Lithgow Diabetes Management

Quality Improvement Collaborative

2025-2026

phn
NEPEAN BLUE MOUNTAINS
An Australian Government Initiative

Wentworth Healthcare
Blue Mountains | Hawkesbury | Lithgow | Penrith

We acknowledge the traditional custodians of the lands on which we work and pay our respect to Aboriginal Elders, past, present and emerging. The Darug, Gundungurra and Wiradjuri people are acknowledged as the traditional owners of the land in our region.

Contents

Introduction

Welcome to the Lithgow Diabetes Management Quality Improvement (LDMQI) Collaborative. This Handbook has been developed to support your participation in the LDMQI Collaborative or simply "the Collaborative". Diabetes is a serious chronic condition that can affect the entire body and requires a holistic approach to care and management.

We have partnered with the Nepean Blue Mountains Local Health District (NBMLHD) to make diabetes a joint priority. In 2020, 5.6% of the Nepean Blue Mountains (NBM) population were registered with the National Diabetes Services Scheme (NDSS), with 86.2% of those registered diagnosed with type 2 diabetes[1]. The Lithgow local government area (LGA) has the highest rates of diabetes and diabetes related hospitalisations remain above the NSW average despite a slight decrease in recent years. The Lithgow LGA also has the highest rates of obesity in the NBM region (32.68%), with 7.35% of residents with an increased or greatly increased waist circumference. Additionally, general practice data shows that of the patients with physical activity level recorded in their clinical record, 42.4% have recorded insufficient or sedentary levels of activity. The aim of the project is to support people living with diabetes in the NBM region to have variable access to optimal diabetes care in the community. This will be done through addressing financial barriers, increasing workforce capacity and capability, bridging the gap in knowledge of existing system resources, and improving care coordination and integration between primary healthcare providers and services with the Local Health District in the Lithgow LGA.

The LDMQI will run from June 2025 to March 2026. A Collaborative follows a wave timeline with participating practices attending learning workshops, undertaking activity periods, and submitting data to track improvement. Practices participating in the Collaborative will engage with other general practices through peer-to-peer learning lead by clinicians and quality improvement experts on topics including pharmacological interventions, multidisciplinary management and data cleansing.

Foundation work was undertaken in 2024 through an Expert Reference Panel (ERP) workshop facilitated by Prestantia Health[2] to develop the aim, measures and change ideas for the Diabetes Management QI Collaborative that ran between July 2024 to June 2025. These have been reviewed and adapted for the LDMQI 2025-2026. The ERP consisted of representation from A range of primary and tertiary clinicians and allied health professionals as well as a consumer with lived experience of diabetes. We are appreciative of the involvement of these representatives and their contributions to the co-design of the Diabetes Collaborative and the development of this Handbook.

To support the design and delivery of the LDMQI Collaborative, WHL is working closely with Prestantia Health utilising their quality improvement expertise, as well as their experience in clinical leadership, quality and safety in healthcare, and high performing primary care and digital health.

We look forward to working closely with participating general practices throughout this initiative. While participating in the Collaborative will mean additional work for practices, this initiative is also an exciting opportunity for general practices to improve outcomes for patients with diabetes in Lithgow.

Lizz Reay,

Chief Executive Officer

Diabetes in Australia

In 2022, approximately 24,000 Nepean Blue Mountains (NBM) residents were living with diabetes. The local government areas (LGAs) of Lithgow and Penrith have the highest rates of diabetes within the NBM region and prevalence of diabetes related hospitalisations remain above the NSW average despite a slight decrease in recent years[3]. Diabetes is one of the fastest growing chronic condition in Australia[4] and while there is currently no cure, diabetes can be effectively managed. Early diagnosis, optimal treatment and effective ongoing support and management reduces the risk of diabetes related complications. There are three main types[5] of diabetes:

Type 1 Diabetes

Type 1 diabetes is a lifelong autoimmune disease that can be diagnosed at any age. The exact cause is unknown but is believed to be the result of an interaction of genetic and environmental factors. A person with type 1 diabetes needs insulin replacement that will be required every day for the rest of their life. People with type 1 diabetes must also maintain a careful balance of diet, exercise, glucose management and insulin intake.

Type 2 Diabetes

Type 2 diabetes is a condition in which the body becomes resistant to the normal effects of insulin and gradually loses the capacity to produce enough insulin in the pancreas. The condition has strong genetic and family-related risk factors and is also often associated with modifiable risk factors. The exact genetic causes of type 2 diabetes are unknown. People may be able to significantly slow or even halt the progression of the condition through changes to diet and increasing the amount of physical activity they do.

Gestational Diabetes

Gestational diabetes occurs when higher than optimal blood glucose is diagnosed in pregnancy. This generally occurs in the second or third trimester of pregnancy, among women who have not previously been diagnosed with other forms of diabetes and can result in complications for the mother and baby. While gestational diabetes may resolve after the baby is born, it can recur in later pregnancies and greatly increases the risk for both mother and baby of developing type 2 diabetes later in life. Some women can manage their gestational diabetes by changes to diet and physical activity, while others require oral hypoglycaemic medications, insulin therapy or both.

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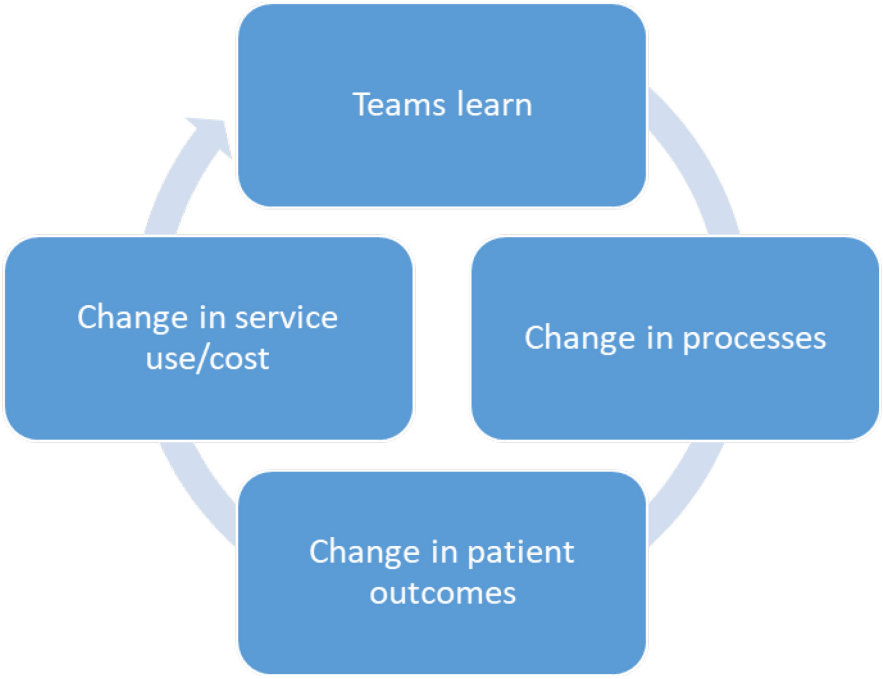
About the Diabetes Management Quality Improvement Collaborative

What is a Quality Improvement Collaborative?

A Quality Improvement Collaborative is a simple and powerful approach for quality improvement. It involves groups of professionals coming together to learn from and motivate each other to improve the quality of health services. Collaboratives often use a structured approach, such as setting common aims and undertaking rapid cycles of change leading to meaningful improvements[6]. Broadly collaboratives collaborating and compare practice, which motivate professionals and teams to do things differently, which in turn improves patient outcomes and ultimately improves service use and costs.



The approach is underpinned by:

1. a focus on a specific topic using a structured and evidence-based framework to assess and guide actions for people with diabetes.
2. clinical experts and experts in quality improvement provide ideas and support for improvement – including the expert reference panel.
3. multi-disciplinary teams from multiple practices building a culture of trust, peer learning and support and the engagement of clinical leaders.
4. a model for improvement setting goals, defining measures of success, testing changes, collecting data and inspiring and motivating others.
5. a collaborative process involving a series of structured activities with experiential learning by doing and using data to drive improvement.

There is practical support all the way from the Nepean Blue Mountains Primary Health Network team.

Mission of the LDMQI Collaborative

The overall mission for the LDMQI Collaborative is to address the capacity, capability, and coordination barriers to optimal diabetes care for patients living with type 2 diabetes in the Lithgow area. In practice this means:

- Improving the management of diabetes patients living with diabetes.
- Improving the quality of life of people living with diabetes.
- Increasing confidence of primary care teams to look after people with diabetes with support as needed from the public health system.
- Increasing awareness of access to public health services, private allied health and other services available to people living with diabetes amongst general practice staff and consumers.
- Enhancing self-management and care capabilities of people living with diabetes.
- Strengthening coordinated, integrated, and multidisciplinary team care.

Integrated Care

The LDMQI Collaborative will utilise Fulop's typology of integrated care, encompassing:

- Organisational integration – how the organisation of care is structured.
- Functional integration – how non-clinical and back-office functions are integrated.
- Service integration – how clinical services are integrated with each other.
- Clinical integration – at the clinical team level is care for patients integrated in a single process both intra and inter-professionally through, for example, the use of shared guidelines along the entire pathway of care?

Optimal Diabetes Care

There are a range of evidence-based resources to support the management of people living with diabetes. For example:

- Diabetes Australia has developed a range of best practice guidelines for the prevention, diagnosis and management of all diabetes types.
- The Royal Australian College of General Practitioners (RACGP) Management of type 2 diabetes: A handbook for general practice.
- The Living Evidence for Diabetes Consortium has developed evidence-based clinical guidelines for diabetes which contain recommendations regarding medical device technology for the management of type 1 diabetes and medications for blood glucose management in adults with type 2 diabetes. These living guidelines are regularly updated to reflect the most recent recommendations or new evidence

- The Australian Diabetes Society has produced a number of clinical guidelines through their Clinical Standards/Guidelines Advisory Committee.
- The Agency for Healthcare Research and Quality (AHRQ) specifies the internationally recognised composite measure of optimal diabetes care:

> *"The percentage of adult patients who have type 1 or type 2 diabetes with optimally managed modified risk factors"*

whereby modified risk factors include HbA1c, Cholesterol (LDL), blood pressure, tobacco use and Ischemic Vascular Disease

The Australian National Diabetes Strategy 2021-2030 recognises the need for a multi-sectoral response, delivered at a community level to overcome barriers to improving diabetes prevention and management.

Components of the strategy include:

Vision

Strengthen, integrate and coordinate all sectors to improve health outcomes and reduce the social and economic impact of diabetes in Australia.

Principles

1. Facilitation of person-centred care and self-management throughout life
2. Reduction of health inequities
3. Collaboration and cooperation to improve health outcomes
4. Coordination and integration of diabetes care across services, settings, technology and sectors
5. Measurement of health behaviours and outcomes

Goals

1. Prevent people developing type 2 diabetes
2. Promote awareness and earlier detection of type 1 and type 2 diabetes
3. Reduce the burden of diabetes and its complications and improve quality of life
4. Reduce the impact of pre-existing diabetes and gestational diabetes in pregnancy
5. Reduce the impact of diabetes among Aboriginal and Torres Strait Islander peoples
6. Reduce the impact of diabetes among other priority groups
7. Strengthen prevention and care through research, evidence and data

Enablers

Factors that influence capacity to achieve goals, such as leadership and governance, workforce, information and research capacity, financing and infrastructure, partnerships and networks, and the adaptability and accelerated change opportunities associated with public health challenges.

The AHRQ's composite approach to the measurement of optimal care is reflected in the Australian National Diabetes Strategy along with other measures. For example, goals 3, 5 and 6 include the following measures:

Outcome Measures	Process Measures	Balancing Measures
People with diabetes who achieve target levels of HbA1c, albuminuria, cholesterol and blood pressure. People who are overweight or obese or have other modifiable risk factors. Mental health and wellbeing outcomes, particularly related to depression, anxiety/ distress and positive coping. People with diabetes who achieve target rates of regular assessment for complications. People with diabetes complications. People with diabetes-related blindness. People with diabetes-related foot amputations.	People with diabetes who receive regular testing for complications. People who have had their medication plan reviewed by a doctor or pharmacist. People treated for diabetes-related end-stage kidney disease requiring dialysis. People with diabetes among priority groups who have a Chronic Disease Management Plan.	People with diabetes admitted to hospital with diabetes-related illnesses. Quality standards for diabetes in hospitals. Quality standards for self-management programs in primary care.

The Australian National Diabetes Strategy highlights the need to adopt a systems approach to improvement including, for example, the following strategies and associated process measures:

- Support the involvement of people with diabetes, and of healthcare providers who care for people with diabetes, in quality improvement processes. This may include healthcare providers reporting data against clinical guidelines and outcomes, and data collection in partnership with Aboriginal Community Controlled Health Organisations.
- Consider how specialist skills can be shared across the GP and specialist relationship – for example, using case conferencing approaches.
- Encourage uptake and use of My Health Record among healthcare providers as an accessible online management tool for conditions and treatment regimens.
- Enhance data linkage to improve clinical care.

Aim of the LDMQI Collaborative:

The aim of the LDMQI Collaborative builds on the goals of the Australian National Diabetes Strategy and has been adapted from the aim developed by the ERP in June 2024.

The aim of the LDMQI Collaborative is to:

"Within 10 months, our practice aims to improve the optimal care of 20 type 2 diabetic patients by 20% by the end of March 2026".

Defining Optimal Care

Defining optimal care is multidimensional. The goals for optimal care include individual goals and clinical management goals. Individual goals may be related to diet, weight, exercise, smoking, alcohol. Clinical management goals refer to HBa1c, lipid levels, blood pressure levels, urine albumin screening and immunisation status. Increasingly goals of care are personalised for

individuals so each individual patient may have a target HbA1c or Lipid target or blood pressure target.

An important principle in quality improvement is to have a measurable aim that ideally is from naturally occurring data (i.e. data captured in the process of providing clinical care).

In defining the aim for this collaborative, the subject matter experts have sought a balance between optimal care as defined above and what realistically measurable on a regular basis in line with quality improvement methodology.

Composite measure

The LDMQI Collaborative will encompass active adult patients aged 18-75 in the community living with type 2 diabetes (excluding those receiving palliative care, living in aged care or who are pregnant).

Whilst optimal care is multi-dimensional and needs to incorporate the lens of the patient, the carer and the clinician, for the purposes of the LDMQI Collaborative the composite measure of optimal care will embrace a bundled indicator set encompassing the following process and outcome measures:

Process Measures

- The proportion of active type 2 diabetic patients aged 18-75 years who meet all of the following targets:
    - HbA1c and total cholesterol and blood pressure recorded in the previous 12 months
    - Influenza vaccination in last 12 months
    - GPMP/TCA recorded in last 15 months
    - GPMP/TCA review recorded in last 9 months
    - GP Chronic Condition Management Plan recorded (as of 1 July 2025)
    - Registered with NDSS

Outcome Measures

- The proportion of active type 2 diabetic patients aged 18-75 years who show improvement in the following:
    - 1% improvement in HbA1c from last HbA1c result recorded
    - 5% reduction in waist circumference
    - Improvement in participation in physical activity
    - Improvement in consumption of fruits and vegetables
    - Improvement in sedentary behaviours

    Using Pre and Post Patient Survey

Pre and Post Program Survey

At the beginning of the LDMQI Collaborative, invite your 20 selected patients to complete a short online survey that will assess their healthy eating and lifestyle behaviours before you begin working with them to improve their diabetes care. This first survey will be the ***Pre-Program survey*** and will be used as a baseline.

At the program mid-point in September 2025, invite your 20 selected patients to complete the ***Mid-Program survey***. Collecting this survey at the mid-point of the LDMQI will allow you to see if the patient is making any improvements to their healthy eating and lifestyle behaviours.

At the end of the LDMQI, invite your 20 selected patients to complete the ***Post-Program HEAL survey***. This will allow you to see what improvement the patient has made to their healthy eating and lifestyle behaviours over time and compare this to the Pre-Program HEAL survey.

**Please note that the Pre, Mid and Post-program surveys ask them same 6 questions.*

The LDMQI Collaborative Framework

The LDMQI Collaborative will run over a period of 10-months and will consist of activity periods, data collection and a series of online and face-to-face learning workshops. The workshops will be interspersed with activity periods, in which participating practices will submit data, and test and implement changes within and across their systems.

Baseline data collection

Baseline data is collected at the beginning of the Collaborative. This provides a snapshot of your general practice's position before making improvements and enables the team to see their starting point.

Learning workshops

Learning workshops provide you with evidence-based information, the opportunity to share knowledge and experiences with peers, and to build on knowledge gained from previous workshops. You will hear others' ideas and generate new ideas that will translate into improvements within your organisation. You will also benefit from protected 'team time' sessions at learning workshops, where you can formulate plans for action. These plans for action may include multiple teams where changes are required across multiple points of the healthcare system to bring about an improvement.

Activity periods

Activity periods are the periods of time between and after learning workshops. They enable your team to test their improvement ideas, and progress is measured through ongoing monthly data collection. A vital component of an activity period is the proactive and practical assistance provided by your Primary Care Engagement Officer and our LDMQI Collaborative Program Development Officer.

Rules of Improvement

Researchers identified 10 key challenges for those involved in quality improvement. These challenges present opportunities to reframe your improvement culture and approach, shifting from and to:[7]

From	To
Convincing peers that there is a problem	Humble inquiry to identify the pain points for colleagues and teams
Convincing peers that the solution chosen is the right one	We find our way to the solutions together
Getting data collection and monitoring systems right	Data is important – we start somewhere and get going – it can be stories and numbers
Excess ambitions and 'projectness' – treating the intervention as a discrete, time-limited project, rather than as something that will be sustained as part of standard practice	We are going to work in new ways so what we do today is better than what we did yesterday; and what we do tomorrow is better than what we do today
The organisational context, culture, and capacities	Improvement is everyone's business – we start somewhere and keep going
Tribalism and lack of staff engagement	Maybe we need to approach engagement differently
Leadership	Focus on the habits of improvers for all (refer to graphic 1)
Balancing carrots and sticks – harnessing commitment through incentives and potential sanctions	Focus on intrinsic motivation – purpose, autonomy and mastery
Securing sustainability	Apply the five lens – me, my team, our practice, our patients, the system
Considering the side effects of change	Anticipate and monitor for these potential unintended consequences but not let it stop us improving

When preparing for and conducting quality improvement within general practice, consider the habits of improvers that you would wish to see reflected in your improvement team and activities.

Figure 1: Habits of Improvers

How will the LDMQI Collaborative work?

The LDMQI Collaborative will be implemented in a way that will build on the positive mindsets for improvement and utilising the quality improvement tools with fidelity. Your practice will be supported to:

- Work out your starting point by understanding your patient population and segmenting to help priortise patients e.g. people who have an at risk HbA1c levels
- Learn, think, and share with your peers through a series of learning workshops and webinars. The workshops and webinars will include a mixture of expert and local speakers to build the group's understanding of the evidence and issues relating to care of patients with two or more chronic health conditions, such as frailty. There will also be time for group work for you to develop ideas for action.

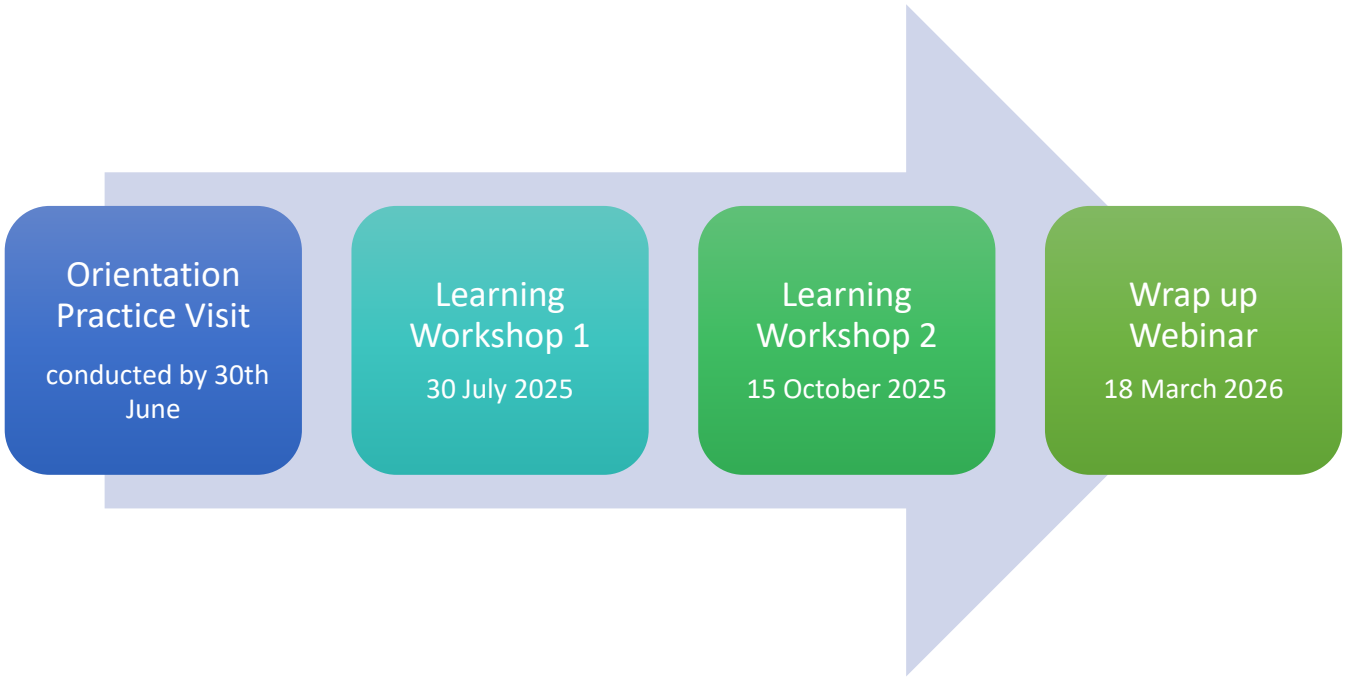
The Collaborative will commence with an **Orientation Webinar**. This will provide an overview of:

- The Collaborative Methodology;
- The Diabetes Management Collaborative aim(s), measures, change principles and change ideas;
- Key dates and links to resources.

Throughout the Collaborative **two face to face Learning Workshops** will be held.

Practices must send at least two clinical representatives (e.g. 1x practice nurse and 1x GP, 2x GPs, 1x practice nurse and 1x diabetes educator) to each workshop. This is because each workshop builds on learnings and teamwork developed in previous workshops.

Learning Workshop Dates



Instructions on how to register for the workshops will be distributed closer to the date of each workshop.

Both the July and October learning workshops will be held face-to-face at locations to be confirmed closer to the event dates via an online registration form. All event locations will be held in Lithgow.

The face-to-face workshops will start at 6pm and finish at 9pm, with dinner provided.

The final event is an online Webinar in March 2026. The time for this will be advised closer to the date and registration for this can also be done via an online registration form.

The overall progress of all practices participating in the LDMQI Collaborative will be discussed at the Learning Workshops. Please be reassured that only aggregated, de-identified practice level data will be shared. To support the spread of good ideas, practices that are meeting or exceeding targets may be asked to share learnings on what they have implemented at the learning workshops.

Making a simple plan is important for turning an idea into action. Documenting your plan and how implementation went is important so that you can quickly identify and share changes that are worth making permanent. A template for you to document your goals, ideas and plans for action using the very simple 'Model for Improvement' (sometimes referred to as the Plan-Do-Study-Act or PDSA cycle) will be provided by us.

To support you with progressing in your improvement journey we will ask you to:

- Submit PDSAs and the data tracking spreadsheet at the end of each Activity Period (these will be provided to you by us).

Reflective template

Our reflective template takes a very simple approach and ask you to reflect on:
What, **So What** and **Now What**?

Question	Questions for you to consider
What?	What improvement activities have you done in the last month? How may PDSAs have you done?
So What?	What worked well? What could we have been done differently?
Now What?	What are we going to do next month in how we approach quality improvement, our measurement and the PDSA cycles?

Copies of the reflective template will be available at each of the face-to-face learning workshops. Digital copies can be supplied upon request.

Data Collection and reporting

Our organisation will provide you with data tracking template that can be used to track improvement measures. Some measures may be extracted from Primary Sense, other measures may require self-reporting.

The data you collect must be de-identified prior to submitting to our organisation where it will be collated into a de-identified data audit report that will be sent to participating practices at the end of each activity period so that you can track your progress against the LDMQI Collaborative measures.

The purpose of collecting and reporting data against the program measures is to help everyone see if what they are doing is working - *It is not for judging participants' performance or for research.*

How Nepean Blue Mountains Primary Health Network will support you

Throughout the LDMQI Collaborative you will receive proactive and practical support from our organisation.

The following representatives will support your practice throughout the duration of the LDMQI Collaborative:

Your **Primary Care Engagement Officer (PCEO)** will be your first point of call for all matters related to the Collaborative. This will include providing practices with benchmark reports, assisting with implementing the MFI/PDSA cycles and regular feedback and support to guide quality improvement.

The **LDMQI Collaborative Program Development Officer and your PCEO** will review your PDSAs as part of the activity periods to ensure they meet the minimum requirements and provide feedback to you.

CPD Hours

Practices participating in the LDMQI Collaborative will be eligible to self-report CPD hours for the 2023-2025 triennium. Certificates of attendance for the learning workshops will be emailed out after each workshop. Breakdown of minimum CPD hours that can be claimed for the LDMQI Collaborative as follows:

Education Activities: 8 hours

- Orientation practice visit = 0.5 hours
- Learning workshop 1 = 3 hours
- Learning workshop 2 = 3 hours
- Wrap up webinar = 1.5 hours

Measuring Outcomes: 9 hours

- Tracking patient data (4 x data submissions x 1 hour per submission) = 4 hours
- Clinical audit reviews (4 x clinical audit reviews x 0.5 hours per review) = 2 hours
- 6 x PDSAs x 0.5 per PDSA = 3 hours

Reviewing Performance: 3.5 hours

- Orientation practice visit = 0.5 hours
- 6 x PDSAs x 0.5 hour per PDSA = 3 hours

**Please note this is just a guide. Your actual hours may be more or less than what has been stated above*

Change Drivers, Ideas, Tools, and Resources

The change ideas you take forward will be determined by your team, analysis of your practice data and identified pain. This section provides ideas for action with case studies and helpful tips to assist you. There are drivers that will help us achieve our aim. Each driver[8] will have many change ideas associated with it. The diagram below helps to represent the relationship of all our change ideas, the drivers, and our aim.

There are very many change ideas associated. Can you think of any you would like to add?

The below change principles and ideas are based on evidence of what works to improve the care of people living with diabetes in the community setting supported by higher performing primary care services.

Change Principle	Change Idea
Improve the management of people living with diabetes	• Measure what matters • Collect qualitative pre and post knowledge data • Adopt a learning system approach: data to knowledge, knowledge to practice, practice to data • Change the process and system of carte to better manage people who live with diabetes • Involve members of the practice team • Adopt a quality improvement approach to small scale incremental tests of change • Reflect and learn
Improve the quality of life of people living with diabetes	• Patient reported measures • Have holistic and personalised care plans
Increase confidence of primary care teams to look after people with diabetes with support as needed from public health system	• Empower your core and extended care team members to assist • Facilitate group sessions (e.g. Discuss pain points)
Strengthened coordinated, integrated and multidisciplinary team care	Utilise Fulop's Typology of Integrated Care: *Organisational Integration* • Use a multidisciplinary team to facilitate reliable care delivery • Clarify core and extended care team arrangements • Foster relationships between partnered teams

	Functional Integration • MyHR Shared Health Summary • Shared Care Plan (may be on digital platform) • Measure through interactions between services, shared care plans, general practice management plans and team care arrangements *Service Integration* • Identify and utilise outreach services (Allied health providers, virtual care) • Use of Health Pathways • Use of specialist 'hotlines' • Utilise case conferencing • Asynchronous communication (for example clinician to clinician email exchanges *Professional Integration* • Joint educational activities • Use of single registries and data • Clinician to clinician mentorships • Clinical multidisciplinary and interprofessional education • Clinical advice hotline
Increase awareness of, and access to public health and private allied health and services,	• Increase awareness of services in the diabetes space (e.g. HealthPathways) • Establish social prescribing in primary care diabetes setting • Measure through NDSS referrals and number of referrals • Establish/utilise a hotline • Establish a dedicated intake (e.g. inbox to assess referrals and appropriate services)

Enhance self-management and care capabilities amongst people living with diabetes	• Establish clear definitions of self-management and what self-management support involved • Co-produce sick day action plans and incorporate in Chronic Care Plan • Capture Patient Reported Measures (PRMs) • Ensure patients are involved at the centre of care (e.g. ensure they sit in the MDT case conferences)

Keeping Score - Measure your Progress

LDMQI Collaborative Measures

It is important to have clear measures that track progress towards achieving the objective/s of the Collaborative.

The following LDMQI Collaborative measures were previously selected by the Expert Reference Panel.

Process Measures	Numerator	Denominator
Diabetes Register	The number of active patients that are correctly coded with type 2 diabetes	The number of active patients with diabetes
HbA1c and total cholesterol and blood pressure	The number of active patients with type 2 diabetes that have HbA1c and cholesterol and blood pressure result recorded in the last 12 months	The number of active patients with diabetes
GPMP/TCA recorded	The number of active patients with type 2 diabetes that have a GPMP/TCA recorded in the last 15 months	The number of active patients with diabetes
GPMP/TCA review	The number of active patients with type 2 diabetes that have a GPMP/TCA review recorded in the last 9 months	The number of active patients with diabetes
GP Chronic Condition Management Plan recorded	The number of active patients with type 2 diabetes that have a GP Chronic Condition Management Plan recorded (from 1 July 2025)	The number of active patients with diabetes
Influenza Vaccinations	The number of patients that have an influenza vaccination recorded in the last 12 months	The number of active patients with diabetes

Outcome	Measure
HbA1c improvement	The number of active patients with type 2 diabetes that have a 1% improvement in HbA1c from the last HbA1c result recorded
Reduction in waist circumference	The number of active patients with type 2 diabetes that have up to a 5% reduction in waist circumference from the last waist circumference recorded
Improvement in physical activity	The number of active patients with type 2 diabetes reporting an improvement in physical activity by the end of the Collaborative using the Pre and Post Health Eating and Active Lifestyle Survey
Improvement in nutrition	The number of active patients with type 2 diabetes reporting an improvement in consumption of fruits and vegetables by the end of the Collaborative using the Pre and Post Health Eating and Active Lifestyle Survey
Improvement in sedentary behaviours	The number of active patients with type 2 diabetes reporting an improvement in sedentary behaviours by the end of the Collaborative using the Pre and Post Health Eating and Active Lifestyle Survey

Templates & Guides

The Model for Improvement is a tool for developing, testing, and implementing change[9]. The Model consists of two parts that are of equal importance.

1. The 'thinking part' consists of 3 Fundamental Questions that are essential for guiding improvement work
2. The 'doing' part is made up of Plan-Do-Study-Act (PDSA) cycles that will help you to test ideas and implement change

Part 1: The 3 Fundamental Questions

Note: Each new GOAL (1st Fundamental Question) will require a new Model for Improvement form to be completed.

Date: _____

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The Model for Improvement

The Model for Improvement is a tool for developing, testing and implementing change, and consists of two parts:

PART 1: The ***'Thinking Part'***
Consists of three **Fundamental Questions** that are essential for guiding improvement work

Fundamental Question 1: What are we trying to accomplish?

*By answering this question, you will develop your **S.M.A.R.T. GOAL** for improvement*

Fundamental Question 2: How will we know that a change is an improvement?

*By answering this question, you will develop your **MEASURES** for tracking your goal*

Fundamental Question 3: What changes can we make that will lead to an improvement?

*By answering this question, you will develop **IDEAS** you can test to achieve your goal*

IDEA 1: .....

IDEA 2: .....

IDEA 3: .....

IDEA 4: .....

IDEA 5: .....

Part 2: Plan-Do-Study-Act

You will have noted your ideas for testing when you answered the 3rd Fundamental Question in Step 1. You will use this PDSA cycle to test one of those ideas.

Date: _____

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Plan-Do-Study-Act Cycle

PART 2: The ***'Doing/Testing Part'***
Consists of **Plan-Do-Study-Act (PDSA) Cycles** that will help you test and implement the ideas you have developed in Step 1

IDEA: Choose an idea from **Fundamental Question 3**

PLAN: What exactly will you do? Include who, what, when, where, predictions & data to be collected

*By answering this question, you will further develop the **IDEAS** you can test to achieve your goal*

Who: .....

What: .....

When: .....

Where: .....

Predictions: .....

Data to be collected: .....

DO: Was the plan executed? Document what happened (expected or unexpected events)

STUDY: Record, analyse and reflect on results

ACT: What will you take forward from this cycle? What is your next step or PDSA Cycle?

Tools and Resources

- **Chronic Care Model (Wagner)**

  Model_Chronic_Care.pdf (act-center.org)

- **Care Coordination Model**

  Care Coordination Model | ACT Center (act-center.org)

- **Fulop's Typology of Integrated Care**

  Fulop's Typology of Integrated Care

References

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For more information about Wentworth Healthcare, provider of the Nepean Blue Mountains PHN, visit:
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