Innovation to improve care in Australian Primary Health Network: an insider's perspective

David Stewart Briggs
University of New England, Australia, and
Richard Nankervis, John Baillie, Catherine Turner, Kevin Rigby and Lorin Livingstone
Hunter New England Central Coast Primary Health Network, Newcastle, Australia

Abstract

Purpose – The purpose of this paper is to review the establishment of Primary Health Network (PHN) in Australia and its utility in commissioning Primary Health Care (PHC) services.

Design/methodology/approach – This study is an analysis of management practice about the establishment and development of a PHN as a case study over the three-year period. The PHN is the Hunter New England and Central Coast PHN (HNECCPHN). The study is based on "insiders perspectives" drawing from documentation, reports and evaluations undertaken.

Findings – HNECCPHN demonstrates a unique inclusive organisation across a substantial diverse geographic area. It has taken an innovative and evidence-based approach to its creation, governance and operation. HNECCPHN addresses the health challenges of a substantial Aboriginal and/or Torres Strait Islander population. It contains significant and diverse urban, coastal and distinct rural, regional and remote populations. It can be described as a "virtual" organisation, using a distributed network of practice approach to engage clinicians, communities and providers. The authors describe progress and learning in the context of theories of complex organisations, innovation, networks of practice, knowledge translation and social innovation.

Research limitations/implications – The study provides initial publication into the establishment phase of a PHN in Australia.

Practical implications – The study describes the implementation and progress in terms of relevant international practice and theoretical concepts. This paper demonstrates significant innovative practice in the short term.

Social implications – The study describes significant engagement and the importance of that with and between communities, service providers and health professionals.

Originality/value – This is the first study of the results of the implementation of an important change in the funding and delivery of PHC in Australia.

Keywords Communities of practice, Innovation, Commissioning, General practice, Primary Health Care (PHC), Primary Health Network (PHN)

Paper type Research paper

Introduction

The Australian health care system including that of Primary Health Care (PHC) is set in a Federation style of government, with each level of government having partial responsibility for both funding and delivery of services. Primary health care is substantially the responsibility of the federal or national government. Overall, the Australian health system is

recognised as one of the best in terms of its OECD context (Briggs, 2017; Dixit and Sambasivan, 2018; Rapport *et al.*, 2017).

PHC has had a history of fragmented delivery, often with inadequate support to general practices. These concerns led to the establishment of "Divisions of General Practice" of 110 defined geographic areas. These divisions were subsequently recast into a smaller number of 61 geographically larger organisations called "Medicare Locals" (MLs). The MLs had a wider remit of population health planning and a mix of service delivery roles. They had a broader governance perspective that included GPs and other PHC clinicians as well as community representatives (Briggs, 2017).

MLs have been described as one of the "shortest – lived features of the Australian health care landscape" lasting just four years from 2011 (Javanparast *et al.*, 2015). Again, at a change of government, it was foreshadowed that MLs would not survive. A subsequent report suggested that they failed to appropriately support general practice and lacked clarity of purpose (Horvarth, 2014). However, a study in one Australian state suggested that MLs were successful in "identifying local needs and building good relationships with a range of stakeholders and health providers, particularly GPs and allied health professionals" (Javanparast *et al.*, 2015). This study suggested that "continual policy changes and uncertainty in the PHC landscape constrained collaboration and saw a loss of valued health workforce through the restructures" (Javanparast *et al.*, 2015, p. 219). This theme of constant health reform with no effective change or unexpected consequences and being "too complex to navigate" (Calder *et al.*, 2019) is consistent with the findings of other studies (Briggs *et al.*, 2012).

This paper adopts a descriptive qualitative case study approach, within a framework of relevant theoretical approaches of management learning through communities of practice (CoPs) and the innovative lens (Corradi *et al.*, 2010). The study utilises the experience of one Primary Health Network (PHN) to describe, from the "insiders" perspective, the experience that occurred in the establishment and development of the PHN. The PHN is the Hunter New England and Central Coast PHN, known as HNECCPHN. It provides a case study approach to describe a new innovative attempt to commission and fund primary health care in Australia.

Context of PHN in the Australian health system

PHNs have been established to improve health care outcomes of consumers and communities through commissioning of services through health care providers. This is achieved by competitive funding that requires providers to meet objectives in the contracts that emphasise quality outcomes required and new approaches to delivery and influence service design and pre-requisites of integration, coordination and collaboration to improve outcomes. Second, the PHN delivers capacity building and support services to providers to enhance both the service delivery and the quality of outcomes. These requirements are built into the contractual arrangements and, while evaluation processes are in place, the impact of this initiative will require a longer time frame to achieve credible evaluation. Importantly, PHNs do not directly provide health care services.

There was no restriction on who could submit an expression of interest (EOI) to establish a PHN; the successful applicants were substantially non-government organisations. They would be governed by a skills-based board accountable for performance, with contractual funding arrangements with the Commonwealth to commission and fund PHC services and to engage with and support general practice(s) but not to provide services directly.

The establishment of HNECCPHN occurred as a result of the vision of the pre-existing MLs who agreed to a joint bid to combine their previous geographical MLs of the New England, The Hunter Valley and the Central Coast. This marked an innovative approach in the establishment of a PHN in which the three areas were distinct, naturally occurring geographic regions. There is a diversity of major urban concentrations on the central coast, closely located to the Sydney Basin and the lower Hunter based around

Newcastle and significant regional, rural and remote populations from the upper Hunter valley, and the regional centre at Tamworth extending out to smaller and some remote communities that are geographically known sub-regions such as the Slopes, Plains and Tablelands that meet the Queensland border. Geographically, it is of the size of England; the driving distance from the southern perimeter of the PHN to its northern boundary of the Queensland border is more than 9 hours.

In 2016, this extended region had a population of 1,217,004. There are some 1,250 general practitioners, numerous allied health and PHC nursing roles, 12 Aboriginal Medical Services, more than 30 hospitals and 300 pharmacies across 23 local government areas.

Methodology

The authors adopted a theoretical framework, available to them from the inaugural considerations of the development of the proposal to establish the PHN. This theory and the use of the term innovative lens and the wider discourse of management learning recognise that management learning can be derived from practice and through CoPs. The practitioner views, experience and objects are observed through that lens and then looks to a range of theories as opposed to a single theory to inform knowledge and future practice. The framework is further developed through the analysis and described in our discussions and conclusions (Corradi *et al.*, 2010).

The authors contributed perceptions from their practical experience of involvement in the organisation through the analysis of the documentation available to them as "insiders". The data include the minutes and decision making that achieved agreement between the former MLs to bid for and establish a PHN, the contractual agreements with the Commonwealth, the subsequent minutes of the newly established Board and its subcommittees. It includes action and directions established in the strategic plan and subsequent iterations, as well as a range of consultant reports obtained for the purposes of commissioning services from internal staff and board evaluations of commissioning cycles, service co-design and provider engagement.

This research that is set in the dynamics of organisational culture and engages with disadvantaged communities, social entrepreneurial entities and non-government providers and is said to best fit into methodologies of the interpretive or hermeneutic traditions (Grimm *et al.*, 2013). The hermeneutic, phenomenology approach is relevant where making sense of experience to develop shared meaning is an objective and where the health management role requires understanding rather than explanation. In complex circumstance, we need to draw on knowledge embedded in experience. In other words, "things cannot be separated from the experience of them, and interpretation can only make explicit what is already understood" (Bassett, 2004, p. 158; Briggs *et al.*, 2012).

This context reinforces the need for "insiders" that have expertise and experience in both management and the health professional role to interpret findings. This is consistent with the Heideggerian view "that prior understanding is about knowing, not about being or just about acquiring new knowledge". This implies that what is already understood comes to be interpreted and our presuppositions help with the interpretation of meaning of the phenomenon (Briggs *et al.*, 2012). The findings have also been found to have meaning and confirmation in relevant organisational and management theory. Therefore, they reflect the position that the "insider" is both important and essential because it is about "interpreting frequently taken-for-granted shared practices and common meanings" (Briggs, 2009, p. 91).

The "insiders" are the authors, six in number, of this paper and represent board governance, chief executive (CE) and senior executive management personnel of the PHN who among them share a range of academic and clinical qualifications (physiotherapy and nursing), commercial, accounting and marketing qualifications and expertise. These insiders mostly have had extensive practice and expertise in the Australia health system including prior experience in the acute care sector and in PHC.

Health managers are central to reform and our objective is that our findings might be built on by others in further studies (Briggs *et al.*, 2012). The authors have used an "innovative lens" approach consistent with our HNECCPHN purpose "to deliver innovative, locally relevant solutions".

Importance of HNECCPHN Aboriginal and Torres Strait Islander (ATSI) population

HNECCPHN has an Aboriginal and/or Torres Strait Islander population that is above the average for NSW and Australia. The PHN proportion of Indigenous people is at 4.2 per cent compared to the NSW and Australian proportion of 2.5 per cent. Within HNECCPHN, there are between 10 and 20 per cent significant Indigenous populations, as well as those that reflect state and national percentages. HNECCPHN contains and acknowledges ten Aboriginal nations. Further data about the region can be found in Health Planning Reports and Profiles (HNECCPHN, 2019a).

Establishment of HNECCPHN

Discussions as to what might be possible and appropriate in establishing PHNs took into consideration that ideally the size and location of PHN boundaries should reflect the existing boundaries of local health districts (LHDs) or in some states, networks (LHDs) and the acute care providers. In HNECCPHN, this meant the consolidation of two MLs: the New England and the Hunter. However, once the PHN boundaries were announced by the Commonwealth Government, the Central Coast ML was also included, and the preference was to apply based on the three extant MLs and two LHDs combining.

A working party of the three MLs consisted of two board members and the CE of each was formed to quickly negotiate an agreement and submit a proposal to become a PHN. As an early exemplar of both vision and innovation, the working party invited the two LHDs into the working party. This board governance arrangement with the inclusion of the two LHD CEs remains innovative and, in comparison with other PHNs, is an outlier as most others have not purposely been identified with the local acute care sector in this way.

The board also agreed to the appointment of an independent chair, with skills based on consideration of the distinct geographical regions, and subsequently included Indigenous members. A distributed organisational network of office locations was adopted to consolidate support for the principles of localism and subsidiarity that is engaging with clinicians and communities at a local level, a specific requirement of PHN roles. It also reinforced the fact that this was a new organisation rather than a merging of existing MLs and that the governance should consider the differing clinical practice and communities of interest. These characteristics of HNECCPHN as a new entity with a distributed organisational network set its establishment as being distinctive. In the transition from MLs to HNECCPHN, the Commonwealth took a dividend (budget cut) in operational funds. This meant less resources for the PHN and not all staff could be transitioned across to PHNs.

The inaugural board determined that "innovation" was to be a continuing contribution to the organisational purpose. Second, the concepts of evidenced-based management and best practice clinical care/service were to underpin executive and governance decision making (Agterberg *et al.*, 2010, p. 87). Concepts of diversified senior executive locations and office accommodation were established that could be described as the organisation functioning in a virtual context using technology, to effectively engage with both clinicians and communities.

The creation of PHNs also emphasised that the organisation might increasingly operate in contexts of networks. Complex adaptive systems theories are also relevant because they add meaning to social organisational processes and challenge traditional models of change. This emphasises the importance of management focussing on networks and

systems and being aware of and resistant to the isomorphic tendency for organisation to become similar in structure and in practice (Briggs, 2009). For researchers, PHNs provide a rich field for further management and organisational empirical research.

Theoretical framework

Complex systems cannot be represented or explained by unified theory. Innovation is both a process and an outcome but is also an uncertain process with multiple meanings (Grimm *et al.*, 2013). Social innovation is seen as a move away from existing focus on technology and economic dogma to encourage "societal and systemic changes" and is said to be attractive to policy makers given the difficulty traditional welfare systems have in responding to communities such as those with which HNECCPHN is engaged. Social innovation can be described as a new combination or configuration of practice and as a "means to an end" that can be described as "a process oriented social innovation" (Grimm *et al.*, 2013. p. 450).

An appropriate theoretical framework was developed based on the application of complexity theory and management learning and knowledge theory and the concepts of innovation as a social organisational structure (Pestoff and Brandsen, 2010). This required us to adopt the concepts of knowing and the use of applying the lens to CoPs as previously described (Corradi *et al.*, 2010). The discussion of these theoretical concepts and their relevance follows.

Complexity and networks of practice (NOPs)

The concepts of networks, in CoPs and NOPs, within and across organisations is not new but a move in those directions has provided HNECCPHN with the potential to more effectively govern, manage and organise in a knowledge-based organisation. Managers must manage NOPs to reap the benefits of geographically dispersed knowledge. The inherently "emergent nature of NOPS implies that management control may frustrate practice-related knowledge to be shared" (Agterberg *et al.*, 2010, p. 85). The management of NOPs and the value of this approach is worthy of further research and evaluation in PHNs. This concept defines organisation management as having "a knowledge-based view of the firm" (Agterberg *et al.*, 2010, p. 86) that requires knowledge to be integrated and made available to all. This means that we need to re-imagine knowledge utilisation and frame knowledge as part of practice, not apart from it (Corradi *et al.*, 2010; Gkeredakis *et al.*, 2010, p. 2).

Networks and CoPs have currency in health services and our thesis is that there is a significant value in extending those practices into distributed networks of practice (Hustad, 2010). HNECCPHN has achieved this move across organisations, service providers and clinicians by the use and adaption of technology described as "PeopleBank" and more fully described later but accessible at HNECCPHN (HNECCPHN, 2019b). This provides a platform for organisations, clinicians and communities to engage, be sustained and cultivated in both open and closed forums (Hustad, 2010). HNECCPHN has established CoPs in specific programs such as youth mental health, chronic disease management and alcohol and other drugs treatment services.

Organisational learning and practice

Management and organisational learning is recognised as occurring at and within the workplace. This occurs through, observing and identifying through our own knowledge, our lens, to interpret practice and know new Knowledge (Corradi *et al.*, 2010).

Innovative context

The implementation of PHNs can be described as "innovative" in that for the first time the concept of commissioning of services was introduced to the context of the Australian health

care system. The knowledge of practice in commissioning needed to be sourced from the UK National Health System and elsewhere. The devolution of service planning and commissioning from direct Commonwealth Government agencies to PHNs was innovative in that, without debate, it heralded an unannounced commitment to the principles of localism and subsidiarity, suggesting that PHC requires local engagement with communities and providers and that this should occur at the lowest (or closest) point where the services are meant to be delivered. Localism is a form of governance that is based on the principle of subsidiarity that "government should only fulfil a subsidiary function for those tasks that cannot be dealt with by local tiers" (Hartwich, 2013).

In a UK-based review of reform of PHC this was described as a "handing back of PHC responsibility for local planning representing a return to the dominant model of primary care policy and that reorganisation of complex systems produces results in predictable and emergent change" (Checkland *et al.*, 2018, p. 266). Localism suggests that health services currently do not reflect local needs and are delivered in ways that do not engage communities and are focussed on sickness services, reducing illness without much emphasis on improving health and well-being or providing enough emphasis on public and population health and prevention. Localism provides the opportunity to work with others and across organisational boundaries.

The boundary alignment of PHNs with LHDs, the state based acute care providers is innovative and gives "licence" for the first time, to explore health service delivery at the local level, outside traditional normative approaches (Briggs, 2014). Ferlie (2010) suggested that localism is a reaction against top down target led approaches and that the new localist idea brings into prominence the role for non-profit organisations, giving managers permission to respond to opportunity and to also provide "generative space" to discuss and debate how to do things better (Briggs, 2014).

Innovation in HNECCPHN is given prominence by its inclusion in the name and activity of a specific board subcommittee, the Strategic, Innovation, Research Service Design Population Health Committee, with a strategic intent that innovation is part of our purpose at governance, executive and staff levels. This approach is further extended across our networks, described above through an online platform entitled "innov8", a health development initiative accessible at PHN webpage. The online hub is designed to share ideas and to meet other people with interest and expertise in aspects of health care.

One of the significant and enduring features of our innovation approach has regularly been generated "Pitch Nights". These nights are designed to seek innovative projects from organisations and communities that reflect a significant regional PHC need to gain some one-off funding to implement a specific project. Examples include healthy weight activities and Aboriginal health. Initiatives undergo rigorous assessment before the proponents pitch their idea to a public audience who then vote on the extent of "funds" each audience participant allocates to about three projects. The process builds on community need, community passion and clinician enthusiasm, and underlines a process of clinician and community engagement through innovation. This practice also depends on the characteristics of networks described as self-organising, shared practice, the acceptance of "weak ties" and technology support (Agterberg *et al.*, 2010) that can bring together the diversity of interests "to focus on complex, entrenched systemic problems" (Bailie *et al.*, 2018, p. 1).

Commissioning strategy

The rationale for establishing PHNs was to enable the planning, commissioning and funding of PHC services through the regionally established PHNs. General practice delivers PHC directly to patients through fee for service arrangements that could include reimbursement of some or all the costs via the Medical Benefits Scheme. A patient-based co-payment often applies. The PHNs are meant to sustain the delivery of quality primary

care in general practice by attracting and retaining general practitioners and other professions. This is achieved by support to general practice for education and quality improvement in clinical care and business practices, expansion of service-based health professionals into general practice, notably practice nurses and allied health professionals. PHNs in planning, commissioning and funding attempt to be inclusive of general practice through both formal engagement of clinical councils and the use of techniques of collaboration, connecting and integration, co-design, in persuasive ways as services are designed and commissioned.

HNECC has developed a "Commissioning Framework" which has been adapted by many of its counterparts. It guides the commissioning strategy. The commissioning process was developed within a short time frame based in part on HNECCPHN ideation of the existing "quadruple aim" as initiated by Bodenheimer and Sinsky (2014). This was a significant development as many other agencies continue to use the IHI triple aim.

While the commissioning process required almost immediate commencement, commissioning, staff, executive, the board and, importantly, providers had to be educated to demonstrate that the implementation was only the start of the process as commissioning was cyclical and dependant on population health planning and community, clinician and provider engagement. HNECCPHN strategic intent of commissioning was set in time frames over years called "horizons" and was understood by all to be a learning process requiring rigorous evaluation following each commissioning cycle or process and followed nationally agreed principles in commissioning health services.

Applying the theory to HNECCPHN practice
Performance of PHNs reflects practices and national headline indicators of potentially preventable hospitalisations, childhood immunisation rates, cancer screening rates and mental health treatment rates. The priority areas were further defined as mental health, ATSI health, population health, health workforce, digital health and aged care. Local priorities within the diverse HNECCPHN were determined to be cancer screening, mental health, ATSI populations needs, transport, health literacy, child, maternal and youth health care. Local priorities were assessed to be health risk behaviours, rural health access, health workforce, aged care and dementia, chronic disease, low birth weights and drug and alcohol treatment. These priorities resulted from the HNECCPHN needs assessment and the development of the "health planning compass" which defines and describes a range of specific demographic, socio-economic and health status data for the region and for each local government area within the region. The compass can be viewed at HNECCPHN (2019c).

HNECCPHN had to utilise new titles for staff, new organisational language, new and complex ways of designing and delivering PHC that in Australian contexts were unknown, not tested and required experimentation. Approaching complex challenges within systems can result in unpredictable and emergent changes that requires a cautious approach and incremental achievement requiring commissioners to build in "incompleteness" in change and implementation ahead of closure (Checkland *et al.*, 2018). Gkeredakis *et al.* (2010) suggested that for commissioning managers to be successful, they need to mediate national expectations in ways that make change understandable to the practice of practitioners use of knowledge in delivering services locally and building trust in how that is achieved.

The initial contracting was transactional but moved to a relational approach as the practice matured. An assessment of HNECC's capability to commission, through comparison with the NHS World Class Commissioning Competencies, identified that commissioners, providers and communities lacked capacity and capability in the processes (McCafferty *et al.*, 2012). These circumstances required the development of the relational

approach with and among stakeholders to ensure that the policy and processes were effective. This also led to a greater emphasis on network practice across disciplines, sectors within local contexts and resourcing of grants and scholarships for education across the sector.

The capacity building strategy undertaken by HNECCPHN was significant and within one six-month period, 162 education courses were delivered at a rate of more than 6 courses per week. More than half of the courses focused on national key performance indicators and the remainder were delivered to PHC staff around content that supported their collective and individual practice. More than 2,600 people attended those courses within that six months providing an average attendance above 22 people. Grants were made available to build capacity in the areas of Alcohol and Other Drugs and Indigenous Mental Health in response to an identified need. Scholarships have been provided to enhance workforce capacity in clinical areas, including Aboriginal Health, Primary Care Support, Practice Nursing and Diabetes Education. Practice support education, interactions and engagements were additional to the formal education events. This is a significant investment that is a continuing feature in both capacity and capability building across the PHN underpinning the PHNs understanding that the use of knowledge and learning is an interactive and iterative process that makes commissioning effective.

The ongoing evaluation of commissioning process also focussed on improving reporting measures and developing key performance indicators to include a suite of patient reported outcomes and patient reported experience measures. The use of patient reported measures as a measure of quality linked to payment has been tested by HNECC, a first in Australia. While the contractual and tendering aspects of the PHN are enshrined in processes that ensure probity, audit and independence from external influence, it is incumbent on PHNs to engage with PHC clinicians and communities. The input at the design stage and the adoption of recommendations does necessarily include public discussion and input from the clinical advisory and community advisory committees appointed by the board. A formal subcommittee of the board, the Quality and Safety Committee, monitors funded providers and recommends adoptions and changes to the board and monitors the contractual compliance of providers, particularly where questions of performance might arise.

Consistent with knowledge translation theory and the concept of organisations being described as learning organisations, the evaluative approach of practices and commissioning will continue as a focus. In recent contexts, a series of principles and practice enablers were developed in recognition that lessons from the NHS experience suggest that "progress is made in 'bite sized pieces of work' requiring substantial effort" (Shaw *et al.*, 2013). Billings and de Weger (2015) in a critical review of contracting for integrated health and social care suggest that we are learning by doing and will require continuous assessment around the suitability of commissioning requirements and that we should have debate about the best way to contract for health including critical debate about current models of care and their value.

The debate in our progression over three years of experience has included to what extent should the PHN determine what models of care should be funded. We have used published evidence, clinical experts and provider and community forums as well as our community and clinical councils to progress that debate. The option of one model of care across the region has been challenged given the tyranny of distance, variable access to health services, workforce shortages, and different forms of clinical practice across the very diverse region. In this debate, the importance of how communities' access distant services and the need to sustain a scarce health workforce together with avoiding the loss of social capital of rural communities are significant considerations. An effective commissioning system in our view needs to be iterative, adaptive and to be credible, needs to be receptive to context.

Through our evaluative processes, we have come to establishing principles and enablers for consistency of understanding across and within the organisation and to our providers and communities. These principles are:

(1) Models of care should be capable of variable adoption to meet community and clinical needs including the needs of ATSI communities and capacities in different geographic areas. We need to be open to different models of care being funded and different funding models being used.

(2) We should develop, sustain and increase an approach that commissions at a manageable scale but ensures that local provider or practice competitive and comparative markets exist and are sustained through contracting or sub-contracting arrangements under a value for money approach.

(3) While seeking to ensure value for money in service provision, we should avoid service provider changes that only achieve a relocation of existing staff and contractors rather than an increased workforce capacity.

(4) Consultation and engagement with clinicians and communities outside our established advisory committees should be dependent on how that might advance significant changes in practice and service delivery and be consistent with and limited by resource and time constraints available.

(5) Small funded projects or pilots should be aggregated up into larger and potentially longer term projects with the purpose delineated as an expected outcome.

(6) Geographic-based funding needs to consider local government boundaries, the established commercial trade routes of communities and traditional transport flows of communities to services.

(7) We should attempt to encourage local service delivery rather than drive/fly in and drive/fly out (DIDO or FIFO) providers.

(8) We utilise a range of approaches to commissioning that include open and selective tenders, EOI and direct approaches to existing approved providers. The rationale for the method selected needs to be confirmed as a desired approach, as required.

(9) Commissioning should include strategic requirements to encourage potential providers, within the process, to address how they will respond to outcome requirements for greater collaboration, integration, improved access, client/patient navigation through services, increased emphasis on prevention and promotion and innovation generally.

(10) The piloting of outcome measures, model comparison, service co-design approaches are consistent with these principles.

(11) As far as possible and within the limited available resources, we attempt to ensure that clinician and consumer and subject matter expertise consultations be completed before internal recommendations/decisions are attempted.

(12) The performance and effectiveness of existing providers be properly assessed and considered in the tender process, decision making and in management of the service contract.

The experience of the authors is that the PHN has adapted commissioning to the geographic and clinical realities evident in diverse sub-regions and has consistently and progressively applied the principles of localism and subsidiarity. The practices of innovating, coordinating and strategizing and so forth "constitute an emergent and complex social phenomenon that

depends on the active involvement of practitioners" (Gkeredakis *et al.*, 2010, p. 7). While practitioners exercise judgement, they are invariably "constrained by justification of a community of practitioners" (Gkeredakis *et al.*, 2010, p. 7). Managers in commissioning apply "norms and collective understandings" to constitute understanding and to resolve commissioning decisions, while practitioners use knowledge in action that makes a difference in practice (Gkeredakis *et al.*, 2010, p. 8). This theory represents the context and the reality in which the authors and the organisation operate.

Complex systems cannot be represented or explained by unified theory. Innovation is both a process and an outcome but is also an uncertain process with multiple meanings (Grimm *et al.*, 2013). Social innovation is seen as a move away from existing focus on technology and economic dogma to encourage "societal and systemic changes" and is said to be attractive to policy makers given the difficulty traditional welfare systems have in responding to communities such as those with which HNECCPHN is engaged. Social innovation can be described as a new combination or configuration of practice and as a "means to an end", that can be described as "a process oriented social innovation" (Grimm *et al.*, 2013, p. 450).

HNECCPHN outcomes
The authors offer the following evidence from their analysis of progress so far in innovative commissioning. The evidence is based on the identifiers of social innovation described by Pestoff and Brandsen (2010). They are examples of our initial and continuing contribution to health reform:

Governance has been deliberately innovative in the inclusion of an independent Chair, the inclusion of CEs of the major acute care providers (LHD) on the Board and the inclusion of skilled based Indigenous persons on the Board.

The establishment online of our engagement and innovation processes of "Peoplebank" and "Innovate8", supported by our "compass data" are innovative. This innovation has been supported by eight other PHNs adopting "Peoplebank" and two other PHNs adopting "Innovate8".

The inclusion of clinical and community based advisory committees, actively engaged in the commission consultation processes has been significant. This has been enhanced with provider forums, engagement of clinicians and communities in "pitch nights" and extensive education forums that all give impetus to social innovation being about "new user – provider relationships, public consultations and participation in decision-making processes" (Grimm *et al.*, 2013, p. 440).

Co-production and co design of services, include the youth complex mental health services, the diabetes alliance model utilising clinical case conferencing in general practice and the Mental Health and Suicide Prevention Access and Referral Service. These are exemplars of social innovative that suggest multi-method approaches, that engages directly with providers and target groups that might be marginalised and economically disadvantaged (Grimm *et al.*, 2013).

An extensive investment in examining the impact of obesity as a pre-determinant of high levels of chronic disease has been achieved by the adoption of a healthy weight program. It has at its centre a randomised control research project that examines assessment and interventions through general practice. Early results of this study suggest very positive results that will be the subject of a future publication. The project has also provided funding and incentives for community-based action. The authors are confident that this will become an exemplar of innovation in improved PHC outcomes.

The PHN is implementing an innovative rural communities project to allow the PHN to become more closely engaged with distant rural communities and the clinicians that do not have adequate access to health services. The project has engaged directly with two communities, clinicians, local government to assess their views of health status, and has sought community determination of what are priority health needs and how best to meet them. This innovation will allow the testing of placed based commissioning.

The PHN is implementing some navigation pilot programs where positions of "navigators" will be engaged, in some communities, to ensure connectedness between patients and their general practitioner diagnosis, treatment directions and access to those services. It will emphasise improved health literacy and the effectiveness of implementation of general practice advice. These pilots have potential to better support patients between general practice visits and visits to psychological, nursing, allied health, mental health and diagnostic services, particularly for those with a burden of chronic disease. A similar Aboriginal Health worker role in general practice also sustains mental health status with a focus on cultural and spiritual underpinnings and the two roles might prove to be at least complementary.

The engagement of Aboriginal communities is a considerable focus. HNECC has developed a set of principles to guide commissioning of funds which are culturally appropriate and deliver to locally identified needs of Aboriginal and Torres Strait Islander people while working closely with local Aboriginal Community Controlled Health Organisations (ACCHOs) (HNECCPHN, 2019d). These principles are available at HNECCPHN website. We have used the community of practice approach to determine the best ways to deliver services in different communities. The challenge of responding culturally to local communities, while managing service demand has been significant. Capacity building grants have been made available for local ACCHOs, to enhance their current services or to offer programs which build the health literacy and self-management of the community.

The strength of the partnerships that HNECCPHN has formed with the Local Health Districts within the region has enabled a maturity in the area of joint commissioning that has yet to be achieved by other PHNs. Both HNELHD and CCLHD have established formal alliances with HNECC which enable clinicians and managers from partnered organisations to work on truly integrated programs to develop and test new models of care. The alliances have shared agreed performance measures which enable the partners to evaluate the impact of programs on the goals of each of the partners. This has also enabled the partners to combine funding and resources to enable integrated care across a range of clinical treatment areas. These include diabetes, chronic obstructive airways disease and urgent care.

Conclusion

The authors conclude that the early insistence on giving priority to innovation and wherever possible evidence-based decision making has provided an internal organisational discipline that has had a positive effect on the work we do. This approach has enabled us to re-imagine knowledge and better frame it as part of what we all do in our daily work practices. The practices of innovating, coordinating, collaborating and strategizing in the PHN are examples of the language we use in our daily work practices that require us to be skilled in being adaptive.

The funding of the PHN has increased exponentially reflecting a significant increase of PHC services across the region. The funding is defined mostly through contractual relationships. The core funding supports the PHN operational purposes including support services to PHC practitioners, the bulk of the funding is provided in specific funding for services, notably mental health, drug and alcohol services, aboriginal health to name a few. The purpose of the funding is defined in contracts and mostly limited to annual funding. The authors conclude that this reflects a resource difficulty in annual re-negotiation for continued funding and presents hesitancy for providers and contracted health professions to be committed to a service or location. The authors suggest a longer contractual term.

The authors agree that networks developed have played a significant role in the commissioning purpose of the PHN, particularly in enacting health system strengthening through effecting greater stakeholder engagement to focus on solving complex and often entrenched systemic problems.

In conclusion, the first three years of progress of PHNs and HNECCPHN has achieved a rich tapestry of services and interconnections between providers, clinicians and communities. It provides the potential to build on what has been achieved and to meet identified significant priorities.

References

Agterberg, M., Van den Hooff, B., Huysman, M. and Soekijad, M. (2010), "Keeping the wheels turning: the dynamics of managing networks of practice", *Journal of Management Studies*, Vol. 47 No. 1, pp. 85-108.

Bailie, J., Cunningham, F.C., Bainbridge, R.G., Passey, M.E, Laycock, A.F., Bailie, R.S., Larkins, S.L, Brands, J.S.M., Ramanathan, S., Abimbola, S. and Peiris, D. (2018), "Comparing and contrasting 'innovation platforms' with other forms of professional networks for strengthening primary healthcare systems for Indigenous Australians", *BMJ Global Health*, Vol. 3 No. 3, pp. 1-8.

Bassett, C.C. (2004), "Phenomenology", in Bassett, C.C. (Ed.), *Qualitative Research in Health Care*, Whurr, London, pp. 1-185.

Billings, J.R. and de Weger, E. (2015), "Contracting for integrated health and social care: a critical review of four models", *Journal of Integrated Care*, Vol. 23 No. 3, pp. 153-175.

Bodenheimer, T. and Sinsky, C. (2014), "From triple to quadruple aim: care of the patient requires care of the provider", *Annals of Family Medicine*, Vol. 12 No. 6, pp. 573-576.

Briggs, D.S. (2009), "The lived experience of health services managers, their perceptions of the health system and the health management role", unpublished doctoral thesis, University of New England, Armidale.

Briggs, D.S. (2014), "Localism: a way forward?", *Asia Pacific Journal of Health Management*, Vol. 9 No. 1, pp. 4-6.

Briggs, D.S. (2017), "Challenges for health systems: Australian perspectives", *Public Administration and Policy*, Vol. 20 No. 1, pp. 6-17.

Briggs, D.S., Cruickshank, M. and Paliadelis, P. (2012), "Health managers and health reform", *Journal of Management and Organization*, Vol. 18 No. 5, pp. 641-658.

Calder, R., Dunkin, R., Rochford, C. and Nichols, T. (2019), "Australian health services: too complex to navigate, a review of the national reviews of Australia's health service arrangements", Australian Health Policy Collaboration, Melbourne, available at: www.mitchellinstitute.org.au/reports/australian-health-services-too-complex-to-navigate/

Checkland, K., McDermott, I., Coleman, A., Warwick-Giles, L., Bramwell, D., Allen, P. and Peckham, S. (2018), "Planning and managing primary care services: lessons from the NHS in England", *Public Money and Management*, Vol. 38 No. 4, pp. 261-270.

Corradi, G., Gherardi, S. and Verzelloni, L. (2010), "Through the practice lens: where is the bandwagon of practise – based studies heading?", *Management Learning*, Vol. 41 No. 3, pp. 265-283.

Department of Health, Australian Government (2018), "Hunter New England and Central Coast PHN profile", available at: www.health.gov.au/internet/main/publishing.nsf/Content/PHN-Hunter_New_England_Central_Coast (accessed 18 November 2019).

Dixit, S.K. and Sambasivan, M. (2018), "A review of the Australian healthcare system: a policy perspective", *SAGE Open Medicine*, Vol. 6, pp. 1-14, available at: https://journals.sagepub.com/doi/10.1177/2050312118769211#articleCitationDownloadContainer

Ferlie, W. (2010), "Public management 'reform' initiatives and the changing organization of primary care", *London Journal of Primary Care*, Vol. 3, December, pp. 76-80, doi: 10.1080/17571472.2010.11493306.

Gkeredakis, E., Swan, J., Clarke, A., Powell, J., Nicolini, D., Scarbrough, H., Roginski, C. and Taylor-Phillips, S. (2010), "Understanding knowledge utilisation in healthcare management practice", paper submitted to the 7th Biennial International Conference in Organisational Behaviour in Health Care (OBHC), University of Birmingham, Warwick.

Grimm, R., Fox, C., Baines, S. and Albertson, K. (2013), "Social innovation, an answer to contemporary societal challenges? Locating the concept in theory and practice", *Innovation – The European Journal of Social Science Research*, Vol. 26 No. 4, pp. 436-455.

Hartwich, O. (2013), "A global perspective on localism", occasional paper, The New Zealand Initiative and LGNZ, Wellington, available at: http://nzinitiative.org.nz/reports-and-media/reports/a-global-perspective-on-localism/

HNECCPHN (2019a), "Health planning reports and profiles", available at: www.hneccphn.com.au/planning-commissioning/health-planning-reports-profiles/ (accessed 18 November 2019).

HNECCPHN (2019b), "PeopleBank", available at: https://peoplebank.hneccphn.com.au/ (accessed 18 November 2019).

HNECCPHN (2019c), "Profiles", available at: www.health.gov.au/internet/main/publishing.nsf/Content/PHN-Profiles (accessed 18 November 2019).

HNECCPHN (2019d), "Indigenous commissioning", available at: www.hneccphn.com.au/media/13920/indigenous-commissioning-principles-oct16.pdf (accessed 18 November 2019).

HNECCPHN (2019e), "Commissioning strategy", available at: www.hneccphn.com.au/media/14991/016753-phn-hnecc-commissioning-strategy.pdf (accessed 18 November 2019).

Horvarth, J. (2014), "Review of Medicare Locals: report to a the Minister for Health and Sport", available at: www.health.gov.au/internet/main/publishing.nsf/Content/review-medicare-locals-final-report (accessed 18 November 2019).

Hustad, E. (2010), "Exploring knowledge work practices and evolution in distributed networks of practice", *Electronic Journal of Knowledge Management*, Vol. 8 No. 1, pp. 69-78.

Javanparast, S., Baum, F., Barton, E., Freeman, T., Lawless, A., Fuller, J., Reed, R. and Kidd, M. (2015), "Medicare Locals: local health network partnerships in south australia: lessons for primary health networks", *The Medical Journal of Australia*, Vol. 203 No. 5, pp. 219.e1-219.e6.

McCafferty, S., Williams, L., Hunter, D., Robinson, S., Donaldson, C. and Bate, A. (2012), "Implementing world class commissioning competencies", *Journal of Health Services Research and Policy*, Vol. 17 No. 1, pp. 40-48.

Pestoff, V. and Brandsen, T. (2010), "Public governance and the third sector: opportunities for co-production and innovation?", in Osborne, S.P. (Ed.), *The New Public Governance? Emerging Perspectives on Theory and Practice of Public Governance*, Routledge, London and New York, NY, pp. 223-236.

Rapport, F., Braithwaite, J., Mitchell, R., Westbrook, J. and Churruca, K. (2017), "Transitional care in a federated landscape", in Aase, K., Waring, J. and Schibevaag, L. (Eds), *Researching Quality in Care Transitions: International Perspectives*, Palgrave Macmillan, London, pp. 179-200.

Shaw, S.E., Smith, J.A., Porter, A., Rosen, R. and Mays, N. (2013), "The work of commissioning: a multisite case study of healthcare commissioning in England's NHS", *BMJ Open*, Vol. 3 No. 9, pp. 1-10.

About the authors
David Stewart Briggs, BHA (NSW), MHM (First Class Honours), PhD (UNE), DrPH (Hon.NU), FACHSM and FHKCHSE, is Adjunct Professor at the Faculty of Medicine and Health, University of New England, Australia, Director and Deputy Chair at Hunter New England Central Coast Primary Health Network, Adjunct Professor at ASEAN Institute of Health Development Mahidol University, Thailand. He served as Editor for *Asia Pacific Journal of Health Management* and Editor-in-Chief for *ASEAN Journal of Public Health and Development*. He is immediate past President of Society for Health Administration Programs in Education, Fellow and Past National President of the Australasian College of Health Services Management (ACHSM) and founding Fellow of the Hong Kong College of Health Service Executives and in 2014 was awarded an Honorary Doctorate in Public Health, by Naresuan University, Thailand. He was the recipient of the National ACHSM Gold Medal Award in 2004 and the NSW ACHSM Presidents Award 2014 for his extensive contributions to the college and health services. David Stewart Briggs is the corresponding author and can be contacted at: dsbriggs007@gmail.com

Richard Nankervis, BSc (USyd), BAppSc (Physiotherapy, USyd), MHA (UNSW) and GAICD, is Chief Executive at Hunter New England Central Coast Primary Health Network. He is a founding Director on the Governing Board of the NSW Regional Health Partners (NSWRHP) Centre for Innovation in Regional Health and sits on the Aboriginal Health Committee of the Hunter New England Local Health District Board.

John Baillie, RGN, Bachelor of Health Science (Nursing) and Master in Health Management, is Executive Manager Primary Care Improvement at Hunter New England Central Coast Primary Health Network. John has previously held several senior health management positions prior to his current role, including CEO Hunter Medicare Local, CEO of a community aged care organisation, Director of Nursing in the NSW public system and Regional Manager for Disability Services in NSW. In total, John has in excess of 40 years' experience in the public and private health and disability services at an operational and strategic level, including urban, regional and rural settings.

Catherine Turner, BHSc (Nursing, CSU), MIHM (UNE), GAICD and MRCNA, is Executive Manager, Commissioning at Hunter New England Central Coast Primary Health Network.

Kevin Rigby, BCMM (USQ), is Manager, Marketing, Engagement and Strategy at Hunter New England and Central Coast Primary Health Network.

Lorin Livingstone, BBus (Accounting and Finance) (UTS), CA (CAANZ) and GradDipPsych (UNE), is Executive Manager, Corporate Services at Hunter New England Central Coast Primary Health Network.