Outcomes Map

Service Name

THE SERVICE
Describe what the service is trying to do.

	OUTCOMES (What is success for each?)	OUTCOME INDICATORS (What will we see if we're on track?)	ACTIVITIES (How will we achieve outcomes?)	ACTIVITY INDICATORS (How is each activity going?)
PERSON				
CLINICAL				
SYSTEM				
PROVIDER				

EXAMPLE

Outcomes Map

Building Collaborative Care with Community

THE SERVICE
Describe what the service is trying to do.

Improved management of adult patients living with Congestive Cardiac Failure (CCF), Chronic Obstructive Pulmonary Disease (COPD), and Diabetes in the health service postcode catchment area.

	OUTCOMES (What is success for each?)	OUTCOME INDICATORS (What will we see if we're on track?)	ACTIVITIES (How will we achieve outcomes?)	ACTIVITY INDICATORS (How is each activity going?)
PERSON	Improved patient experience: understanding of their disease, ease of accessing services, and feeling supported	• Reduction in Did Not Attend (DNA) rates for local service providers for 2017 compared to previous years • Qualitative and quantitative measurements of patient experience, at the start of 2017 compared to the end of 2017: - Cross-sectional survey (twice) - Small sample of follow-up patients	• Development of localised care pathways • Engagement activities with consumers to identify needs and gaps • Education, training and awareness building activities • Identification and/or development of information packages for patients	• No. of care pathways developed • No. of consumer workshops held • No. of consumers participating in workshops • No. of qualitative interviews completed • No. of participants • No. of packages developed
CLINICAL	Fewer hospitalisations of patients suffering Congestive Cardiac Failure (CCF), Chronic Obstructive Pulmonary Disease (COPD), and Diabetes	• Reduction in hospital presentations and admission rates for 2017, compared to previous years • Reduction in hospital readmission rates for 2017, compared to previous years	• Development of shared care/management plans for patients living with CCF, COPD and/or Diabetes	• No. of patients with a management plan
SYSTEM	Patients linked in with the right services at the right time	• Increase in referral rates to and between local services, for 2017 compared to previous years	• Development of strategies, initiatives and outcomes for the collaborative working group (includes health and social care services) • Planning and organisation of two network forums for health and social care professionals in the community • Survey of patients	• No. of Working Group meetings held • % attendance at meetings by the Working Group membership • No. of initiatives identified • No. of initiatives completed • No. of people attending the forum • No. of respondents
PROVIDER	Increased awareness for health professionals of the services available in the local area	• Increase in the knowledge of health professionals regarding the availability and types of community and social care services at the start of 2017 to the end of 2017 • % of health professionals satisfied with the content provided at the network forums	• Engagement activities with social care service providers • Survey of health professionals	• No. of people attending the workshop/s • No. of meetings held • No. of respondents