Information for ITC commissioning bodies

This document outlines the roles and responsibilities of current and prospective 'commissioning bodies' in the context of transitioning the Integrated Team Care (ITC) program to the Aboriginal and Torres Strait Islander community controlled sector.

Currently, Primary Health Networks (PHNs) serve as the primary 'commissioning bodies', funded by the Department of Health, Disability and Ageing (the department) to deliver the ITC program and engage health services within their respective regions.

This transition does not seek to replicate the PHN model in full, recognising that the role of PHNs as commissioning bodies extends beyond the ITC program alone. Community controlled organisations also have expertise in a range of commissioning-like functions. However, future commissioning bodies will be expected to maintain key responsibilities outlined in this document while implementing locally tailored solutions.

This document should be read in conjunction with the ITC implementation guidelines and transition fact sheet and FAQs.

Scope

This document applies to potential grant recipients (i.e., PHNs and Aboriginal and Torres Strait Islander Community Controlled Organisations (ACCOs[1])) for the ITC program.

Role

The ITC commissioning body will:

Be eligible to apply for the ITC program grant opportunity offered by the department to secure funding for ITC program delivery.

Be responsible for delivering the ITC program for one or more PHN regions.

Demonstrate a transparent and accountable governance framework and have robust systems in place to identify, declare, and manage conflicts of interest, including independent oversight and documented procedures.

Support clear financial stewardship, equitable and compliant procurement processes and mechanisms for ongoing engagement with all potential ITC stakeholders.

[1] As defined in clause 44 of the National Agreement on Closing the Gap.

Quick navigation

Responsibilities of an ITC commissioning body

A list of dos and don’ts for potential commissioning bodies that administer the ITC program.

A commissioning body does:

- **Commission health services.** They assess local health needs and fund health services to fill identified gaps in chronic disease management.
- **Support community controlled services and mainstream health pathways.** They invest in the community-controlled and mainstream sectors to ensure equitable access for First Nations people in their region.
- **Ensure program visibility.** They ensure clients and providers have clear up-to-date access to service and referral information. They maintain a publicly accessible mechanism for complaints.
- **Facilitate formal agreements.** They support memoranda of understanding or partnership agreements to enable smooth client transfer and cross-sector operations.
- **Promote integration across the system.** They encourage collaboration between ACCOs, hospitals, specialists, GPs, community health and other providers to reduce fragmentation, support best practice, cultural safety and care integration at all client touchpoints.
- **Advocate for service providers.** They work with service providers to enable program delivery without administrative (i.e., MBS issues) or financial barriers (i.e., negotiating payment plans/bulkbilling with specialists and providers where price hiking occurs).
- **Monitor, evaluate and report.** They track client access patterns (referrals across private/mainstream and ACCHSs; suburb or LGA), satisfaction, and outcomes to identify barriers, refine pathways, inform improvements and reflect what matters to First Nations communities.

A commissioning body doesn’t:

- × **Provide direct clinical services.** They do not deliver care themselves – they fund and coordinate others to do so for the region/s.
  Note: We are exploring a model in which an organisation may both deliver services and subcontract other providers. While this **does not** align with the traditional definition of commissioning, we are keen to engage further with stakeholders in regions where this approach is appropriate and consider how potential conflicts of interest could be effectively managed, on a case-by-case basis. To avoid confusion, such a model would not function as a commissioning body and would instead operate under a different designation.
- × **Control individual providers.** They influence care through contracts and support but do not manage or direct the operations of independent healthcare providers.
- × **Fund all healthcare services.** They focus on specific areas, ensure service coverage and are not responsible for the entire health system.
- × **Make ITC policy.** While they may inform policy through data and consultation, commissioning bodies do not set national healthcare policy.

Why community controlled commissioning?

Increased investment in the community controlled sector aligns with Priority Reform 2 of the National Agreement on Closing the Gap, supports self-determination and contributes to improved health outcomes for First Nations people. Community controlled commissioning presents an opportunity to guide First Nations targeted health programs in a new and responsive way.

A regional approach enables service planning to be more closely aligned with the communities served, allowing for greater ties to local health needs, cultural contexts and service gaps. It supports the development of embedded partnerships, fosters community trust, enhances workforce retention through local employment, and promotes innovation tailored to distinct regions. Regional models can adapt more quickly to emerging issues, reduce administrative complexity and improve accountability through more direct engagement with service providers.

The enablers offered by First Nations led organisations, include, but are not limited to, the following:

- planning, funding, and management of services ensures these services meet the specific needs of community;
- decision making about services and supports will be made by Aboriginal and Torres Strait Islander Communities;
- nuanced understanding of health needs and aspirations which nurture and protect community wellbeing is a core tenet;
- profound connections to culture, language, and land;
- responsive to the needs of community but are also an expression of the community's aspirations and values; and
- understanding of the holistic concept of health, encompassing physical, social, emotional, spiritual, and cultural well-being of the whole community.

ITC across the commissioning cycle

The commissioning body leads, connects, and enables effective delivery of the ITC program across the commissioning cycle – ensuring that chronic disease management and care for Aboriginal and Torres Strait Islander people is locally relevant, culturally safe and accessible no matter where a person enters the health system.

The table below provides an example of the key roles and functions of commissioning bodies at each stage of the commissioning cycle, broken down into steps in delivering the ITC program. A stakeholder map which outlines how the commissioning body may interact with other organisations at these stages can be found at Appendix 1.

Commissioning phase	Function	Responsibilities
1. Strategic planning	Needs Assessment	– Analyse health and service patterns to assess chronic disease burden and design innovative approaches to realise community aspirations and instil Aboriginal and Torres Strait Islander worldviews, cultural practices and values within program design.

Commissioning phase	Function	Responsibilities
		– Map existing services, workforce and assets. – Engage stakeholders and First Nations communities to validate findings.
	Priority setting	– Identify target conditions based on need and community priorities. – Align with strategic health plans and equity goals.
	Stakeholder engagement	– Establish inclusive advisory structures (clinical, consumer, cultural). – Ensure Aboriginal and Torres Strait Islander leadership is embedded in planning.
2. Service design	Model of care	– Define evidence-informed, culturally anchored care models that are responsive, collaborative, equitable and emphasise self-determination. – Include care coordination and supplementary services, client advocacy and self-management support. – Tailor models to suit local context and ensure equity of access for the population.
	Performance framework	– Comply with the requirements of the grant agreement offered by the department and the ITC program implementation guidelines. – Establish outcomes and KPIs across clinical, access, equity, quality of life and experience domains. – Data solutions and integration.
	Collaborative design	– Co-design models with First Nations clients, communities and service providers. – Ensure culturally responsive design processes and governance. – Collaborate with stakeholders to integrate system-level data on private GP practices, prioritising areas with high First Nations populations to improve efficiency, cultural safety and equity of access.
3. Procurement and contracting	Improve access to culturally safe mainstream	– Identify cultural capability deficits across mainstream primary care, with a focus on safeguarding program entry and for clients

Commissioning phase	Function	Responsibilities
	primary health care	accessing care from private GPs and mainstream services. – Support innovation and integrated care partnerships. – Ensure client choice is maintained across all health services (GPs, ACCHSs, allied health, specialists) when approaching the health sector.
	Procurement	– Run transparent, outcomes-focused procurement processes. – Consider cultural safety, program linkages, Indigenous data sovereignty and sharing in planning. – Uphold high probity standards and obtain independent probity advice if required. – Apply robust methods to ensure conflicts of interest identified, recorded and managed.
	Contract management	– Adopt culturally anchored, relational approaches to commissioning health services and managing contracts. – Monitor performance, manage risks. – Treat underperformance with strengths-based approaches. – Enable responsive contract variations based on outcomes and feedback.
4. Monitoring, evaluation and assurance	Performance monitoring	– Implement regular performance monitoring against KPIs.[2] – Analyse provider and systems-level data. – Require structured reporting and narrative-based good news stories to align with ITC's core outcomes. – Consider and implement platforms (e.g., communication information systems) that efficiently capture information to optimise this process.
	Evaluation	– Commission independent evaluations where appropriate.

[2] The department may take the opportunity to review the existing ITC performance indicators. It is noted that information collected by a commissioning body may extend beyond the department's grant requirements.

Commissioning phase	Function	Responsibilities
		– Use participatory and culturally safe methodologies.
	Governance and assurance	– Ensure that all health workers delivering services to vulnerable clients hold the appropriate qualifications, registrations and have completed all mandatory safety checks. – Use ethical, transparent and accountable practices.
5. Review and improvement	Service improvement	– Use evidence and feedback to refine service design and delivery. – Facilitate shared learning forums with providers.
	Feedback and accountability	– Close feedback loops with communities, providers and partners. – Publish outcomes and learning where appropriate.
	Sustainable planning	– Support long-term viability through workforce, leveraging economies of scale, cross-sector partnerships and health system enablers.
	Communities of practice	– Establish and sustain peer support and professional development activities for ATSIHPOs, Care Coordinators and Outreach Workers across the region. – Enable knowledge sharing, innovation and continuous learning.
	Advocacy	– Amplify the voice of service providers with government funders, and regulators. – Address policy and regulatory barriers to effective program delivery which may include working with other primary care providers and networks.
6. Transition management	Decommissioning	– Decisions to be transparent, evidence-based and include input from all providers and affected communities.
	Change management	– Communication plans, transition supports and monitoring to avoid service disruption or erosion of trust.

Grant management

The commissioning body will enter into a legally binding grant agreement with the Commonwealth and must comply with its terms and conditions. Sample grant agreements are available on the Department of Finance's website. The Grant Opportunity Guidelines for the ITC program outline the objectives of the program and can be accessed by creating an account on Grant Connect.

Commissioning bodies can expect the following reporting obligations to the Commonwealth to apply across the program milestones.

Report type	Details
Needs assessment[3]	A regional assessment using quantitative and qualitative data to identify health gaps and demonstrate how the ITC program will address them. Ensures an evidence-based, targeted approach aligned with local needs and health infrastructure/pathways.
Activity work plan	A detailed plan and budget outlining objectives, key activities, timelines, and funding allocations for each financial year of the Activity Period. This should demonstrate alignment with grant outcomes and responsible use of funds.
Performance reports	Twelve-month performance reports detailing progress against objectives/KPIs, key achievements, challenges, and any variations to the Activity Work Plan, ensuring accountability and continuous improvement for each financial year.
Final report	A comprehensive summary of program outcomes at completion of the grant period, including any formal evaluations, key findings and lessons learnt for the grant activity across the entire grant period.
Commissioning services report	An up-to-date register of all stakeholders and service providers contracted under the ITC program. This list must be maintained and made available to the department upon request, ensuring transparency in procurement and partnership arrangements.

[3] An ideal needs assessment is a comprehensive document designed to inform program delivery for a minimum of 3 years. However, the department acknowledges that short-term program extensions may limit the ability to produce a full assessment, with current reporting focused on minor updates and confirmation that the existing needs assessment remains relevant. The transition will aim to provide the sector with sufficient time to undertake appropriate planning and preparation.

Report type	Details
Audited income and expenditure statements	Financial acquittal reports for the same period as the performance report and final report. This includes a certified financial statement detailing all income and expenditure related to the program, audited by an independent qualified auditor. Must include a signed financial declaration confirming funds were used in accordance with the grant agreement.

Supporting documents

A collection of resources has been developed by PHNs as experienced commissioning bodies.

Organisations may find them useful for self-assessing capacity and capability, or to support strategic planning efforts at https://www.health.gov.au/resources/collections/primary-health-networks-phn-collection-of-administrative-and-guidance-documents. These resources were developed with the broader PHN commissioning model in mind. Please note that ITC is a distinct standalone program with a specific focus on First Nations chronic disease outcomes only.

Appendix 1 - Commissioning stakeholder map for the ITC program

This example illustrates how various health stakeholders may collaborate to support the ITC program by interacting with the commissioning body. It is not exhaustive, and commissioning bodies may adapt their approaches to reflect local priorities, health infrastructure and existing provider relationships.

Function / Role	Commissioning body (e.g., PHNs, ACCOs)	PHN (outside of commissioning)	Mainstream health services and GPs	Local Hospital Networks (LHNs)	ACCHSs	Collaboration Notes
Needs assessment	Lead population needs assessments; identify gaps in chronic disease care and pathways.	Provide local insights and data to inform population health priorities.	Provide clinical insights and practice data.	Contribute hospital and specialist data.	Inform cultural, clinical, local and community health insights.	Establish joint needs assessment that includes community voices and clinical data.
Program planning	Develop commissioning priorities based on assessed needs.	Contribute contextual knowledge to align services.	Contribute to service design and care pathways.	Align hospital / outpatient services, specialist bulkbilling.	Co-design services that are culturally appropriate.	Regular service planning forums across stakeholders.
Program and service design	Facilitate co-design workshops and ensure consumer input.	Offer input to ensure services can leverage existing pathways and do not duplicate.	Participate in design of care pathways and shared care models.	Ensure alignment with discharge planning and outpatient care.	Lead cultural design of service models.	Embed culturally safe care and shared decision-making.
Procurement and contracting	Procure and fund services aligned with priorities. Ensure regional coverage and maintain client choice.	Share general information on the primary care landscape and partnership opportunities.	Eligible for funding or sub-contracting to deliver services. May also partner in service delivery.	Engage in service agreements or partnership arrangements where relevant.	Eligible for funding or sub-contracting to deliver services. May also partner in service delivery.	Transparent, accountable procurement practices; equitable access for ACCHSs
Implementation	Monitor roll-out; manage partnerships.	Help build awareness of the program and	Deliver culturally competent / safe	Deliver culturally competent / safe secondary / tertiary	Deliver culturally safe services to First Nations clients.	Use shared care protocols and

Appendix 1

Function / Role	Commissioning body (e.g., PHNs, ACCOs)	PHN (outside of commissioning)	Mainstream health services and GPs	Local Hospital Networks (LHNs)	ACCHSs	Collaboration Notes
		support communication with primary care practices.	services to First Nations clients.	care and rehabilitation.		communication tools.
Workforce development	Fund and coordinate training and workforce development (i.e. communities of practice, cultural competency).	Assist in identifying gaps in cultural competency and gaps within the local workforce.	Participate in CPD; engage in cultural awareness training.	Train and support culturally aware multidisciplinary teams.	Build capacity in the ACCHS workforce.	Develop shared training platforms and communication tools to build a culturally competent workforce.
Data and reporting	Set KPIs, support data systems and monitor outcomes.	Share and interpret regional data to inform program outcomes. Leverage existing data infrastructure.	Record and share data on care delivery and outcomes. Provide community outcomes and client feedback.	Provide hospital data (emergency department admissions, potentially preventable hospitalisations).	Record and share data on care delivery and outcomes. Provide community outcomes and client feedback.	Use shared data dashboards and real-time feedback loops.
Consumer engagement	Engage First Nations people in all aspects of commissioning.	Facilitate connections with community groups.	Include patient feedback on referral pathways and participation.	Seek patient/clinician feedback to improve chronic disease pathways.	Ensure cultural protocols for engagement.	Joint consumer advisory groups that reflect diversity.

Appendix 1

Function / Role	Commissioning body (e.g., PHNs, ACCOs)	PHN (outside of commissioning)	Mainstream health services and GPs	Local Hospital Networks (LHNs)	ACCHSs	Collaboration Notes
Decommissioning and change management	Identify underperforming services and apply strength-based treatments, lead structured change processes and transition plans.	Provide regional context and support transition planning. Leverage existing experience.	Provide clinical input on affected services; adapt workflows; communicate with patients and be involved in patient transfer.	N/A (Should be involved in communications to note new referral pathways or establish relationships)	Provide clinical input on affected services; adapt workflows; communicate with patients and be involved in patient transfer.	Work collaboratively to develop transition plans that ensure client service continuity with appropriate lead time for communications.