right care
right place
right time

phn
WESTERN NSW
An Australian Government Initiative

Western Health Alliance Limited Commissioning Framework

Table of Contents

1. Introduction

The Western NSW Primary Health Network (WNSW PHN) is one of 31 Primary Health Networks established by the Australian Government Department of Health in 2015.

Primary Health Networks are expected to support and strengthen the effectiveness of general practice and other primary health care services for patients and to improve coordination of care to ensure patients receive the right care in the right place at the right time. Responding to the needs of people who are most at risk of poor health outcomes is a particular priority for Primary Health Networks.

Our role as a Primary Health Network can best be characterised as one of helping General Practice (GP) and primary health care services to work better in meeting the population's needs. There are various ways we might do that. We can seek to remove barriers that make it hard for people to access those services. We can offer support to providers which helps them tackle unmet needs. We can work with our hospitals and other health services to better co-ordinate and link their services with those offered by GP and primary health care services. We can provide assistance to enable the emergence of new providers or encourage the establishment of new services where gaps currently exist. And, in some instances, we may deliver services ourselves if we identify a genuine need which no-one else is willing or able to address.

In common with all other Primary Health Networks we must also set realistic expectations for what we can achieve. We work within a complex health system where services are delivered by an array of government, non-government, private sector and voluntary organisations. Our contributions will necessarily be constrained by the limited budget we have available. That is why we must ensure that every dollar we spend is spent in a way that achieves the best possible value for money in delivering the outcomes our communities need. Nevertheless, we must recognise that priorities have to be set and some needs will inevitably remain unmet despite our best endeavours.

We face some very specific challenges that arise from the context in which we operate. WNSW PHN serves a population of around 310,000 people who are spread across an area of more than 430,000 km^2. Our main centres of population are separated by vast distances and each serves numerous smaller communities that are themselves widely dispersed. 10.5 per cent of our people (around four times the average proportion nationally) identify as Aboriginal and are thus more likely to have poorer health outcomes. Many of the areas we serve are classified as districts of workforce shortage. The Australian Government defines such districts to be areas in which the population's need for medical services has not been met but, in the case of Western NSW, those workforce shortages are also felt in respect of allied health and other health professions.

We are a young organisation, faced with some major challenges, so we need to focus our efforts. Our core business is, and must always be, primary health care – general practice and other community based health services. For that reason, we will work closely with current and potential users and providers of such services across our region. At the same time, however, those services are one element in a larger health sector so we need also to maintain close and effective relationships with a broad range of other stakeholders.

We will only succeed if we work in partnership with others in the health sector: the two State Government Local Health Districts that serve our region (Western NSW and Far West); Aboriginal Community Controlled Health Services; the Royal Flying Doctor Service; private general practitioners, pharmacists and allied health professionals; and voluntary/not-for-profit organisations. Acknowledging the part that broader socio-economic factors play in influencing

health risks and shaping health outcomes we also need to collaborate with bodies in education, employment, transport, justice and other human services areas.

The Western Health Alliance Limited, which operates the Western NSW Primary Health Network, has adopted, as its vision:

> *"Supporting, strengthening and shaping world class, person-centred primary health care system in Western NSW"*

That vision forms the basis for the Primary Health Network's strategic direction and underpins its commissioning framework as documented here.

2. What is commissioning?

The ultimate aim of commissioning is to enable Primary Health Networks to allocate available resources in ways which best address identified needs.

This WNSW PHN Commissioning Framework has been established to provide guidance to the organisation on planning and implementing its health commissioning responsibilities under its funding agreement with the Australian Government. It also aims to inform current and prospective health service providers, and the community, about the Primary Health Network's approach to commissioning for the current funding period up to 30 June 2021.

Primary Health Networks are expected to use commissioning to achieve their objectives of:

- increasing the availability, efficiency and effectiveness of primary health care services for patients, particularly those at risk of poor health outcomes; and

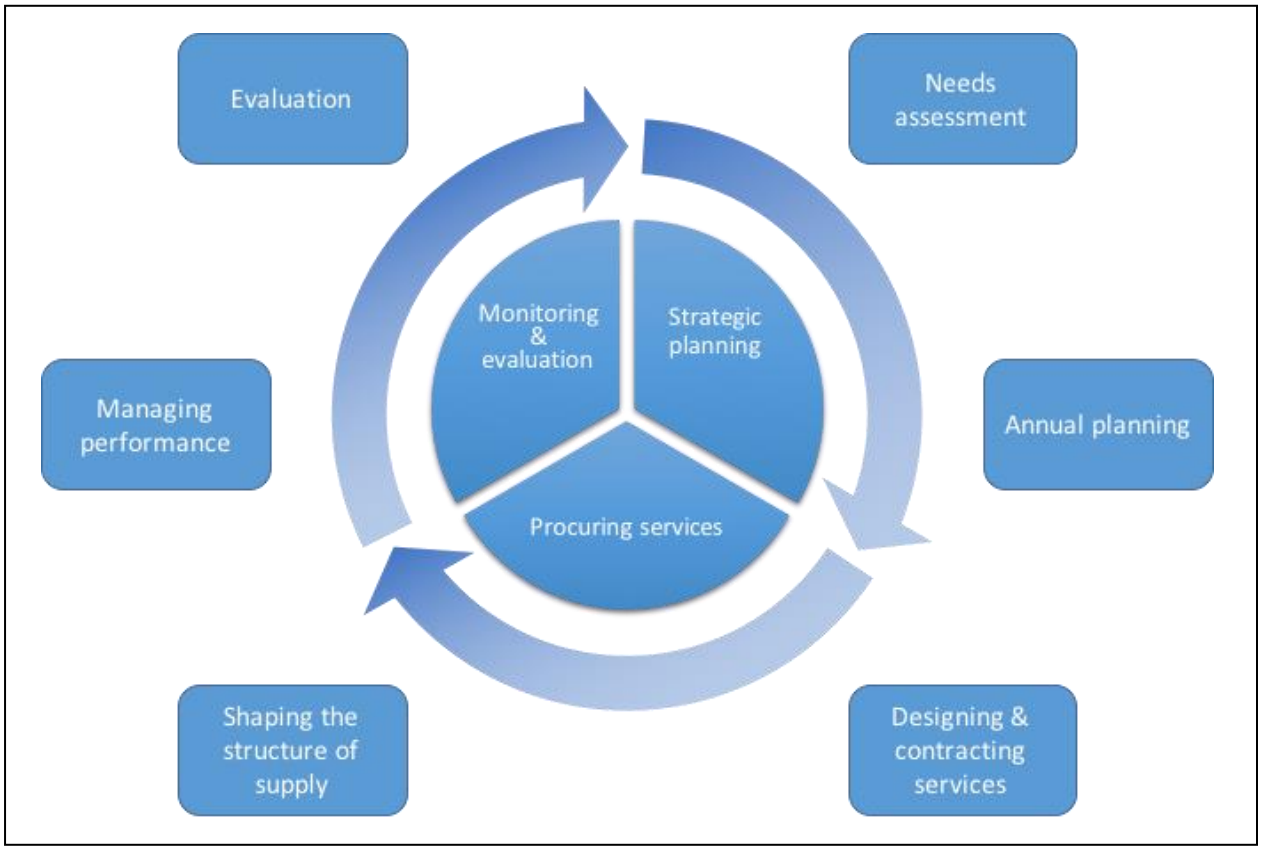
- improving coordination of care to ensure patients receive the right care in the right place at the right time.

Commissioning is a process. It is often described in terms of a cycle of activities (Figure 1).

Those activities, in turn, can involve numerous tasks such as:

- identifying and understanding needs;
- in consultation with providers and the community, determining how best those needs can be met – what activities or outcomes should be sought;
- assessing how existing providers might be able to meet needs;
- building capacity among current and potential providers so they can be better able to meet needs;
- encouraging new services and/or new providers where necessary;
- negotiating and agreeing contracts for services with providers;
- managing contracts;
- reviewing and evaluating providers' performance and achievements;
- incorporating knowledge and experience gained into future commissioning activities; and
- providing feedback and intelligence to the provider community as a means to build longer-term sustainability.

Figure 1: The commissioning cycle



Our view of what constitutes successful commissioning goes beyond simply ensuring that contracts are signed and services are delivered. To be an effective commissioner we will need to work with others in our region, in and beyond the health sector as commonly defined, to foster collaboration and build the capacity needed to tackle the unique challenges we face.

In light of the above, there are several pre-conditions for successful commissioning:

- Deep local knowledge and understanding – of needs, of current or potential service providers and of cultural or other factors that influence how best to tackle specific issues.
- Agility – to adapt our approach to commissioning and work with others in a flexible, collaborative manner to address changing needs, respond to unanticipated problems and capitalise on emerging opportunities.
- Openness and partnership – working together, on the basis of 'no surprises', both with those who will use services and with those who deliver them (or could deliver them) is necessary to ensure that expectations are met and that innovation is fostered.
- Clinical input – to ensure that existing clinical services continue to be appropriate for addressing identified health needs, to align new/expanded services with existing services and ways of working, and to shape services that attract, support and keep health professionals. Our two Clinical Councils and Aboriginal Health Council have been established to provide clinical input to the commissioning process.
- Community engagement – to identify needs (especially among underserviced groups and those who lack 'voice') and to obtain feedback on commissioned services. We have two Community Councils and an Aboriginal Health Council which support our work in community engagement.
- Careful management of relationships – with communities, health professionals and service providers (whether contracted or not) to maintain awareness of emerging

issues, foster collaboration and realise synergies. The Western NSW and Far West Local Health Districts together with our region's Aboriginal Community Controlled Health Services and the Royal Flying Doctor Service are key partners with whom we will seek to develop and maintain close working relationships.

It will also be important for us to ensure that clinicians, communities and other stakeholders in our region are aware that commissioning is **not**:

- passive purchasing – it involves much more than simply signing contracts and making payments;
- constrained by the *status quo* – our communities' healthcare needs are constantly changing and 'business as usual' may not always be the best solution so we will work with providers to help them ensure their services also evolve and we will be open to new ways of working and willing to engage with new services that can meet emerging needs;
- deliberately disruptive – while focused on achieving positive change commissioning must also recognise the value of established roles and relationships and the financial, emotional and intellectual investments that service providers and users may have made in existing arrangements;
- purely transactional – while formal contracts are key to defining expectations they are only part of an ongoing and close relationship between a commissioner and a service provider;
- able to address all unmet needs – commissioners work within fixed budgets and so they need to ensure that both the 'what' and 'how' of their investments achieve the best possible health outcomes for every dollar that is spent and, at the same time, commissioners, service providers and communities must recognise that priorities have to be set and some needs will inevitably remain unmet.

3. Why will we commission services?

We will use commissioning to build and maintain a closer alignment between health needs and primary health care services in our region.

Our task as a commissioner is to direct the resources at our disposal to:

- fund existing treatment and prevention services to do more;
- encourage the establishment of new services where none are currently available to meet an identified need;
- provide support to current and potential new service providers to build their capacity and increase their effectiveness, efficiency and/or viability; and
- work in partnership with other health sector players to ensure more seamless and better integrated services for patients and communities across the spectrum of health promotion, disease prevention and screening, general practice, other primary health care, community and hospital care.

Needs Assessments are a key element in the commissioning process. The Assessment ensures that resources are directed to those areas where their impact will be greatest. It can also reduce the risk of funds being used for services that are of little value, have limited impact or duplicate/displace existing services that are already working well.

Several important priority areas of need have been confirmed in our recent update of the Health Needs Assessment for our region. Many of these are also common to other Primary Health Networks. In our case they are complicated by the fact that we serve a vast geographic

area, the prevalence of risk factors for ill-health is greater and health outcomes poorer among rural/remote communities, and there are relatively few private sector health providers in many parts of our region.

Our Health Needs Assessment indicates that the main areas where challenges exist and where our commissioning activities should thus be focused are:

- aboriginal health;
- chronic and complex care;
- older persons' care;
- maternal and child health;
- services for people living with disabilities;
- mental health and substance abuse;
- risk factors / prevention;
- access to services;
- coordination, integration, collaboration; and
- workforce.

In each of those areas we will aim to use our available resources to strengthen existing services or to encourage the development of new services where critical gaps exist. Our overriding goal in doing so will be to deliver measureable improvements in the population's health outcomes

In addition to undertaking a broad Health Needs Assessment, the Australian Government Department of Health also requires that we complete a separate Needs Assessment to report upon specific, targeted assessments and analyses of our region's needs in respect of mental health, suicide prevention and drug and alcohol services. These reports are available on our website.

Operational plans are then developed to identify how commissioning will meet the needs and priorities identified in the Needs Assessment. Activity Work Plans are available on our website.

4. Core Guiding Principles

Our commissioning is underpinned by the following guiding principles:

1. Cultural safety

All commissioned services must demonstrate that they are culturally safe, especially for Aboriginal and Torres Strait Islander people and communities and comply with the WNSW PHN Cultural Safety Framework.

2. The Quadruple Aim

- Improved health outcomes
- Better value health care
- Improved patient and carer experience of care
- Improved provider experience

3. Building a better integrated health system

- Embedding the 10 building blocks of the Patient Centred Medical Home
- Embedding stepped mental health care

- Embedding digital health
- Supporting the Western NSW rural and remote workforce plan

4. Clinical Governance

All commissioned services must comply with the WNSW PHN Clinical Governance Framework to establish and maintain appropriate clinical governance and quality assurance arrangements services.

5. Consumer and Community Engagement

In commissioning services the WNSW PHN looks to engage with consumers as partners and advocates for health system improvement. Services should be based on understanding of consumer and community need as described in the WNSW PHN Consumer and Community Engagement Framework.

6. Supporting research and innovation

- Adoption of best practice
- Facilitating translation of research into service delivery
- Supporting training and continuing skills development

5. What will we commission?

We will commission services that address the issues arising from our needs assessment. Some services will be delivered directly to patients and communities. Others may take the form of technical or other support services that are delivered to service providers in order to enhance their ability to meet the needs of patients and communities.

The needs we have identified fall into a number of broad categories:

- some relate to specific sub-groups of our population - e.g. Aboriginal health and older person's health
- some focus on particular conditions or groups of conditions - e.g. chronic and complex care, mental health and substance abuse;
- some are, in part at least, about the distribution and configuration of services and the ways they are delivered - e.g. access to services;
- some will be addressed by changes to the characteristics of services - e.g. coordination, integration, collaboration; and
- some are about inputs to services - e.g. workforce.

Those needs are not mutually exclusive. There are older Aboriginal people. Mothers and children may have needs for mental health services. Workforce shortages and/or poor service coordination can impact across the whole of health care. All services need to be accessible and responsive to the needs of people living with disabilities.

As a smart commissioner we should be able to invest in services or activities which address more than one need concurrently. We may look to contract for provision of a range of services for a defined population; for comprehensive services in a particular location; or for activities that build capacity among providers in ways that enable them to respond better to current and emerging needs.

Different approaches to commissioning

Given the size and diversity of the region we serve there will be instances where a 'one size fits all' approach to commissioning is inappropriate. Approaches that work in regional centres may not be effective in remote areas. Localised approaches to commissioning may also be more suitable as a means to reflect specific community needs and expectations, and allow for more responsive negotiation and oversight of contracts. Accordingly, we will seek to work with our Health Councils, Local Health Districts and other key players to define 'zones' or sub-regions where that would enable us to have a more coherent basis for locally responsive commissioning, collaboration and capacity building.

Co-design is a commissioning approach WNSW PHN will move towards in the future. This approach involves commissioners working with consumers, clinical leaders and potential providers to develop services options, with the aim of ensuring consumer needs are central to the process. Through an Alliancing model of co-design different parties work together to develop a coherent whole system vision of what the future should look like, with the belief that multiple organisations can achieve better results together. Such approaches can be used to strengthen the commissioning process and promote cultural safety and improved patient experience in service design.

Commissioning must also foster innovation. In 2009 the National Health and Hospitals Reform Commission identified a national goal of establishing 'an agile and self-improving health system for long-term sustainability'. That goal is no less relevant for our region today and it will underpin our efforts to commission services that empower providers to identify and address the changing health needs of their communities.

Examples might include capitation-based funding for providers delivering particular types of services, support for the establishment of patient-centred medical homes (see Box), innovative use of e-health and telemedicine, development and use of clinical pathways, experimentation with new funding mechanisms and provision of health 'navigators'.

Patient-centred medical home

A patient-centred medical home (PCMH) is a primary care provider with which an individual has chosen to affiliate and recognize as being responsible for their ongoing, comprehensive, whole-person medical care. By investing in the development of PCMH a Primary Health Network could address the following needs:

- chronic and complex care – by coordinating preventive and treatment services from different members of the care team;
- older persons' care – by delivering clinical services and ensuring communication with other support services for older people;
- maternal and child health – by providing call and recall for ante- and post-natal care, performing well-child checks and ensuring immunisations are up-to-date among affiliated individuals;
- risk factors and prevention – by developing and maintaining registers of affiliated individuals and offering screening, health checks, advice etc;
- access to services – by establishing systems to facilitate access to disease management and preventive care services and ensuring access to after hours care;
- coordination, integration and collaboration – though oversight of a multi-disciplinary care team and effective communication with community and secondary care services; and
- workforce – by offering staff opportunities to work in a fulfilling professional environment with a 'critical mass' of patients.

A portfolio of services to meet need

Our aim over time will be to commission a 'portfolio' of services and other activities which, when taken as a whole:

- address identified needs – noting, as discussed above, that some investments may impact on multiple needs;
- deliver the best value for money – assessed in terms of service quality and expected health gains relative to cost;
- are affordable – noting that our budget for commissioning services is inevitably capped;
- build capacity – by fostering learning, growth and innovation which will contribute to the long term viability of services in our region;
- are supported by evidence – our commissioning decisions will, whenever possible, be based on the best available evidence of identified needs and 'what works' in addressing those needs; and
- foster equitable outcomes – in ensuring all members of the communities we serve have equal opportunities to achieve and maintain the best possible health.

There may be a need to make trade-offs among those objectives and some investments may be mandated by our funders. In 2016/17, for example, we received 'earmarked' funding from the Department of Health to commission primary mental health services. We have also received further additional funds to boost the alcohol and other drug treatment sector and reduce demand for 'ice' (methamphetamine) in our region.

While we are strongly committed to supporting established services that meet a genuine need we must also recognise that health priorities may change over time. The make-up of the populations we serve may alter, communities' preferences may shift or new evidence might point to a need adopt new models of care. Also levels of funding available to our Primary Health Network may change. In those circumstances it may be necessary for us to reallocate funding among services or, in some cases, 'decommission' a specific service(s) so that resources can be re-prioritised. We will only do so after careful consultation with affected providers and users of the services concerned.

6. From whom will we commission?

We will be open to commissioning from a broad range of service providers. Some may be existing providers who have delivered services for our predecessor Medicare Locals. We will also seek to identify and involve providers with whom we have not previously done business and, where appropriate, may take steps to encourage the establishment of new providers. Opportunities for new providers are likely to emerge in areas where existing providers are struggling to meet needs, where new challenges are emerging or where there is scope for innovation in service delivery.

Our fundamental role is as a commissioner and not a direct provider of services. There may be some instances where no suitable provider exists and we are unable to generate interest from new providers to enter the market on realistic terms. In those circumstances, where there is clear evidence of market failure, we may need either to provide a service ourselves or to enter into a partnership with another party to ensure their viability as a provider. Before we do so we are required to demonstrate to the Australian Government Department of Health that the service in question is necessary and we have investigated alternative avenues for service delivery.

Our region encompasses a number of communities that are situated close to the border with a neighbouring Primary Health Network. If it appears some of those communities' needs can be better met by the neighbouring Primary Health Network then we will endeavour to commission services from that network. Likewise, if we establish contracts that are able to meet the needs of border communities in other Primary Health Networks' regions then we will explore opportunities to extend their scope accordingly.

7. How will we commission?

Much of our commissioning will build on established relationships with existing service providers. We anticipate they will have good advance knowledge of our purchasing intentions.

We will also put in place arrangements that enable potential providers with whom we are not currently working to 'pre-register' and be informed of suitable opportunities as and when they arise.

Once we have identified a specific need we may use a number of alternative arrangements to engage a suitable provider(s):

- we may offer additional funding or support to enable an existing provider to increase their capabilities and extend or enhance their service;
- we may approach a Local Health District, the Royal Flying Doctor Service, an Aboriginal Community Controlled Health Service or another non-government body to explore opportunities to form partnerships and jointly fund or deliver a service;
- we may issue a request for expressions of interest to solicit ideas from suitably qualified parties as to how best the need might be met; or
- we may move directly to a formal competitive tendering process when we consider there are several potential providers who could deliver a safe and cost-effective service without undue disruption to established players.

Our procurement principles are:

- purchasing for better health outcomes;
- value for money;
- support for sustainable services;
- ethical behaviour and fair dealings;
- accountability and transparency;
- evidence based decision making;
- preference for local providers and workforce; and
- use of open and effective competitive process where appropriate.

We acknowledge that smaller providers and new entrants who have the potential to meet needs may be at a disadvantage and thus may require additional support in the commissioning process. We also recognise that there are likely to be diseconomies of scale when services are delivered to small and/or remote communities and thus costs may be higher.

Contracts with providers will typically be funded in any of three ways: on a fee-for-service basis; by means of block funding or via payment for outcomes. In some cases, there may be merit in using a 'blended' payment approach which combines elements of all three to achieve a particular outcome.

Determining the preferred contacting approach for specific services will be an important component of the commissioning process

Fee-for-service contracts will typically detail:

- service eligibility/access criteria (i.e. where, when and for whom the service is to be made available);
- type(s) and volume(s) of services to be delivered;
- service quality standards to be maintained; and
- sums to be paid and basis for payment.

Block funded contracts will offer lump sum payments to providers without necessarily defining levels of activity to a high degree of detail. Under these contracts the provider is responsible for working out the best ways to achieve the required health outcomes. If costs are lower than expected and requirements are met, a block contract can allow the provider to re-invest surplus funds to deliver additional services. If cost overruns arise, however, the provider must bear the resultant financial risk.

Payment for outcomes contracts link all or some of the provider's income to the achievement of defined outcome targets. Such contracts may be appropriate in the case of services where we want to see a defined (and measureable) impact and to ensure that certain standards are met (e.g. in respect of access and quality) but are not concerned to specify in detail the specific types or volumes of services that should be delivered to achieve that impact.

In some cases, we may determine that it would be more effective for us to work with other agencies such as the Royal Flying Doctor Service, Aboriginal Community Controlled Health Services or our region's Local Health Districts to commission services jointly. For example, delivery of programmes which aim to reduce the need for hospital admissions and thus can offer 'win-win' outcomes for both primary and secondary care providers, may be an area of particular interest for joint commissioning with Local Health Districts.

We might also identify opportunities to join with one or more other Primary Health Network(s) to commission services that naturally extend across boundaries or where we consider we could bolster our purchasing power or obtain economies of scale by commissioning for a larger population.

There will be a requirement for service providers who deliver services for Aboriginal people to be culturally competent.

Joint commissioning with agencies working in fields such as education, justice and housing could also provide a means for us to begin addressing the broader social determinants of health in our community.

Alongside joint commissioning we will also explore the scope for delegated commissioning, whereby we invite another agency (such as those identified above) to commission services on our behalf. That might be particularly relevant in the case of services aimed at hard to reach populations with which 'mainstream' providers struggle to engage due to issues of culture, language, geography or lifestyle.

We anticipate that our use of joint and delegated commissioning approaches (which together are commonly referred to as co-commissioning) will grow as we gain more experience of the commissioning process. It will require close alignment of objectives, outlooks and principles among the co-commissioning partners. Business arrangements for co-commissioning will also need to be robust. They should offer clarity as to the services being commissioned (volumes, locations, quality, timeliness etc as appropriate), define roles and responsibilities of the parties involved, specify the relevant financial arrangements, indicate how risks will be managed and detail dispute resolution procedures. Failure to adequately prepare for co-commissioning will

have detrimental impacts both on the commissioning partners and on the service providers with whom they work.

Just as we see ourselves working progressively closer with other agencies in respect of co-commissioning we also expect that, over time, the nature of our relationships with providers will evolve to reflect all or some of the principles that underlie 'alliance contracting'. They require the commissioner and providers to work closely together in an alliance whereby:

- everyone wins or everyone loses depending on whether the alliance has met its objectives – which suggests a move towards more financial risk-sharing between us and our partners;
- members of the alliance all have a say in decisions for it – meaning close and ongoing collaboration, possibly extending to joint management, between commissioner and provider(s);
- risks and responsibilities are shared and managed collectively rather than allocated to individual members – so that if and when performance concerns or other unanticipated issues arise we work jointly with the provider to see them addressed;
- there is a "no blame culture", - with dispute resolution mechanisms underpinned by a clear definition of responsibilities within the alliance and thus no expectation of recourse to legal remedies; and
- communication between commissioner and provider(s) is transparent and open - transactions are conducted on an "open book" basis.

8. How will we know what's working and what isn't?

Comprehensive monitoring and evaluation of the results of our commissioning is a key element in the process. It can provide insights both into the results of our commissioning processes and into the processes themselves. It does so by:

- determine what activities and outputs have been completed;
- giving us information on what outcomes have been achieved from our commissioning to meet health and other needs;
- highlighting further areas of unmet or emerging need for future commissioning;
- informing us about our relationships with providers and their experience of working with us; and
- helping us continuously improve our approach to commissioning.

The timing of our monitoring and evaluation activities may vary. For some low-risk, fixed-term contracts they may take place at or towards the end of the contract period. In the case of multi-year contracts and/or contracts that are particularly risky or innovative we may need to schedule mid-term, or more frequent, checks on progress.

Essential pre-requisites for effective monitoring and evaluation, which will be reflected in our contracts, include:

- clearly defined expectations as to what an initiative is expected to achieve – ideally in the form of SMART objectives (Specific, Measurable, Agreed, Realistic and Time-bound)- with the focus being on outcomes, rather than process, wherever possible;

- robust arrangements for data collection and reporting – with unambiguous definitions of data items sought and levels of disaggregation required (e.g. by population group and/or locality); and
- availability of both 'before' and 'after' data – to allow changes associated with the initiative to be identified (noting they may not always be wholly attributable to the initiative itself).

It will be important not only to ensure such measures are in place when we contract with service providers or set up co-commissioning arrangements but also to establish equivalent measures as the basis for assessing our own performance as a commissioner.

Subject to due process and contractual compliance, arrangements may be amended (or even terminated) in response to changing needs, emerging opportunities or significant under-performance by a provider.

Monitoring and evaluation processes are also relevant to our efforts to support and foster a culture of learning, growth and ongoing capacity building throughout the health services in our region. By sharing findings and lessons learned with providers we will be able to assist them to review their own activities and explore improvement opportunities.

As noted above, monitoring and evaluation is not just about assessing the achievements of service providers. It can also help us to look more closely at our own performance as a commissioner and to assess the effectiveness of the processes we use to plan what to commission, how to commission and from whom to commission going forward.

As one of 31 Primary Health Networks across Australia (and a wider community of similar primary health organisations internationally) we also have the opportunity to learn from and contribute to broader research, performance measurement and improvement initiatives.

In keeping with our aspiration to be a learning organisation we anticipate that WNSW PHN will build on current working relationships and establish new partnerships with universities, research institutes and other academic bodies. We will seek to draw on those relationships to gain insights into the evidence base underpinning best practices in commissioning, for technical support in our own research and evaluation work, and to bring our achievements to the notice of the broader academic, policy and health management communities.

9. Key activities for commissioning

Commissioning will become our core business progressively from July 2016. Accordingly, our proposed commissioning activities will lie at the heart of, and be a key component in, our annual planning and budgeting processes. Commissioning by Primary Health Networks is guided by our funding contract with the Australian Government Department of Health and as such the service mix, funding allocated and contract periods for commissioned services are influenced by this agreement.

Faced, as we are, with tight deadlines and competing priorities we will need to take a realistic view of what can and cannot be achieved. We are a young organisation that is still growing. We are still developing and embedding some of the systems and capabilities that underpin our vision of building "a world class person-centred primary health care system" for our region.

The Department of Health, as our principal funder, has specified a number of commissioning-related tasks that we must complete during the current financial year. In particular, an Annual Plan and Budget for the financial year is provided to the Department of Health in May each year. This dictates where our priorities will lie and how resources will be allocated.

Figure indicates the key activities that constitute the commissioning process for a new activity, while **Figure 3** indicates key activities for the annual review of existing contracts for commissioned services.

Figure 2: Key Commissioning Activities - New Activity

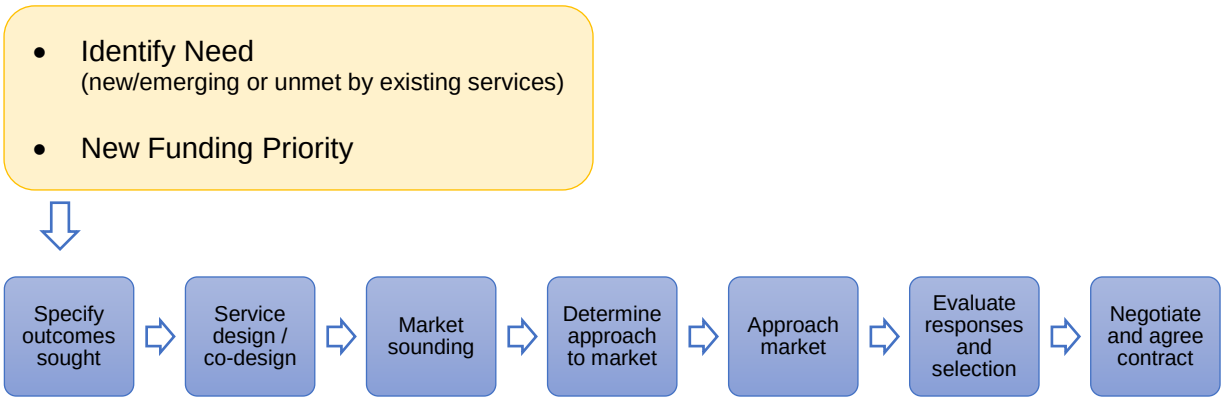
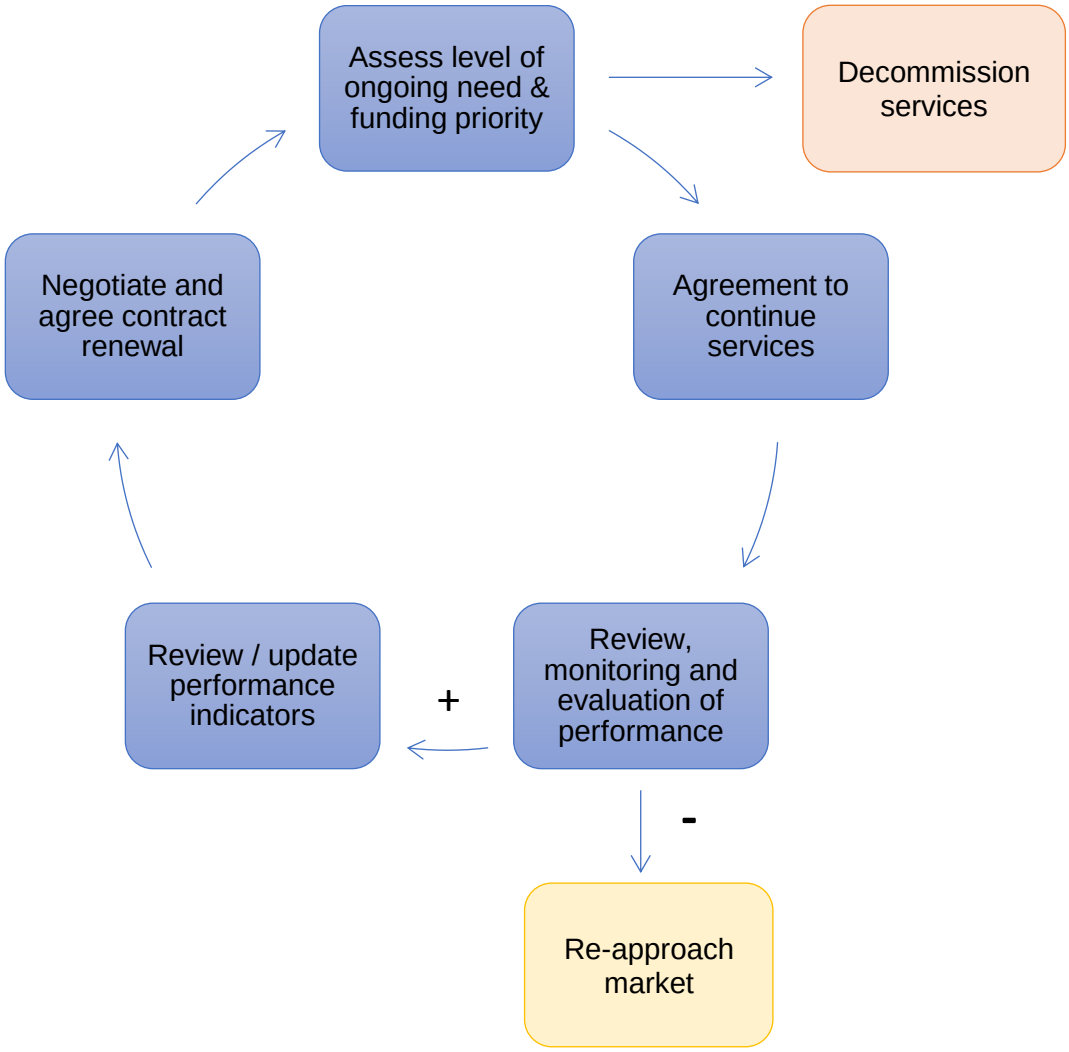


Figure 3: Key Commissioning Activities - Annual Review of Commissioned Services



10. What new tools and capabilities will we need?

To succeed in our role as a commissioner we will need to develop or acquire a number of new tools and capabilities. They include:

- A comprehensive database of current and potential service providers, their capabilities and, where relevant, their track record of performance. The database should encompass:
    - providers we are already working with;
    - potential providers who are known to us but with whom we do not currently have a contractual relationship; and
    - potential providers who are not yet known not to us – details of whom we may obtain via other players (e.g. LHDs) or soliciting expressions of interest from potential providers interested in working with us.
- Capacity to identify and maintain up-to-date information on potential partners and opportunities for co-commissioning with other players whose goals and interests are aligned with ours.
- Formally documented procurement processes including details of
    - approaches to tender evaluation – including how we will address cost/quality trade-offs should the need arise;
    - arrangements to ensure probity;
    - protocols for communicating with potential providers in the course of a procurement.
- Systems to record contract details, payment schedules etc.
- In-house skills and capabilities and/or relationships with universities, research institutes and other agencies to conduct comprehensive review, monitoring and evaluation of our investments and commissioning processes.
- Networks with other Primary Health Networks and similar bodies to support mutual learning and knowledge exchange.

In addition to the above, we will keep our commissioning capabilities under constant review and schedule actions to address any shortcomings that we identify.

11. Governance

Commissioning Strategy Committee

The Commissioning Strategy Committee provides oversight for the commissioning of services and makes recommendations to the Board to support and strengthen the appropriateness and effectiveness of the organisation's commissioning. Membership of the Committee comprises no less than three Directors, the Chairs of each of the PHN Advisory Councils and a Senior Executive of the WNSW LHD and the FW LHD. The Chair of the Committee is appointed by the WHAL Board from the Director members of the Committee.

Advisory Councils

WNSW PHN has five advisory councils; the Western Clinical, Far West Clinical, Western Community, Far West Community and the Aboriginal Health Council. These councils support the commissioning of services by providing strategic advice at key points in the commissioning cycle including:

- Needs Assessment, Council Members advise on methods to consult, contribute to consultation and assist in setting health need and services priorities
- Activity Work Plan review
- Service design, including recommendations for co-design processes.

Additionally, council Chairs have ongoing involvement in the commissioning process through membership of the Commissioning Strategy Committee.

phn
WESTERN NSW

An Australian Government Initiative

right care
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right time

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Bathurst **Bourke** **Broken Hill** **Orange**

We acknowledge that we work on the traditional lands of many Aboriginal clans, tribes and nations. We commit to working in collaboration with our region's Aboriginal communities and peoples to improve their health, emotional and social wellbeing in the spirit of partnership.