of project, the terms of reference, project integration and progress to date.

Project background

One of the stakeholders discussed the reasons for the development of the initiative citing a large number of women, particularly Maori or Pacific Island women who were falling through the cracks.

In 2004, [it] was brought to my attention that the diabetes in pregnancy clinics... only 30% of the women that were being seen there had any reasonable follow-up and had a post-delivery glucose tolerance to clarify their diabetes status...which meant Maori and Pacific women were, at best, being seen at clinics, at worst maybe made one visit then delivered their babies and were lost to follow up.

Also mentioned by a number of stakeholders was a review of diabetes and pregnancy in the Counties Manukau region in 2006, a number of key issues were identified including: an increasing diagnosis of diabetes and pregnancy, lack of co-ordination between other diabetes and/or pregnancy care providers, barriers to the care delivery model, high risk patients disengaged from recommended services and care provided during pregnancy generally not leading to effective long-term management of diabetes.

Purpose

Many of the stakeholders admitted that they were unclear about the purpose of the work stream; however, most were still able to identify a key purpose as improving the diabetes and pregnancy Service for women. Three elements to achieving this purpose were identified: integration of primary and secondary care through improved communication, integration of disparate secondary care services through an improved GDM clinic, and to increase awareness of diabetes in pregnancy among the DHB's population.

[Diabetes and Pregnancy is] a fantastic integration project, one that really needed to be done, one with growing needs, and one that really moved across multiple services within secondary care.

To relook at the whole service, and try and find a better way of educating people with diabetes in pregnancy. So to have a more efficient clinic, that was more patient-focused and fitted the clientele that we're seeing.

It was noted that the integration process needed to be multi-disciplinary and examine the needs of the service, clients and workforce.

We've got all these disciplines round the table, let's look at what's best for the service, let's look at what's best for the women, let's look at what's best for our workforce, and come out with something.

Stakeholders also struggled to separate out the purpose of the work stream as a whole, the role of the MSG and the role of the Working Groups. Many were unable to identify the Working Group(s) to which they belonged without prompting by the interviewer.

Stakeholders were confused about the exact purpose of the multidisciplinary steering group. Some felt that the purpose of the group was to analyse the current and future situation of the service.

I think the primary purpose of the steering group was actually to build a straw man; what have we got, what's the matter with it, how can we make it better, this is what we are building.

Others thought that the group's purpose was to look at the workforce issues experienced in the service.

I think they try and define what the workforce needs would be. The problem was you can't define the workforce needs until you've really defined your Model of Care needs.

Another stakeholder felt that the purpose of the stakeholder group was to redefine the Service's Model of Care.

We need to look at, models of care in the service. Because ...there's been no job structure [for the diabetes midwives] ... we became clinical midwife specialists, and someone can be a clinical midwife specialist day one within the role, which to me seems a bit ridiculous.

One stakeholder mentioned that the outcomes of the Work Stream are intangible.

One thing that is tricky about this initiative is that there's no real tangible kind of physical... I think the results and outcomes for this initiative are downstream a bit more. They're a little further out.

Terms of Reference

Conventionally, new project groups establish Terms of Reference (TOR) to help set out goals, objectives, and a specific work plan to guide the group. Stakeholder's awareness of whether or not the Diabetes and Pregnancy Work Stream had Terms of Reference was mixed, with some stakeholders readily identifying TOR, and others having no knowledge of any in existence. Although some stakeholders were able to identify the Terms of Reference, it was reported that they were not used as guidance for the group.

When the current Project Manager came on board we established terms of reference for the steering group and the working groups. To be honest I can't say that those were adopted real well. It was the kind of thing where in the first couple of meetings kind of establish what the goals and principles were, and the Project Manager drafted up proper terms of reference on paper and submitted them for review at subsequent working group meetings. And it was kind of just a head nod from people, so I'm not going to act like these are documents that are referenced often, but yeah we tried to establish them from the start.

Project Integration

The majority of the stakeholders did not perceive that the project was integral to their primary, day-to-day roles; they saw their responsibility largely limited to attending the meetings.

Not on a day-to-day basis, it's probably more so at the meetings because so far nothing much have come out of it, it's not a daily thing. We go to meetings, we have discussions, sometimes from the discussions at the meetings, we might be given little things we need to do, which we do... nothing really on a daily, day-to-day basis.

Progress to Date

Many of the stakeholders commented about the lack of overall progress of the project at the time of the interviews.

It's been slow. I think it hasn't been necessarily always well-facilitated. There's been a couple of project managers. And there's been traction lost in the translation from one to the other.

Stakeholders reported poor overall productivity of the steering group and working groups. The notable exception was the Group Education working group; however, this group was run parallel to LBD, rather than as part of an issue identified by the steering group.

I might have unrealistic expectations, but I don't really think anything has come out of any of them [the meetings]. Maybe IT I think, you know there's a database started, but really I don't think there's been any really hard, concrete things come out of it, unless the dietician's group sessions has come out of it. I don't think it's [the project] made a jolt of difference. ...Which is very frustrating for people who have put a lot of energy into it.

The presence of a new Project Manager from April 2008 helped to advance the project.

And then the current Project Manager came on board, and he sort of took the bull by the horns and started getting some work streams together and doing some more frequent meetings, which is great. And that was good for a while, and then we sort of slowed down the emphasis.

A few stakeholders saw some productivity in the meetings; however, it was evident that stakeholders did not perceive productivity on an overall project level.

They've been productive in that they've generated discussion. But as far as output or making change, or affecting change, I don't know if they've actually got very far at all.

According to comments made by the stakeholders, the project lacked common and clear understandings of the purposes of each of the groups, including the Work Stream itself. Stakeholders instead shared a view that, despite attempts made, little progress had been made from the project meetings as yet.

4.2.2 Barriers

Stakeholders identified a number of barriers to the progress of the project including service fragmentation, difficulties with the way stakeholders were engaged in the project, problems with organisational structures such as meetings, a lack of leadership and a lack of open-mindedness.

Service Fragmentation

Division of the different CMDHB medical services and departments involved in the Diabetes and Pregnancy Service was seen to be a primary barrier to the progression of the project.

Service divisions were seen to contribute to the lack of project ownership.

I guess it's more the problem that we haven't got one person taking ownership of the whole part of that service, because it is fragmented.

Some of the stakeholders indicated that this departmental fragmentation led to communication issues.

I think maybe it's because Women's Health is very separate and has very different needs ...or whether it's because you've got two completely different departments.

One stakeholder linked the challenges to obtaining collaboration in the environment of fragmented services.

We're dealing with a couple different services here, everybody has their own interests, everybody has a different dog in a fight, and I guess that's the nature of collaboration, isn't it? Everybody's got a different perspective.

Initial Stakeholder Engagement

A number of stakeholders discussed the prevailing perception that the project had been imposed upon the Diabetes and Pregnancy Service, which contributed to a lack of project progress, poor buy-in and resistance among personnel involved in the Service.

From the initial time... it didn't seem to have a lot of structure to it. You know, we were struggling to grasp where they were coming from, coming from outside our service. And we

sort of got the overall picture, but it really didn't go very fast or anywhere at that point in time.

Concerns were raised about the process of attempting to obtain stakeholder buy-in.

But I know myself that I didn't have buy-in into it, because I felt like that this was being imposed on us from outside of our service... I'm certainly not opposed to joining the wider diabetes services and the whole LBD thing. That's great that they've actually included [Women's Health], as part of it... I don't know whether it was the best strategy to get the buy-in that they needed from the providers, the health professionals within our services around diabetes.

Them [Diabetes and Pregnancy Service] being included from the outset [would lead to buy-in] as opposed to seeing it as something being done to them. It was a case of... here are some people who have an idea how they're going to change our service, and they are going to come and tell us how to change our service. Not... there's a group of people who may think that there's a better way of doing this... can we work our best to do it. It was a perception of something being done to them, felt more strongly by some clinicians than others, but definitely there.

Organisational Structures

Meeting Structure and Content

Meetings were a key factor in the progression of the project; the objectives of the project were to use these meetings to facilitate inter-disciplinary collaboration and to work on aspects of the project, then make recommendations to the steering group to action decisions at higher levels. Stakeholders reflected on the meeting structure, their productivity, and whether or not attending the meeting was a priority for them.

Some stakeholders felt that the meetings needed to be more tightly controlled and centralised due to the diverse nature of the personnel involved with the Diabetes and Pregnancy Service.

The meetings need to be really focused and really well facilitated, because they are such divergent points of view. And I'm not too sure how much work has been done underneath to get the work stream functioning better.

Others felt that the issues with the meetings were due to lack of planning by the individual members attending, rather than the facilitation of the meetings, which lead to repetitive meetings.

I think the meetings were well run. ...I think that people tended to... put a lot of thought into the meeting, but very little before or after. And so what that tended to mean was that people talked a lot in the meeting about their concerns--this is that, and we haven't fixed that up, but didn't bring to the meeting any ideas or things they could do. By the next meeting, well it was almost like the same track on the record was playing again.

Many stakeholders expressed irritation at the repetitive discussions in the meetings.

I think the issue around the circular nature of the discussions that go on is because there's so many players within in that particular part of the service with their own agenda.

Some felt strongly that the groups shared too many members, which slowed the initiatives impetus.

I think they're too big. I think we've got... I think we're so inclusive that we've actually paralysed ourselves. I think it needs to be small, targeted groups to move it forward.

Others saw that it was important to have some overlap, but speculated that there were too many for this project.

I think you need overlap, but I don't know if you need as many overlapping... certain representatives maybe. For example, both diabetes midwives wouldn't need to be in every group, but I think to represent all of us, there probably should be an obstetrician, a diabetes physician ...so I don't think we need to be in all of the groups but there needs to be a representative.

One stakeholder commented that the meetings seem to become focussed on the factors that could not be changed, rather than identifying and working at issues which could be resolved. Suggestions for a different approach were offered.

I'd pick things that you knew were easy to be achievable, and leave the harder things till later. For instance, you might have chosen [to improve] ...follow up on women's Oral Glucose Tolerance test, so what we'd like to do is how can we achieve that, and the outcome might be that we need to appoint a person to do that...If that had been something that we were going to do, then it has happened, and it has been successful, and we're following up a higher percentage of people post pregnancy for their diabetes. And then it would have been a win, and then move on to take things in smaller bites.

Meeting Attendance

Meetings were critical to the forward movement of the project; however, many stakeholders expressed frustrations regarding the lack of attendance of key stakeholders. Poor attendance was seen to hinder the initiative.

It reflects on the group that if the attendance [is poor], and then someone comes in and reignites a discussion they should have ignited last time, when it was actually what was on discussion... we are slowing down the progress, and slowing down the progress of the group such as this has got an opportunity cost.

One stakeholder commented that when key stakeholders did not attend meetings, they failed to represent their views to the group, and decisions could not be made without their input.

People haven't attended and on most occasions, where people haven't attended, they have not seen their lack of attendance as requiring some other attention. For example briefing

someone and deputising them [or otherwise communicating their views to the group] ...Non-attendance usually was after having already gotten instruction that it was a suitable date. ...I think it's been rude actually.

Meeting prioritisation

The priority of attending the meetings varied among the stakeholders. Some felt strongly that the project was important to the Service and the DHB as a whole, therefore they made significant effort to attend the meetings.

Yes it certainly is, because it's a service that really needs to be developed, given the context of the environment that we have at Counties. And we really need to be progressing it.

Others attended the meetings because they felt that they had an important role to the project.

I try to attend all of the meetings. I am a bit nosy and I like to know what's going on, and how we are progressing. And then if there's anything that I can do to help facilitate the progression and get things moving along. ...I've got a lot of background, knowledge about how things used to be and what used to happen ...I want to crank it along, so that we can see some progress.

Some of the stakeholders said that attending meetings was not a priority due to the manner in which the project was initiated.

No frankly. It hasn't been. We felt very much as if the Let's Beat Diabetes project was something that was done to us, that we were not included in. It was, we were informed and a report was produced, the preliminary report was produced that probably did not reflect... it certainly reflected some of my views... but my views weren't necessarily the same as some of my colleagues. And there was certainly a degree of resistance to get involved because it felt as if this was something that was going to happen irrespective of what the outcomes were.

Others pointed to conflicting clinical duties as a reason for their inability to attend meetings.

Unfortunately...with all meetings, I've, got clinical service commitments during the week, which just can't move. So if I have to do a walk around in the hospital in the morning I just can't go a meeting at the same time.

One person commented that some people did not prioritise the meetings due to the perceived lack of project momentum.

I think for me, and I think for others that the focus is kind of off the boil. It becomes less of a priority, less inertia, there's not really ever been a good rolling ball for people to cling onto and be pulled along. There's not been the momentum, and that's not to say that [the Project Manager] hadn't tried ...I think the complexities of who's involved and the time they have to be involved and in some cases the wish to be involved, and their own interest, it's all competing interests. It's all very diverse and quite a difficult group to bring together, as he's found.

Leadership

Many of the stakeholders discussed leadership of the project. While the leadership from LBD was seen as a positive, it was felt that leadership from clinical management was lacking. The lack of a clinical driver affected the ability of the stakeholders to make decisions to progress the project.

Definitely lack of leadership. ...I don't think anyone within our service has actually taken this [project], the bull by the horns and actually said 'right, I'm owning this, supported by LBD, or the wider diabetic services, and I will drive it through my service'. There's no key person that we can say is the person that will take that on.

Without a clear clinical driver, no one was willing or able to make the necessary decisions; the lack of decision-making was a barrier to progressing the project.

And with both the work streams [Models of Care and Workforce Development] it's about who makes the decision. ...It's about somebody standing up and saying right, this is what we want, this is what we're going to do and put that out there.

While the lack of leadership was seen as a barrier to progress, the stakeholders did not feel that leadership was the job of the project manager; it needed to come from the clinical part of the service.

[The Project Manager's] job is to facilitate it [the meeting] ...maybe there needs to be somebody else... who will say, 'right, this is what we've heard, we need to make it [the decision], somebody has got to lead the group, because we don't, there's not a leader. ...Maybe that's why decisions are not being made.

Stakeholders did not feel that a clinical champion had been identified at the beginning of the project. There were differing opinions as to who should be responsible for driving the project.

I guess it's looking at who is the right person to actually do that. And that was never really identified, right from the beginning. It was [LBD] coming from outside to try and move our service along in this direction with this... the work streams etc, which was great having that outside support. But it also needs to come from within the service. You know, the direction and drive to actually make that change.

Lack of open-mindedness

One stakeholder made reference to the lack of open-mindedness among a number of stakeholders and that this needed to be worked on to facilitate some more active discussion.

But I don't think we've got the people really to that completely open minded ...we haven't gotten them to the point where they keep repeatedly asking why, why, why, why, drilling right down to what we actually do. You know they're still a bit accepting of, because that's the way we have always [done it]. But that's quite difficult to get to that point where you're really saying, well how are we going to do this. But I think raising the question about how do we do things is the important thing.

Key barriers mentioned by stakeholders included the difficulty of collaboration between fragmented services and departments, and a lack of buy-in related to ownership of the project. Barriers relating to the meetings included that meetings were not resulting in agreements or outcomes, that meeting attendance was unsatisfactory, and that the meetings were not always a priority for all involved. Further barriers mentioned were a lack of clinical management leadership in regards to this project, and lack of open-mindedness.

4.2.3 Stakeholder Collaboration

Collaboration is a key element of the successful development and implementation of a programme. Successful collaboration involves an element of change through shared vision, values, working together, and sometimes in the way organisations or individuals think and or act.

A collaboration scale (Figure 1, Page 9) was used to help stakeholders rate the collaboration for the initiative. Views on the level of collaboration amongst stakeholders involved in the project were varied. Almost half of the stakeholders felt that the steering group was just beginning the collaboration process at the level of participation, moving toward cooperation. A few perceived the group to be further along the spectrum, reaching the initial stages of partnership. While there was not a decisive opinion, the rest of the ratings were clustered and evenly distributed at the levels of cooperate, coordinate, and collaborate.

A number of stakeholders explained their perspective about the level of collaboration within the Work Stream, MSG or working groups.

One stakeholder noted that there was a desire among most stakeholders to get involved and participate, it was the process of moving on from participation that was proving to be difficult.

I think in general, I think we all want to participate... get involved. I don't know in particular if there is any pooling of resources and there certainly hasn't really been any formalising of commitment, apart from the group and the 'Healthware'. I think we do ...commit to changing, it's just the process seems to be very long process.

Stakeholders views of the level of collaboration reached were dependent upon which group they were referring to, and therefore, varied. However, the overall impression was that collaboration achieved was in the lower spectrum, being mostly participative, when involving people from more than one department or sector.

4.2.4 Positive aspects of the Work Stream

A number of positive aspects of the Work Stream were identified, for example, a perceived increase in the level of buy-in, overlap of membership of groups was also seen as positive and communication was viewed to be clear and relatively straightforward.

Levels of buy-in across the project have varied over time; one stakeholder saw that buy-in had increased.

There's probably more buy-in now; because it seems like, you know within the next few months more of the things from the [Working] Groups are going to be moving ahead and ... things are going to be happening.

A few stakeholders felt that the overlap of membership on the various working groups and steering group was useful, as the stakeholders were interested in aspects of multiple working groups.

I think it helps... that's the whole point of this is that we've got people working in different spheres and to get them together in the same room, and originally what we outlined was the Project Manager's role would be to bridge these groups and keep one informed of the other. I think because the stakeholders and the meeting members who were involved in these groups have an interest in multiple [Working Groups] they do end up being the same attendees.

Some felt that communication was straightforward and generally unproblematic, through meeting minutes and other communication methods.

I think it's been very easy. ... I've made a real effort to keep everybody informed or involved whether or not they're able to attend. Just send out those minutes and emails, and yes from that perspective, if I need to get hold of someone on the phone I haven't had any problems communicating with them.

4.2.5 Key Achievements

Despite the frustrations regarding the speed of the project, stakeholders identified a number of achievements. Accomplishments included the inclusion of a range of disciplines with complementary practices, recognition of issues experienced by the stakeholders, a diabetes component for the information system and the facilitation of the GDM Group Education project.

Multidisciplinary meetings and recognition of issues

Stakeholders felt that at a very basic level, a key achievement was creating a forum, through the meetings, for the different disciplines to gather and reflect on issues pertinent to their areas of work.

I think the key achievements have been firstly that we got all the parties in the room. Because what had happened up until then, had been that patients, clients, whatever, the women, pregnant women, were the transaction, but nothing else was. So firstly, we removed it from this transaction of clinical care to actually meeting together.

Furthermore, the meetings provide a place to generate discussions among stakeholders.

We show up for a meeting and get things going, it's not dead air. So everybody is there for a reason and definitely has something to say, and quite strong opinions, which is helpful I think.

A commonly cited positive outcome of the project has been the ability of stakeholders to discuss their issues and acknowledge some of the problems currently faced by the Diabetes and Pregnancy service.

I think up until we started with LBD that there has been...just no direction, really. And I think now with this project, as I said earlier, they are coming to understand and acknowledge where we've been at and where we'd like to go and helping to facilitate that to move forward. I think that's been the biggest thing, I think it's just recognising that there've been a lot of issues and frustrations, and being able to bring those to the table, get them out there and have people looking at them and working together to try and sort out the varied, different things, and coming up with solutions and moving, moving forward.

Healthware

At the time of the interviews, a new diabetes component was being introduced to CMDHB's Information System, Healthware. Many of the stakeholders expressed excitement about the potential for the software to facilitate better collection of data from women with GDM and their infants.

On the 3rd of March we're putting a new version of Healthware out, and in that version there is a Diabetes Folder ...which is new. It hasn't been used before. And it's got a diabetes folder for mum and baby. So we will be starting to record specific diabetic information.

Though one stakeholder was pleased with the ability to input diabetic information, she expressed concerns about the additional administrative burden.

Well except for the fact that we now have to data entry that information and there are only two of us with ...about 90 patients between us that we are looking after and we have one computer. So we will see. Who knows how long it will take get it in, but it's there and we can start data entering which is really good.

GDM Group Education Sessions

One of the dieticians working in the service developed a trial of group education for new GDM patients, in order to facilitate patient learning and streamline the clinicians' work methods. The GDM Group Education trial was developed parallel to the Diabetes and Pregnancy Work Stream, with reportedly positive results. However, supporters of the project struggled to integrate the Group Education Sessions into business practices; LBD was able to facilitate the integration through an evaluation conclusively demonstrating the importance of the sessions.

As far as changing things to a group session in the morning, there was a lot of resistance and fortunately, the Let's Beat Diabetes [Diabetes and Pregnancy] Project Manager got involved, and was very good at running those meetings, and helping the dietician to move the project forward. Because I think without his involvement, it wouldn't have happened. There was a lot of resistance to change at that point. But that [the group education sessions] was the dietician's initiative, not from the steering group.

Stakeholders reported that key achievements of this project included the creation of a forum which has facilitated open discussion between the different departments and disciplines, the development of an IS diabetes component that will enable data entry and collection, and the group education trial that was assisted through LBD support.

4.2.6 Project Future

Overall stakeholders were positive about the visions and goals of the project and hoped to see it progress into the future. Stakeholders assessed the current sustainability of the project, discussed the key challenges to making the project sustainable, and the future steps needed to progress the initiative.

The slow progression of the project was a concern to some of the stakeholders, and it was unknown if CMDHB or LBD would be available to continue to support the project.

In the end we've been really slow at getting something together, now we're finally just about ready to, and the organisation has moved to other priorities. So it would be nice to think that we've still got the support of the organisation to continue to develop and funding and resources to our part of the service as well.

Current Sustainability

Most of the stakeholders did not believe that the initiative was sustainable in its current form.

No. It's as sustainable as a truck with a heavy load driving up a hill, you know. It requires a lot of horse power, to get it to happen.

No I don't think it's at a point where if LBD left tomorrow, things would keep progressing. ...If LBD were to drop off the face tomorrow, I think [the Community Liaison Coordinator] would still push it. I don't know if I'd define it sustainable just yet.

A few of the stakeholders believed that, at the time of the interviews, the project was starting to get traction and progression toward sustainability was being made.

I think it is from now. Now we've put something down on paper around models, to ... take some initiative there in developing, formalising, the diabetic midwife's role, and developing an educator role within that service, that's probably our start that we can make. Because it's something that I can manage, it's within my service, I can drive it, take ownership of it, and move it forward. I probably can't change the physician or obstetric consultant part of the service, but the Gynaecological Service Coordinator may be able to. ...So between the two of us hopefully we can get some change starting to happen.

Next Steps

Stakeholders identified steps that needed to be taken in order to continue the work of the project into the future. The steps included: identification of a clinical champion, revisiting the objectives and re-approaching the project, setting specific deadlines for decision-making, and formalising decisions made in the meetings.

Leadership was seen to be a critical factor to move the project forward and achieving some outcomes.

If we really are serious we are going to make a difference there, there has to be a project manager who will really drive this. And who will be of such standing, that people will fall in behind, if only because it's a hierarchy and he said.

The need for a clinical champion was seen as an important driver to the process. This was linked to obtaining a greater buy-in from clinicians involved in the Service.

I think that if it's to get some more legs and get moving, it needs clinical champions to run it, as opposed to a facilitator or project manager, that's more likely to get better buy in. It doesn't matter too much whether that's an obstetrician, or a physician or midwife, who actually ...runs the process and be seen as the diabetes in pregnancy person whose getting this all going.

A few stakeholders suggested re-launching the project as a method of obtaining greater buy-in and inertia.

I think it's really got to re-stock. See what objectives are going to be, ... I think what's happened so far has not been productive and we really need to regroup and actually decide how we're going to approach it again. Be a bit clearer about what we want to achieve, and do things in bite size amounts, rather than breaking off in four different, quite large groups.

In order to facilitate the decision-making process one stakeholder suggesting that a specific endpoint to the debate is identified.

I think there should be a deadline; they should maybe ask a few other people who are also involved, rather than just the people that come to the meetings, like anybody that's involved in the service, in particular the clinic. And it's time to make some decisions.

Some stakeholders were very prescriptive in their suggestions for future steps. They saw that the project needed firm direction by management.

I think the chief planner and funder, our CEO, and the clinical lead of LBD, probably need to meet, probably need to come up with a policy as to why this is so pressing in the quarter. Then need to talk to the GM and [the Chief of Women's Health], and then invite them to say how best do you think we can look at this situation and move it forward.

One stakeholder felt that buy-in would need to occur at a management level before it would occur at the level of individuals.

In terms of buy-in, we would need to have, to start us off again; we need to have buy-in from, from the Chief of Women's Health, to direct traffic, and say, to attend, please. I don't know how you do that.

Formalising agreements and decisions was seen as one method of giving the project momentum.

There needs to be some agreement on paper and at a higher level between some of these different services about how they want to manage the clinic. ...once folks do reach an agreement on it and again it's going to have to be at a higher level, up with the general managers to put this down on paper and say yes, this is the way we're going to do business from here forth. And at that point to me it's sustainable because it's fairly binding in a way.

It was also suggested that the women using the service should be asked how it could be improved.

Maybe it will be a good idea to see what some of the women think of the service and how they think it could be improved. It would be a good idea asking them what they would want because I know a lot of them don't like coming to the diabetes in pregnancy clinic for various reasons. I mean I think it shouldn't be on an afternoon, you know, because it's one to four, and you know we have quite a high DNA rate and they're going to pick up their kids which is obviously what they need to do...So yeah, looking at it from their perspective.

For the project to be sustainable in the future, stakeholders believed that management needed to drive it, perhaps with formalisation of agreements, and those involved to take ownership.

5. Discussion and conclusions

The aim of this evaluation was to promote a learning environment, whereby a process of review and reflection is encouraged in order to facilitate the development of the initiative. Through the analysis of documents provided to the evaluation team and the key stakeholder interviews a range of information was gathered around the development, implementation and current status of the initiative. This section provides a discussion of the key findings in relation to the evaluation questions that were developed in collaboration with the Work Stream.

5.1 Summary of findings

This section provides a summary of the findings from the documentary analysis and key stakeholder interviews.

According to documentation received, five objectives were being addressed through the meetings. Two working groups successfully developed their TOR, an IS was developed, and a midwife specialist role was being reviewed, as per the short term objective outcomes. Additionally, CME presentation topics were discussed and a session tentatively booked, and an evaluation of GDM Group Education was undertaken, with a report published from this. Documentation of meeting attendance revealed that many meetings had low attendance. This was especially so for the WD working group. The highest attendance numbers were recorded from IS working group meetings, and the second MOC working group meeting.

Stakeholders felt that a number of things were lacking from the project or its working groups, such as, a commonly understood purpose, collaboration between services, ownership by members, a strong leadership to drive it, and more tangible ways to determine progress made. These issues needed to be addressed in order to improve progress within the Work Stream and its future sustainability.

5.2 Answering the evaluation questions

The following is a summary of the evaluation questions posed in collaboration with stakeholders, which guided the evaluation of the Diabetes in Pregnancy Work Stream.

How was the initiative developed?

GDM is a growing problem for pregnant women in New Zealand, and was seen to be a particularly pertinent issue for women in Counties Manukau. In 2004 and 2005 the issue was scoped; however, there was little momentum until 2008. A scoping document was completed that added weight to the issues identified. There is a sense among some key stakeholders that the Work Stream was developed without a clear sense of consultation and this has had an impact on buy-in, continuous collaboration, and the progress within the Work Stream to date.

What are the key goals and target groups and how were these determined?

Based on the data collected, it is apparent that there is no set of clearly defined goals and objectives set out for the Work Stream. There are a range of documents with various goals and objectives; however it is unclear whether these are still relevant to the current stakeholders and the work being done in the Work Stream. Although most stakeholders can identify a broad vision of what the Work

Stream is meant to achieve, many stakeholders cannot identify achievable objectives for both the steering group and working groups. This seems to have contributed to a sense of frustration among members.

What was the intended programme logic?

A programme logic has been developed based on documents provided to the evaluation team and key stakeholder interviews. This programme logic is presented in Section 4. While the programme logic has been based on evidence, it has yet to be validated with the stakeholders. The programme logic is driven by an overarching project goal and is underpinned by a series of assumptions. Activities occurring in the work stream currently take the form of the facilitation of a number of working groups, theoretically being governed by a multi-disciplinary steering group. While it is clear that there are some products that have resulted from these meetings, they are not necessarily leading to the achievement of the short-term outcomes; this in turn hinders the progression of the Work Stream to effectively impact on the service being provided to women with diabetes in pregnancy.

Determine what the key programme resources are and how they were intended to be used.

Funding and support through a Project Manager has been made available by Counties Manukau District Health Board through the Let's Beat Diabetes programme. While it is clear that the Project Manager has facilitated the stabilisation of the working groups and the multi-disciplinary steering group, the work being carried out needs to be led by someone with influence in the field. Other key resources include background documents that were used by some stakeholders to add weight to the urgency of the situation. It was noted by one key stakeholder that while there are plenty of documents providing evidence for the seriousness of the issue, this does not seem to have provided the momentum required.

What are the factors that influence stakeholder engagement?

Stakeholder involvement varies, some have been part of the Work Stream from its scoping period, and others are fairly new to the area. A report that was commissioned in part by Let's Beat Diabetes in the early stages of the Work Stream is viewed negatively by a number of key stakeholders, which has had serious implications for further stakeholder engagement. A rigorous consultation process needs to be carried out in an area such as Diabetes in Pregnancy as it impacts on a range of services for both primary and secondary care. Furthermore, stakeholders do not feel as though changes should be made to the service without appropriate consultation; unfortunately the initial engagement of stakeholders was unsuccessful and has marred the work to date.

What is the process and level of collaboration for stakeholders within the working groups and steering group?

Collaboration can be defined as *"a process involving shared norms and mutually beneficial interactions"*. Successful collaboration includes a number of key characteristics including environmental, membership characteristics, processes and structures, communication, purpose and resources. Based on the collaboration continuum, from being willing to help (participate) to formalising commitment to goals (integrate), stakeholders are clear about where collaboration within the Work Stream sits. There were a range of views about the nature of collaboration of the Steering Group, some stakeholders saw it at the beginning stages characterised by a group of people

willing to help and starting to get involved; while other stakeholders perceived the Steering Group to have more of a partnership level of collaboration. Based on the characteristics of successful collaboration there are a number of key components that seem to be problematic. The current environment that the Work Stream operates within is viewed by stakeholders to be fragmented and uncooperative, this impacts on the development and agreement of clear purpose and objectives. Also related to this is the lack of clear processes and structures that are involved with running Diabetes in Pregnancy services. Some stakeholders made it clear that work force development and model of care issues, while the focus of the Work Stream, are not only strained but restricted by unwillingness to change. While it has been noted that communication has improved considerably among stakeholders over the past year, discussions in meetings continue to be circular in nature characterised by a lack of decision making and clear leadership.

Meeting attendance data suggests that not only is there poor attendance to many of the meetings, but attendance varies across the working groups and steering group. Attendance was noted to be a source of frustration by the stakeholders who suggest that this seriously impinges on the activity being carried out in the work stream.

Underlying all the activity within the Work Stream is a clear sense of unease based on the way the Work Stream was developed and the interdisciplinary nature of the work.

What factors of the organisational process are likely to help or interfere with the initiative's progress?

There are a number of processes that are seen to interfere with the progress of the initiative, these include attendance at meetings and lack of appropriate leadership. While there has been varied attendance at meetings for the Work Stream, overall, attendance at meetings has been poor and this is reflected in the comments made by a number of stakeholders. Furthermore, given the work the stakeholders are already carrying out, attendance and work towards the initiative is not seen to be a priority. One of the most notable issues that hinders activity within the Work Stream is the lack of appropriate leadership. While the Project Manger was seen to assist in gaining some momentum in the Work Stream, this person was not seen to be the right leader for the processes and discussions that needed to take place. Stakeholders discuss having a leader who can champion the cause and has the required clinical and technical skills to be well respected by all stakeholders. This person must be able to assist in making high-level decisions that will influence change in the services. Currently there is no one sitting in this role and activity and issues seem to stagnate within working groups or the Steering Group.

Describe stakeholders' perceptions of results obtained thus far.

The evidence suggests that while there has been some discussion towards Work Stream objectives, and there has been increased awareness of the most pertinent issues to the Diabetes in Pregnancy services, there has been a lack of significant activity and decision-making occurring. There is a sense among almost all of the stakeholders that something needs to be done, but that the Work Stream in its current form is not going to produce the results required.

The most notable achievements of the Work Stream include the development of Healthware to improve the Diabetes in Pregnancy IT processes and the support of the group education sessions,

although there is some hesitance by stakeholders as to how this relates to the current objectives in the Work Stream.

5.3 Issues to consider

Based on the analyses conducted for this evaluation, there are a number of issues to consider:

1. Appointment of clinical leader /clinical champion closely related to the service

Work stream members must consider the most appropriate way to engage in a discussion to decide where the leadership for this Work Stream should lie. Due to the original misgivings regarding perceived lack of consultation with key people involved directly in the diabetes and pregnancy clinic, some stakeholders perceive that that leadership for the Work Stream should sit with someone closely related to this service. The sense of urgency for clear leadership is evident.

2. Clarify objectives and achievable targets to gather momentum

Although there is evidence of a shared vision, the Diabetes and Pregnancy Work Stream must consider further developing objectives that are specific, measurable, and achievable within a specified timeframe. The programme logic is an excellent starting point to review the vision of the Work Stream as well as what are the desired outcomes and by what means these will be achieved. The evaluation team will facilitate the validation of the programme logic as a starting point for this process to occur.

3. Review membership and re-assess stakeholder commitment

Stakeholder commitment has varied considerably throughout the timeline of this project. The Work Stream stakeholders must consider how participating in this Work Stream fits within their priorities and assess their level of involvement and commitment. Steering group and working group membership can be reassessed to establish whether it is appropriate for all members to participate in all levels of Work Stream organisation.

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Appendices

Appendix A: Documents used in the documentary analysis

The documents used included:

- Diabetes and Pregnancy in Counties Manukau (by Ray Naden)
- Terms of Reference
- Gestational Diabetes in New Zealand: Technical Report
- Meeting minutes:
 - MSG: Minutes from May 2008 – March 2009
 - IS Working Group: Minutes from June 2007 – September 2008
 - MOC Working Group: Minutes from June 2008 – September 2008
 - WD Working Group: Minutes from July 2008 – November 2008
- Diabetes in Pregnancy CMDHB Project Brief

Appendix B: Key Stakeholder Interview Guide

Background/Project Development

1. Please tell me about your role as a key stakeholder in the Diabetes in Pregnancy work stream?
Which groups are you a member of? (steering group/working group)
2. How does your involvement in the Diabetes in Pregnancy working/steering group(s) fit with your primary role and what you do day-to-day?
Is attending the meetings a priority for you? Can you explain why?
3. Can you describe the development of the Diabetes in Pregnancy work stream?
4. What is the purpose of the steering group and/or working group(s) with which you are involved?
5. Are there clear Terms of Reference for the working group/steering group of which you are a member?
6. To what degree do you think this group/these groups are productive– ie they fulfil their purpose?
7. The steering group and working group have a large overlap of members, does this help or hinder the work stream?
8. What is your perspective of the meetings you attend? What do you think about the content and manner in which the meetings are held?
9. From your experience, can you identify any specific achievements or impacts of the working/steering group(s) thus far?
 - a. What are the key factors that contributed to this success?
10. During your involvement with the working/steering group(s), have you encountered any barriers to achieving the vision/aims set out in the working group(s)/the steering group?

Stakeholder Collaboration

Next we want to discuss collaboration--having shared vision, values, and working together; it involves an element of change, sometimes in the way organisations and individuals think and act.

11. Using the scale provided, where would you rate the collaboration among the stakeholders in the Diabetes in Pregnancy working/steering group(s)?
12. How easy or difficult has it been to communicate and coordinate with other stakeholders?
 - a. Prompt identification of working group v steering group stakeholders
13. Buy-in describes the level of commitment a person puts forth toward a shared goal. Has there been buy-in from all stakeholders?
 - a. Prompt identification of working group v steering group stakeholders

Project Future

14. Do you see that the project in its current form is sustainable and/or able to move forward?
15. Are there key opportunities or challenges ahead?
16. Do you have any suggestions for the future work with the Diabetes in Pregnancy work stream?