Commissioning Framework

June 2019

phn
MURRUMBIDGEE

An Australian Government Initiative

TABLE OF CONTENTS

Murrumbidgee Primary Health Network acknowledges the Traditional Custodians of the land in the Murrumbidgee region. We pay respect to past and present Elders of this land: the Wiradjuri, Yorta Yorta, Baraba Baraba, Wemba Wemba and Nari Nari peoples.

Murrumbidgee Primary Health Network gratefully acknowledges the financial and other support from the Australian Government Department of Health. The Primary Health Networks Programme is an Australian Government Initiative.

1. MURRUMBIDGEE PRIMARY HEALTH NETWORK

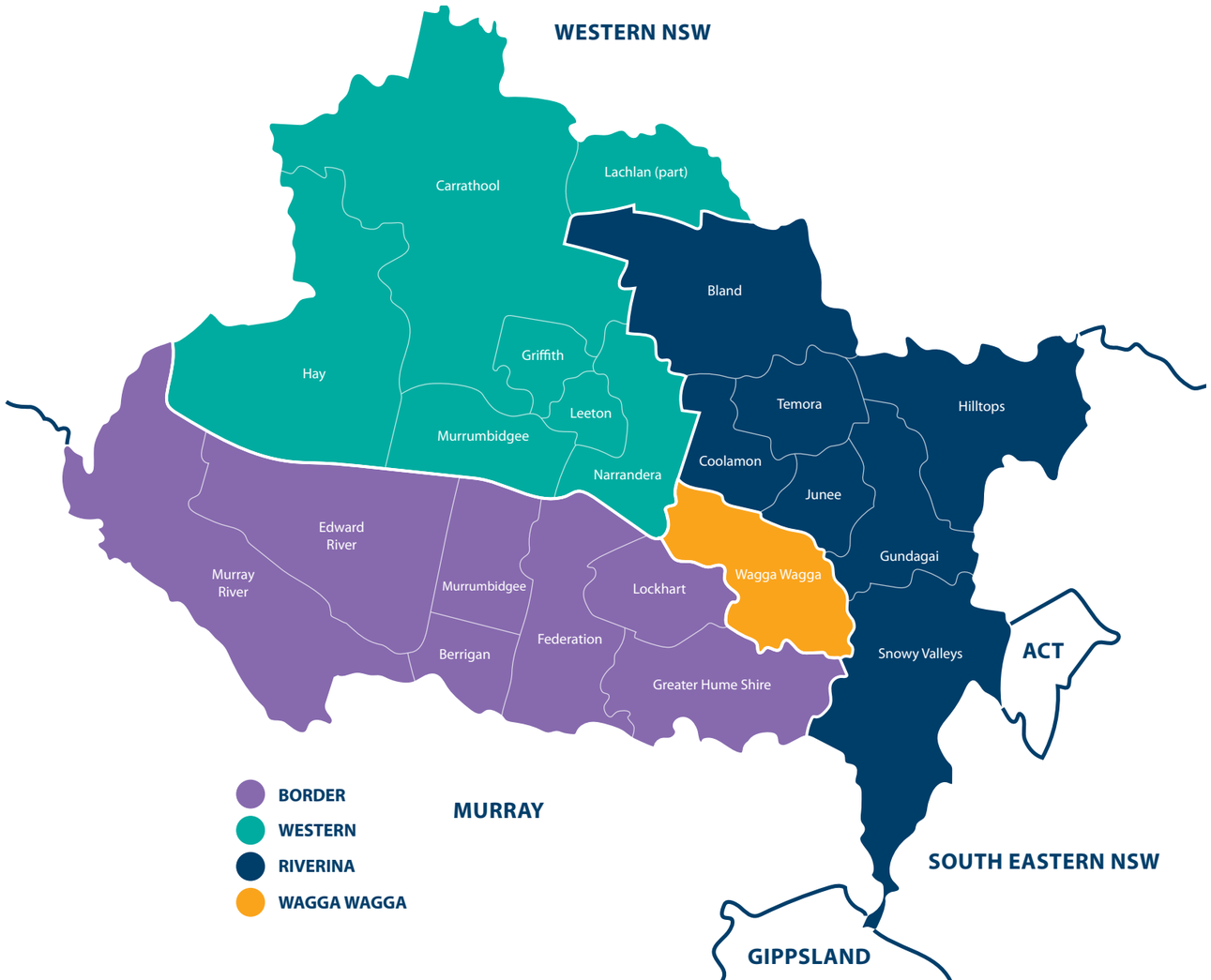
Our vision is for Well People, Resilient Communities across the Murrumbidgee. This means working with health service providers, consumers and communities to improve coordination of care, ensuring consumers receive the right care in the right place at the right time.

MPHN covers a land area of 136,898 square kilometres and services a population of 242,962. The area is covered by 21 Local Government Areas across four sectors: Riverina, Wagga Wagga, Border and Western.

Primary Health Networks were established in 2015, and have nationally been set seven key priorities for targeted work: mental health; Aboriginal and Torres Strait Islander health; population health; health workforce; digital health; aged care, and; alcohol and other drugs.

Through our work, we are committed to addressing social disadvantage in our communities, and identifying health needs across the lifespan of people in the region. This is achieved by commissioning activities that prioritise and address the needs of those most vulnerable.

In partnership with health professionals, government agencies, community based organisations and community members, we are working to better understand the health and social needs of our population.



OUR STRATEGIC GOALS

As an organisation, our work is guided by five strategic goals. The approach to commissioning set out in this document has been designed with these overarching goals in mind.

GOAL 1: STRENGTHEN OUR UNDERSTANDING OF HEALTH NEEDS AND INEQUITY

STRATEGIES:

Improve our understanding of the health of people in our communities and factors that impact their health

Facilitate data sharing to improve understanding of health needs

Empower communities to participate in health needs assessment and increase awareness of community health needs

GOAL 2: ENHANCE ENGAGEMENT WITH CONSUMERS, PARTNERS AND STAKEHOLDERS

STRATEGIES:

Explore and identify opportunities to facilitate strong engagement with consumers, partners and stakeholders

Increase regular communication to consumers, partners and stakeholders

Continually provide opportunities for consumers to be involved and participate in decision making

GOAL 3: OPTIMISE COMMISSIONING PRACTICES

STRATEGIES:

Partner with existing and future funders to co fund initiatives and improve outcomes

Identify new investment opportunities to support innovation and emerging possibilities

Increase the capacity of current and future commissioned providers to respond to need

Adopt a robust approach to assess and promote cost effectiveness of initiatives

GOAL 4: INCREASE HEALTH SYSTEM AND SERVICE INTEGRATION

STRATEGIES:

Identify and trial new models of care to enhance service integration

Collaborate to develop locally informed solutions to promote integration across the primary and acute health settings

Develop local pathways to support clinical decision making and referral pathways

GOAL 5: ENHANCE CAPACITY AND CAPABILITY OF PRIMARY HEALTH CARE

STRATEGIES:

Support initiatives in General Practice focussed on quality

Increase use of digital health technologies to support patient care

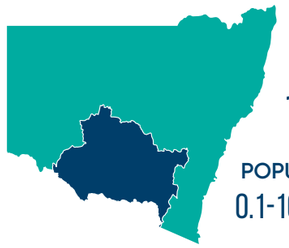
Partner to develop and support a sustainable local health workforce

OUR REGION

POPULATION
242,962

TOWNS 514

TOTAL BIRTHS 2,411 2.4%



LAND AREA
136,898 KM²

POPULATION DENSITY
0.1-16.3 PERSONS/KM²

AGE, GENDER & LIFE EXPECTANCY

	♀	♂
POPULATION	119,829 49%	121,782 51%
LIFE EXPECTANCY	83.0 YEARS	78.5 YEARS

OVER 65 YEARS OF AGE
46,958 19.3%

ABORIGINAL & TORRES STRAIT ISLANDER

TOTAL	OVER 55 YEARS	MEDIAN AGE AT DEATH
12,350 5.1%	1,583 9.1%	66 YEARS

HEALTH & LIFESTYLE

OBESE
38.9 PER 100 PEOPLE

36.9 PER 100 PEOPLE

SMOKERS
23.6 PER 100 PEOPLE

15.1 PER 100 PEOPLE

INACTIVE
73.6%

PSYCHOLOGICAL DISTRESS
11.1 PER 100 PEOPLE

CONSUME ALCOHOL AT RISKY LEVELS
19.9 PER 100 PEOPLE

AREA PROFILE

31 PUBLIC HOSPITALS

3 ABORIGINAL MEDICAL SERVICES

87 GENERAL PRACTICES

247 GENERAL PRACTITIONERS

147 PRACTICE NURSES

2. INTRODUCTION

This framework sets out Murrumbidgee Primary Health Network's (MPHN) approach to commissioning. It is intended to guide consistent and best practice commissioning across the organisation, and to provide a way of communicating our approach to our communities and stakeholders.

The framework will continue to be refined and updated as our commissioning experience grows, and as our approach continues to develop.

The objectives of this framework are to:

1. provide guidance to our stakeholders on our approach to commissioning primary health services and programs across the region;
2. guide commissioning activities in a way that targets investment towards areas of greatest need in our communities;
3. guide the implementation of consistent and good practice commissioning activities that drive high quality outcomes; and
4. ensure all services and programs that we commission are consistent with our values and guiding principles.

3. WHAT IS COMMISSIONING?

Commissioning is more than procurement. It is an iterative and continual cycle involving the development and implementation of services based on planning, procurement, monitoring and evaluation. While commissioning is used in a range of sectors, it has been a particular feature of the health system.

The success of commissioning as an approach to identifying and meeting service needs has been recognised, particularly in the UK, and a number of success factors have been identified.[1] However, there is no 'blueprint' for successful commissioning that can be transferred from one setting to another; the approach needs to be tailored to the local context.

PRIMARY HEALTH NETWORKS

In the Australian healthcare context, PHNs have been established as commissioning agencies to plan and contract health care services that are appropriate and relevant to the needs of their communities. While commissioning is relatively new in the Australian context, there is a body of Australian literature which suggests that primary health commissioners have real capacity to drive systemic improvements to primary health care.[2]

As a new model, it is expected that the capabilities of PHNs in commissioning will continue to grow.[3] This is particularly so given the shifting focus toward commissioning more integrated care, which delivers outcomes that matter to the community. Key elements of commissioning in this context are outcomes and co-design.

OUTCOMES BASED COMMISSIONING

Traditionally, purchasing has focused on contracting specified services, with providers delivering defined inputs and activities. Outcomes based commissioning, on the other hand, means moving towards a greater focus on achieving outcomes for the population, rather than simply providing services. Outcomes based commissioning is a way of paying for services by rewarding the delivery of outcomes that are important to the people using them.

CO-DESIGN AND PARTICIPATION

Co-design aims to incorporate the knowledge of stakeholders in the design and development of commissioning activities. This empowers stakeholders and communities to participate in the design of their own care.

In health and human services, this approach is being increasingly adopted in recognition of the knowledge and insight that service users can offer. Co-design is a way of harnessing that insight, and applying it to identify the outcomes that matter to communities, and develop effective ways of delivering them.

1 The King's Fund, University of Melbourne and PricewaterhouseCoopers (PwC) 2016. Challenges and lessons for good practice – Review of the history and development of health service commissioning. Available at: https://www.health.gov.au/internet/main/publishing.nsf/Content/PHNCommissioningResources; Smith J, Curry N, Mays N, Dixon J. Where next for commissioning in the England NHS? The Nuffield Trust and the King's Fund 2010

2 Horvath, J. (2014). Review of Medicare Locals – Report to the Minister for Health and Minister for Sport. Available at: http://www.health.gov.au/internet/main/Publishing.nsf/Content/review-medicarelocals-final-report

3 Australian Government Department of Health (2014). Primary Health Networks Grant Programme Guidelines, December 2014 – Version 1.1.

4. OUR GUIDING PRINCIPLES

The following principles have been developed to guide our approach to commissioning. They are consistent with and support our overarching organisational vision, values and strategic goals, and should be considered together with our commitment to supporting vulnerable populations

Through our commissioning approach, we will:

1. **Listen to our communities, including those who haven't traditionally been given a voice in shaping health services, and engage meaningfully to understand their needs and co-design solutions with communities**
2. **See the whole person and put them at the centre of their care, recognising the impacts of a person's circumstances on their health needs at all stages of life**
3. **Improve access to health care across our region by removing barriers and increasing the equity of services, including in relation to their location, cost and appropriateness**
4. **Develop new solutions and initiatives that are based on evidence, flexible to local settings, and deliver value for money**
5. **Collaborate with existing and new partners to deliver a seamless experience for consumers and carers across the health journey, without duplicating effort**
6. **Invest in our providers to build local capabilities and support local workforce development**
7. **Partner with our providers to understand whether initiatives are making a difference, to share successes, and to learn from and continuously improve what we do together**

MPHN will incorporate the following social disadvantage principles, we will:

1. **Work to address inequality through raising awareness and increase access through developing the capacity and capability of our staff and our providers.**
2. **Identify, quantify and geographically locate areas of social disadvantage. The HNA process includes a systematic analysis of data and information on demographic, health and service usage across the region and more importantly consultation with community members and health care professionals. This approach will inform planning to address identified needs in particular for those with social disadvantage.**
3. **Ensure through our HNA and HNA Live process we identify vulnerable populations such as Aboriginal and Torres Strait Islanders, Culturally and Linguistically Diverse, Lesbian, Gay, Bisexual, Transgender and/or Intersex, homeless people, mentally unwell people, elderly isolated people, veterans and those exiting the justice system. We will work to ensure that the above people are not marginalised and excluded from accessing services.**
4. **Identify local and emerging issues associated with social disadvantage and address specific local needs through co-design.**
5. **Commit to 'wrap-around' care and support ensuring that a person is at the centre of their care and through commissioning will encourage innovative programs across the health and social sectors.**
6. **Foster cooperative relationships to ensure that all children across the region have access to the building-blocks of a self-defining and self- fulfilling life.**
7. **Collaborate with other organisations to establish broad inter-sectoral support to advocate for public policies that address current socio-environmental issues that have impact upon the health of individuals and communities in our region.**
8. **Create viable and sustainable programs that address the needs and aspirations of our communities.**

More information is detailed in our Vulnerable Populations Framework.[4]

4 Available on the Publications page of our website: https://mphn.org.au/publications

THE QUADRUPLE AIM

Throughout all stages of our commissioning framework, we consider the four elements of the Quadruple Aim.[5] These measures – across population health, consumer experience, value for money and provider experience – provide guidance in making decisions and prioritising solutions that deliver outcomes for all those involved in the health system.

Population health

- Improving health outcomes
- Ensuring equitable access to services
- Delivering quality health and care
- Reducing the burden of disease

Consumer experience

- Reducing waiting times for services
- Improving access to services
- Meeting consumer and carer needs
- Focusing on the consumer experience of the service

Value for money

- Improving the cost effectiveness of service delivery
- Reducing potentially preventable hospitalisations
- Rationalising the ratio of primary and acute care funding
- Increasing efficiency in service delivery

Provider experience

- Increasing clinician and staff satisfaction
- Promoting teamwork and integrated care
- Promoting leadership in best practice
- Promoting a culture of continuous quality improvement

5 Berwick DM, Nolan TW, Whittington J. (Insitute for Healthcare Improvement) 2008. The Triple Aim: care, health, and cost. Health Affairs 27:3, 759-769; Bodenheimer T, Sinsky C 2014. From Triple to Quadruple Aim: Care of the Patient Requires Care of the Provider. Annals of Family Medicine 12:6, 573-576.

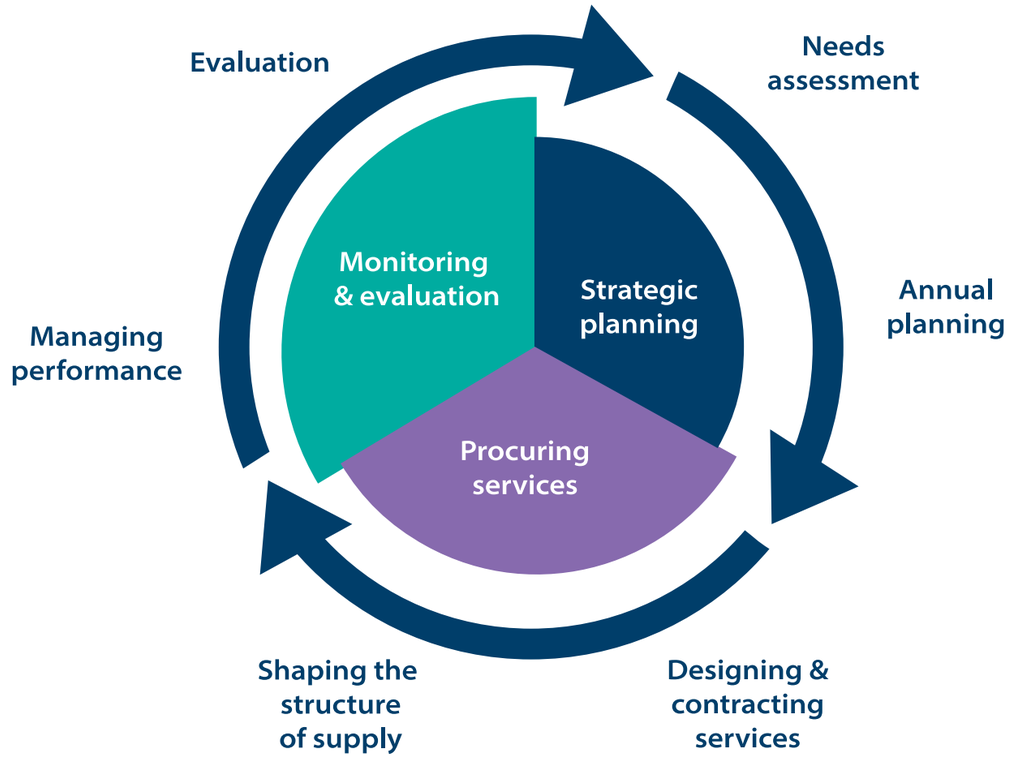
5. OUR COMMISSIONING FRAMEWORK

MPHN has adopted the commissioning model developed by the Australian Government Department of Health. This model is a continual and iterative cycle.

The first phase of the cycle is strategic planning, including assessing the health needs of the community and prioritising them through annual Activity Workplans. In the second phase, procuring services, initiatives are designed and contracted, working closely with providers. The final phase, monitoring and evaluation, encompasses performance management and evaluation to inform continuous improvement and learning.

At all points throughout the cycle, stakeholder input through consultation, engagement and co-design is crucial.

While this model provides a useful way to communicate our approach to commissioning, in reality it is more complex. Multiple initiatives are often happening at the same time, requiring careful planning, coordination and prioritisation across all of our activities.



STRATEGIC PLANNING

HEALTH NEEDS ASSESSMENT

The Health Needs Assessment is how we identfy the health needs of the Murrumbidgee population, including the make-up of the community, the main issues faced by the community, and what people in the community think about their health needs and access to services. A formal approach is taken to the Health Needs Assessment each year, but it is reviewed and updated continuously to identify emerging needs.

We take into account what demographic, population health and service data tells us, and what is considered important by each community. With this information, we can begin working to address the identified health needs that are important to the community's health.

Although it is focused on health, the assessment also considers the range of social factors and circumstances that can affect a person's health and ability to engage with health care.

We use a supply and demand approach to conduct the assessment, and to find gaps in services. Our approach incorporates clinical considerations, cost effectiveness, and community and consumer perspecitves. This allows us to identify, prioritise, and plan strategies and programs to address gaps.

Some key features of our approach include:

- **HNA Live**, which allows community members and health care professionals in the region to tell us their concerns about emerging health issues. HNA Live takes the pulse on health issues and services in the Murrumbidgee region, and provides a way for people give us real time feedback about what they need.
- We have developed a **Data Prioritisation Tool** allowing us to take a robust and evidence-based approach to the prioritisation of health and social needs. The tool enables us to identify the areas of greatest need in our community on a population group and local government area basis.
- **Validation of results** with communities and key stakeholders following identification of needs and priorities. This lets us confirm our findings, and refine them if needed, before they are finalised.

ANNUAL PLANNING

Once we have identified needs, we work to identifty priorities and options for commissioned services. We collaborate with consumers, communities, clinicians and other stakeholders through co-design to prioritise needs, and develop solutions.

Annual planning is driven by our needs assessment, in addition to other factors including cost, capacity and timing. The key output of the strategic planning phase is Activity Workplans, which set out our agreed priorities and intiatives to address them.

We're committed to collaborating with existing and new partners to deliver a seamless experience for consumers and carers across the health journey, without duplicating efforts. This means working closely with partners throughout the planning phase to identify how we can better work together and coordinate our responses.

PROCURING SERVICES

DESIGNING AND CONTRACTING SERVICES

Designing and contracting services is the step in the cycle that has traditionally been referred to as 'procurement.' Our procurement approach will be designed to meet the particular needs and objectives of each initiative.

Activities in this step may include:

- working with our stakeholders (including communities, people with lived experience, providers and clinical experts) to co-design strategies or initiatives to address needs;
- partnering with communities where they can be empowered to implement initiatives themselves, with our support;
- assessing whether providers have the capacity and capability to deliver identified strategies, including considering whether any support is needed to help them develop or grow;
- talking to existing and potential new providers, to test the appropriateness and feasibility of service models and seek their feedback; and
- determining the most appropriate contracting model.

In some cases, it might be necessary to discontinue or decommission services. A decision to reduce or replace a service will be based on evidence, and will consider the changing needs and priorities of the community.

SHAPING THE STRUCTURE OF SUPPLY

A key part of our role is to support the growth of a thriving and sustainable market of local providers in the Murrumbidgee. We are committed to working with local providers to shape and support the development of our local market.

Market shaping and development activities might include:

- investing in developing the capacity and capability of providers;
- encouraging providers to come together and collaborate, including providing opportunities to form a consortium where appropriate;
- working with providers to identify service gaps and how they can be filled by the market;
- supporting innovation in service delivery, and creating opportunities for providers to think differently and bring forward new ideas; and
- supporting continuing professional development, including through training events, scholarships and accreditation support.

"We are committed to working with local providers to shape and support the development of our local market."

MONITORING AND EVALUATION

Monitoring and evaluation is key to knowing whether our initiatives are making a difference.

We are committed to taking a partnership approach to monitoring and evaluation. This means sharing success stories, learning from our experience, and working with providers to identify where improvements are needed.

MANAGING PERFORMANCE

Performance monitoring allows us to track the delivery of services, and to measure progress towards the delivery of outcomes.

Reporting arrangements are agreed with providers through the procurement process. In all instances, we seek to balance the need for information without imposing burdensome reporting requirements on providers. We work closely with peak bodies to facilitate the coordination and streamlining of reporting requirements, as well as working with other funders, where feasible,

We work with providers to ensure the delivery high quality services and the development and implementation of robust clinical governance arrangements. Auditing and reporting processes seek to ensure that services are effective, efficient, accessible, appropriate, equitable and safe and are provided by competent and skilled staff.

We also report back to providers on performance as part of our continuous quality improvement approach, providing direction and support to achieve better quality, cost effectiveness and outcomes for consumers and providers.

EVALUATION

Importantly, evaluating our initiatives allows us to refine and improve the way we do things. We are committed to doing this in partnership with providers so we can continuously improve how we work together. This means not taking a punitive approach, and instead bring providers along on the journey with consumer outcomes front of mind.

In some instances, we may decide to commission an independent evaluation of an initiative, so we can better understand whether it is working. Some examples of evaluations undertaken include:

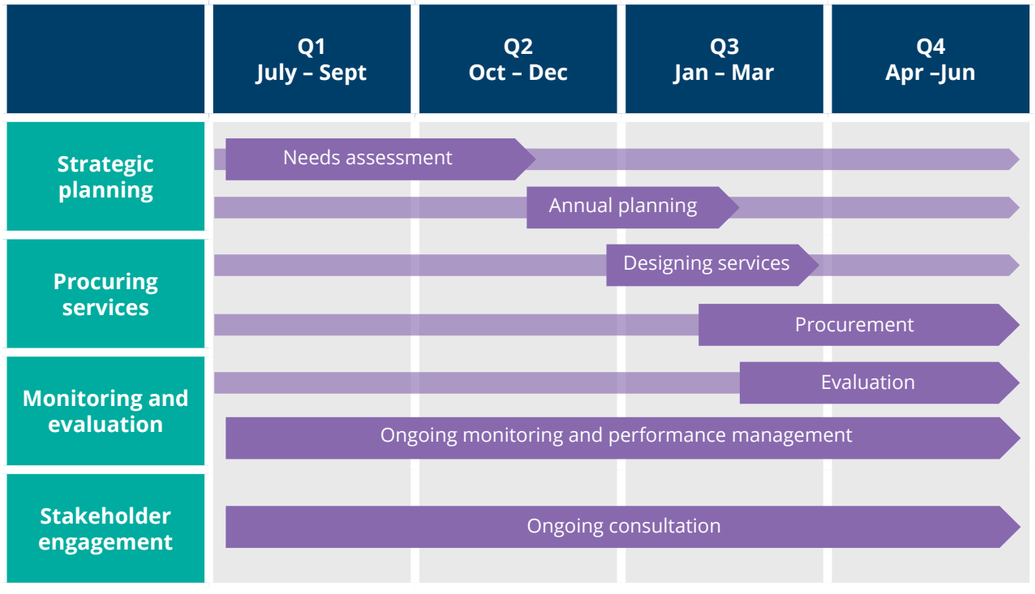
- working with Charles Sturt University to evaluate the locally designed Murrumbidgee Lifestyle and Weight Management Program, which showed positive trends for both wellness and weight loss;
- an evaluation undertaken by the University of Notre Dame of our Vitality Passport program, which aims at reducing or halting the progression of frailty in older people, highlighted positive outcomes for consumers through satisfaction surveys;
- commissioning an evaluation of a pilot cancer screening program, implemented in collaboration with Cancer Institute NSW, which highlighted improvements in the knowledge and skills of general practitioners and practice staff;
- commissioning the Australian National University to evaluate a general practice capability improvement program, and the evaluation showcased the improvement of practice data and collaboration between teams in participating practices; and
- commissioning Charles Sturt University to undertake two evaluations, one of the team care for severe mental illness program and one for low intensity mental health service NewAccess in the headspace program, with results helping to inform the commissioning of mental health services into the future.

TIMING FOR CO-DESIGN

Co-design plays a role at every step of the commissioning cycle, throughout the strategic planning, procurement and evaluation phases. At each step, there are opportunities to involve the community and key stakeholders in improving our commissioning activities.

TIMEFRAMES

The diagram below provides a high level overview of the timing of our commissioning activities. It has been designed to align with submission of required deliverables to the Department of Health, and shows the changing focus of our commissioning activities each quarter. In reality, however, all of our commissioning activities are ongoing throughout the year.



It is essential that the framework is flexible and agile, so we can respond to emerging needs and varied funding cycles.

6. CO-DESIGNING WITH OUR COMMUNITIES

We are committed to listening to our communities, and using co-design at all steps of commissioning. Co-design is an approach to understanding the needs of the community, setting a vision, prioritising the use of resources and designing services.

The Australian Healthcare and Hospitals Association has developed four principles for co-design.[6] Our approach and activities are undertaken with these principles in mind.

1. **Equality:** Everyone has skills, abilities and experiences to contribute and no one group is more or less important than another.
2. **Diversity:** The process is inclusive and diverse to represent all stakeholders. This may require special efforts and alternative approaches to ensure seldom heard groups and those who haven't traditionally been given a voice are included.
3. **Accessibility:** Attention to accessibility is required to ensure everyone has equal opportunity to participate fully in ways that suit them best.
4. **Reciprocity:** Reciprocity means people get something back for putting something in. In order to achieve this, it is important to foster equal relationships between participants and the organisation.

Co-design is an iterative process, and a variety of methods may be used to achieve different goals. Co-design activities can include workshops, interviews, storytelling and surveys, among other methods. The approach should be tailored to suit the particular goals of the consultation and the needs of stakeholders.

"Co-design is an iterative process, and a variety of methods may be used to achieve different goals."

6 AHHA 2017. Experience Based Co-design Toolkit. Available at: https://ahha.asn.au/experience-based-co-design-toolkit

Some of our approaches to co-design have included:

- visiting towns right across the region to have casual 'conversations on the couch' with community members and health professionals, to take the pulse on primary healthcare services and hear what is and isn't working well;
- co-hosting in partnership with the Local Health District and participating in forums for our 32 Local Health Advisory Committees across the Murrumbidgee, to hear diverse local perspectives on health-related issues;
- using our HNA Live platform to seek real time feedback from community members and health care professionals in the region; and
- conducting small focus groups and targeted interviews to seek the views of providers and consumers to inform new models of care.

Some of our co-designed initiatives include:

- developing the Murrumbidgee Lifestyle and Weight Management Program through a co-design process with a local allied health provider, general practices and MPHN, as well as seeking input from consumers;
- consulting with general practices through a series of co-design workshops to develop the General Practice Capability Building and Quality Improvement Initiative;
- consulting with service providers and community members through workshops to develop our approach to delivering a community-based support to people with severe mental illness;
- developing capability in general practice to co-design local approaches to support at-home palliative care options; and
- working with service providers and communities to review and improve on how we currently deliver mental health and allied health services.

STAKEHOLDERS

Co-design can involve a range of stakeholders, from medical experts to service users. All are equal partners in sharing their knowledge, experiences and expertise.

As shown below, there are three key overlapping stakeholder groups who should be considered in co-design in the health sector.

- **Communities and consumers**, including those with lived experience, consumers, carers and the broader local community.
- **Providers**, including existing and potential providers, general practices and clinicians, Aboriginal health services, other medical experts and providers in related sectors.
- **Commissioners**, including partners such as Local Health Districts, local councils, and other government agencies with a role in service delivery.

7. ROLES AND RESPONSIBILITIES

Everyone across our organisation, from the Board to all staff, plays a key role in the successful implementation of our approach to commissioning. The table below highlights key responsibilities at each level of MPHN, including our advisory councils and committee.

Position	Role and responsibilites
MPHN Board	• Oversee governance and strategic directions.
Sub-committees to the Board	• Providing recommendations to the Board on the development of strategies to improve healthcare for consumers in the region.
Community Advisory Committee	• Providing a community perspective to the Board to ensure decisions, investments and innovations are person centred, locally relevant and aligned to local care experiences. • Identifying and advising on issues relevant to local consumers and communities.
Clinical Councils	• Providing advice to the Board on integrated systems and models, emerging issues and priorities for communities, emerging issues and priorities for general practices and clinicians, recruitment and retention, and education and research.
MPHN Executive	• Developing commissioning strategies and approaches. • Guiding needs analysis and the design of solutions. • Establishing partnerships and collaborative arrangements. • Identifying market development needs and designing strategies.
MPHN employees	• Conducting Heatlh Needs Assessment. • Designing and conducting stakeholder engagement and co-design activities. • Assisting with development of Activity Workplans. • Conducting market analysis and soundings. • Designing and managing procurement processes. • Monitoring provider performance.

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