Commissioning Framework

2022-2027

phn
DARLING DOWNS AND WEST MORETON
An Australian Government Initiative

Local Integrated Primary Health Care

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Our purpose

Our PHN works in partnership with local community organisations, healthcare professionals, regional hospital and health services, state and federal governments and the public, private and not-for-profit sectors to support and influence a high-quality health system.

Our key objectives are to:

- Increase the efficiency and effectiveness of medical services, particularly for those most vulnerable in community.
- Improve coordination of care ensuring patients receive the right care in the right place at the right time.

We do this by:

- System coordination and integration: reducing fragmentation and enhancing coordinated, integrated care by working collaboratively across services and sectors.
- Regional commissioning: bridging the jurisdictional, hospital-community-primary and cross-sector divides through collaborative commissioning with a focus on the primary healthcare system.
- Primary care system stewardship and management: progressively improving system quality, access and equity.
- Primary healthcare education, training and workforce development: building the general practice/primary care workforce of the future.
- Health system transformation and reform: progressing agreed system reform objectives.

Our goals

Our behavioural charter

This behavioural charter represents a shared commitment from all staff to improving the future ways of working at Darling Downs and West Moreton PHN. The purpose of this charter is to outline the behaviours and actions expected by leaders and all staff across the PHN.

 **Collaboration**	 **Innovation**	 **Integrity**
• I will actively look for opportunities to collaborate across both offices, teams and functions. • I will embrace diverse views and opportunities to work in new ways. • I will contribute to creating an enjoyable environment for others.	• I will balance the use of data with the human elements of effective service delivery. • I will be flexible and adaptable to new ways of working. • I will support others to cope with ambiguity and uncertainty by being positive.	• I will self-reflect regularly on my contribution to being a high performing PHN team member. • I will be authentic and honest with care in my interactions with others. • I will demonstrate vulnerability and admit when I do not have all the answers.
 **Transparency**	 **Accountability**	 **Respect**
• I will acknowledge mistakes as a learning experience for myself and others. • I will be clear and concise with ownership when explaining decisions to my peers and each other. • I will openly share information and knowledge.	• I will be open and willing to accept feedback and view it as a way to reflect and learn. • I will behave in an 'above the line' manner, demonstrating ownership, accountability, and responsibility for my actions and our collective responsibilities.	• I will acknowledge the concerns of my peers and support them through change. • I will respond to others in a timely manner. • I will be polite and considerate of others and welcoming of all views.

Our approach

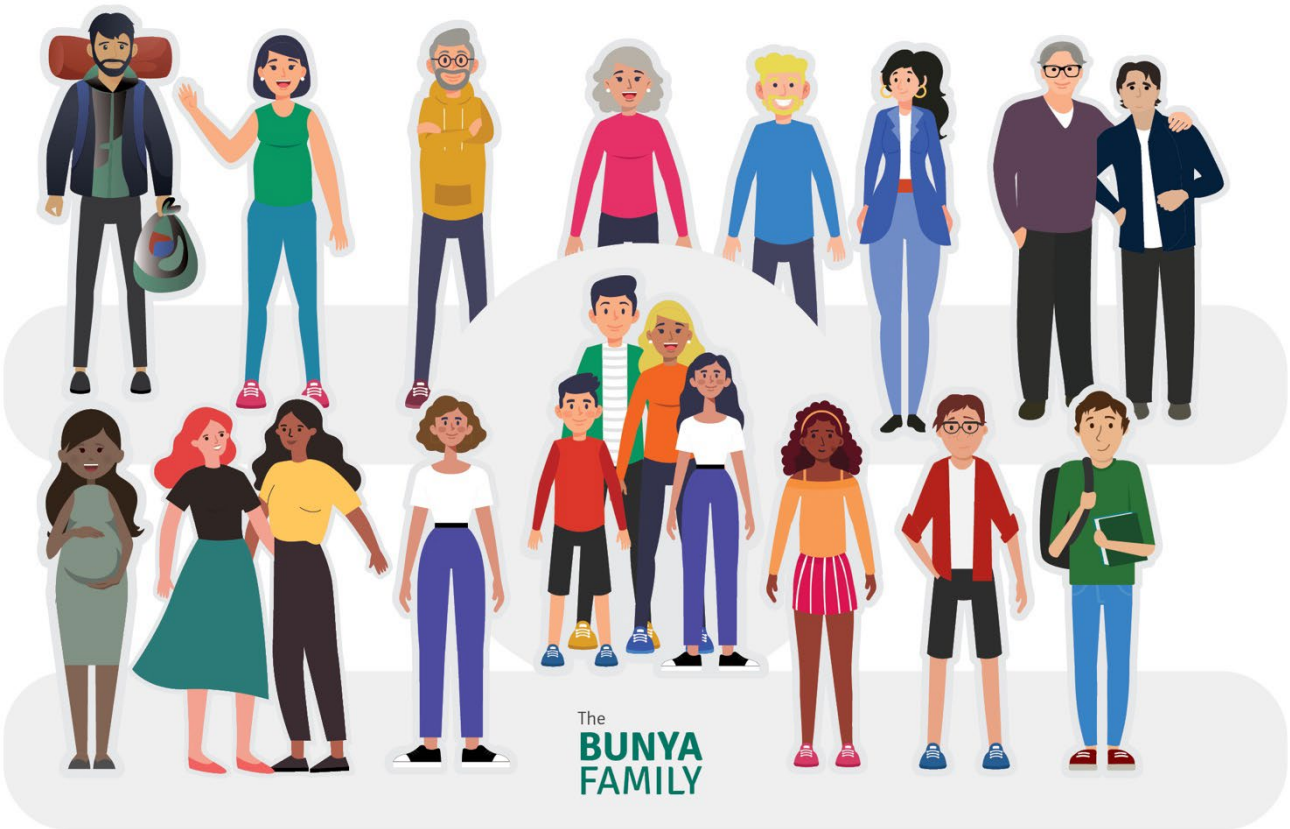
At our PHN – 'commissioning is everyone's business'. Taking a broader, strategic approach involves much more than procurement. It's about how, as commissioners, we reshape the health system to improve population health through focusing on four core aims of healthcare, which include:

- Enhancing the patient's experience of care.
- Improving provider satisfaction.
- Ensuring sustainable cost.
- Improving quality and population outcomes.

Person-centred care and the Bunya family

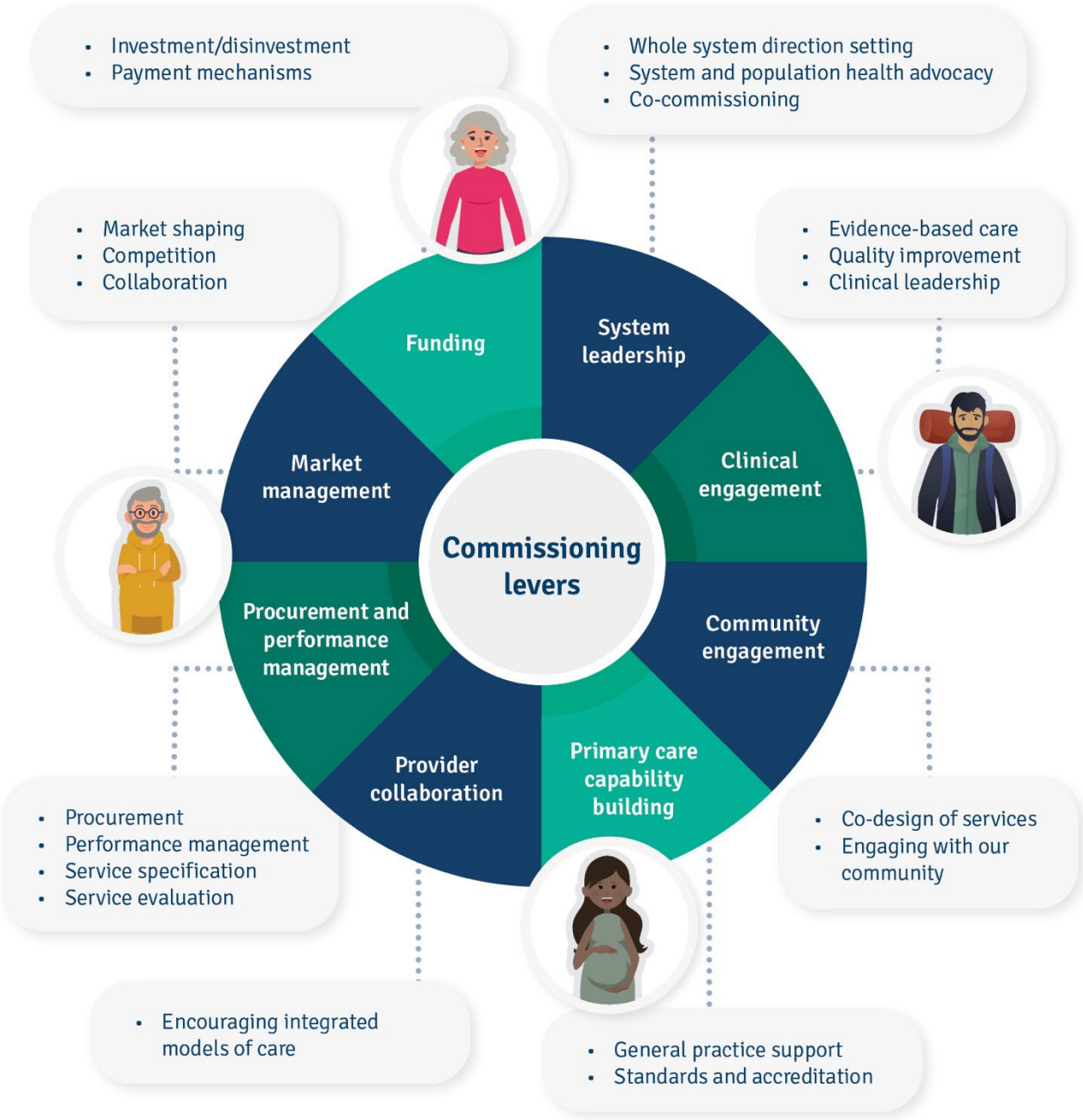
Fundamentally, what we do is person-centred. Our person-centred approach ensures people who access health system supports and services, including carers and close supporters, are the experts of their personal health situation and need to be at the centre of our planning and commissioning decision-making. Our person-centred approach delivers care and support in partnership with the community to achieve the best outcomes for the community. This approach attempts to address the traditional power dynamic of system versus beneficiary to one where commissioners, providers and communities are equal system partners and we will look to patient experience measures to test its effectiveness.

Our PHN has implemented the 'Bunya Family´ as a scenario planning tool. The Bunya Family comprises a number of avatars of family members who represent 'real life' scenarios within the South Burnett. The use of the Bunya Family is based on the Welsh model of the 'Jones Family' which used the family to steer conversations away from territoriality and toward improving patient care.



Our commissioning levers

To deliver on the core aims of healthcare and move our local health system towards sustainable models of care, we need to employ a range of change levers that builds system leadership, enhances primary care capability, and engages community, clinicians and consumers.



Rebbeck, 2017, *Rebbeck Consulting* <Rebbeck.com>

Our commitment to place-based and person-centred commissioning

Place-based commissioning is a core mechanism to leverage community and clinical engagement. This nuanced approach recognises, embraces and responds to the unique social and environmental factors at a local and regional level and recognises that 'one size does not fit all'. Our place-based approach targets the specific circumstances of a community or group, engages local people and service providers as active participants in the identification of issues and challenges, and shared decision making around the development and implementation of solutions. Importantly, our approach involves all partners collaborating to improve health and wellbeing, rather than a focus on separate organisations and structures (i.e., 'siloes') and looks to longer term, sustainable solutions.

Where we are	Where we are evolving
Health and care focus	Population focus
Organisational focus	System focus
Contract enforcer	System enabler
Transactions	Relationships
Decision-maker	Convener for collective decisions
High bureaucracy, low-trust	Low bureaucracy, high trust
Monitoring organisational performance	Monitoring system wide performance and providing improvement support
Follow national guidelines	Develop local solutions

Hambleton, D, 2021, *South Tyneside Clinical Commissioning Group* <England.nhs.uk/author/dr-david-hambleton/>

Transformational change

Core to our evolution is co-production, which includes the co-design and co-evaluation of service delivery. Co-design brings together the right stakeholders in a coordinated program to improve services. Importantly, this requires a willingness amongst partners to listen to ideas and feedback that may be different to what was expected.

A critical success factor will be the establishment of robust relationships across traditional sector boundaries in collaborative and integrative ways, with partners who contribute to health and social care (such as hospital and health services, local government, housing, employment, community services, and family and social supports) to tailor and implement solutions that respond uniquely to a place.

Our commitment to place-based and person-centred approaches is long-term – transformational change cannot happen overnight. With longer term commitment to investing resources and working in partnership with communities we believe we have the right foundations for transformational and sustainable change.

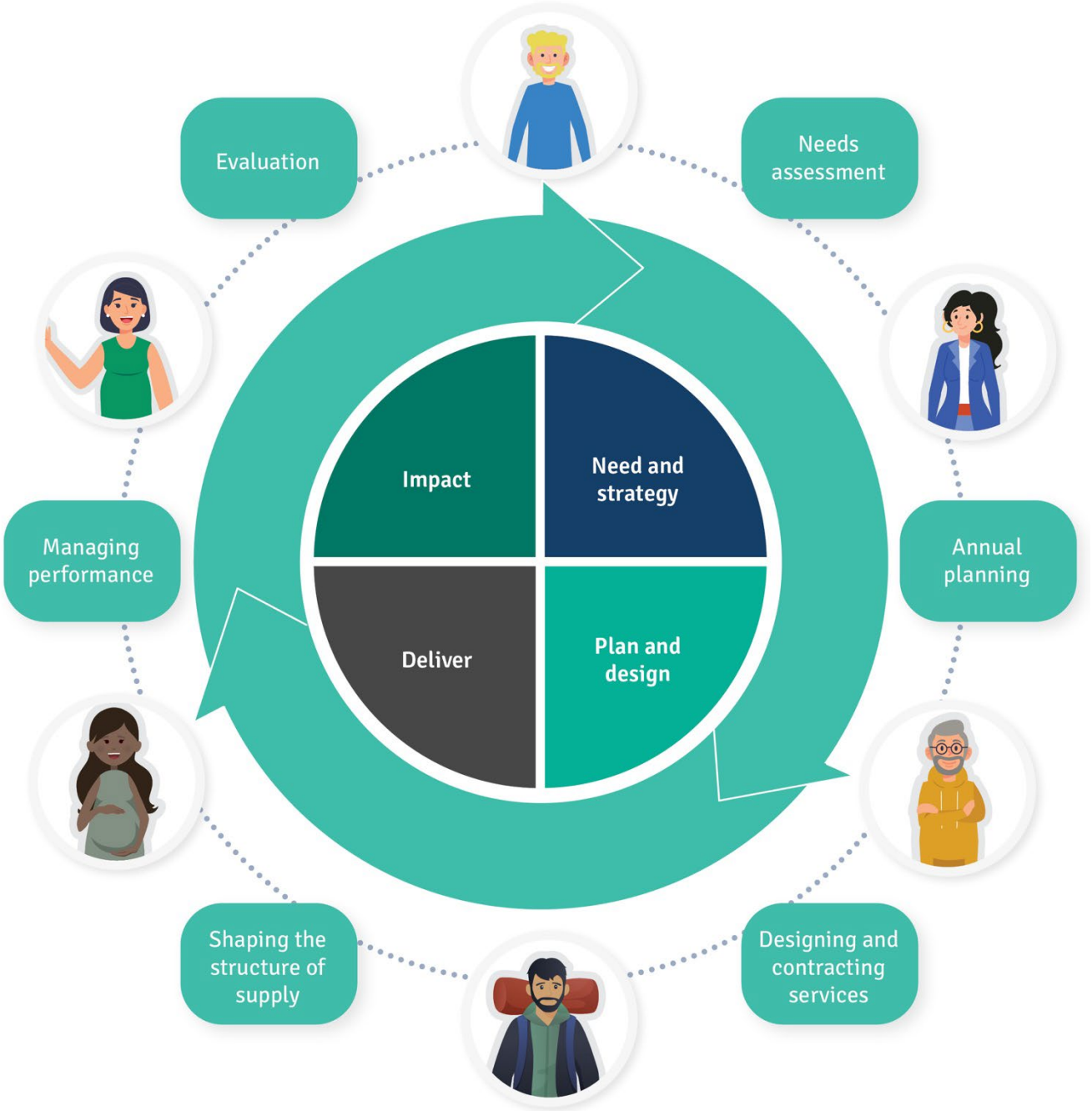
Our theory of change

If we focus on:	By (dynamic capability):	This will result in:	And eventually lead to:	Contributing to the broad goal of:
Listening to the consumer's voice and placing them at the centre of what we do.	Aligning the delivery of primary health services with consumer and community needs.	Person centred, place-based models of care.	Improved consumer experience of care (reduced waiting times; improved access; and patient and family needs met).	Better primary health outcomes.
Developing effective relationships with communities.				
Building strong, connected cross agency partnerships.				
Building the internal capability of our PHN.	Improving our internal and external capacity to adapt and learn.	Stronger service delivery partnerships between the PHN and primary and secondary care providers.	Sustainable cost (cost reduction in service delivery; reduced avoidable or unnecessary hospital admissions; ratio of funding for primary acute care; return on innovation costs invested).	
Increasing the capability and engagement of our primary care service providers'.			Improved provider satisfaction (sustainability and meaning of work; increased clinician and staff satisfaction; teamwork; leadership and quality improvement culture).	
Creating genuine partnerships with our key stakeholders.				
Using data and evidence to inform our commissioning decisions.	Designing and investing in initiatives that address the needs of those most at risk.	Commissioned services focused on outcomes.	Quality population health, including improved health outcomes, equality of access and reduced burden of disease.	
Prioritising vulnerable groups and service gaps.				

Our PHN commissioning function

'Commissioning' as a PHN function, is best explained as a continual and iterative cycle involving the development and implementation of services based on needs assessment, planning, co-design, procurement, monitoring and evaluation. Commissioning encompasses this full range of activities; it is not simply the procurement of services.

It is depicted in the following graphic:

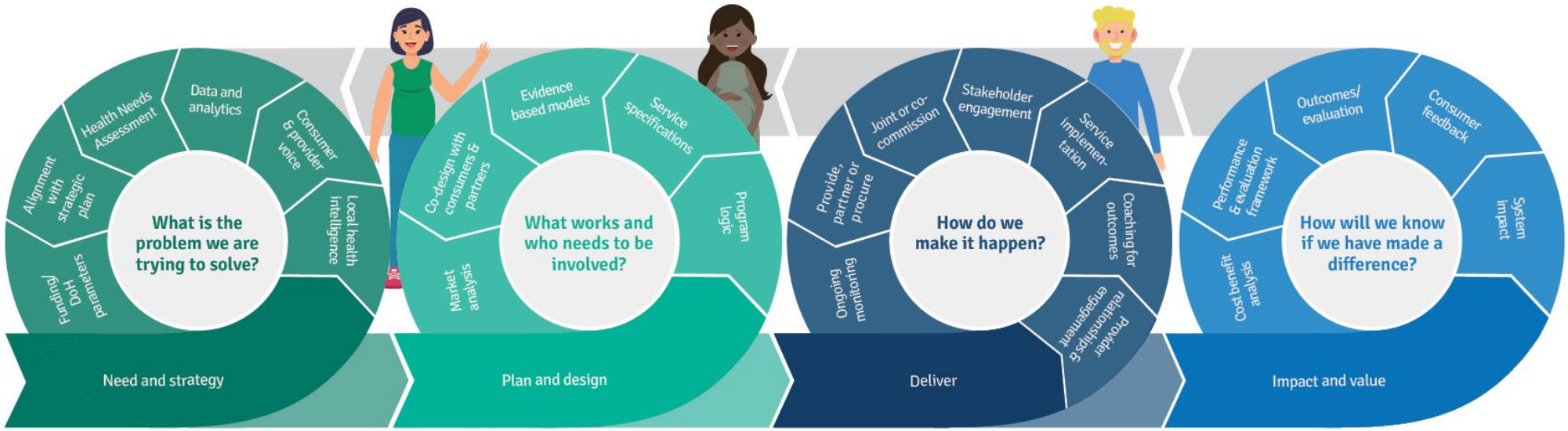


Our commissioning principles

Our PHN commissioning principles outline the values our organisation considers when undertaking a commissioning process, underpinned by the importance of working collaboratively with our stakeholders.

1. Understand the needs of the community by engaging and consulting with consumers, carers and close supporters, providers, peak bodies, community organisations and other funders alongside other relevant sources of evidence and data.
2. Enable innovation by focusing on the outcomes and impact we aim to achieve rather than restrict through prescriptive input and activity-based models.
3. Apply a place-based approach which targets investment in areas of disadvantage where the need is greatest to enhance parity of access and impact across the region.
4. Lead a person-centred culture by actively engaging people with lived experience in co-designing, co-producing and co-evaluating approaches and solutions throughout the commissioning cycle.
5. Invest in building the capacity of community and service providers to take them on the journey with us.
6. Ensure procurement and contracting processes are fair, transparent, and accountable by implementing the most appropriate approaches aligned with our Health Needs Assessment (HNA) and market analysis, rigorous risk assessment and due diligence processes, and investing in ongoing systems development to increase efficiency and enhance auditability.
7. Build partnerships and elevate integration and collaborative approaches across sector boundaries that respond to the complexity of our region, consider the whole system and help us to achieve transformational change through a culture of trust and reciprocity.
8. Drive efficiency and value for money through effective prioritisation of investment, procurement, and proactive monitoring, support, and evaluation.
9. Prioritise accessibility and responsiveness throughout engagement, planning, design, capacity building, procurement, monitoring, and evaluation with a focus on vulnerable groups and populations.

Our Localised Commissioning Cycle



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Our PHN's Localised Commissioning Cycle incorporates the principles of a Results Based Accountability Framework to focus our PHN on making a difference. We do this by asking ourselves four fundamental questions throughout the commissioning process:

1. What is the problem we are trying to solve? (Need and strategy)

Understanding need, or defining the problem, is fundamental to the commissioning cycle. To target investment towards priority places and to a ensure balanced regional approach, a deep understanding of the region's health 'problems' or 'need' is critical. To do this, we can draw on a range of information and resources.

Local health intelligence

Using a place-based Community Development Engagement Framework our PHN provides community members and stakeholders (consumers, health service providers, local government, and others) with a framework for identifying and responding to local needs and improving social, emotional, and physical wellbeing in a particular location. The information gathered through this PHN lead process provides nuanced, local insights into health need and service gaps, which informs the commissioning cycle.

Consumer and provider voice

We engage with community members, healthcare providers and their workforce, hospital, and health services, councils, and universities to 'ground-truth' to data. Members of our Board as well as our Clinical Council and Community Advisory Committees provide expert advice, and we have established networks throughout our region who are able to tell it like it is.

Data and analytics

We have access to a comprehensive range of data and dataset, both regional and national. Our in-house Data and Analytics team support us in finding meaning and insights from data to inform health needs and what we need to focus on to improve health outcomes for our communities.

Health Needs Assessment

Our PHN Health Needs Assessment (HNA) identifies the health priorities and opportunities for our region. It is an integrative, ongoing process that brings together information from the community, local health services and workforce, to provide a clear picture of health need and gaps in service delivery. It helps us understand how we can help improve the health of people living in our region. This includes programs and services that can provide people with the right care, in the right place, at the right time.

Our 10 community-driven priorities for the region have been identified through a rigorous process of research and community-facing consultation, focused around the seven national PHN priority areas: Aboriginal and Torres Strait Islander health, aged care, alcohol and other drugs, digital health, health workforce, mental health, and population health.

Alignment with Strategic Plan

Ensuring alignment with our PHN's Strategic Plan seeks to optimise our finite resource and identify other levers to drive the greatest impact on population health in our region. Rather than spread our resources thinly, limiting our ability to drive transformational change or have any sustainable impact, resources are aligned to priority populations, places, and systems, concentrating our efforts so that the greatest impact can be achieved.

Departmental obligations

Our PHN is funded by the Commonwealth Government. Funding is aligned with the seven national priority areas and comes with parameters, reporting obligations and expected outcomes. During the problem definition phase, our obligations to our funder must be properly considered.

2. What works and who needs to be involved? (Plan and design)

Once the problem has been properly defined and determined to fit within our remit, the next step involves researching the evidence around what works to solve the problem and involving those stakeholders critical to the solution in the process.

Program logic (Expected outcomes and evaluation)

Our PHN uses program logic models to describe the activities it is commissioning and implementing. The development of a program logic and evaluation early in the commissioning cycle is critical to defining the desired outcome of a service or intervention and framing an evaluation framework to determine whether the service or intervention had an impact. The logic models illustrate how we anticipate program design will bring about change. Cascading down from our Strategic Plan and lifting locally identified need, the development of program logic models, during planning, ensures that we make explicit how we expect our activities to be implemented, what immediate and short-term outcomes we anticipate and how these contribute to medium-and long-term health system and population health outcomes.

Service specifications

The development of outcome-based specifications describes the purpose or function that a service or intervention must fulfill to meet the desired consumer outcomes. Ideally the program logic informs the service specifications.

Specifications for solutions to the problems we are trying to solve are written in terms of the desired outcomes along with the capabilities needed to achieve them rather than as requirements regarding how things should be done. This affords the necessary flexibility to make design trade-offs so that overall outcomes are advanced rather than only the outputs of processes.

Ensure specifications describe outcomes rather than prescription for how each might be achieved.

- Describe the system in terms of capabilities and the performance needed to achieve and sustain desired outcomes. These should be measurable, realistic, sustainable, and verifiable.
- Specify standards where applicable to indicate performance and compliance requirements.
- Specify interactions and dependencies that the system will operate within. The system must be more than the sum of its parts and it must participate in the larger context in the same way.
- Identify uncertainties related to the outcomes and capabilities.

Ensure that all specifications have a value-based healthcare evaluation criteria that validates outcomes and measures success meaningful to the stakeholders.

Co-design with consumers and partners

Where possible and appropriate our PHN conducts planning and design in a collaborative and inclusive way through co-design. This might involve other hospital and health services, and potential providers. Most importantly, consumers and close supporters (people with lived experience) representative of priority populations and places are involved in the development of the high-level service specifications and solutions.

Co-design can occur around what will be commissioned based on intended results, through to detailed specifications of services or activities to be delivered. This would usually be followed by a procurement process, creating further opportunity for providers to innovate and build on the model in response to their unique contexts.

Evidence based and data driven

Co-design entails a process where our PHN design team researches the evidence and literature to identify interventions and models of care that have worked elsewhere, appraising the findings for quality and applicability to the local environment and then testing those potential models with consumers and key stakeholders.

Market analysis

'Market analysis' is a critical step in the development of service specifications and involves considering the range of activities and services available within our region, and the kinds of relationships that exist between them.

This helps us to understand market maturity, emerging trends, service saturation and gaps. In turn, this means we can further prioritise investment, reduce duplication, enhance efficiency, and identify opportunities for engagement to inform our procurement approach in the context of place.

Our PHN is committed to building capacity of the sector to help shape the services landscape in response to assessed need.

Our market analysis seeks to consider:

- **Location and reach** – physical location and geographic reach (urban, regional, rural, remote) operating hours, modes of delivery such as locally based services, fly-in / out, outreach services and use of digital technology.
- **Utilisation** – including measures of occasion and duration of service with considerations of under-utilisation, duplication and efficiency.
- **Accessibility and responsiveness** – geographic, financial and cultural accessibility, eligibility criteria, access to specialists and secondary referred services and wait times.
- **Quality** – relevant accreditations, consumer experience and satisfaction with the quality of provision, provider experience.

3. How do we make it happen? (Deliver)

Once we have defined the problem, researched the evidence, developed the program logic, identified and involved the key stakeholders, we need to consider and execute the plan through a decision to provide, partner or procure the service.

Provide, partner or procure?

Provide: In some instances, it may be appropriate for our PHN to lead an initiative. Such situations include where there is specific direction from the Department of Health (such as the provision of General Practice Support), or where the PHN is best-placed to deliver either through skills or relationships.

Partner: Our PHN partners with another organisation to jointly lead an initiative or work towards a mutually beneficial and shared goal.

Procure: When the design phase results in a new specification we may 'approach the market', which means providing an opportunity for providers to assess alignment with their own strategies and priorities, and to respond. As a commissioner, it opens opportunities to 'test the market', to reveal new or different providers and solutions. Although this approach is often specification based, the level of specificity would depend on context. Wherever possible we would enable flexibility to respond innovatively to the outcomes being sought.

The approach is determined by several factors relevant to the specific context including:

- Strength of the market and how developed the provider community is.
- Size of procurement opportunity and the level of resource available.
- Urgency and time available to stand up the initiative.
- The service specifications.
- The uniqueness or targeted specifications that require additional considerations.
- The likely level of competition and contestability amongst the provider community.

Our PHN may use a range of tools to go to market, including an expression of interest or request for tender process. Each selection process has regard for value for money, probity, confidentiality, ethics and fair dealing, accountability, and transparency.

The selection process broadly involves:

- Evaluation of eligible applications against the agreed evaluation criteria.

- Due diligence checks.
- Moderation of independent scoring.
- Other robust evaluation, including interviewing shortlisted applicants.
- Formal notifications.
- Negotiation.
- Opportunities for feedback.
- Contracting.

Provider relationships, engagement, and monitoring

A strong relationship between commissioners and providers is the 'cornerstone' of outcomes-based commissioning. Relationship management with providers is just as, if not more, important than the systems for effective contract management. Collaborate on solving minor issues and escalating major issues.

Joint or co-commission

Joint commissioning, or co-commissioning, means joining with other commissioners to fund or resource approaches, services, or outcomes where there is alignment in strategic priorities. The benefits of joint commissioning and pooling resources offers the potential to increase scale, depth or reach of approaches; and enhance an integrated systems-approach to addressing local health and service needs. This may mean, as local commissioners, we collaborate with our Hospital and Health Service partners in the planning and implementation of service models that deliver better care outcomes.

Stakeholder engagement – consumer/provider consultation

We appreciate the determinants of health: Social, economic, physical, and individual are many and complex and means we cannot improve population health outcomes on our own. Therefore, we need partnerships across traditional sectoral boundaries to explore and commission solutions together. Our strategic planning therefore also seeks to identify opportunities to enhance our approach by working collaboratively towards shared goals with our partners.

Darling Downs and West Moreton PHN Stakeholder Engagement Framework

Our system partners with whom we transform the system

Who:
Darling Downs Health, West Moreton Health, peak bodies, Aboriginal Medical Services, Local Government, universities, workforce training agencies and other relevant health and human services organisations.

Why we engage:
We cannot transform the health system on our own. We engage with our partners to understand our joint needs and priorities, and where there is alignment of care. Together we integrate and coordinate care across providers.

Represented by:
- Board
- Clinical Council
- Senior Leadership Team (SLT).

Engagement approach:
- Involve
- Collaborate
- Empower.

Engagement lead:
- General Manager - Service Delivery
- CEO to CEO.

Engagement through:
Health Needs Assessment, committee meetings, joint projects, place-based working groups, joint Board engagement opportunities, senior departmental and ministerial engagements and Board / SLT representation at strategic networking events.

Our primary care service delivery partners

Who:
General practice, Aboriginal Medical Services, Allied Health, Pharmacists and Specialists.

Why we engage:
Our primary care partners are the cornerstone providers of healthcare in our communities. We engage with them to understand their needs and then work with them to be best positioned to provide high quality, sustainable care to their patients.

Represented by:
- General Practitioners
- GPLOs
- Clinical Council
- Practice staff
- AHP and Pharmacy.

Engagement approach:
- Inform
- Consult
- Involve.

Engagement lead:
- Primary care and PCLOs
- GPLOs
- Digital Health Team.

Engagement through:
- Face to face and digital
- Clinical Council meetings
- Education and training
- Events
- Chapter and hub meetings
- Health Pathways.

Our commissioned services who provide specialised service delivery

Who:
Commissioned services in mental health, alcohol and other drugs, chronic diseases and maternity care.

Why we engage:
To effectively deliver on our health priorities, we need strong relationships with our commissioned service providers. Our service providers share on the ground intelligence; we need them to deliver on our KPIs - quality deliver impacts all our reputations.

Represented by:
- Commissioned organisations
- Service user representatives.

Engagement approach:
- Inform
- Consult
- Involve.

Engagement lead:
- Commissioned services.

Engagement through:
- Regular meetings, co-design and other workshops
- Place-based activities.

Our internal stakeholders

Who:
Darling Downs West Moreton PHN staff and Board.

Why we engage:
This is where the magic happens. Our staff contribute to, and understand our health priorities, and are ambassadors for the PHN. They are integral to delivering on our strategic plan. Our Board understands and sets the direction for our business; they advocate for our priorities within their sphere of influence.

Represented by:
- Staff (Teams)
- Board (Chair).

Engagement approach:
- Inform
- Consult
- Involve
- Collaborate
- Empower

Engagement lead:
- CEO
- General Manager - Strategy and Operations.

Engagement through:
- Face to face
- All staff and team meetings
- Regular emails
- Performance planning.

Our governance partners

Who:
Department of Health, Queensland Health, Federal Minister for Health, State Minister for Health.

Why we engage:
These stakeholders impact our ability to deliver on our strategic plan. We must maintain their confidence in our ability to perform. Strong relationships with these stakeholders enable us to advocate on behalf of our communities and our primary care partners to improve and reform healthcare delivery in our region.

Represented by:
- Department Secretary
- PHN Branch
- Director General (DG)
- Clinical Excellence Division
- Electorate staff.

Engagement approach:
- Inform.

Engagement lead:
- CEO
- General Manager - Service Delivery
- Board (Chair).

Engagement through:
- Briefings
- Reporting
- Meetings.

Our communities across the region

Who:
Vulnerable and priority populations, such as Aboriginal and Torres Strait Islander people, older persons, refugees, people facing challenging socio-economic situations, school and education representatives.

Why we engage:
The health priorities of our communities are central to the way we do business. We engage so we know these priorities and we work with our community partners to provide innovate and sustainable solutions. Place-based engagement enables us to tailor our healthcare responses to the specific needs of each community.

Represented by:
- Community Advisory Council
- Local Government
- Co-design and working groups
- NGOs
- Elected representatives.

A place-based engagement approach:
- Involve
- Consult
- Inform.

Engagement lead:
- Stakeholder Engagement and Communication
- CEO to CEO.

Engagement through:
- CAC meetings
- Consultative committees
- Working groups
- Mainstream and social media platforms.

Inform
To provide the community, particularly those who are most vulnerable with information to make informed choices about their care and improve health literacy.

Consult
To obtain feedback on options and decisions around primary care activities and initiative.

Involve
To work directly with stakeholders to ensure that both community and health professional concerns are understood.

Collaborate
To partner with key stakeholders around decision making including co-designing services.

Empower
To place the final decision making in the hands of the stakeholder.

Understanding person centred care – the Bunya family

To focus our partners on delivering on person centred care, Darling Downs West Moreton PHN has developed the Bunya family. The Bunya family model was introduced as a scenario planning tool. The "Bunya Family" comprises a number of avatars of family members who represent "real life" scenarios. The use of the Bunya Family is based on the Welsh model of the "Jones Family". The NHS in Wales used the Jones Family to steer conversations away from territoriality and toward improving patient care. To date, the Bunya family has been used to improve health outcomes in youth mental health; aged care; cancer screening and health pathways; and chronic disease planning across the region.

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Service implementation

This step involves the finalisation and execution of the necessary funding agreement and schedule between our PHN and provider/s required to get the service operating. Alternatively, dependent on the decision whether to partner/procure or provide, it may involve the formalisation partnership arrangements to implement a particular model of care or terms of reference to bring together key stakeholders around a particular issue.

Coaching for outcomes

Outputs are designed around the amount of activity being provided, whereas outcomes focus on the person receiving the service. Designing, delivering, and monitoring with a focus on achieving the desired outcomes drives value within the health system. It is contingent upon our PHN staff to work alongside our providers and/or partners to encourage a focus on outcomes.

A focus on outcomes can contribute value by improving:

- Health outcomes that matter to patients and the community.
- Experiences of receiving care.
- Experiences of providing care.
- Effectiveness and efficiency of care.

Using coaching as an approach to support provider development, which involves our PHN staff actively listening, challenging beliefs, and allowing providers to come up with their own solutions to be accountable and learn from mistakes.

4. How will we know if we have made a difference? (Impact and value)

System impact

Impact measurement. Theory of change. Impact evaluation. Program logic. Outcomes measurement. These terms are bandied around a lot in our PHN and can be confusing or even intimidating for people. Impact measurement is about how our PHN demonstrates the results of our work. It's about going beyond tracking what we and our providers 'do' (monitoring) and articulates the 'so what'?

At its heart, system impact measurement helps our PHN understand whether we are driving positive change. This is vitally important for all PHNs. By better understanding our impact, we can make decisions about which activities to start, enhance, stop, or change.

In practice, impact measurement summarises the data collected throughout the lifecycle of an 'initiative' or 'service implementation' to evidence our theory of change (program logic). It takes the logic of our theory of change and looks for ways to evaluate, back up and (ideally) prove change is happening on the ground and positively influencing our regional health system.

Consumer feedback (PREMs and our PHN's TALK ABOUT strategy)

TALK ABOUT is a way for our PHN to ask consumers about their experience with healthcare in their community. We routinely ask consumers to TALK ABOUT what they think is working well and what they think could be done better. This process is augmented by a series of consumer led 'kitchen table' discussions around core topic areas.

The valuable qualitative data gleaned through the TALK ABOUT strategy augments our HNA with a rich source of valuable information that provides local insights into our region's health needs and service delivery gaps.

Patient-Reported Experience Measures (PREMs) gather information on patients' views of their experience while they are receiving care or accessing a service. They indicate the quality of patient care received by a patient, although they do not measure it directly.

Outcomes/evaluation

Continuous monitoring of service delivery forms a basis for our PHN's ongoing evaluation of programs and activities. This is a critical step to understand whether the activity or program has been implemented as intended and is likely to contribute to the desired performance, quality, and outcomes that we seek over the longer term. Programs and activities can be prioritised for evaluation by considering the size, strategic significance, and degree of risk of the activity or program.

Once the purpose of the evaluation has been identified by stakeholders, the key questions and available resources can provide context for the evaluation design. The evaluation design, data collection tools and methods will focus the evaluation. A range of designs and methods can be applied to evaluation. Collecting, analysing and integrating both qualitative and qualitative data can enable evaluators to draw on the strengths of each approach and to explore diverse perspectives.

Evaluation results provide us with information about whether the program or activity should be continued, expanded, modified, or discontinued. This information assists us to further understand regional needs, and how our programs and activities meet those needs. Monitoring and evaluation results can be used to engage and work within the healthcare system, with our providers and with local communities to continuously improve the services that we provide to ultimately improve health and wellbeing for everyone.

Evaluation results will be noted in several ways from our regular reporting to government, to direct community and provider feedback (e.g. TALK ABOUT results), review of our Health Needs Assessment and input into our commissioning processes.

Performance and evaluation framework

Our PHN collates key performance indicators which are uniform across all PHNs as part of the National PHN Program Performance and Quality Framework and our localised PHN Performance and Outcomes Framework. This enables us to capture consistent, comparable, and measurable outputs and outcomes across the whole of our region. In addition, we develop other key performance indicators and metrics collaboratively, that are aligned to the approaches we take through joint commissioning, service provision, place-based and partnership opportunities.

We establish and monitor process indicators and short-term outcomes across domains including access, appropriateness, fidelity, efficiency, consumer health, and program performance (such as consumer experience of care, cost efficiency and sustainability), viewed through the overarching lens of quality and safety. This information is considered in layers; at the individual provider level, at the program level and at the organisational level (all commissioned activity), in context of 'place', sub regionally and whole-of-region.

Our PHN actively monitors key performance indicators and other metrics within programs and services against planned targets and accesses, analyses and responds to real time data throughout the commissioning cycle.

This helps us to understand:

- What is working well, so we can build on these aspects and share good practice.
- Where there are challenges emerging, so we can provide proactive support to identify solutions and work through barriers.
- Any gaps and opportunities, so that we can respond effectively.

Increasingly, in alignment with our place-based and partnership approaches, we provide aggregated data back to partners in relation to our collective place-based targets, which helps to focus our shared approaches and further our sense of mutual accountability.

Monitoring is underpinned by formal quarterly reporting processes that include qualitative and quantitative data capture, analysis, reporting and consultation with our commissioned providers and partners.

Cost/benefit analysis

A cost benefit analysis is a process by which our PHN can analyse decisions, systems or projects, or determine a value for intangibles. It involves identifying the benefits of an action as well as the associated costs and subtracting the costs from benefits. When completed, a cost benefit analysis can yield concrete results that can be used to develop reasonable conclusions around the feasibility and/or advisability of a situation, model of care or service implementation.

phn
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