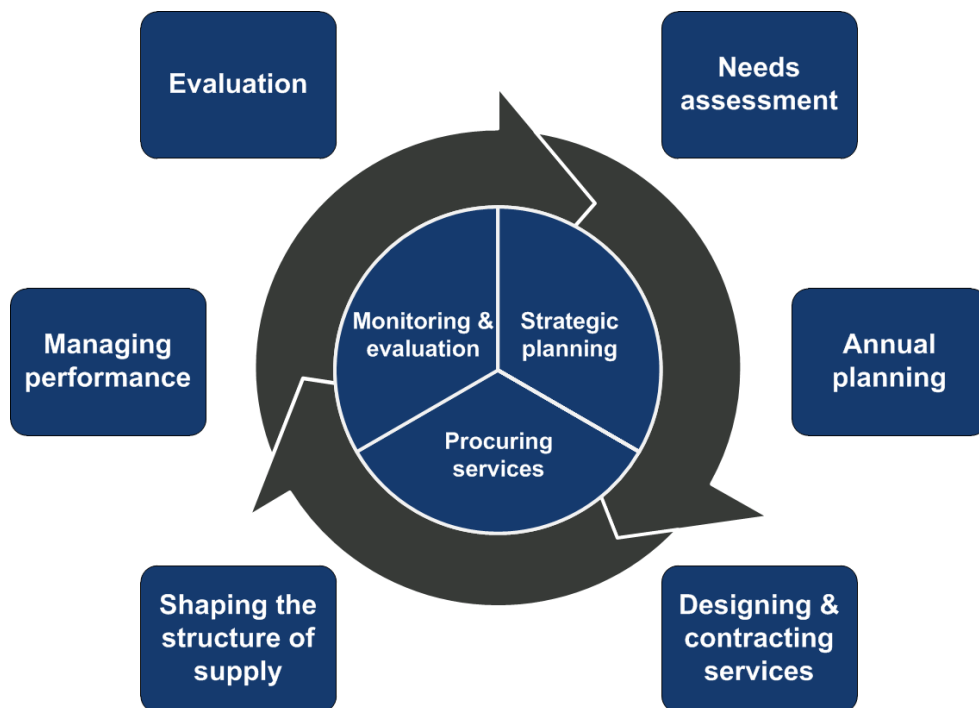# Change Management and Commissioning Competencies Guidance

July 2018

Acknowledgement

This document has been developed by the Australian Government Department of Health and PwC as part of a project funded by the Department to develop guidance, tools and training for Primary Health Networks (PHNs) on commissioning. It has been co-designed with PHNs through the PHN Commissioning Working Group and the relevant sub-group and informed by interviews with, and case studies from, some PHNs.

The active contribution of the PHNs in the development of this guide is appreciated.

Contributions from Helen Dickinson, Associate Professor Public Service Research and Director Public Services Research Centre, University of New South Wales, Canberra have provided insight on the commissioning evidence base.

Preferred citation: Australian Government Department of Health. (2018). *Change Management and Commissioning Competencies Guidance*. Available at: http://www.health.gov.au/internet/main/publishing.nsf/Content/PHNCommissioningResources

Disclaimer

Opinions expressed in this document are those of the authors and not necessarily those of the Australian Government Department of Health. Data may be subject to revision.

Note

This guidance does not override the requirements set out in the PHN Funding Agreement.

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Acronyms used in this guidance

ACCHS   Aboriginal Community Controlled Health Services
COI   Conflict of Interest
EOI   Expression of Interest
GP   General Practitioner
KPIs   Key Performance Indicators
MoU   Memorandum of Understanding
OBC   Outcomes Based Commissioning
PHN(s)   Primary Health Network(s)
RACI   Responsible, Accountable, Consulted, Informed
VFM   Value for Money

Definitions of some key terms used in this guidance

Cultural awareness (in relation to Aboriginal and Torres Strait Islander cultures)

Demonstrates a basic understanding of Aboriginal and Torres Strait Islander histories, peoples and cultures. There is no common accepted practice, and the actions taken depend upon the individual and their knowledge of Aboriginal and Torres Strait Islander culture. Generally accepted as a necessary first step and a foundation for further development, but not sufficient for sustained behaviour change.[1]

Cultural competency

Cultural competency is a key strategy for reducing inequalities in health care access and improving the quality and effectiveness of care for Indigenous people.

Cultural competence is more than cultural awareness; it is the set of behaviours, attitudes and policies that come together to enable a system, agency or professionals to work effectively in cross-cultural situations.[2]

Cultural safety

Identifies that health consumers are safest when health professionals have considered power relations, cultural differences and patients' rights. Part of this process requires health professionals to examine their own realities, beliefs and attitudes. Cultural safety is not defined by the health professional, but is defined by the health consumer's experience - the individual's experience of care they are given, ability to access services and to raise concerns. The essential features of cultural safety are:

a) An understanding of one's culture

b) An acknowledgment of difference, and a requirement that caregivers are actively mindful and respectful of difference(s)

c) It is informed by the theory of power relations; any attempt to depoliticise cultural safety is to miss the point

d) An appreciation of the historical context of colonisation, the practices of racism at individual and institutional levels, and their impact on First Nations people's living and wellbeing, both in the present and past

e) Its presence or absence is determined by the experience of the recipient of care and not defined by the caregiver.[3]

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[1] Australian Health Ministers' Advisory Council. (2016). Cultural Respect Framework 2016-2026 for Aboriginal and Torres Strait Islander Health. Available at: http://www.coaghealthcouncil.gov.au/Publications/Reports

[2] Bainbridge R, McCalman J, Clifford A, and Tsey K. (July 2015). *Cultural competency in the delivery of health services for Indigenous people. Issues Paper No.13 produced for the Closing the Gap Clearing House.* Available at: https://aifs.gov.au/publications/cultural-competency-delivery-health-services-indigenous-people

[3] Australian Health Ministers' Advisory Council. (2016). Cultural Respect Framework 2016-2026 for Aboriginal and Torres Strait Islander Health. Available at: http://www.coaghealthcouncil.gov.au/Publications/Reports

1 Overview

1.1 Purpose

This guidance considers the competencies and skills required to effectively commission primary health care services in Australia. This guidance will assist PHNs to:

- Understand the different mindset and broader set of competencies required to undertake commissioning.

- Identify characteristics of commissioning competencies to determine 'what good looks like'.

- Assess the maturity of their PHN in relation to commissioning competencies.

- Encourage different conversations within their region that will assist them in enhancing the efficiency and effectiveness of the primary health care system.

- Adopt new ways of working that encourage culture change within the PHN and the broader system, and build capability.

1.2 Context for this guidance

As commissioning organisations, PHNs can benefit from building on the skill sets of previous primary health organisations (such as Medicare Locals) to successfully secure primary health care outcomes. Currently, limited guidance exists for PHNs to support the development of competencies and skills that are required to undertake commissioning.

PHNs' paths to becoming leading commissioners are developing, as commissioning is still an emerging practice in Australia. High quality commissioning takes time and investment to get right, and progress is often impacted by a broad range of factors which include:

- Increasing demand for primary health care services.

- Increasing prevalence of chronic and complex conditions.

- Ongoing reform and complexities in the commissioning landscape.

- The nature of the Australian health system (i.e. Commonwealth and state/territory Government split in responsibility and funding respectively between the primary and acute health care systems).

- Working with a wide range of stakeholders that directly and indirectly impact on the health outcomes that PHNs are focused on achieving.

- The markets capability and maturity in relation to working with PHNs as commissioners.

It is also important to acknowledge that PHNs are operating as a part of the broader health system. The services and outcomes that PHNs commission will be influenced by the services that are funded and commissioned by other parts of the system (as well as other sectors that more directly influence social determinants of health, such as housing, education and human services) at the Commonwealth and state and territory government levels, and at the private sector provider level.

However, there is a considerable body of Australian and international literature spanning many years, which suggests that primary health care commissioners (now PHNs) – individually and collectively – have a real capacity to play a role in systemic improvements to primary health care. This was a key finding of the Horvath Review of Medicare Locals and lies at the heart of the PHN Program.[4]

PHNs' role as part of the broader health system has a key influence on how PHNs work with other parts of the system; how they commission primary health care services; and how they move towards incorporating commissioning on an outcomes basis. The point here is twofold:

- Firstly, if PHNs are to incorporate a greater focus on outcomes it is important to recognise the complexity of contribution and attribution. This will impact how PHNs monitor and evaluate what they commission (see *Monitoring and Evaluation Guidance*[5] for further information on this).

- Secondly, in order to secure the best possible outcomes for Australians and secure more integrated care, it is likely that PHNs will work with other parties to co-commission solutions. It is also important to acknowledge that many providers are also likely to be working with these other funders and commissioners.

This guidance also considers commissioning in the context of the needs of Aboriginal and Torres Strait Islander people and the needs of culturally and linguistically diverse (CALD) populations. It recognises the need for cultural safety; taking a paradigmatic approach and creating an enabling environment for the system players to take a strengths based approach.

This guidance has been developed to help PHNs accelerate their development. Given the breadth and diversity of the PHNs and the market, it is important that there is a clear and consistent understanding and approach to being an effective commissioner.

1.3 Key messages from this guidance

The key messages that PHNs should take from this guidance are:

- A new mindset and broader set of competencies are required to support commissioning.

- Patients and communities are to be at the heart of everything that commissioners and providers do.

- Creating an environment of concordance between the PHN, ACCHS and other providers and Aboriginal and Torres Strait Islander people, and between the PHN and providers and CALD populations, is critical to supporting those groups. This might include consideration of collaborative decision making; and people, processes and systems that are culturally safe. Change management is critical to achieve behaviour change in clinicians, providers and communities, as well as within the PHN organisation and the broader primary health care system.

- Building and maintaining relationships with the people and organisations who can best influence and effect change can take considerable time and effort but is critical.

- Collaborative effort by PHNs, partner organisations and providers helps with the design and delivery of changes that transform the primary health system.

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[4] Horvath J. (2014). *Review of Medicare Locals*. Recommendation 1. Available at: http://www.health.gov.au/internet/main/publishing.nsf/content/review-medicare-locals-final-report

[5] Australian Government Department of Health. (2018). *Monitoring and Evaluation Guidance.* Available at: http://www.health.gov.au/internet/main/publishing.nsf/Content/PHNCommissioningResources

1.4 How should this guidance be used?

This document provides guidance that PHNs may have regard for in the context of other guidance and requirements, such as the PHN Grant Programme Guidelines[6]. This guidance is just one step in the journey to improve the capability of the system. It is not intended to provide comprehensive instructions or requirements.

PHNs could consider using this guidance to:

- Determine their current and future capability levels

- Guide their organisational structure, human resource development pathways and other resource investments

- Engage with the broader health system and promote new ways of working.

PHNs should come to their own views as to how this guidance is best applied, considering their own operating context, priorities and resources, as well as wider competency development activities.

This document does not provide in-depth guidance on all the competencies for commissioning, and should be used in conjunction with the other commissioning guidance and tools made available by the Australian Government Department of Health. This guidance is complemented by two supporting tools:

- *PHN Commissioning Competencies Self-Assessment Tool*[7]: this enables PHNs to assess their own commissioning competency, and as a result, build an action plan for commissioning improvement and development.

- *Change Management and Commissioning Competencies Resources Toolkit*[8]: this provides links to tools developed by a range of sources that could support PHNs in applying the key commissioning competencies.

This guidance broadly aligns with the outcome theme of 'capable organisations' which is included in the PHN Program Performance and Quality Framework (the Framework). This guidance considers the aspects of capable organisations' which are included in the Framework as shown in Table 1.

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[6]Australian Government Department of Health. (2016). *Primary Health Networks Grant Programme Guidelines*. Available at: www.health.gov.au/internet/main/publishing.nsf/Content/PHN-Program_Guidelines

[7] Australian Government Department of Health. (2018). *PHN Commissioning Competencies Self-Assessment Tool*. (Unpublished).

[8] Australian Government Department of Health. (2018). *Change Management and Commissioning Competencies Resources Toolkit*. Available at: http://www.health.gov.au/internet/main/publishing.nsf/Content/PHNCommissioningResources

Table 1: Aspects of 'Capable organisations'

Aspects	Relevant section / competency in this guidance
• Governance • Operational management • People management • Financial management	Section 3.6 Operational capability competency.
• Commissioning • Relationship management	Throughout this guidance (all key commissioning competencies).

2 A commissioning mindset

Commissioning is a relatively new way of working for PHNs and the Australian health system. It requires a new mindset that is supported by new competencies and culture change. Table 2 summarises the key aspects of a commissioning mindset, as adapted from The King's Fund (UK)[9] for applicability in the Australian context.

Table 2: Key shifts in mindset for PHNs and their market

Pre-commissioning mindset	Commissioning mindset
Programmatic and centrally devised approach to funding activity.	Deeper understanding of the health needs of the population to assist in informing how funding will be prioritised on a needs basis.
Service inputs and activity specified and paid for on that basis.	A greater focus on service performance and the achievement of outcomes, rather than just volume in individual service activity.
Service provider driven models of care that decide what is best for the patient.	Models driven by outcomes that matter to the patient and community, including the ability to exercise choice and take ownership of their health.
Funding and delivery of services are to be kept within existing accountability structures.	Working collaboratively at a local level through shared resources (including, where appropriate, pooled budgets) and decision making. Governance and accountability structures are still in place with an increased emphasis on transparency and shared decision making.
Focusing on individual services or single diseases/conditions.	Strategically overseeing, in partnership or in collaboration with the local health system, and ensuring the market is diverse and sustainable.
Centralised decision making on resource allocation and funding of programs.	Devolving decision making to enable a more place-based approach that suits local community needs and circumstances.
Recognition that other services supplement clinical care and are best managed through referrals.	Enabling integrated and coordinated care teams to deliver a range of primary health care services from a variety of sectors, including working in collaboration with others who can more directly address social determinants of health, particularly where they can support or enhance the delivery of clinical care.
A clear split between the contracting approach applied to, and services provided by, for-profit and not-for-profit organisations.	Embedding commercial discipline in, whilst leveraging the social motives of, the not-for-profits sector to drive improved performance.

Traditional approaches to service delivery have relied on activity or service based funding where requirements are stated in service terms, and providers are evaluated and paid based on what has been done rather than what outcomes have been achieved.

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[9] The King's Fund. (2017). *What is commissioning and how is it changing?* Available at: www.kingsfund.org.uk/publications/what-commissioning-and-how-it-changing

As Table 2 indicates, a commissioning mindset requires a deeper understanding of the health needs of the population to develop outcomes that matter to the patient and community. It recognises that to achieve these outcomes, PHNs need to work collaboratively with the market and community to develop, deliver and monitor patient centric models of care. Evidence on commissioning suggests that this is more than a technical or operational process, it is also value-based and relational[10], as emphasised throughout this guidance.

Key to a commissioning mindset is that PHNs put patients and the community at the centre of all thinking and action which involves co-design, engagement and/or making commissioning decisions in collaboration, and with input from the community.

This is of particular importance for Aboriginal and Torres Strait Islander people and communities, who seek cultural safety, cultural competency and cultural awareness in the provision of services. In applying a commissioning mindset, PHNs should take into account the PHN and ACCHS Guiding Principles[11]. The Guiding Principles were developed in consultation with ACCHS and PHNs, and provide guidance for actions to be taken by each party across key domains: Closing the Gap, cultural competency, commissioning, engagement and representation, accountability, data and reporting, service delivery, and research. These principles recognise the commitment by PHNs and ACCHS to work together to improve access to health services and improve health outcomes for Aboriginal and Torres Strait Islander people and communities, including building a market of providers which is culturally safe in all its undertakings.

At every contact point with the health system, the opportunity exists to provide care that is culturally safe, high quality, responsive and accessible for all. This is relevant to all populations, with particular consideration for Aboriginal and Torres Strait Islander people and communities. All services delivering primary health care at the local, regional and state levels can seek to optimise their engagement and involvement with all relevant populations to improve health outcomes.

Therefore, the development of commissioning to support the outcomes that matter to Aboriginal and Torres Strait Islander people and communities is a key focus for PHNs. This involves PHNs being culturally safe and culturally competent; and building a market of providers that are culturally safe.

PHNs can play a significant role in how they operate to create an enabling environment which responds not only to patients and their primary health care needs but also to the patient's situation and family and community context. This context for Aboriginal and Torres Strait Islander people and communities is a significant consideration as PHNs build their commissioning capability and capacity, and develop their commissioning mindsets.

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[10] Robinson S, Dickinson H and Durrington L. Australian Journal of Primary Health 22(1) 9-14. (2016). *Something old, something new, something borrowed, something blue? Reviewing the evidence on commissioning and health services.* Available at: www.publish.csiro.au/py/py15037

[11] Australian Government Department of Health. (2015). *PHN and ACCHO Guiding Principles.* Available at: www.health.gov.au/internet/main/publishing.nsf/Content/PHN-Accho

3 Key commissioning competencies and skills

Drawing on international experience, this section provides an overview of the key competencies that have been shown to improve the success of commissioners in increasing the capacity and capability of health systems.

The guidance does not attempt to define all competencies at a local level for PHNs, or replace existing competencies that PHNs may already have developed. Rather, it provides an overview of the broader set of competencies that will assist PHNs to be successful commissioners. This guidance gives further detail about the competencies on which there is less guidance available to PHNs that is directly relevant to the Australian context.

Figure 1 identifies the broader set of key competencies that can assist PHNs to be successful commissioners, and sections 3.1 to 3.6 of this guidance provide further detail on each. The key competencies are relevant at all stages of the PHN commissioning framework.

Figure 1: Key commissioning competencies

The key competencies are also discussed in other resources, such as the 2015 *PHN Needs Assessment Guidance*, the 2016 *Planning in a Commissioning Environment Guidance*, the 2016 *Designing and Contracting Services Guidance*, the 2018 *Change Management and Commissioning Competencies Toolkit*, the 2018 *Market Making and Development Guidance* and the 2018 *Monitoring and Evaluation Guidance*.[12]

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[12]Australian Government Department of Health. (2016). *Monitoring and Evaluation Guidance.* Available at: www.health.gov.au/internet/main/publishing.nsf/Content/PHNCommissioningResources

3.1 Leadership and change management

This competency is about collaboratively leading change internally and externally to support the primary health care system towards place based and commissioning approaches. A key focus of this is embedding sound change management approaches, building capability and shifting the culture and behaviours to be open to and undertake new and integrated ways of working together.

For the purposes of this guidance, the leadership and change management competency is discussed in its two component parts.

3.1.1 Leadership competency

This competency involves:

- PHNs being collaborative local market leaders to collectively embed a commissioning approach.
- Strong, clinically informed leadership that provides clear strategic direction and empowers staff and the community to work towards this direction.
- Creating an environment conducive to learning and continuous improvement.

The focus of this competency is on the leadership of the PHN, as an organisation, rather than individuals within the PHN. However, the guidance includes practical tips at an individual/team level too, recognising that to develop the leadership of the PHN, this will depend on developing the leadership of staff and executive who constitute the PHN.

3.1.2 Leadership context for PHNs

To design and embed effective reform at scale, PHNs could consider creating a shared leadership model that enables them and others to lead beyond authority, and be credible and well respected by the community and the health sector.

Leadership is key to the success of PHNs as:

- PHNs have a role in ensuring that providers focus on local health priorities. Where required, PHNs should drive collaboration, partnerships and innovation to achieve better health outcomes.
- PHNs have a relatively small proportion of the health system funding, which restricts their scope to achieve system-wide change. Leadership is critical in enabling PHNs to bring other stakeholders to the table to form partnerships, steer the market, leverage resources and strategically invest in key areas.
- PHNs are the change champions to embed a commissioning approach and new ways of working across the system. Commissioning can result in changes to the roles and requirements of some individuals and organisations. PHN leadership is a key factor in enabling this ongoing culture change.
- PHNs as local leaders will play a key role in ensuring that markets support change and work collaboratively together to support better outcomes in more coordinated and integrated ways.
- Moving towards incorporating outcomes based commissioning can be complex and sustained, resilient and visionary leadership will help to secure this longer term strategy and approach.

- It brings stakeholders together and influences those sectors that have the remit to directly impact on the social determinants of health, so that the collective system works in more coordinated and integrated ways.

3.1.3 Leadership approaches

Approaches that could be considered by PHNs in the move to exhibiting best practice leadership include:

Place based leadership

This is an approach to leadership which maximises local resources to deliver health care services based on a specific geographic location[13]. Characteristics that actively support this approach include:

- Engaging with local communities around the role of PHNs and how commissioning can support better outcomes.

- Recognising the similarities and differences (such as cultural competency, objectives, geographic boundaries and patient focus) between local organisations (such as providers, other commissioners/funders) that impact on local population health outcomes.

- Using population health frameworks and tools that connect commissioning programs together and help apply a more strategic approach to understanding needs.

- A system of local leadership – clinical, consumer and community, supported by PHN leadership that will mirror and support the way local and community decision making is made.

- A focus on the communities of the region and co-creating solutions based on their needs, including Aboriginal and Torres Strait Islander people and communities, and those at risk of poor health outcomes.

- Utilising and strategically connecting national, state/territory and local data and programs that are being collected and delivered in isolation / overlap, to better understand target the health needs of the population.

- Collaboration with other funders and commissioning agencies to address the local needs of the population. This could include shared regional and local planning with shared activities and financial resources.

Leading beyond authority

It is important to acknowledge that PHNs are operating as a part of the broader health system, and that PHNs are not the sole (and sometimes not the most important) source of support in seeking to develop health service provider markets. Leading beyond authority for PHNs is the ability to lead outside their direct circle of control and effect change across the primary health care system and other connected systems[14].

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[13] The King's Fund. (2015). *Place based systems of care.* Available at: www.kingsfund.org.uk/sites/default/files/field/field_publication_file/Place-based-systems-of-care-Kings-Fund-Nov-2015_0.pdf

[14] Middleton J. Alchemy Assistant, *Leading Beyond Authority*. Available at: https://www.alchemyassistant.com/topics/DRcBuht2nn3R7Dib.html

Common Purpose, a not-for-profit organisation that develops leaders who can cross boundaries, recommends 'leading beyond authority' as a leadership approach. Many of the core principles of this approach are intuitive, and relevant to PHNs, including[15]:

- Taking the *right approach* requires:

  - **Courage and passion** - trying new models of care and ways of working that may not be proven and proactively engaging with stakeholders. This is important for PHNs in aiming to embed patient centred care, and as change agents for improving primary health care.

  - **Independence** – taking a balanced view to health priorities and needs, designing and contracting services, and monitoring and evaluation and working with providers.

- Developing a *strategic mindset* requires:

  - **Strategic thinking and a good sense of timing** - recognising that there will be unique issues in each PHN region to tactfully resolve, using key levers at the right time and seizing opportunities. This involves PHNs being patient in implementing long term reforms, such as transitioning to outcomes based commissioning and in developing markets.

- Taking a *people approach* requires:

  - **Building coalitions** - commissioning cannot be undertaken in isolation and can benefit from strong relationships formed with diverse networks at a senior level. This can accelerate the creation of new learning and ideas that improve primary health care.

Entrepreneurial leadership

Entrepreneurship has been defined as the pursuit of opportunities involving major risk, responsiveness to systematic changes and the development of innovations.[16] Due to the complexity of the health care environment, a level of entrepreneurial leadership that is innovative, opportunities-driven and that engages with risk, is important in helping to support effective commissioning. According to the Institute for Healthcare Improvement, "Health care organisations of the future will depend on nimble, sophisticated, and creative employees to meet their objectives"[17]. Primary health care, like many sectors, is being influenced by technology and increasing community expectations which requires an increasing level of entrepreneurship. Taking an entrepreneurial approach to leadership could help PHNs to leverage this influence and meet expectations. This type of leadership is based on:

- Creating an acceptable environment for learning and growth, where failures are ultimately viewed as opportunities to learn.

- Communicating a strong common goal that all parties can contribute to (which can enable the PHN to jointly commission outcomes with a diverse set of stakeholders).

- Setting expectations on ways of working and seeking out passionate individuals to collectively empower others to contribute towards this goal.

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[15] Common Purpose. (2017). *What is Leading Beyond Authority?* Available at www.commonpurpose.org/knowledge-hub/all-articles/leading-beyond-authority/

[16] Guo, K L. (2009). The Health Care Manager Journal. *Core Competencies of the Entrepreneurial Leader in Health Care Organisations.* Available at: pdfs.semanticscholar.org/fcfb/54363bf4d03efabe48ae5cf589ae9702c3b2.pdf

[17] Institute for Healthcare Improvement (2017). *Leadership.* Available at: www.ihi.org/Topics/Leadership/Pages/default.aspx

- Embracing the chance to explore new models of care and critically review services for decommissioning or scaling up.
- Encouraging continuous improvement and sensible risk taking to ensure the PHN does not just 'do nothing' or 'take blind risks'.
- Balancing risk taking and the potential impacts to reputation and stakeholder relations.

3.1.4 Practical tips and skills for developing leadership

The tips in Table 3 aim to provide practical actions for PHNs to develop this competency at the following levels:

- System – Those within the PHN region that are strategically influencing system wide reform
- Organisation – PHN leadership / executives
- Individual/team – operational level of the PHN

Tables with this structure of 'system/organisation/individual' are used in each subsequent chapter of this guidance to provide practical actions for PHNs for each of the other competencies.

Table 3: Practical tips and skills for leadership

System	Organisation	Individual / team
1. Use relationship management skills to leverage networks within and across regions to collaborate and streamline commissioning resources. 2. Use the PHN network to further develop leadership skills and help increase PHNs' influence at the system level. 3. Focus on the PHN being a collaborative leader, to share and devolve leadership, such as joint decision making with Aboriginal and Torres Strait Islander organisations, including ACCHS, and enable this through 'convening' (rather than 'leading'). 4. Use tools such as Memorandums of Understanding, collaborative governance arrangements, and regional plans that facilitate shared leadership. 5. Practice communication and presentation skills to lead and effect change at scale.	1. Articulate a clear strategic direction and inspiring vision. 2. Dedicate time to plan and prioritise resources in line with impacts on outcomes, and articulate strategic direction. 3. Promote a high representation of clinicians and diversity in leadership positions. 4. Create a communications strategy that provides consistent messaging on the PHN priorities and embedding a commissioning approach.	1. Build and maintain strong relationships with key stakeholders at a local level to steer the market towards priorities. 2. Use coaching as an approach to support team development, which involves the leader/coach actively listening, challenging beliefs and allowing team members come up with their own solutions to be accountable and learn from mistakes. 3. Set expectations and conditions for teams and individuals to take risks, considering reputation and stakeholder management. 4. Encourage and support individuals to practice and build their communication and presentation skills to help lead and effect change and foster innovation from the market.

3.1.5 Change management competency

This competency involves:

- Defining and leading the process of change both within PHNs and across stakeholders.
- Embedding new approaches and adapting organisational culture to be open to new ways of working.

3.1.6 Change management context for PHNs

Change management is critical to achieving behaviour change in providers and consumers, as well as within the PHN organisation and the broader primary health care system. Effective change management is critical for PHNs to maximise the opportunity to help strengthen Australia's primary care system and ensure the benefits of improved health and wellbeing flow to the community.

To move from a traditional mindset to a commissioning mindset and to be agents of change and reform (see Table 2), PHNs would benefit from embedding commissioning as a way of undertaking business across the system. In doing so, PHNs may face significant barriers. PHNs may need to develop their change management competencies to overcome these barriers and bring all their partners on this transformational journey.

3.1.7 Levers of PHNs to effect change

Understanding the levers that are available to PHNs to effect change is the first step for PHNs in applying sound change management. The levers that can help PHNs accelerate change are summarised in Table 4.

Table 4: Levers available to PHNs in leading change[18]

Lever	Opportunity
Mandate to commission primary health care services	• It can be more efficient for stakeholders to engage with PHNs on system wide issues rather than various individuals in the market. Particularly where there are system wide service challenges and gaps, such as after-hours care.
Governance groups as a source of relationship building (Clinical Council and Community Advisory Committee)	• Strengthen PHNs' local knowledge, lead the local health agenda and drive reforms tailored to local problems. • Build strong relationships with stakeholders and continually identify service gaps and at-risk populations. • Identify areas for upskilling and promoting professional development of health professionals, as well as approaches to upscaling general practices to reduce pressures on the secondary care system and improve the efficiency of services. • Communicate what commissioning is, the PHN's vision and other key missions, including targeted preventative health campaigns.
Impartiality (as PHNs' focus is commissioning, rather than being the provider of choice)	• Ability to be an effective convenor, providing a platform to bring together and influence a range of stakeholders, promote coordination and jointly advocate for system reform.
Evidence and advocacy	• Increasing skill and expertise in the collection, analysis and interpretation of data to improve services. The more insight that commissioners have regarding the needs of the population the more evidence and advocacy they can apply.
Promoting contemporary practice	• Quality improvement and developing cultural awareness, cultural competency and cultural safety provides significant opportunities for PHNs to support transformation.
Contracts and partnership arrangements	• Drive improved service performance, integration of service delivery and a greater focus on improving patient choice and outcomes for the local population at better value for money.

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[18]Adapted from: Duckett S, Beaumont M, Bell G, Gunn J, Murphy A, Wilson R & Crowley T (2016). Australian Healthcare & Hospital Association. *Leading Change in Primary Care*. Available at www.ahha.asn.au/sites/default/files/docs/policy-issue/leading_change_in_primary_care.pdf

Lever	Opportunity
More flexible funding (with certain constraints)	• Targeted use of funding to encourage more appropriate risk sharing, integration and innovation amongst providers.
Funds pooling	• Influencing other commissioners and agencies to pool funds to achieve bigger and better outcomes for the population.

3.1.8 Approaches to change management

Taking into account these levers, some approaches that can help support and enable change in a PHN setting include:

- Developing an evidence base and case for change by understanding the current problems in the sector / outcomes not being achieved and the benefits to the community and stakeholders.

- Strong communication skills that create a common language for change across the system and facilitate engagement with communities in a culturally safe manner which brings them on the journey.

- Developing influencing skills to build key relationships and gain the support and advocacy for change from well-respected people in primary health care professions, organisations and the community.

- Adopting a single best practice change management methodology to provide structure (refer to those identified in the 2018 *Change Management and Commissioning Competencies Resources Toolkit*[19]). PHNs should use a single methodology that is best suited to their local circumstances.

- Fostering an adaptive and innovative culture that encourages new ways of working.

- Developing guidance and tools to build the capability, capacity and confidence of the PHN, market and community.

- Building the negotiation and stakeholder management skills to the level needed to effectively deal with those who are most impacted or resistant to change.

- Providing opportunities and the bandwidth for the market to propose system solutions that are outcomes based and following through with these solutions where they can be tested and implemented.

- Strategically position the PHN by initially focusing on 'quick win' changes to build momentum and confidence.

- Invest in system capability and capacity to form the architecture that can deliver long term and large scale change.

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[19] Australian Government Department of Health. (2018). *Change Management and Commissioning Competencies Resources Toolkit*. Available at:
http://www.health.gov.au/internet/main/publishing.nsf/Content/PHNCommissioningResources

3.1.9 Practical tips and skills for change management

To undertake effective change management, PHNs should consider the tips in Table 5.

Table 5: Practical tips and skills for change management

System	Organisation	Individual / team
1. Achieve a shared understanding of the existing problems faced by the sector, i.e. case for change, and commitment to solve these problems. 2. Build relationships with other commissioners and the market to leverage opportunities (e.g. utilise their capacity and capability to support a shared agenda). 3. Collaborate and share change management strategies, approaches and experiences across the PHN network. 4. Form strong relationships with community and representative groups, including ACCHS to agree and communicate what the change is, what has been achieved and what is needed to fully realise the benefits. 5. Communicate evidence specific to the PHN region to support the change. This may include investments or partnerships with research providers to obtain this data, link it and communicate it in a clear and transparent manner. 6. Negotiate with key decision makers across the system to influence their agenda to support local change.	1. Implement a single, clear and best practice change management methodology such as ADKAR (Awareness, Desire, Knowledge, Ability, Reinforcement)[20] as the basis for a change implementation plan, with cultural safety embedded at a grass roots level. 2. Measure and report on key change objectives, celebrating successes and assessing the PHN's development of cultural safety and other competencies in commissioning. 3. Build the PHN's cultural competency to build trust and respect to co-design, communicate and achieve buy-in (in particular, work more closely with Aboriginal and Torres Strait Islander people and communities to effect change). 4. Communicate clear and consistent messages about the benefits of change, and the PHN's actions to support change across the system.	1. Provide staff with the time and training to develop their commissioning competencies and embed new practices into business-as-usual activities as part of their performance plans. 2. Consider quality improvement methodologies to assist in driving contemporary practice. 3. Develop leadership skills to motivate teams to implement the change and leverage passionate individuals to be community change champions. 4. Co-develop contracts and manage performance to provide scope for partners to transform themselves and achieve change, while still ensuring continuity of services during transition. (Contracts of appropriate length, and which include appropriate transition and service continuity requirements are important here.) 5. Constructively challenge behaviour that does not support collaboration or build the desired culture.

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[20] Prosci. (2018). *ADKAR Model*. Available at www.prosci.com/adkar

3.2 Co-design and community engagement

This competency involves:

- Engaging with a diverse range of stakeholders for their perspectives and input to better inform and support the commissioning process.

- Encouraging active participation and provider innovation in identifying needs, developing solutions, and achieving outcomes.

- Leveraging the collective knowledge to foster innovative, patient centred services focused on achieving outcomes.

3.2.1 Co-design and community engagement context for PHNs

Commissioning relies on working collaboratively with various stakeholders to collectively contribute to commissioning processes. PHNs can draw on their collective views to better inform and support the commissioning of services. This is particularly relevant given that the context, needs, expectations, challenges and outcomes sought by individuals are constantly changing, and PHNs require collaborative practices to ensure they are well informed and can address need. Community engagement and co-design are therefore key tasks that are critical to the overall success of commissioning.

Community engagement can be depicted as a spectrum[21]. Where low level engagement involves PHNs telling / informing the community about an issue (e.g. via consultation), to high level engagement, where PHNs collaborate and empower the community (e.g. co-design). Community engagement can vary depending on what the PHN is trying to achieve and the ability of the specific group to participate in the engagement. PHNs should also keep in mind what form of engagement will be most effective in targeting communities.

Co-design goes beyond consultation, by PHNs working with providers, communities, other stakeholders and potentially other co-commissioners who are affected by or attempting to address health needs. It is a key approach to bringing various stakeholders together to collectively contribute to designing or developing solutions, and it incorporates the following benefits:

- Brings together the expertise of a range of stakeholders.

- Enables PHNs to understand patient experiences, rather than relying on attitudes or opinions.[22]

- Brings together co-commissioners and other agencies to set a vision and to identify the potential for collaborative arrangements, such as the pooling of funds.

- Ensures diverse needs and views, including the needs of Aboriginal and Torres Strait Islander people and communities and those at risk of poor health outcomes, are reflected in PHN's commissioning decisions to optimise service design early on, achieve buy-in for new models of care and avoid marginalising people in the community.

- Brings stakeholders on the commissioning journey, which builds capacity and creates collective leadership and ownership in achieving the intended outcomes.

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[21] Australian Institute of Family Studies. (2016). *Community Engagement*. Available at: aifs.gov.au/cfca/publications/community-engagement/what-community-engagement

[22] Allat K. (2017). The King's Fund. *The reality of collaboration*. Available at: www.kingsfund.org.uk/audio-video/kate-allatt-reality-collaboration

- Accesses insights from the provider market relating to operational thinking, best practices and an understanding of the latest technological advancements that impact service delivery at an earlier stage than other approaches. This can help foster innovation and better service delivery approaches.

3.2.2 Considerations for co-design and community engagement

Key to effective co-design is active contribution from a diverse mix of stakeholders and ensuring the service users' experiences and needs are central to the design process. Key considerations across pre-engagement, engagement and post-engagement for PHNs include:

3.2.3 Pre-engagement

- Design the engagement approach based on the purpose and target audience, which may involve bringing together or segmenting stakeholders. (Case study 1 in this guidance provides an example of how engagement with segmented groups of stakeholders can bring value determining needs and outcomes).

- Leverage past engagements and existing governance structures, networks and communication channels, such as Clinical Councils, Community Advisory Committees, and ACCHS, to minimise engagement fatigue and to build on existing ways of working.

- Invest in understanding the PHN's communities prior to engagement through research and relationship building[23]. This is particularly important for engaging with Aboriginal and Torres Strait Islander people and communities and those at risk of poor health outcomes to understand their experiences (this helps minimise clouding the design process with false assumptions particularly where those communities assist in co-designing how the engagement occurs).

- Understand stakeholder interests, motivation and principles and tailor the engagement to suit this to minimise potential conflicts of interests / biases, particularly when co-designing with influential local providers in less competitive or rural and remote markets.

- Identify and build relationships with key stakeholders to ensure that co-design activities are representative of a variety of groups.

3.2.4 Engagement

- Provide clarity on the aims, scope and role of co-design, including whether co-design sits within or outside of formal procurement, as part of expectation management as well as to address probity or intellectual property concerns.

- Consider how to set expectations on the co-design process (i.e. how long it will take to co-design, and identify that a range of stakeholders will be involved, with a diversity of views).

- Consider patient motivations[24] to ensure the service design encourages patients to participate and 'self-care'[25].

- Consider how to provide an appropriate space for all stakeholder groups, to ensure co-design activities are accessible to all groups.

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[23] Waitemata District Health Board. (2010). *Health service co-design.* Available at: www.healthcodesign.org.nz/01_engage.html

[24] Allat K (2017). The King's Fund. *The reality of collaboration*. Available at: www.kingsfund.org.uk/audio-video/kate-allatt-reality-collaboration

[25] Australian Health Policy Collaboration. (2018). *The State of Self Care in Australia.* Available at: www.vu.edu.au/sites/default/files/the-state-of-self-care-in-australia.pdf

- Expand engagement to non-traditional / broader stakeholders to gain alternate views and insights from other sectors.

- Consider preferences of affordability and rurality in determining the engagement method (for example, engaging with rural stakeholders face to face rather than through videoconference. The latter may be preferred due to cost and time if there is a pre-existing relationship between the PHN and the participants, or if the engagement is not with a key stakeholder).

- Consider how to balance and choose between opposing views of importance.

- Consider engaging with Aboriginal and Torres Strait Islander people and communities through local community members to facilitate open engagement, as it is likely that they have already built trust between each other.

- Ensure that engagement is underpinned by cultural awareness, cultural competency and cultural safety. When engaging with Aboriginal and Torres Strait Islander people and communities, language should be framed from an experience perspective.

3.2.5 Post-engagement

- Follow up with participants to build on relationships and provide outcomes and next steps of co-design.

- Seek feedback on the experience of stakeholders with the engagement in a timely and simple manner.

- Consider ways to establish real time engagement and further build on co-design.

Case study 1: Co-design in working towards an outcomes based contract on the Gold Coast

Situation: Gold Coast PHN (GCPHN) identified a need for additional services to be available for people with severe and complex mental illness. Data sources indicated 9,000-12,000 people who had the potential to benefit from improved clinical mental health services in the primary care setting. A redesign of current services would therefore create the opportunity to address a currently fragmented system and move towards more integrated and coordinated care.

Task: GCPHN used this redesign opportunity to move towards a more outcomes based commissioning approach which enhances the potential to move towards a more integrated and coordinated system of provision.

The team involved a wide range of stakeholders in a considered way to build consensus on the outcomes that matter to recipients, underpinned by the data available in both the needs assessment and through stakeholder involvement over the past 2 years. The task included mapping these needs to the Triple Aim[26] to articulate the benefits, using a population health approach.

Action: Over a 4 month period the planning and consultation process was undertaken. What made this co-design process different was the segmentation then consolidation of the constituent groups. This enabled the PHN, along with its health system, to build a broader and deeper understanding of needs plus the opportunity to construct a new approach to longer term planning across the Gold Coast region.

The stakeholder segmentation included: commissioners, potential co-commissioners and payers who have a role in the system to create architecture and solutions. These stakeholders were from the justice system, schools and youth, police, disability, housing and human services, ambulance and health services; the community and providers from primary, community and hospital settings; consumers, carers, consumer organisations; and providers from a range of sectors and backgrounds that supported consumers in this specific area of need.

The stakeholder events were all different in nature and designed to fit the purpose of that particular group and included interviews and coaching to support stakeholder preparations, lived experience capture and global contemporary practice review. A synthesis of the outputs was undertaken and a consolidation event took place which encouraged all groups to participate and provided an open and transparent feedback mechanism to all audiences. This was followed up with a market event so providers could build a picture of needs prior to a formal tender process.

Result (in the context of this case study): As a result of this co-design approach the PHN has a deep and rich understanding of the needs of the population in respect of severe and complex mental illness. The outputs of the engagement along with the data from the health needs assessment were developed into a specification that has gone to market.

The outcomes for the recipients have been included in the specification and the contractual arrangements describe a journey towards outcomes. As a result of the co-design work, one of the three areas described in the specification is entirely new and had not been previously identified. The co-design approach itself was key to developing the outcomes that matter to recipients.

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[26] Institute for Healthcare Improvement (2017). *The IHI Triple Aim*. [online] Available at: www.ihi.org/Engage/Initiatives/TripleAim/Pages/default.aspx [Accessed 1 Dec. 2017]

3.2.6 Practical tips and skills for co-design and community engagement

Table 6 provides some practical tips that PHNs could consider in undertaking co-design and community engagement.

Table 6: Practical tips and skills for co-design and community engagement

System	Organisation	Individual / team
1. Build the co-design process together across the system, to leverage the expertise and resources of other commissioners/agencies. 2. Collaborate and share co-design approaches, experiences and lessons learned across the PHN network. 3. Use data to inform stakeholders. (This data should be accessible and open, where possible)[27]. 4. Apply a 'no door is closed' mindset by expanding engagement to non-traditional partners from a variety of sectors to gain additional insights. 5. Utilise relationship management skills to leverage existing networks, such as ACCHS, to create partnerships that encourage two-way engagement. 6. Engage with stakeholders and understand their perspective and input into the design of services.	1. Foster experimental design and evaluation skills and tools that allow the PHN to test and prototype (implement at a small scale)[28] that allows for iterative design. 2. Promote a variety of communication channels, (such as social media and face to face), based on affordability, population and location 3. Design an engagement plan that appropriately separates out and/or brings together communities and populations based on primary research/data. 4. When involving providers consider the co-design approach in the context of the procurement stage so there is transparency, which encourages openness and full involvement[29].	1. Be open to generating new ideas and changing the engagement approach over time to get the most out of the engagement. 2. Create cultural competency and safety to engage with all populations (including Aboriginal and Torres Strait Islander people and communities and those at risk of poor health outcomes). 3. Be appreciative of participants' involvement to encourage more extensive participation and build community respect. 4. Use communication and facilitation skills to host engagement sessions that encourage equal and active participation and effectively inform the community. 5. Expand PHN's procurement skills to build co-design into procurement, such as through interaction with bidders, which focuses on innovation and refining key performance drivers.

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[27] NSW Treasury and NSW Department of Finance, Services & Innovation. (2016). *NSW Commissioning & Contestability Practice Guide.* Available at: www.treasury.nsw.gov.au/sites/default/files/pdf/NSW_Commissioning_and_Contestability_Practice_Guide_-pdf.pdf

[28] Baeck P. (2013*). The Power of Co-design and Co-Delivery*. Available at: https://media.nesta.org.uk/documents/the_power_of_co-design_and_co-delivery.pdf

[29] Australian Government Department of Health. (2016). *Designing and Contracting Services Guidance.* Available at http://www.health.gov.au/internet/main/publishing.nsf/Content/PHNCommissioningResources

3.3 Applying a population health approach

This competency involves:

- Balancing the different aims of a health system, including delivering: improved clinical outcomes; improved patient experience; improved provider and workforce experience; and reducing the cost of health care.

- Utilising population-level data to help demonstrate the evidence base for what the PHN is seeking to address, and identify where best to intervene in order to improve population health.

- Building strategies that target population cohorts based on needs assessments, predictive analytics and evidence based interventions.

- Working with partners in other parts of the health system, and connecting interventions across communities and other sectors that addresses the wider determinants of health, including housing, education and human services.

3.3.1 Additional resources available to PHNs for this competency

A key reading on the context for population health systems is from The King's Fund[30]. This provides guidance on using population health to 'join up the dots' where integrated care encompasses a range of health, social and wider interventions to target outcomes for the local population.

Population Health Approaches to Planning by the Victorian HealthCare Association[31] also provides a clear and simple Population Health Planning Framework. Other resources specifically written for PHNs include 2015 *PHN Needs Assessment Guide*[32], 2018 *Monitoring and Evaluation Guidance*[33], and the 2018 *PHN Commissioning Competencies Self-Assessment Tool*[34] that accompanies this guidance.

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[30] The King's Fund. (2015). *Population Health Systems*. Available at: https://www.kingsfund.org.uk/sites/default/files/field/field_publication_file/population-health-systems-kingsfund-feb15.pdf

[31] Victorian Healthcare Association. (2012). *Population Health Approaches to Planning*. Available at: vha.org.au/docs/20121003--position-statement--phap.pdf

[32] Australian Government Department of Health, (2015). *PHN Needs Assessment Guide.* Available at: http://www.health.gov.au/internet/main/publishing.nsf/Content/PHNCommissioningResources

[33] Australian Government Department of Health. (2018). *Monitoring and Evaluation Guidance.* Available at: http://www.health.gov.au/internet/main/publishing.nsf/Content/PHNCommissioningResources

[34] Australian Government Department of Health. (2018). *PHN Commissioning Competencies Self-Assessment Tool.* (Unpublished).

3.3.2 Practical tips and skills for population health

Table 7 provides some practical tips that PHNs should consider in developing this competency.

Table 7: Practical tips and skills for population health

System	Organisation	Individual / team
1. Be open with providers to identify existing and new sources of qualitative and quantitative data on the wider determinants of health, to obtain a more holistic understanding of the local population. 2. Identify leading General Practitioners who have a good understanding of population health needs and the data that supports improvement. 3. Utilise the expertise of other PHNs in relation to data analysis. 4. Look beyond the obvious partners; keep looking for new connections and build on existing connections to co-commissioners and link providers together. 5. Communicate with a variety of sectors (not just health) in a way that resonates with these sectors and better targets different populations.	1. Utilise a population health framework that clearly defines outcomes based on a balanced score card, such as the Quadruple Aims (health of the population, patient experience, cost, and workforce experience). 2. PHN leaders to support the organisation to move out of its comfort zone and from single organisation to integrated and inter-sectoral planning to better target different populations, particularly Aboriginal and Torres Strait Islander people and communities and those at risk of poor health outcomes. 3. Use techniques to better connect with different cultures, and follow and plot the patient journey. 4. Improve the analytics capabilities of the PHN to collect, access and analyse multiple data that accurately presents a holistic picture of the health of the population now and in the future, including inequities in population groups, and to effectively illustrate change.	1. Consider whether certain aims have greater importance or may require greater focus for particular population groups e.g. Aboriginal and Torres Strait Islander people and communities or those at risk of poor health outcomes, where access to care from improving trust may be particularly important. 2. Better connect with local communities in a way that the population/ patients are comfortable with. 3. Use contract management and evaluation skills to effectively monitor and evaluate provider performance, identifying inequities that impact on the health of the whole population.

3.4 Collaborative arrangements

This competency involves:

- Strong partnerships and robust working arrangements with other commissioners to help PHNs achieve more effective outcomes.
- Building bridges across organisations and creating formal arrangements to work collaboratively with partners and stakeholders.

3.4.1 Collaborative arrangements context for PHNs

Designing and delivering the changes needed to transform the primary health care system involves collaborative efforts by PHNs, partner organisations, clinicians and providers. As highlighted in the PHN Grant Programme Guidelines[35] PHNs are expected to:

- Develop collaborative working relationships with Local Hospital Networks (LHNs) and public and private hospitals to reduce duplication and increase the PHN's ability to commission services.
- Act as regional champions for locally relevant clinical care pathways.
- Develop cross-border cooperative arrangements where patient flows cross jurisdictions.

It is important that PHNs work collaboratively with each other, and that they share their experiences in commissioning, including strategies and approaches that they have used to tackle problems, and lessons learned. These processes are important in further supporting commissioning capability building across the PHN network.

To achieve better health outcomes for patients in commissioning services, PHNs could consider the direct and wider determinants of health. Often a multitude of interventions are required to target high risk populations and those with complex chronic conditions. It is important for PHNs to establish collaborative arrangements with partners from other sectors (such as secondary health care, community care, housing, education and justice) who can influence, plan, provide or commission for the provision of the relevant services.

Mutual benefits can be derived from doing this. Together PHNs and these organisations could commission integrated programs that provide a multitude of interventions, and thereby better target improved outcomes for people with complex chronic conditions and high risk populations.

3.4.2 Considerations for PHNs

It can be difficult to bring together different sectors and organisations, which may have conflicting goals and are used to operating only in their own regions and domains. For PHNs, this can be exacerbated by the separate funding regimes, with state/territory governments operating (and partially funding acute health services, community health, and some human services), and the federal government funding primary health care services and other human services. Consequently, organisations are not necessarily incentivised to work together to solve the more systematic issues (or address other issues).

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[35] Australian Government Department of Health. (2016). *Primary Health Networks Grant Programme Guidelines*. Available at: www.health.gov.au/internet/main/publishing.nsf/Content/PHN-Program_Guidelines

Collaborative arrangements help break down these barriers and are particularly relevant to overcome barriers to market entry. The collective knowledge and insight of a variety of partners help PHNs:

- Design more appropriate service(s)
- Commission effective delivery models and stimulate innovative practices
- Scale up supply, as appropriate
- Deliver services that better meet the needs of a diverse population
- Achieve better health outcomes.

In building collaborative arrangements PHNs can consider the benefits of collaborative decision making with stakeholders, particularly with Aboriginal and Torres Strait Islander people and communities, through Aboriginal Advisory Boards, Steering Committees and at program level utilising existing structures in communities.

PHNs should be aware of the potential for these arrangements to become 'talking shops'. To help avoid this, PHNs can establish a clear focus through shared objectives, a work program, a clearly defined approach to manage consultation, and review and improvement arrangements.

The Collective Impact framework[36] and Partnership Model[37] applied by Brisbane North PHN are approaches that PHNs could consider for collaborative arrangements. The Partnership Model can also be used in managing contracts, and includes:

- Underlying principles for working together, objectives and indicators of success to maintain a clear focus.
- Governance structures and frameworks, such as an MoU and other agreements and work programs.
- Business rules, such as performance measurement and service integration.
- Monitoring and evaluation, such as performance reporting on services provided and service satisfaction measures.

Case study 2 provides an example of collaborative arrangements to target chronic conditions and achieve better outcomes.

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[36]Kania J and Kramer M (2018). Collaboration for Impact. *Collective Impact.* Available at: www.collaborationforimpact.com/collective-impact/

[37]Brisbane North PHN. (2016). *Steady, invested, strong: A Consortium and Commissioning Toolkit.* Available at: www.brisbanenorthphn.org.au/content/Document/PHN%20toolkit_web.pdf

Case study 2: Collaborative arrangements in Western Sydney

Situation: Diabetes is one of the most significant health challenges for Western Sydney PHN (WSPHN). The region is now a diabetes hotspot with rates more than double that of Sydney's eastern and northern suburbs. Unless action is taken, the problems will continue to worsen with more than 60% of the Western Sydney population being overweight and at risk of developing type 2 diabetes. If unaddressed, by 2028 there will be a substantial economic and societal burden on the state's health care system.

Task: The decision was made in 2015 that the normal ways of tackling chronic conditions through existing funding mechanisms and health care interventions in primary care and hospital settings would not succeed against the rise of diabetes in Western Sydney. New contemporary practice and innovations were required, not only in clinical practice but also in the way in which the system works to resolve the complex determinants that manifest together.

Action: In 2015 WSPHN, in partnership with Western Sydney Local Health District (LHD) and Diabetes NSW and ACT, commenced a program of development to:

- Heighten the awareness of the issues in the Western Sydney community

- Build an alliance of sectors and agencies to address the complex determinants

- Introduce more integrated and contemporary practices for primary and secondary prevention

- Consider the case for change through an economic lens that could articulate the impact of shifting how care is determined and delivered in terms of its value to the health system in particular, and society more broadly.

Result (in the context of this case study): The Western Sydney diabetes strategy is now a multifaceted program of cross sector and agency effort that has built interventions that are far more interconnected and focused towards primary and secondary prevention. It has also built, and continues to mature, a unique collaboration and alliance of organisations that are working together to identify root causes and design interventions. This collaborative arrangement is one element that forms part of this broader project to achieve the intended outcomes.

The Western Sydney diabetes alliance has over 80 members with leadership from the PHN, LHD, NSW Government (Premier and Cabinet), and Diabetes NSW & ACT.[38] This alliance has an extensive range of Government agencies and departments including councils, universities and research institutions, primary health care organisations, NGOs, Peak bodies, local clubs and societies, food production and supply industry and retailers. The governance, communication and collaborative arrangements are reviewed on an annual basis and adapted to meet the needs of the growing alliance.

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[38] Western Sydney Diabetes. (2018). Available at: www.westernsydneydiabetes.com.au/about-us/the-core-team

3.4.3 Practical tips and skills for collaborative arrangements

Table 8 provides some practical tips that PHNs should consider in developing this competency.

Table 8: Practical tips and skills for collaborative arrangements

System	Organisation	Individual / team
1. Identify organisations that carry out similar activities, face similar problems or with valuable networks, to determine whether there would be mutual benefit in collaborating or forming strategic partnerships. 2. Network with other PHNs to identify successful collaboration processes. 3. Consider risk sharing arrangements to incentivise joint working. 4. Build on the PHN's strategic planning skills to form joint planning arrangements. 5. Regularly demonstrate progress to all partners in a way that aids their understanding, motivation and focus. 6. Network and negotiate with stakeholders to form arrangements that will create a mutual benefit. 7. Work collaboratively with ACCHS and other community representative bodies, through 'convening' rather than 'leading'.	1. Consider the use of tools that will help to build collaboration and alliances, for example, a memorandum of understanding[39]. 2. Identify potential conflicts of interest prior to forming collaborative arrangements to determine what safeguards can be put in place and manage probity considerations. 3. Convene forums with potential partners and share data and information (as appropriate) to build trust and encourage collaboration. 4. Establish formal agreements where practical to document accountabilities, including clear and transparent governance arrangements to regularly and jointly monitor and review the partnerships to ensure they are achieving the objectives.	1. Design processes with market soundings and interactions and less prescriptive requirements to encourage partnerships and collaboration. 2. Encourage and reward ownership of partnerships across all levels of the PHN.

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[39] NSW Department of Human Services (2010), *Joint Practice Guidelines.* Available at: www.community.nsw.gov.au/__data/assets/pdf_file/0017/322361/joint_practice_guidelines.pdf

3.5 Market management

This competency involves:

- Gaining a strong understanding of the market (to help address gaps or deficiencies, or market failures).
- Encouraging provider participation in minimising service gaps and fostering healthy competition.
- Monitoring the performance of the market and being a collaborative partner.
- Creating new and/or shaping existing markets and supporting their development to be sustainable and support moving towards incorporating outcomes based commissioning.

3.5.1 Context for market management

To successfully commission the primary health care services and outcomes that PHNs identify as priorities based on their needs assessments and planning, the market needs to understand, interpret, respond and deliver effectively. Therefore, it is critical that PHNs are able to understand, influence, support, develop and work collaboratively with markets.

PHNs are required to understand the structure of the market in their regions, where the market may require development, and the root causes of gaps or deficiencies. It also requires PHNs to develop an awareness of the tools that they can use to improve markets and to put these levers into practice. PHNs will also need to think differently about how they interact with the market, building on previous methods and approaches. Likewise, providers will also need to evolve their approaches to working with PHNs, operating more collaboratively and in a more flexible way.

In a commissioning context, PHNs will be looking to work with the market in three key areas, as described below.

- **Obtaining insight:** PHNs will seek to work with the market to capture and use their insights and knowledge in a range of areas. This may include providers sharing information, being involved in agreeing key priorities, or providing feedback on how a procurement process might enable maximum participation.
- **Securing the delivery of services with a greater focus on outcomes:** PHNs need markets to provide a range of primary health care services that meet the needs of the communities in their regions, including services that are culturally safe and culturally appropriate. Within a commissioning context, PHNs will take a close interest in the health of markets to ensure that providers are supplying the services that are required, and to identify and support opportunities to transition to a greater focus on outcomes based commissioning, where appropriate.
- **Generating innovation:** In a commissioning context, PHNs will want to increasingly work with the market to develop innovative ideas and new ways of working, as well as looking to national good practice. Accordingly, PHNs will be looking for the market to be more actively involved in generating innovation.

More information about markets in the PHN context can be found in the 2018 *Market Making and Development Guidance*[40] and the 2018 *Market Making and Development Toolkit*[41].

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[40] Australian Government Department of Health. (2018). *Market Making and Development Guidance*. Available at: Available at: http://www.health.gov.au/internet/main/publishing.nsf/Content/PHNCommissioningResources

[41] Australian Government Department of Health. (2018). *Market Making and Development Toolkit*. Available at: Available at: http://www.health.gov.au/internet/main/publishing.nsf/Content/PHNCommissioningResources

3.5.2 Practical tips and skills for market management

Table 9 provides some practical tips that PHNs can consider in developing the market management competency.

Table 9: Practical tips and skills for market management

System	Organisation	Individual / team
1. Utilise strategic skills to develop a clear sense of the desired outcomes the PHN is seeking to achieve and ensure that activities to change the structure of markets are targeted and aligned to the desired outcomes. 2. Expand data capabilities by considering what data can be gathered from government bodies both at a federal and state level and other data sources. 3. Collaborate and co-commission with other funders to create additional scale as a means of attracting innovative providers from other locations / areas to enter the market. 4. Network with state/territory and local agencies to hold industry wide capability development programs and events to support individuals to get the required skills to enter the market, including partnerships with local TAFE or private education providers. 5. Network with other PHNs to identify innovative ways to manage markets.	1. Design systems to record insights and market analysis from informal (once validated) and formal market engagement. 2. Use analytics to present market analysis in a meaningful way, such as by market segmentation and using geographical information systems that identify service gaps. 3. Build a communications strategy to raise awareness of the market opportunity, focusing on both traditional and non-traditional providers who could provide services, and present the PHN as attractive to work with.	1. Communicate and engage with the market (such as through market forums or soundings) to ensure a detailed understanding of underlying issues and test remedy approaches. 2. Structure arrangements to stimulate market interest whilst achieving outcomes, such as bundling or breaking-up of contract packages as well as appropriate risk allocations. 3. Consider seed funding or initial financial performance waivers to allow small providers to transition and establish in markets with limited competition. 4. Improve facilitation skills for hosting knowledge sharing and brainstorming events with diverse stakeholder groups to develop innovative ideas around specific service areas. 5. Engage with providers and develop standardised engagement material throughout the commissioning framework to evolve the relationship with providers, minimise inefficiencies and improve consistency.

3.6 Organisational capability

This competency involves:

- **Governance** - Clear accountability and timely decision making, including proactively managing risk and probity considerations.

- **Operational management –** Establishing effective systems, process and ways of working to maximise efficiency and effectiveness to deliver outcomes, including effective contract and financial management.

- **People management** - Developing the PHN's workforce and encouraging behaviours that support effective commissioning.

3.6.1 Organisational capability context for PHNs:

High quality commissioning organisations have robust governance, operational management and high quality staff to deliver transformational and cultural change. As with other organisations, the right systems, processes and corporate capabilities are needed to function day to day. To drive continuous quality improvement internally and externally across the primary health care system, PHNs should consider building the below organisational capabilities.

3.6.2 Considerations for building the organisational capability:

Governance

- PHN boards have a role in setting the organisation's strategy, risk appetite, managing this risk and taking difficult decisions, such as decommissioning services and testing new integrated approaches, to meet their strategic priorities. The Australian Institute of Company Directors outlines governance principles that are highly relevant to PHN boards.[42] PHNs should regularly review whether they are effectively carrying out their roles, demonstrating requirements in the PHN Program Performance and Quality Framework, best practice governance principles and achieving their objectives.

- Working with other parties on joint or coordinated commissioning is a complex area. Establishing joint governance arrangements early on, such as a shared vision, joint accountabilities and diversity in leadership can help reduce this complexity and ensure robust arrangements. This is particularly important for Aboriginal and Torres Strait Islander people and communities, where PHNs can consider where co-design and joint working could be practically connected with governance through joint forums, steering groups, committees etc. Any joint governance and decision making should reflect the values of the PHN and its constitution.

- A challenge for PHNs is managing potential confidentiality issues (including intellectual property), conflicts of interest and potential perceptions that PHNs favour certain providers. (This is particularly relevant for markets with limited competition where the same providers continually input into the design and procurement processes).

- In such circumstance, PHNs should consider engaging current, previous and new providers, when undertaking a co-design approach.

- It is important that PHNs are able to manage probity considerations while also gaining expert input. Maintaining a fair and transparent process will protect the PHN's reputation and encourage providers to openly participate in the commissioning process.

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[42] Australian Institute of Company Directors. (2013). *Good Governance Principles and Guidance for Not-for-Profit Organisations* Available at: http://aicd.companydirectors.com.au/resources/not-for-profit-resources/good-governance-principles-and-guidance

Operational management

A capable organisation should have policies and processes which support the effective and efficient delivery of their objectives. This involves implementing the systems and processes to help them to function efficiently and effectively day-to-day and focus more on strategic system wide issues. These systems and process include:

- **Customer relationship management (CRM) system:** enables the PHN to maintain relationships that facilitate the improvement of the health care system within their region. Key aspects of CRM for PHNs include the ability to share engagement insights with other parts of the organisation and stakeholders, receive timely feedback and develop more targeted engagement.

- **Program and project management processes:** including project planning and reporting on progress to manage key risks and meet deliverables. Standardised agreements and tender documents that the market is familiar and comfortable with can be used to reduce procurement costs and focus effort on generating greater value and innovation for all parties.

- **Contract management systems and processes**: that allow the contract manager and governance groups to track contracts (including variations), report on and monitor the performance of providers and key risks. It enables better monitoring of contracts and greater focus on managing and improving the relationship and performance of partners, as well as knowledge being retained within the system.

- **Relationship management:** this is just as, if not more, important than the systems for effective contract management. Contracts cannot be future proofed and cannot always be relied upon. Key principles for effective relationship management that PHNs could consider include:

  o Lay the foundations for success prior to the contract commencing (governance framework, identifying success, skilled resources, contract management tools, change controls, risk management, approach to dispute resolution).

  o Agree to principles of how to work together.

  o Understand the objectives and focus on managing the big issues (such as achievement of significant milestones) rather than focusing on details that may not be as critical to the relationship.

  o Utilise the contract management tools and stick to project timeframes and communicate delays.

  o Ensure timely decision making and documenting of agreed decisions.

  o Encourage a culture of quality improvement.

  o Collaborate on solving minor issues and escalating major issues.

  o Recognise success and continually invest in building skills and relationships.

- **Quality management systems:** PHNs could consider implementing quality management systems that are in line with international standards (ISO 9001:2015). Particularly in relation to data, internal processes, and customer feedback and improvement opportunities to meet policy/regulatory requirements and improve its effectiveness and efficiency on a continuous basis.

- **Organisation structure:** PHN should consider, as part of their organisational structures, how to best reflect their commissioning responsibilities. PHNs may seek to establish a commissioning team (dedicated to delivering some of the more technical and procedural aspects of commissioning) or ensure the whole organisations develops the full commissioning competencies. The benefits and disadvantages of these different structures are summarised in Table 10.
- **Financial management:** Establishing systems and processes that support effective contract and financial management (which could include designing and managing contractual and financial structures that are linked to the achievement of outcomes).

People management - workforce

As identified in the PHN Program Performance and Quality Framework, PHNs will need a well-trained and supported workforce that is able to deliver to a high standard to meet the needs of the organisation, stakeholders and region.

Strategic workforce planning that focuses on both internal and external skills development and recruiting from adjacent sectors in commissioning will help supplement the pool of available experience.

Development for all staff could incorporate a minimum level of training and support in the key commissioning competencies and cultural awareness, cultural competency and cultural safety.

Table 10: Comparison of commissioning organisation structures

Approach	Potential benefits	Potential implications
Commissioning team approach	• Allows for greater specialisation. • Contact with the market is streamlined through the one team, minimising multiple contact points for the market. • Less need for whole of organisation commissioning capability building.	• More difficult to embed a commissioning mindset across the PHN and discourages a holistic organisational approach to commissioning. • Other staff (outside commissioning team) may not properly understand commissioning requirements. • Commissioning team may not always be familiar with broader agendas. • Less capacity and flexibility of commissioning resources during busy periods. • Opportunity for career development and advancement may be more limited.
Commissioning organisation approach	• Encourages a broader 'whole of organisation' approach. • All PHN and board members are more aligned with all commissioning ambitions. • Encourages more consistent communications and inclusiveness. • Encourages all to consider the implications of their commissioning activities.	• Can limit specialist capacity/capability. • Burdens some staff who do not need to be familiar with the commissioning details. • Less regular contact with the same team for the market.

Both approaches have their advantages and disadvantages and PHNs should consider their organisational approach carefully.

One analogy in thinking this through is the delivery of workplace health and safety in Australian companies. Whilst companies may have specialist teams focussing on health and safety, it is the responsibility of all employees and have regard for workplace health and safety needs and requirements.

In commissioning terms, PHNs can establish specialist commissioning teams if preferred, but they should also embed a commissioning mindset across the whole organisation, so that all parts of the PHN are familiar with the implications of commissioning and what they can do to support it.

3.6.3 Practical tips and skills for organisational capability

Table 11 provides some practical tips that PHNs could consider in developing the organisational capacity competency.

Table 11: Practical tips and skills for organisational capability

System	Organisation	Individual / team
1. Introduce standard templates and agreements that could be used as a basis for contracting with third parties, to reduce administrative and commercial inefficiencies from reconfirming and redrafting what is market practice.	1. Regularly conduct a skills audit at all levels (including the board) against the commissioning framework and key commissioning competencies to identify capability gaps and develop strategic workforce plans for improving capability.	1. Build relational skills through training to increase the commissioning capability of the PHN.
2. Proactively manage heightened bias that may occur in markets with limited competition, such as challenging provider opinions from a system lens and involving patients in the discussion, and address probity considerations.	2. Invest in robust systems and processes for contract management, risk management and quality improvement, that enable PHNs to automate some tasks (as appropriate), track progress and operate more strategically.	2. Involve contract managers in new procurements and redesigns for similar services, to pass on their experience and to build on their relationships and understanding of the market.
3. Regularly review governance arrangements to ensure there are balanced discussions around past performance, current activities and future plans.	3. Establish and use effective technology that encourages and facilitates communication across organisational silos.	3. Collaborate and plan using tools such as a responsibility assignment matrix RACI (which defines who is responsible, accountable, should be consulted or informed) to manage projects and minimise overlaps/efficiencies across teams.
4. Regularly review the governance composition for the right mix of skills (clinical, transformational, strategic, risk and professional) and diversity that represent the local population, particularly for joint commissioning[43].	4. The whole organisation participates in developing commissioning competencies.	
5. Work with other PHNs to identify successful organisational capability building approaches, to benefit PHNs individually, and strengthen the network.		

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[43] Duckett S, Beaumont M, Bell G, Gunn J, Murphy A, Wilson R & Crowley T. (2016). Australian Healthcare & Hospitals Association. *Leading Change in Primary Care.* Available at: www.ahha.asn.au/sites/default/files/docs/policy-issue/leading_change_in_primary_care.pdf