Evaluation of the Primary Health Networks Program

Final Report

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Acknowledgement

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1. Executive summary

The Evaluation of the Primary Health Networks (PHN) Program

On 1 July 2015, the Australian Government Department of Health (the Department) established 31 PHNs across Australia as part of a suite of policy initiatives aimed at improving the efficiency and quality of primary health care. The objectives of the PHN Program are to: (1) increase the efficiency and effectiveness of medical services for patients, particularly those at risk of poor health outcomes; and (2) improve coordination of care to ensure patients receive the right care, in the right place, at the right time.

This Evaluation has been conducted with the aims of: (1) assessing how the PHN Program was implemented in local contexts; (2) understanding the extent to which the PHN Program had an impact and achieved its intended objectives; and (3) informing the ongoing implementation of the PHN Program. The Evaluation did not assess individual PHNs but used their experiences to evaluate the effectiveness of the PHN Program as a whole.

The findings in this report will help to inform the ongoing improvements within the PHN Program, which is funded through to 2021.

Outcomes of the Evaluation

The PHN Program is still a relative newcomer to the health services landscape in Australia. While PHNs are working towards achieving their objectives, they are maturing at an appropriate rate. As independent regionally-based organisations, they are bringing value to the system and their communities by proactively working to help improve service integration and address health service needs and gaps.

The vast majority of stakeholders interviewed as part of this Evaluation confirmed that the overarching Program objectives are sound and that PHNs have a critical role in helping to deliver sustainable, integrated and safe primary health care in Australia.

The PHN Program is well-aligned with other primary health care reforms and the broader policy context. One of the key challenges for the PHN Program will be developing levers to encourage Local Hospital Networks (LHNs), state and territory health departments and other agencies, to more actively engage in regional planning and support integrated service delivery at the local level.

An overview of the key findings by each Evaluation Question is presented below.

Evaluation Question 1: To what extent are PHN functions fit for purpose?

PHNs are on the way to cementing themselves as the pre-eminent primary health care organisations to effect change in the integration and delivery of health care services in their regions.

PHNs are independent, incorporated entities limited by guarantee. They provide a health system infrastructure that is separate from the Department, and this enables them to take a more agile and community inclusive approach to fulfilling their role in: (1) addressing health needs and service gaps; (2) integrating services; and (3) supporting general practice. In fulfilling these roles, it appears that the organisational design of PHNs is appropriate for achieving their regional objectives.

Importantly, while being companies limited by guarantee, PHNs are also accountable to the Department and their communities. As such, they need to be able to show that they: have robust and fit for purpose governance; have appropriate capability and capacity; and can demonstrate progress towards achieving health outcomes both locally and nationally over the medium to longer term.

Over the Evaluation period, PHNs have been strongly focussed on developing optimal governance arrangements and understanding the implications of their role as regional commissioners of health services. While several PHNs are still evolving their governance arrangements (for example, membership structures and determining the role of Clinical Councils and Community Advisory Committees) to best meet their objectives, overall, substantial progress has been made in this regard.

It is clear that building PHN capability and capacity, as well as undertaking the associated change management, requires significant time and effort. PHNs would benefit from a period of stability so that they can continue to embed their core functions into business as usual. To fulfil their mandate for reform, PHNs require time to continue to establish their relationships, trust and respect with key local stakeholders. A key risk is that new and competing priorities could take the focus away from core business, if not managed carefully.

The Department's internal development of the PHN program and external communication activities would be significantly strengthened by: (1) a Program Framework, which is set within a broader national primary health care strategy, that clearly sets out the longer-term strategy for the Program and how it interrelates with other reforms; and (2) ongoing development of relevant Program guidance materials (which form part of the Program Framework). These key supports will also assist PHN staff and external stakeholders to better understand the intent of the PHN Program and how it is expected to operate.

A key strength of the PHN Program has been the very collaborative way in which PHNs support each other and work together for the benefit of the network. This can be leveraged to continue to build capability and capacity of PHNs. Further, the collaborative work of the PHNs can be used to strengthen the Program and its governance, for example by establishing a Governance Working Group. The newly established PHN Chief Executive Officer (CEO) Cooperative, if appropriately supported, will be important to establish the national profile of PHNs, and to better enable PHNs to engage with national stakeholders.

A potential limitation to the PHN Program's ongoing development is the very "lean" nature of most PHNs' operating models, particularly for PHNs in rural and remote areas. Without sufficiently resourced operating models, PHNs will be hindered in their ability to build capability and scale-up to meet future expectations. Strategies to mitigate this risk include identifying potential economies of scale, as well as leveraging and formalising the collaborative approach. Reviewing the current program-based funding model could enable greater flexibility in how PHNs utilise their resources to achieve expected outcomes, and revising the weighting in operational and program-based funding could better support rural and remote PHNs. In addition, longer-term funding cycles would enable PHNs to better plan and align funding arrangements with LHNs.[1]

Evaluation Question 2: Has the PHN Program increased the efficiency and effectiveness of medical services for patients, particularly those at risk of poor health outcomes?

The PHN Program is showing indications of progress in achieving early outcomes. For example, PHNs are: demonstrating a better understanding of the health needs of their communities (through analysis and planning); identifying and building effective partnerships to address shared priorities; and are developing innovative ways of commissioning services. The Program is fostering the development of a primary health care commissioning model to suit the Australian context, with ongoing investment required to ensure PHNs have sufficient capability and capacity to commission effectively.

[1] Local Hospital Networks is the term used in this report, but the term also encompasses their equivalents: Local Health Districts (New South Wales) and Hospital and Health Services (Queensland).

The PHN commissioning model is a developmental one where PHNs have been learning as they go and evolving their approaches, some faster than others. Many PHNs are still working through what is required to deliver leading practice methods of commissioning which are relevant to their local contexts. During the establishment period of the PHN Program, the focus was on maintaining continuity of care. Following this, commissioning activities have focused on addressing needs and gaps to improve access to services. To date, the majority of commissioning activity has focused on mental health, drug and alcohol treatment services and Indigenous health services with over 2,900 service providers were commissioned through PHNs in 2016-17.[2] Given this, it would perhaps be appropriate to broaden the definition of the PHN Program objective to include all 'health' services, not just medical services.

Given the relatively small size of their commissioning budgets, PHNs need to work strategically with all their stakeholders (such as the Department, LHNs, state and territory health departments, service providers and other agencies, communities and consumers) to optimise opportunities for partnerships and coordinated approaches to influence the efficiency and effectiveness of health services. This requires a non-transactional approach to commissioning that values the time it takes to engage properly with all relevant stakeholders and commission according to prioritised need and expected impact. The reality of one year funding cycles has been a significant limitation in this regard.

Importantly, PHNs have developed partnerships with LHNs to support better integration of services. These partnerships have enabled alignment of objectives and activities, for example, through coordination, commissioning and through establishing joint governance structures. However, whilst there are examples of developing relationships between PHNs and LHNs, much still depends on the goodwill of individuals rather than being systematically embedded throughout the PHN Program.

Effective consumer engagement, including patient feedback for shaping future service design, is an ongoing area of development. While Community Advisory Committees provide an opportunity for this, other mechanisms need to be put into place by PHNs to enable them to engage better with the people in their regions.

Many non-government service providers were initially threatened by the new commissioning approach since it was a major change, and some providers lost contracts due to needs and priorities changing. It has taken time for PHNs to build or rebuild trust with service providers and further work is required across the system to better educate all stakeholders about PHN commissioning. In general there needs to be a stronger recognition that commissioning should be a mechanism to drive the integration, and not fragmentation, of services through co-design, coordinated commissioning and cooperative partnerships.

In the absence of other levers, PHNs' power to influence the efficiency and effectiveness of medical services provided within general practice has also been more indirect than direct, for example via the provision of practice support. Practice support is not a new notion for organisations like PHNs, however, there is still work to be done to increase PHNs' reach into the less engaged quarters of general practice. To date, most PHNs have relied on fairly resource-intensive approaches to practice support (for example, practice visits, face to face education sessions), but more scalable strategies will need to be explored (for example, by utilising technology). The implementation of My Health Record provides PHNs leverage to achieve a broader level of reach.

The upcoming implementation of the *Primary Health Networks Program Performance and Quality Framework (Version 2)* provides an opportunity to systematically measure the Program's efficiency and effectiveness (based on a set of agreed outcomes and accountabilities) and thus inform its ongoing development. Underpinning this will be the successful collection of data both locally and at scale, from which improvements can be measured and attributed at both a PHN and Program levels.

Evaluation Question 3: Has the PHN Program improved the coordination of care to ensure patients receive the right care, in the right place, at the right time?

The Evaluation has demonstrated that PHNs have made some progress in building the strong foundations required to improve regional coordination of care to benefit patients and the health system as a whole. They have done so through their relationship-building and system integration and capacity-building activities (for example, supporting general practice), as well as through broader service-level and patient-level integration activities (for example, referral pathways and the establishment of referral units).

The strategic capability of PHNs to identify key relationships and partnerships has increased over time. PHNs have established the building blocks to allow stakeholder partnerships to continue to improve as PHNs and local stakeholders have more opportunities to work together. More formal and innovative arrangements (for example, with LHNs), are already in progress to achieve the shared objectives of improving local integration and coordination of care.

The PHN Program has also provided opportunities for the Australian Government and state and territory governments to implement policies supporting greater integrated care (particularly in New South Wales and Queensland). These policies are consistent with, and aimed at, leveraging the Program's objectives of enabling greater care coordination, as well as improving the efficiency and effectiveness of medical services. To this end, in the longer term, it may also be appropriate for PHNs to have a role in supporting regional preventive health activity to help influence and reduce the overall demand for health care services.

The next National Health Agreement, starting in 2020, will be an important vehicle for the jurisdictions to further signal their longer-term intent to improve coordinated care for patients with chronic and complex conditions. The commitment to joint planning and funding at a local level in the Council of Australian Government's recent 2018 Heads of Agreement certainly signals this intent.[3]

Better engagement and improved ways of working with service providers remains a priority for PHNs, particularly with the Aboriginal Community Controlled Health Sector. Many PHNs experienced challenges in having the appropriate capability to work with their local Aboriginal and Torres Strait Islander communities, as well as ensuring adequate skills representation from these communities within their governance structures. Most PHNs also need to engage more effectively with their wider community to understand and influence expectations of the health system; Community Advisory Committees are an important part of this engagement process.

Given the range of reforms[4] which PHNs are involved in, it will be worthwhile considering what other levers they can employ to ultimately become the link between the primary, acute and community sectors within their regions. Linking the various sectors will enable more planned, navigable, coordinated and equitable person-centred care.

It will also be useful to consider which levers the Australian Government and the Department can employ to full effect. For example, the Australian Health Ministers' Advisory Council could take responsibility for removing disincentives to PHNs and LHNs working together and ensuring there are sufficient incentives for LHNs and states and territories to work in partnership with PHNs.

[3] Based on the 2018 Heads of Agreement, the key themes will be: paying for value and outcomes; joint planning and funding at a local level; nationally cohesive health technology assessment; empowering people through health literacy; prevention and wellbeing; enhanced health data; and private patients in public hospitals.

[4] Including the stage one trial of Health Care Homes, My Health Record participation trials, the Mental Health Reform Lead Site Project and the National Suicide Prevention Trial.

Evaluation Question 4: How are the information, advice and support needs of PHNs identified in relation to the national support function and how effective has the Department been in providing support?

At the outset of the program, it was acknowledged that there was tension between the Department's roles as funder, centralised support and performance manager for the PHN Program. Although this was not fully resolved during the evaluation period, the Department (led by the PHN Branch) built a generally trusting and transparent relationship with the PHNs, while also developing its own capability and capacity to respond to the rapidly evolving nature of the PHN Program. This was very important in facilitating the roll-out of the PHN Program and provides a strong basis for future support.

While the Department recognised the need for materials and support to PHNs, given the rapidly evolving needs and demands of the PHN Program this was challenging and, as a result, support to PHNs was somewhat reactive at times. It is timely for the Department to take a more proactive approach to the PHN Program's development. The implementation of the *Primary Health Networks Program Performance and Quality Framework (Version 2)* provides the Department with a good opportunity to demonstrate this change in approach, particularly as it establishes itself more in the role of 'performance manager'. This includes identifying those PHNs which require a stronger focus on performance improvement, while allowing those who are performing well to get on with their roles and functions.

To date, the PHNs' use of and access to timely and granular data has been limited. The introduction and implementation of the *Primary Health Networks Program Performance and Quality Framework (Version 2)* will also provide an opportunity for the ongoing development, access and monitoring of timely and relevant data for both PHNs and the Department. However, the Department's technical expertise needs to be enhanced to provide appropriate guidance and support to PHNs in this area. There is also a need for the Department to ensure improved information and data sharing with and between PHNs; this could be through a more proactive approach to data management, access and release.

Taking a more proactive approach to national support would enable greater collaboration and innovation across the Department and strengthen its ability to manage the PHN Program, for example, by consolidating the learnings from all ongoing evaluations involving PHNs[5] and enhancing the Program's design and implementation. A unified approach, which has the internal governance arrangements in place to support this, would also reduce duplication and improve the Department's operational management of the PHN Program.

[5] ibid.

Opportunities for future development of the PHN Program

The PHN Program has the potential to help address some of the key structural challenges which impact the ability of the Australian health care system to provide efficient and effective services across the continuum of care.[6,7]

The findings throughout this evaluation relate to 11 common themes, and as a result, the opportunities for the future development of the Program can be grouped thematically as outlined in Table 1.

Table 1: Summary of key findings and opportunities for the development of the PHN Program

Finding		Opportunities for future development of the PHN Program
Governance	Governance has been an area of ongoing development and improvement across the PHN Program. Further work is required to ensure that all governance structures (Board, Clinical Councils and Community Advisory Committees) are robust and fit for purpose.	• The Department and PHNs to periodically review the appropriateness and effectiveness of PHN governance arrangements (Boards, Clinical Councils and Community Advisory Committees) to ensure they are fit for purpose, have appropriate input and are working effectively. • The Department and PHNs to explore opportunities to enhance the role of Clinical Councils and Community Advisory Committees to ensure they are: (1) relevant to local circumstances and context; and (2) to strengthen community participation in decision-making. But also to ensure there are mechanisms in place for consumer participation.
External collaboration and stakeholder engagement	PHNs need to continue to establish their authority with key stakeholders through appropriate mechanisms and by working together effectively. There is a need for a more developed program of engagement between PHNs and national stakeholders. While PHNs are engaging locally and at a jurisdictional level, it will be important moving forward to engage on a national level to understand how PHN decisions are received and their impacts.	• The Department and PHNs to strengthen stakeholder engagement and communication across the PHN Program through identifying mechanisms to engage with national peak bodies and state and territory governments, e.g. through the PHN CEO Cooperative, bilateral agreements, and health care agreements. • The Department and PHNs to better enable local knowledge to be leveraged to direct national policy and use PHNs as agents for system change. • The Department to explore the scope for PHNs to have a longer-term role in supporting regional preventive health activity to help influence and reduce overall demand for services. • PHNs to work with their Clinical Councils and other stakeholders to increase their engagement and reach with general practice and enhance general practice capability and capacity (e.g. through sharing best practice and lessons learned).
Commissioning	The commissioning role of PHNs was new and seen by some stakeholders and service providers as a threat if they perceived competition or conflict of interest. Ongoing education and engagement of providers will be required to enable increasingly coordinated commissioning and cooperative partnerships to build system capacity.	• The Department to support PHNs to apply a continuous improvement approach to ensure commissioning and decommissioning is appropriate, effective and efficient, and that PHNs are fit for purpose for commissioning. • The Department to support PHNs to engage with stakeholders in a regionally coordinated way to co-design and co-commission services, and enable market development. • The Department to support PHNs to ensure they manage conflicts of interest appropriately and employ best practice probity strategies to support commissioning.
Performance management	Performance management across the PHN Program has been a challenge, and will continue to be, given that each PHN is unique. It is also challenging for the Department to balance its roles as funder, national support and performance	• The Department and PHNs to collaborate to implement the *PHN Program Performance and Quality Framework (Version 2)* and use strategic evaluation to identify risks, challenges and opportunities to improve the effectiveness and efficiency of the PHN Program. • The Department to better align the monitoring and evaluation processes undertaken by PHNs to enable greater consistency in approach and build their capability in this area.

[6] Department of Health 2016. *Better Outcomes for People with Chronic and Complex Health Conditions: Report to Government on the Findings of the Primary Health Care Advisory Group,* December 2015.

[7] EY, Menzies Centre for Health Policy & WentWest 2015. *A Model for Australian General Practice: The Australian Person-Centred Medical Home. A sustainable and scalable funding model to improve care for people with chronic and complex care needs. How can we make it happen?* November 2015

Finding		Opportunities for future development of the PHN Program
	manager. As PHN performance management moves from activity based reporting to outcomes based, appropriate ongoing support and capability building for both the Department and PHNs will be important.	
Program guidance	There is limited documentation on the PHN Program that can be shared with external stakeholders which clearly articulates its intent and how the PHNs are expected to operate. A Program Framework and other external guidance materials would improve stakeholder engagement.	• The Department to develop program guidance materials, as part of the Program Framework, which are public and can be shared with external stakeholders to assist them to better understand the intent of the PHN Program, including, for example: – the policy intent of the PHN Program; – objectives and outcome expectations; – ongoing and additional materials for commissioning processes; – governance processes; – PHN Program operations and performance management; and – Department roles as funder, performance manager and national support.
Operations: Departmental	In the early stages of the Program, there was potential for fragmented management of PHNs in the delivery of different programs. There is a need for the Department to strengthen how it manages the PHN Program as one program, with internal governance arrangements in place to support this.	• The Department to strengthen the operational management of the PHN Program by: – developing and implementing the Program Framework; – developing program guidance materials; – improving information resources on the intent and purpose of the PHN Program; – improving internal business processes to reduce duplication and the reporting burden on PHNs, e.g. rationalisation and alignment of funding schedules; and – putting into place internal governance structures to support management of the PHN Program as a whole, for example, through an internal PHN Program Board and a designated executive champion for the Program.
Operations: PHN Program	A strength of the program to date has been the very collaborative way in which PHNs support and work together for the benefit of the network, and their communities.	• The Department to continue to encourage and facilitate PHNs in sharing good practice and learnings, including: – championing and supporting the PHN CEO Cooperative; and – supporting PHN collaboration and sharing of resources through various fora, such as SharePoint and PHN Forums. • The Department and PHNs to explore opportunities for a shared service model including, for example, corporate services and data analytics.
Funding model	A potential limitation to the PHN program's ongoing development is the 'lean' nature of most PHNs' operating models which could hinder their ability to build capability and scale-up to meet future expectations.	• The Department to periodically review the PHN funding model to ensure PHNs are able to deliver their key functions (including practice support). • The Department to support/encourage PHNs to continue to explore opportunities to creating efficiencies across the network through increased collaboration and sharing of ideas.
National support function	The Department built strong relationships with the PHNs while developing capability and capacity to respond to the rapidly evolving nature of the PHN Program – providing a strong basis for the next stage of the program.	• The Department to champion and strengthen existing PHN information-sharing mechanisms and processes.
Aboriginal and Torres Strait Islander health	Many PHNs experienced challenges achieving appropriate skills representation from the Aboriginal and Torres Strait Islander communities on governance structures, and engaging with these people and communities was sometimes limited.	• The Department and PHNs to increase engagement and strengthen relationships with Indigenous health services and Aboriginal and Torres Strait Islander communities, including through encouraging participation on PHN governance structures. • PHNs to share best practice across the Network where engagement and relationships with the Indigenous Health sector and Aboriginal and Torres Strait Islander communities is working well.

Finding		Opportunities for future development of the PHN Program
		• The Department to reiterate the importance of the PHN and Aboriginal Community Controlled Health Organisations (ACCHO) – Guiding Principles[8] that recognise the commitment by PHNs and Aboriginal Community Controlled health services to work together to improve access to health services and improve health outcomes for Aboriginal and Torres Strait Islander people. • The Department to work with Indigenous health sector stakeholders and PHNs to clarify what the role of the PHN Program is in commissioning Indigenous health services.
Use of data in the PHN Program	PHN access to and use of timely and granular data is limited. Enhancement of the Department's technical expertise would assist them to provide guidance and support to PHNs.	• The Department and PHNs to explore opportunities to harness existing infrastructure and provide economies of scale for identified data access, information sharing and governance needs. One option in this regard includes partnering with the Australian Institute of Health and Welfare (AIHW). • PHNs should continue to work with local stakeholders to improve access to smaller area data (e.g. GPs and LHNs) to inform needs assessments and commissioning priorities, as well as measure outcomes from commissioned services.

[8] http://www.health.gov.au/internet/main/publishing.nsf/Content/PHN-Accho

2. The Primary Health Networks Program

2.1 Primary health care in Australia

Since the 1980s, there has been an international trend towards strengthening primary health care in recognition of its contribution to improving population health, reducing health inequalities and costs, and increasing patient satisfaction.[9,10] The form that primary health care organisations take, the issues they address and the strategies available to them are shaped by the system in which they operate.

Australia, like a number of other countries, created primary health care organisations as a vehicle for developing primary health care through program implementation, local leadership, coordination and support. These organisations were also intended as a vehicle through which governments can engage the sector in reform and policy development.[11]

In 1992, Divisions of General Practice were established to improve the health outcomes for patients by encouraging general practice to work together and with other health professions to improve the quality of health service delivery at the local level.

Following the Government's health review, *A healthier future for all Australians,* by the National Health and Hospitals Reform Commission in 2009, 61 Medicare Locals were established, evolving from or replacing the Divisions of General Practice. Medicare Locals were established to coordinate and integrate primary health care, address service gaps and improve navigation of the health system.

In parallel to the establishment of the Medicare Locals, state and territory governments created regional organisations called Local Hospital Networks (LHNs)[12] to regionally manage and coordinate state-funded hospital and health services. Most Medicare Locals formed strong partnerships with local services in their regions including LHNs. However, although there were examples of good work performed by Medicare Locals, a review conducted by Professor John Horvath in 2014 recommended they be replaced by a new form of regional primary health organisations.[13] The Review identified a need for an organisation to be charged with improving patient outcomes through working collaboratively with health professionals and services to integrate and facilitate a seamless patient experience, including boundary alignment with LHNs for engagement and flexibility to accommodate local circumstances.

[9] Starfield B & Shi L 2002, 'Policy relevant determinants of health: an international perspective', *Health Policy* 60: 201–18.

[10] Kringos D, Boerma W, Hutchinson A, van der Zee J & Groenewegen P 2010, 'The breadth of primary care: a systematic literature review of its core dimensions'. *BMC Health Services Research* 10(1): 65.

[11] Nicholson C, Jackson CL et al. 2012, 'The Australian experiment: how primary health care organizations supported the evolution of a primary health care system', *Journal of the American Board of Family Medicine* JABFM, 25, pS18–S26.

[12] Local Hospital Networks is the term used in this report, but the term also encompasses their equivalents: Local Health Districts (New South Wales) and Hospital and Health Services (Queensland).

[13] Professor John Horvath, Review of Medicare Locals, 2014. URL: http://www.health.gov.au/internet/main/publishing.nsf/content/review-medicare-locals-final-report

2.2 The Primary Health Networks Program

Establishment of the PHN Program

The Australian Government announced the PHN Program in the 2014–15 Budget. On 1 July 2015, the Australian Government Department of Health (the Department) through a competitive tendering process (the *Invitation to Apply* process)[14] established 31 PHNs across Australia as part of a suite of policy initiatives aimed at improving the efficiency and quality of primary health care. Appendix A illustrates the distribution of PHNs.

The PHN Program differs from other Australian Government Department of Health programs in that PHNs are independent, regional, membership-based organisations limited by guarantee. The premise of PHNs as independent organisations is that they provide an infrastructure which is not of the Department, but rather of the system. This aims to facilitate PHNs being embedded within their communities (including providers, particularly general practice and the broader primary health care sector) and their role as planners, commissioners and integrators of services for their region. PHNs are able to make local commissioning decisions independent from government(s), as well as establishing a more local presence.

PHNs have a regional commissioning and system integration role, with strong stakeholder engagement. They are intended to provide a regional infrastructure across Australia for implementing national primary health care policy and programs, as well as linkages across the health system. The devolved governance model for PHNs allows them to allocate funding for health services in their region based on locally identified need.

Objectives of the PHN Program

PHNs were established with two overarching objectives.

1. To increase the efficiency and effectiveness of medical services for patients, particularly those at risk of poor health outcomes.
2. To improve coordination of care to ensure patients receive the right care, in the right place, at the right time.

Role of PHNs and their priorities

To achieve the objectives of the PHN Program, PHNs have three main roles.

1. Commission health services that meet the needs of the people in their regions and fill identified gaps in primary health care.
2. Work closely with general practitioners (GPs) and other professionals to build health workforce capacity and provide the highest quality standard of care through practice support activities.
3. Work collaboratively to integrate health services at the local level to create a better experience for patients as they navigate the health system, reduce waste and red tape and eliminate service duplication.

In establishing the PHN Program, the Government set six priorities for targeted work by PHNs: mental health; Aboriginal and Torres Strait Islander health; population health; health workforce; digital health; and aged care.

Some of the key defining characteristics of PHNs on top of being independent, regional, membership-based organisations limited by guarantee include:

- they do not directly provide services, except in the case of market failure; and
- they have Clinical Councils and Community Advisory Committees as fundamental components of

[14] The *Invitation to Apply* process provided the opportunity for applicants to apply to become a PHN through a competitive process. Applications were assessed against eligibility and selection criteria, as outlined in the *Primary Health Networks Grant Program Guidelines*.

their governance structures (see Appendix B for an overview of their intended roles).

Despite being a smaller player in the Australian health system in terms of their funding allocation, PHNs increasingly play a large and important role in improving the coordination of care and in turn, improving the efficiency and effectiveness of health services in Australia through the effective use of their funding.

PHN funding model

PHNs receive four streams of funding from the Department, with funding agreements outlining the activities and outputs expected of PHNs.

1. Operational funding: this is for the administrative, governance and core functions of PHNs. This funding is used to support the operations and maintenance of PHNs (e.g. premises, governance and Board, core staff, and office administrative costs including information technology (IT) requirements). Operational funding enables PHNs to conduct needs assessments and associated population health planning. It is also used to fund Clinical Councils and Community Advisory Committees, stakeholder management and engagement, and practice support activities.
2. Flexible funding: this enables PHNs to commission services in response to national priorities identified by the Australian Government and PHN-specific priorities. These include programs relating to Aboriginal and Torres Strait Islander health, culturally and linguistically diverse health services.
3. Program funding: this funding is tied to commissioning services for the national priority areas (for example drug and alcohol treatment services, and mental health and suicide prevention).
4. Innovation funding: this is intended for PHN investment in new innovative models of primary health care delivery.

National support for the PHN Program

The Department provides support for the PHN Program through the National Support Function in the PHN Branch. The role of the National Support Function is to:

- provide strategic program management to ensure program objectives are achieved and broader Departmental objectives are supported;
- provide communications, leadership and support to all PHNs; and
- gather and share intelligence at both PHN and Departmental levels.

Further details on the National Support Function are included in Section 8.1.

The Department also has responsibility for monitoring the performance of the PHNs and funding the PHN Program. Monitoring performance was initially undertaken using the *PHN Program Performance Framework (Version 1.0)* for the initial core funding schedules and contracts. A new *PHN Program Performance and Quality Framework (Version 2)* is under development that accommodates the expansion of the PHN Program into new program areas. Further details of performance management are included in Section 8.2.

PHN contextual factors

Most of the organisations selected as PHNs were formerly Medicare Locals, with some forming a direct 1:1 transition from Medicare Local to PHN region. Some PHNs transitioned directly from a Medicare Local with the same boundaries; some were formed by a partnership of multiple Medicare Locals; some were new membership-based entities; and some were operated by state and territory health organisations (where changes to the Board required approval by the state or territory Health Minister).

In some cases, PHNs have direct alignment with the boundaries of an LHN, whereas other PHNs have multiple LHNs within their region adding to the complexity of their local context. The areas that PHNs serve range from large areas with sparse populations, to rural and regional areas with mixed population densities, to smaller and higher-density areas in metropolitan areas. The contextual

information on each PHN, including state and territory alignment, area size, population size and organisational history is shown in Table 2.

Table 2: Contextual information on the 31 PHNs[15]

PHN	State	Area (square km)	Population	Organisational history[16]
Central & Eastern Sydney	NSW	626	1,472,849	Previously Medicare Local [iv]
Northern Sydney	NSW	890	878,153	Previously Medicare Local [iv]
Western Sydney	NSW	766	885,634	Previously Medicare Local [i]
Nepean Blue Mountains	NSW	9,063	356,230	Previously Medicare Local [i]
South Western Sydney	NSW	6,186	904,609	Previously Medicare Local [i]
South Eastern NSW	NSW	50,177	592,245	Previously Medicare Local [iii]
Western NSW	NSW	433,379	307,201	Previously Medicare Local [iii]
Hunter New England & Central Coast	NSW	130,646	1,223,548	Previously Medicare Local [iv]
North Coast	NSW	32,047	501,290	Previously Medicare Local [i]
Murrumbidgee	NSW	124,413	238,807	Previously Medicare Local [i]
North Western Melbourne	VIC	3,212	1,28,789	Previously Medicare Local [iii]
Eastern Melbourne	VIC	3,956	1,422,366	Previously Medicare Local [iv]
South Eastern Melbourne	VIC	2,935	1,396,800	Previously Medicare Local [iv]
Gippsland	VIC	42,012	263,858	Previously Medicare Local [i]
Murray	VIC	97,068	578,588	Previously Medicare Local [i]
Western Victoria	VIC	79,843	599,083	Previously Medicare Local [iv]
Brisbane North	QLD	3,901	925,896	Previously Medicare Local [i]
Brisbane South	QLD	3,770	1,073,633	Previously Medicare Local [iii]
Gold Coast	QLD	1,798	551,530	Previously Medicare Local [i]
Darling Downs and West Moreton	QLD	95,639	532,579	New organisation
Western Queensland	QLD	937,118	71,828	New organisation
Central Queensland, Wide Bay & Sunshine Coast	QLD	154,426	811,880	Previously Medicare Local [ii]
Northern Queensland	QLD	510,684	689,457	New organisation
Adelaide	SA	1,553	1,187,349	Previously Medicare Local [ii]
Country SA	SA	963,296	483,478	Previously Medicare Local [ii]
Perth North	WA	2,975	1,036,793	Previously Medicare Local [iii]
Perth South	WA	5,148	942,992	Previously Medicare Local [iii]
Country WA	WA	2,477,561	542,310	Previously Medicare Local [iii]
Tasmania	TAS	68,018	513,159	Previously Medicare Local [i]
Northern Territory	NT	1,345,558	240,759	Previously Medicare Local [i]
Australian Capital Territory	ACT	2,351	381,488	Previously Medicare Local [i]

[15] Details regarding information provided in the Population column is based on the "ML_PHN concordance September 2015" spreadsheet provided by the Department of Health on 28 November 2016

[16] [i] Direct transition from Medicare Local

[ii] PHNs that directly transition from a Medicare Local to a PHN with expanded boundaries (taking in areas previously covered by other Medicare Locals)

[iii] A consortium of Medicare Locals and other organisations (for example, service providers, universities, NGOs, Local Government, LHN, peak bodies) establishing a PHN with member organisations.

[iv] Multiple Medicare Locals forming a partnership as a PHN

Evolution of the PHN Program

The PHN Program has grown significantly since its commencement. Originally, PHNs were funded for $880 million over three years under the Core Schedule to deliver local primary health care services based on local needs, and to improve the coordination, efficiency and effectiveness of health services. PHNs were also funded at this time to deliver $241 million in After Hours services over four years and $287 million in Partners in Recovery activities to better support people with severe and persistent mental illness.

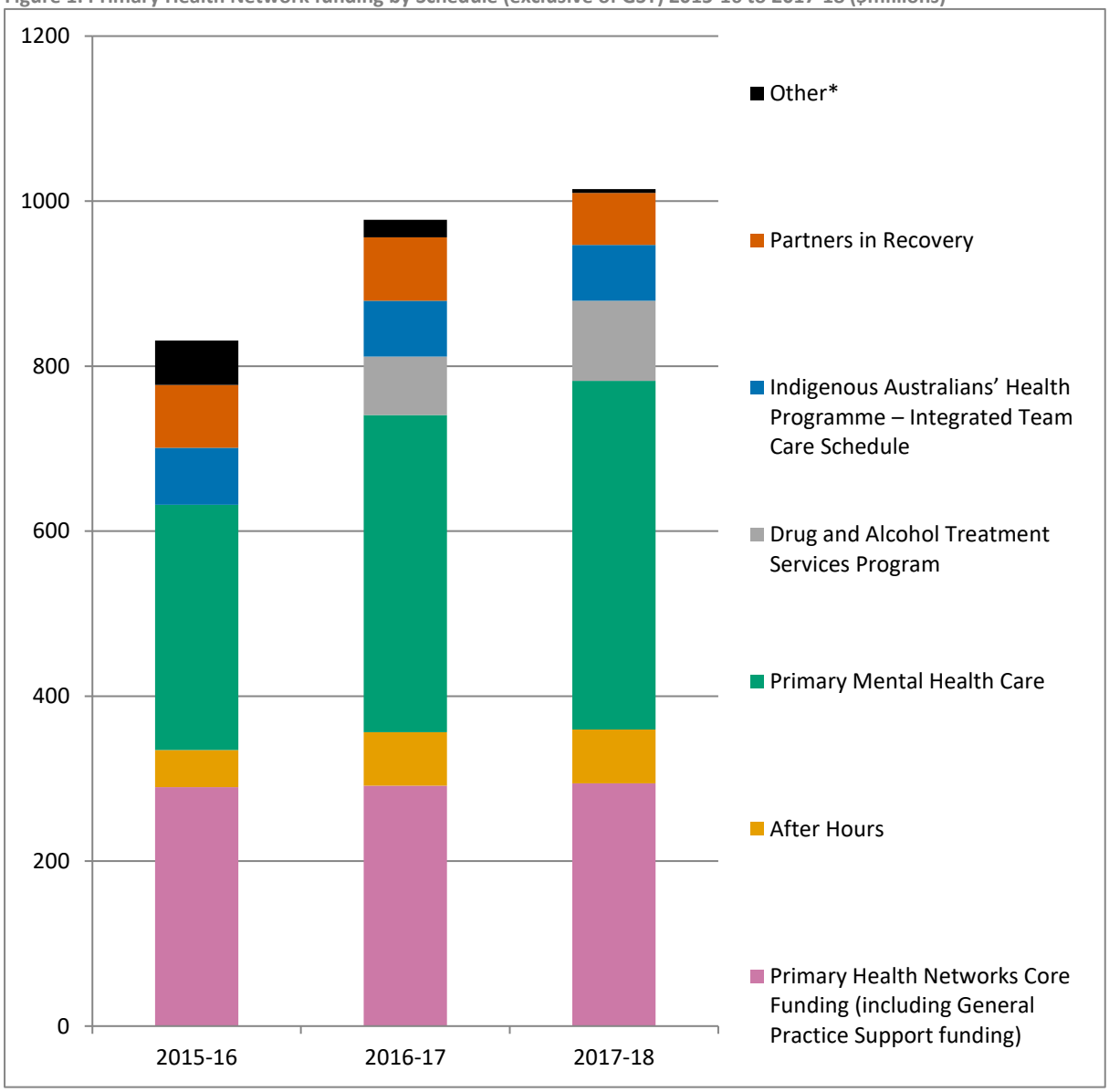
Additional funding has been provided to PHNs to undertake significant new activities in their regions including:

- $1.5 billion in Primary Mental Health Care funding directed through PHNs to ensure a range of mental health services are available to better match individual and local population needs.
- $241 million in additional funding under the National Ice Action Strategy to commission drug and alcohol treatment services.
- $204 million in additional funding for the Indigenous Australians' Health Programme – Integrated Team Care Schedule, to commission locally tailored services for Aboriginal and Torres Strait Islander people.
- $36 million for 12 suicide prevention trial sites across the country (2016–17 mid-year economic and fiscal outlook).
- $28.9 million for 10 additional headspace centres by 2019, bringing the overall total to 110.
- $80 million over four years to implement the National Psychosocial Support measure to assist people with severe mental illness resulting in reduced psychosocial functional capacity who are not eligible for assistance through the National Disability Insurance Scheme.
- $4.3 million for 10 PHNs to support the implementation of the Health Care Homes trial.
- $39.5 million for PHNs to assist the Australian Digital Health Agency with the delivery of the My Health Record Expansion Program.
- $8.3 million to support the *Greater Choice for At Home* palliative care measure through 10 PHNs (January 2018).[17]

Figure 1 summarises PHN Program funding for three financial years from 2015-16. It is worth noting that additional funding provided to PHNs varied in the level of flexibility afforded to PHNs and this influenced how they could affect change.

[17] Funding breakdown provided by the Australian Government Department of Health, April 2018.

Figure 1: Primary Health Network funding by Schedule (exclusive of GST) 2015-16 to 2017-18 ($millions)[18]



**'Other' includes program funding that has ceased, or provided to individual PHNs for specific purposes, including trials.*

2.3 The operating context of the PHN Program

The context in which PHNs operate is continually evolving. A number of major reforms have been introduced by the Australian Government which have implications for both PHNs and primary health care more broadly:

- Release of Contributing Lives Thriving Communities: National Review of Mental Health Programmes and Services report (April 2015).
- Establishment of the Medicare Benefits Schedule Review Taskforce (June 2015).
- Introduction of the stage one trial of Health Care Homes (March 2016) with recruitment of practices now underway – following the Primary Health Care Advisory Group review (December 2015).
- Practice Incentive Payments scheme revised focus on after hours in general practice (July 2015).

[18] $10 million was withheld from the PHN's Primary Mental Health Care 2017-18 allocation as contingency for any future unforeseen requirements.

- Establishment of the Australian Digital Health Agency (July 2016) which has a major role in supporting the national expansion of My Health Record during 2018 (announced in May 2017).
- Announcement of Private Health Insurance Review reforms (October 2017).

As these areas of reform were not included in the scope of this Evaluation, this report does not assess the impact of these; rather, they provide context to the progress of PHNs and the PHN Program.

3. The Evaluation of the Primary Health Networks Program

3.1 Objectives and scope of the Evaluation

The aims of the Evaluation of the PHN Program were to: (1) assess how the PHN Program was implemented in local contexts; (2) understand the extent to which the PHN Program had an impact and achieved its intended objectives (as set out in Section 2); and (3) inform the ongoing implementation of the PHN Program. The Evaluation did not assess individual PHNs but instead used their experiences to evaluate the effectiveness of the PHN Program as a whole.

The primary questions for the Evaluation were:

1. To what extent are PHNs fit for purpose? Due to the complexity of this question, the Evaluation considered it in two parts:
   a. To what extent are PHN operational foundations fit for purpose?
   b. To what extent are the PHN functions fit for purpose?
2. Has the PHN Program increased the efficiency and effectiveness of medical services for patients, particularly those at risk of poor health outcomes?
3. Has the PHN Program improved the coordination of care to ensure patients receive the right care, in the right place, at the right time?
4. How are the information, advice and support needs of PHNs identified in relation to the national support function and how effective has the Department been in providing this support?

3.2 Evaluation approach

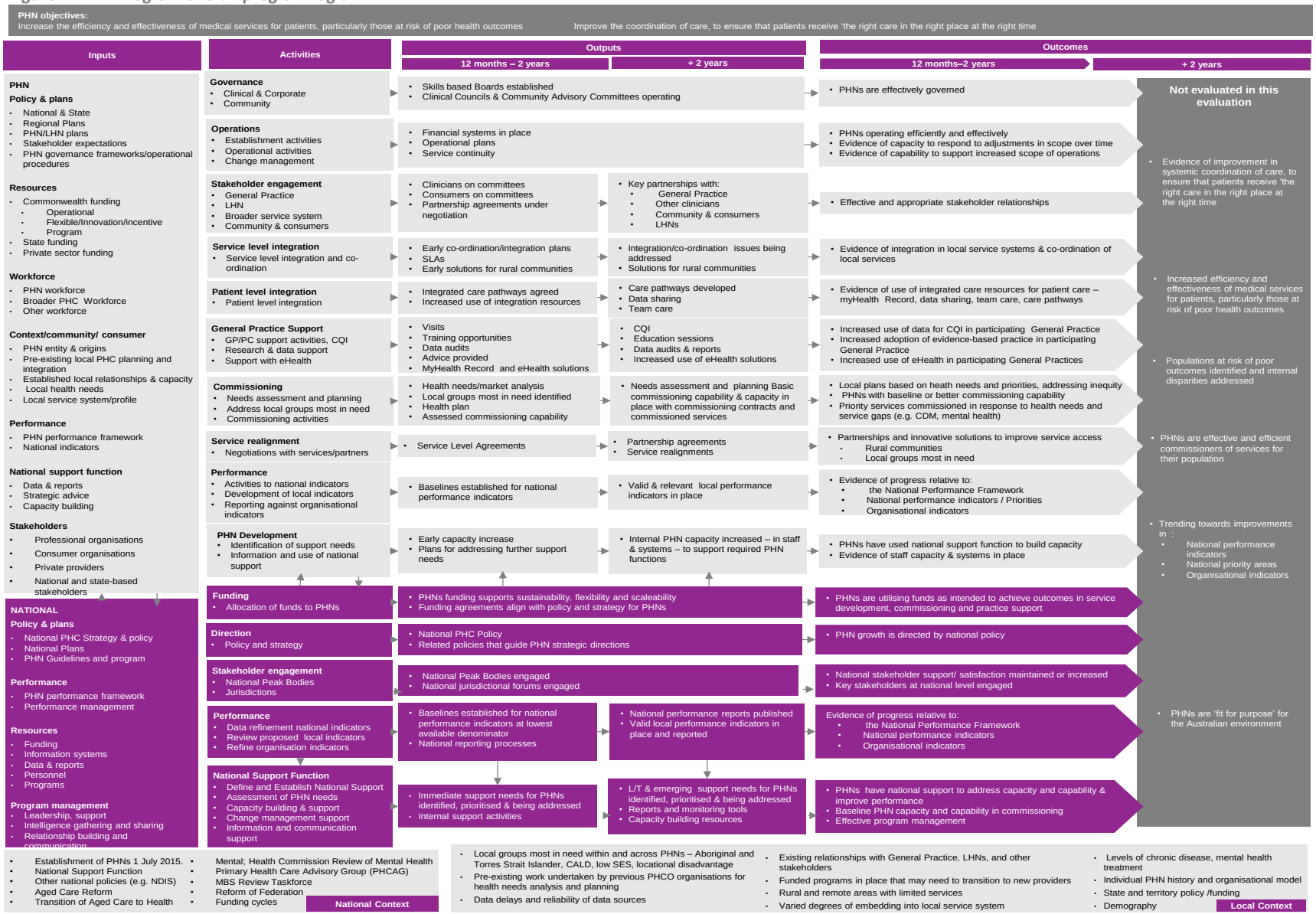
The Evaluation was guided by a program logic of the PHN Program and was both formative and summative in approach. With the extension of PHN core funding to 2021, the focus of the Evaluation was adjusted to inform the ongoing development of the PHN Program.

PHN Program program logic

The PHN Program program logic was developed by the Evaluation Team to align with the objectives of the PHN Program. It was derived from the *Primary Health Networks Grant Program Guidelines*,[19] and focuses on the roles, functions and areas of activity expected of PHNs to achieve the program objectives. The overall program logic is set out in Figure 2 and a lower-level program logic is set out in Appendix C.

[19] Australian Government Department of Health 2016. Department of Health Primary Health Networks Grant Program Guidelines February 2016 – Version 1.2. URL: http://www.health.gov.au/internet/main/publishing.nsf/Content/PHN-Program_Guidelines

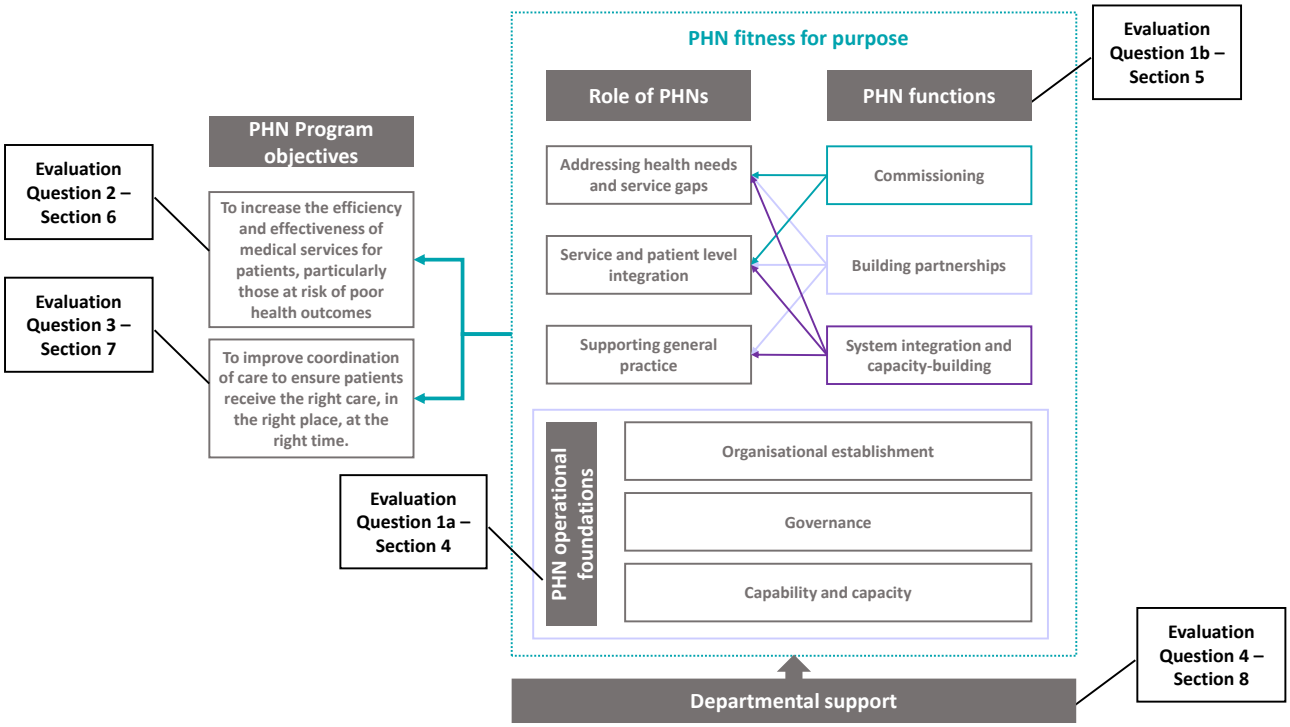
Figure 2: PHN Program overall program logic



An overview of the program logic and how it links to the evaluation questions is outlined below in Figure 3.

As shown in the program logic, the assessment of the achievements of PHN Program objectives was not within the timeframes for the Evaluation. However, several outputs and early outcomes, which showed progress toward meeting the overall objectives of the PHN Program, were expected to be achieved during the Evaluation period (as outlined in Figure 3 and Appendix C).

Figure 3: Overview of the PHN Program program logic and how it aligns to the Evaluation Questions and this report



A formative and summative evaluation approach

The formative component of the Evaluation aimed to examine the development, implementation, reach and impact of PHN operational foundations, functions and activities to inform the continuous development and improvement of the PHN Program.

As the Evaluation progressed, a more summative approach was planned with an emphasis on measuring progress in PHN functions and activities and their contribution to early outcomes. Given the timeframe of the Evaluation, the maturity of the PHN Program and the availability of relevant data (see limitations of the Evaluation) the summative components of the Evaluation as described in the program logic were measured where possible.

In addition, with the Australian Government extending PHN core funding to 2021, the focus of the Evaluation was shifted to inform the ongoing development and improvement of the PHN Program.

Evaluation methods

The Evaluation was conducted between July 2015 and December 2017 and involved five stages of work:

- Design of the Evaluation: July 2015 – January 2016;
- Baseline data collection: February 2016 – July 2016;
- Midpoint data collection: August 2016 – August 2017;
- Endpoint data collection: September 2017 – December 2017; and
- Final Evaluation Report: December 2017 – May 2018.

In addition, four Progress Reports were developed throughout the Evaluation which influenced the development of the PHN Program through the National Support Function, providing the evidence base for ongoing improvement.

The evaluation methods used to collect data and information for the Evaluation are outlined in Table 3.

Table 3: Summary of evaluation methods

Method	Description	Stakeholder group	Timing
Key informant interviews	Interviews were used to gather perspectives on the implementation and influence of PHNs, their role, activity (with barriers and facilitators), achievements and contribution to improving primary health care.	• PHNs (CEO and Chair) • Australian Government Department of Health • State and territory health departments • A sample of agreed national organisations with an interest in the PHN Program See Appendix D for stakeholders consulted	• Baseline (all stakeholders) • Midpoint (Department only) • Endpoint (all stakeholder groups; sample of 10 PHNs)
PHN survey	Online surveys were used to gather self-reported evidence from all 31 PHNs to: • understand context, strategy, activities and achievements in a standardised way; • determine how these elements shaped and influenced PHNs; • reflect on and self-assess performance to date; and • track changes over time Individualised survey output reports were also provided to PHNs to help inform their ongoing development. See Appendix E for further detail on the PHN survey.	• PHNs	• Baseline • Midpoint • Endpoint
PHN case studies	Case studies were used to understand the operation of four PHNs within their individual contexts, including the factors impacting implementation and outcomes. Specific aims included: • identifying key contextual factors influencing the structure, function and performance of PHNs; and • using this data to inform other components of the PHN evaluation, for example challenges experienced in certain contexts. Case study sites were chosen based on a purposeful maximum variation sampling strategy, including: • geography (rural, regional, remote, metropolitan or combination); • organisational models (including extent of PHN and LHN representation on boards); • organisational continuity (PHNs transitioning directly from Medicare Locals and PHNs starting as new organisations); • size (budgets) and scope; • jurisdiction; and • demographic characteristics of populations (socio-economic status and high needs populations). See Appendix F for further detail on the context of the case study sites (which are referred to as PHN1,	• Four PHNs (including Board, executive, staff, Clinical Council, Community Advisory Committee members) • Local service providers (including LHNs, GPs and other local service providers)	• Midpoint

Method	Description	Stakeholder group	Timing
	PHN2, PHN3 and PHN4).		
Regional workshops	Three regional workshops formed part of the case study process to engage a broader range of local stakeholders to: • understand PHN impacts on the local service systems and population health; • support a deeper analysis of cases within local contexts; and • provide stakeholders the opportunity to share views and experiences.	• Local stakeholders at three case study PHN regions (one PHN did not participate in the regional workshop)	• Midpoint – Endpoint
Clinical Council and Community Advisory Committee focus groups	One Clinical Council focus group and one Community Advisory Committee focus group was conducted to discuss and understand the composition, structure, membership, use, achievements and areas of improvement in PHN governance structures.	• Up to 10 Chairs of the Clinical Councils of selected PHNs were invited to participate (with five participants attending) • Up to 10 Chairs of the Community Advisory Committees of selected PHNs were invited to participate (with eight participants attending) Representatives for the focus group were from the same 10 PHNs who participated in the endpoint key informant interviews (see Appendix D for PHNs)	• Endpoint
Program documents	Program documents were reviewed to inform the broader reform context, the framework within which PHNs operate, PHN inputs and activities, and PHN relationships to other national and state programs. They were also used to inform other data collection activities, in particular the case studies.	• N/A	• Ongoing
Public datasets and performance reports	Existing, publicly available data and reports from the AIHW, Australian Commission on Safety and Quality in Health Care, Australian Bureau of Statistics, the former National Health Performance Authority, and other sources were reviewed to inform consideration of whether impacts and outcomes of the PHN Program could be measured quantitatively (*such data were not available through which changes could be attributed to the PHN Program*).[20]	• N/A	• Endpoint

[20] As the *PHN Performance Framework (Version 1.0)* was used as a monitoring tool only for the core schedule and the *PHN Program Performance and Quality Framework (Version 2)* was in development during the Evaluation, evaluative performance information of PHNs was not available. However, performance monitoring information such as reporting information and other contractual documentation was reviewed.

Limitations of the Evaluation

Given the timing of the Evaluation, many of the data items referenced in the PHN Program program logic required for measuring outcomes were still in development. These included:

- consistent and useable measures of PHN performance relating to local and organisational outcomes; and
- national data for measuring and attributing changes in health outcomes.

As a result, the Evaluation Questions are primarily addressed by the qualitative data collected as part of the Evaluation and supported by quantitative data where available.

3.3 Guide to this report

This report has been structured to respond to each of the Evaluation Questions. The key findings are presented by Evaluation Question:

- **Section 4:** Evaluation Question 1a – To what extent are PHN operational foundations fit for purpose?
- **Section 5:** Evaluation Question 1b – To what extent are PHN functions fit for purpose?
- **Section 6:** Evaluation Question 2 – Has the PHN Program increased the efficiency and effectiveness of medical services for patients, particularly those at risk of poor health outcomes?
- **Section 7:** Evaluation Question 3 – Has the PHN Program improved the coordination of care to ensure patients receive the right care, in the right place, at the right time?
- **Section 8:** Evaluation Question 4 – How are the information, advice and support needs of PHNs identified in relation to the national support function and how effective has the Department been in providing this support?

In each of these sections, the 'Overview' provides a summary of key features, characteristics and achievements of PHNs, 'Progress to date' details the evaluation findings in detail, and 'Challenges and Gaps' outlines the areas for future development for the Program.

Evaluation findings from PHN surveys, case studies and interviews have been referenced throughout the report:

- Findings from interviews form the basis for a large proportion of the findings presented unless otherwise referenced.
- Survey findings have been presented in charts and figures, and survey data referenced in footnotes.
- Case study findings have been presented in labelled boxes.

Section 9 details the opportunities to further develop the PHN Program based on the evaluation findings.

4. Key findings: Evaluation Question 1a

To what extent are PHN operational foundations fit for purpose?

In this Evaluation, fitness for purpose refers to the extent to which the PHN Program has been set up to focus on the right issues; has the scope, role and authority to enable it to address these issues; and has established a network of organisations which have the structure, governance, partnerships, and capability and capacity to deliver on the scope and role.

For PHNs, fitness for purpose refers to the extent to which they have in place the following operational foundations:

- PHN organisational establishment;
- PHN governance structures; and
- PHN organisational structures, capability and capacity.

4.1 PHN organisational establishment

Overview

PHNs are independent companies limited by guarantee. They were formed from a range of existing and new entities following the outcome of the *Invitation to Apply* process, which resulted in a range of models and starting points.[21] Some PHNs transitioned directly from a Medicare Local with the same boundaries; some were formed by a partnership of multiple Medicare Locals; some were new membership-based entities; and some were operated by state and territory health organisations (where changes to the Board required approval by the state or territory Health Minister). This diversity in models influenced the process of establishment and how PHNs developed.

PHN establishment was influenced largely by the *Invitation to Apply* process,[22] the *Primary Health Networks Grant Program Guidelines*[23] and funding agreements. The process was easier for PHNs where the geography was less complex (e.g. 1:1 boundaries with a LHN compared to multiple LHNs within their region, smaller geographic coverage in metropolitan PHNs compared to rural and remote PHNs); where there were existing positive relationships; where state and territory health departments were engaged; and where organisations had previous experience with activities related to those of a PHN (see Section 2 and Appendix A for contextual information on the PHNs).

The PHN Program grew substantially from commencement (see Section 2), with over $3 billion committed in Forward Estimates by the end of the Evaluation period. The commitment reflects the confidence of the Australian Government in the PHN Program, including the ability of PHNs to meet the Program's objectives.

PHNs were designed as independent, adaptable, agile and innovative organisations. These characteristics were regularly put to the test, but particularly so during the establishment period (1 July 2015 to 30 June 2016). As new organisations, with different starting points in terms of capability and capacity, PHNs were faced with very tight timeframes, high expectations (for example, the expectations of stakeholders,

[21] The *Invitation to Apply* process provided the opportunity for applicants to apply to become a PHN through a competitive process. Applications were assessed against eligibility and selection criteria, as outlined in the *Primary Health Networks Grant Program Guidelines*.

[22] The *Invitation to Apply* process provided the opportunity for applicants to apply to become a PHN through a competitive process. Applications were assessed against eligibility and selection criteria, as outlined in the *Primary Health Networks Grant Program Guidelines*.

[23] Australian Government Department of Health 2016. Department of Health Primary Health Networks Grant Program Guidelines February 2016 – Version 1.2. URL: http://www.health.gov.au/internet/main/publishing.nsf/Content/PHN-Program_Guidelines

the ability to undertake roles and functions as new organisations) and a rapidly expanding Program scope (through the addition of new funding and Schedules). The majority of stakeholders reported that PHNs navigated these early years well, given the scale and pace of program expansion, building strong foundations for their future development.

Progress to date

In general, PHNs that transitioned directly from a Medicare Local experienced a smooth transition and were better able to maintain momentum and fit the vision of the Department into their strategic direction. Newly created organisations tended to face more challenges, including: little to no existing intellectual property; difficulties recruiting staff; and legacy issues from former Medicare Locals which impacted relationships, partnerships and governance arrangements. These PHNs also had to invest more effort and resources to understanding and create trust with the stakeholders in their region.

Insights from the case studies

Some PHNs, including PHN1 and PHN3 (see Appendix F for details on the contextual factors of each case study PHN), faced additional challenges in their establishment as newly created organisations covering large rural and remote regions with dispersed populations. Stakeholders reported that these PHNs also had to overcome some distrust in the service provider network, and experienced resistance from some former Medicare Locals turned service providers.

PHN1's establishment was described as "abrupt", with essentially no handover from any Medicare Locals. The PHN started with a very small number of staff and covered a large rural and remote area with a large Aboriginal and Torres Strait Islander population, and requiring multiple regional offices. To meet expanding responsibilities, the PHN continually recruited workforce but experienced challenges due to the lack of availability of skilled workforce in the region, and legacy issues from workforce who had had poor experiences with other former Medicare Locals. Considerable effort in stakeholder engagement and participation in an Australian Government program trial assisted to some extent in building trust in the region and overcoming legacy issues.

Compared to PHN1, PHN3 had a relatively smooth journey. While also a new organisation, they had some continuity from several former Medicare Locals (alongside complex relations with others). They reported their shared services model provided economies of scale that allowed more efficient allocation of resources, a broader pool for staff recruitment, and a better sense of strategic development. They saw one advantage as a new organisation, in aligning all staff to a clear strategic vision that differed from the predecessor Medicare Local.

During the establishment period, PHNs focused on setting up organisational and governance structures and developing the capability and capacity needed for their intended functions. They also had to develop stakeholder relationships, provide ongoing support to general practices and other health care providers (noting this function built on the work of Medicare Locals), sustain existing services and maintain continuity of care, and prepare for commissioning (which commenced in their second year, from 2016–17) – all within the context of a rapidly growing program.

There has been substantial progress in organisational maturation across the PHN Program since July 2015. All PHNs are undertaking their expected functions, including engaging with key stakeholders in the region, understanding needs and planning, commissioning, and supporting primary health care. Importantly, all PHNs have established awareness of their presence within their region and begun to develop working relationships with both state and territory health departments and LHNs to improve the integration and coordination of care – a key objective of the program.

Stakeholders are generally supportive of the PHN Program, although some stakeholder groups gave mixed feedback (see Section 5.1 for further detail on stakeholder views). The reasons for this were wide-ranging, often context-specific and not, overall, based on an objection to the concept of the PHN Program itself.

Overall, PHNs were able to become operational and respond to the growth of the PHN Program in an agile if, at times, 'reactive' way. The introduction of new program areas to PHNs, such as primary mental health care, drug and alcohol treatment services and the Integrated Team Care program, impacted in different ways. For some PHNs, it made it difficult to perform their original core functions of addressing health needs

and service gaps, facilitating service-level and patient-level integration, and supporting general practice to the extent they wanted to. On the other hand, the new program areas provided extra impetus to the PHN Program. Most PHNs were able to be flexible and rearrange the workforce to effectively meet the required timeframes and extra responsibilities, establish new relationships and create additional capacity where needed.

Challenges and gaps

A substantial amount of time and resources is needed to set up a new program, especially one of this size, and with new organisations that need to develop stable and sustainable structures – this was a key learning from the establishment of the PHN Program. Timeframes (largely due to budgetary cycles) were an issue for both the Department and PHNs early in the program and reflected the maturity of the program at the time. There was a lack of timeliness of some early guidance and advice (which some PHNs were reliant on) and there was rapid growth into new program areas. Nonetheless, despite these early challenges most PHNs were able to continue with their functions and make progress.

The PHN Program could have benefited from having additional time to establish the foundations required for a successful and sustainable program; however, this did not negatively impact the program moving forward and developing over time.

The establishment period was further impacted by the lack of a clearly articulated strategic plan for the PHN Program. This affected PHNs in the building of trust with stakeholders and was made more challenging by stakeholders not knowing the direction of government. The development of a Program Framework and more information resources on the intent of the PHN Program would assist in continuing to build trust with stakeholders, recognising PHNs as a vehicle for change.

4.2 PHN governance structures

Overview

Corporate governance refers to the systems and processes put in place to control and monitor – or 'govern' – an organisation. Good governance is embedded in the good behaviour and the good judgement of those who are in charge of running an organisation. Effective governance structures allow organisations to create value, through innovation, development and exploration, and provide accountability and control systems commensurate with the risks involved.[24]

Overall, PHNs developed stronger corporate governance arrangements (constitutions and membership, skills-based Boards, Clinical Councils and Community Advisory Committees) over the period of the Evaluation. Recognising the workload of PHNs and the importance of strong governance, the Department took the lead in helping improve governance across the network. The influence of good governance became increasingly evident to key stakeholders in the performance of the PHNs over the evaluation period. By the end of the Evaluation, they reported that the problems remaining related only to a small number of PHNs.

Progress to date

PHN constitution and membership

PHNs are independent companies limited by guarantee and are registered as charities under the Australian Charities and Not-For-Profits Commission. PHNs operate in the context of a federated government and, therefore, have a significantly different model of governance to primary health organisations in other countries where commissioning has been implemented (e.g. New Zealand and the United Kingdom where the primary health care organisations are closely aligned with government and cannot be said to operate

[24] Australian Institute of Company Directors 2013. Good Governance Principles and Guidance for Not-for-Profit Organisations.

independently). While this has in some circumstances enabled PHNs to be more agile and innovative than they otherwise would have been, it has also presented challenges for a consistent and cohesive approach to governance across the network.

Constitutions, membership and other governance arrangements vary considerably across PHNs (e.g. the number of member organisations, the structure of Clinical Councils and Community Advisory Committees). The variance reflects that PHNs are independent companies and the desire of Government to not be too prescriptive in governance models in order to encourage innovative designs. This limited guidance on preferred governance arrangements during the *Invitation to Apply* and establishment of the PHN Program led to the diversity of arrangements. See Appendix B for further details of the *Primary Health Networks Grant Program Guidelines: PHN Governance Arrangements.*

PHN governance arrangements have evolved (including refinement of their constitutions) to better reflect their intended functions, particularly in relation to commissioning (e.g. where member organisations were also service providers) and engagement of member organisations. The implications of some arrangements were not well understood, for example: the trialling of the Hospital and Health Services model by the Queensland government which deemed the PHN a controlled Queensland Health service entity and impacted the independence of the organisation; and the perceived or real conflict of interest of PHN commissioning activities with member organisations. The Department and PHNs have worked towards more streamlined and transparent governance arrangements to ensure PHNs are better fit for purpose. This included reviewing and refining Board membership, constitutions and external review processes. At endpoint, some PHNs still had some work to do in this area and their governance arrangements will need to continue to evolve to ensure fitness for purpose.

PHNs which reported that their constitution had worked well from the outset tended to have a diverse membership base, a manageable number of members and continuity of membership from the previous Medicare Local(s). Generally, the majority of PHNs wanted to avoid member organisations being funded to provide services to avoid any conflicts of interest, noting that there are now processes in place within the Department to manage these conflicts.

PHN Boards

The *Primary Health Networks Grant Program Guidelines,*[25] in line with the guidance from the Australian Institute of Company Directors, required PHNs to establish skills-based Boards. However, at the beginning the Department provided limited additional guidance about the skills, make-up and diversity of Boards in recognition that PHNs were independent organisations. As a result, Boards were set up with varying functions, membership, skill sets and levels of independence from the organisation. This reflected the different levels of governance maturity across the PHNs. For example:

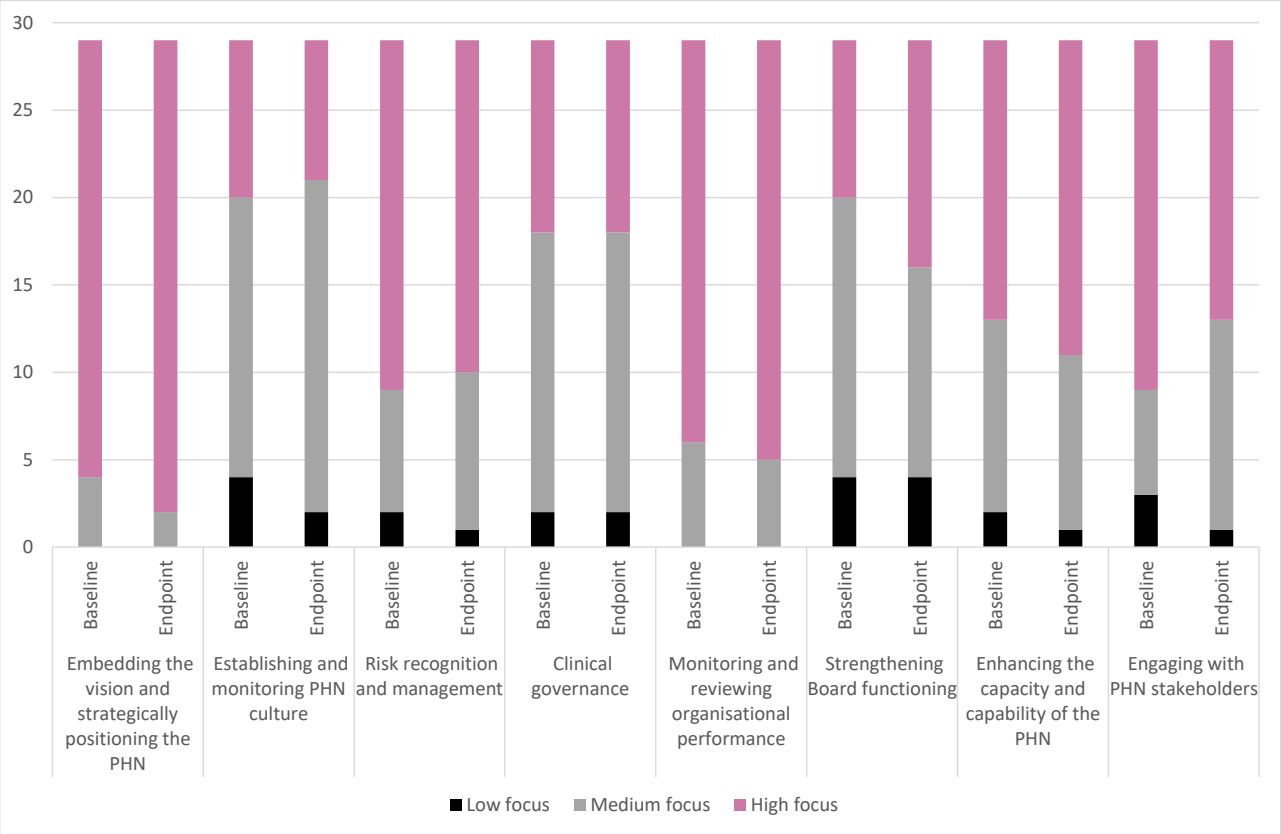
- some PHNs undertook a more rigorous approach than others in the selection of some Board members (i.e. whether an individual's skill set or representative role took precedence in selection, and how actively PHNs addressed possible conflicts of interest);
- some Medicare Locals took steps during the *Invitation to Apply* process to reorganise their Board to eliminate any conflicts of interest that would exist as a PHN; and
- one PHN reported that it worked with an independent probity auditor to ensure a robust and transparent selection of Board members.

Stakeholders (including PHNs and the Department) reported that PHN Boards matured and strengthened as their understanding of the functions of a PHN and the importance of a strong Board evolved. They became more strategic (e.g. seeking other funding opportunities) and came to understand better the work of the Department and the primary health care plans of the Government. They became more active in setting strategic directions, setting up other governance mechanisms, guiding the PHN through the

[25] Australian Government Department of Health 2016. Department of Health Primary Health Networks Grant Program Guidelines February 2016 – Version 1.2. URL: http://www.health.gov.au/internet/main/publishing.nsf/Content/PHN-Program_Guidelines

establishment period and establishing the organisation as a commissioner. Figure 4 provides an overview of how the focus of PHN Boards shifted over the evaluation period. Some areas of focus remained key: 'embedding the vision and strategically positioning the PHN', 'monitoring and reviewing organisation's performance', and 'risk recognition and management'.

Figure 4: Change in focus of PHN Boards at baseline and endpoint as reported by PHNs (count, n=29)*



**The Western Australia Primary Health Alliance Board incorporates Perth North, Perth South and Country WA PHNs. Only one survey was used to account for the three PHNs*

As PHN Boards gained a greater understanding (through learning, experience and reviews) of the structure, role and skills required, they developed their membership, composition, sub-committee structure and reporting processes accordingly. All but two PHNs reported having in place a Director and/or Board performance review process (internal or external) to determine fitness for purpose and to ensure they had the range of skills required to support the PHN as the PHN Program continued to grow.[26] At the end of the evaluation, 55 per cent of PHNs reported making changes to the Board membership in the prior six months, 34 per cent reported changes in Board composition and 21 per cent reported changes to the Board structure.[27, 28] Generally, PHNs with no history as a Medicare Local reported that they had to make more changes to their membership, composition and structure.[29]

Another area of ongoing development was how the Board Chairs interacted with their CEOs and the broader network of PHN Board Chairs. Some PHNs found it was more difficult to distinguish between the roles and responsibilities of the Chair and the PHN CEO, particularly where the Chair was actively involved in the day-to-day operations of the organisation. This was sometimes by necessity (e.g. when the CEO

[26] PHN Program Evaluation – Endpoint PHN Survey, December 2017

[27] Board membership refers to changes in members, Board composition refers to changes in the mix of skills and experience, and Board structure refers to changes in positions, committees and sub-committees.

[28] PHN Program Evaluation – Endpoint PHN Survey, December 2017

[29] PHN Program Evaluation – Endpoint PHN Survey, December 2017

changed) and at other times reflected their understanding of the role.

By the end of the evaluation and at a broader level, the Chairs were working better together as a network, becoming better connected and sharing learnings and experiences on a more systematic basis. Nevertheless, a small number of PHNs were still working to resolve challenges resulting from how their Boards were set up, for example, where there had been a focus on organisational representation rather than skills. The Department and PHNs should periodically review the skills, capability and capacity of Boards and Board members to ensure they continue to be fit for purpose.

Clinical Councils and Community Advisory Committees

Clinical Councils and Community Advisory Committees are a requirement of the PHN Program. It took time for PHNs to determine their specific roles and they were established slowly, in many cases starting with interim arrangements. While the PHNs saw value in these groups, the exact use and their relationship with the Board was defined (in the *Primary Health Networks Grant Program Guidelines*[30]), but not necessarily followed at the outset. At the end of the Evaluation, all but one PHN reported that their Clinical Councils reported to the Board, and all but two PHNs reported that their Community Advisory Committees reported to the Board.[31]

Across the evaluation period, PHNs noted that Clinical Councils and Community Advisory Committees were being utilised with differing levels of maturity, with some PHNs still trying to define an appropriate role and thus work with them in a meaningful way by the end of the Evaluation period. As illustrated in Figure 5 and Figure 6, most PHNs had determined that an advisory role was most appropriate. This was because PHNs who had engaged the groups in procurement decisions faced conflict of interest challenges

[30] Australian Government Department of Health 2016. Department of Health Primary Health Networks Grant Program Guidelines February 2016 – Version 1.2. URL: http://www.health.gov.au/internet/main/publishing.nsf/Content/PHN-Program_Guidelines

[31] PHN Program Evaluation – Endpoint PHN Survey, December 2017

Figure 5: The extent of Community Advisory Committee involvement in PHN activities (as prescribed in the *Primary Health Networks Grant Program Guidelines*) at baseline and endpoint (count, n=31)

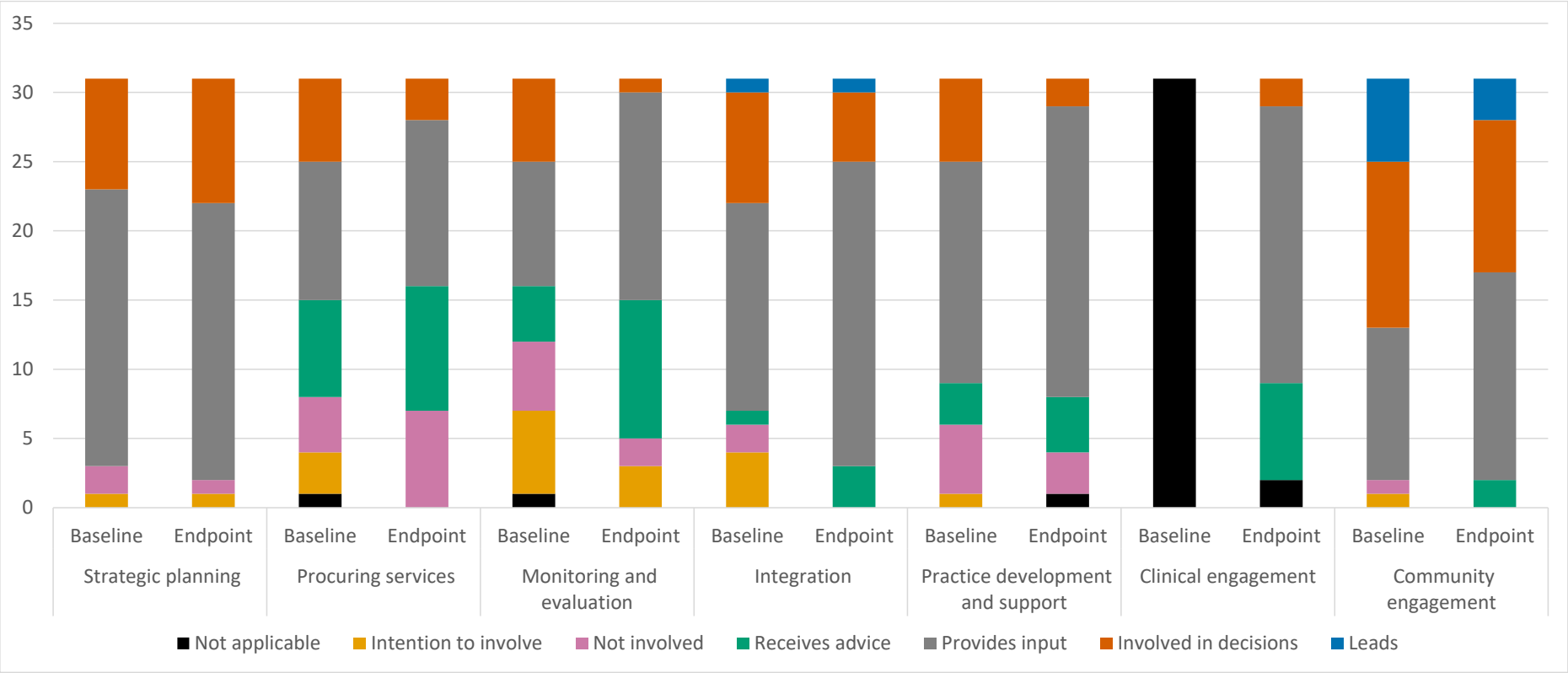
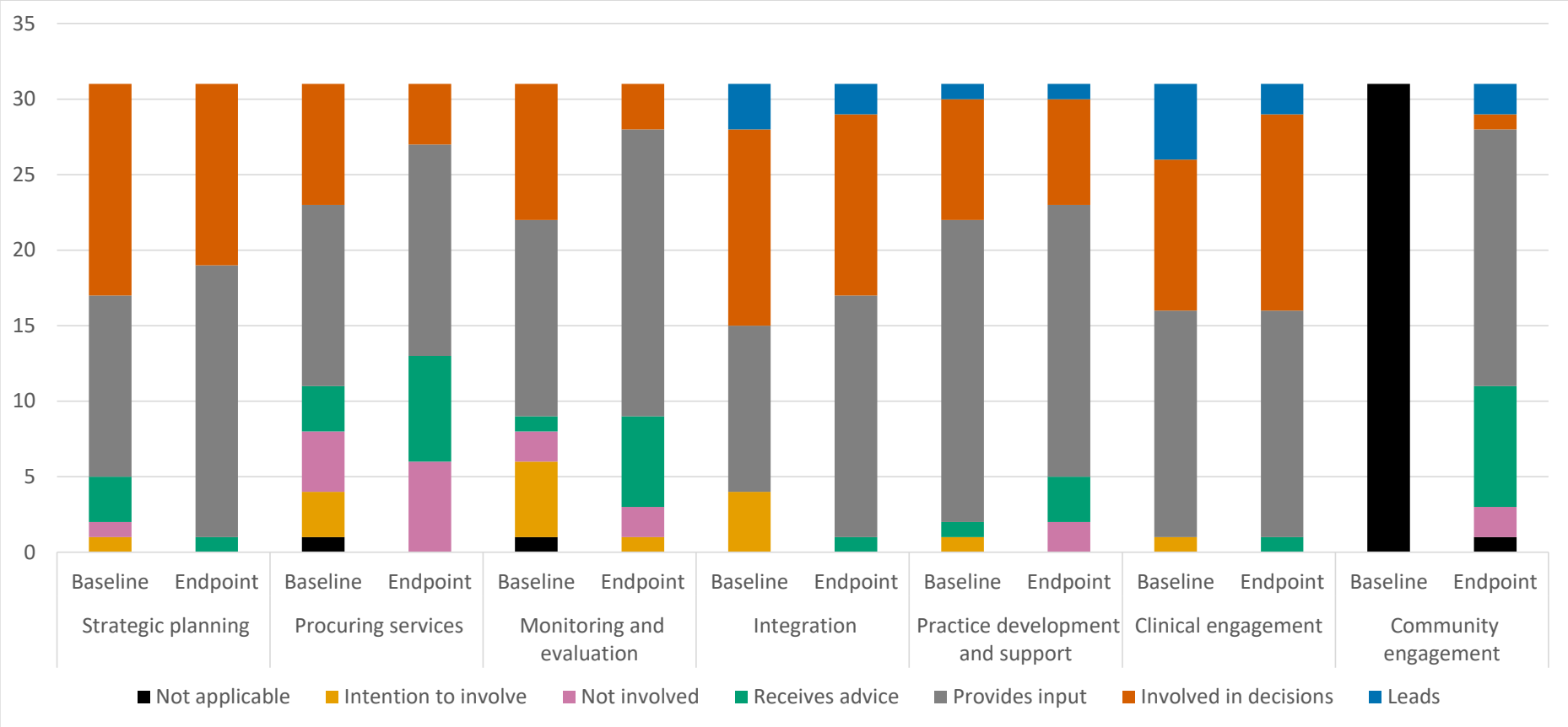


Figure 6: The extent of Clinical Council involvement in PHN activities (as prescribed in the *Primary Health Networks Grant Program Guidelines*) at baseline and endpoint (count, n=31)



Another consideration was the Clinical Councils' and Community Advisory Committees' fit with pre-existing structures and their relevance to the local context. In some cases, these issues were addressed by repurposing existing committees (e.g. from the previous Medicare Locals or LHNs) and establishing regional or multi-level committees, particularly in regional and rural PHNs and those where they felt they had distinct sub-regions. PHNs also sought input from other advisory groups, with some setting up their own advisory groups for priority issues (for example, mental health and chronic disease) and/or linking into already established groups in the region. These supplemented the skills, knowledge and experience of Clinical Councils and Community Advisory Committees.

The Community Advisory Committees are not intended to be representative of consumers, rather they provide the community perspective to inform the work of the PHN.[32] As such, separate consumer arrangements needed to be put into place to undertake effective planning functions involving the consumer perspective. See Section 5.1 for examples of how PHNs implemented separate arrangements to gather consumer perspectives on planning decisions.

Clinical Councils and Community Advisory Committees appeared to be working well where they were actively engaged by the PHN and operated within clear guidelines, such as:

- members being aware their involvement was to provide their individual insights and expertise and not just the views of their sector or organisation;
- a transparent reporting and feedback process to the PHN Board; and
- a preference for multidisciplinary composition.

The areas where PHNs obtained the most meaningful advice from their Clinical Councils and Community Advisory Committees included:

- processes for broader consultation and engagement with the community or stakeholder groups, for example with respect to developing commissioning plans;
- planning and prioritising local issues, gaps and needs for the purposes of commissioning; and
- ensuring the PHN followed a robust process for commissioning that was free of conflict of interest.

At the end of the evaluation period, 68 per cent of PHNs reported they had made changes to Clinical Council membership in the prior six months.[33] Similarly, 48 per cent of PHNs had made changes to Community Advisory Committee membership in the prior six months.[34]

It is worth noting that general practice stakeholders were initially concerned that their engagement through the Clinical Councils would be tokenistic. However, at endpoint they reported that the Clinical Councils appeared to be fulfilling the function of general practice engagement and leadership, a key focus of the PHN Program.

Consumer stakeholders emphasised the need for PHNs to continue to develop effective engagement strategies with consumers and the community, at both governance and operational levels, and to become increasingly sophisticated in their approach. It was observed by PHNs and stakeholders that skills representation by members of the Aboriginal and Torres Strait Islander community on all governance structures across the PHN network was not consistent. The Minister for Indigenous Health, the Hon Ken Wyatt AM, MP, has encouraged the broadening of the range of member organisations involved in PHNs, and ensuring an appropriate range of skills on their boards, to ensure the specific needs of the diverse groups in the community are considered when commissioning health services.[35]

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[32] Australian Government Department of Health 2016. Department of Health Primary Health Networks Grant Program Guidelines February 2016 – Version 1.2. URL: http://www.health.gov.au/internet/main/publishing.nsf/Content/PHN-Program_Guidelines

[33] PHN Program Evaluation – Endpoint PHN Survey, December 2017

[34] PHN Program Evaluation – Endpoint PHN Survey, December 2017

[35] Media Release: Call for Indigenous skills to assist Primary Health Networks; The Hon Ken Wyatt AM, MP (1 March 2017)

Insights from the case studies

Case study PHNs found it difficult to define the role and function of their Community Advisory Committees due to minimal guidance from the Department and PHNs' inexperience with the use of Community Advisory Committees. Each PHN underwent revisions in the scope and purpose of the Community Advisory Committee to better align with PHN key functions. This led to early difficulties in maintaining engagement of members. In general, the Community Advisory Committees' contribution has been limited to reviewing health needs assessments and activity work plans based on lived experience, with all case study PHNs planning to involve them more substantially in the future.

At PHN4 (which had a long history as a primary health care organisation), the Community Advisory Committee was "still finding its feet" in early 2017. The Community Advisory Committee Chair commented that:

> "Timeframes are really tight [which] makes it really hard for [the Community Advisory Committee]. The PHN is often coming to the Community Advisory Committee with virtually a finished piece. But they have a transparent relationship and this is improving or will improve hopefully. The [Community Advisory Group] has come a long way and they are beginning to work well. I feel that they will be able to engage a lot earlier in the future, but there needs to be business process changes for the PHN as well. We need capability improvement in the PHN to make everyone understand where consumer [and community] engagement is necessary […to gather understanding of the needs]."

All PHNs used their Clinical Councils more regularly to provide input into needs assessments and activity work plans as well as to engage with service providers and clinical governance processes. PHN4 used its Clinical Councils well through establishing early and regular communication and using their input strategically to inform and review PHN commissioning activities. PHN4 also established several additional advisory groups including consumer and community as well as clinical representatives to advise on commissioning activities in specific areas (e.g. mental health, drug and alcohol treatment services, and diabetes).

PHN2 displayed effective use of their Clinical Councils and Community Advisory Council when they used their input to develop innovative engagement strategies with the community. This included both online and face-to-face networking 'speed dating' events. See call-out box on page 41 for an example.

Challenges and gaps

It was observed that while the Department had deliberately limited its direct control over PHN governance arrangements, the PHN Program could have benefited from a greater focus on the governance arrangements required for commissioning organisations during both its setup and early implementation. The ongoing challenge for the PHN Program will be the ability of PHN governance structures to respond to developments in the Program as PHNs take on more responsibility. The Department and PHNs will need to ensure that the PHNs' constitution and membership, Boards, Clinical Councils and Community Advisory Committees all remain fit for purpose.

In addition, the Department and some PHNs did not understand at the beginning of the PHN Program how resource-intensive it can be to maintain strong governance arrangements. The time and cost involved in managing governance structures in large geographic areas or where there were multiple committees were reported to be significant, as was the time required to develop roles and form new ways of working. It will be important to continue to ensure that resources for governance are well supported as the PHN Program grows (for example, the time and cost of compliance as a company limited by guarantee), recognising the importance of strong governance for the program.

Many PHNs experienced challenges in achieving wide enough skills representation in their Clinical Council and Community Advisory Committees, particularly in relation to skills and knowledge from the Aboriginal and Torres Strait Islander community. It was notable that even in case study PHNs with a large Aboriginal and Torres Strait Islander population in their region, engagement with Aboriginal and Torres Strait Islander people and communities was limited. Some PHNs sought to overcome this by working closely with their local Aboriginal Medical Service; however, this remained an area of development for the whole PHN Program at the end of the evaluation period.

4.3 PHN organisational structures, capability and capacity

Overview

Strong primary health care can contribute to more efficient and effective use of services and better coordination of care, with regional primary health care organisations having the potential to facilitate this.[36] By the end of the evaluation, the PHNs were beginning to be recognised within the broader health care system for this role.

The rapid increases in funding and policy responsibilities, coupled with tight timeframes meant PHNs expanded quickly and faced a steep learning curve early in the program. This required a fast scale-up of their capability and capacity, but they did not necessarily have the time to plan and develop the workforce for the required changes.

Nevertheless, PHN capability and capacity building has generally kept pace with their ability to fulfil their functions. At the same time, PHNs, together with the Department, states and territories, and local stakeholders, were still learning about the PHN Program, its potential and what capability and capacity are needed to realise the objectives of the Program. By the end of the Evaluation, the balance of evidence indicates that the majority of PHNs can do what is currently required of them to meet their objectives. Where they are not, they need to be actively managed and supported by the Department to move forward.

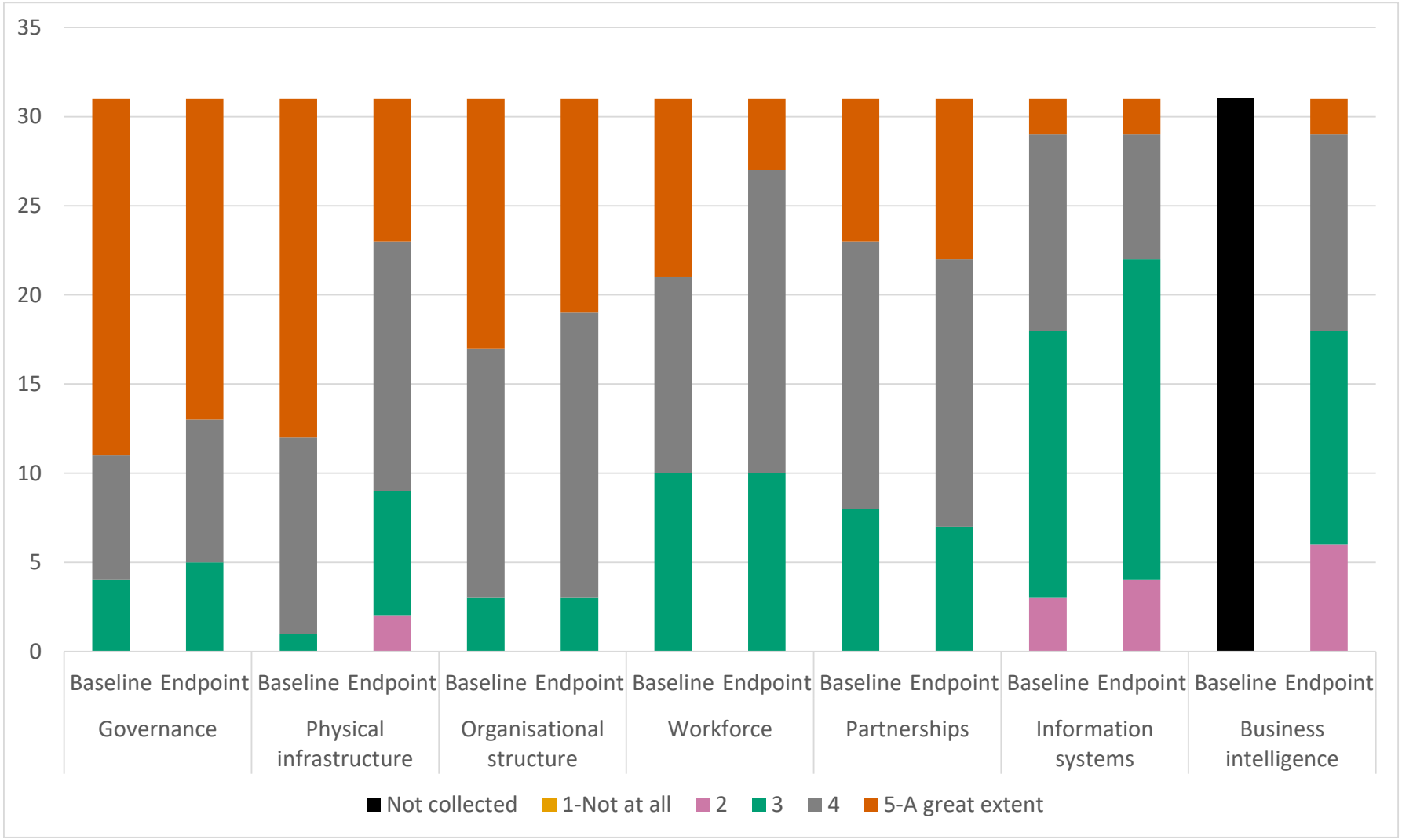
Progress to date

As demonstrated in Figure 7, PHNs reported that their functions were fit for purpose across the evaluation period with some gaps.[37] Information systems and business intelligence were the areas identified for further development across the network at the end of the Evaluation. Metropolitan PHNs generally rated the fitness for purpose of their functions higher than their regional and rural counterparts.

[36] Macinko J, Starfield B & Shi L 2003. 'The Contribution of Primary Care Systems to Health Outcomes within Organization for Economic Cooperation and Development (OECD) Countries, 1970–1998', *Health Services Research*, 38(3), 831–865; Shi L 2012. 'The Impact of Primary Care: A Focused Review', *Scientifica*, 2012, 432892; Starfield B et al. 2005. 'Contribution of Primary Care to Health Systems and Health', *Milbank Quarterly* 83(3): 457–502; World Health Organization. (2008). *The World Health Report. Primary Health Care. Now More than Ever.* Geneva: World Health Organization.

[37] PHN Program Evaluation – Endpoint PHN Survey, December 2017

Figure 7: Extent to which PHNs reported they had in place the right capability and capacity to support its intended functions at baseline and endpoint (count, n=31)



Some of the factors reported by stakeholders which positively impacted PHNs' ability to develop the capability and capacity needed to fulfil their intended functions included:

- Establishment from one or more former Medicare Local. If a PHN has established from a former Medicare Local, it usually had already developed core capabilities in governance, program delivery and stakeholder relationships. These PHNs were also better able to maintain stability in the leadership, workforce and strategic direction of the organisation;
- The skills and experience of the CEO. For example, if they were entrepreneurial, well-connected, had established good relationships, and managed their resources well. These CEOs were often also supported by a unified and high-calibre PHN Board; and
- Positive team cultures. This assisted PHNs to manage the rate of change and maintain engaged and committed staff to develop and evolve as an organisation.

However, PHNs had limited capacity to focus on staff development during the rapid growth of the establishment phase. This issue was exacerbated for some PHNs that were previously Medicare Locals who had to quickly shift focus from service provision to commissioning by consolidating positions or moving staff to new roles without appropriate training or support. Workforce constraints were also an issue for PHNs located in regional, rural and remote areas where finding people with the right skills was difficult. In metropolitan areas, PHNs were competing with a wider range of employers for scarce talent. There was also considerable downsizing and outsourcing of staff and functions in several PHNs.

The funding model was also a potential barrier to ongoing capability and capacity building. The vast majority of the increased program funding (ranging from 92 to 94 per cent depending on the program area) was channelled into commissioning direct service delivery, with a small amount allocated to PHN operational funding for investment in organisational development to manage this growth. This issue had a greater impact on PHNs covering large rural and remote areas where infrastructure needs and overheads for organising and providing services across a vast region were reported to be much higher than their metropolitan counterparts.

Insights from the case studies

PHN3 was the only PHN that felt that the funding matched their current needs. This may reflect that the PHN realised increased efficiency from aligning their executive and corporate functions with the two other PHNs within their Alliance. This meant that rather than replicating functions such as contract management between the three PHNs in the state, one contract management function was established to manage the three PHNs in the Alliance.

As a result, and compared to other PHNs, this PHN noted that it found efficiencies in its operational funding which resulted in more funding to become available for activities related to system capacity building activities such as building effective partnerships and practice development and support.

PHNs adopted two key strategies to help increase the capability and capacity of their organisations in a sustained way.

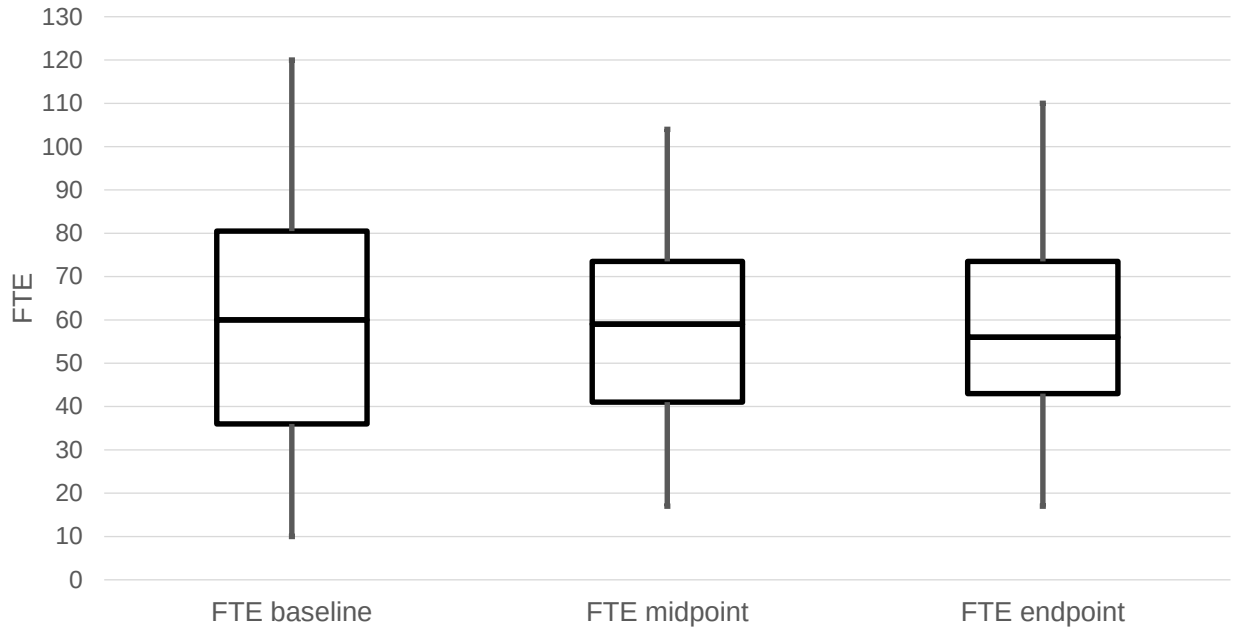
Firstly, most PHNs undertook regular reviews of their organisational structure and capability. This helped to ensure they had the right operating model in place and that resources were organised effectively to fulfil their intended functions, while maintaining what was described as 'lean' operations and reducing (where possible) internal overheads. As part of this process, some PHNs underwent significant restructures following the establishment period; PHNs reduced their headcount (see Figure 8 for the consistent reduction in median PHN FTE[38]) during the evaluation period. As a result, it was observed that PHNs are lean and non-bureaucratic organisations, with a focus on resource efficiency.

[38] The box and whisker plot above identifies the distribution of responses across PHNs. The whiskers represent the distribution of the bottom 25% and top 25% of responses. The lower box represents the 25% to 50% response range and upper box represents the 50% to 75% response range, with the midpoint corresponding to the median response.

Secondly, PHNs worked together (supported in many instances by the Department) to build capability and capacity by:

- sharing lessons learned among PHNs, for example, via the working groups established by the Department (e.g. Commissioning Working Group), state-based PHN alliances (see Section 5.1), PHN Forums and conferences; and
- enabling a more coordinated approach to the implementation of core systems and processes to minimise duplication and re-work. Work had also started to consider opportunities in this regard for clinical governance, data governance and management (e.g. data warehouse).

Figure 8: Changes over time of total FTE of PHNs



By the end of the Evaluation, the PHNs had identified their needs and were in the process of formalising these arrangements by establishing their own governance structure (the PHN CEO Cooperative) to help lead and drive the development of capability and capacity across the network and to facilitate engagement with national organisations. This is currently under development and supported by the Department.[39]

Challenges and gaps

PHN capability and capacity underpinned all PHN activities and impacted on their ability to deliver the objectives of the PHN Program. PHNs reported that their capability and capacity building had broadly kept pace with their ability to fulfil their functions, although some observed that they desired further improvement and had some skills gaps. Identified areas for further development included improved diversity in both staffing profiles and on advisory groups, data and analytics, and continued development of engagement with stakeholders within PHN regions. In particular, engagement with Aboriginal and Torres Strait Islander people and communities, both in regard to PHN staff and advisory groups, is an ongoing challenge for the PHN Program.

Ongoing capability and capacity development would ideally be supported by robust performance management where clear expectations of PHNs are set, real-time feedback provided, and capacity reviewed to support continuous improvement. It will be important to factor PHN capability and capacity

[39] The CEOs of each of the 31 PHNs have formed the National PHN CEO Cooperative which is designed to provide an operational forum for PHN CEOs to shape and inform shared agendas, to articulate and demonstrate the value of PHNs to key stakeholders and the Government, and to actively engage with the Primary Health Care Reform agenda. The PHN CEO Cooperative is PHN-funded and will include the appointment of an Executive Officer role.

development and the skills required to be commissioners into the implementation of the *Primary Health Networks Program Performance and Quality Framework (Version 2)*.

As discussed, PHNs operate as "lean" organisations. Some of the reduction in operational funding (e.g. the 30 per cent reduction in operational funding for mental health) seems to have occurred on the premise that by 30 June 2018, PHNs will have in place a well-developed commissioning process that can be directly applied to commissioning activities. However, this is not necessarily the case at this point in their maturity and the extent of commissioning experience and capability will need to be considered in funding arrangements.

The "lean" nature of most PHNs' operating models, may also hinder their ability to build capability and scale-up to meet future expectations, for example, commissioning and in rural and remote areas. It may assist to review the current program-based funding model to enable greater flexibility in how PHNs utilise their resources to deliver required outcomes. Consideration could also be given to: revisiting the weighting in operational and program-based funding to better support rural and remote PHNs; and longer-term funding cycles which enable PHNs to better plan for the longer term and align funding arrangements with LHNs.

5. Key findings: Evaluation Question 1b

To what extent are PHN functions fit for purpose?

This section explores the extent to which PHN functions are fit for purpose in order to achieve their objectives at this stage in their development. The PHN functions (as outlined in Section 3.2) include:

- Stakeholder engagement and partnerships (Section 5.1);
- Commissioning (Section 5.2); and
- System integration and capacity-building (Section 5.3).

5.1 Stakeholder engagement and partnerships

Overview

All PHN functions – building effective partnerships, commissioning, system integration and capacity building – require stakeholder engagement. As such, engaging with stakeholders is core business across the PHN Program.

PHNs have invested significantly in stakeholder engagement. They are building partnerships, which has been a complex and time-consuming process. Partners need to develop trust in each other and in the partnership's longevity. They also need to trust that the partnership benefits them, understand the perspective of others, and see value in their investment of time and other resources. All of this has taken more effort, time and resources than initially anticipated. But given its importance, PHNs continue to invest heavily in this area.

As the program has progressed, PHNs have taken a more strategic approach to identifying key relationships and partnership opportunities. They have moved from predominately ad hoc engagement and informal partnerships to more formal arrangements. This includes formal partnerships with state and territory health departments, LHNs and other service providers which have enabled activities such as co-design and coordinated commissioning, with some early example of co-commissioning (see Engagement with states and territories and LHNs). PHNs are also becoming more mature in their communication with stakeholders, for example engagement is becoming more purposeful and often includes metrics around engagement in order to reach strategic commitments regarding practice support and community engagement.

Progress to date

Early in the PHN Program, PHNs invested significantly in activities focused on building (or rebuilding) trust with key stakeholders in their region. They used open communication methods as well as educational activities to improve understanding in the wider community (including with service providers) about the role of PHNs and on commissioning. PHNs aimed to manage the community's expectations about what the PHN Program could achieve and how, in addition to developing a shared understanding of health needs and priorities in the region.

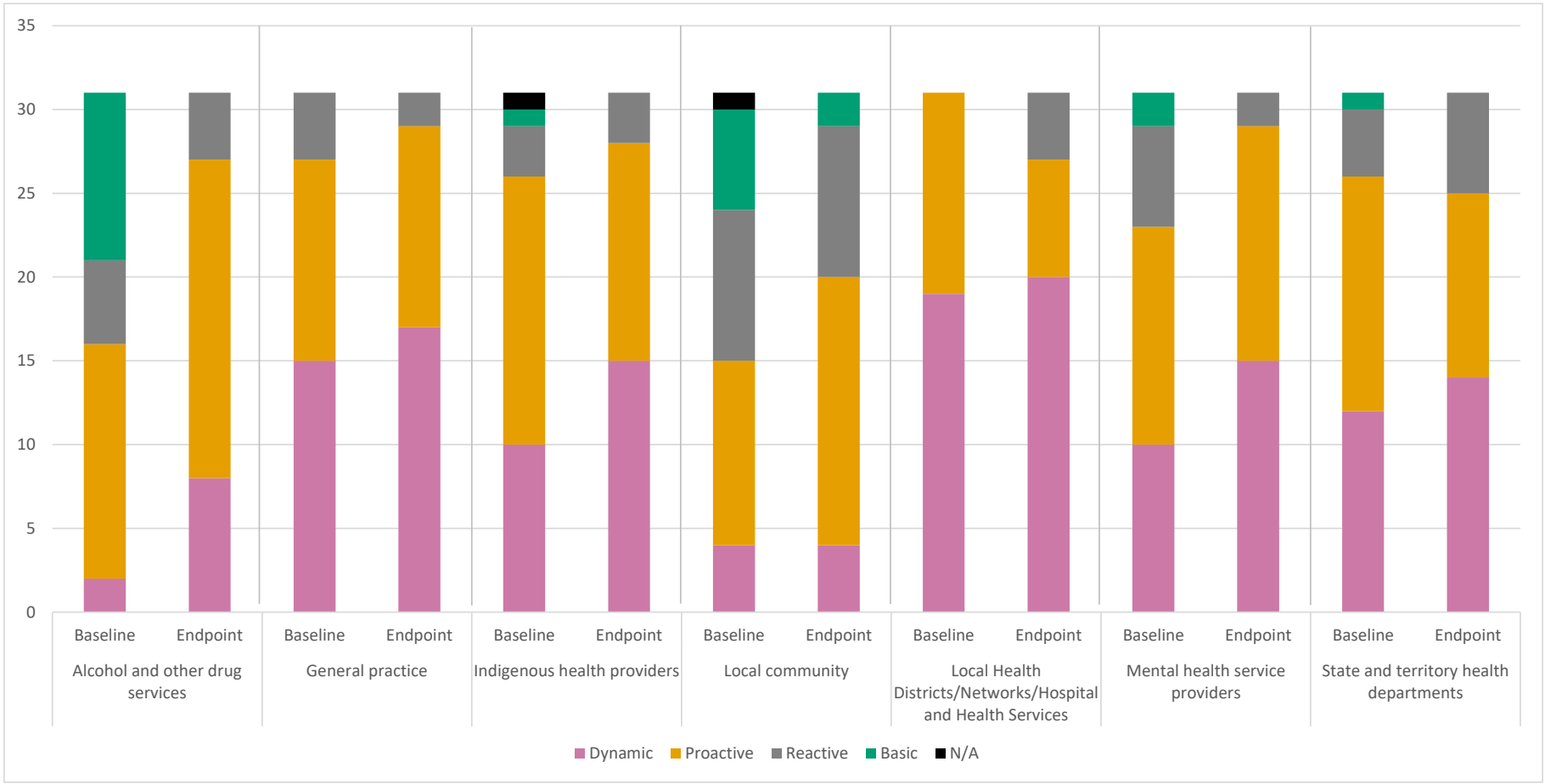
By the end of the evaluation period, PHNs employed different methods for stakeholder engagement and building effective partnerships from each other, and across sectors (Figure 9). PHNs used a variety of means to engage with stakeholders. Membership in advisory groups, Memorandum of Understanding and shared governance arrangements, for example, provided formal mechanisms for engagement with key stakeholders. Practice support was another method for formal engagement with primary care stakeholders. Each PHN also engaged informally through continuing professional development, educational forums, online forums, surveys and other functions and events, but with varying levels of emphasis. This evolved through an iterative approach to engaging and understanding the needs of their region.

Nevertheless, face-to-face engagement was the most commonly used and most effective means of engagement as it assisted in breaking down barriers and building trust in the early stages of the Program and it assisted PHNs to show presence, engagement and investment in key stakeholder issues as the Program progressed.

PHNs most mature relationships were reported to exist with general practice and LHNs. The level of maturity of relationships with all stakeholders is trending upwards, with the greatest improvement reported with drug and alcohol service providers. Despite PHNs reporting that the maturity of relationships has improved with Indigenous health service providers, key Aboriginal and Torres Strait Islander stakeholders (service providers and community representatives) provided mixed views during key informant interviews and case studies.[40] As evident from Figure 9, the least progressed relationships existed with local community (i.e. the users of the services which the PHNs have commissioned) which was reported by PHNs to be impacted by factors such as timelines to deliver on PHN responsibilities, capability and capacity of the PHN, the vastness of their geography and the diversity of the population in the PHN region.

[40] PHN Program Evaluation – Endpoint PHN Survey, December 2017

Figure 9: PHN reported stakeholder relationship maturity at baseline and endpoint (count, n=31)[41]



[41] Basic: At the starting point of developing or forming the foundations of a relationship (for example, there currently is no joint planning, no sharing of data/information)
Reactive: Relationship is responsive in relation to particular situations, needs or requests (for example, there currently is ad hoc joint planning, ad hoc sharing of data/information)
Proactive: Relationship has developed to the point of actively being prepared for a particular situation, need or request (for example, there currently is activity-based joint planning, regular sharing of data/information, some sharing of resources)
Dynamic: A strategic partnership has been developed with formal agreements/mechanisms in place – such as an MOU (for example, there currently is regular joint planning, regular and ongoing sharing of data/information based on an agreement, regular and ongoing sharing of resources, co-design)

Engagement with general practice

The PHN Program has evolved from the previous Divisions of General Practice and Medicare Local Program which placed general practice at the centre. Although the *Primary Health Networks Grant Program Guidelines*[42] states that general practice remains a central focus of the Program (based on recommendations from the Horvath review[43]), there were concerns at the commencement of the Program that the new structure would disenfranchise general practice, or at least give that perception that they were no longer a central part of the primary health care reform agenda.

Although some dissatisfaction has remained amongst general practice stakeholders (e.g. in regards to perceptions of bureaucracy), overall there was an improvement in engagement, with some PHNs having excelled through practice development and support activities, supporting general practice with health reform – such as the stage one trial of Health Care Homes, My Health Record and other activities. Section 5.3 provides further detail on the system integration and capacity building role of PHNs and working with general practice. It is currently estimated that approximately 46 per cent of all general practices are providing data to PHNs for quality improvement advice.[44]

While engagement with general practice varied across the PHNs, substantial progress has been made in this area since the commencement of the PHN Program. By the end of the Evaluation period, just under 50 percent of PHNs reported that practices in their region were highly engaged.[45] Types of engagement included support (including eHealth, quality improvement, integration, etc.) as well as consultation (as part of the commissioning cycle).[46]

Figure 9 (above) shows that the majority of PHNs reported their relationship with general practice is 'proactive' or 'dynamic'. Little variation was reported based on geography (metropolitan, regional or rural) or PHNs with a history as a Medicare Local compared to those that do not.[47] Nevertheless, although engagement of general practice was not a new function for most PHNs, the variation which exists amongst general practices (for example, corporate, private and sole practices), as well as regional context, made engagement complex for PHNs.

Engagement with states and territories and Local Hospital Networks

State and territory health departments have become increasingly engaged with the PHNs as the program matured, with engagement generally being viewed as constructive across most states and territories. As a result of PHN activities aimed at increasing visibility (such as PHN representation at state or territory strategic planning meetings or representation of state and territory health departments at PHN meetings), state and territories were increasingly seeing PHNs as a mechanism to utilise for their own reforms, in line with their level of maturity. In particular, they better understood the importance of PHNs as a point of interaction at the regional level, and provided them with access to a part of the health system which they have little influence over, i.e. general practice (see Section 7 for discussion of bilateral agreements). Figure 9 (above) illustrates the maturity of PHNs' relationships with state and territory health departments. Those PHNs with more mature relationships with state and territory health departments (including formalised agreements) were beginning to undertake co-commissioning, as discussed in Section 5.2 and Section 6.

PHNs utilised a range of mechanisms for engaging with state and territory health departments, including Memoranda of Understanding, shared meetings, co-planning, collaborative frameworks, data sharing,

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[42] Australian Government Department of Health 2016. Department of Health Primary Health Networks Grant Program Guidelines February 2016 – Version 1.2. URL: http://www.health.gov.au/internet/main/publishing.nsf/Content/PHN-Program_Guidelines

[43] Professor John Horvath, Review of Medicare Locals, 2014. URL: http://www.health.gov.au/internet/main/publishing.nsf/content/review-medicare-locals-final-report

[44] PHN Branch, Australian Government Department of Health, 2018.

[45] PHN Program Evaluation – Endpoint PHN Survey, December 2017

[46] PHN Program Evaluation – Endpoint PHN Survey, December 2017

[47] PHN Program Evaluation – Endpoint PHN Survey, December 2017

shared resources, co-funded projects, and regular Ministerial meetings. Relationships with state and territory health departments were assisted by state and territory government policy which was in line with the objectives of the PHN Program. Nevertheless, building more effective working relationships with some state and territory health departments was impeded by conflicting policies, the turnover of key staff, resistance to engagement, and resistance to share data from either side.

There are examples of developing relationships between PHNs and LHNs and of co-commissioning. However much of that still depends on the good will of individuals rather than being systemic. For example, some PHNs reported having developed "really good" working relationships with their LHN(s) which facilitated shared projects with organisations. This was the most commonly reported partnership with LHNs. More systematic approaches included PHNs partnering with LHNs through formal agreements and co-commissioning, establishing an ongoing and reciprocal relationship.[48]

It was found that the type of partnerships with LHNs differed depending on PHN geography (metropolitan, regional or rural), with more PHNs in metropolitan locations reporting to have developed more formalised, systematic partnerships and co-commissioned with LHNs.[49] Partnerships between the two sectors were fostered when: boundaries were aligned; they were built on strong local connections; and where there was a supportive environment at the state or territory level (e.g. state and territory health policy encouraging engagement, data sharing and regional planning). PHNs and LHNs generally worked best together and developed a systematic partnership when they had a shared objective, supported by appropriate governance and sufficient capacity. Where these factors were not immediately apparent and there were limited incentives for LHNs to engage with PHNs, additional investment of time and resources were required to establish relationships, ways of working and a common objective.

Insights from the case studies

LHN collaboration was exemplified at PHN4, which had multiple formal collaborative agreements with the LHN covering the identical region, and a children's hospital network. These relationships involved many other organisations including other government departments and service providers. While there were some independent agreements with other service providers and organisations, most collaboration was integrated into the relationship with the LHN.

These relationships were fostered by a strong commitment, vision and investment by the PHN (which evolved from a Division of General Practice and a Medicare Local). The PHN acknowledged that their commitment to their vision and strategy over many years, as well as stability in the organisation, enabled them to foster long, sustainable and purposeful partnerships with a number of organisations. This included the LHN and state and territory health department.

PHNs working as a network

In New South Wales, Queensland and Victoria, PHNs have set up and funded state-based coordination or alliances. Informally, the Queensland alliance includes the Northern Territory PHN; the Tasmanian PHN is connected to the Victorian alliance; and the Australian Capital Territory PHN is part of the New South Wales alliance. The Western Australian PHNs (Perth North, Perth South and Country WA PHNs) are set up under the Western Australian Primary Health Alliance, an organisation which oversees the strategic commissioning functions of the three PHNs.[50] The two South Australian PHNs (Adelaide PHN and Country South Australia PHN) have co-located offices and regularly work together to develop state-based solutions (e.g. shared commissioning frameworks).

PHNs set up these alliances to provide coordination between PHNs within a jurisdiction, including: sharing of knowledge and experience; building PHN capacity and capability; engaging state-based stakeholders

[48] PHN Program Evaluation – Endpoint PHN Survey, December 2017

[49] PHN Program Evaluation – Endpoint PHN Survey, December 2017

[50] http://www.wapha.org.au/about-wapha/

(including state and territory health departments); and addressing state-wide issues. Alliances have an informal role within the PHN Program and are limited by the funding that PHNs can contribute to them. However, the benefit of these alliances to PHNs is significant: providing a mechanism for sharing resources and expertise, as well as problem solving (for example, through a range of sub-groups which are designed for working through elements of the program in more detail and engaging a broader range of PHN staff).

At the end of the evaluation, PHNs are beginning to think beyond their own state or territory boundaries and aiming – via the PHN CEO Cooperative – to work together in a more coordinated way to share lessons, engage with stakeholders and develop capability and capacity across the network. In this way, the PHN CEO Cooperative, as well as the PHN alliances, are beginning to work as a key strategic driver of the PHN Program, strengthening areas for development and harnessing opportunities through the network to achieve the key objectives.

Engagement with the community and consumers

Mainstream national consumer stakeholders are generally strong supporters of the PHN Program. These stakeholders recognise the important role that PHNs have in improving service integration and coordination for patients at the local level. National consumer stakeholders acknowledged PHNs' key role in driving policy reforms (e.g. the implementation of the My Health Record national roll-out, Health Care Homes) through their local influence.

Due to the number of PHNs across the country, national consumer stakeholders found it difficult to engage consistently. The Department assisted this engagement through a number of mechanisms such as forums and workshops but the creation of the PHN CEO Cooperative should enable more direct engagement with national consumer and community organisations (rather than via the Department). This should improve the consistency of engagement and help PHNs to sharpen and improve their approach to community engagement, including the role that Community Advisory Committees play in engaging with local community members and consumers. See 'Engagement with local stakeholders' (below) for more detail.

Engagement with local stakeholders

Early and regular engagement was reported as beneficial to bringing local stakeholders 'along the journey' and gathering input in key PHN activities. Some PHNs started gathering community perspectives even before responding to the *Invitation To Apply* process (see Section 4.1 for more detail on the *Invitation To Apply*), which enabled them to structure the organisation to reflect community need (e.g. teams which focused on specific community issues). Most PHNs maintained regular local stakeholder engagement through a range of activities, including roundtable meetings, visits to stakeholders, marketing and communication, and educational sessions. One PHN undertook a region-wide community engagement process through an online portal (see right).

Gippsland PHN's *Tell Maria* campaign

Gippsland PHN launched a region-wide campaign to gather input from community stakeholders on what is needed most to improve health outcomes.

Gippsland PHN launched the Tell Maria initiative in September 2016 to encourage the Gippsland community to provide their input to help determine what the health priorities are for Gippsland.

Through looking at what the community and health professionals report, in addition to available datasets, Gippsland PHN was able to determine priorities for support and investment in the region.

Another key mechanism for engagement of local stakeholders has been through Clinical Councils and Community Advisory Committees. All PHNs have used these structures to gather local stakeholder perspectives; however, the frequency and depth of engagement varied.[51] PHNs whose Clinical Councils and Community Advisory Committees met fewer times naturally gathered less input from their Clinical Council and Community Advisory Committee members. In some instances, PHNs overcame gaps in input from the Clinical Councils and Committee Advisory Committee through engagement with other advisory groups or other consultation processes.

[51] PHN Program Evaluation – Endpoint PHN Survey, December 2017

Clinical Councils and Community Advisory Committee members involved in the focus groups reported that they predominantly provided input into assessing need and prioritisation. Only a few Clinical Councils, and even fewer Community Advisory Committees, were involved in providing input into other commissioning processes or key PHN activities. PHNs avoided potential conflicts of interest by excluding Clinical Councils or Community Advisory Committees from procurement decisions. However, many PHNs reported that they would benefit from more Clinical Council and Community Advisory Committee input into monitoring and evaluation processes to inform the ongoing improvement of commissioned services as their maturity in this area increases (further detail on Clinical Council and Community Advisory Committee engagement is included in Section 4.2).

Generally, feedback from stakeholders about engagement by PHNs was positive, although some reported that they did not have the opportunity to provide input into key PHN activities. Timeframes and PHN capability and capacity had the biggest impact on PHN engagement with local stakeholders. Due to tight timeframes, many local service providers (particularly smaller entities) found it difficult to respond to PHN requests. Further, local contexts – such as distances, geography and the local market – impacted on engagement and made regular face-to-face contact difficult. Where this was the case, some PHNs set up innovative approaches to engagement through solutions such as satellite offices and digitally-enabled solutions. However, overcoming challenges due to vast distances is still an area where PHNs were still trialling solutions to enable regular, proactive engagement with all parts of their region.

Engagement with Indigenous health sector stakeholders[52]

Working to improve the health outcomes of Aboriginal and Torres Strait Islander people is one of the six priority areas for PHNs. The *PHN and ACCHO Guiding Principles* set out the need to involve Indigenous stakeholders in the consultation process, and working with the Indigenous sector to understand the implications of their needs and services for commissioning.[53] While some progress appears to have been made in engaging with Indigenous health sector stakeholders, this was considered an area of ongoing development for all key stakeholders – the Department, the National Aboriginal Community Controlled Health Organisation (NACCHO), Aboriginal Community Controlled Health Services, Aboriginal Medical Services and PHNs. Some Indigenous health sector stakeholders found it contentious to channel funding for the Integrated Team Care Program – even though it was previously provided by Medicare Locals – and new funding for mental health and drug and alcohol treatment services through PHNs. In particular, concern was expressed about:

- the degree to which PHNs engage with Aboriginal and Torres Strait Islander key stakeholders and their ability to commission culturally appropriate services;
- the ability of PHNs to understand where targeted investment has already been made in Aboriginal and Torres Strait Islander health services and their ability to effectively commission services that complement and/or improve current services; and
- the impact on Aboriginal Community Controlled health services and Aboriginal Medical Services if PHNs do not involve these services early in the commissioning process.

As a result, there is still progress to be made in terms of building trust and developing meaningful relationships and mechanisms of engagement between the relevant parties. Nevertheless, some PHNs have developed proactive engagement and strong partnerships with their local Aboriginal Community Controlled health services and Aboriginal Medical Services, primarily through maintaining their relationship from Medicare Locals to PHNs, or establishing Indigenous-specific governance structures. While the skills, knowledge and cultural competency of PHNs working with the Aboriginal Community Controlled health

[52] 'Indigenous health sector stakeholders' refers to representatives from the Department, the National Aboriginal Community Controlled Health Organisation, Aboriginal Community Controlled Health Services and Aboriginal Medical Services unless otherwise stated.

[53] Australian Government 2015, PHN and ACCHO Guiding Principles. Department of Health: Canberra. URL: http://www.health.gov.au/internet/main/publishing.nsf/Content/PHN-Accho

services and Aboriginal Medical Services is variable, the majority of PHNs recognise the importance of these relationships and are working towards improving them in a proactive way as set out in the *PHN and ACCHO – Guiding Principles*[54] (as indicated by Figure 9 above). This may be aided by following the *PHN and ACCHO – Guiding Principles* more closely and working more with the Department, NACCHO, Indigenous health state and territory peak bodies and other PHNs (through the PHN CEO Cooperative).

Insights from the case studies

The case studies provided an example of the strong concerns expressed by a number of Aboriginal and Torres Strait Islander leaders. Firstly, given the large and widely dispersed Aboriginal and Torres Strait Islander population, it was expressed by local stakeholders that PHN1 had insufficient staff capability and capacity to address the identified needs. Secondly, it was felt that there was a need to improve the coordination between services, in order to avoid the perception of multiple government and non-government organisation visitors who are largely uncoordinated, sometimes duplicative and therefore, often ineffective. Thirdly, Aboriginal Medical Services feared that their models and business intelligence were being replicated and there was a chance that their services may be pushed aside, which was a concern highlighted from key Indigenous stakeholders at other PHNs as well.

PHN1 had some success with Indigenous health and partnerships, including bringing all the region's Aboriginal Medical Services together for the first time in many years, and enabling a training program for Aboriginal health workers in communities. A LHN stakeholder appreciated the flexibility of the PHN to talk face-to-face with Aboriginal and Torres Strait Islander communities. The PHN planned to continue this region-wide engagement to facilitate more coordinated services, which was a particular issue in many parts of the region.

PHN4 made a significant impact on its smaller and less remote Aboriginal and Torres Strait Islander population by preventing the closure of a local Aboriginal Medical Service. In order to maintain service continuity for the community, the PHN managed the Aboriginal Medical Service for a year, then passed management to an Aboriginal Community Controlled Health Organisation after a tender process. The Aboriginal Community Controlled Health Organisation was then linked in to participate in a local collaborative group with the PHN and LHNs. This enabled regular communication between the PHN, LHN and the Aboriginal Community Controlled Health Organisation, input into region-wide planning and increased the PHNs, LHNs and Aboriginal Community Controlled Health Organisations ability to make commissioning decisions that affect the health outcomes of Aboriginal and Torres Strait Islander people in the region.

Challenges and gaps

PHNs are relatively small players in the broader health system in terms of funding. Their ability to facilitate improvements in the health system (and achieve their objectives) primarily comes from how well they can work with or influence others – state and territory departments of health, LHNs and general practice, other primary health care providers and non-government organisations – to effect change. The ability of PHNs to influence general practice is a challenge given it is a predominately fee-for-service system, providing PHNs with limited levers to work with.

It is difficult for PHNs to achieve their objectives without stronger incentives and disincentives to encourage LHNs, and other key stakeholders, to truly engage with PHNs in regional planning, and to support integrated service delivery at the local level.

If PHNs and LHNs are to plan and support integrated service delivery together, they need to share information and intelligence. Any barriers to that sharing need to be removed. This means they need to know what each other is doing and be engaged upfront in planning and decision making, and in the commissioning and procurement processes. There is benefit to governments working better together at the national level to take responsibility for identifying and removing disincentives to PHNs and LHNs working together, such as lack of sharing of information and data, and barriers to LHNs and PHNs sitting at the table as equals in the planning and commissioning processes.

[54] Australian Government 2015, PHN and ACCHO Guiding Principles. Department of Health: Canberra. URL: http://www.health.gov.au/internet/main/publishing.nsf/Content/PHN-Accho

A number of PHNs experienced challenges in engagement due to their capability and capacity, timeframes and external stakeholders' lack of understanding of the role of PHNs, creating some variability in PHN engagement with stakeholders.

Some stakeholders felt concerned by the PHN Program initially; PHNs had to do a lot of work educating stakeholders about their role, managing expectations and building relationships. There needed to be better recognition of the time needed and resources required to move into a new sector and develop the trust required to build collaborative relationships to co-design local service solutions. This will need to be considered as the program develops.

PHNs found it harder to engage with national and state peak bodies and organisations compared to local stakeholders because of the emphasis on PHNs being locally responsive bodies and a lack of any structures to connect with them. In response to this (and other challenges), PHNs initiated solutions to assist with the facilitation of engagement. This was firstly done with the state-based PHN alliances, and more recently with the establishment of the PHN CEO Cooperative. This will require ongoing development to ensure PHNs are accessible and open to stakeholders not only at a local level, but also at a jurisdictional and national level. This includes collectively developing ways of ensuring national engagement, including with consumers.

There was an acknowledgement among stakeholders, as well as PHNs themselves (see Figure 9 above), that more work needs to be done to improve PHNs' reach into the community, including: employing more sophisticated ways to engage with their local communities and increase awareness of the work of PHNs among consumers; better developing the capability and capacity of members of the Community Advisory Committees; and using the Community Advisory Committees to engage more proactively with the community.

Engagement of the Aboriginal Community Controlled health sector remains variable across the PHN Program, providing the opportunity for improvement of this relationship. Reiterating the importance of the *PHN and ACCHO – Guiding Principles* is a good starting point to highlight the need to improve engagement and relationships.

5.2 Commissioning

Overview

Commissioning is a key mechanism through which PHNs are to achieve the objectives of the PHN Program. Commissioning describes a broad set of linked activities, including needs assessment, priority setting, procurement through contracts, monitoring of service delivery, and review and evaluation. PHNs are funded to undertake commissioning to ensure that resources are best directed to addressing local primary health care needs to deliver positive health outcomes for the community and improve health system integration.

The PHN Program is the first model of primary health care commissioning undertaken on a large scale in Australia. Although commissioning is relatively new in Australian primary health care, it has been evolving since the 1990s in various forms in New Zealand, the United Kingdom, the United States and some European countries.[55]

Commissioning as a core function of PHNs and in the Australian context was not always well understood early in the PHN Program (by many PHNs, the Department, local service providers and other key stakeholders). It was often conflated with procurement. However, the Department and PHNs quickly worked to develop a more comprehensive and shared understanding of commissioning through developing

[55] Robinson S, Dickinson H & Durrington L 2016, ' Something old, something new, something borrowed, something blue? Reviewing the evidence on commissioning and health services', *Australian Journal of Primary Health* 22(1): 9–14

guidance and resources to support needs assessments and annual planning as well as designing and contracting services.[56] Overall, PHNs took a conservative and iterative approach to commissioning, building on lessons learned by the network, reflecting the complexity of the primary health care landscape, the novelty of commissioning in the Australian context, the rapid expansion of the PHN Program (particularly with mental health funding) and tight timeframes.

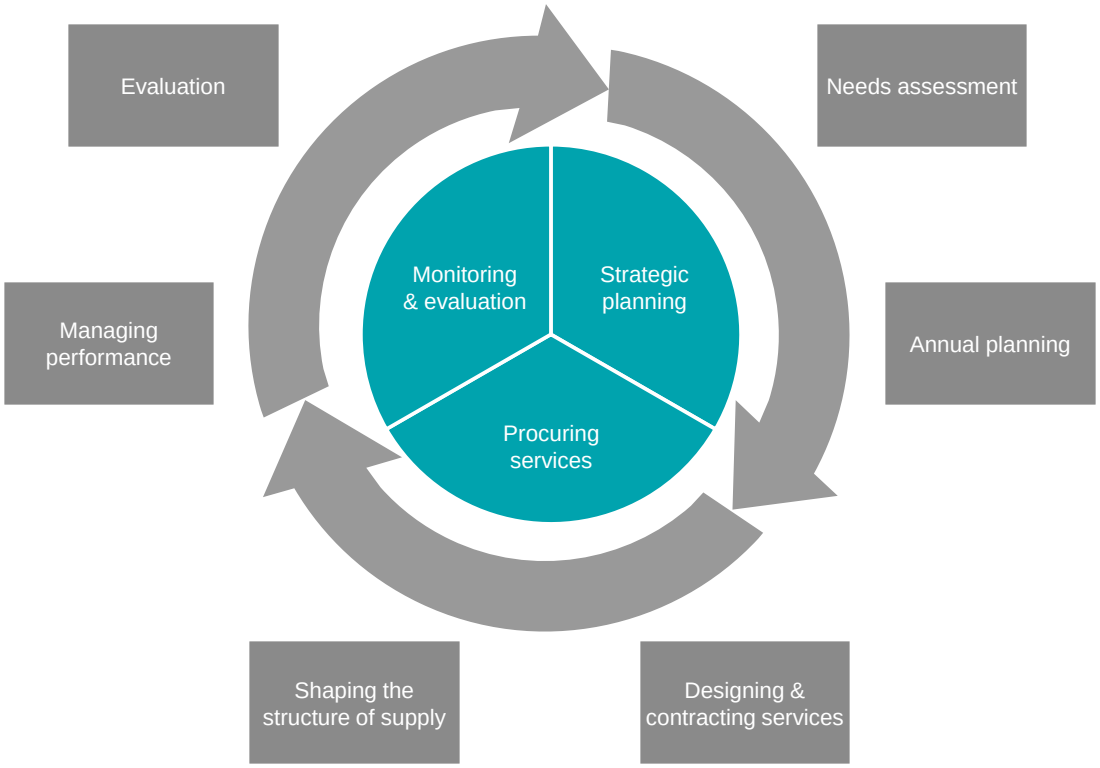
All PHNs undertook commissioning activities following the commissioning cycle, working to improve efficiency and effectiveness through localised decision-making and spending. By the end of 2017, PHNs were undertaking commissioning, co-commissioning and decommissioning. The quality of PHNs' commissioning activities as well as early outputs or outcomes from commissioning, coordinated commissioning, co-commissioning and decommissioning was reported as variable, but improved overall as lessons from previous cycles were applied to the next round. A key lesson learned has been that proper co-design and co-commissioning takes time and money to effectively engage and work with key stakeholders (such as LHNs, service providers, consumers, communities and a whole range of other stakeholders).

Progress to date

It has taken time for PHNs to establish themselves as commissioning organisations. This is due to a range of factors, including the smaller scale of PHNs' commissioning remit as compared to the overall expenditure on primary health care in Australia, and the higher level of funding that is available to other key funders and commissioners (particularly LHNs), as well as factors such as PHNs' level of experience with commissioning, relationships and partnerships, market capacity, data availability and local context.

To support PHN commissioning activities, the Department – in consultation with PHNs – developed the PHN Commissioning Framework (Figure 10), which articulated the key stages in commissioning as strategic planning, procuring services, and monitoring and evaluation.

Figure 10: PHN Commissioning Framework



[56] Australian Government, 2016, Needs Assessment Guide, Planning in a Commissioning Environment, and Designing and Contracting Services. Department of Health: Canberra

The development and release of commissioning support materials took longer than anticipated, and the materials were predominantly based on international experiences of commissioning. However, these materials provided supporting information to assist PHNs in undertaking their needs assessments and strategic planning, and in designing and contracting the commissioned services. They also served as a basis for workforce development, and assisted PHNs in engaging and managing the expectations of service providers. Regardless of how much experience individual PHNs had, PHN commissioning activities (following the commissioning cycle) have taken more time and resources than the PHNs or Department had anticipated. PHNs are yet to reach the proper maturity for commissioning, and as such, ongoing investment in this process will be required.

Strategic planning[57]

PHNs developed their capability and capacity for strategic planning through experiential learning, the recruitment of a skilled workforce and the support of the Department. This included improved sharing and utilisation of data, developing data analysis skills, improved prioritisation of needs and gaps, and broader stakeholder engagement.

PHNs increasingly sought broader stakeholder input into their strategic planning activities, recognising the value of this input – including understanding the needs and gaps in the region, priority setting, the development of targeted solutions, and better understanding the health landscape and impacts of commissioning decisions, to avoid duplication and further fragmentation of the system. This was achieved through Clinical Councils, Community Advisory Committees, and other advisory groups and consultation processes.

Nevertheless, at the end of the evaluation there was still an observable difference in the quality of Needs Assessments and Activity Work Plans and in the alignment between the two deliverables. This indicated that variability in commissioning capability remained, but was improving with time and experience.

Procuring services[58]

Given the pressures of timelines and expectations, most PHNs had to develop their capability and capacity as they undertook procurement processes for commissioning. They did this by sharing experience and learnings and taking a pragmatic and conservative approach. A common view was that creating system change required building relationships and working with other organisations to make gradual, significant movements.

In the first year of commissioning, most PHNs focused on continuity of services through reviewing and adapting previous contracts, and in this way, they began developing their contracting processes. PHNs' commissioning activities in the second year were largely focused on mental health and drug and alcohol treatment services with the new program funding.

From the endpoint PHN survey, 90 per cent of PHNs reported that they were mostly or fully satisfied with the effectiveness of their procurement processes for mental health services. 83 per cent of PHNs were mostly or fully satisfied with the effectiveness of procurement processes for drug and alcohol treatment services and 81 per cent with core services.[59]

Procurement strategies varied based on PHNs' local context and leadership. For example, some PHNs placed greater emphasis on shaping the structure of supply through facilitating service providers to come together and build capacity through upskilling existing organisations, sharing resources, and through

[57] Strategic planning includes the two key elements of: (1) needs assessment; and (2) annual activity planning.

[58] Procurement includes the two key elements of designing and contracting new services and shaping the structure of supply: (1) Designing and contracting services: Identifying the required outcomes/services to be delivered and working with the community, providers and others to co-design potential solutions. Procuring and effecting contractual arrangements to supply services and decommission existing services where they are unwarranted; (2) Shaping the structure of supply: Stimulating a thriving and sustainable market to meet the ongoing health needs of the population and responding to commissioners' requirements.

[59] PHN Program Evaluation – Endpoint PHN Survey, December 2017

coordination between services, e.g. when there was failure in the market (most common in rural and remote areas where primary care was often provided by non-general practice service providers). In comparison, in some metropolitan areas there was greater emphasis on designing and contracting new services through competitive tendering. The different approaches largely reflect the availability and maturity of the local market in those regions. Some PHNs trialled new models of care (e.g. chronic disease management, after hours and mental health) and used the findings to inform new models of care in subsequent rounds of commissioning.

Some stakeholders and service providers reported some anxiety about the potential impact of PHN commissioning activities. However, as PHNs became more sophisticated in their strategic planning processes and took the time to develop relationships, many service providers reported that they felt encouraged to collaborate with the PHNs. In some cases, service providers (who were previously in competition with each other) worked together with PHNs to develop a model of care which responded to local needs. It was reported that proper co-commissioning was still a challenging area for some PHNs as it required significant effort to develop a shared understanding and objectives, navigate funding allocations, share data and commence co-planning, however, progress was being made (see right).[60]

Decommissioning was a steep learning curve for many PHNs, and was also an area of anxiety for service providers. PHNs were quick to share lessons learned from decommissioning for the benefit of other PHNs. They also became more sophisticated in their approaches by making better use of evidence to support commissioning decisions, engaging service providers early and often, and developing a deeper understanding of the broader system impact that decommissioning a service may have. However, this is an area reported by most PHNs as requiring further development.

Victorian Suicide Prevention trials

The PHNs in Victoria have used a common objective to partner with the Victorian Government and other agencies to implement a systemic, coordinated approach to suicide prevention through setting up trial sites in 12 local government areas over six years. Exploring the particular issues related to Aboriginal people will be part of this.

At each site, a local suicide prevention group including representatives from the local agencies and PHNs will develop a plan to reduce suicides in the area. Each site will be supported to implement the nine proven suicide prevention interventions:

- prevention awareness programs
- school-based programs
- responsible media reporting
- gatekeeper training
- frontline staff training
- general practitioner support
- reduce access to lethal means
- high-quality treatment
- continuing care after suicide attempt.

[60] Victorian Department of Health and Human Services, 2016. *Victoria's 10-year Mental Health Plan: Victorian Suicide Prevention Framework 2016–25*. Available from https://www2.health.vic.gov.au/about/publications/policiesandguidelines/victorian-suicide-prevention-framework-2016-2025

Insights from the case studies

Overall, local stakeholders reported that areas for further development in designing and contracting services in a commissioning environment included: how PHNs develop and stimulate the market (including the ability for local markets to respond and sufficient timeframes); increasing community and consumer engagement in the commissioning process; and greater co-design with service providers.

PHN3 established two key stakeholder relationships which greatly assisted in the procurement of services. The first was between the PHN contracts team and the then Health State Network in the Department, which facilitates effective contracting and commissioning through designing contracts that meet the requirements of the funding and the objectives of the PHN. The second was co-commissioning with the state-based Mental Health Commission and developing a comprehensive state-wide mental health strategy, which was seen as an outstanding achievement.

Local stakeholders from PHN4 had mostly positive views of the procurement processes undertaken by the PHN. Although most stakeholders understood the time pressures experienced by PHNs, many expressed that those pressures were pushed onto them in responding to tenders. Some stakeholders, including Indigenous Health service providers reported limited capability and capacity to respond to tenders; short timeframes made responding even more difficult. Others reported that PHN communication processes around commissioning decisions could improve, explaining that there was often a "one-way flow of information without a feedback loop to local stakeholders".

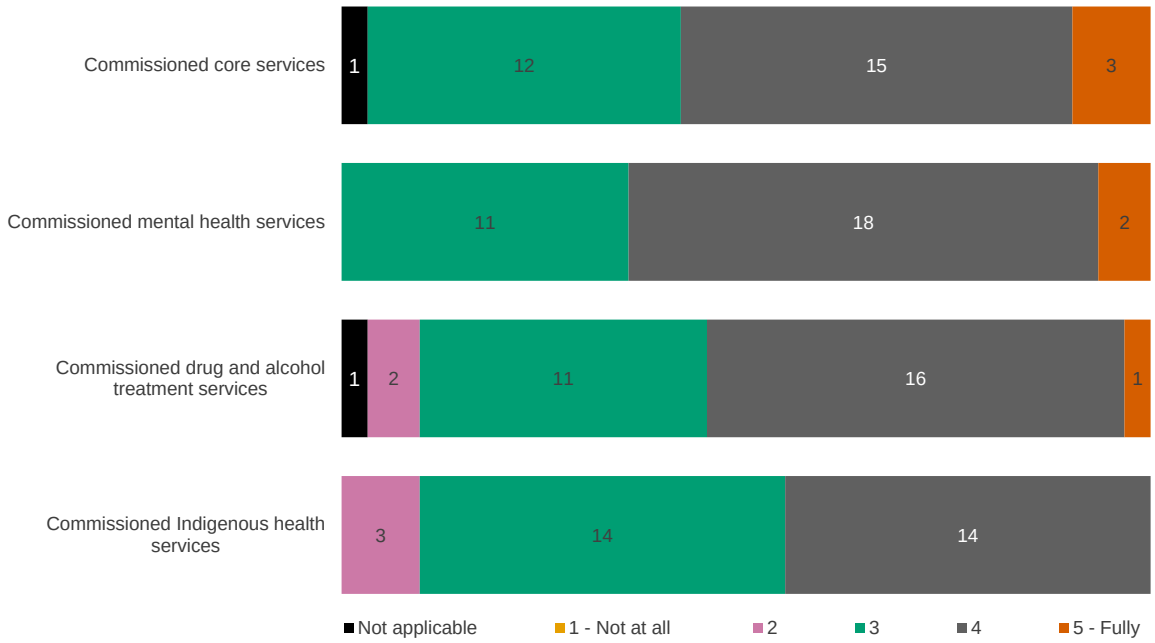
Monitoring and evaluation[61]

Most PHNs are still developing their capability in monitoring services and consequently there is also limited evidence to demonstrate that PHNs have evaluated commissioned services. In the second round of commissioning, most of the focus for PHNs was on monitoring the delivery and occasions of service and had not yet matured to include an evaluative perspective, for example, in terms of impact or outcomes. By the end of the Evaluation, as illustrated in Figure 11, PHNs reported variability in their ability to monitor and evaluate the quality of commissioned services.[62]

[61] Monitoring and evaluation includes the two key elements of managing performance and evaluation: (1) Managing performance: acquiring and analysing information about provider performance (including the broader relationship) to monitor, assess and deliver quality and, where necessary, challenge the quality of services. It also involves building and maintaining relationships with providers to support the sustainability of the contract; (2) Evaluation: understanding and evaluating the quality of delivery and the impact that it is having against agreed standards and PHN goals. This informs ongoing or future needs assessment, planning and procurement/contracting as part of a continuous commissioning approach, designed to meet PHN objectives and agreed national priorities.

[62] PHN Program Evaluation – Endpoint PHN Survey, December 2017

Figure 11: PHN reported ability to monitor and evaluate the quality of commissioned services at endpoint (count)



PHNs are developing their ability to monitor and evaluate commissioned services by ensuring adequate reporting mechanisms are built into contracts. This has required ongoing development of the capability of service providers and PHN staff, particularly in relation to working with data. In addition, the wide variety and quantity of local performance measures, their limited alignment with national measures and the challenges with the *PHN Performance Framework (Version 1.0)* made it difficult for PHNs to develop monitoring processes for service providers.

Some PHNs used advisory groups or external contractors to evaluate the performance of commissioned services. Advisory groups were also used for advising on improvements to the contracting process to facilitate better service provision.

Challenges and gaps

Commissioning is still a relatively new concept for primary health care in Australia, and the Department, PHNs and other stakeholders (as well as international experience) recognise that it is challenging. The evidence base for the benefits of commissioning is mixed, and observed impacts are highly dependent on context.[63] Internationally, commissioning is being superseded by other approaches such as the accountable care model in the UK,[64] and these lessons will be important for the PHN Program. In Australia, the understanding of commissioning, as it relates to the PHN Program, is also evolving.

As the scale of PHNs' funding for commissioned services is smaller than that of other key funders and commissioners in the Australian health system (particularly LHNs and state and territory governments), it is especially important that PHNs strategically apply the leverage they have in order to achieve the greatest impact. This is challenging for PHNs as commissioning and funding decisions to date have often had to be made quickly to comply with Government requirements and funding cycles. This has meant that PHNs have had less time to engage and work with key stakeholders to strategically allocate funding. This has led to a more transactional approach and some strain with stakeholders, including the Aboriginal Community

[63] Gardner K, Powell Davies G, Edwards K, McDonald J, Findlay T, Kearns R, Joshi C & Harris M 2016 'A rapid review of the impact of commissioning on service use, quality, outcomes and value for money: implications for Australian policy', *Australian Journal of Primary Health* Special edition on commissioning 22(1) 40–49

[64] Charles A 2017. Accountable care explained. The King's Fund. Available from https://www.kingsfund.org.uk/publications/accountable-care-explained

Controlled Health Sector, and some LHNs, non-government organisations and service providers.

Some stakeholders and service providers were dissatisfied with PHN commissioning in the new program areas of mental health, drug and alcohol treatment services, and Indigenous health services. Commissioning of services for Aboriginal and Torres Strait Islander people has been particularly challenging and was often not well received; the perception was that this work by the PHNs was infringing on the model of Aboriginal Community Controlled Health Services. While the intention was that the work of PHNs would align to the principles of the Aboriginal Community Controlled Health Sector and enhance the good work already being done, variable engagement of, and by the sector, across the PHN Program has made this a challenging area for PHNs.

Shaping the structure of supply was an area for the PHN Program to develop, including the ability of PHNs to stimulate the market to meet the ongoing health needs of the population and respond to requirements of the commissioner. In recognition of this, the Department contracted an external consultancy for two commissioning resources projects. The first of these, undertaken in 2015-16, including the development of guidance for PHNs on designing and contracting services, and the second consultancy project, which commenced in October 2017, focused on the development of guidance, tools and training for PHNs on market making and development; change management and commissioning competencies and skills; commissioning for outcomes; and monitoring and evaluation. While these capability building activities are important, PHNs will require ongoing support in shaping the structure of supply, particularly in regions outside of major metropolitan centres where the options for the market and workforce are more limited.

The dissatisfaction of some service providers with PHNs' procurement processes was also evident in the Evaluation, and requires ongoing attention. They cited, for example, a lack of clarity in contracting processes and time pressures. As the PHN Program progresses, PHNs and the Department acknowledged the pressures that were passed on to commissioned services and continue to adapt processes and educate service providers to improve their capability and capacity to meet commissioning requirements.

There also needs to be better recognition across the PHN Program, that procurement in commissioning does not always require a competitive tendering process. In some situations (for example, where there is a very limited supply of providers who could deliver the required services, and/or in cases where a competitive process would not be commensurate with a smaller scale or value commissioning process), a competitive process may be counter-productive and reduce continuity of care. As part of the commissioning process, procurement can be designed to integrate (using mechanisms such as cooperative partnerships and integrated service provider networks), where service providers work together for the benefit of the community and consumer.

Although access to granular data for needs assessment did improve through relationships and partnerships with state and territory health departments and LHNs, it continues to be an area for development for the PHN Program. Specific areas of improvement included timely access and consistency of data availability across all areas of the PHN Program including mental health, drug and alcohol treatment services, and Indigenous health.

Overall, areas of particular concern for PHNs included the time and resources required to undertake a full commissioning cycle and the scope of, and outcomes required by, PHN commissioning activities. PHNs need the time and appropriate funding structures to be effective commissioners (i.e. flexible and context-specific), particularly as they move towards building more strategic partnerships for co-design and co-commissioning.

5.3 System integration and capacity building

Overview

System integration and capacity-building has been a focus of primary health care policy for the Australian Government (through the Medicare Local Program and Divisions of General Practice) and remains a key role for PHNs. As set out in the *Primary Health Networks Grant Program Guidelines*,[65] it involves: (1) practice development and support (e.g. education, practice improvement activities); and (2) system integration facilitation (e.g. care pathways, data support) through engagement with general practice, primary health care and broader health system players (e.g. state and territory health departments, LHNs). Although PHNs are tasked with a major role in system integration and capacity building, many have been limited in their ability to influence change due to the evolving nature of PHN capability and capacity and funding allocation for such activities.

PHNs that evolved from Medicare Locals have been able to build on their pre-existing capability and capacity more quickly than those that were established as new organisations (see Section 4.1). Nevertheless, all PHNs have established system integration and capacity building functions and are working to build stronger capability and capacity in this area.

Progress to date

Practice development and support

While the intention of PHN practice development and support is to cover all of primary health care, the capability and capacity of PHNs and funding constraints meant that many PHNs had to focus their initial efforts on general practice, while balancing their other responsibilities. Over time, PHNs expanded their practice development and support activities to a broader range of primary health care services as their capability and capacity became better established. PHNs initially provided development and support activities through three main approaches:

1. Some PHNs took a broader primary health care focus, including general practice, which focused on building the leadership, capability and capacity of primary health care organisations through the use of data for continuous quality improvement, planning and business support. These PHNs saw system integration and capacity building as a key driver for the patient-centred care model, and invested significant resources in it, which in some cases, delayed their ability to make progress.
2. In rural and remote areas and locations where there was a smaller and/or less functional general practice community and fewer ways to provide practice support, PHNs reported focusing on capacity and capability development, support, and system enablement among general practice and other primary health care providers including nurse-led clinics. In many cases, this required innovative approaches to overcome significant workforce shortages.
3. Many PHNs took a more 'traditional' practice development support approach which involved providing systematic support (e.g. continuing professional development, accreditation support) to general practice in their areas. These PHNs acknowledged their role in system integration and capacity-building and considered it to be a function of both the practice development and support activities they were providing and commissioning.

All PHNs have a role in providing practice development and support; however, some PHNs also provide support to general practice in the roll-out of reforms such as the stage one trial of Health Care Homes (10 PHNs) and the My Health Record participation trials (four PHNs). The additional responsibility of involvement in reforms meant that some PHNs were stretched in their capability and capacity to undertake these roles. Nevertheless, PHNs have an integral role in supporting general practice and other service

[65] Australian Government Department of Health 2016. Department of Health Primary Health Networks Grant Program Guidelines February 2016 – Version 1.2. URL: http://www.health.gov.au/internet/main/publishing.nsf/Content/PHN-Program_Guidelines

providers in navigating these reforms, assisting in engagement strategies and improving coordination of care.

Working with general practice

Due to the heterogeneous nature of general practice in Australia (e.g. in terms of size, geographic dispersion, ownership, accreditation and culture), most PHNs targeted their efforts to engage general practices those practices most willing to engage and improve their services. PHNs planned to expand engagement as their capability and capacity increased and their role in system integration and capacity building became more widely understood.

By early 2016, 80 per cent of PHNs reported they had canvassed the majority of general practices in their region to determine their practice development and support needs.[66] PHNs also used their Clinical Councils, Needs Assessments and other approaches (such as community-wide surveys – see the Gippsland PHN *Tell Maria* Campaign call-out box in Section 5.1) to understand practice development requirements and support the needs of general practice.

In working with general practice, PHNs responded to identified needs in areas such as Continuous Quality Improvement, eHealth and system integration, with some PHNs taking a more holistic approach through the Patient Centred Medical Home or Health Care Homes model. PHNs reported that they engaged with general practices through a range of methods depending on the focus of practice support, but personal visits and face-to-face training were the most regularly used methods of engagement.[67]

Use of Continuous Quality Improvement

PHNs reported (via the PHN survey) that their focus on Continuous Quality Improvement is one of the key aspects of practice development and support.[68] 84 per cent of PHNs reported that they offered support in Continuous Quality Improvement including areas such as Continuing Professional Development, accreditation support and the implementation of practice guidelines for quality improvement, patient satisfaction surveys and developing primary care collaboratives.[69]

Over time, PHNs made progress in developing their capability and capacity (e.g. through the recruitment of a skilled workforce and targeted staff development) and engaging with general practice. PHNs reported that over 50 per cent of practices in the region had accepted support in activities such as Continuing Professional Development, and the development and implementation of practice guidelines and accreditation guidelines.[70] As a result of PHN efforts in this area, the Department reported that approximately 46 per cent of general practices are providing data to PHNs in order to receive quality improvement advice.[71]

eHealth

Evidence shows that timely and accurate information-sharing between hospitals and primary health care can contribute to prevent readmissions.[72] Health policies, such as My Health Record, recognise the importance of making better use of information from medical record systems in general practice, especially to improve the quality of care and especially for patients with chronic conditions.[73] 90 per cent of PHNs

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[66] PHN Program Evaluation – Baseline PHN Survey, May 2016.

[67] ibid. and case study site visits, 2016 and 2017.

[68] PHN Program Evaluation – Endpoint PHN survey, December 2017.

[69] ibid.

[70] ibid.

[71] PHN Branch, Australian Government Department of Health, 2018.

[72] Curry N & Ham C 2010, *Clinical and service Integration: The route to improved outcomes*. Kings Fund.

[73] Australian Dept of Health and Ageing 2009. *Primary Health Care Reform in Australia: Report to Support Australia's First National Primary Health Care Strategy.*

reported that they offered support to practices for My Health Record (or a Patient Centred Electronic Health Record) while supporting practices to register and then enrol patients in My Health Record.[74]

PHNs reported that they also provided support to practices in areas such as secure messaging, electronic transfer of care, telehealth and sharing of patient information across providers.[75] Other focus areas of eHealth support by PHNs included the use of electronic patient records (as opposed to My Health Record) where they worked with providers to move from paper-based to electronic systems and develop capability.

Enablement of electronic health records and collection of data for sharing purposes supported better understanding of health needs in the region and improved reporting. Some PHNs have been assisted in this area by aligned state or territory health policies and/or the investment of their LHN (see right).

Western Sydney Data Linkage Project

Western Sydney PHN together with NSW Health and Western Sydney LHD is conducting a pilot study, exploring the utility of general practice data for linkage to multiple NSW Health-related datasets. The intent is to enhance information from general practices and inform NSW health policy and planning.

The Project aims to:

- Provide information about health care use and mortality among general practice patients
- Investigate the patterns of acute health service use in relation to patient characteristics and other health service utilisation to inform health system planning.

The first aim relates to adding value to general practice data in order to inform policy and planning. The second is primarily to support the NSW Integrated Care Strategy by developing a model that can predict patients' level of future health service use.

System integration facilitation

PHNs provide support to improve system coordination and integration through working with and developing partnerships with state and territory health departments, LHNs, general practice, and non-general practice primary health care organisations (such as allied health, pharmacy and the Aboriginal Community Controlled health sector). Important aspects of these partnerships for achieving improved system integration include sharing data, common goals and co-planning.

As PHNs' capability and capacity developed and they built trust and presence within their region, their ability to build effective relationships and partnerships improved. PHNs in jurisdictions with well-developed integrated care strategies were more easily able to engage with service providers, as there was an imperative to develop innovative solutions to integrated care across the region.

PHNs administered Integrated Team Care for teams of Indigenous Health Project Officers, Aboriginal and Torres Strait Islander Outreach Workers and Care Coordinators to assist eligible Aboriginal and Torres Strait Islander people to access coordinated primary health care. PHNs with experience in Integrated Team Care and greater capability and capacity in Aboriginal and Torres Strait Islander health made more progress in this area. However, key Aboriginal Community Controlled health services and Aboriginal Medical Services reported that improvements were still required in PHNs' ability to consistently engage and effectively deliver outcomes in Aboriginal and Torres Strait Islander health.

Challenges and gaps

The change from the Medicare Local Program to the PHN Program meant all PHNs had to work hard to overcome challenges, such as change fatigue and disengagement, with general practice. Also, given the very heterogeneous nature of general practice in Australia, overcoming these challenges meant that all PHNs had to dedicate more resources than expected to practice development and support.

Undertaking system integration and capacity-building (for the purposes of practice development and support as well as the development of partnerships) by using operational funding only was a challenge for the majority of PHNs. Some PHNs limited their system integration and capacity-building activities as they felt that operational funding did not stretch to also cover internal functions. For example, one PHN that was established from a new organisation chose a "light touch" approach to practice support during the establishment phase as they prioritised building their internal capability and capacity using the operational

[74] PHN Program Evaluation – Endpoint PHN Survey, December 2017

[75] PHN Program Evaluation – Baseline PHN Survey, May 2016; and case study site visits, 2016 and 2017.

funding. They then increased their support once they had established the capability and capacity that they required.

Workforce shortages in regional, rural and remote areas hindered the ability of PHNs to undertake system integration and capacity-building activities effectively across the region. While there were examples of effective general practice support in these areas, there remains work to be done to define and implement effective engagement and support across large and dispersed areas and primary health care is often delivered through unique models (e.g. nurse-led or Aboriginal Health Worker-led).

Achieving improvements in access to after hours services was challenging for PHNs, particularly in rural and remote areas where there is higher potential for market failure. Developing sustainable solutions for after hours primary health care and reducing avoidable hospital presentations is an ongoing challenge for PHNs.

In the context of the current stakeholder environment, further work is required to determine PHNs' role in providing system integration and capacity-building support for the Aboriginal Community Controlled health sector and Aboriginal Medical Services, for example in relation to data use, reporting and management, and market development.

Other areas for development included working with mainstream primary health care providers to provide culturally safe care and improve the quality of services provided to Aboriginal and Torres Strait Islander communities as well as culturally and linguistically diverse populations. This was affected by PHNs' lack of internal capability to offer such support and the market need for providers.

6. Key findings: Evaluation Question 2

Has the PHN Program increased the efficiency and effectiveness of medical services for patients, particularly those at risk of poor health outcomes?

One of the two key objectives of the PHN Program is to increase the efficiency and effectiveness of medical services for patients, particularly those at risk of poor health outcomes. PHNs are to achieve this by:[76]

- Understanding the health care needs of their communities through analysis and planning, knowing what services are available and identifying and addressing service gaps, while getting value for money.
- Working with other funders of services and commissioning health and medical/clinical services for local groups most in need.

As outlined in Section 3, the achievement of the objectives of the PHN Program was not expected to be realised during the period of the Evaluation; however, progress towards this objective can be assessed by looking at the outputs and early outcomes (as set in the program logic in Section 3) being achieved by PHNs. For example: demonstrating a better understanding of the health needs of their communities (through analysis and planning); identifying and building effective partnerships to address shared priorities; and developing innovative ways of commissioning services.

Overview

The Australian health care system is complex, with a mix of funding arrangements (Australian Government, state and territory governments, private etc.), stakeholders, service delivery and interdependencies. As such, there are many factors within the system that impact the efficiency and effectiveness of medical services for patients. In addition, it is a long journey from implementing change for achieving different health care, to seeing improved efficiency and effectiveness of this care. The work of PHNs can contribute to this outcome; in particular, PHNs are ideally placed to achieve value for money through understanding and making funding decisions at the local level based on the health care needs of the region, while also influencing the wider system.

As already stated, due to the infancy of the PHN Program, further maturity will be required to generate large-scale efficiency and effectiveness of medical services and to improve health outcomes. However, as outlined in Sections 4 and 5, the PHN Program already shows strong indications of successfully working towards its objectives. For example, as PHNs better understand the health needs of their communities through analysis and planning, they are identifying and building effective partnerships to address shared priorities and developing innovative ways of commissioning.

Overall, PHNs' commissioning capability and capacity is increasing and their understanding of local systems is maturing. This is enabling better commissioning decisions and allocation of resources to those most at risk of poor health outcomes.

Progress to date

PHNs – through their needs analysis, planning and subsequent commissioning decisions – have been focusing their efforts on the areas of greatest health need and associated service gaps, while working with consumers, the community and clinicians to define and design more effective care.

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[76] Australian Government Department of Health 2016. Department of Health Primary Health Networks Grant Program Guidelines February 2016 – Version 1.2. URL: http://www.health.gov.au/internet/main/publishing.nsf/Content/PHN-Program_Guidelines

Variable capability in strategic planning was observed early in the PHN Program, with some PHNs engaging external assistance for developing Needs Assessments due to limited PHN capability, or wanting to engage best practice expertise. Initial Needs Assessments identified many areas requiring attention but with limited detail and prioritisation. PHNs developed more informed and specific Needs Assessments and Activity Work Plans over the evaluation period, which were better aligned to one another and were reported to be more useful in strategic planning. For example, PHNs reported that the usefulness of their Core Needs Assessment increased by 13 per cent from the first to the second round of assessments, while the usefulness of their Activity Work Plan was reported to have increased by 16 per cent.[77] It was observed, and reported by stakeholders, that PHNs were developing and evolving their understanding of the health needs of their communities.

While the roles of Clinical Councils and Community Advisory Committees were still being determined by PHNs, those members who participated in the focus groups reported that their input had been sought for assessing need and prioritisation. This included providing input into new models of care, future service design, and monitoring and evaluation of commissioned services, using their expertise to recommend changes to services or contracts aiming to improve the efficiency and effectiveness of commissioned services. Where this approach had been utilised, PHNs and other stakeholders reported that it provided a more insightful and robust approach to understanding needs and addressing gaps.

Insights from the case studies

Approaches to developing strategic planning capacity varied across the case study sites. Initial Needs Assessments identified large numbers of health needs and service gaps, but inconsistent data was being used and there were unclear frameworks for prioritisation. As the PHNs developed their capability and capacity based on learnings from the first round of needs assessments, the quality of their needs assessments in terms of completeness and consistency improved and the depth of sub-regional analysis improved.

Activity Work Plans for PHNs 1, 2, and 3 were initially written with a high-level perspective but became more detailed and aligned to needs in the second round of commissioning. PHN4's plans directly addressed priority items, showing substantially greater alignment than other sites, especially for the second plan. By contrast, PHN1 continued to show alignment only in very broad terms. At PHN2, plans were somewhat better targeted than at PHN1, but generally covered broad areas of the Needs Assessment, rather than specific high priority items. PHN3 had a mix of broad and targeted plans. All PHNs saw the second round as an opportunity to gather greater understanding of issues in sub-regions and begin to develop an allocative efficiency model.

Differences in quality reflect a number of challenges including access to relevant data, and sufficient PHN capability and capacity and timelines to undertake the strategic planning process. All four PHNs indicated that timelines were a significant challenge but PHNs 1, 2 and 3 also faced challenges with access to relevant data and PHN capability and capacity, particularly in data analytics. The case study PHNs improved their ability to undertake strategic planning processes by forging data sharing agreements with state and territory health departments and LHNs, recruiting data analytics capability and sharing learnings from the first round of strategic planning processes in PHN forums.

In 2016–17, a total aggregate of around 2,900 service providers were commissioned through PHNs.[78] To date, the majority of commissioning activity has focused on mental health, drug and alcohol treatment services and Indigenous services, which are outside of the traditional MBS-funded medical services (as referred to in Evaluation Question 2).[79] Given this, it would perhaps be appropriate to broaden the definition of the PHN Program objective to include all 'health' services, not just medical services.

PHNs are also becoming increasingly effective in using the knowledge of their region to work with their partners to address health needs based on shared priorities. As such, co-planning, co-designing and co-commissioning activities are becoming more commonplace as relationships are strengthened and common

[77] PHN Program Evaluation – Endpoint PHN Survey, December 2017

[78] Australian Government Department of Health, March 2018.

[79] For the purpose of the Evaluation, medical services are defined as MBS-funded (non-hospital) services.

goals are established with key stakeholders.

Co-commissioning was being undertaken by over half of the PHNs at the end of the Evaluation, with 55 per cent of PHNs reporting that they had co-commissioned a new service with another party (e.g. state or territory health departments, LHNs) in the previous six months.[80]

PHNs reported that key areas of focus for co-commissioning activities have been chronic disease management, mental health and after hours services[81] (see example, right).

Further, PHNs are using needs assessments and prioritisation activities as evidence to decommission services. Decommissioning activities by PHNs results in the cessation of activities that are no longer deemed essential or effective, which is one of the early indicators of how PHNs are working towards improving the efficiency and effectiveness of services for patients. At the end of the Evaluation, 74 per cent of PHNs reported that they had decommissioned a service in the previous six months.[82] PHNs have learnt along the way the importance of stakeholder engagement throughout the decommissioning process in order to have the most effective outcome.

Homeless to Home Healthcare After Hours Service

The Homeless to Home Healthcare After Hours Service is a collaborative initiative between Mater Health Services, Micah Projects, Brisbane South PHN and Brisbane North PHN.

The service is a nurse-led outreach in a multi-disciplinary team to people living on the streets and vulnerable individuals who have been housed.

The strategic intent of the collaboration is to ensure the rapid re-housing of homeless people and to provide cost-effective healthcare services at all stages of the housing process (i.e. before, during and after re-housing) in order to reduce the personal and social costs and impact of homelessness to the individual and the community.

Evaluation of the service has shown that the net social benefit of the service which is the sum of health system cost reductions and monetised Quality of Adjusted Life Years gains is estimated to be between $12.61-$21.26 million.

The ability to significantly increase the efficiency and effectiveness of medical services for patients, particularly those at risk of poor health outcomes, also depends on the effectiveness of PHNs in engaging and influencing stakeholders (e.g. LHNs) to enable service providers to innovate and increase integrated and coordinated care. This is because PHNs have few other levers to work with in order to influence the behavioural and organisational change of service providers at a system level. As described in Section 5.1, PHNs have made good progress in this regard, with some strong examples of partnerships and co-commissioning emerging, particularly with LHNs. This is a positive development and should continue to be an area of investment in the Program.

PHNs participating in the stage one trial of Health Care Homes are likely to be in a better position to influence the efficiency and effectiveness of services and data collection behaviours at practices through their change management activities. It will be important to capture the lessons learned from this work to see which elements could be scaled up to benefit the wider PHN Program. However, for this to be possible, there is still work to be done to increase PHNs' reach more broadly into general practice. Given PHNs' resources and the heterogeneous nature of general practice, including a high proportion of sole proprietorships, PHNs have understandably focused their practice support efforts on those general practices which are already more engaged, which has traditionally not included the larger or corporate practices. However, with the trend towards consolidation as well as the large number of corporate practices now participating in the stage one trial of Health Care Homes, PHNs will need to develop a specific engagement strategy for these larger groups, as well as identify more innovative ways to engage the harder-to-reach sole practices.

[80] PHN Program Evaluation – Endpoint PHN survey, December 2017.

[81] PHN Program Evaluation – Endpoint PHN survey, December 2017.

[82] PHN Program Evaluation – Endpoint PHN survey, December 2017.

Challenges and gaps

There have been a number of attempts by successive governments to improve the efficiency and effectiveness of Australia's health care system. However, challenges to reform have included unclear responsibility, inadequate design and implementation, poor resourcing and an absence of political will at all levels of government.[83] Another challenge to this endeavour has been the fact that Australia does not yet have a nationally unified and agreed method of data collection to measure efficiency and effectiveness. Without reliable data, there can be no evidence of outputs and how these translate into positive health outcomes. The PHN Program is now in the early process of engaging in the development of appropriate data collection and management to support the implementation of the *Primary Health Networks Program Performance and Quality Framework (Version 2)*. Indeed, the difficulties associated with developing the performance framework itself (e.g. see Section 8.2 for a discussion of the difficulties) speaks to challenges of achieving alignment in this area.

The work of PHNs to build system capacity to improve the efficiency and effectiveness of medical services, including the development of partnerships at both a system and practice level, is not a fast process and it may take many years to see the benefits. The variable reach into the general practice community remains a challenge and this activity is impacted by: (1) the current funding model for practice support which is sourced from PHNs' fairly limited operating budgets; (2) the limited levers (i.e. incentives) PHNs have to encourage service providers to change; and (3) the challenges of dealing with a fee-for-service payment system which is driven by volume, which possibly has the most impact on the willingness/ability of general practice to engage with PHNs. However, it also highlights the importance of developing partnerships in the absence of such incentives for mutual benefits such as: the two-way flow of knowledge, data sharing, workforce development and problem solving.

[83] Efficiency in Health, Productivity Commission, April 2015

7. Key findings: Evaluation Question 3

Has the PHN Program improved the coordination of care to ensure patients receive the right care, in the right place, at the right time?

One of the two key objectives of the PHN Program is to improve coordination of care to ensure patients receive the right care, in the right place, at the right time.

Coordination of care refers to the organisation of services which facilitate the appropriate delivery of health care services, both individual instances and over time. Better coordinated care is a strategy for achieving improved efficiency and effectiveness of services by ensuring consumers receive the right care, in the right place, at the right time. A key function through which PHNs achieve this is system integration and capacity-building, which includes: (1) facilitation of service-level and patient-level integration; and (2) support to general practice.

As outlined in Section 3, the achievement of the objectives of the PHN Program was not expected to be realised during the period of the Evaluation; however, progress towards the objectives can be assessed by looking at the outputs and early outcomes being achieved by PHNs.

Overview

While there have been ongoing efforts to improve coordination and integration of care at all levels of the health system, PHNs provide a targeted mechanism to facilitate and drive this on a more regionally coordinated basis. This is being achieved through the development of effective partnerships, and activities aimed at facilitating integration and building system capacity. With PHNs not intended to undertake direct service delivery, they therefore do not compete with local service providers. This enables PHNs to work *with* service providers and other key stakeholders to benefit patients However, as outlined in Section 5.1, PHNs have made some good progress in developing relationships with stakeholders, but there is still further work to be done to develop trust and effective working partnerships that ultimately improve the coordination of care.

77 per cent of PHNs reported at the end of the Evaluation that they were not involved in any direct service delivery.[84] Programs where PHNs reported that they were providing direct service delivery included mental health, alcohol and drug services, after hours primary care and chronic and complex care. Many services were being delivered to assist with the continuation of services where there is market failure, with the view to commission the services following the identification of an appropriate provider. Direct service delivery was considered to be temporary.

Furthermore, as the PHNs are located within the community they are best placed to improve the coordination and integration of care within their local regions, as they hold valuable information about the health needs of the populations, service gaps and the local context within which services are provided. PHNs are using this knowledge of their regions to work with service providers and partners to address shared priorities for improved coordination of care.

PHNs are increasing their use of processes that support better integration and coordination, such as care pathways, increased use of data for quality improvement, and supporting implementation of Health Care Homes and My Health Record (see below for further detail).

[84] PHN Program Evaluation – Endpoint PHN Survey, December 2017

This progress is significant given the complexity of the Australian health care landscape. PHNs have established a space within this context and made progress in a short period of time. It is also apparent that there will continue to be opportunities for them to increase the coordination of services, however they require time to grow and mature into this role, particularly in developing partnerships and building trust with stakeholders.

Progress to date

PHNs have focused on the health of the populations within their regions for the purpose of improving coordination and integration of care – by looking at gaps, needs and opportunities. Regional needs assessments, commissioning, and working in partnership with stakeholders in the region have been critical to this role with PHNs continuing to develop the skills and knowledge required to coordinate an appropriate response. PHNs have needed to develop a strong understanding of the policy, plans and services within their jurisdictions to avoid duplication or further fragmentation of services through commissioning activities.

As the PHN Program has progressed, PHNs' strategic capabilities to identify key relationships and partnerships have increased. Stakeholder partnerships should continue to improve (both the number and strength of partnerships) as PHNs and local stakeholders have the opportunity to undertake more work together. PHNs were seen by both LHNs and state and territory health departments as a partner in the improved coordination of care for primary health care services. More formal arrangements are already in progress to enable shared objectives (as described in Section 5.1) – benefiting all parties, but primarily servicing local populations. A further benefit of these formal partnership arrangements includes data sharing, particularly valuable in local, region-wide or state-wide planning and, in some cases, co-commissioning of services.

Insights from the case studies

PHN4 sought innovative investments that could maximise the impact of the limited funding available. The PHN established a formal relationship with the LHN through a Memorandum of Understanding, facilitating data sharing, co-planning and co-commissioning. Both the PHN and the LHN described the partnership as beneficial, with the LHN CEO describing the PHN as a "really serious partner" who provided good strategic leadership, saying, "it is their thinking, their consistent analysis of Commonwealth and state policy and contribution to imagining how best to make policy for the consumer."

PHN4 highlighted many examples of co-location and joint projects between the LHN and primary health staff such as in mental health, dementia, community health and integrated children's care. A major initiative with the LHN and other partners was the development of a diabetes "big data" minimum data set. PHN4 worked consistently to implement this project as the basis for an integrated care platform for all chronic disease, rather than solely for diabetes.

PHN4 was directly aligned with the LHN boundaries and came together through a shared objective. Further, the state health department in which they operate developed state-wide strategy that encouraged LHN and PHN collaboration to improve integration of health services. The PHN and LHNs in the region used this as a basis to work together and expanded their partnership a number of other identified areas of need.

PHNs reported using a number of methods to address gaps and identify solutions for coordination and integration of care. For example, one PHN held a region-wide workshops with stakeholders, establishing a shared approach to discharge and referral planning, e.g. via referral units. PHNs which were more experienced in system integration and capacity-building worked with other organisations (e.g. LHNs, aged care, disability services, the Australian Medical Association and Royal Australian College of General Practitioners) to develop targeted approaches to care integration, such as a region-wide strategy for chronic disease management. In addition, Clinical Councils and Community Advisory Committees have enabled local consultation, facilitating the identification of such solutions. These experiences should be

shared with the broader network (e.g. via the PHN CEO Cooperative and working groups) in order to harness the learnings more broadly.

By the end of the Evaluation, all PHNs had made progress towards achieving the expected outputs and outcomes in system integration, capacity-building and supporting general practice, for example:[85]

- High acceptance of PHN support in the area of *practice capacity-building*: 74 per cent of PHNs reported that the majority or all practices in their region accepted their practice-capacity building support.[86] This included support for recruitment of additional staff, etc.
- Integration and coordination of local services (e.g. Health Care Homes, Integrated Team Care and referral pathways): PHNs reported a high focus on integration and coordination activities and reported that just under 50 per cent of practices accepted their support in this area.[87]
- Increased referral pathways developed: Over 7,000 pathways were developed by 2016–2017.[88] These provided services with localised best practice care pathways for specific conditions, assisting in the coordination of care, discharge planning and working towards patients receiving the right care, in the right place, at the right time. PHNs are working with other stakeholders to develop these for their regions in order to improve the coordination of care for patients.
- Increased offering and acceptance of Continuous Quality Improvement support: All PHNs reported a high focus on quality improvement activities with almost all PHNs offering support for practices in this area. 65 per cent of PHNs reported that the 'majority' or 'all' engaged practices accepted this support.[89]
- Increased use of eHealth (My Health Record, data sharing): All PHNs reported a high focus on eHealth activities and 67 per cent of PHNs reported that the majority, or all engaged practices, accepted this support.[90] PHNs involved in the My Health Record participation trials directly assisted in the establishment of over 970,000 new My Health Records created for individuals across the Nepean Blue Mountains and Northern Queensland PHN regions.[91] They did this through directly supporting practices and the wider community in understanding the uses and requirements of the My Health Record through forums, education sessions and face-to-face visits.

Further, PHN have made progress in improving local integration and coordination of care through working with and supporting general practice and other primary health care providers (e.g. LHNs, public health services, allied health and community services) to improve coordination of care as described below:

[85] PHN Program Evaluation – Endpoint PHN survey, December 2017

[86] ibid.

[87] ibid.

[88] Australian Government Department of Health, 2018.

[89] PHN Program Evaluation – Endpoint PHN survey, December 2017

[90] ibid.

[91] Australian Government Department of Health, 2017. My Health Record Opt-Out and Opt-In Trials report.

North Brisbane Health Alliance	Western Sydney Integrated Health Partnership	Western Australian Mental Health and Alcohol and Other Drugs State-wide Plan
Metro North Hospital and Health Service and Brisbane North PHN have formed a partnership providing better-connected health care in the northern Brisbane region to enable collaboration and integration between primary, tertiary and community health and social support through shared planning and vision to benefit patients. The Alliance builds on the Pathways Program, which provides GPs with evidence-based localised care pathways for their patients.	This partnership between Western Sydney Local Health District, Sydney Children's Hospital Network and Western Sydney PHN has formalised a shared commitment to strengthening collaboration and consolidating investment in innovation and health care integration models and strategies. Stakeholders share ways of working for the improvement of health and social outcomes in the Western Sydney Integrated Health Partnership Framework. It provides a forum for collaboration, communication, engagement and decision-making to assess, prioritise and plan for services to best meet local health care needs.	This project enables improved coordination of services through co-planning and co-commissioning of services for coordinated investment, contributing to an effective and coherent system of services. Western Australia Primary Health Alliance has led, supported by the Mental Health Commission, the development of the Integrated Atlas of Mental Health, Alcohol and other Drugs – Western Australia. The Integrated Atlas provides a state-wide snapshot of the location and nature of mental health and drug and alcohol treatment services across Western Australia.

PHNs have taken a key role in supporting the implementation of a range of reforms which aim to improve the coordination of care, including the stage one trial of Health Care Homes, the Mental Health Reform Lead Site Project and the National Suicide Prevention Trial. For example, the stage one trial of Health Care Homes includes periodic bundled payments to a general practice or Aboriginal Community Controlled Health Services for ongoing care to patients with chronic conditions and complex care needs. However, these trials are currently in progress, with impacts and outcomes yet to be evaluated.

By the end of the evaluation period, all PHNs reported having proactive or dynamic relationships with general practice (see Figure 9) but some PHNs reported a decline in their relationships over time.[92] General practice stakeholders reported that although there was still some dissatisfaction amongst the general practitioner community in regards to engagement, there had been a marked improvement since the establishment of the PHN Program.

[92] PHN Program Evaluation – Endpoint PHN survey, December 2017.

Insights from the case studies

Support for and engagement with practices varied. PHN4 has implemented multiple GP engagement strategies providing weekly updates; creating online resources for practices; and providing educational training to GPs. However, one external stakeholder thought that "the PHN was strongly focused on highly engaged general practices, with which it embodied national and international best practice, but they needed to expand beyond that core."

PHN3 also used a resource-intensive model, similar to the Patient Centred Medical Home approach. As with PHN4, this intensity limited the amount of practices and GPs that could be engaged. PHN3 and PHN4 implemented their models with the objective of achieving the quadruple bottom-line: improved health outcomes, improved consumer experiences, reduced costs and improved provider experiences.

By contrast, PHN1 and PHN2 took a more transactional approach, where they identified gaps and issues with general practices and worked with them to address those gaps and issues. This approach also required significant resources.

Through undertaking further evaluation, PHNs plan to understand the cost-benefit of their models which can be used to provide improvements going forward.

Key general practice, state and territory health department and LHN stakeholders supported the role of PHNs in engaging and working with general practice (e.g. through better capture and use of data, integration and coordination activities and capacity-building) and acknowledged areas of good engagement. However, there is much work to do, particularly in engaging non-accredited general practices and rural and remote practices, but also in working with primary health care providers more broadly.

Challenges and gaps

Improving care coordination to benefit patients is an ongoing challenge. Such a vision requires a nexus of factors including an understanding of the social determinants of health; a consideration of the fit between policy and local need; and a consideration of a range of organisational, behavioural and cultural factors.[93] PHNs cannot achieve this on their own, given their limited funding (and funding restrictions) to incentivise and create levers for change, so they require strong and effective stakeholder relationships and partnerships to influence change. However, work needs to be done with the Aboriginal Community Controlled health sector and it is suggested that more effective engagement is also needed with consumers and the community, particularly in the areas of mental health and drug and alcohol treatment services. Peak consumer organisations highlight that consumer involvement is critical for informing what is "the right care, the right place and the right time". Co-design by PHNs requires the time and resources to do this effectively, including engagement with people with lived experience.

By sharing commissioning responsibility among 31 local organisations, there is also a potential risk that commissioning will lead to greater disintegration and fragmentation, and ultimately inhibit coordination of care between different health services. This is a particular criticism of the current system in England, highlighting the importance of planning and supporting providers in the commissioning process.[94] However there is evidence of some collaboration and co-commissioning across PHN boundaries, which is a positive outcome of the Program and should be shared and supported going forward.

PHNs reported a number of challenges in regards to strategic planning for commissioning which need to be considered and addressed moving forward. These include: having time to engage and consult with stakeholders and obtaining their input into the planning process, developing the market to respond to PHN

[93] Martin-Misener R, Valaitis R, Wong ST, Macdonald M, Meagher-Stewart D, Kaczorowski J et al. 2012. 'A scoping literature review of collaboration between primary care and public health', *Primary Health Care Res Dev*. 13(4): 327–43

[94] PwC, The King's Fund and University of Melbourne 2016. *Challenges and lessons for good practice: Review of the history and development of health service commissioning.* March 2016.

commissioning needs, access to the required data at a sufficient level of granularity, and having the systems to enable and support analysis and planning.

8. Key findings: Evaluation Question 4

How are the information, advice and support needs of PHNs identified in relation to the national support function and how effective has the Department been in providing support?

Evaluation Question 4 explores how well the Department has managed the program, what support has been provided to PHNs and how effective the Department has been in providing it. This question also looks at how the Department has used information from the PHN Program to tailor their program and performance management functions and support needs and the development of the PHN Program.

8.1 Departmental management of the PHN Program and support function

Overview

For the Department, the PHN Program represents a new way of working and managing a program, in that responsibility for the PHN Program is dispersed across a number of Divisions and Branches. This means that although the PHN Branch has overall responsibility for the PHN program, the involvement of individual program areas and the nature of PHN contracts means that multiple areas have responsibility for different aspects of the program.

Unlike Medicare Locals and the Divisions of General Practice before them, there is no external national representative body that offers a support or national coordination function. Therefore, the Department provides this national support function in the deliberate absence of a central body.

The roles of the Department as funder, performance manager and support function, in a rapidly changing policy context, has made the management of the Program very complex for the Department, PHNs and other stakeholders.

In the early stages of the PHN Program, the Department was challenged to keep up with timelines for implementation and navigating the role of support function vs funder and, therefore, remain proactive with support needs. The Department sought to manage these issues through developing trusted working relationships with the PHNs to work through challenges and co-design resources where possible. A positive outcome of how the Department has managed the PHN program is the open and transparent relationship that has been developed with PHNs, particularly by the PHN Branch.

Progress to date

The Department's management of the PHN Program

Departmental responsibility for the management of the PHN Program is with the PHN Branch, which also provides the National Support Function. Policy responsibility for specific programs and service types commissioned by PHNs and management of the PHN contracts rests with other areas of the Department, such as the Mental Health Services Branch, Alcohol and Other Drugs Branch, Indigenous Health Division, and Health Grants and Network Division. This dynamic of multiple divisions and branches having responsibility in the PHN Program has increased the complexity of managing the PHN Program and required new and different roles, responsibilities and new ways of working across the Department.

In particular, as program areas have their own program and performance arrangements, it has been challenging for the Department to align requirements to effectively support and manage the performance of PHNs (see Section 8.2).

The PHN Branch sought to meet regularly with other areas of the Department to discuss challenges and mitigating strategies for the Program. This would have been better supported by the establishment of formal governance arrangements, such as the identification of an Executive Champion to oversee and promote the Program internally to the Department, the development of a Program Framework, and an internal PHN Program Board to provide a structure for joint decision making, consideration of risk, timing and resource pressures, and to strengthen accountability. These arrangements could be expanded over time to include other agencies which impact on social determinants of health.

The Department's ability to identify information, advice and support needs of PHNs has been assisted by the strong working relationship that developed between the Department and PHNs. A culture of openness and transparency was established early on in the program. PHNs described the relationship as positive and supportive, and felt listened to. PHNs attributed this to, for example:

- the responsiveness of the Department to feedback provided by PHNs, which demonstrated the goodwill of the Department and a preparedness to answer questions and have open conversations;
- key personnel from within the PHN Branch and the Department who fostered a collaborative environment with the PHNs, improving two-way communication;
- PHNs' improved understanding of Departmental workings and the associated restrictions that are placed on a government department, fostering a more considerate approach from PHNs;
- more realistic expectations by the Department (e.g. around timing) and flexibility in their requirements (e.g. some funding provisions, such as rolling over after hours flexible funding). Further, the Department sought to improve the reporting burden on PHNs through a review and consolidation of PHN requirements. Both changes reflected feedback from PHNs and enabled PHNs to meet Departmental expectations more effectively; and
- the Department worked continually to evolve and improve engagement activities, for example, the establishment of working groups which enabled the Department to better understand the needs of PHNs and provide more targeted support through co-designing resources with PHNs (see right).

Department and PHN co-design activities

Based on early learnings, the Department has utilised PHN working groups and advisory groups to co-design materials and initiatives developed by the Department for the Program.

These groups have been well received by both PHNs and the Department, given they enable a co-design approach and utilise the experience and expertise of PHNs to develop outputs that reflect Australian context.

A number of working groups have been utilised including both PHN and Departmental representatives, each with a specific focus, including commissioning materials and the *PHN Program Performance and Quality Framework (Version 2)*.

Departmental support to PHNs

The Department has taken a multifaceted approach in its delivery of support to PHNs by delivering: (1) nationally consistent guidance materials for all PHNs; and (2) targeted and specific support to PHNs as needed. Departmental support to PHNs included:

- provision of guidance material for specific PHN activities (e.g. PHN commissioning resources, *Primary Health Networks and Aboriginal Community Controlled Health Organisations – Guiding Principles*);
- the opportunity to co-design activities to develop targeted resources;
- responding to areas of individual PHN needs and potential risks (for example, addressing governance risks and providing mentoring for CEOs);
- streamlined and regular Departmental communications for disseminating information and advice useful for PHNs from across the Department;
- facilitation of regular communication, information sharing and networking opportunities among the PHNs and with other parts of the Department or with peak organisations through meetings and workshops;
- development of a SharePoint site specifically for PHNs to provide opportunities for information sharing, discussion and collaboration;

- provision of Commonwealth data to support PHN Needs Assessments; and
- training and access to the data analytics program, Qlik Sense.

The Department had to develop its own capability and capacity to provide this support as the PHN Program developed and, as such, matured in its support role – improving the targeted provision of support to PHNs. The most effective areas of support reported by PHNs included PHN networking, forums and working group opportunities. Other useful areas of support identified by PHNs included advocacy for PHNs, the PHN SharePoint, and resources for understanding good governance (including targeted support for suboptimal governance arrangements).[95] In addition, the PHN Branch worked closely with other areas of the Department to clarify roles and information channels in providing support to the PHNs.

Insights from the case studies

All case study PHNs considered that they now had a positive relationship with the Department, which was "improving and gaining traction over time". Especially in the first year, all PHNs had "the same frustrations with timing and overburden" (PHN3), in particular in relation to reporting.

It took time for the Department to develop an understanding of PHN structure, service placement and influence. However, "the Department were doing the best they can in a changing environment" (PHN2). Department staff have been accessible and helpful; in particular, strong relationships by PHN staff with Department PHN regional managers (PHN2), were very important. This made it "easy to engage at all levels" (PHN3), and it was recognised that there had been a "significant change to a much more civilized and respectful" relationship (PHN4). PHN3 saw it as a partnership, and had a very close relationship with the then Health State Network regional office.

Two PHNs mentioned that undertaking a trial (such as My Health Record participation trials) has particularly assisted with developing a relationship with the Department and they felt that they were supported throughout the trial.

The overall attitude from these PHNs was that the imposed structures and processes were challenging, but that the Department was cognisant of the need to be flexible with these emerging organisations.

In addition to Departmental support, PHNs have also sought support and information from other sources. This includes, for example, through the establishment of state-based PHN alliances for sharing experiences, learnings and development of resources and working groups; the Australian Healthcare and Hospitals Association, for advocacy, forums and support across a range of topic areas (e.g. priority areas for PHNs, governance, clinical governance and Health Care Homes); other national peak bodies, for stakeholder information and in some cases advocacy for the role of the PHN; and state and territory health departments, for support to PHNs in particular programs. This demonstrates that PHNs are acutely aware of the overall landscape in which they are operating and are engaging widely with relevant and appropriate organisations for support and in undertaking strategic activities to ensure that they are best placed to deliver on their objectives.

Challenges and gaps

There is no overarching Program Framework in place that incorporates all the aspects required for the management of the PHN Program; it is currently in development. This remains a key risk. A Program Framework would provide a suite of agreed and documented polices and processes for managing the program, including internal governance arrangements. Without this, there is potential for siloing, inefficiency and mismanagement. It also places a greater emphasis on the existing relationships between PHNs and key Departmental staff, which presents a risk when those staff change.

As the Department has the role of funder, performance manager and support for PHNs, there is potential for conflict of interest, as well as a tension in relationships should concerns arise with the performance of

[95] PHN Program Evaluation – Endpoint PHN survey, December 2017.

individual PHNs. A Program Framework, as well as internal operational governance arrangements will mitigate these risks to a large extent. Further, taking a more proactive approach to national support through initiatives such as consolidating the learnings from all ongoing evaluations involving PHNs[96] would enable greater collaboration and innovation across the Department and strengthen its ability to manage the PHN Program as a whole.

A tension for PHNs, as independent organisations implementing Government programs, is that there is not an independent national coordinating and advocacy body. The establishment of the PHN Cooperative will mitigate this to some extent, although clear demarcation of roles and responsibilities between the Cooperative and the national support function will need to be agreed to prevent duplication or gaps in support.

Engagement with national stakeholders is one area where a national strategy is required, either through the Department's national support function, the CEO Cooperative, or both. While PHNs are engaging locally and at a jurisdictional level, there is a need for a program of engagement between PHNs and national stakeholders. This would provide opportunities to share expertise and engage in strategic planning for the PHN Program at a national level. Additionally, as PHNs develop their capability and make decisions that transform service provision within their regions, it will become critical that the Department, and indeed PHNs, engage formally with key national stakeholders to understand how their decisions are received and what impacts they are having.

As the PHN Program and PHNs mature, the Department will also have to work to ensure that support provisions remain relevant and timely. To date, this has been a challenge and will remain so, particularly as additional requirements are added to the PHN Program and/or there are capacity constraints within the Department.

8.2 Performance management of the PHN Program

Overview

The Department's role in performance management involves the effective management of the use of public funds by improving PHNs' operations and achievements overall. The Department acknowledged that performance management will continue to be challenging due to the uniqueness of each PHN, but aimed to be clear on the outcomes that PHNs should achieve, and how they would be measured. Further, a number of stakeholders reported that performance management is challenging for the Department due to the tension of being a funder, support function and performance manager. This was not clearly defined at the outset of the PHN Program and, as such, it has taken time for the Department to establish how it would undertake each role. It remains an ongoing area of development.

In developing the *PHN Performance Framework (Version 1.0)*, the Department experienced the complexity of monitoring and measuring the performance of a complex program – particularly given the limited availability of data. Following the release of the *PHN Performance Framework (Version 1.0),* a number of additional program areas were added to the PHN Program, resulting in the first version of the performance framework no longer aligning with PHN responsibilities. The Department commenced the development of the *PHN Program Performance and Quality Framework (Version 2)* in 2017. In the interim, the Department used the first version of the performance framework as a monitoring tool, as well as other mechanisms such as contractual arrangements, feedback from stakeholders and routine reporting.

As the *PHN Program Performance and Quality Framework (Version 2)* is implemented, and the way that performance management is conducted in the PHN Program shifts, this will be an area of significant development and will require evaluation to inform ongoing improvement. In recognition of this, the

[96] ibid.

Framework incorporates a biennial review that will consider whether:

- the program logics and outcomes remain relevant;
- new outcomes should be included;
- the indicator specifications, including performance criteria, require amendment;
- new indicators should be included to assess outcomes; and
- indicators that are no longer fit for purpose should be removed.

Progress to date

The *PHN Performance Framework (Version 1.0)* is effective from March 2016 to June 2018 and aims to: (1) provide an approach to monitoring, assessing and reporting on the performance of PHNs; (2) establish performance indicators that cover the broad range of PHN activities; (3) describe how performance indicators will be developed, measured, assessed and reported; and (4) cover the operational and flexible funding streams.

Key issues with the framework were identified early in the PHN Program. It was intended that the framework evolve to reflect the development of the PHN Program; however, it does not incorporate new program areas. Rather, the responsibility for performance monitoring in these areas remains with the relevant policy branch. Both PHNs and the Department reported that the performance indicators that had been developed at a national, local (of which there were too many) and organisational level are not as useful as they could be.

This has created a risk to the program in terms of inconsistent and fragmented reporting, which not only has placed greater reporting burden on PHNs, but has also impacted the Department's ability to monitor and measure the performance of PHNs. As such, the Department has used a number of additional mechanisms to measure and monitor PHN performance, including:

- monitoring and supporting PHNs to self-assess and improve their governance arrangements in recognition that good governance can have a positive influence on performance;
- using the performance framework, contractual arrangements and reporting requirements for compliance and performance monitoring;
- developing policies and procedures to provide guidance to the broader Department on how to treat different circumstances affecting performance;
- using different areas of the Department to provide input into the monitoring of PHN performance including the PHN Branch, Health State Network and other Policy areas (e.g. Mental Health Branch); and
- regularly engaging with key stakeholders of the PHN Program to gather insight on PHN performance and compliance, while also working closely with those PHNs who were identified as at risk of underperforming.

Given the limitations of the current framework, the *PHN Program Performance and Quality Framework (Version 2)* has three purposes: (1) identifying areas for improvement for individual PHNs and the PHN Program; (2) supporting individual PHNs in measuring their performance and quality against tangible outcomes; and (3) measuring the PHN Program's progress towards achieving its objectives.

Challenges and gaps

Implementing an effective performance mechanism for the PHN Program has been challenging. PHNs reported a lack of clarity regarding performance management roles and responsibilities of different Branches of the Department. The disparate reporting and data requirements of program areas meant that PHNs were required to collect different depths and breadths of data making collection and reporting complex. It was often unclear whether data collection for performance monitoring was intended to measure compliance, accountability and/or quality improvement.

As the PHN Program evolves, a key tension will be moving from activity based performance management to outcomes based performance management. Capability and capacity will be required within the Department to effectively support PHNs in transitioning to this new way of reporting and building their capability.

Furthermore, the Department, and in turn PHNs, will need a clear understanding of how the Performance Framework will be used to not only determine individual PHN performance but also PHN Program performance overall. Clear guidance and information is paramount for ensuring that PHNs are aware of what they are reporting on. Further, additional consideration of the evaluative requirements to understand the overall performance of the PHN Program and how this will inform future funding decisions as the Program continues will be required.

9. Opportunities

The PHN Program is still a relative newcomer to the health services landscape in Australia. While PHNs are still working towards achieving their objectives, they are maturing at an appropriate rate based on the PHN Program program logic (see Appendix C). As independent regionally-based organisations, they are bringing value to the system and their communities by proactively working to help improve service integration and address health service needs and gaps.

The vast majority of stakeholders interviewed as part of this Evaluation confirmed that the overarching program objectives are sound and that PHNs have a critical role in helping to deliver sustainable, integrated and safe primary health care to the Australian people.

As such, the PHN Program is well-aligned with other primary health care reform and the broader policy context. One of the key challenges of the PHN Program will be developing levers to encourage LHNs, state and territory health departments and other agencies, to truly engage with PHNs in regional planning and to support integrated service delivery at the local level.

9.1 Summary of key findings and opportunities

The PHN Program has the potential to help address some of the key structural challenges which impact the ability of the Australian health care system to provide efficient and effective services across the continuum of care.[97,98]

Figure 4 provides a summary of the key findings of the Evaluation and the associated opportunities for the future development of the PHN Program.

Table 4: Summary of key findings and opportunities for development of the PHN Program

Finding		Opportunities for future development of the PHN Program
Governance	Governance has been an area of ongoing development and improvement across the PHN Program. Further work is required to ensure that all governance structures (Board, Clinical Councils and Community Advisory Committees) are robust and fit for purpose. See Section 4.2, p.31	• The Department and PHNs to periodically review the appropriateness and effectiveness of PHN governance arrangements (Boards, Clinical Councils and Community Advisory Committees) to ensure they are fit for purpose, have appropriate input and are working effectively. • The Department and PHNs to explore opportunities to enhance the role of Clinical Councils and Community Advisory Committees to ensure they are: (1) relevant to local circumstances and context; and (2) to strengthen community participation in decision-making. But also to ensure there are mechanisms in place for consumer participation.
External collaboration and stakeholder engagement	PHNs need to continue to establish their authority with key stakeholders through appropriate mechanisms and by working together effectively. There is a need for a more developed program of engagement between PHNs and national stakeholders. While PHNs are engaging locally and at a jurisdictional level, it will be important moving forward to engage on a national level to understand how PHN decisions are	• The Department and PHNs to strengthen stakeholder engagement and communication across the PHN Program through identifying mechanisms to engage with national peak bodies and state and territory governments, e.g. through the PHN CEO Cooperative, bilateral agreements, and health care agreements. • The Department and PHNs to better enable local knowledge to be leveraged to direct national policy and use PHNs as agents for system change. • The Department to explore the scope for PHNs to have a longer-term role in supporting regional preventive health activity to help influence and reduce overall demand for services. • PHNs to work with their Clinical Councils and other stakeholders to increase their engagement and reach with general practice and

[97] Department of Health 2016. *Better Outcomes for People with Chronic and Complex Health Conditions: Report to Government on the Findings of the Primary Health Care Advisory Group,* December 2015.

[98] EY, Menzies Centre for Health Policy & WentWest 2015. *A Model for Australian General Practice: The Australian Person-Centred Medical Home. A sustainable and scalable funding model to improve care for people with chronic and complex care needs. How can we make it happen?* November 2015

Finding		Opportunities for future development of the PHN Program
	received and their impacts. Section 5.1, p.43; and, Section 5.3, p.53.	enhance general practice capability and capacity (e.g. through sharing best practice and lessons learned).
Commissioning	The commissioning role of PHNs was new and seen by some stakeholders and service providers as a threat if they perceived competition or conflict of interest. Ongoing education and engagement of providers will be required to enable increasingly coordinated commissioning and cooperative partnerships to build system capacity. See Section 5.2, p.48.	• The Department to support PHNs to apply a continuous improvement approach to ensure commissioning and decommissioning is appropriate, effective and efficient, and that PHNs are fit for purpose for commissioning. • The Department to support PHNs to engage with stakeholders in a regionally coordinated way to co-design and co-commission services, and enable market development. • The Department to support PHNs to ensure they manage conflicts of interest appropriately and employ best practice probity strategies to support commissioning.
Performance management	Performance management across the PHN Program has been a challenge, and will continue to be, given that each PHN is unique. It is also challenging for the Department to balance its roles as funder, national support and performance manager. As PHN performance management moves from activity based reporting to outcomes based, appropriate ongoing support and capability building for both the Department and PHNs will be important. See Section 8.2, p.69.	• The Department and PHNs to collaborate to implement the *PHN Program Performance and Quality Framework (Version 2)* and use strategic evaluation to identify risks, challenges and opportunities to improve the effectiveness and efficiency of the PHN Program. • The Department to better align the monitoring and evaluation processes undertaken by PHNs to enable greater consistency in approach and build their capability in this area.
Program guidance	There is limited documentation on the PHN Program that can be shared with external stakeholders which clearly articulates its intent and how the PHNs are expected to operate. A Program Framework and other external guidance materials would improve stakeholder engagement. See Section 4.1, p.24; and, Section 5.1, p.43.	• The Department to develop program guidance materials, as part of the Program Framework, which are public and can be shared with external stakeholders to assist them to better understand the intent of the PHN Program, including, for example: – the policy intent of the PHN Program; – objectives and outcome expectations; – ongoing and additional materials for commissioning processes; – governance processes; – PHN Program operations and performance management; and – Department roles as funder, performance manager and national support.
Operations: Departmental	In the early stages of the Program, there was potential for fragmented management of PHNs in the delivery of different programs. There is a need for the Department to strengthen how it manages the PHN Program as one program, with internal governance arrangements in place to support this. See Section 8.1, p.66.	• The Department to strengthen the operational management of the PHN Program by: – developing and implementing the Program Framework; – developing program guidance materials; – improving information resources on the intent and purpose of the PHN Program; – improving internal business processes to reduce duplication and the reporting burden on PHNs, e.g. rationalisation and alignment of funding schedules; and – putting into place internal governance structures to support management of the PHN Program as a whole, for example, through an internal PHN Program Board and a designated executive champion for the Program.
Operations: PHN Program	A strength of the program to date has been the very collaborative way in which PHNs support and work together for the benefit of the network, and their communities. See Section 5.1, p. 43.	• The Department to continue to encourage and facilitate PHNs in sharing good practice and learnings, including: – championing and supporting the PHN CEO Cooperative; and – supporting PHN collaboration and sharing of resources through various fora, such as SharePoint and PHN Forums.

Finding		Opportunities for future development of the PHN Program
		• The Department and PHNs to explore opportunities for a shared service model including, for example, corporate services and data analytics.
Funding model	A potential limitation to the PHN program's ongoing development is the 'lean' nature of most PHNs' operating models which could hinder their ability to build capability and scale-up to meet future expectations. See Section 4.3, p.35.	• The Department to periodically review the PHN funding model to ensure PHNs are able to deliver their key functions (including practice support). • The Department to support/encourage PHNs to continue to explore opportunities to creating efficiencies across the network through increased collaboration and sharing of ideas.
National support function	The Department built strong relationships with the PHNs while developing capability and capacity to respond to the rapidly evolving nature of the PHN Program – providing a strong basis for the next stage of the program. See Section 8.1, p.66.	• The Department to champion and strengthen existing PHN information-sharing mechanisms and processes.
Aboriginal and Torres Strait Islander health	Many PHNs experienced challenges achieving appropriate skills representation from the Aboriginal and Torres Strait Islander communities on governance structures, and engaging with these people and communities was sometimes limited. See Section 4.2, p. 31; and, See Section 5.1, p. 43.	• The Department and PHNs to increase engagement and strengthen relationships with Indigenous health services and Aboriginal and Torres Strait Islander communities, including through encouraging participation on PHN governance structures. • PHNs to share best practice across the Network where engagement and relationships with the Indigenous Health sector and Aboriginal and Torres Strait Islander communities is working well. • The Department to reiterate the importance of the PHN and Aboriginal Community Controlled Health Organisations (ACCHO) – Guiding Principles[99] that recognise the commitment by PHNs and Aboriginal Community Controlled health services to work together to improve access to health services and improve health outcomes for Aboriginal and Torres Strait Islander people. • The Department to work with Indigenous health sector stakeholders and PHNs to clarify what the role of the PHN Program is in commissioning Indigenous health services.
Use of data in the PHN Program	PHN access to and use of timely and granular data is limited (see Section 5.2, p.48). Enhancement of the Department's technical expertise would assist them to provide guidance and support to PHNs (see Section 8.1, p.66).	• The Department and PHNs to explore opportunities to harness existing infrastructure and provide economies of scale for identified data access, information sharing and governance needs. One option in this regard includes partnering with the Australian Institute of Health and Welfare (AIHW). • PHNs should continue to work with local stakeholders to improve access to smaller area data (e.g. GPs and LHNs) to inform needs assessments and commissioning priorities, as well as measure outcomes from commissioned services.

[99] http://www.health.gov.au/internet/main/publishing.nsf/Content/PHN-Accho

Appendices

Glossary of Terms

Term	Definition
Fit for purpose	A term used to conceptualise and assess the extent to which an organisation is capable of achieving its objectives. It refers to the relationship between the focus of an organisation; its role and scope; organisational type and structure; and its authority in relation to achieving its objectives and addressing the problems it is intended to address. In this Evaluation, the fitness for purpose of the PHN Program can be assessed in terms of the extent to which the PHN Program: – Has been set up to focus on the right issues (significant problems in the primary and broader health care system for which a PHN is a cost-effective solution) – Has a scope and role that enable it to address these issues – Has an organisational type and structure that matches this scope and role – Has the authority and capacity needed to fulfil its mandate
Coordination of care	Coordination of care refers to the organisation of services so that they facilitate the appropriate delivery of health care services, both in individual instances of service and over time. In primary care, patient/provider relationships can be established with a GP or single provider but are now increasingly with a team of providers spanning general practice and other health and social care services. Coordination often extends to social services such as housing and employment, and case managers may be appointed to facilitate both health and social services. Care provided by different professionals is often coordinated through a common purpose and plan. Care plans are important tools for bridging current and past care and for arranging for future needs. They should remain flexible to accommodate changes in patients' needs and circumstances. Coordination activities fall into two groups: (1) those at the patient level which facilitate communication and support for providers and patients; and (2) the organisational structural and process arrangements that support coordination.
Patients receive the right care, in the right place, at the right time	This concept refers to the appropriateness and quality of care received by patients and whether the care is delivered in a setting or service that is acceptable to the client and appropriate to their needs. In this Evaluation, the concept can be assessed through measures of avoidable hospitalisation and quality indicators such as timely access or population risk (measures to be confirmed).
Effectiveness	Effectiveness refers to an assessment of the key achievements, impacts and outcomes of a program with respect to the extent to which the program has met its key objectives. Through the program logic, the Evaluation articulates and is designed to assess and track the translation of the PHN program inputs through its activities to short-term and longer-term impacts leading to outcomes. The achievement of outcomes considered within the Evaluation are directly linked to the key program objectives and together with the outputs or short-term results, measurement of outcomes articulates the benefit to clients, populations and the health system of the program. Measures of performance on indicators identified in the National Performance Framework lie outside the Evaluation but a focus on assessing, at each level, the effectiveness of organisational and care processes which lead to these outcomes is key. These include an assessment of the extent to which implementation of key activities such as commissioning and CQI meet best practice standards or specifications where these are available; the reach, distribution and perceived effectiveness of these activities across practices and populations; performance on local indicators where these are meaningful indicators of progress toward achieving outcomes; and the impact on care processes or shifts in care such as through measures of increased screening, reduced preventable hospitalisation and reduced duplication, where these are available.
Efficiency	Efficiency measures whether healthcare resources are being used to get the best value for money. It is concerned with the relation between resource inputs (costs, in the form of labour, capital, or equipment) and either intermediate outputs (numbers treated, waiting time, etc.) or final health outcomes (lives saved, life years gained, quality adjusted life years (QALYs)).[100]
Local Hospital Network	A local hospital network (LHN) is an organisation that provides public hospital services in accordance with the National Health Reform Agreement. A local hospital network can contain one or more hospitals, and is usually defined as a business group, geographical area or community.
Medical services	For the purpose of the Evaluation, medical services are defined as MBS-funded (non-hospital)

[100] BMJ 1999; 318 doi: https://doi.org/10.1136/bmj.318.7191.1136 (Published 24 April 1999)

Term	Definition
	services.[101]
People at risk of poor health outcomes	People at risk of poor health outcomes are those with conditions that are associated with poor health outcomes such as chronic disease or mental health conditions, or population groups that experience social and economic disadvantage which results in poor access to health care and poor health outcomes. Local groups most in need will vary with geography but include Aboriginal and Torres Strait Islander populations, people from culturally and linguistically diverse backgrounds, refugees and prison populations.
Integration	Integrated care refers to the systematic coordination of primary health care with other social support and specialist services that is required to facilitate care for people with multiple health care needs. A system approach to integration emphasises a person-centred and population-based approach with responses at the clinical (micro), professional and organisational (meso) and system (macro) levels.[102] Although integration is not specifically identified as an objective in the PHN Guidelines, it underpins much of the work to be undertaken to achieve PHN objectives and is a key enabler in establishing coordinated care, developing referral pathways and establishing shared accountabilities for some health outcomes. Through it, program logic and data collection, the Evaluation focuses on identifying integration at the different levels, from clinical/patient to organisational and system level. Early evidence of integration may be foundational achievements such as SLAs or MOUs, agreements to work together and agreement on priority service gaps to be addressed. Longer-term integration will be evidenced by changes in service delivery, organisational accountability and ways of working that demonstrate that foundational work has been effective in translating into changes in practice and improvements in patient care.
Capacity and capability	Organisational capacity and capability refers to the knowledge, skills and resources that are available to an organisation and which underpin its performance. Organisational capacity is multifaceted and continually evolving. The Evaluation will assess the capacity and capability of PHNs as they build over time including the extent to which the new governance arrangements, workforce, knowledge and skills, partnerships and support provided through the national support function enable or constrain the program to implement its key activities and functions and meet the program objectives.
Operating costs	Operating costs are the expenses which are related to the operation of a business. They are the cost of resources used by an organisation to maintain its existence.
Local	Local refers to the geographical area as defined by the PHNs' jurisdictions.
Commissioning	A continual and iterative cycle involving the development and implementation of services based on planning, procurement, monitoring and evaluation. The objectives of PHN commissioning are to: (1) understand health care needs and identify service gaps within their region through analysis and planning; and (2) address priority service gaps by working with other funders and/or purchasing relevant services to achieve value for money.
Co-commissioning	The ways in which relevant organisations might work together and with their communities to make the best use of limited resources. This will often involve using a pooled or aligned budget.
Recommissioning	This is a term that has not gained a huge amount of traction in the broader literature, although it has been used to underpin a number of processes in the Australian public service context. Essentially this process is used to refer to the initiation of a new commissioning process after a service has already been commissioned. This derives from the notion of re-contracting, where a further round of contract negotiations are entered into when a contract expires or there are changes to the sorts of services needed or terms of the relationship.
Decommissioning	This concept is concerned with ceasing activities that are no longer deemed essential or effective. This encompasses the replacement and removal of a product or service as part of evidence-based practice at the organisational level, and also policies to remove interventions from across wider geographical areas and/or patient populations, and strategic reconfiguration of services leading to organisational downgrading of closure.

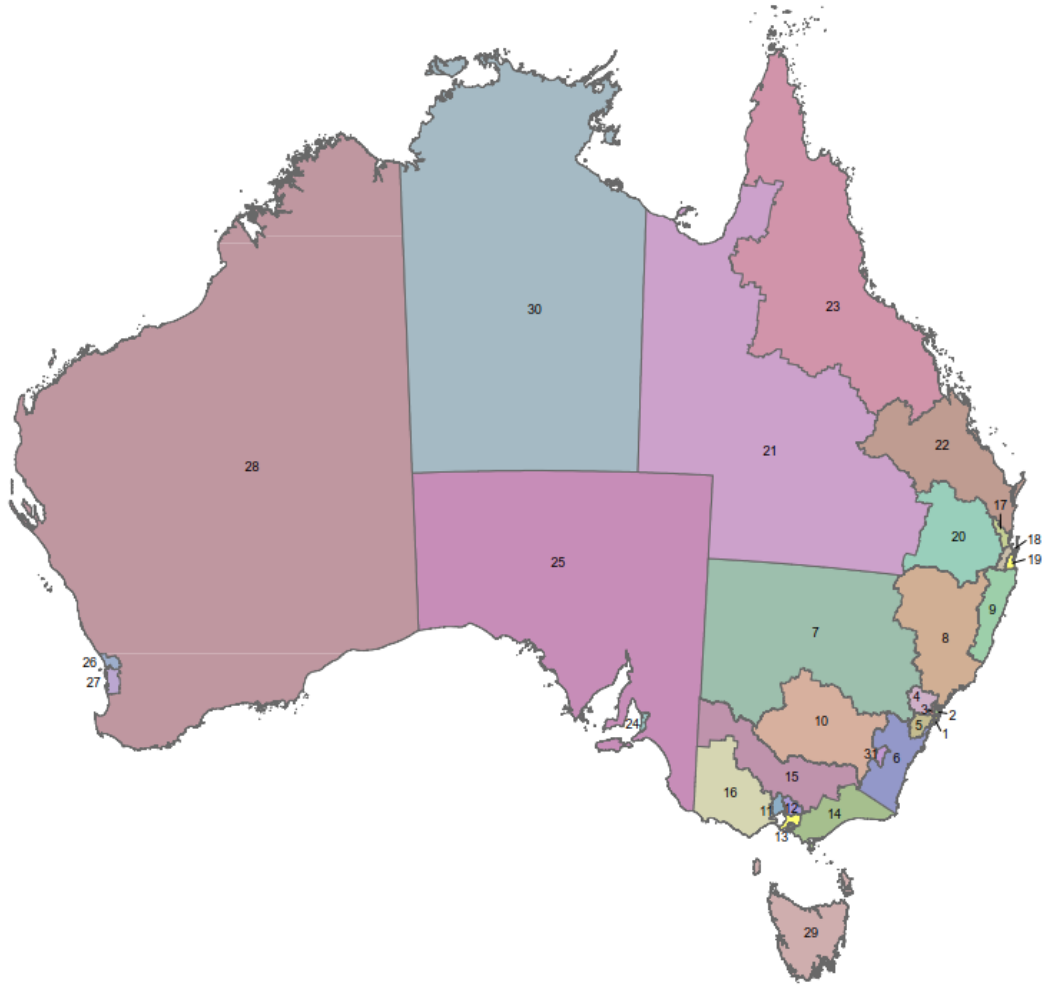
[101] Department of Health advice

[102] Valentijn et al. 2013. 'Understanding integrated care: a comprehensive conceptual framework based on the integrative functions of primary care', *Int J Integr Care* 2013; Jan–Mar, URN: NBN: NL: UI: 10-1-114415

Acronyms and abbreviations

Term	Definition
AIHW	Australian Institute of Health and Welfare
CEO	Chief Executive Officer
GP	General Practitioner
IT	Information technology
LHN	Local Hospital Network
MBS	Medicare Benefits Schedule
NACCHO	National Aboriginal Community Controlled Health Organisation
PHN	Primary Health Network
The Department	The Australian Government Department of Health

Appendix A: PHN distribution across Australia[103]



New South Wales – 10
1. Central and Eastern Sydney
2. Northern Sydney
3. Western Sydney
4. Nepean Blue Mountains
5. South Western Sydney
6. South Eastern NSW
7. Western NSW
8. Hunter New England and Central Coast
9. North Coast
10. Murrumbidgee

Victoria – 6
11. North Western Melbourne
12. Eastern Melbourne
13. South Eastern Melbourne
14. Gippsland
15. Murray
16. Western Victoria

Queensland – 7
17. Brisbane North
18. Brisbane South
19. Gold Coast
20. Darling Downs and West Moreton
21. Western Queensland
22. Central Queensland, Wide Bay and Sunshine Coast
23. Northern Queensland

South Australia – 2
24. Adelaide
25. Country SA

Western Australia – 3
26. Perth North
27. Perth South
28. Country WA

Tasmania – 1
29. Tasmania

Northern Territory – 1
30. Northern Territory

Australian Capital Territory – 1
31. Australian Capital Territory

[103] Australian Government 2015. 31 Primary Health Networks Boundaries – September 2015. Department of Health

Appendix B: Primary Health Networks Grant Program Guidelines: PHN Governance Arrangements[104]

PHN Governance Arrangements

The governance of PHNs should reflect sound corporate governance principles.[105] They should operate efficiently and effectively and deliver against national outcomes and locally relevant primary health care needs, minimising administrative overheads.

At a minimum, Boards should be skills-based and managers and staff should be appropriately qualified and experienced. Boards will have accountability for the performance of the PHN in relation to outcomes, as well as clinical, financial, risk, planning, legal and business management systems. PHNs should be structured to avoid, or actively and appropriately manage conflicts of interest, particularly in relation to purchasing, commissioning and providing services.

PHNs are required to have GP-led Clinical Councils and representative Community Advisory Committees to report to the Board on locally relevant clinical and consumer issues. PHNs must have broad engagement across their region including with Local Hospital Networks (LHNs) (or equivalent), public and private hospitals, Aboriginal Medical Services, nurses, allied health providers, health training coordinators, state and territory government health services, aged care providers and private health insurers.

In addition, where patient flows cross state and territory borders, PHNs are expected to develop cross-border cooperative relationships and shared Clinical Councils and Community Advisory Committees where appropriate.

Clinical Councils

PHNs must establish and maintain GP-led Clinical Councils that will report on clinical issues to influence PHN Board decisions on the unique needs of their respective communities, including in rural and remote areas.

While GP-led, it is expected that Clinical Councils will comprise other health professionals, including but not limited to nurses, allied and community health, Aboriginal health workers, specialists and hospital representatives. Clinical Councils will assist PHNs to develop local strategies to improve the operation of the health care system for patients in the PHN, facilitating effective primary health care provision to reduce avoidable hospital presentations and admissions. Clinical Councils will be expected to work in partnership with LHNs in this regard.

Clinical Councils are also expected to report to and influence their PHN Boards on opportunities to improve medical and health care services through strategic, cost-effective investment and innovation. They will act as the regional champions of locally relevant clinical care pathways designed to streamline patient care, improve the quality of care and utilise existing health resources efficiently to improve health outcomes. This will include pathways between hospital and general practice that influence the follow-up treatment of patients.

Pathways to be prioritised will be those that align with national or PHN specific priorities, including ensuring population cohorts experiencing chronic and complex conditions are better and more efficiently managed within the primary health care system. Where relevant, Clinical Councils in neighbouring PHNs will be expected to work together to ensure that pathways follow patient flows including across PHN boundaries.

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[104] Australian Government Department of Health 2016. Department of Health Primary Health Networks Grant Program Guidelines February 2016 – Version 1.2. URL: http://www.health.gov.au/internet/main/publishing.nsf/Content/PHN-Program_Guidelines

[105] ASX Corporate Governance Council, Corporate Governance Principles and Recommendations, 3rd ed.

In cross border regions, it is expected that there are formal relationships between Clinical Councils and Community Advisory Committees, for example, the Australian Capital Territory and Queanbeyan.

Clinical Councils will work in tandem with Community Advisory Committees.

Community Advisory Committees

Community Advisory Committees will provide the community perspective to PHN Boards to ensure that decisions, investments, and innovations are patient centred, cost-effective locally relevant and aligned to local care experiences and expectations. PHNs are expected to ensure that Community Advisory Committee members have the necessary skills to participate in a committee environment and are representative of the PHN.

Appendix C: PHN Program program logic

Program logic models have been developed to guide the Evaluation on two levels: one for the national-level PHN Program; and three for individual PHN-level activities.

These logic models are aligned with the strategic objectives for the PHN Program. The national PHN program logic captures the context within which the Program was established and is working, and the relationship between inputs, activities, outputs and outcomes.

A second set of logic models at the individual PHN level shows the context for individual PHNs, key activities that are being implemented, and their relationships with outputs and outcomes. These provide greater detail at the organisational level of the key activities undertaken and their impacts across the trajectory to outcomes. These individual-level logic models are derived from the PHN Guidelines and focus on the areas of activity expected of PHNs in achieving their overall objectives. The logic models describe the inputs, activities, outputs and outcomes for:

- Addressing health needs and service gaps:
  - Understanding the health care needs of their PHN communities through analysis and planning.
  - Knowing what services are available and helping to identify and address service gaps where needed, including in rural and remote areas, while getting value for money
  - Working with other funders of services and purchasing or commissioning health and medical/clinical services for local groups most in need, including, for example, patients with complex chronic conditions or mental illness.
- Facilitating service-level and patient-level integration (a key element of addressing health needs and service gaps, but of enough significance to warrant its own logic model).
- Supporting general practice:
  - Providing practice support services so that GPs are better placed to provide care to patients subsidised through the Medicare Benefits Schedule (MBS) and Pharmaceutical Benefits Scheme (PBS), and help patients to avoid having to go to emergency departments or being admitted to hospital for conditions that can be effectively managed outside of hospitals
  - Supporting general practices in attaining the highest standards in safety and quality through showcasing and disseminating research and evidence of best practice. This includes collecting and reporting data to support continuous improvement
  - Assisting general practices in understanding and making meaningful use of eHealth systems, in order to streamline the flow of relevant patient information across the local health provider community.

PHN objectives:
Increase the efficiency and effectiveness of medical services for patients, particularly those at risk of poor health outcomes — Improve the coordination of care, to ensure that patients receive 'the right care in the right place at the right time

Inputs	Activities	Outputs: 12 months – 2 years	Outputs: + 2 years	Outcomes: 12 months–2 years	Outcomes: + 2 years

PHN
Policy & plans
• National & State
• Regional Plans
• PHN/LHN plans
• Stakeholder expectations
• PHN governance frameworks/operational procedures
Resources
• Commonwealth funding
  • Operational
  • Flexible/Innovation/incentive
  • Program
• State funding
• Private sector funding
Workforce
• PHN workforce
• Broader PHC Workforce
• Oher workforce
Context/community/ consumer
• PHN entity & origins
• Pre-existing local PHC planning and integration
• Established local relationships & capacity
• Local health needs
• Local service system/profile
Performance
• PHN performance framework
• National indicators
National support function
• Data & reports
• Strategic advice
• Capacity building
Stakeholders
• Professional organisations
• Consumer organisations
• Private providers
• National and state-based stakeholders
	Governance
	• Clinical & Corporate
	• Community
		• Skills based Boards established
		• Clinical Councils & Community Advisory Committees operating
				• PHNs are effectively governed	**Not evaluated in this evaluation**

	Operations • Establishment activities • Operational activities • Change management	• Financial systems in place • Operational plans • Service continuity		• PHNs operating efficiently and effectively • Evidence of capacity to respond to adjustments in scope over time • Evidence of capability to support increased scope of operations	• Evidence of improvement in systemic coordination of care, to ensure that patients receive 'the right care in the right place at the right time

	Stakeholder engagement
	• General Practice
	• LHN
	• Broader service system
	• Community & consumers
		• Clinicians on committees
		• Consumers on committees
		• Partnership agreements under negotiation
			• Key partnerships with:
			  • General Practice
			  • Other clinicians
			  • Community & consumers
			  • LHNs
				• Effective and appropriate stakeholder relationships	

	Service level integration • Service level integration and co-ordination	• Early co-ordination/integration plans • SLAs • Early solutions for rural communities	• Integration/co-ordination issues being addressed • Solutions for rural communities	• Evidence of integration in local service systems & co-ordination of local services	
	Patient level integration • Patient level integration	• Integrated care pathways agreed • Increased use of integration resources	• Care pathways developed • Data sharing • Team care	• Evidence of use of integrated care resources for patient care – myHealth Record, data sharing, team care, care pathways	• Increased efficiency and effectiveness of medical services for patients, particularly those at risk of poor health outcomes
	General Practice Support • GP/PC support activities, CQI • Research & data support • Support with eHealth	• Visits • Training opportunities • Data audits • Advice provided • MyHealth Record and eHealth solutions	• CQI • Education sessions • Data audits & reports • Increased use of eHealth solutions	• Increased use of data for CQI in participating General Practice • Increased adoption of evidence-based practice in participating General Practice • Increased use of eHealth in participating General Practices	
	Commissioning • Needs assessment and planning • Address local groups most in need • Commissioning activities	• Health needs/market analysis • Local groups most in need identified • Health plan • Assessed commissioning capability	• Needs assessment and planning Basic commissioning capability & capacity in place with commissioning contracts and commissioned services	• Local plans based on heath needs and priorities, addressing inequity • PHNs with baseline or better commissioning capability • Priority services commissioned in response to health needs and service gaps (e.g. CDM, mental health)	• Populations at risk of poor outcomes identified and internal disparities addressed

	Service realignment
	• Negotiations with services/partners
		• Service Level Agreements	• Partnership agreements
			• Service realignments
				• Partnerships and innovative solutions to improve service access
				  • Rural communities
				  • Local groups most in need
					• PHNs are effective and efficient commissioners of services for their population

	Performance
	• Activities to national indicators
	• Development of local indicators
	• Reporting against organisational indicators
		• Baselines established for national performance indicators	• Valid & relevant local performance indicators in place	• Evidence of progress relative to:
				  • the National Performance Framework
				  • National performance indicators / Priorities
				  • Organisational indicators	

	PHN Development
	• Identification of support needs
	• Information and use of national support
		• Early capacity increase
		• Plans for addressing further support needs
			• Internal PHN capacity increased – in staff & systems – to support required PHN functions	• PHNs have used national support function to build capacity
				• Evidence of staff capacity & systems in place
					• Trending towards improvements in :
					  • National performance indicators
					  • National priority areas
					  • Organisational indicators

NATIONAL **Policy & plans** • National PHC Strategy & policy • National Plans • PHN Guidelines and program **Performance** • PHN performance framework • Performance management **Resources** • Funding • Information systems • Data & reports • Personnel • Programs **Program management** • Leadership, support • Intelligence gathering and sharing • Relationship building and communication	**Funding** • Allocation of funds to PHNs	• PHNs funding supports sustainability, flexibility and scaleability • Funding agreements align with policy and strategy for PHNs		• PHNs are utilising funds as intended to achieve outcomes in service development, commissioning and practice support	
	Direction • Policy and strategy	• National PHC Policy • Related policies that guide PHN strategic directions		• PHN growth is directed by national policy	
	Stakeholder engagement • National Peak Bodies • Jurisdictions	• National Peak Bodies engaged • National jurisdictional forums engaged		• National stakeholder support/ satisfaction maintained or increased • Key stakeholders at national level engaged	
	Performance • Data refinement national indicators • Review proposed local indicators • Refine organisation indicators	• Baselines established for national performance indicators at lowest available denominator • National reporting processes	• National performance reports published • Valid local performance indicators in place and reported	Evidence of progress relative to: • the National Performance Framework • National performance indicators • Organisational indicators	• PHNs are 'fit for purpose' for the Australian environment
	National Support Function • Define and Establish National Support • Assessment of PHN needs • Capacity building & support • Change management support • Information and communication support	• Immediate support needs for PHNs identified, prioritised & being addressed • Internal support activities	• L/T & emerging support needs for PHNs identified, prioritised & being addressed • Reports and monitoring tools • Capacity building resources	• PHNs have national support to address capacity and capability & improve performance • Baseline PHN capacity and capability in commissioning • Effective program management	

National Context

- Establishment of PHNs 1 July 2015.
- National Support Function
- Other national policies (e.g. NDIS)
- Aged Care Reform
- Transition of Aged Care to Health
- Mental; Health Commission Review of Mental Health
- Primary Health Care Advisory Group (PHCAG)
- MBS Review Taskforce
- Reform of Federation
- Funding cycles

Local Context

- Local groups most in need within and across PHNs – Aboriginal and Torres Strait Islander, CALD, low SES, locational disadvantage
- Pre-existing work undertaken by previous PHCO organisations for health needs analysis and planning
- Data delays and reliability of data sources
- Existing relationships with General Practice, LHNs, and other stakeholders
- Funded programs in place that may need to transition to new providers
- Rural and remote areas with limited services
- Varied degrees of embedding into local service system
- Levels of chronic disease, mental health treatment
- Individual PHN history and organisational model
- State and territory policy /funding
- Demography

PHN will achieve objectives through addressing health needs and service gaps:

- Understanding the health care needs of their PHN communities through analysis and planning.
- Knowing what services are available and helping to identify and address service gaps where needed, including in rural and remote areas, while getting value for money
- Working with other funders of services and purchasing or commissioning health and medical/clinical services for local groups most in need, including, for example, patients with complex chronic conditions or mental illness.

Inputs

Policy & plans
- Regional Plans
- LHN plans
- Pre-existing local plans

Resources
- Commonwealth funding
  - Operational
  - Flexible
  - Innovation
  - Programme
- Existing data sources
  - PHN
  - LHN
  - National/State

Workforce
- PHN planners
- Clinical Councils
- Community Advisory Committees

Stakeholders
- Clinical Councils
- Community Advisory Committees
- Community members
- Local groups most in need
- Local service system

National support function
- Data & reports
- Specific guidelines e.g. for commissioning
- Capacity building
- Capability development
- Change management
- Infrastructure support
  - NHSD
  - Primary Health Map
  - Communication channels
  - Information dissemination
- Ongoing assessment and response to PHN needs

Activities

Stakeholder engagement for needs assessment and planning
- General Practice
- GPs
- Allied Health/Nurse Practice
- Allied Health/Nurse professionals
- Engage local groups most in need
- Regional/State providers
- Local service system
  - LHNs
  - ACCHOs
  - NGOs
  - Local Government
  - State Government
  - Universities
  - Social services

Strategic planning
- Collation of available data
- Data collection and evidence
- Analysis and reporting
  - local groups most in need
  - Priority health needs
  - Service profiles
  - Service gaps
  - Market analysis
- Priority setting
- Shared planning to address service gaps and inequity
- Provider development
  - General Practice
  - Other services

Procurement/Design
- Service specifications
- Contract design
- Contract implementation
- Provider development

Monitoring and Evaluation
- Supporting patient choice
- Managing contracts
- Managing performance

Redesign and Realignment
- Identify opportunities for existing service realignment and redesign
- Negotiate with service stakeholders
- Develop solutions for rural and remote communities

= Service redesign activities

= Commissioning activities

Outputs

12 months – 2 years

Key partners involved in needs assessment and planning:
- General Practice / GPs
- Clinical Council / Clinicians
- Community Advisory Committee / Consumers and carers
- LHNs
- ACCHOs
- NGOs
- Universities
- Local Government
- State Government
- Social services

- Needs assessment identifying populations with poor access and inequity

- Plans addressing local groups most in need and health needs

- Agreement for service integration and realignment to address service gaps
- SLAs and partnership agreements under negotiation
- Early solutions for rural and remote communities and communities with limited or no providers

- Commissioning capability & capacity increasing in PHNs
- PHNs commissioning and contracting services, prioritising local groups most in need and priority heath needs
- Commissioning to address service gaps
- Patient feedback systems in place
- Early system understanding of commissioning

+ 2 years

- Key partners provide ongoing input into needs assessment and planning
- Additional key partners identified and engaged
- Clinician and consumers feedback informing needs assessment, planning and commissioning

- PHN needs planning integrated with other services
- Integrated delivery plans between services for selected priorities

- Solutions for rural and remote communities and communities with limited or no providers
- Service realignment/redesign for service gaps

- Innovative strategies developed
- Partnerships established
- Service gaps being addressed

- Commissioning capability & capacity increasing in PHNs
- PHNs commissioning and contracting services
- Patient feedback shapes future service design
- System understanding of commissioning maturing
- Market realigning in response to commissioning

Outcomes

12 months–2 years

PHNs understand the health needs of their communities

Local plans based on health needs and priorities, addressing inequity and disparities

Increased integration with services beginning to realign to address shared priorities

PHNs working with partners and using their knowledge of service availability and service gaps to address health needs, including in rural and remote areas, while getting value for money

PHNs have baseline or better commissioning capability

Priority services commissioned for people most in need, prioritising chronic disease management and mental health

+ 2 years

Not evaluated in this evaluation

Improved coordination of health services, to ensure that patients receive 'the right care in the right place at the right time

Increased efficiency and effectiveness of medical services for patients, particularly those at risk of poor health outcomes

PHNs are effective and efficient commissioners of services for their population

Improvements in
- National performance indicators
- Local Indicators
- National priorities

PHNs are 'fit for purpose' for the Australian environment

National Context

- Establishment of PHNs 1 July 2015.
- National Support Function
- Other national policies (e.g. NDIS)
- Aged Care Reform
- Transition of Aged Care to Health
- Mental Health Commission Review of Mental Health
- Primary Health Care Advisory Group
- MBS Review Taskforce
- Reform of Federation

Local Context

- Levels of chronic disease, mental health treatment
- Local groups most in need within and across PHNs – Aboriginal and Torres Strait Islander, CALD, low SES, locational disadvantage
- Pre-existing work undertaken by previous PHCO organisations for health needs analysis and planning
- State and Territory policy and funding priorities
- Data delays and data reliability
- Existing relationships with General Practice, LHNs, Universities, local government and other local stakeholders
- Funded programs in place that may need to transition to new providers
- Rural and remote areas with limited services
- Varied degrees of embedding into local service system
- Individual PHN history and organisational model
- Demography and geography

PHN will achieve objectives through facilitating service level and patient level integration

Inputs

Policy & plans
- State/Territory policy re integration
- Local provider policy and plans
- Health Needs Assessment
- Market assessment

Resources
- PHN funding
- Funding from other services
- State/Territory targeted funding
- PHN held data
- Data held by others
- Needs assessment and analysis

Workforce
- PHN staff
- Staff in wider service system
- Clinical Councils
- Community Advisory Committees

Systems
- Patient/Client information systems
- PCHER

Stakeholders
- Local service system
- Consumers
- Community

National support function
- Data & reports
- Capacity building
- Capability development
- Change management
- Infrastructure support
  - NHSD
  - Primary Health Map
  - Communication channels
  - Information dissemination
- Ongoing assessment of and response to PHN needs

Activities

Stakeholder engagement
- General Practice / GPs
- Allied Health / Nurse Practice
- Allied Health / Nurse professionals
- Clinical Council
- Community Advisory Committee
- Other consumers/carers
- Engage Local service system
  - LHNs
  - Aged care and social care
  - ACCHOs
  - NGOs
  - Local Government
  - Universities

Patient level integration
- Engage in care pathways
- Support integrated patient information systems
- Facilitate data sharing between services
- Support use of myHealth Record and electronic transfer of care
- Facilitate use of team care approaches for chronic disease
- Focus on integration in priority areas of mental health and chronic disease management

Service and system level integration
- Facilitate partnership and integration agreements between services
- Support systems for service integration
- Facilitate shared planning to address service gaps
- Facilitate solutions for rural and remote communities
  - Service access
  - Models of practice
  - SLAs re scope and range of services
- Commission to support integration & address local groups most in need

Outputs

12 months – 2 years

- Key partners involved in integration discussions:
  - General Practice / GPs
  - Allied Health / Nursing
  - Community/consumers
  - LHNs
  - ACCHOs
  - NGOs
  - Local Government
  - Universities
  - Aged and social care
- Key stakeholders involved in developing care pathways for priority areas, e.g. mental health, chronic disease
- Increased use of eHealth
  - Agreements on data sharing/shared patient information, including electronic transfer of care
  - Use of myHealth Record in practices
  - Telehealth
- Agreements for service integration and realignment to address service gaps
- SLAs being developed between services
- Partnership agreements under negotiation
- Early solutions for rural and remote communities and communities with limited or no providers

+ 2 years

- Key partners provide ongoing input planning for integration
- Additional key partners identified and engaged
- Consumer feedback being used to guide integration decisions
- Pathways developed for priority areas, e.g. mental health, chronic disease, local groups most in need
- Patient data being shared between consenting services (for consenting patients)
- Use of myHealth Record in practices
- Increased electronic transfer of care
- Increased use of Telehealth
- Increased use of team care arrangements for CDM
- Patient feedback being used to guide integration decisions
- MOUs and SLAs in place, particularly around mental health, chronic disease
- MOUs and SLAs in place, particularly for local groups most in need
- Integrated service delivery plans between services for selected priorities

Outcomes

12 months–2 years

- PHNs increasing the application of their knowledge of service availability and service gaps to address health needs, through facilitating service and system integration
- Increased integration across the service system, with services beginning to realign to address shared priorities
- Increased evidence of use of processes that support integration of patient care between services
  - Care pathways for local groups most in need and conditions adopted and used across providers
  - Patient centred medical neighbourhood
  - Shared patient information between providers including electronic transfer of care
  - Increased use of shared data for quality improvement and monitoring
  - Increased use of myHealth Record

+ 2 years

Not evaluated in this evaluation

Improved coordination of health services, to ensure that patients receive 'the right care in the right place at the right time
- Care pathways more broadly used across providers
- Shared patient information between providers increasing
- Increased use of shared data for quality improvement and monitoring
- Increased use of myHealth Record

Increased efficiency and effectiveness of medical services for patients, particularly those at risk of poor health outcomes

Improvements in
- National performance indicators
- National priorities
- Organisation Indicators

= Integration activities

National Context

- Establishment of PHNs 1 July 2015.
- National Support Function
- Other national policies (e.g. NDIS)
- Aged Care Reform
- Transition of Aged Care to Health
- Mental; Health Commission Review of Mental Health
- Primary Health Care Advisory Group (PHCAG)
- MBS Review Taskforce
- Reform of Federation

Local Context

- Levels of chronic disease, mental health treatment
- Local groups most in need within and across PHNs – Aboriginal and Torres Strait Islander, CALD, low SES, locational disadvantage
- Pre-existing work undertaken by previous PHCO organisations for health needs analysis and planning
- State and Territory policy and funding priorities
- Data delays and reliability
- Existing relationships with General Practice, LHNs, Universities, local government and other local stakeholders
- Funded programs in place that may need to transition to new providers
- Rural and remote areas with limited services
- Varied degrees of embedding into local service system
- Individual PHN history and organisational model
- Demography and geography

PHNs will achieve objectives by supporting General Practice:

- Providing practice support services so that general practice is better placed to provide care to patients subsidised through the Medicare Benefits Schedule (MBS) and Pharmaceutical Benefits Scheme (PBS), and help patients to avoid having to go to emergency departments or being admitted to hospital for conditions that can be effectively managed outside of hospitals
- Supporting general practices in attaining the highest standards in safety and quality through showcasing and disseminating research and evidence of best practice. This includes collecting and reporting data to support continuous improvement
- Assisting general practices in understanding and making meaningful use of eHealth systems, in order to streamline the flow of relevant patient information across the local health provider community

Inputs

Policy & plans
- Regional Plans
- PHN/LHN plans
- PHN guidelines

Resources
- Commonwealth funding
  - Operational
  - Flexible
  - Innovation/incentive
  - Programme

Workforce
- PHN practice support
- PHN eHealth

Context/community/ consumer
- Clinical Councils
- Community Advisory C Committees
- Established local relationships & capacity
- Needs Assessment and plans
- Local service system/profile

CQI
- Data
- Standards
- Accreditation provided

Performance
- PHN performance framework
- National indicators
- National priorities

Activities

Stakeholder engagement
- GPs / Practice Nurses
- Practice Managers
- Clinical Councils
- Community Advisory Committees
- Priority patient groups
- CQI Agencies

Practice Support
- Practice visits/information
- Assistance with evidence-based practice and patient centred models of care
- Engagement with needs assessment and priority health needs

CQI
- Work with CQI Agencies
- ID high priority practices
- Dissemination of research
- Support with use of data for practice improvement
- Support with clinical audits
- Support with accreditation

eHealth
- Support with one or more of
  - myHealth Record
  - HealtheNet
  - Telehealth
  - Electronic transfer of care

National support function
- Data & reports
- Capacity building
- Capability development
- Change management
- Infrastructure support
  - NHSD
  - Primary Health Map
  - Communication channels
  - Information dissemination
- Performance monitoring
- Ongoing assessment / response to PHN needs
- Practice quality tools
- Evidence supporting best practice
- Support for PHNs to drive change in General Practice

Outputs

12 months – 2 years

Clinical and community governance supporting work with General Practice

Priority patient groups engaged in governance and planning

PHN

Proportion of General Practices being offered practice support in areas of identified capacity development

PHNs facilitating development opportunities

PHNs offering data audits and training in data use for CQI to General Practice

PHNs supporting participation in CQI for General Practice

Increased proportion of General Practices offered eHealth support

General Practice

Proportion of General Practices accepting practice support in areas of identified capacity development

Attendance at development opportunities

Proportion of General Practices taking part in data audits and training in data use for CQI

Increased proportion of General Practices engaging in CQI

Increased proportion of General Practices receiving eHealth support

+ 2 years

GP engagement strategies in place

GPs engaged in PHN governance and planning

PHN

Overall increased proportion of General Practices offered practice support in areas of identified capacity development

PHNs facilitating development opportunities tailored to needs of high need Practices

PHNs offering data audits and training in data use for CQI to additional General Practices

Increased proportion of General Practices overall receiving eHealth support

General Practice

Overall increased proportion of General Practices making changes as a result of practice support in areas of identified capacity development

Increased proportion of General Practices engaging in CQI

- Increased use of data for quality improvement in more General Practices
- Increased practice driven data audits & reports
- Increased proportion of General Practices using eHealth tools
- Increased proportion of General Practices using myHealth Record

= Practice support

= Dependent on General Practice response

Outcomes

12 months–2 years

Evidence of increased adoption of evidence based practice

Increased use of models of practice that include patients in their own care

CQI processes established in increased number of General Practices

More General Practices providing care likely to improve:
- National performance indicators
- National priorities
- Local Indicators

More General Practices routinely using data for planning and quality improvement

More clinicians exchanging / accessing quality information on time

Increased adoption of e-health systems in General Practices

+ 2 years

Not evaluated in this evaluation

Evidence of systemic coordination of health services, to ensure that patients receive 'the right care in the right place at the right time

Increased efficiency & effectiveness of medical services for population, particularly those at risk of poor health outcomes

Improvements in:
- National performance indicators
- National priorities
- Organisation Indicators

PHNs are fit for purpose for the Australian environment

National Context

- Establishment of PHNs 1 July 2015.
- National Support Function
- Other national policies (e.g. NDIS)
- Aged Care Reform
- Transition of Aged Care to Health
- myHealth Record
- Mental; Health Commission Review of Mental Health
- Primary Health Care Advisory Group (PHCAG)
- MBS Review Taskforce
- Reform of Federation
- eHealth Review
- Opt in / Opt out

Local Context

- Other agencies offering CQI
- Levels of chronic disease, mental health treatment
- Local groups most in need within and across PHNs – Aboriginal and Torres Strait Islander, CALD, low SES, locational disadvantage
- Pre-existing work undertaken by previous PHCO organisations for health needs analysis and planning
- Existing relationships with General Practice to varying degrees
- History of practice support provided by PHCOs (DGP and MLs)
- GP Accreditation programs
- Capacity of Practices to invest and change
- State/territory policy and involvement in quality
- State/territory differences in primary care provision
- Funded programs in place that may need to transition to new providers
- Rural and remote areas with limited services
- Varied degrees of embedding into local service system
- Individual PHN history and organisational model
- Focus on increased participation in CQI for General Practice
- Patient populations and demographics
- Range of General Practice providers

Appendix D: Stakeholders and timing of key informant interviews

Stakeholder	Timing of consultation		
	Baseline	Midpoint	Endpoint
PHNs (CEO and Chairs)			
Central & Eastern Sydney	✕		✕
Northern Sydney	✕		
Western Sydney	✕		
Nepean Blue Mountains	✕		
South Western Sydney	✕		
South Eastern NSW	✕		
Western NSW	✕		
Hunter New England & Central Coast	✕		✕
North Coast	✕		
Murrumbidgee	✕		
North Western Melbourne	✕		
Eastern Melbourne	✕		
South Eastern Melbourne	✕		✕
Gippsland	✕		
Murray	✕		
Western Victoria	✕		
Brisbane North	✕		✕
Brisbane South	✕		
Gold Coast	✕		
Darling Downs and West Moreton	✕		
Western Queensland	✕		✕
Central Queensland & Sunshine Coast	✕		
Northern Queensland	✕		
Adelaide	✕		✕
Country SA	✕		
Perth North	✕		
Perth South	✕		
Country WA	✕		✕
Tasmania	✕		✕
Northern Territory	✕		✕
Australian Capital Territory	✕		✕
PHN State Coordinators			
Queensland PHN Coordinator	✕		

Stakeholder	Timing of consultation		
	Baseline	Midpoint	Endpoint
New South Wales PHN Coordinator	✕	✕	
Victorian PHN Coordinator	✕		
Australian Government Department of Health			
PHN Branch	✕	✕	✕
Performance, Evaluation and Quality Branch	✕	✕	
Indigenous Health Division	✕	✕	✕
Mental Health Services Branch	✕	✕	✕
Mental Health and Early Intervention Branch	✕	✕	✕
Drug Strategy Branch	✕	✕	✕
Digital Health Branch	✕		
Strategic Policy and Innovation Group	✕		✕
Health Services Division	✕	✕	✕
Health Systems Policy Division	✕	✕	✕
Health State Network	✕	✕	✕
Deputy Chief Medical Officer			✕
Chief Nursing and Midwife Officer			✕
State and territory health departments			
New South Wales	✕		✕
Australian Capital Territory	✕		✕
South Australia	✕		✕
Northern Territory	✕		✕
Tasmania	✕		✕
Victoria	✕		✕
Queensland	✕		✕
Western Australia	✕		✕
Other			
Australian Medical Association	✕		✕
Royal Australian College of General Practitioners	✕		✕
National Aboriginal Community Controlled Health Organisation	✕		✕
Consumers Health Forum of Australia	✕		✕
Australian College of Rural and Remote Medicine			✕
Rural Doctors Association of Australia			✕

Appendix E: Overview of PHN online surveys

Purpose

Online surveys were used to gather information and data from all PHNs and were distributed to PHN CEOs at baseline, midpoint and endpoint. The purpose of the surveys was to:

- Understand the context, strategy, activities and achievements of all PHNs in a standardised way
- Determine how these elements shape PHNs and track changes over time across all PHNs
- Each survey time point built on the previous survey, in line with the expected process of maturity for the PHNs.

Description

The PHN survey was conducted at each data collection point and collected information across a number of themes, including:

1. About you – included details on the contextual factors of each PHN and personnel in the PHN undertaking the survey.
2. Leadership and Governance – gathered details about the leadership, Constitution, Board, Clinical Councils and Community Advisory Committees. This section also gathered detail PHN organisational structures.
3. Commissioning – gathered details on the capability and capacity of the PHN to undertake commissioning activities including needs assessment, procurement and monitoring and evaluation.
4. Practice Development and Support – gathered detail on PHNs approach and aspirations in undertaking practice development and support, their engagement with general practice, and impact made.
5. Conclusion – gathered detail on improvements to the program, PHNs involved in pilot projects or trials.

The development of the survey questions was informed by the outcomes of the key informant interviews undertaken with the PHNs.

There were some common questions asked in each of the PHN surveys across all time points to enable tracking. Each survey was designed to build on the previous survey and in line with the expected process of maturity for the PHNs. For example, the baseline surveys focused on context, key characteristics of populations and inputs, rather than outputs and outcomes. The endpoint surveys focused more on PHN perceptions of their impact on the service system and their success in addressing key program objectives.

Method

Eligibility

All 31 PHN CEOs were invited to complete the survey during each data collection point. It was left to the CEO's discretion to decide who the most appropriate individuals were within the organisation to complete the survey (e.g. General Managers, other managers etc.). The CEO was responsible for forwarding the survey link to relevant people within the PHN and had them to complete any relevant sections.

Recruitment

CEOs were sent a letter informing them of the survey by the Evaluation Team, prior to forwarding the survey invitation email containing a URL link to the survey. CEOs were also provided with a briefing document which outlined how to complete the survey and provided them with the Evaluation Team's contact details should they have any questions or queries.

Survey design

The PHN survey was a single survey instrument. CEOs were required to answer sections/questions of the survey that were relevant to them, and could then forward sections of the survey to the most appropriate colleague to complete.

A 'save' feature was enabled within the survey, allowing participants to jump in and out of the questionnaire when they needed to research specific answers to questions and return to the survey at a later time. The survey was designed in close collaboration with the Department.

Pilot testing

Prior to launching the fieldwork, the survey was thoroughly tested by the Evaluation Team and cognitive tested with one or two PHNs.

The general approach to pilot testing involved completion of the online questionnaire followed by a feedback session with the Evaluation Team. This allowed for identification of any areas for improvement in terms of execution or coverage of the survey.

Approach to analysis

On completion of fieldwork, the data was cleaned and coded by the Evaluation Team. Coding of open ended questions was conducted in-house utilising market research specialist software (nVivo).

Once the data file was ready for analysis, the specific analysis was conducted by the Evaluation Team for baseline, midpoint and endpoint data. Data was then analysed to map trends and to define progress against expected outcomes or outputs or progress of other PHNs.

Appendix F: Context of PHN case study sites

PHN 1:

- Vast, remote to very remote region, with dispersed population (some very isolated)
- Three regional centres
- Large Aboriginal and Torres Strait Islander population and social disadvantage
- New organisation

PHN 2:

- Moderate to large sized region with moderately sized dispersed population
- Three regional centres
- Some very remote areas
- Previously a Medicare Local

PHN3:

- Small region, with a large population
- Mostly regional with a metropolitan centre
- Large Aboriginal and Torres Strait Islander population and social disadvantage
- New organisation

PHN4:

- Small, metropolitan region with a large population
- Large CALD population and social disadvantage
- Previously a Medicare Local

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