Name: Murrumbidgee Primary Health Network

Submission date: 17/06/2025

Participant background

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

   I am a government department/agency

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

   Murrumbidgee PHN has been involved in the NSW Health funded Collaborative Commissioning program since 2021. Key partners involved in the initiative were MLHD, MPHN and NSW Ministry of Health.
   Between early 2021 and Oct 2022 (delays due to COVID19), the MLHD and PHN partnership was funded by NSW Health to undertake the Joint Development Phase of the program which focused on identifying the needs of the region, co-designing a pathway of care to address priority needs, engage key stakeholders, and identify the costs and benefits of the proposed solution.
   The partnership developed a comprehensive care pathway for people with two priority chronic diseases in the region: Chronic Obstructive Pulmonary Disease and Chronic

Heart Failure. The pathway, locally referred to as Living Well, Your Way, included prevention, early intervention, optimising care in the community, supporting rapid escalation of treatment, transition home from hospital, and improving access to rehabilitation.
Proposed costs and benefits were inputs into a dynamic simulation model developed by NSW Ministry of Health, and used to predict potential cost savings from hospital avoidance in the future.
In July 2022, the PHN CEO and MLHD CE presented a three year program implementation plan to the NSW Ministry of Health which was endorsed and funded through a budget supplement to the LHD. Over the three year period, funds have been transferred between the PHN and LHD to facilitate commissioning and service delivery as outlined in the pathway. Funding from NSW Health was always acknowledged to be seed funding for three years only, with aim of advocating for alternative funding pathways between commonwealth and state governments during that timeframe.
Outcomes
The goals of Living Well, Your Way were to:
1. Deliver exceptional rural healthcare, closer to home
2. Support people to stay healthier at home for longer
3. Improve the efficiency and effectiveness of healthcare
More than 30 pharmacies and 40 general practices (>50% of practices in the region) are delivering enhanced services in rural communities through this pathway. Pulmonary and heart failure rehabilitation is available in an additional 10 communities, and Murundhu has been trialled in 3 locations. To date, 28 outreach clinics have been delivered in 10 rural communities, with 232 patients. Of those, 43 have had a new diagnosis of heart failure, 49 predicted hospital avoidance, and 51 sent for further investigation and management.
Over two years, the Living Well, Your Way Winter Strategy has provided targeted support for more than 1,684 patients to prevent deterioration over winter. Patients with COPD and CHF who participated in 2024 winter strategy reported fewer presentations to hospital than in 2023.

Patient experience is measured through surveys and stories. Patients consistently report high rates of satisfaction with new models of care, and are extremely grateful for services delivered closer to home.
More than 2500 patient reported outcome measures have been collected. Surveys used include COPD Assessment Test (CAT), Kansas City Cardiomyopathy Questionnaire (KCCQ-12; heart failure), and EQ-5D-5L (quality of life). When comparing first and second survey results, all three showed improvements after participation in care along the pathway.
Local data estimates that since 2018, triage 3-5 ED presentations for people with COPD and CHF in Murrumbidgee has reduced by 18% and hospital admissions have reduced by 37%.
Formal evaluation to validate these findings and measure outcomes against the quadruple aim, including cost effectiveness, is underway with NSW Ministry of Health and The George Institute, with results expected in October 2025.
Factors that contributed to success
1. Strong partnership between MLHD and MPHN
2. Joint governance, and sponsorship from MLHD and MPHN Chief Executives
3. Dedicated time spent to identify priority problems, local solutions, cost and benefits of a program in a local area

4. Ability to map existing services, and only fill gaps where necessary
5. Transparency between partner organisations, sharing of data, financial reporting, risk management, operational management
6. Bilateral implementation based on the strengths of each partner organisation – e.g. focus of PHN on commissioned services, and partnerships with primary care and LHD on improving service delivery for acute and post-acute care.

Governance
A Patient Centred Co-Commissioning Group (PCCG) was established early on to provide the governance structure for the Collaborative Commissioning program, along with a Partnership Agreement between the PHN and LHD. The PCCG is co-chaired by the two Chief Executives and has continued to operate throughout the duration of the program. The PCCG is responsible for any decisions regarding funding or changes in the program direction, with all decisions requiring joint Chief Executive sign off. Since establishment the PCCG has grown to provide the governance structure for other joint activity between the PHN and LHD including the mental health bilateral agreement activity and collaborative diabetes work.

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

The benefits of collaborative commissioning include reduced duplication of service delivery, improved coordination between acute and primary care, enhanced integration and multidisciplinary models, and better understanding of both state and commonwealth funding and reporting requirements. A strong partnership between the LHD and PHN, and established joint governance has provided a platform to enable a range of other work well beyond the two chronic diseases identified in the Living Well, Your Way initiative. Most importantly, collaborative commissioning enables regions to prioritise the health needs that are most significant to them, and shift the focus existing resources to meeting those needs. It also helps regions understand where the gaps in their care is, and advocate for the needs to fill those gaps more effectively.

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?

The greatest barrier to ongoing work in collaborative commissioning is lack of flexibility in funding at both commonwealth and state levels, and a desire from governments to standardise models of care to ensure consistency, without an ability to localise care to meet the unique needs of rural and regional areas.
Additional barriers include:
- A lack of focus on prevention and early intervention at any level of government
- Limitations in data sharing, and lags in availability of data for platforms that are available (such as Lumos), which make it difficult to quantify outcomes in short timeframes
- Challenges explaining the scale of the change achieved to decision makers
- Relatively short term funding cycles for large scale reform, 3 years is not long enough for this level of transformation.

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.