Commissioning
Framework
2019-2022
phn
CENTRAL AND
EASTERN SYDNEY
An Australian Government Initiative

Contents

Contents ... 2
Introduction ... 3
Objectives ... 3
Central and Eastern Sydney PHN ... 4
Our vision ... 4
Purpose ... 4
Priorities ... 4
A snapshot of our region ... Error! Bookmark not defined.
What is commissioning? ... 7
Our approach to commissioning ... 8
Our commissioning principles ... 8
Commissioning cycle ... 8
Towards outcomes based commissioning ... 10
Program logic ... 10
Governance and leadership ... 12
Co-design and consultation ... 13
Working with the market ... 14
Market analysis and sounding ... 14
Market making and market shaping ... 14
Co-commissioning ... 15
Stage 1: Strategic planning ... 16
Needs assessment ... 16
Activity planning ... 16
Stage 2: Procuring services ... 17
Stage 3: Monitoring and evaluation ... 18
Monitoring and contract management ... 18
Evaluation ... 18
Completion and transition ... 19
Where are we going next? ... Error! Bookmark not defined.

Introduction

Primary Health Networks (PHNs) were established by the Australian Government in 2015 to support primary healthcare in Australia through service improvement, integration and the commissioning of services as needed to address identified gaps and needs in their local areas.

Primary health care is the frontline of Australia's healthcare system. Primary health services are delivered in the community, are broad-ranging and include health promotion, prevention and screening, early intervention and treatment.

PHNs commission other organisations to deliver services on their behalf. This represents a fundamental shift in the way that primary health care services are planned for and funded at the regional level.

Objectives

This document details Central and Eastern Sydney PHN's approach to commissioning. It is intended to guide practice across the organisation, as well as providing a way to communicate our approach to our stakeholders.

Specifically, the document will:

- establish the principles that guide our commissioning approach
- explain the governance structures that support our commissioning activities
- highlight how our commissioning approach links to our organisational strategy, vision and purpose
- explain the commissioning cycle and important activities that support a strategic commissioning approach.

This framework will be continually reviewed and updated as we continue to learn from our experience, mature as an organisation, and respond to the changing needs of the Central and Eastern Sydney population.

Central and Eastern Sydney PHN

Our region stretches from Strathfield to Sutherland and east to the coastline. It covers Sydney CBD and includes Lord Howe Island and Norfolk Island. Our catchment area spans 626 km2. We are the second largest of the 31 primary health networks across Australia by population, with over 1.6 million individuals residing in our region. By 2031 our region's population will reach more than 1.9 million, with the most significant increase to be seen in the number of people aged over 65 years.

Our catchment population is characterised by cultural diversity. Over 13,000 Aboriginal and Torres Strait Islander people live in our region and 40% of our residents were born overseas. 42% speak a language other than English at home and six percent do not speak English well or at all.

The boundaries of Central and Eastern Sydney PHN align with those of South Eastern and Sydney Local Health Districts, with whom we work closely. Other important partners across our region include St Vincent's Health Network, Sydney Children's Hospitals Network, Justice Health, local GPs, allied health professionals, nurses, secondary care providers and other organisations across the health and human services sector.

Our vision, purpose, values and priorities are detailed in our 2019-2021 Strategic Plan.

Our vision

Our vision is **better health and wellbeing** of the people who live and work across our region.

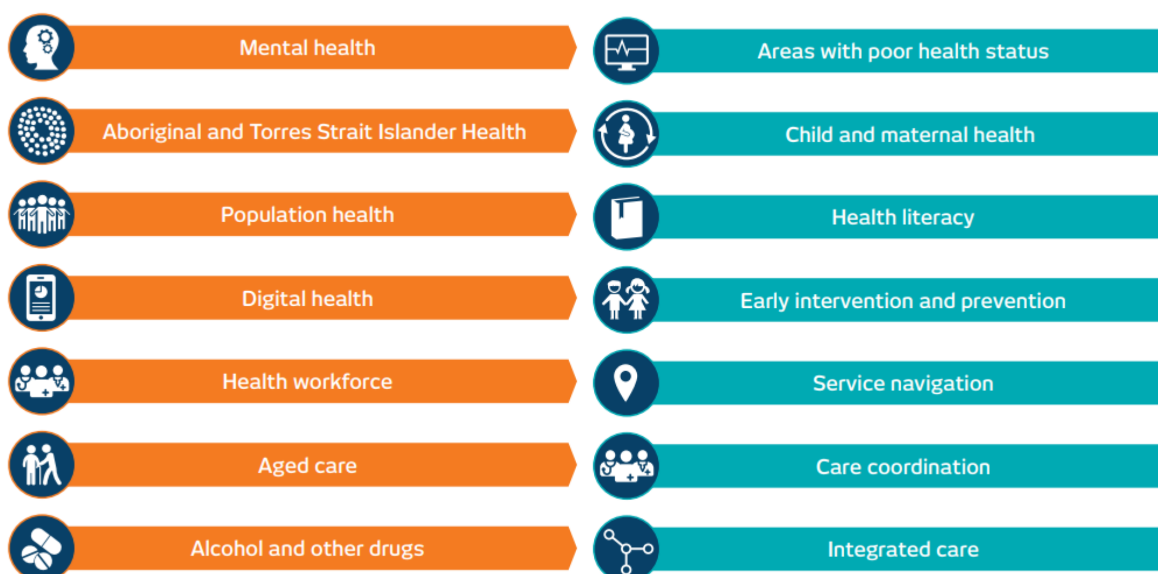
Purpose

The core purpose of Central and Eastern Sydney PHN is to improve and transform care by:

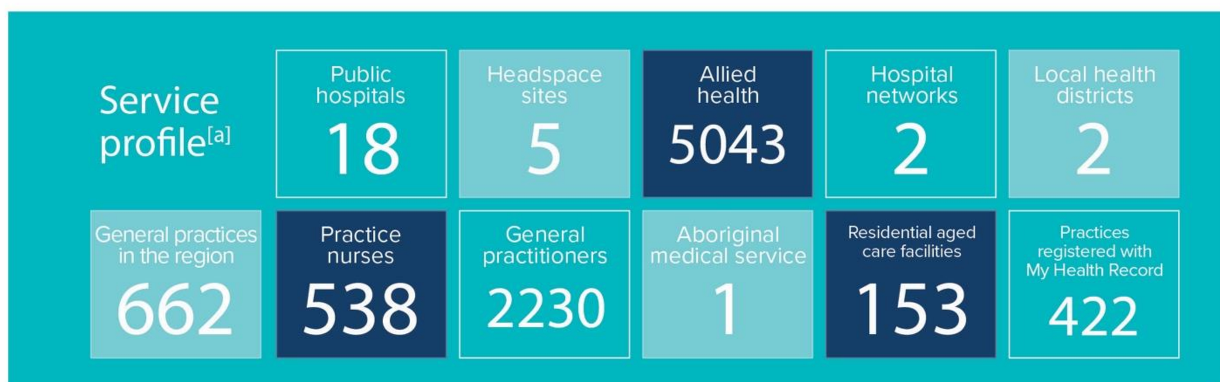
- improving the experience of consumers and carers through better integration, coordination and by encouraging a person-led approach
- improving the provider experience with consideration of clinician and staff satisfaction, flexibility and scope for innovation, and building a strong quality improvement culture
- improving value for money with consideration of cost-efficiency and sustainability.

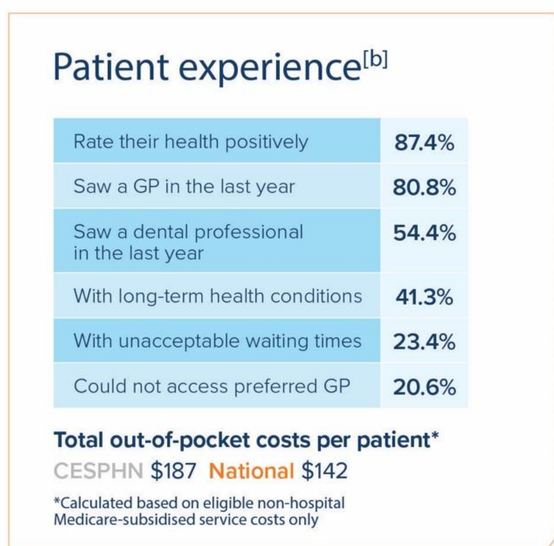
Priorities

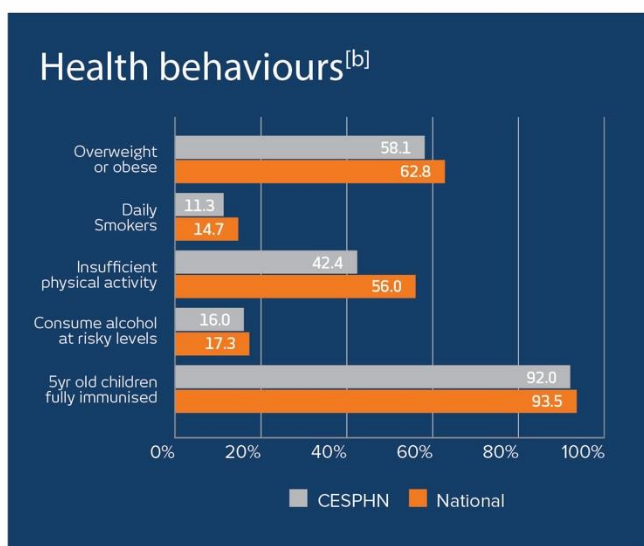
The Commonwealth Department of Health has set seven priorities for PHNs operating across Australia, shown on the left below. Central and Eastern Sydney PHN has identified additional local priorities through needs assessment and consultation, shown on the right below.

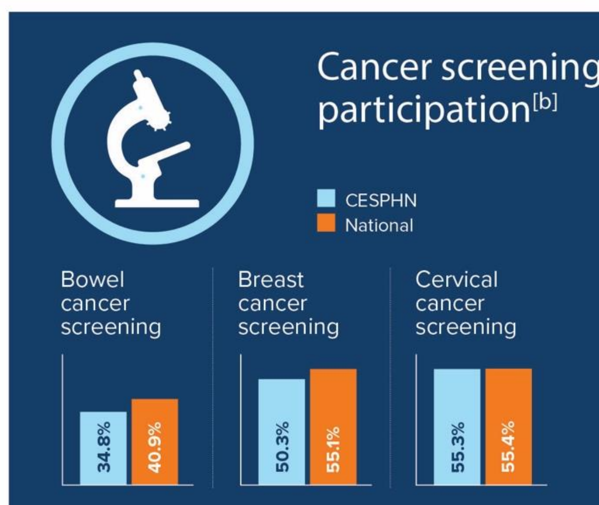


A snapshot of our region









[a] My Hospitals n.d., Australian Institute of Health and Welfare, accessed 3 October 2018 <https://www.myhospitals.gov.au/browse-hospitals/nsw/sydney/sydney>. Needs Assessment 2017, Central and Eastern Sydney PHN

[b] My Healthy Communities n.d., Australian Institute of Health and Welfare, accessed 2 October 2018, <https://www.myhealthycommunities.gov.au/primary-health-network/phn101>.

[c] Social Health Australia of Australia: Primary Health Networks n.d., Public Health Information Development Unit, Torrens University Australia, accessed 2 October 2018, <http://www.phidu.torrens.edu.au/current/data/sha-aust/phn_pha_parts/phidu_data_phn_pha_parts_aust.xlsx>.

[d] ABS 2016 Census of population and Housing; Estimating homelessness 2016 Table 5.1 Homeless Operational Groups and other Marginal Housing by place of enumeration, Statistical Level 3.

Life expectancy[f]

Life expectancy of residents in CESPHN region is

83.8 YEARS

compared to the national average of 82.4 years

Population Projection[e]

	2033	% INCREASE
TOTAL	1,951,132	24%
0-14	315,372	31%
15-64	1,305,432	16%
65+	330,328	58%

Non-resident population[i]

APPROXIMATELY

500,000 people come to CESPHN each day to work, visit or study

Received **50% of NSW HIV** notifications 2017[j]

Same-sex couples

CESPHN has the highest number of same sex couples in NSW[k]

Total resident population[e]

1,497,186

Norfolk Island: 1,748

Lord Howe Island: 382

Aboriginal and/or Torres Strait Islander[e]

Total number of residents in CESPHN who are of Aboriginal and/ or Torres Strait Islander descent:

13,479

equaling 0.84 % of the total population of CESPHN -% of total Australian population = 2.8%

Highest proportion of Aboriginal and/or Torres Strait Islander people reside in Sydney Inner City and Eastern Suburbs- South areas

No. of standard GP consultations in 2016-2017[h]

7,568,288

Language[g]

1. Mandarin
2. Cantonese
3. Arabic
4. Greek
5. Italian

40% of our residents were born overseas

42% speak a language other than English at home

6% do not speak English well or at all

[e] BS Census of Population and Housing 2016 Aboriginal & Torres Strait Island Population
[f] AIHW Nov 2017 Life expectancy and potentially avoidable deaths in 2013–2015
[g] ABS Census of Population and Housing 2016 Language spoken at home by LGA 2016
[h] Medicare Benefits Schedule Data. MBS data by PHN - MBS Item and Reporting Group 2012-13 to 2016-17 <http://www.health.gov.au/internet/main/publishing.nsf/Content/A1F08249E056C796CA257FD400281DBF/$File/MBS%20Items%20and%20Groups%20by%20PHN%201213-1617%2007NOV17%20A.xlsx>
[i] Journey to Work in Australia 2018, Australian Bureau of Statistics, accessed 2 October 2018, <http://www.abs.gov.au/ausstats/abs@.nsf/Lookup/by%20Subject/2071.0.55.001~2016~Main%20Features~Feature%20Article:%20Journey%20to%20Work%20in%20Australia~40>.
[j] NSW Ministry of Health. NSW HIV Strategy 2016 - 2020: Quarter 4 2018 Data Report. Available from: <https://www.health.nsw.gov.au/endinghiv/Publications/q4-2017-and-annual-hiv-data-report.pdf>
[k] ABS Census of Population and Housing 2016 Same-sex couples in Australia, 2016, accessed 6 December 2018, <http://www.abs.gov.au/ausstats/abs@.nsf/Lookup/by%20Subject/2071.0~2016~Main%20Features~Same-Sex%20Couples~85>

What is commissioning?

Commissioning is a strategic, evidence-based approach to planning and purchasing services, based on local priorities and needs. PHNs target and prioritise services to meet the identified needs of their local communities.

Unlike traditional procurement, commissioning goes beyond simply purchasing services. For PHNs, commissioning also means:

- understanding the needs of their local population
- prioritising and planning services to meet those needs
- working closely with stakeholders, service providers and communities to ensure that what is needed can be delivered
- purchasing or procuring new services to address gaps
- monitoring and evaluating the effectiveness of those services, to learn and improve.[1]

As a continuous cycle, commissioning enables responsiveness and innovation in frontline services. It allows resources to be invested in activities that will have the greatest impact, and in ways that better integrate and coordinate care between different parts of the health system.

The relationship that develops between the commissioner and service providers also means that problems can be discussed and resolved in real time, and the service model adjusted, if required.

The success of commissioning in the healthcare sector has been recognised, particularly in the UK.[2]

This approach to commissioning services results in:

- a better understanding of the needs of local populations
- a greater focus on health outcomes that matter to people
- consumers being the centre of care, with services organised around their needs
- better relationships between stakeholders, providers and patients
- better value for money through open and transparent procurement processes.

Increasingly, commissioners are also moving towards incentivising providers to deliver outcomes, rather than purchasing specified services. As the capabilities of PHNs continue to grow, and their flexibility increases in line with long-term sector reforms[3], their focus is expected to shift towards commissioning for and incentivising providers to deliver on outcomes.

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[1] Australian Government Department of Health 2019. *A commissioning overview in the PHN context.* Available at: https://www1.health.gov.au/internet/main/publishing.nsf/Content/E7C2647FBB966A98CA2582E4007FE11F/$File/Provider%20Info%20Sheet%20-%20Commissioning%20overview%20v1.1.pdf

[2] The King's Fund, University of Melbourne and PricewaterhouseCoopers (PwC) 2016. *Challenges and lessons for good practice – Review of the history and development of health service commissioning*. Available at: https://www.health.gov.au/internet/main/publishing.nsf/Content/PHNCommissioningResources; Smith J, Curry N, Mays N, Dixon J. Where next for commissioning in the England NHS? The Nuffield Trust and the King's Fund 2010

[3] Council of Australian Governments (COAG) 2018. *Heads of Agreement between the Commonwealth and the States and Territories on public hospital funding and health reform*.

Our approach to commissioning

Our commissioning principles

The following principles have been developed to guide our approach to commissioning.

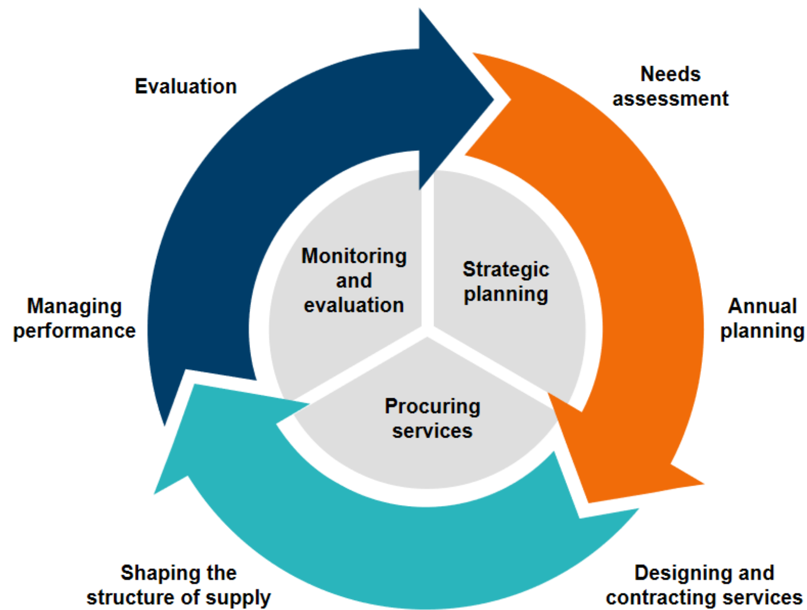
1. We will seek to understand the diverse needs of the communities across our region, including Aboriginal and Torres Strait Islander peoples, people from culturally and linguistically diverse backgrounds, from low socioeconomic communities and populations, and people from vulnerable or marginalised groups
2. We will commission services that address identified needs and deliver individual and population health outcomes
3. We will collaborate with our partners to commission integrated services in a way that provides a seamless experience for consumers and reduces duplication
4. We will co-design services where appropriate, involving the right people at the right time in a purposeful way
5. We will value everyone's perspective equally in co-designing services, whether they are someone with lived experience, a service provider, a commissioning partner or a clinical expert
6. We will shape the market by investing in providers and supporting them to build capacity, develop and collaborate
7. We will manage procurement in a way that promotes probity, maintains fairness and manages conflicts of interest
8. We are committed to learning as an organisation and will monitor and evaluate our activities in partnership with providers and in a way that informs our continuous improvement.

Commissioning cycle

Central and Eastern Sydney PHN has adopted the model of the 'commissioning cycle' as recommended by the Australian Government.[4]

The first stage of the cycle, **strategic planning**, includes assessing the needs of the population, and planning for initiatives to meet those needs. The second stage, **procuring services**, includes those steps traditionally thought of as 'procurement,' including contracting services but also working with the market to shape the structure of supply. The final stage, **monitoring and evaluation**, includes contract and performance management, as well as evaluation to inform continuous improvement.

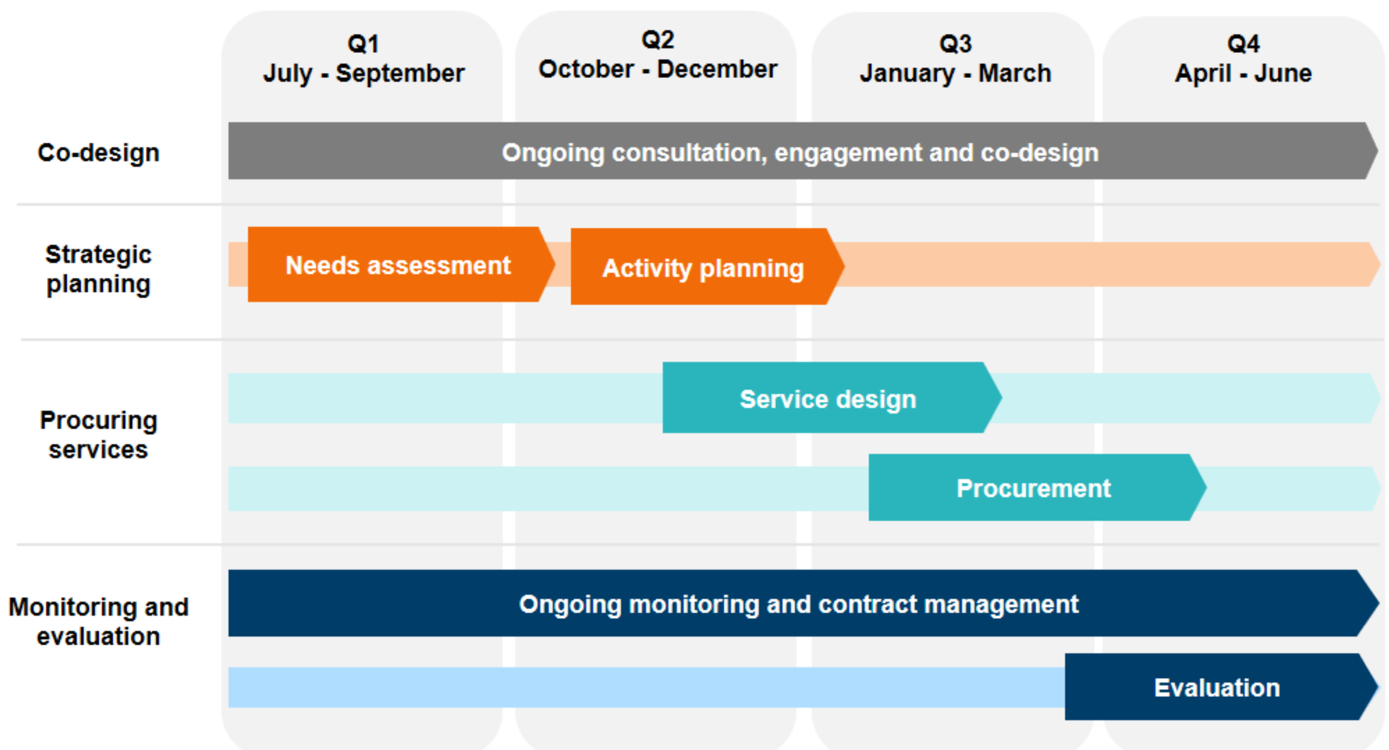
[4] Australian Government Department of Health. *PHN Commissioning Resources*. Available at: https://www1.health.gov.au/internet/main/publishing.nsf/Content/PHNCommissioningResources



While this model provides a useful way of communicating our approach, in practice it is often more complex with multiple activities happening at the same time. This is important as it allows us to be flexible in our responses to emerging needs and changing priorities.

Importantly, the commissioning cycle is iterative, rather than linear. This allows us to continuously improve what we do and means that we are always planning with the 'end in mind' – such as thinking about how we will monitor and evaluate an initiative while in the planning stages.

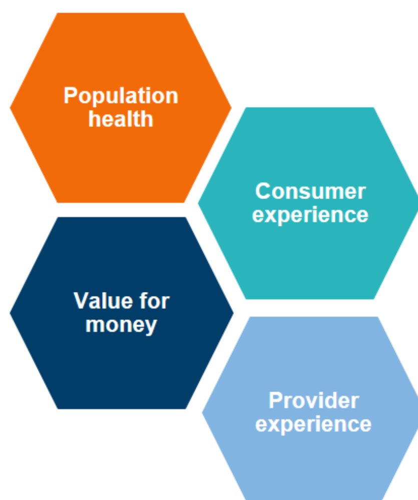
The diagram below shows the general timing of our commissioning activities throughout the year. While this is more complex in reality, annual funding and reporting requirements mean that we will have a greater focus on particular commissioning stages at certain times.



Towards outcomes-based commissioning

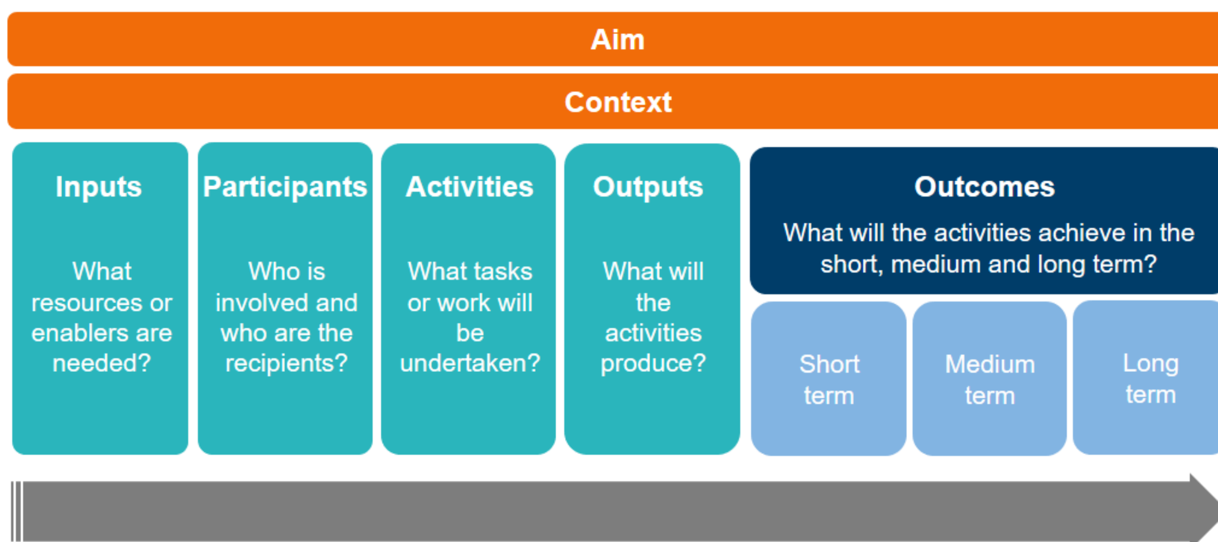
Central to our approach to commissioning services is an increasing focus on the outcomes that matter to the people using them. This means that when we are planning activities, and designing and procuring services, the outcomes that we are striving to achieve will always be front of mind.

As we develop target outcomes for commissioned programs, we will consider the four elements of the Quadruple Aim.[5] The Quadruple Aim provides an important reminder to consider the outcomes that will matter to the range of actors involved in the health system.



Program logic

Program logics provide a clear line of sight between inputs, activities, outputs and desired outcomes to help us understand what we want to achieve and how we think we will achieve it. It also helps in the selection of indicators to monitor progress and evaluate the success or otherwise of the program. It provides a core enabler to coproduction with communities and providers in building services that meet population needs, by encouraging consideration of a program in full – from inputs to outcomes.



[5] Berwick DM, Nolan TW, Whittington J. (Insitute for Healthcare Improvement) 2008. The Triple Aim: care, health, and cost. *Health Affairs* 27:3, 759-769; Bodenheimer T, Sinsky C 2014. From Triple to Quadruple Aim: Care of the Patient Requires Care of the Provider. *Annals of Family Medicine* 12:6, 573-576.

Each program we design is underpinned by a program logic, which identifies the short-term, medium-term and long-term outcomes the program aims to achieve, including how it contributes to Central and Eastern Sydney PHN’s overarching program logic.

Program logic is a key tool in setting the evaluation criteria and methodology from the outset of a project.

Governance and leadership

Our governance structures provide oversight and direction to guide our commissioning approach and activities. Our Board of Directors has a role in determining the overall purpose of CESPHN's commissioning strategy. The Board is the key decision-making body and approves strategic and annual commissioning plans, provides direction to the CEO and senior management on the approach to commissioning and approves funding allocations.

Our Board of Directors is supported by finance, audit and risk, governance and nominations committees and receives strategic advice from our two councils.

The Community Council provides advice to the Board on the delivery of person-led care that is relevant and aligned to the experiences and expectations of consumers, carers and communities. The Clinical Council advises the Board on issues such as the quality, efficiency and effectiveness of care, population health planning, service commissioning and services to support local and national priorities. Our advisory groups provide input and advice regarding specific issues.

Our seven member networks include five general practice companies, one allied health network and a community network. They use their combined expertise to advocate for and support general practice, allied health and the community to improve health outcomes in our region.

Our senior management and staff are responsible for implementing all stages of the commissioning cycle. Our workforce is supported operationally by corporate systems, policies and processes, including procurement and contract management, human resources, finances, information technology and management, marketing and communications.

Procurement activities are governed by aa coherent suite of policies, procedures and templates which ensure risk management, probity, value for money and clinical governance paramount through consistent processes which are clearly documented and are applied at all stages of procurement and contract management.

Co-design and consultation

Co-design is a process of engaging with those who will be affected by a decision about health services such as consumers, the community and service providers. Co-design seeks to meaningfully involve them in the decision-making process. It's a way of working that focuses on listening and understanding the experience and skills of those who use, provide or are potential service users, to inform and shape health service improvement.

Co-design recognises that consumers and communities know what works best for them.

We recognise the importance of co-design in encouraging innovative solutions that are tailored to local circumstances and that address identified community priorities. Importantly, our approach to co-design values the perspectives of all participants equally – whether they are service providers, service users, clinical experts, or people with lived experience.

The Australian Healthcare and Hospitals Association (AHHA) has developed a co-design toolkit[6] which puts forward the following principles for co-design. Our co-design activities are designed with these values in mind.

There are opportunities to undertake co-design and involve stakeholders at every stage of the commissioning cycle. This is particularly important as we move towards more contemporary and innovative models across the care continuum, and as integration and coordination between our partners and providers continues to grow.

It is important to involve the right people at the right time in a meaningful way. This means that we don't take a 'one size fits all approach,' but that we tailor the approach to the stakeholders and the purpose of the engagement. This also means being clear and realistic about what stakeholders will and won't be able to influence.

In some instances, it won't be necessary or appropriate to undertake co-design – for example, when we are procuring a service with highly specified requirements and there is limited opportunity for stakeholders to influence the service design. It is also critical to maintain our probity protocols and to manage conflicts of interest when undertaking co-design, particularly with current and potential providers.

[6] AHHA 2017, *Experience Based Co-Design Toolkit*, adapted from UK Social Care Institute for Excellence. Available at: https://ahha.asn.au/experience-based-co-design-toolkit

Working with the market

More than just a new approach to procurement, commissioning represents a transformative shift for the healthcare sector, and for the service providers who make up our market. This means we need to work with the market to manage change, encourage innovation and ensure providers have or are able to develop the capacity and capability to meet the needs of the population.

This also means welcoming ideas and innovation from the market. At times, this may take the form of unsolicited proposals that will be considered within the confines of probity and tendering protocols.

As we continue to develop our commissioning capabilities and the sector continues to mature, our appetite for risk in working with the market will grow - while continuing to ensure that clinical governance is properly maintained. While we have a low risk appetite where the potential impacts are to service delivery and clinical governance, we have a greater risk appetite to trial innovative projects where the risk is not at the consumer end.

Key activities in working with our market include market analysis and sounding, market making and shaping, and co-commissioning.

Market analysis and sounding

As part of working in partnership with the market, it is critical that we understand and consult with current and prospective providers to inform our decision making in relation to commissioning. As well as involving providers in co-design, market analysis and sounding activities will usually be undertaken as part of service design and procurement.

Market analysis and sounding is key to understanding:

- the capabilities and capacity of providers to meet the needs of the population, including any gaps that need to be filled
- the appetite and capacity of providers to adjust to new models of care and commissioning approaches
- the likely impacts of change on the market, including the ongoing sustainability of providers
- the most appropriate procurement approach.

As well as directly consulting current and prospective providers in the market, activities might involve analysing provider data, mapping provider funding sources, reviewing past provider performance and reviewing markets in comparable sectors or regions for comparison.

Market making and market shaping

While there are many service providers in the central and eastern Sydney region, there are still areas where the collection of providers that we have available are not appropriate. This can be due to a lack of coverage in particular areas or because they don’t offer the range of services that we require. Equally, smaller service providers may need support to build their capacity to operate successfully in a growing and maturing market.

Where this occurs, market making and shaping activities are required to help ensure our market can be responsive to the changing needs of the population. Where necessary and appropriate, while designing services we will undertake market shaping activities to drive these outcomes.

This may involve:

- supporting providers to come together, develop collaborative models and share good practice
- encouraging and facilitating consortiums and joint ventures
- supporting providers to develop their capacity to deliver contemporary models of care, such as digital health models or models that are integrated in innovative ways
- encouraging providers to expand their services into new regions or areas
- driving capability uplift among smaller providers to develop the core tendering capabilities needed to compete in a maturing market

- communicating regularly and explaining how to work with us and what to expect.

Co-commissioning

Commissioning also allows us to work more closely with partners in the healthcare market, including to co-commission services. There is no one approach to co-commissioning, and it will vary depending on the particular program, service and partnership. Co-commissioning can mean working together at various stages of the commissioning cycle, whether to jointly identify needs, design solutions or procure services.

The strength of co-commissioning is that it provides a way of:

- pooling funds to expand our reach and impact
- reducing duplication to increase the efficiency of services
- increasing the coordination and integration of services to provide a seamless healthcare experience for consumers
- trialling innovative models that require collaboration.

We are always exploring opportunities to co-commission, whether as the lead commissioner, in partnership or as a contributor.

Stage 1: Strategic planning

Needs assessment

The purpose of needs assessment is to identify population health needs and service gaps. The findings are intended to inform appropriate responses that support and strengthen our primary health system.

Needs assessment is an ongoing and iterative process. Our first baseline needs assessment was submitted to the Department of Health in 2016, and was undertaken in partnership with South Eastern Sydney Local Health District, St Vincent's Hospital Network and Sydney Children's Hospital Network. This needs assessment identified the baseline health and health services needs of the central and eastern Sydney community.

Since then, it has been updated annually. This process has involved re-examining the health needs and service gaps of the region, updating data, integrated new input from stakeholders and communities, and analysing outcomes from activities undertaken in the previous 12 months. Additional needs assessments have been undertaken to identify needs and gaps relating to local health issues, such as a targeted mental health and suicide prevention needs assessment, and drug and alcohol needs assessment.

We take a mixed method approach to needs assessment, drawing on:

- quantitative data from internal, administrative and census-based sources
- qualitative data from purposeful and incidental engagement activities, including consultation with advisory groups and member networks, and surveys of stakeholders.

We are always working to improve our approach to needs assessment and data collection. The sheer number of services and providers across the region makes mapping services to population and priority areas a significant and ongoing task. Some of the ways we are working to increase the level of sophistication of our needs assessment include:

- capturing and monitoring data in an ongoing way, to capture emerging issues and changing needs in real time
- undertaking 'deep dive' assessments into targeted areas
- improving our methods for capturing and analysing qualitative data to provide context and analytical rigour
- drawing on data derived from the outcomes and outputs of services we have initiated and commissioned, and data derived from general practices
- collaborating with our partners to build health intelligence
- advocating for and participating in the conduct of research to fill evidence gaps.

Activity planning

Once needs have been identified, we work to identify and prioritise options for commissioned programs. Decision making around priorities and potential programs will consider a range of factors, including:

- the needs of the population, and the potential of the program to increase the efficiency and effectiveness of health services
- the potential of the program to improve service integration and coordination
- the potential of the program to improve equity of access
- the availability of funding, and the potential of the program to provide value for money
- the commissioning landscape and broader sector reforms
- our strategic objectives
- requirements under the PHN Performance and Quality Framework.

Stage 2: Procuring services

The second phase of the commissioning cycle involves designing and contracting services, traditionally thought of as procurement. Our intention is to contract in a way that supports our collaborative ambitions and manages risk to both Central and Eastern Sydney PHN and our providers.

Activities in this stage will usually include:

- working with stakeholders to co-design services to address identified and prioritised needs
- assessing the capacity and capability of the market to deliver services through market analysis and soundings
- determining the most appropriate procurement model
- where appropriate, working with partners to co-commission services.

Our approach to procurement is detailed in our Procurement and Contracting Policy, which includes principles and operating procedures for all staff in the selection of goods and providers of services and in the creation, review and execution of agreements.

Our procurement processes are also underpinned by a robust Procurement Plan, which guides managers through the procurement process from tender to contract. The Plan details all required steps, milestones and approvals, and requires managers to identify and rate potential risks and develop mitigation strategies.

While an open tender is always our preferred procurement approach, in some instances it may be appropriate to take a more limited or direct procurement approach. This may be because a more direct approach will deliver the best outcomes for consumer need, or to meet an urgent and unforeseen need.

We appreciate the importance of maintaining and adhering to proper probity practices throughout the procurement process. We have developed a suite of policies and guidance for all staff responsible for managing procurement processes. Relevant policies include:

- Probity Principles Policy
- Conflict of Interest Policy
- Tender Clarification and Negotiation Guidelines
- Delegations Policy
- Privacy Policy.

Stage 3: Monitoring and evaluation

Monitoring and contract management

Performance monitoring and contract management allows us to track the delivery of services, and to measure progress towards the delivery of outcomes. Rather than monitoring and managing contracts from a distance, we are committed to working in close partnership with our providers. This will help ensure that we are able to learn and continuously improve how we work together, and that we can respond to emerging issues and changing needs in real time.

Performance monitoring and contract management will consider a range of factors depending on the program or service, but will include consideration of:

- whether key performance indicators are being met
- whether a high standard of clinical governance is being maintained
- whether the program or service is well integrated, coordinated and easy to navigate
- whether there are any challenges and how they can be addressed
- whether providers require any support or capacity building
- how monitoring will contribute to learning and continuous quality improvement for providers and the PHN.

Our monitoring and contract management approach keeps the outcomes we are aiming to achieve front and centre. This means enabling ongoing refinement of the service model in response to learnings, unexpected issues and emerging opportunities, to drive progress towards outcomes.

There are numerous core contract management requirements that must always be followed, including:

- having a detailed contract management plan in place, which has been agreed with providers as part of the procurement process
- having clearly defined escalation pathways and prescribed behaviours in place.

The specific contract management approach and plan will be developed according to the intensity of management required with consideration of the value, risk and complexity of each contract.

Evaluation

Evaluation is the systematic collection and analysis of information to make judgements, usually about the effectiveness, efficiency and appropriateness of a program. We are committed to evaluating our commissioning activities and approaches in collaboration with providers, so that the findings can help us improve how we work together.

In doing so, we are not necessarily evaluating provider performance – instead, we are evaluating our approach, the effectiveness of the model of care and the achievement of outcomes.

Our approach to evaluation is documented in our Evaluation Framework, which has been designed to ensure that evaluations are high quality, ethical and focused on improving outcomes for our population. The Framework also provides guidance on the scale and type of evaluation that should be undertaken, depending on the nature of the program being evaluated.

The scale of the evaluation will depend on the size, value, risk and complexity of the program. This will also influence whether the evaluation is undertaken internally by the PHN, or by an independent evaluator.

The type of evaluation will depend on the questions that need to be answered, and the stage of program development and implementation. It may use one or more of the types listed in the table below.

Type	Program logic	Key questions
Process	Inputs, activities and outputs	▪ Have activities been implemented as planned?

		▪ What aspects of the program are working well and what aspects could be improved?
Outcome	Outcomes	▪ Is the program meeting its stated objectives? ▪ What difference did the program make in the short, medium and long term?
Economic	Inputs and outcomes	▪ Does the program provide value for money? ▪ Did the benefits justify the costs?

Completion and transition

As per the iterative cycle of commissioning, decisions about the completion and transition of contracts will be informed by what we have learned through monitoring, evaluation and our continuing assessments of needs. It is critical to consider the changing needs of the target population, equity of access to services, and the changing service landscape.

This step will always involve consulting closely with partners and providers and building consensus on any changes, while maintaining our duty of care to ensure the needs of service users continue to be met.

Implementation strategies

Looking forward, as we continue to develop and continuously improve our commissioning capabilities some of our key areas of focus include:

- Continuing to build our capabilities in commissioning for outcomes, with a view to moving beyond procuring services and towards paying for outcomes
- Continuing to involve stakeholders in everything we do, through meaningful co-design and consultation at all stage of the commissioning cycle
- Providing learning and development opportunities for all staff in our organisation to support the continuous improvement of our knowledge and capabilities and to ensure that we embed in our culture and behaviours the strategic direction set out in this framework
- Collaborating across the PHN network at a state and national level, to share learnings and practice, to support capability uplift and consistent approaches across the country
- Continuing to work closely with our partners, to explore opportunities for co-commissioning and to improve service integration and coordination, providing a seamless and easy-to-navigate healthcare experience for consumers