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phn NORTH COAST
An Australian Government Initiative

North Coast Primary Health Network
Innovation Activity Work Plan 2016 - 2018

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Introduction

Overview

The key objectives of Primary Health Networks (PHN) are:

- increasing the efficiency and effectiveness of health services for patients, particularly those at risk of poor health outcomes; and
- improving coordination of care to ensure patients receive the right care in the right place at the right time.

In line with these objectives, the current PHN Innovation Funding stream will support PHNs to engage in innovative approaches and solutions that improve the efficiency, effectiveness and co-ordination of locally based primary health care services.

In the context of the PHN Innovation Funding under this stream, innovation includes *an idea, service, approach, model, process or product that is new, or applied in a way that is new, which improves the efficiency, effectiveness and co-ordination of locally based primary health care services*.

At a minimum, activities under the current PHN Innovation Funding stream must:

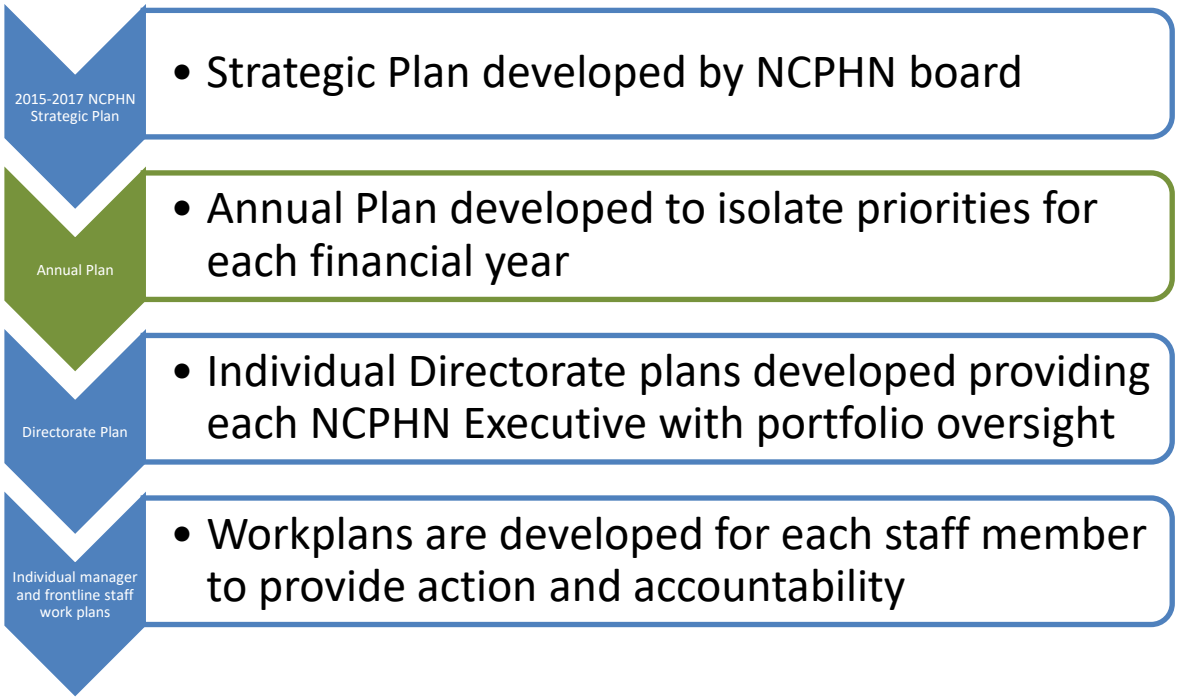
- be new or innovative;
- align with PHN Programme objectives;
- relate to the recommendations of the Report of the Primary Health Care Advisory Group, *Better Outcomes for People with Complex and Chronic Conditions*, and the Australian Government's response;
- be beyond the activity expected under the Core Funding Schedule and not duplicate activity funded under other schedules (eg. After-Hours, Mental Health, Drug and Alcohol) or other funding sources; and
- link to local need (as identified via needs assessment) and/or support the application or expansion of innovative solutions across the PHN network.

Primary Health Networks can utilise 2015-16 PHN Innovation Funding to: engage expertise and work with partners to develop innovative models; implement an identified innovation(s) or expand its application; and/or undertake evaluation of local innovation.

Primary Health Networks are required to outline planned activities, milestones, expected costings and outcomes to provide the Australian Government with visibility as to the activities of each PHN.

Strategic Implementation

This Activity Work Plan represents the second phase in the NCPHN planning process. To ensure all elements of the NCPHN Strategic Plan become operationalised, a cascading implementation plan structure is used. This enables a direct line of sight between the organisation's strategic objectives and work plan actions for individual front line staff. All teams report on their progress monthly to the Executive Team.



Planned activities funded under the Activity – Primary Health Networks Innovation Funding

Proposed Activities	Description
Activity Title / Reference	**IN1.1 Integrated Patient Centred Medical Home Program**
Description of Activity	North Coast Primary Health Network (NCPHN) is undertaking a quality improvement (QI) initiative with the aim of transitioning general practices and AMS' to integrated Patient Centred Medical Homes (PCMH). This is part of broader strategy to build a person centred health care system, one which 'works as one' to deliver accessible, equitable, high- quality, integrated care. The integrated PCMH model aims to deliver the highest standard of care to patients. The key features of an integrated PCMH are: • *Person Centred* - partners with patients and families to be responsible for the provision of care even when the patient is not in the practice. The PCMH encourages self-management and patient involvement in care planning. • *Accessible* - manages appointment systems to provide timely routine appointments and arrangements for acute care needs and after hours care. • *Coordinated* - integrates care through a team-based approach including clinicians, practice staff, allied health professionals and specialists with clear roles, goals and communication pathways. • *Comprehensive* - considers a patient's whole of person needs and ensures needs are met by the most appropriate care providers. • *Focused on Quality and Safety* - systematises approaches to continuous quality improvement and data management making full use of eHealth technologies. The integrated PCMH Program will involve the following key activities: 1. Preparing the first edition of the *Australian Handbook for Transitioning to an integrated Patient Centred Medical Homes* – this resource for general practices will provide tools for transforming a practice into a an integrated medical home. The handbook will set out criteria and tools for transitioning along a continuum to becoming a PCMH. A handbook of this kind does not yet exist for the Australian context. The Handbook will include: a rationale for

	general practices to transition into PCMHs, expected criteria to be reached by practices along a maturation continuum and tools for assessment and implementation of the elements of the Medical Home model. 2. Developing an integrated PCMH Program and implementing it with an initial cohort of general practices and Aboriginal Medical Services (AMS') - we will seek expressions of interest from practices across our footprint to be part of an initial cohort of practices to undergo the Program. Practices who participate in the program will receive support in the form of learning and development opportunities, practice visits, a resource Handbook, additional data analytics and quality improvement support by NCPHN QI staff. Tools provided in the Handbook will be refined based on experience generated through the PCMH program. Key activities to be carried out as a part of the PCMH Program will include: • development of measures to evaluate the effectiveness of general practices transitioning into PCMHs • patient and practitioner experience surveys • PCMH workshops with participating practices • administering and analysis of PCMH Self Assessment tool with practices • capacity building of NCPHN General Practice Quality Improvement Support Officers to implement the program • quality improvement support to develop practice resources and tools for PCMH implementation • practice network gatherings to monitor progress and share learning • ongoing development and refinement of the PCMH Handbook. 3. Increasing overall local preparedness and interest in general practices and AMSs to transition into integrated PCMHs - this activity will focus on those practices that did not initially enrol in the Program but express an interest in knowing more about the PCMH model. The increase in local interest will be sought by visits to general practices and events held across the region, including a formal launch of the PCMH Transformation Handbook in November 2016. 4. Establishment of a Primary Health Care Nurse Network (PHCNN) Program – the objective of the PHCNN Program will be to support primary care nurses to build capacity to deliver quality care based on the PCMH model. The program will involve: • providing clinical updates (eg. immunisation updates) • sharing of information about local health issues and challenges • networking opportunities with peers

	• opportunities to be involved in quality improvement and health system improvement initiatives • continuing professional development opportunities. 5. Development of an *Australian Handbook for Allied Health Professionals in a Person Centred Integrated Health System* – this resource will provide allied health professionals and general practices with tools for strengthening the coordination of care within an integrated health system. The Handbook will become part of a broader strategy for engaging with allied health and increasing care coordination between allied health professionals and general practices. The Allied Health Handbook will include: • a rationale for creating a person centred integrated health system • approaches to quality improvement in healthcare services • improvement ideas based on best practice experience and literature review • resources and tools for implementation by allied health professionals. Amendments to 2016-17 AWP: • Additional detail provided regarding activity planned for 2017-18. This includes the establishment of a Primary Health Care Nurse Network to build capacity to deliver high-quality person centred care. Also, the development of an allied health handbook to increase coordination of care between allied health and general practices.
Rationale	• The PCMH Program contributes to Health Care Home readiness in general practices later to be involved in the following phases of the HCH Initiative • The PCMH model has the potential to transform care coordination and outcomes for many different populations and groups. One such group are patients experiencing chronic or complex conditions. In the NCPHN region **over 280,000** services for chronic disease management were reported by GPs between 2014-15 (Based on data for MBS items 721-758 in 2014-15) • There are currently 175 general practices, including 11 ACCHOs (Aboriginal Community Controlled Organisations) and 7 AMSs, in the NCPHN region. This Program will enhance the ability of all general practices to increase the quality of services being offered to their patients. • The PCMH model is an effective and efficient way to achieve the triple aim of higher quality, lower cost, and improvement in the person's and provider's experience of (health) care.

	Institute for Healthcare Improvement. IHI Triple Aim Initiative [Internet]. 2015 [cited 15 July 2015]. Available from: http://www.ihi.org/engage/initiatives/TripleAim/Pages/default.aspx o Lembke, T. *The person-centred health system and the medical home* [Internet]. WordPress, 2014 [cited 15 July 2015]. Available from: http://medicalhome.org.au/the-person-centred-health-system-and-the-medical-home/ o Christensen EW, PhD., Dorrance KA,M.C.U.S.N., Ramchandani S,M.C.U.S.N., Lynch S, B.S., Whitmore CC, PhD., Borsky AE, M.P.P., et al. Impact of a Patient-Centered Medical Home on Access, Quality, and Cost. Mil Med 2013 02;178(2):135-41. • PCMHs are associated with improvements in patient experiences, on both overall measures of patient satisfaction and measures of patient-reported or patient-perceived level of care coordination. o Kemper AR, Hasselblad V, Dolor RJ, Williams JW, Jr., Jackson GL, Gray R, et al. The patient-centered medical home: a systematic review.(IMPROVING PATIENT CARE). Annals of Internal Medicine. 2013;158(3):169.
Strategic Alignment	• Primary Health Networks need to play a key role in the quality improvement of general practice. Therefore, NCPHN sees a key role in PHNs facilitating the transition of general practices into PCMHs. • The PCMH Program and Handbook directly relates to the recommendations of the *Report of the Primary Health Care Advisory Group, Better Outcomes for People with Complex and Chronic Conditions*, and the Australian Government's response; as it is seeking to assist in the creation of numerous PCMHs connected and not connected to the chosen trial sites. • Related to After Hours Priority Area 3 in NCPHN Activity Work Plan • The 2016 NCPHN Needs Assessment revealed that 52% of service providers surveyed mentioned incompatible systems as the most significant barrier to coordination of care in the region. The PCMH Handbook directly responds to this gap.
Scalability	Resources, tools and experiences generated by the PCMH Program are applicable and will be shared with general practices and other PHNs around the country via the NCPHN website: http://ncphn.org.au/medical-home/

	Ongoing telemeetings, webinars and conference presentations are also currently increasing the implementation of the PCMH Program
Target Population	Consumers, general practitioners, practice staff, quality support officers, allied health professionals, specialists, clinicians in a hospital setting and employees of Primary Health Networks. The PCMH Handbook has the potential to support the work of numerous health practitioners in the health system. Based on the NCPHN's 2016 Needs Assessment there are 830 General Practitioners, and 8,192 Allied Health Professionals in the NCPHN region that could be impacted by this project. The initial focus of development and testing the Australian adaptations of measures and transition tools or processes will focus on a set of self-selecting practices within NCPHN.
Coverage	Targeting whole of population in NCPHN region and potentially other PHN regions based on the utilisation of other PHNs of this resource.
Anticipated Outcomes	Anticipated outcomes include: • Increased general practice capacity to support patients by providing person-centred, accessible, coordination, continuous and safe care with increasing quality. • Availability of data providing evidence of the impact of the transition of general practices into PCMHs on patient and practitioner experience. • Increased capacity of the PHN to support the transition of general practices towards more of the features of a PCMH. • Increase PHN capacity to support general practice in quality improvement approaches. Following the establishment of a baseline it is anticipated that implementation of PCMH tools will result in an increase in: • Patient centred care • Patient access to routine, acute and after-hours care • Quality care • Coordination between care providers and clear means for communication • Comprehensive care based on whole of person needs • Effective means for data collection and use

	• Appropriate use of eHealth technologies.
How will these outcomes be measured	Measures will be developed to evaluate the effectiveness of general practices transitioning into PCMHs. Measures will be both qualitative and quantitative and will include the use of patient, practitioner and staff surveys.
Collaboration	Strategic direction and refinement for this program is being supported by clinical advisors, community engagement teams, general practices in NCPHN, WentWest PHN, South East Melbourne PHN, South West Sydney PHN, International Foundation for Integrated Care, Murrumbidgee PHN, Capital Health Network, Adelaide PHN, Sydney North PHN, Wentworth Healthcare, Central and Eastern Sydney PHN, OCHRE Health, Flinders University, *University of Newcastle Department of Rural Health, Agency for Clinical Innovation, University of Technology Sydney –Centre for Health Economics Research and Evaluation and Australian General Practice Accreditation Limited (AGPAL).*
Timeline	• Development of initial version of PCMH Handbook – by November 2016 • Formal launch of PCMH Handbook – by December 2016 • Recruit and enrol initial cohort of practices – by December 2016 • Implement Program with initial cohort of practices – from January 2017
Indigenous Specific	This project is targeted at General Practices and Aboriginal Medical Services.

Proposed Activities	**Description**
Activity Title / Reference	**IN1.2 Centre for Health Care Knowledge and Innovation**
Description of Activity	**Background:** *Centre for Health Care Knowledge and Innovation* (The Centre) has the objective of enhancing knowledge and stimulating innovation on the North Coast and neighbouring regions. Health professionals and community members in metropolitan regions have greater opportunities to attend symposiums, workshops and

	conference and hear international and national scholars; this opportunity is limited for regional and rural clinicians and community members. *The Centre* brings national and international scholars to the North Coast to share their knowledge with the local health and social services workforce to fuel innovation and creativity and stimulate change and reform. *The Centre's* knowledge partners are the International Foundation for Integrated Care (www.integratedcarefoundation.org); Southern Cross University and the University Centre for Rural Health. *The Centre* is an initiative of the NCPHN, it has its own Board structure and is seen as a much needed catalyst for advancement of knowledge and conversation about integration and reform. *The Centre* governing Board oversees the portfolio of work, including events, studies and research. *The Centre* was launched on 15 June 2016. The launch was attended by the *Centre's* knowledge partner International Foundation for Integrated Care (IFIC) Chief Executive Officer Dr Nick Goodwin. Following the launch, Dr Goodwin presented a workshop on "Commissioning integrated care services effectively; implementing integrated care and developing the softer skills". This workshop was attended by over 60 health and social services professionals. A number of effective gathering were organised during Dr Goodwin's visit to engage with Clinician Leaders and the members of the Integrated Care Program Guiding Coalition. *The Centre* has already run two major workshops with international scholars Dr K Viktoria Stein, Senior Fellow and Head of the Integrated Care Academy International Foundation for Integrated Care and Dr Nick Goodwin. These workshop have been extremly well received, well attended and have resulted in much conversation and advancement. The Centre plans to run a number of significant events in 2016/17, including: • Transformers Special Event Series – 5 international scholars from the International Foundation for Integrated Care (IFIC) will visit the North Coast in November and December 2016 to share their knowledge and expertise with local practitioners. 10 workshops, symposiums and service visits are planned as part of the series of events. • Transformers mini-series event (Port Macquarie) – Professor Anne Hendry (Clinical Lead for Integrated Care Scotland) and Dr Nick Goodwin (IFIC CEO)will facilitate an event on our mid north coast focused on health system sustainability from an international perspective and the building blocks of integrated care.

	• Risk Stratification Workshop – in March 2017 the Centre will invite clinicians, leaders and planners from primary healthcare and local health districts to hear about recent developments in integrated care and risk stratification from national and international experts. Particular focus will be on person-centred care and how to use predictive risk modelling to measure performance for high risk populations. • 'Working Together for Cooperative Disability Care' –a cross agency, co-design workshop is planned for May 2017 to prepare the region for the roll out of the National Disability Insurance Scheme (NDIS). Targeting non-government organisations, allied health, local health districts, social services and community services the workshop will involve NDIS experts working with small groups to puzzle out the implications of the roll out and design practical local strategies. • Mental Health Symposium – a 2 day event, planned for June 2017, will bring three national and international scholars to the North Coast. Participants will gain understanding and insight into national and international models for access to psychiatry with the aim to develop a model relevant to the NSW rural context and culture. The intention in 2017-18 is to continue to build the brand and reputation of the Centre. The Centre plans to inject further knowledge into the region in relation to integrated person centred care by holding a number of major events including: • Transformers II Series - a number of scholars from the International Foundation for Integrated Care (IFIC) will visit the North Coast in November 2017 to hold a series the series of events similar to the successful 2016 Transformers Special Event Series. A taskforce will be established to plan the series of events which will include workshops, symposiums and service visits across the NCPHN footprint. A potential theme of "linking social services with primary care providers" is being explored for the event. • IFIC Summer School – IFIC has agreed to run their first southern hemisphere international summer school in Australia. Planning is underway with IFIC to hold this on the NSW North Coast in March 2018. The Summer School will be run over 5 days as a residential program. The target audience will be public sector leaders committed to driving integrated care. For example, current clinician champions, leaders from Primary Health Networks (PHNs) and Local Health Districts (LHDs), leaders of regional programs and partner agencies. Participants will be exposed to a mix of international and Australian case studies, and encouraged to workshop solutions throughout the week. They will also work on their own strategies and

	challenges. A possible theme for the event is how PHNs can use their commissioning roles to drive integration. The proposed objectives of the IFIC Summer School will include: o Gain understanding and insight into International case studies and discover how applicability can be reached in Australia o Bring different stakeholders together to learn from the varying sectors and establish a common language around quality of care o Motivate participants to plan together, share together, pool together and get integration happening on the North Coast o Strengthen linkage and partnership with the International Foundation of Integrated Care while creating tangible output for varying scenarios. The Centre also intends to hold other events in 2017/18 program that prepare the region for various change initiatives and reforms. Similar to the 'Working Together for Cooperative Disability Care' event, which aims to prepare the region for the roll out of the National Disability Insurance Scheme (NDIS), the Centre will bring together non-government organisations, allied health, local health districts, social services and community services as required to co-design local strategies. For example, preparing the region of the rollout of the My Health Record and other digital health initiatives. Amendments to 2016-17 AWP: • Additional detail provided regarding activity planned for 2017-18. This includes information about our plans to inject further knowledge into the region in relation to integrated person centred care through events such as a second series of Transformer series and an IFIC Summer School.
Rationale	Knowledge is critical to fuel change and innovation. Health professionals and community members in rural and remote regions do not have the opportunity to hear and engage with international and national scholars. *The Centre* brings scholars and researcher to the North Coast to share their knowledge with the local health and social services workforce; engage in programs, projects, research, run workshops, and undertake practice and site visits. This has proven to be extremely successful and has already led to in innovation, conversations with clinicians (GPs) resulting in advancement.

Strategic Alignment	*The Centre* will actively improve both the efficiency and effectiveness of health services for patients and the coordination of care those patients receive; the two key objectives of PHNs. This is achieved by: • Disseminating best practice and emerging knowledge to large numbers of General Practitioners and other clinicians, practice managers and others in an engaging and interactive format • Delivering new information though consistent program of high profile speakers thus fostering a growing culture of interest, engagement and discussion in best and emerging practice amongst medical services. *The Centre* directly relates to the recommendations of the *Report of the Primary Health Care Advisory Group, Better Outcomes for People with Complex and Chronic Conditions*, as it promotes a culture of innovation and quality improvement that continually improves primary health care.
Scalability	NCPHN is already in discussion and collaborating with other PHNs to share the visiting scholars it brings to the region. Currently NCPHN is collaborating with Gold Coast PHN and we are also sharing the program with other NSW PHNs.
Target Population	General Practitioners, LHD clinicians, AMS Clinicians, Health professionals, Social Services, Allied Health Professionals and consumers.
Coverage	Targeting whole of population in NCPHN region, multiple PHN regions, east coast
Anticipated Outcomes	*Centre for Health Care Knowledge and Innovation* will: 1. Bring at least 20 scholars to the North Coast region to share their knowledge and learning 2. Organise at least 20 symposiums, workshops, service visits using national and international scholars 3. Initiate 10 program, research and projects as the result of the events and programs of *the Centre* 4. Engage 800 health professionals; medical, nursing and allied health clinicians; social service professionals in the Centre's programs that advance care coordination and integration and improve o patient experience and outcomes o value

	o upskill or professional development of clinicians and professionals.
How will these outcomes be measured	• Number of visiting scholars • Number of events • Number of participants • Number of projects and program • Impact of the program on patient experience and outcome (care integration)
Indigenous Specific	While the program is not indigenous specific, it will assist in the development of Aboriginal health professionals and services.

Proposed Activities	Description
Activity Title / Reference	**IN1.3 PITCH (Practical Ideas to Change Healthcare) and CIS (Copernican Inversion Series)**
Description of Activity	**Background:** This Innovation Activity covers two initiatives: 1. The PITCH (Practical Ideas To Change Healthcare); and 2. The Copernican Inversion Series (CIS) breakfasts. Each initiative is described in more detail below. **PITCH** The PITCH provides the opportunity for the health clinicians and professionals and wider community to present ('PITCH') their creative ideas, including ideas for improving the efficiency, effectiveness and co-ordination of locally based primary health care services. Each series of the PITCH involves a different theme (eg. 'Improving health care and quality of life for people living in a residential aged care facility'). Community members and those involved in the healthcare sector are then invited to PITCH an idea in writing that addresses the theme. The most creative, unique and implementable ideas are then invited to PITCH in person or via video clip (http://healthynorthcoast.org.au/the-pitch/). NCPHN implements the most outstanding PITCH from

	each round, and as many of the other PITCHs with merit as possible. Events are held at different locations across the NCPHN footprint to facilitate local healthcare communities coming together. The PITCH is part of an ongoing effort by NCPHN to channel the creative energies that exist in the health sector and the wider community, nurture local ideas and develop solutions to problems. This is a successful program initiated by former North Coast Medicare Local in 2012 and copied by many organisations including in Vancouver, in Canada and RICH by NSW Agency for Clinical Innovation. **CIS Forums** Copernicus was a 16th century Polish astronomer and mathematician who proposed that the Sun, not the Earth, was the centre of the solar system. This turned not only human knowledge but the human psyche inside out, creating what is known as the Copernican Inversion. The term 'inversion' is now used to denote major leaps in knowledge, a progressive shift or change in perspective. In the context of healthcare NCPHN uses Copernican Inversion to denote placing the 'patient' like the sun in the centre of care design and delivery. The Copernican Inversion Series (CIS) is a coming together of local healthcare community - clinicians, service providers, administrators, consumers, volunteers, policy makers, educators and researchers – to network, discuss innovations and generate ideas to bring about change. Each event involves presentations of innovative work in various fields (primary healthcare, acute sector, non-government sector etc) by 2 or 3 presenters for no longer than 10 minutes each. This is followed by a facilitated discussion about the role of innovation and creativity in improving healthcare services. Events take place in different locations across the footprint to facilitate local healthcare communities coming together. During 2016-17, NCPHN focused on launching its Centre for Healthcare Knowledge and Innovation (The Centre) and successfully organising a number of major events, including the Transformers Special Event Series. This slowed progress with regard to relaunching the PITCH and CIS breakfasts. NCPHN plans to relaunch its PITCH and CIS events in 2017-18. Whilst PITCH and CIS events have been successful in the past (note: over 10 rounds of PITCH have previously taken place with over 40 needs and ideas for improving health care making their way to the final round) NCPHN plans to review the way it has previously implemented these initiatives, including research and evaluate other ideas and formats. NCPHN will also look at re-branding both initiatives, especially in light of new initiatives such as its Centre for Healthcare Knowledge and

	Innovation. The intention is to continue to use PITCH & CIS events to generate and surface innovative ideas for improving the healthcare system at a local level. The Centre for Healthcare Knowledge and Innovation events will compliment this approach by injecting knowledge into the region and fueling innovation. Our key activities for 2017-18 will include: • Developing a revised strategy for both PITCH & CIS events • Developing an implementation plan, including themes / topics for events • Relaunching both initiatives across our footprint • Implementing events as per the plan. Amendments to 2016-17 AWP: • Additional details provided regarding activity planned for 2017-18. This includes information about our plans to relaunch PITCH & CIS.
Rationale	NCPHN is committed to creating a culture of innovation, pushing the boundaries and reflection. The PITCH and CIS encourage innovative thinking and harness a culture of creativity and dissemination of ideas and innovation to bring about change. NCPHN recognises that health system reform requires working collaboratively with key stakeholders and that sustainable change and improvement comes from all parts of the system 'working as one'. The PITCH and CIS are part of an ongoing effort to channel the creative energies that exist in the health sector and the wider community, nurture local ideas and develop solutions to local problems that result in improved health outcomes for people living on the North Coast.
Strategic Alignment	NCPHN works alongside its communities and health professionals to ensure access to well coordinated, quality health care. NCPHN wants to be a most innovative and engaged PHN in Australia and a leading authority on the health care needs of, and solutions for, North Coast NSW communities. To achieve this NCPHN needs to engage and support its key stakeholders – health professionals and the community – in the delivery of health care services. The PITCH and CIS are about encouraging innovation and implementing these in a systematic fashion.

	They also provide strong and unique engagement and marketing opportunities. They increase NCPHN's visibility and assist in increasing understanding and awareness of the NCPHN amongst health professionals and the North Coast local communities. Both activities are in alignment with the recommendations of the Report of the Primary Health Care Advisory Group, Better Outcomes for People with Complex and Chronic Conditions, in that they: • Promote a culture of ongoing innovation and quality improvement within the health care system • Support the need for a continually improving primary health care system • Facilitate culture change across the healthcare system, including improving communication and breaking down barriers between health professionals • Acknowledge that the workforce and the community need to be engaged in the change process.
Scalability	The concept could easily be expanded within the PHN (eg. we could do more events subject to additional resourcing and funding). The concept could also be expanded to other PHNs as has already been adapted by others. In fact, both initiatives have been tried and proven to be highly successful and replicated by previous Medicare Locals, the NSW Agency for Clinical Innovation (RICH) and in Canada.
Target Population	The target population for the PITCH and CIS is the North Coast healthcare community – this includes all consumers, providers, clinicians and allied health professionals, administrators, volunteers, policy makers, educators and researchers. Events take place in different locations across the footprint to facilitate local healthcare communities coming together.
Coverage	Targeting whole of population in NCPHN region
Anticipated Outcomes	The PITCH and CIS are about facilitating and driving quality improvement within the healthcare system. Anticipated outcomes include: • Generation of ideas to improve the efficiency, effectiveness and co-ordination of locally based primary health care services. • Solutions that contribute to a continually improving health care system and lead to improved patient experience and outcomes • Increased clinician and community participation in shaping the design of solutions

	• Increased engagement of stakeholders • A culture of ongoing innovation and quality improvement • Innovations implemented that deliver change in health care delivery.
How will these outcomes be measured	• Number of events (PITCH and CIS) • Number of attendees (PITCH and CIS events) • Number of innovative ideas received • Number of innovative ideas implemented • Feedback on events
Collaboration	The programs embrace the entire social and health services sectors. The activities will be planned and implemented in consultation with relevant key stakeholders, including Local Health Districts (LHDs) and the North Coast Allied Health Association. NCPHN will utilise existing clinician and community advisory structures such as its Clinical Councils and joint NCPHN and LHD Community Reference Groups.
Timeline	Events will be conducted each quarter at various locations across the NCPHN footprint.
Indigenous Specific	While these programs are not indigenous specific, they do extend to Aboriginal health professionals, services and community.