Delivering quality care more efficiently inquiry

Questionnaire response 70

Name: The Health Alliance, a joint initiative of Metro North Health and Brisbane North PHN

Submission date: 6/06/2025

Participant background

1. For the purposes of this consultation, which of the following best describes you:

   I am an organisation that provides or coordinates care services

2. Which of the following care sectors will your feedback relate to? Please select all that apply.

   Health

3. What kind of care supports, services and programs do you have experience with, and in what jurisdictions?

   The participant did not respond to this question.

1. Reform of quality and safety regulation to support a more cohesive care economy

1. To what extent do differences in quality and safety regulation make it costly or complex to provide or access care services?

   The participant did not respond to this question.

2. What are the reasons for your answer?

   The participant did not respond to this question.

3. To what extent should quality and safety regulations be more aligned across the different care service sectors and jurisdictions?

   The participant did not respond to this question.

4. What are the reasons for your answer?

   The participant did not respond to this question.

2. Embed collaborative commissioning to increase the integration of care services

1. What is your experience with collaborative commissioning

   Through the Health Alliance, Metro North Health and Brisbane North PHN have developed a co-commissioning spectrum. This recognises that different commissioning activities require different commissioning approaches.

   Compete - Funders do their own thing, irrespective of others.
   Communication - Funders inform each other of what they are doing.
   Consult - Funders seeks the input of other funders in their planning.
   Coordinate - Funders adapt and align their plans with each other.
   Collaborate - Funders work together on shard goals, processes & decision making.
   Combine - Funders pool funds into a single funding process.

(We have a graphic that depicts the above on a spectrum).

Much of our co-commissioning is at least 'coordinated', where we:
• share information on who we fund, the level of funding and type and quantity of service provision
• use information shared to inform own procurement plan and decisions, including adapting current/planned activity considering the activity of others
• align (where possible) procurement timelines, processes, taxonomies, assessment criteria, KPIs and contract lengths

When we commission collaboratively we also:
• agree that when new funds are made available for the region, we will discuss and agree on the best use of the funds
• ensure that our funding and procurement activities complement the activities of others.
• jointly plan upcoming procurement activities, including contributing to procurement documents, processes and assessment criteria.
• participate in each other's procurement assessment processes, where relevant.

When we combine our commissioning we also:
• explore and respond to opportunities to make combined funding proposals to government.
• explore options to combine funding into one procurement process, for relevant activities where appropriate.
• agree that one member may lead a procurement activity on behalf of others.
• enter into formal, legal agreements in relation to any lead procurement activities (i.e., to facilitate the transfer of funds between members).
• share single reporting processes (by funded providers) to reduce reporting burden.

5 x Case Studies provided separately.

2. What are the benefits of pursuing greater collaborative commissioning?

Whole of system, whole of person view – Working together to assess the needs of the local community allows us to better understand the needs of people and their lives in totality, rather than individual body parts or conditions. It also allows us to see how the whole health system functions and what impact a change in one part of the system would have on another part. This holistic, systems view leads to better planning and commissioning decisions.

Efficient use of available public resources – By planning together we can make the most out of the limited public funds available by ensuring the funds are spent where they are most needed. Shared data analysis and planning functions reduce duplication and costs and increase the depth and breadth of joint working.

Focus on the 'missing middle' – By PHNs and HHSs working together we are able to jointly address the needs of people with chronic and complex conditions who often fall between the primary and acute care systems. This approach intervenes earlier to support people, allows for care to be delivered closer to home and reduces demand on hospital services. This is good for the patient and the health system.

Integrated service planning & delivery – Working together to plan and commission services allows us to design a health system that is integrated and seamless for the patient. We are better to ensure the right services are available at the right time and in the right place. We can ensure that all parts of the health system are aware of and can interact with each other.

Less burden on funded providers – A more consistent approach to planning and especially procurement and contract management leads to less burden for funded providers. Combining planning processes means less time spent in separate planning processes. Combined procurement activities leads to less time writing applications. Shared monitoring and reporting approaches and systems leads to less compliance costs for providers.

3. What are the barriers to collaborative commissioning, and do you have any suggestions for solutions that would lead to better collaboration in the commissioning of care services?

Less tied funding – Much of the funding that comes to HHSs and PHNs is tied to specific activities, services and programs as determined by state and federal governments. There is little 'flexible funds' which would allow us to respond to the needs of the local community, as determined by the Joint Regional Needs Assessment. Attempts to 'move care closer to home' are hampered by the way most hospital activity is funded (NWAU) and the restrictions this has on how and where services can be delivered and by whom. Under the next National Health Reform Agreement, a significant pool of flexible funds should be made available to HHSs and PHNs to jointly commission services and activities to meet local needs (especially for complex care in the community – see below).

Longer funding agreements – Most of the services and activities developed by the Health Alliance have relied on short-term funding and pilots. This causes significant disruption as needed services come and go and are difficult for clinicians and GPs to keep track of. Stakeholders can also be reluctant to invest time in developing and implementing new service models, which only last a few years. The uncertainty over continued funding (often right up to the end of the financial year) means staff and providers start to close down and exit services, leading to disruption of service continuity and loss of expertise. Funding certainty of at least 5 years should be provided to allow for commissioning on a medium to long term basis.

Recurrent funding source for complex care in the community – Funding for primary health services is secure through the MBS and for acute services is secure through the NWAU and other hospital funding. But for services in the community for people who have complex needs, there is no sustainable funding source. This 'missing middle' population group, who often have several co-morbidities and social complexities, are too complex for primary care (as currently funded) to respond to and not acute enough to require hospital care. There is not agreement between federal and state governments on who should pay for these services. People therefore often don't get care when and where they need it, leading to avoidable and costly presentations to emergency departments and hospital admissions. Ongoing funding of services in the community for people with chronic and complex conditions is needed.

Involvement of other funders – While the facilitation and resourcing of greater

collaborative commissioning between HHSs and PHNs would be welcomed and be an improvement on the current state, the involvement of other funders would take this even further. In order to understand the needs of local communities, map services/funding currently provided to address these needs, and make collaborative planning and commissioning decisions, other key funders need to be involved. This is especially true in aged care and disability services, where a mismatch between need and service provision can have negative consequences for general practice, hospitals and patients. A placed-based approach to regional planning and commissioning should include a wider range of funders than just HHSs and PHNs.

More data-sharing – Metro North Health and Brisbane North PHN have made great strides recently in sharing data for planning, delivery and evaluation purposes. We have a data sharing agreement in place and have been able to use linked data to follow the patient through the health system and help evaluate the effectiveness of services (e.g. Care Collective). These local arrangements take a lot of time and resources to develop and would benefit from standard agreements (which Queensland has developed) and dedicated funding (see governance below). Improved data sharing from other sources within the health system and beyond would also create a better and fuller picture of local needs, facilitate greater patient care and allow more robust monitoring and evaluation

Shared minimum data set and outcomes framework – Having agreed to jointly commission a service or activity, we then face the decision of how to monitor activity and measure outcomes. Different parts of the health system have different minimum data sets, with different data definitions and stand-alone IT platforms. Where care is funded and provided jointly under a shared care agreement or through multidisciplinary teams, funding source requirements may mandate the use of different systems. Similarly, agreeing desired outcomes and how to measure these is different across the health system. A single minimum data set and outcomes framework for the health system is required (and which can interface with other systems e.g. disability and aged care).

Resource local governance arrangements – Coming together as two (or more organisations) and building trust and ways of working takes time. Developing and delivering joint commissioning activities also takes time and effort. While the Health Alliance has been in existence since 2017, the funding for it has to be negotiated each year and often found outside regular, secure funding. This funding has also varied in amounts each year, dependant on what can be found (rather than what is needed). Collaborative commissioning capacity needs to be appropriately resourced across the commissioning cycle (needs assessment, planning, delivery (inc. procurement), evaluation).

3. A national framework to support government investment in prevention

1. What are the main barriers to governments investing in evidence-based prevention programs across the care economy?

The participant did not respond to this question.

2. What are some examples of successful prevention programs (this could include discontinued programs)?

The participant did not respond to this question.

3. How can governments better support investment in prevention activities that have broad and long-term benefits for the Australian community?

   The participant did not respond to this question.

Cover sheet: Supporting document #1

The Health Alliance

Supporting documents

Delivering quality care more efficiently

Consultation questions | May 2025

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Question 5: What is your experience with collaborative commissioning?

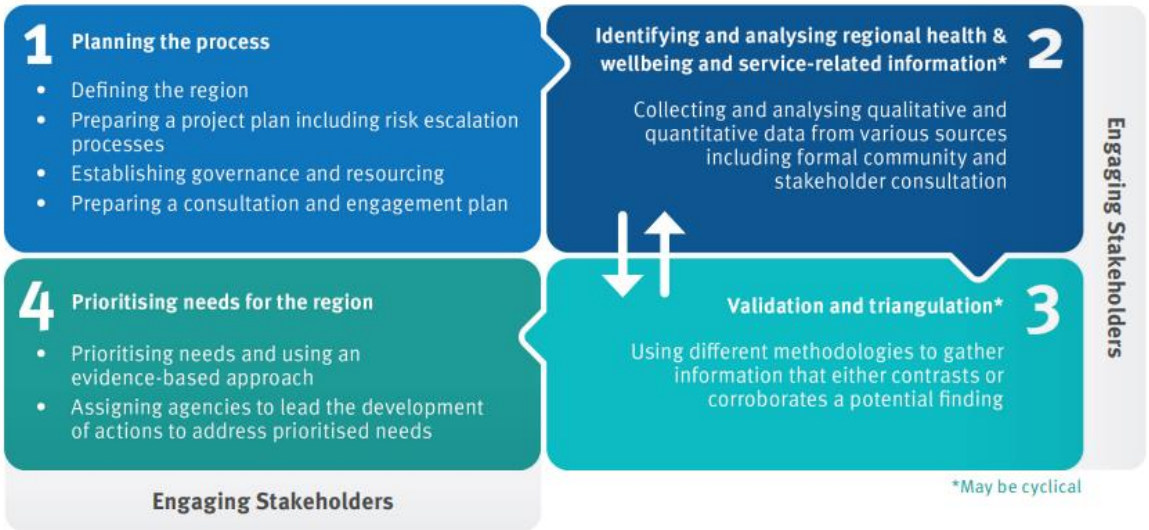
Case Study 1: Joint Regional Needs Assessment

The Joint Regional Needs Assessment is a detailed assessment of health needs, based on an analysis of local level data, and community, clinician and service partner consultation. The region's community health and service needs are met by primary, private, and Non Government Organisation (NGO) providers to name a few. The Brisbane North PHN in partnership with Metro North Health and collectively in close consultation with other partners undertook this needs assessment in 2024 (completed periodically every 3 years).

The scope of the JRNA included:

- The geographical area serviced by both Metro North Health and Brisbane North PHN.
- Adults and children residing in the region, and accessing care across primary care, community, and hospital and health services.
- All public and private health services delivered in the region across the care continuum, including primary care, acute, sub-acute, non-acute, ambulatory and palliative care, mental health, oral health, and aged care.
- Services delivered by Children's Health Queensland (CHQ) within the region.

The JRNA was developed over a period of 10 months and required access to expertise in health service planning, community engagement and consultation, health data analysis and reporting, design and administrative support. The process of development is summarised by the four steps below in line with the Queensland JRNA Framework.



Case Study 2: Care Collective

The Care Collective, a proof-of-concept project led by the Health Alliance, aims to reduce demand on Emergency Departments by identifying a targeted cohort of chronic and complex patients and implementing a case management approach. The project builds on and enhances existing pathways and programs for chronic obstructive pulmonary disease (COPD), congestive heart failure (CHF), and conditions that lead to presentations for debility (e.g. dementia, falls). The Care Collective has been underpinned by authentic collaboration between a range of stakeholders across Metro North Health, Brisbane North PHN and local primary health care providers.

The initiative places a Complex Care Coordinator in 18 General Practices across Caboolture and Redcliffe and one Aboriginal Medical Service to enhance practice capacity and improve patient quality of life, health literacy, health outcomes and reduce emergency department presentations and hospital admissions.

The interim evaluation showed:

- 63% reduction in Emergency Department presentations for Care Collective clients.
- $429,000 saving back into the health system per month
- 450 per cent return on investment
- the program is delivering a diverse range of impactful health and social outcomes for clients and their families, given the flexibility and ‘gap filling’ nature of the program.

The original pilot funding for the Care Collective ends June 2025, with funding found by Metro North Health and the Commonwealth government for an additional year as a smaller scale. No recurring funding has been found to date.

Case Study 3: Specialist Pain Assistance Network (SPAN)

Through joint regional planning, the Health Alliance identified access to affordable community-based pain services as a high priority issue in the region.

The Health Alliance engaged with clinicians and consumers across tertiary, primary and community settings to co-design a model of care to reduce wait times for patients to access specialist outpatient services.

At the completion of this design, the Health Alliance then secured funding through the Queensland Government to establish the Specialist Pain Assistance Network (SPAN). Patients are referred to the Tess Cramond Pain and Research Centre (Metro North Health) for assessment and those with lower acuity are streamed to the community service commissioned by the PHN and deliveries by allied health providers.

SPAN has quickly demonstrated impact – reducing waiting times for 350 patients from 510 days to 21 days, reducing patient travel distance by 600km/patient, increasing patient attendance at outpatients’ appointments and achieving 95% patient satisfaction.

SPAN is funded by the Queensland government through the Connected Community Pathways program via Metro North Health.

Case Study 4: Ageing Well Initiative

Between 2017 and 2020, the Health Alliance co-designed a new model of care with the health and aged care sectors and with older people, their families and carers.

Known as the Ageing Well Initiative, it sought to support older people to stay healthy, well and independent in their home and community – with a focus on outcomes that matter to patients and reduced reliance on Emergency Department and hospital beds for needs that are best serviced in the community or at home.

While closely aligned to strategic state and national health reform agendas at the time, the model relied on a complex 'cashing out' of hospital funding to a population health fund to deliver more preventative activities. This model was unable to proceed due to a lack of funding flexibility.

Case Study 5: 2025: Our Approach to Wellbeing

The upcoming regional plan, Our Approach to Wellbeing, is supported by a sophisticated governance structure designed to enable genuine co-commissioning. At the centre of this structure is the Executive Partnership Group, comprising senior executives from the region's major mental health funders including Metro North Hospital and Health Service (HHS), the Queensland Mental Health Commission, Children's Health Queensland, and Queensland Health.

Demonstrating its deep commitment to collaborative reform, Metro North HHS has co-funded a dedicated position based at Brisbane North PHN. This role is tasked with facilitating the work of the partnership, coordinating strategic efforts, and supporting implementation across all stakeholders. By investing in shared capacity, Metro North HHS has enabled a more integrated and consistent approach to driving regional priorities.

Importantly, lived experience is embedded at the heart of decision-making, with executive-level representation from people with lived and living experience incorporated into governance structures across partner organisations. This ensures that commissioning decisions are shaped by those directly impacted by the services we design and deliver.

Key joint initiatives include:

- Medicare Mental Health Centres (MMHCs): Co-commissioned by all partners, from initial codesign through to procurement and service implementation, reflecting a highly integrated approach.
- Workforce Development: Joint commissioning of training to upskill workers with dual qualifications in mental health and AOD support, addressing current and future workforce needs.
- Brisbane MIND Program Review: A collaborative review of this long-standing program to inform future service design and funding directions.
- Crisis Reform Strategy: Co-development of a regional strategy to provide alternative pathways to emergency departments for people in acute mental health distress. This work includes a comprehensive implementation plan for system-wide change.
- Lived Experience Life Cycle: An approach for engagement with lived experience representatives which will now be used across each of the organisations

First Nations Mental Health, Suicide Prevention, and AOD Strategy

In parallel with broader regional plan, Brisbane North PHN is working alongside PHN partners in Brisbane South and the Gold Coast to develop a unified strategy for First Nations mental health, suicide prevention, and alcohol and other drug services.

This work is being carried out in partnership with the Institute for Urban Indigenous Health (IUIH) and local Hospital and Health Services across the three PHN regions. A strategic working group has been established, and all participating organisations have committed to developing a single, region-wide plan to guide future investment and co-commissioning.

While still in the early stages, this initiative lays the groundwork for culturally safe, community-led services that reflect the strengths and priorities of Aboriginal and Torres Strait Islander communities. The shared commitment to "one plan" across multiple regions and systems represents a significant step forward in collaboration and cultural leadership.