CAD in Australia

Identifying drivers of disparities in regional settings & approaches for measurable improvements

Thursday, 5 September 2024

10:00 AM - 4:00 PM AEST

Ocean View Room
The Central Building 230
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Special thanks to the following:

- Dr Joyce Donovan
- Professor Judy Mullan
- Ms Sophie Whittaker
- Professor Caleb Ferguson
- Mr Peter Goddard
- Professor Gemma Figtree
- A/Professor Peter Psaltis
- ACvA staff
- All our workshop speakers.

Executive Summary

The Australian Cardiovascular Alliance (ACvA) Clinical Theme Initiative aims to galvanise the cardiovascular and stroke research sectors to strategically address unmet needs and improve patient outcomes in coronary artery disease (CAD), heart failure, arrhythmia, stroke and hypertension. By bringing together researchers, clinicians, industry, government, and consumers, the initiative fosters national, ambitious, and transdisciplinary research solutions that can attract diverse funding and demonstrate impact.

The "CAD in Australia" workshop is the second in the ACvA CAD Clinical Theme series, focused on understanding the drivers of disparity in the Illawarra/Shoalhaven region of NSW. This follows on from a previous workshop in Dubbo NSW, with a third planned for the Riverland region of South Australia.

The Illawarra/Shoalhaven

1. The Illawarra/Shoalhaven region of NSW has a unique and diverse geographic and demographic profile, spanning large regional centres such as Wollongong and smaller

townships such as Culburra. The area also demonstrates a broad socioeconomic distribution - low SES, as well high-income families and individuals.

   a. The region has an ageing population, with almost 10% being over 70 years of age. 4.3% of the population are First Nations' Peoples. In addition, the region's population will grow faster than anywhere else in NSW over the next 20 years. These factors will put increased pressure on the health system and access to services across primary and acute care settings.
   b. 32.6% of the local population has one or more chronic health condition; 12.2% of the population smoke; and 63.6% of the population are overweight or obese.

2. Coronary heart diseases are the number one cause of death in the Shoalhaven sub-region and the number two cause of death in other sub-regions of the Illawarra and Shoalhaven area, dementia being the number one cause in the other area. Dementia has similar risk factors to CAD, meaning that improvements in prevention, risk factor management, treatment and secondary prevention in CAD could also positively impact dementia.

3. There is clear local leadership and a desire to increase collaborative efforts in the region, using CAD as a test case that would be applicable more broadly to chronic diseases. There is also a recognition that this could serve as an implementation exemplar for aspects of the new National Health Reform Agenda that will commence on 1 July 2025. This local leadership is demonstrated participation in this workshop, which included, industry, the Local Health District, the local Primary Health Network, Cardiology, the CEO of the Australian Cardiovascular Alliance, and the strengths and focus of the local research community, with its national and international linkages and networks.

Workshop unites key players to identify a priority area for collective effort.

The purpose of the workshop was to:

- gain a shared understanding of the drivers of disparity in the region, the current and planned initiatives to address these disparities
- better understand the data and evidence that is available and/or being used to identify priorities and measure improvements
- identify pressure points in the continuum of care and discuss local initiatives, including research, being undertaken to address these pressure points
- gain a preliminary understanding of where effort could best be directed and test innovative approaches to make tangible improvements in the region.

Key messages

- The critical gaps in patient care occur at the transition points of care in the health system (e.g. the transition from acute care to primary care, primary care to home/community care, or acute care to aged care). The policy, funding and system gaps in these areas are yet to be fully addressed. Strengthening engagement between Local Health Districts (LHDs) and Public Health Networks (PHNs) is critical to overcoming the challenges at these transition points.
- There is an urgent need to support general practice and address the gap between demand for services and their supply, and to rethink models of care.
- Social determinants are critical factors driving burden of disease in the Illawarra/Shoalhaven region, with health literacy being a significant factor in empowering

patients to better understand their health risks, how to address them and how to navigate the health care system.

- Local health practitioners, academics, community members, PHNs and LHDs are committed to working together, with broad agreement that CAD could serve as a test case, with wider applicability to other chronic diseases.
- Local approaches, local data and the availability of near real time information to guide clinical practice is critical to improving patient care. Such data will inform local priorities, interventions, community engagement and mobilise targeted research efforts. The Cardiovascular Health Leadership Research Forum (CV HLRF) has an important role to play in in championing greater coordination of effort at all levels in health care systems and policy (local, state and national).
- Aligning local, collaborative efforts to opportunities and challenges presented by the Health Reform Agenda will support successful advocacy and arguments for policy change.

Next steps

1. Engage key local health leaders and data experts from the local health system (LHD, PHN, Cardiology, General Practice and Consumer groups) with the ACvA's CAD Clinical Theme leads, in a focussed workshop to identify the priority question(s) that needs to be addressed, ensuring health system needs and data are driving this discussion.
2. The ACvA to work with local stakeholders to develop a pathway for delivery, including the research, evaluation and other expertise that needs to be brought together to address the question(s) identified through the above process, determine appropriate governance and identify potential funding/resourcing arrangements.

Introduction

This Report provides a snapshot of the drivers of disparity in coronary artery disease prevention, treatment and secondary prevention in a major regional area. It describes and analyses the Illawarra Shoalhaven Region as a case study, using a mix of presentations and facilitated discussions in a workshop setting.

The workshop was facilitated by the Australian Cardiovascular Alliance as part of its Clinical Themes Initiative and the findings and report will be disseminated under the framework established by the Cardiovascular Health Leadership Research Forum (CV HLRF) – a strategic platform that engages with State and Federal governments to leverage data, evidence, and expertise in identifying health disparities and prioritising areas for research focus.

The workshop enabled diverse stakeholder perspectives to be articulated to drive an initial discussion on local priorities and metrics for addressing coronary artery disease in the region and their alignment to national priorities and metrics.

Stakeholders groups (full attendance list at Appendix 1):

Stakeholder Group
Local Aboriginal Elder
Local Health District representative
Clinical trialists
Cardiology
Local General Practice representatives
Local Public Health Network representative
Local nursing practitioner/academic
Local pharmacists/academic
Local consumer representative
Federal Government officials
State Government officials
Industry representatives
ACvA Coronary Artery Disease Clinical Theme co-leads
Interstate academics.

Workshop Structure

The workshop was divided into four sessions:

1. Setting the scene
2. What do we know from the data - national and state perspectives?
3. What do we know from the different elements of the healthcare system - local perspectives?
4. What would possible measures look like to improve CAD management?

The sessions cascaded from national and state policies and projects to understanding the alignment with local perspectives. National and State perspectives were provided by senior government health officials and local perspectives were provided by key players in the Illawarra Shoalhaven health system and included a local consumer perspective on CAD diagnosis and treatment, while living and interacting with the various parts of the health ecosystem in the Illawarra.

Setting the scene

National context

Cardiovascular diseases (CVD), including coronary artery disease (CAD) remains the leading cause of death in Australia. In 2023, 304,800 years of healthy life lost was attributed to CAD (AIHW). CAD also disproportionally affects First Nations Peoples and low SES Australians. The number of people impacted by CVD (including CAD) is expected to increase in the future as the population ages further. This is particularly pertinent in the Illawarra Shoalhaven Local Health District (ISLHD), where 9.8% of the region's population is over 75 years, and this is projected to be 13.6% by 2041.

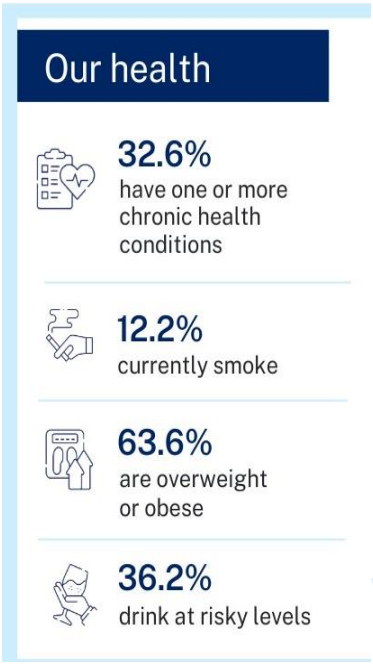
Whilst the burden of cardiovascular disease is massive, much of it has the potential to be solved through strategic and coordinated research and implementation efforts, focussed on the most pressing needs facing patients and the health system challenges. Enabling such an approach is the reason that the ACvA established the cardiovascular health leadership research forum (CV HLRF).

By way of background, the CV HLRF was established in 2022, after endorsement by the Health Chief Executives Forum and serves as a government engagement platform that brings health leaders, data experts and researchers together, to identify cardiovascular and stroke priorities for the health system, support continuous improvement and address gaps and inequities where research can play a role.

Key to this work is achieving aligned (minimum data sets across the country), including those being developed/used in various jurisdictions and by various research teams, many working to achieve reporting and visualisation in near real time (dashboards) to help measure and demonstrate impact and support implementation of interventions into the health system.

The Illawarra Shoalhaven Local Health District (ISLHD)

The Illawarra Shoalhaven Local Health District (ISLHD) spans an area of 5,687 km^2 and serves a population of approximately 422,500 people. In contrast, Metropolitan Sydney covers a much smaller area of around 126 km^2 but has a much larger population exceeding 5 million people.



The ISLHD covers some of the most advantaged and disadvantaged areas in NSW and its population will grow faster than any other region in NSW for the next 20 years. 4.3% of the ISLHD population identifies as Aboriginal or Torres Strait Islander.

The LHD employs almost 8,000 staff across 7 hospitals and 38 community services. The Illawarra Heart Health Centre is located at Wollongong Hospital and deals with cardiac rehabilitation, heart failure services, outpatient heart failure clinic and cardiology clinical trials unit.

National and State Chronic Disease Policy overview

In 2022, 1 in 2 Australians had one or more of 10 selected chronic conditions and 22% had 2 or more.

National Policy

Australia's approach to managing chronic conditions and cardiovascular health is guided by two key strategic policy initiatives:

- The National Strategic Framework for Chronic Conditions 2017-2025 (the Framework). The intent of the Framework is to enable all levels of Government and health professionals to work towards the delivery of an effective and coordinated national response.

- The National Strategic Action Plan for Heart Disease and Stroke 2020. The Action Plan has the following priority areas: Prevention and early detection; Diagnosis and treatment; Support and care; Research.

The Australian Government has key initiatives of the Australian healthcare system and funding bodies to support cardiovascular conditions, they include:

- The Medical Research Future Fund (MRFF)– funds medical research for CV conditions
- National Health and Medical Research Council (NHMRC) – funds medical research for CV conditions
- The Medical Benefits Schedule (MBS) - supports payment for patient care, including Chronic Disease Management plans and Heart Health Checks
- The Pharmaceutical Benefits Scheme (PBS) - subsidises medicines used to treat vascular conditions and their symptoms. The Australian government spends around $1.3 billion per year to subsidise medications for treating heart conditions and stroke
- The Australian Institute for Health and Welfare (AIHW) – manages the National Centre for Monitoring Chronic Conditions (NCMCC) to provide big picture view of chronic diseases in Australia

The State Regional Health Policy

The NSW Regional Health Strategic Plan for 2022-2032 is specific to regional, rural and remote communities and will guide NSW Health's strategic focus for the next 10 years.

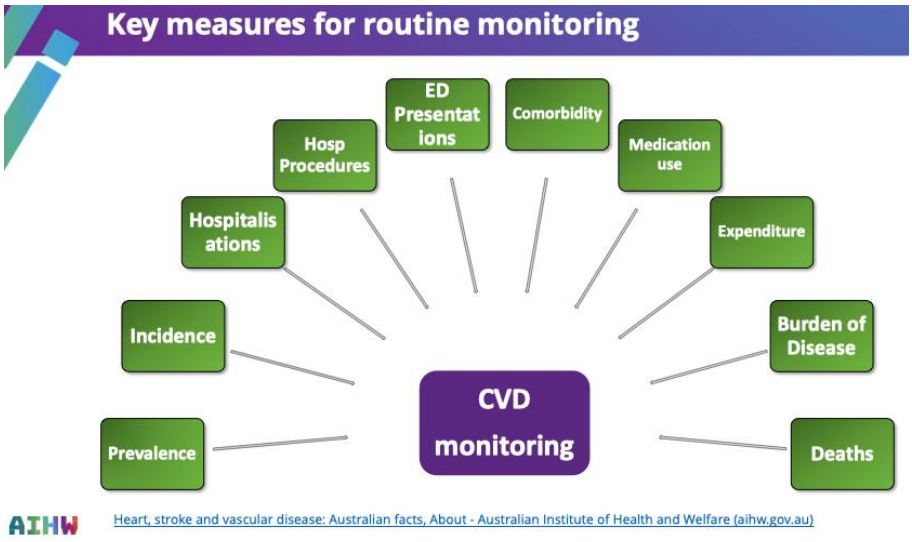
- The plan is a roadmap for the future provision of health services that understands, and celebrates, the diverse and unique nature of regional communities.
- The plan's vision is: a sustainable, equitable and integrated health system delivering outcomes that matter most to patients and the community in regional, rural and remote NSW, and six strategic priorities have been identified.

State priorities and approaches as outlined in the Regional Health Strategic Plan

For our communities
• Enhance patient experience, health outcomes and access to services • Provide an opportunity for expanded community contribution • Increase communication about what matters to the community
For our regional health workforce
• Enhance education, training and peer support (state-wide learning and education opportunities) • Increase engagement and job satisfaction by training and supporting staff to work at full scope of existing roles • Enhance opportunities for local workforce to contribute to development of innovation
For the system
• Maintain the benefits of the one system approach to health in NSW whilst creating structures and mechanisms to facilitate policy and strategy development specific to regional health services • Leveraging NSW Health assets to drive improvements in all aspects of health care delivery • Develop performance and outcome measures relevant to regional health services and communities

National Cardiovascular Data sets (Australian Institute for Health and Welfare (AIHW)

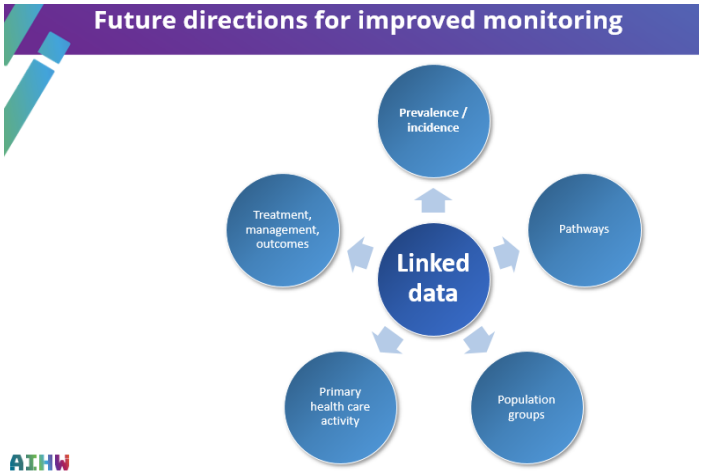
The AIHW *Heart, stroke and vascular disease: Australian facts* report provides key information for monitoring CVD in the Australian population, focussing on cardiovascular risk factors, major subtypes, treatment and impact. Incidence, prevalence, hospitalisation and mortality are described for each disease, with additional analysis of priority population groups. Data is collected from a range of sources. Key measures for routine monitoring and proposed future directions for AIHW are shown below.



National Health data linkage for improved health monitoring

The National Health Data Hub (NHDH), formerly the National Integrated Health Services Information (NIHSI) analytical asset, is a major national health data linkage system for health research and analysis.
The NHDH comprises de-identified and enduring health data from state and territory, and Commonwealth data sources. It brings together data on admitted patient care services (public hospitals) with limited private hospitalisations data (Qld, Vic and ACT), emergency department services and outpatient services in public hospitals for all states and territories with the exception of Western Australia and the Northern Territory.

See here for the list of data and data items.



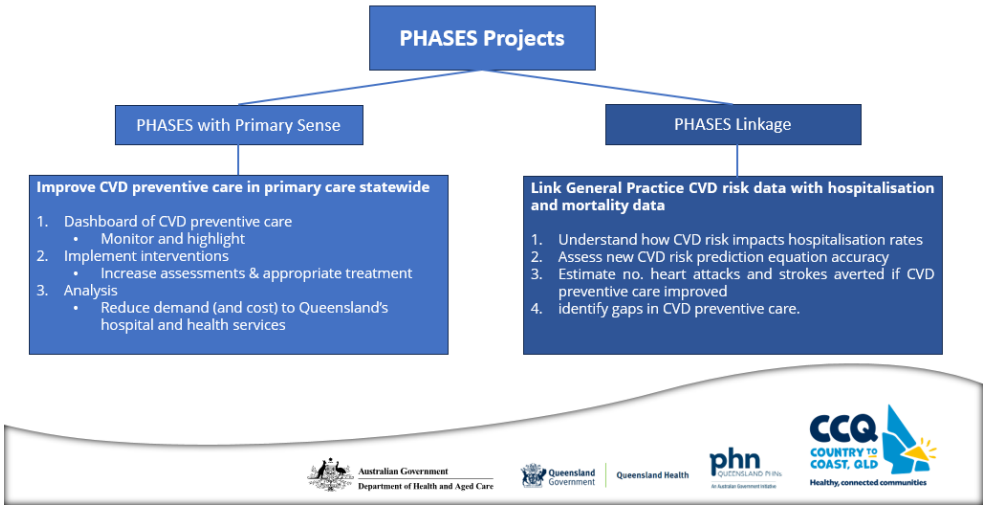
The Importance of National CV health Surveillance

National health monitoring is indispensable for understanding, managing, and improving public health outcomes. In the context of cardiovascular disease, it not only helps with early detection and improved treatment but also plays a key role in shaping policies, targeting interventions to greatest need, directing resources, advancing research, and promoting public awareness. However, currently in Australia there is no centralised, comprehensive population level surveillance system dedicated to cardiovascular disease.

Exemplar: Queensland primary prevention Initiative: Preventing Heart Attacks and Stroke Events through Surveillance (PHASES) Project – Professor Kim Greaves

The PHASES Project is a partnership between Queensland Health and seven Primary Health Networks (PHNs). Its goal is to develop a single dashboard for preventative care in the primary care sector, with a focus on improving the quality of data entry, extraction, and the use of prevention (and secondary prevention) data. The project will also link the primary care CVD risk data with hospital admission and mortality datasets to begin to cover the patient journey. The project is supported by the Queensland PHN collective and co-funded by Queensland Health and the Commonwealth Government.

Current work is focussed on Queensland; however the project has national scalability and discussions are underway to examine how a hypertension project being progressed in Tasmania might be a use case for scalability.



Discussion/observations

Data

- There is a wealth of available data regarding CVD (including coronary artery disease) and stroke within the health system, predominantly at the population level, however, there is limited data and limited alignment and utility in respect of data use that can guide and measure improvements at the level of clinical practice.
- While national and international bodies have led the development of evidence-based guidelines, there are no systematic ways of comprehensively measuring compliance to guideline recommendations or to interpreting the impacts of guideline-based care.
- Data that maps to the patient journey and guides clinical practice is unaligned both within and between states, and even when consensus has been achieved, it is often only in one aspect of the patient journey (e.g. acute coronary syndrome for CAD, does not currently capture primary prevention)
- A granular analysis of the drivers of disparity in CVD outcomes that can enable a national discussion at the CV HLRF is not yet possible, although significant work is being undertaken at various levels to address this.

Funding and integration of policy and strategy

- There are frameworks and policies at both national and state levels and a range of forums and strategies to work towards aligning and coordinating these for maximum impact.
- The lack of an overarching funding method and differing jurisdictional priorities makes truly national approaches to solutions difficult to achieve.
- A move to local approaches, with scalable elements has the ability to turn the current paradigm on its head.
- Using a specific clinical area to test new approaches has strong potential to complement current and prospective policies and priorities.
- The CV HLRF provides an important mechanism to bring key players together to identify and prioritise unmet needs and better understand disparities in health outcomes. The ACvA's core mission involves challenging and supporting the research sector to work collaboratively to address these.
- Aligned datasets are critical and outcomes must be able to be measured.

What do we know about the different elements of the local healthcare system – the local perspective

The patient perspective

- You can have significant coronary artery disease and not know it.
- Having a vigilant GP, who knows you, is critical to good health care but is not easy to achieve.
- You need a health advocate to listen and ask questions, so that you know what to do once you are diagnosed or 'fixed'.
- Having the means to pay out of pocket expenses and having private health insurance can be the difference between having treatable coronary artery disease rather than a heart attack.

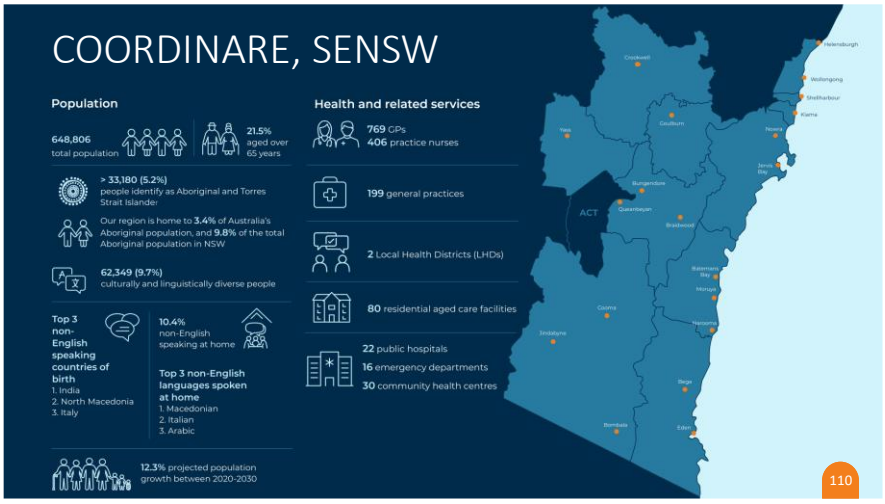
Illawarra Shoalhaven Local Health District (ISLHD) perspective

ISLHD priorities and future considerations include:

- Identifying gaps in service provision due to ageing population
- Ongoing health promotion: comprehensive lifestyle changes such as exercise, education, psychosocial support (services available through the Illawarra Heart Health Centre Rehabilitation team).
- Planning to increase the delivery of tertiary care in recognition of the increasing incidence of cardiac disease.
- Embracing AI and machine learning in cardiology, cardiothoracic surgery and to make research translation into clinical practice faster and more efficient.
- Understanding and 'mapping' our roles in delivering better outcomes and advocating for our region.

The Primary Health Network (PHN) perspective – COORDINAIRE

COORDINARE is the South Eastern NSW Primary Health Network (PHN) with a role to improve the health and wellbeing of the community, which is one of the largest rural and regional populations in NSW.



Key underlying issues in the region:

- Socio-economic disadvantage (remoteness, unemployment, financial stress).
- Housing and homelessness (social isolation, access to health care).
- Education and health literacy.
- Equity of access is a problem, especially for rural regions.
- General practice workforce issues are ongoing and are projected to have increasing gaps between supply and demand.
- Data collection can drive quality improvement, however, we need to acknowledge the limitations in comprehensiveness of the data and recognise our data gaps.

PHN programs/initiatives

- GP innovation models/QI recipes
- Education for GPs and other general practice staff
- Easy access to localised guidelines – e.g Health Pathways
- Support of enhanced multidisciplinary teams in primary care- Allied Health Funding
- Support for management of patients in RACF- GPACI MyMedicare
- Support for digital technologies to improve care.

General practice perspectives

The SIMLR Cohort study – Professor Andrew Bonney

The SIMLR study collected a range of cardiometabolic risk factors from people in the Illawarra Shoalhaven region presenting at the Southern IML Pathology Collection Centres. Conclusions from this study have found:

- At a population level, socioeconomic disadvantage is the single strongest predictor of CVD risk
- Geographic access to primary care does not materially alter the association
- Environmental factors within neighbourhoods do not appear important (which would also include GP practice characteristics)
- Marked costs associated with disproportionate CVD risk
- The evidence suggests we need to rethink approaches to community CVD risk reduction, particularly in disadvantaged communities
- Research on service provision in disadvantaged populations is a priority.

Improving CV outcomes for patients, perspective from the ground – Dr Rene Dostal

What is needed to improve care?

- Resources to assist with data generation, oversight of performance
- Time to identify vulnerable patients and track their care
- Time and resources to improve preventative care
- Accessible private and public referred specialist services
- Support to ensure appropriate referrals
- Address specific regional gaps:
    - Lack of a Public Cardiovascular / Coronary Outpatient Clinic
    - Difficulty accessing stress ECHOs
    - Lack of services readily providing perfusion scans with exercise.
- Tracking percentage of patients with completed cardiovascular risk assessments – could this be a component of our PIPQI data uploads.
- Recognise and advocate for change to address the following:

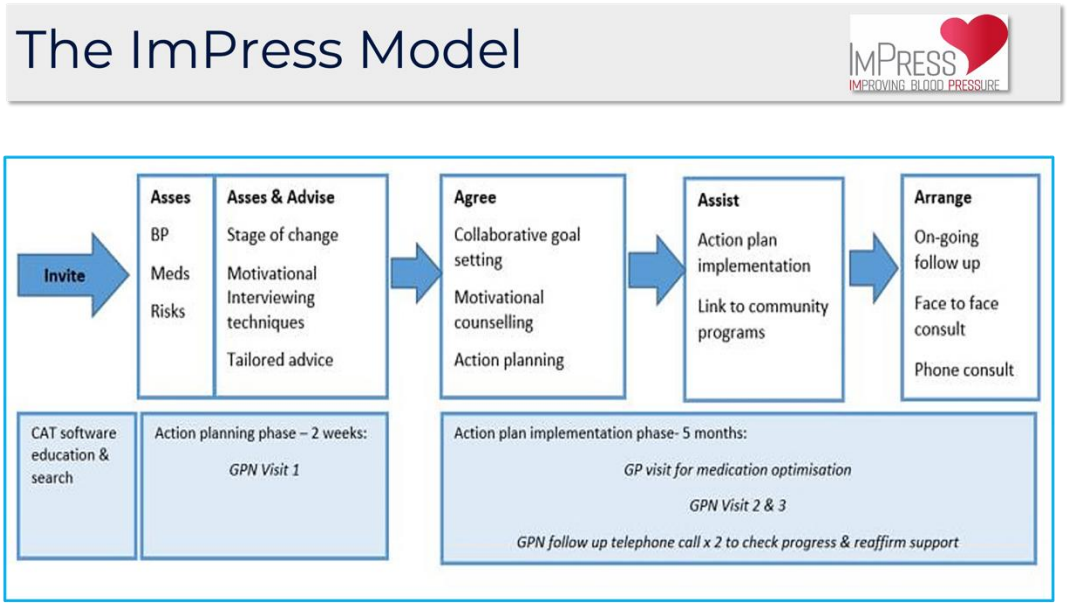
- Evolving intra-practice team care and delegation seem inevitable to improve data generation, patient tracking, follow up and care planning in General Practice. However Federal financial support for employing nurses in general practice (PNIP) is capped for practices with > 5 full time equivalent GP's.
- Recent rebate reduction for GP's to perform and read ECG's
- Recent restriction on Medicare rebates for cardiac echo's ordered by GP's to no more than one every two years.

Nursing perspective

Exemplar: the Impress Study – Dr Catherine Stephens

One in four general practice nurses feel underutilised, including in the field of providing cardiovascular education.

The Improving Blood Pressure in Primary Care (Impress) Study assessed the impact of nurse led models in risk reduction (blood pressure) in primary care. Amongst other things, the study demonstrated that there are significant and evidence-based wins in patient outcomes if nurse practitioners are utilised to top of scope in an integrated fashion in general practice settings. The study showed that such models can enhance a patient's ability to self-manage. In addition, the study has enduring outcomes and is shown to be scalable and would be sustainable if challenges posed by current funding processes were overcome through policy change.



Pharmacist perspective

Pharmacists occupy diverse roles in our health care system, including in the community, in hospitals, as consultants, undertaking medicine reviews, as non-dispensing pharmacists and as academics.

Pharmacists provide a range of services including smoking cessation support, medication management, screening, vaccination, chronic disease management, palliative care and wound management. They are already embedded in collaborative models of care, including in hospital settings and have a key role to play in primary and secondary prevention and ongoing care, related to CAD.

Supporting a patient to adhere to medication is an important role and critical to risk reduction and optimal health management. Studies clearly demonstrate that the factors that contribute to poor adherence, include:

- lack of physical symptoms;
- multiple morbidities & complex regimens;
- duration of treatment
- side effects
- poor health literacy
- stress and time.

Pharmacists are part of a continuum of patient care, and particularly in helping to address and improve health literacy, with demonstrable cost implications on our health system.

Discussion/observations

- Increased mechanisms to support ongoing and enhanced collaboration between Local Health Districts and Public Health Networks are essential. LUMOS, run by NSW Health is a model with strong potential for data linkage and sharing and for assisting in prioritisation and issues identification.
- Further structures and incentives will be needed to enable effective and enduring integration between primary, acute care and care in the community. Evidence-based policy and advocacy will be required to appropriately support multi-disciplinary approaches (e.g., incentives, KPIs, role recognition and definition, nurse practitioners able to work to top of scope).
- Local researchers are leading key studies that have already demonstrated the efficacy of new models of care, and health and cost benefit, which are yet to translate into policy change.
- The ISLHD presents a significant opportunity to draw on state and national initiatives to develop a joined up approach towards locally applicable CQIs and dashboard development that can serve as a model nationally and demonstrate how these can address local priorities and drive change. Using the CV HLRF model locally and ensuring State and national leaders are informed are critical steps in driving measurable change.
- The local change process must be aligned with the Federal Health Reform Agenda (HRA).

What do possible measures look like to improve CAD management?

Implementation Exemplar 1: Heart Matters – Professor Janet Bray

The Heart Matters research aimed to save lives through targeted community health education in eight Victorian local government areas with a high risk of heart attack, low levels of heart health knowledge and low ambulance use.

The study involved targeted grass-roots community education with local coordinators with a common message around heart health.

Over 450 sessions were held, 24 sessions were translated and over 11,000 direct community engagements were made over the study period.

Key findings:

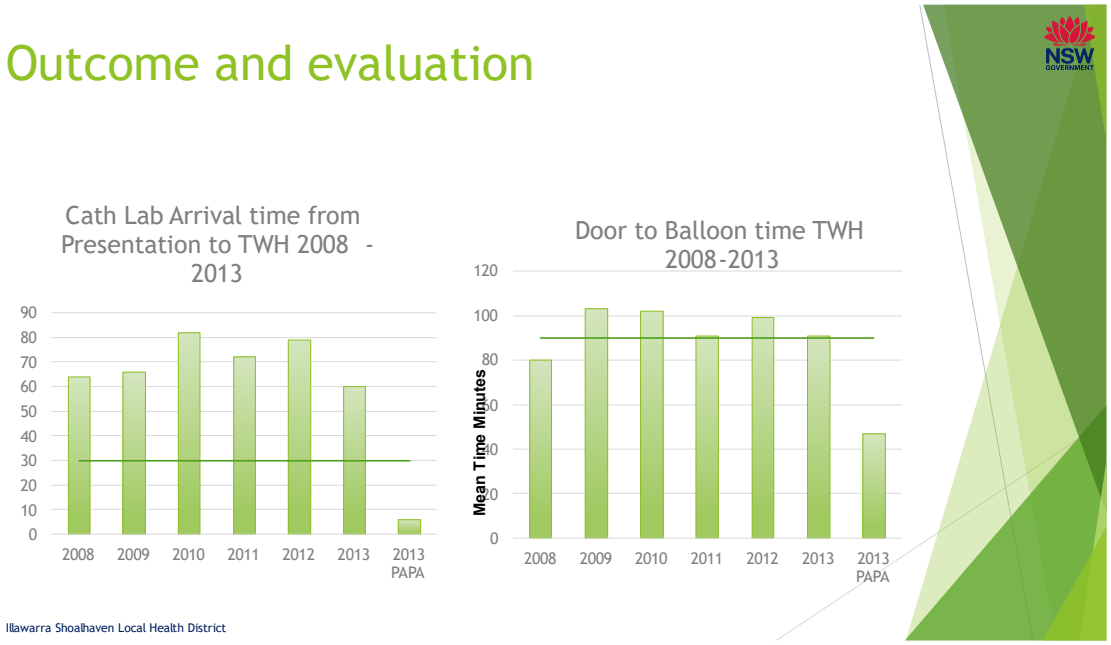
- Community engagement is critical to implementation, particularly in prevention, risk identification and risk management. The key ingredients are:
  - genuine two-way engagement
  - knowing your community and engaging in an appropriate way (language, culture, settings)

- using relatable data
- not letting perfection stand in the way.

- Strong, genuine and well-structured engagement provides a strong pathway for addressing health literacy issues.

Implementation Exemplar 2: The Pre-Hospital Assessment for Primary Angioplasty (PAPA) Study- Dr Michael Tierney

The Pre-hospital Assessment for Primary Angioplasty (PAPA) study was set up help reduce heart damage and improve heart health outcomes in patients experiencing chest pain before they arrive at the hospital. The study involved using ambulance ECGs to detect signs of irregular heart rhythms. Patients with irregular heart rhythms were sent directly to the cardiologist on duty upon arrival or given thrombolysis medication, if deemed appropriate. The aim of the project was to decrease door to balloon time for primary angioplasty at Wollongong Hospital from 100 min to within the national benchmark of <90 min within 6 months.



Key findings:

- The PAPA study demonstrated a significant improvement in Cath lab arrival time and door to balloon time compared with control.
- Clinical trials are integral to implementation and scalability.
- Trials are pivotal in advancing prevention, diagnosis and treatment of heart diseases.
- There is a need for ongoing research and innovation in trial design to overcome challenges and barriers to implementation.
    - Significant challenges include patient recruitment, managing complexity, high costs/resources, and regulatory and ethical hurdles.
    - Trials such as PAPA demonstrate the importance of evidence and data from trials in driving enduring impacts on patient outcomes, facilitating implementation on policy and practice, and providing cost savings to the system.
- PAPA also clearly demonstrates the power and necessity of cross sectoral collaborations in achieving significant health gains and savings.

Discussion/observations

- Health literacy improvements are essential and should be a focus of our local, collaborative efforts.
- New models of care, utilising the diverse skills of all our health care professionals must be an advocacy priority – CAD can lead the way.
- The critical gaps in patient care related to CAD (and more broadly) occur at the transition points, eg the transition from acute to primary care, primary care to home or community care, and/or acute care to aged care. The policy, funding and systems gaps in these areas are yet to be fully addressed. The CV HLRF has an important role to play in identifying precise pressure points and projects that could provide an agreed test case and evidence base for further policy, practice change and increased cross system and cross jurisdictional collaboration.
- Local approaches, local data and the availability of near real time information to guide clinical practice is critical to making measurable improvements for patients with CAD.
- Such data will inform local priorities, local interventions, community engagement and mobilise targeted research efforts.
- Strong engagement between the LHD and PHN is critical.
    - Local health practitioners, academics, community member, PHN and LHD staff are committed to working together, with broad agreement that CAD could be a test case with enduring local benefits and wider applicability.
    - Mapping efforts and recommendations to key stressors in the Health Reform Agenda (HRA), will support advocacy and arguments for policy change.

Next steps

1. Engage key local health leaders and data experts from the local health system (LHD, PHN, Cardiology, General Practice and Consumer groups) with the ACvA's CAD Clinical Theme leads in a focussed workshop to identify the priority question(s) that needs to be addressed, ensuring health system needs and data are driving this discussion.
2. The ACvA to work with local stakeholders to develop a pathway for delivery, including the research, evaluation and other expertise that needs to be brought together to address the question(s) identified through the above process, determine appropriate governance and identify potential funding/resourcing arrangements.

Appendix 1

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Rachael Hanrahan	Abbott
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