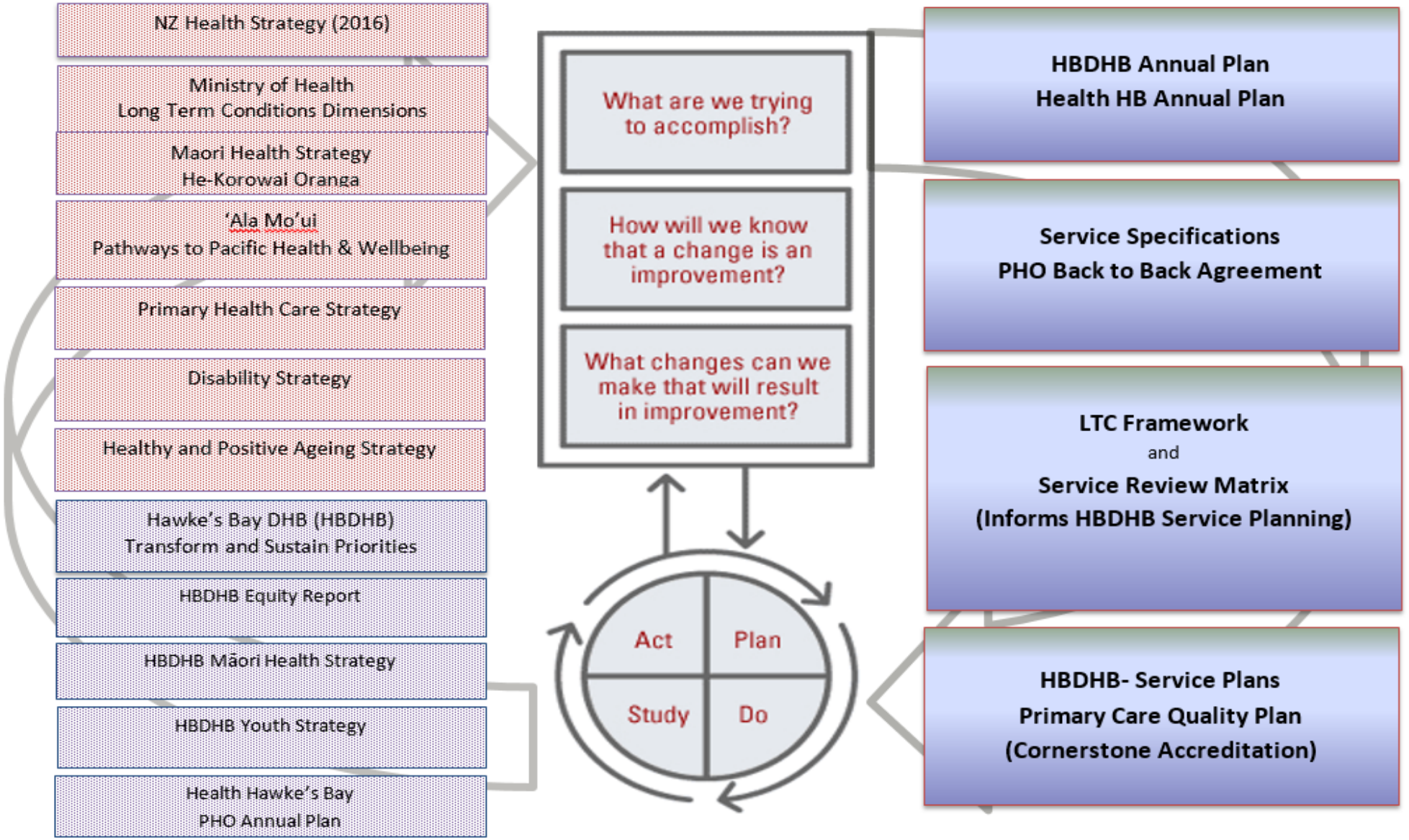
Appendix One: Long Term Conditions –Service Review Matrix (LTC-SRM)



Strengthening an Integrated Approach to Patient Care

The Purpose

The self-review matrix is to build internal capacity within an organisation/service to self-evaluate and self-design areas for improvement.

This matrix has been developed in alignment with the Long Term Conditions Framework and in response to the need to provide an evaluative framework on which to base decision making when a service/provider:

a) maps service performance for areas of strength

b) maps service performance to identify areas for development and where resource and support need to be increased

By using internal expertise with the assistance of critique from an external provider (in this instance the PHO quality leader and quality support team members or in DHB Quality Improvement Advisors). The process of self-evaluation and review follows the plan, do, study, act model (Appendix 1) and is underpinned by results based accountability i.e. outcomes focused.

Suggested methodology

The quality review matrix is designed as a proactive evaluation framework based on evidence based thinking methodologies; results based accountability and the PDSA cycle of review.

1. **Champion Resources (CR)** are identified within each work area but should consist of no less than; x 1 GP/Consultant, x 1 Service Nurse/Registered Nurse x 1 Service Manager/Clinical Nurse Manager, Allied Health Professional team members relevant to the service and Consumer representation. In addition a **Quality Improvement Facilitator** from the PHO/DHB identified for each Service.

2. **Resources** change management, facilitation, interview skills can be utilised to host learning conversations http://www.infed.org/thinkers/argyris.htm

3. **Suggested steps for CR and QL**
   - Work through the quality review matrix, using resources above in particular having the conversations where they feel what best fits against the component parts of the four akas.
   - Assign evidence to substantiate conclusions in line with evidence that has been identified in the matrix.
     Identify and prioritise areas for improvement. Each performance indicator; competent, proficient and excellent are divided into two levels by a number. The **lesser** number indicates **working towards** achieving at this level and the **greater number** indicates **working at this level**.
   - Findings are mapped for each work area. The results can be used to strategically and economically allocate resources, determine both individual service support and support to be provided collectively to groups of services with areas in common for development.
   - Develop an action plan to address the areas for improvement, resources needed, support required, and time frames to achieve success against the identified indicators.

The Four Aka		Components of each Aka	Context
Aka One	Person-Family-Whānau Centred Care	Consumer Voice	Consumers within our systems. Consumers not currently engaged with us
		Health Literacy	What matters to the patients – options grids – choices – full understanding
		Self-Care Management	Relationship centred care – social care networks
		Determinants of Health	Public Health Unit, Māori Health
Aka Two	Person Centred Clinical Systems and Processes	Care Coordination	System wide approach to care coordination (Whānau Ora approach)
		Transition of care	Seam less transitions of care within a patient journey
		Collaborative Pathways	Clinical guidance that support effective care management
		Integrated IT systems	IT, Business intelligence supporting a coordinated care approach
Aka Three	Workforce Development and Enablement	Workforces capacity and capability	Workforce Development – unregulated, careers
		Clinical Leadership	Providing clinical leadership that is visionary, supportive and critical in its analysis
		Clinical Expertise	Attraction and retention of high performing, qualified, experienced staff
		Intersectoral development	20% of care is within our health system – 80% at home. Who do we need to engage with to support wellness
Aka Four	Risk Identification and Mitigation	Population Health	Keeping our population well – strategies we need to support
		Equity	Who do we need to work hardest for – those who have poorest health
		Continuous Quality Improvement	Using the Service Review Matrix to show case the 'success – bright spots' to support innovation in areas that need improving
		LTC Advisory Function	Providing direction for the LTC Framework – as a collective across all LTC

Definitions:

Service Generic identifier of a range of health provision agents which include hospital based services – community services – general practice

TIPs

Work with your quality improvement adviser early on

- They know the methodology of change
- They can guide you in the right direction
- They will assist in your service developing an improvement plan and measures that will indicate success.

To cover the four dimensions within the Matrix

- Choose either **a) One Aka per month** or, **b) One dimension in each Aka** per month to work on.
    - Spend 3 months (e.g. August – October) evaluating the service against the 4 Aka.

Getting started

- Set up regular service meetings (Monthly) and add service planning and review as an agenda item
- Lock in a 20 minute session on the use of the (Long Term Conditions) Service Review Matrix

Identifying what you are going to do

- From your evaluation of your service covered in the starting process

- Identify **your strengths**
    - These are the areas you want to continue and consolidate (and share ideas with others)

- **Identify the areas you want to focus on that were at entry level**
    - Choose **no more than** 3 dimensions that you want to focus on in your service planning

Less is best:

- There are 4 dimensions to each Aka equalling a total of 16 dimensions. Don't focus on change across all dimensions.
- Focus on **1-3 dimensions where you want to make gains**.
- Concentrated efforts in one or two areas will show better results than trying to accomplish everything.
- Your quality improvement facilitator will be able to guide you in a stepped approach

Taxonomy of Terms

System wide approach	W. Edwards Deming described a "system" as a set of interdependent components — structures, people, and processes — working together toward a common purpose. A health care organization is a complex, adaptive system animated by hundreds or thousands of providers, administrators, patients, and support staff. For the organization to deliver on the promise expressed in its mission statement — for every patient, every time — requires that everyone in the system knows what to do and why, how and when to do it, and how to adjust when necessary to maintain fidelity with the organization's mission and values.
Inter-sectoral collaboration	The work carried out by a network of providers of care and or support that is not ONLY confined to the health sector. If we consider that 80% of a consumers care takes place at home and in the social context of one's life then the interface that consumer has with a team of support networks is the Intersectoral network to which we refer.
Options Grids	**Option Grid** is the name for a tool for patients and providers to use together when they are discussing and deciding what best to do about possible options, either treatments or tests. The grid is published in the form of a summary table to enable comparisons between multiple potential treatments or options. The grids do this by using questions that patients frequently ask (FAQs), and are designed for use in face-to-face clinical encounters or to be given to patients to read for a few minutes, ahead of a conversation with a provider. The key to the grids is the use of frequently asked questions (FAQs) that relate to the most common or most important concerns of patients. It is important to choose these FAQs carefully and to limit them to those that can be considered briefly. These FAQs are based on evidence where possible, and final versions are developed by teams of patients, clinicians, and editors. All Grids are written at a reading level of 10–12 years, in accordance with the plain English campaign guides. The evidence summaries upon which Option Grids are based are available for public review at the official Option Grid website.
Tracer Audits	Tracer methodology uses information from an organization or service to follow the experience of care, treatment or services for a patient through the entire health care delivery process. Tracers identify performance issues in one or more steps of the process, or interfaces between processes. The types of tracers include Individual tracer activity: These tracers are designed to "trace" the care experiences that a patient had while at an organization. It is a way to analyze the organization's system of providing care, treatment or services using actual patients as the framework for assessing standards compliance. Patients selected for these tracers will likely be those in high-risk areas or whose diagnosis, age or type of services received may enable the best in-depth evaluation of the organization's processes and practices. System tracer activity: Includes an interactive session with a facilitator and relevant staff members in tracing one specific "system" or process within the organization, based on information from individual tracers. While individual tracers follow a patient through his or her course of care, the system tracer evaluates the system or process, including the integration of related processes, and the coordination and communication among disciplines and departments in those processes.

WHO Taxonomy of Patient Safety	Minimal Information Model for Patient Safety Incident Reporting" (MIM PS) was developed to define a minimum set of common data categories within a universally applicable model to meet the most basic information needs for reporting patient safety incidents. It aims to strengthen effective reporting by identifying the key data features that provide minimal meaningful learning. The taxonomy includes: Incident identifiers – patient – time – location – agent(s) involved, Incident type, incident outcomes, resulting actions, reporter's role
CPO (POAC)	Coordinated Primary Options: The Coordinated Primary Options (CPO) Programme was established in 2003 and is funded by the Hawke's Bay District Health Board (HBDHB). The aim of the programme is to reduce hospital admissions by providing alternative management options for acute medical patients to primary health care providers. Patients are assessed and those that require admission to the hospital, and meet the criteria for CPO are offered care in the primary setting under the guidance of their General Practitioner (GP). The programme is free to patients (patient pays for initial consult). This programme operates under the guidance of the Medical Advisor, CPO Coordinator and CPO Steering Group which consist of HBDHB Planning and Performance, general practice representatives and HHB management. • To be Primary Care led • To reduce acute hospitalisation • To provide services to patients in the community • To ensure patients are linked back to Primary Care • A collaborative pathway for patients to receive consistent evidence based treatment • No cost to patients • Evidence based

Performance Indicators:

Table 1.0 - Global Indicators (vs Individual Indicators in Table 1.1 – below)

Excellence		Improvement		Entry	
6	5	4	3	2	1
Services exhibit a systems wide approach and can be recommended as champions **to lead in All Dimensions within the Aka**		A service that is functioning at this level exhibits good practice in most areas and has evidence to support their **working towards a consistent system wide approach across most of the dimensions within the Aka**		A service that is functioning at this level exhibits areas of **good practice but this is reliant on individual staff vs a consistent system wide approach**.	
Service can provide a body of evidence to support: Demonstrates high performance in both person and population health outcomes. Service design strategies are inclusive of person/family/whānau centred care. Proactive engagement with all health providers that can demonstrate a whānau ora approach) Seamless vertical and horizontal integration in place, with dedicated CQI activities. Attainment of 100% of System Level Measures/Operational Targets. Provision of an integrated range of services (both clinical and support, including total engagement with e-referrals, benchmarking etc.). Demonstrates an inter-professional model – of engagement and membership of professional bodies. Serious and sentinel events are managed and reported and shared learnings conducted internally (IDT) and within external forum.		**Service can provide a body of evidence to support:** Responsive to consumer feedback and demonstrates a proactive approach to gaining feedback. Some integrated models of care being used, e.g. interdisciplinary teams with appropriate utilisation of all services. Some vertical and horizontal integration in place, with dedicated CQI activities. Attainment of 80% of System Level Measures/ Operational Targets (DHB). Engagement and utilisation of clinical and support E-tools. Workforce and service planning is being developed. Able to provide and support professional student placement. Incident register in place with subsequent learnings documented. Serious and sentinel events are managed and reported and used for in-service improvements.		**Service can provide a body of evidence to support:** Responsive to consumer feedback and demonstrates an approach to gaining feedback. Has plans in place to develop integrated models of care to support consumer access. Externally validated minimum standards are recognised by the service in their QA process. e.g. Cornerstone Accreditation (Primary Care), Clinical Standards Secondary Care). Attainment of up to 70% of System Level Measures/ Operational Targets (DHB). Engagement and utilisation of clinical and support E-tools. Provides qualified and experienced workforce at a ratio able to meet the needs of registered population. Incident register in place. Serious and sentinel events are managed and reported.	

Table 1.1 – Individual Indicators (vs Global Indicators in Table 1.0 above)

Aka One	Person-Family-Whānau Centred Care						Evidence
	Excellence		Improvement		Entry		
	6	5	4	3	2	1	
Consumer Voice	• Information gathered from feedback relates to both generic service and specific areas of service needing a greater focus. • There is a causal link between feedback and change within the service. • "Good ideas" are acted on.		• The service has three or more ways to capture feedback. • Information from all methods is fed back to the team and used to implement change. • There is growing evidence to show that feedback is linked to change within the service (not solely complaints).		• A system is in place that generates feedback. • Mechanisms are in place to support feedback being used to implement change. • Complaints register content discussed at service meetings and appropriate actions taken.		**PT experience surveys** **Consumer engagement in feedback** **CQI projects** **Meeting agendas/ action points**
Health Literacy	• 100% of staff have completed health literacy modules. • Information developed and provided for consumers is reviewed and updated regularly. • Complaint register identifies health literacy issues and corrective actions are evident in service design. • Option grids available and some developed by the local service.		• Planning is evident to ensure 80% of staff are have completed health literacy modules. • Health information provided (both oral and written) is tested for literacy and cultural awareness. • Information caters to specific population groups: literacy, culture, age, and ethnicity. • Complaint register identifies health literacy issues for analysis. • Option Grids used in some areas by some staff.		• Staff are supported in undertaking health literacy training. • Health Information is provided in a range of formats. • Input from consumers sought when developing resources.		**Patient / health information and documentation** **Feedback / feed forward from consumers** **Complaints register**
Self-Care Management	• There is an outcomes framework used to evaluate consumer self-management programs. • The outcomes framework includes both Clinical and Quality of Life measures. • Evidence from evaluation framework is used to inform service improvement. • Advanced care planning is part of care planning.		• A MDT approach is used to plan and support consumer self-care • Care planning demonstrates effective transitions of care between and across providers. • Tailored self-care models meet consumers' needs and are informed by Relationship Centred Practice (RCP) models • Data is collected on self-management program; referrals, uptake and completion rates. • Staff are confident in the process of advanced care planning.		• A variety of education support programs have been identified for the consumer • Self- management programs are known to staff with referral system in place • There is a shared understanding of what MDT supported self-management is. • There is a shared understanding of relationship centred care (RCC) • Advanced care planning training is provided to all staff.		**Individual Planning/Discharge Planning** **Education program resources – referral pathways** **Data** **Consumer feedback**
Determinants of health	• Cultural perspectives are a component in all aspects of planning and analysis. • The service engages the wider health network in supporting consumer care (Social Services – Māori Health Providers, Aged Care, etc.).		• Data relating to population risk stratification is known to all staff • Staff trained in the wider determinants of health. • Barriers to accessing health services are identified and used to inform service improvements. Improved Quality of life measures are used to inform service improvements.		• Service managers identify training opportunities for all staff in relation to the wider determinants of health. *(e.g. Treaty responsiveness, healthy homes, disability awareness, aged concern, safer communities, public health, relationship centred care, health literacy).*		**Use of language line** **Service plans** **Training programs** **Performance appraisals** **Patient outcomes data** **DNA rates**

Aka Two	Person centred clinical systems and processes						Evidence
	Excellence		Improvement		Entry		
	6	5	4	3	2	1	
Care Coordination	• Care coordination processes are regularly analysed using agreed methodologies e.g. Tracer audits, patient interviews • Findings from above are used to inform CQI initiatives. • Readmission rates & acute presentation rates are used to inform CQI initiatives and evaluation of same. • Effective care coordination is evidenced in patient experience survey results		• There is a single (and or multi-disciplinary) assessment/planned care framework for the person • The person nominates key health leads within their team for the coordination of their care • The intent of care is to focus on "what really matters to the person vs what's the matter" • There is evidence of detailed coordination within transfer of care planning and implementation.		• Care coordination processes are in place • A complete history has been recorded inclusive of all aspects of the person's wellbeing (holistic) and the team appropriate to their care has been assembled. • The person identifies with key health leads within their care team. • Person verification is evidenced (relationship centred care approach).		**Patient experience surveys** **DNA rates** **ED Presentations** **Acute presentations** **Readmission rates** **ALOS (acute)**
Transition of care	• Shared care record is used by all staff /providers involved in care provision of the consumer. • Tracer audits are used routinely to improve the person's transition of care. • Peer review forums organised by the service to share learnings from CQI initiatives.		• Tracer audits of patient journey through the health care system are used to inform improved transitions of care. (CQI initiatives) • The tracer audit team is multidisciplinary and includes consumers • Complaints registers analysed for trends in; Clinical administration-Process-Transfer of care (WHO Taxonomy Patient Safety).		• Transfer/discharge summaries from/to providers is reviewed against the following criteria; - timeliness, - order of information, - quality of information - health literacy (consumer) • Tracer auditing training has been completed by service leaders (HQ&SC).		**Patient experience** **DNA rates** **Discharge documentation** **Incident / adverse events register**
Collaborative Practice: **• Pathways** **• CPO**	• It is demonstrated through the E-referral processes that staff are utilising the collaborative pathways as the tool to guide what is required in a referral • Corrective actions are put in place to improve utilisation of the CPO programs.		• Evidence shows that staff are utilising the collaborative pathways for continuity of care and align with clinical guidelines. • Services analyse ED presentations and admissions to evaluate the effective use of CPO and Pathways.		• There are pathway and Coordinated Primary Options (CPO) champions within each service who assist in the development and socialisation of same • Staff training and support is provided to ensure maximum uptake and promotion of these programs.		**Uptake of pathways** **Treatment management adherence** **ED referral and admission rates** **ASH rates**
Integrated IT systems	• Improvement cycles support the inclusion of new technology based on robust evidence of efficacy.		• PMS support; single repository for patient information • PMS support electronic functionality across and between providers e.g. e referrals, e records, remote access of multi-providers.		• The quality of information entered into the Patient Management Systems (PMS) is monitored and staff training provided to address inconsistencies.		**PMS** **Data integrity** **Uptake of e systems**

Model of Care (Under Developmental)	• The model of care benefits consumers in Quality of Life /Clinical Outcomes and is evidenced • The model of care benefits staff in attraction-retention-succession planning	• There is role clarity and role definitions within the team • The consumer identifies with key health leads within the team for their care • The consumer experiences seamless provision of care (each time-every time).	• Model of Care terminology understood by all service users and can be articulated by service leaders • Analysis of workforce/workflow has been completed to inform service models.	**Patient experience** **Staff experience surveys** **Recruitment** **SLM-Contributory measures**
Aka Three	**Workforce Development and Enablement**			
	Excellence	**Improvement**	**Entry**	**Evidence**
	6 **5**	**4** **3**	**2** **1**	
Workforce capacity and capability	• There is a process for the team to measure their competency (advanced) against both consumers and peer feedback (360d) • Staff development, education and support are mechanisms used to promote a culture of continuous improvement.	• Team and individual performance is analysed to inform areas for improvement and effective use of skill base. • Patient staff ratios are analysed and used to inform recruitment. • Induction orientation and re orientation programs ensure current/best practice is sustained. • Staff turnover is considered as part of sustainability planning.	• All staff have a current job description, employment agreement and current annual performance appraisal. • Performance appraisals link directly to service strategic planning and service plans. • Areas for development are identified commiserate with consumer/population health needs.	**Staff training programs** **Qualification and registration records** **Performance appraisals and monitoring** **Business continuity planning and sustainability of workforce** **Team functionality analysis**
Clinical Leadership	• National and international standards/guidelines are represented in all aspects of service and lead by a clinical lead. • The service is recognised nationally as an exemplar in all aspects. • The service has succession plans in place and builds future clinical leadership • Research and risk analysis inform all aspects of the service. • Formal professional supervision is in place for all clinical staff.	• Aspects of the service are used an exemplar locally and regionally. • The service has clinical leadership that is a role model to others in the team and external. • A mix of formal and Informal professional supervision is in place for all clinical staff • The team search out challenging opportunities to change, grow, innovate and improve. • Staff present at seminars, workshops and conferences.	• The service has a clinical leadership structure, recognises individual contributions and celebrates team success. • The service has a voice that influences clinical direction locally. • Informal professional supervision is in place for all clinical staff (medical, nursing, allied health, pharmacy).	**CQI initiatives** **Staff recognition methods** **Research projects** **Publication of research** **Governance membership** **Network and Forum membership**
Clinical expertise	• Clinical staff are supported in working to their scope of practice. • Clinical leads are assigned to all aspects of the service. • Clinical standards /guidelines are used to inform quality improvement initiatives. • Collaborative practices are in place that demonstrate a multi team approach.	• Both clinical and admin teams utilise all electronic tools effectively and efficiently to support clinical practice and analysis. • Systems and processes are standardised across the team and their adherence audited by clinical and admin leaders. • There is a direct link between population health needs and professional development plans of staff members.	• All clinical staff belong to a professional body and meet all competencies. • Induction & orientation programs in place. • Support systems are in place for new graduates, locums, newly appointed staff. • Staff to patient ratios are managed re numbers and staff competency to meet service needs.	**Credentialing** **PDRP/PDR** **Staffing Audits** **Orientation** **Induction program** **HR Processes**

		• Reorientation program in place for existing staff and is carried out routinely.		
Inter-sectoral collaboration (see taxonomy)	• The service is represented at a range of professional forums locally, regionally and nationally. • Staff are represented in published research.	• Staff attend local network meetings on a regular basis to support and share learnings across their network. This is external to their own service and is Multi-Disciplinary in its approach. • Staff are involved in local research.	• Staff are represented in - Peer review teams - Service forums - Service Manager forums - MDT forums.	**Professional network membership** **Service meeting** **Research** **Publications**
Aka Wha	**Risk identification and mitigation (partial completion)**			**Evidence**
	Excellence	**Improvement**	**Entry**	
	6 / **5**	**4** / **3**	**2** / **1**	
Population health	• The service meets & exceeds all targets on a quarterly basis • The service proactively determines further population based priorities (risk) • Outcomes for each priority are clearly identified and a plan of action is in place.	• Risk profiling is used to inform both service and individual health plans • A range of strategies are used to inform population and individual health plans. • Strategies for improvement are tailored to specific population groups; age, ethnicity, gender, domicile • Service outcomes achieve some milestones/ targets.	• Data entry and collection is set up correctly to be able to record and retrieve population and individual health data for the service users (e.g. read codes, classifications) • Risk stratification of the registered population is undertaken to inform service planning. • The population health team are involved in informing programs of work.	**Dr Info use** **Equity Data – Māori Health data** **SLM measures** **Risk stratification Models** **CAPS**
Equity	• **NO gap** between Ethnicity in System Level Measures/Health Targets • Determinants of health addressed by the service in a multi sectoral approach to care and support.	• ≥ 5% gap in Ethnicity System Level Measures/Health Targets • Service data is used to analyse and plan strategies for addressing the gap • Limited links to other providers.	• ≥ 10% ethnicity health targets • Relationships in place between providers inclusive of Māori Health Providers.	**Te Whakawaiora Health Targets** **Practice Performance** **Service Targets**
Continuous Quality Improvement	• Proactively reviews risk factors to improve population based outcomes. • Uses tracer (or other) audit processes to identify areas for improvement • Experiences and outcomes are shared with other providers e.g. at professional network meetings / forum • Leader in service continuity planning: fiscal – workforce – equity – population health.	• Service plans reflect robust data analysis of clinical and other indicators (population health) • There is a systems based approach to approaches to quality improvement using recognised methodologies (PDSA-IHI Improvement-HQ&SC) • Trend analysis demonstrates service improvement (and is attached to a basic level of research) • Review of risk factors informs planning.	• Service specifications up to date and available to all staff to reference • Meeting agendas/ minutes include quality standards. • Action plan in place for clinical audit recommendations. • Best Practice Guidelines/ Quality Standards form the basis of all programmes and can easily be accessed by all relevant staff.	**Service Specs** **Trend analysis** **Action plans – CQI** **Service meeting agendas/minutes** **Action research** **Peer reviews** **Clinical/tracer audit audits** **Financial reporting**
LTC Advisory function	• Research grant applications are endorsed by the LTC advisory • Research and evaluation of the framework is used to inform continuous improvement.	• Service plans are monitored to reflect SRM findings and areas identified for improvement • Shifts in performance are achieved within indicated time frames (* measured against the SRM continuum).	• Advisory group formed and meet regularly • SRM completed for all services and areas - best practice identified for learning	**Service meeting agendas/minutes** **Action research** **health target results** **Reports**

	• The LTC Framework – SRM – and Implementation methodology is presented at local, regional, national forum.	• Opportunities are created for the dissemination of best practice and recognition of achievement. • Funding bids addressing areas of improvement are supported in their development and endorsed at EMT /Board/Clinical Council.	- development areas identified for additional support and resourcing • An annual program of work is developed (IHI outcomes methodology used).	**Action Plan Corrective Action Reports**

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Appendix Two: LTC - Service Evaluation Summary

Purpose: The Service Evaluation Summary is tool to be utilised to summarise the analysis of the service evaluations. It acts to provide a strategic view; mapping both areas of strength and areas for development. The purpose of which is to globally look at where expertise can be shared across the 'network of services', where resources need to be allocated to strengthen capabilities.

Summary - Service Review Matrix

				Excellence				Improvement				Entry	
				6	5			4		3		2	1
	Service Improvement Team			Aka One				Aka Two				Aka Three				Aka Four			
				Person Family -Whanau Centred Care				Person Centred Systems and Processes				Workforce Development and Enablement				Risk Identification and Mitigation			
Service (Unit)	**Quality Improvement Facilitator**	**Clinical-Allied Health - Other**	**Consumer**	Consumer Voice	Health and Literacy	Self Care management	Determinants of Health	Care Coordination	Transition of Care	Collaborative Pathways	Integrated IT Systems	Workforce capacity and capability	Clinical Leadership	Clinical Expertise	Intersectoral Collaboration	Population Health	Equity	Continuous Quality Improvement	LTC Advisory Function
Renal																			
Diabetes																			
Respiratory																			
Cancer																			
.....																			
Practice A (Primary Care)																			

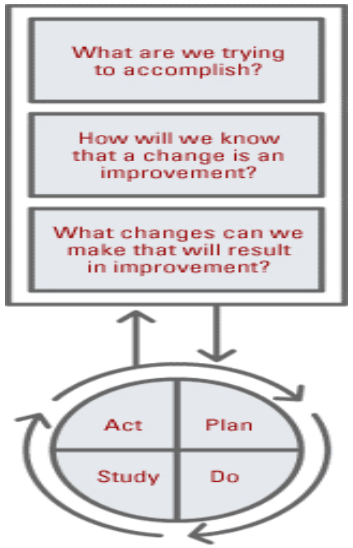
Appendix Three: LTC- Service Review Matrix – IHI Methodology

Methodology:
IHI Improvement Methodology

1. PLAN

Develop a framework on which to base the evaluation using a rubric of performance indicators.

- Use a three-scale model with each performance indicator divided into two levels.
- The higher number indicates achieved. The lesser number indicates working towards achievement.
- **Competent** is to be viewed as covering the minimum requirements to achieve the health outcomes.



2. DO

Try out an Improvement Theory

The report and the action plan

- The report should include:
  - performance in relation to each system measures/health targets
  - recognition of Best Practice that has contributed to high performance
  - recommendations for actions to improve service performance in specific areas
- Following the report being complied staff should discuss and identify areas for improvement and prioritised. **An action plan** is then developed to address the areas for improvement, resources needed, support required and time frames
- **After a period of 2-3 months the resulting outcomes are reviewed**

3. Study / Act (is a continuous review cycle)

Review the results and standardise the improvement

The action plan and reports are reviewed and assessed:

- which component parts have addressed areas that needed strengthening and **need sustaining as part of business as usual**
- Which component parts have not addressed low performance and therefore need to be revised
- What are the new areas of focus (if any) that need to be added to the action plan
- **After a period of 2-3 months the resulting outcomes are again reviewed**

Appendix Four: Moving from an Acute (Reactive) model to a Living Well (Proactive) model

From: **TODAY'S MODEL**	From: **DEFICIENCIES**	To: **FUTURE MODEL**	To: **SAVINGS**
Disease-centred	Rushed/over whelmed practitioners	Person-centred (whanau)	Non-disease
Doctor-centred	Lack of MDT co-ordination	People- whanau with team support to empower	Prevention
Focus on individuals	Lack of proactive care	Population health approach – "Lens"	Pro-active self-management (feedback)
Secondary care emphasis	Time to educate	Self-care emphasis Primary and community care support	Culture change
Reactive, symptom driven	Sickness – medical model	Self-management Proactive, planned interventions	Wellness
Episodic care	**Impact on systems**	Living well Ongoing care	**Impact on systems**
Cure focus	ED and GP presentations	Social holistic Prevention/Self-management focus	↑ Appropriate use of Primary care/ Targeted GP visits
Single setting: Hospital, specialist centre, general practice	Admission rates Visits	At home and closer to home, Community settings, Collaboration, Primary and Secondary care	↓ Ed presentations/admission rates
1:1 contact through visit by patient	High volume work Length of stay	1:1 or group contact. Visit, phone, email web contact	↓ Reduced length of stay
Diagnostics	Health Targets	Self-management, independence	↑ Capacity building in communities / prevention group sessions in community building capacity – lay leaders