Australian Government
Department of Health

phn
An Australian Government Initiative

Updated Activity Work Plan 2016-2018: Primary Mental Health Care Funding

The Mental Health Activity Work Plan template has two parts:

1) The updated Annual Mental Health Activity Work Plan for 2016-2018, which will provide:
   a) A strategic vision which outlines the approach to addressing the mental health and suicide prevention priorities of each PHN;
   b) A description of planned activities funded under the Primary Mental Health Care Schedule which incorporates:
      i) Primary Mental Health Care funding (PHN: Mental Health and Suicide Prevention Operational and Flexible Activity); and
      ii) *Indigenous Australians' Health Programme* funding (quarantined to support Objective 6 – see pages 2-3) (PHN: Indigenous Mental Health Flexible Activity).

2) The updated Budget for 2016-2018 for (attach an excel spreadsheet using template provided):
   a) Primary Mental Health Care (PHN: Mental Health and Suicide Prevention Operational and Flexible Activity); and
   b) *Indigenous Australians' Health Programme* (quarantined to support Objective 6) (PHN: Indigenous Mental Health Flexible Activity).

Hunter New England Central Coast

When submitting this Mental Health Activity Work Plan (referred to as the Regional Operational Mental Health and Suicide Prevention Plan in the 2015-16 Schedule for Operational Mental Health and Suicide Prevention, and Drug and Alcohol Activities) to the Department of Health, the Primary Health Network (PHN) must ensure that all internal clearances have been obtained and it has been endorsed by the CEO.

Additional planning and reporting requirements including documentation, data collection and evaluation activities for those PHNs selected as lead sites will be managed separately.

The Mental Health Activity Work Plan must be lodged to Kate McGregor via email Kate.McGregor@health.gov.au on or before 17 February 2017.

Overview

This Activity Work Plan is an update to the 2016-17 Activity Work Plan submitted to the Department in May 2016. However, activities can be proposed in the Plan beyond this period.

Mental Health Activity Work Plan 2016-2018

The template for the Plan requires PHNs to outline activities against each and every one of the six priorities for mental health and suicide prevention. The Plan should also lay the foundation for regional planning and implementation of a broader stepped care model in the PHN region. This Plan recognises that 2016-17 is a transition year and full flexibility in programme design and delivery will not occur until 2018-19.

The Plan should:

a) Provide an update on the planned mental health services to be commissioned from 1 July 2016, consistent with the grant funding guidelines.

b) Outline the approach to be undertaken by the PHN in leading the development with regional stakeholders including LHNs of a longer term, more substantial *Regional Mental Health and Suicide Prevention plan* (which is aligned with the Australian Government Response to the Review of Mental Health Programmes and Services (available on the Department's website). This will include an outline of the approach to be undertaken by the PHN to seek agreement to the longer term *regional mental health and suicide prevention plan* from the relevant organisational signatories in the region, including LHNs.

c) Outline the approach to be taken to integrating and linking programmes transitioning to PHNs (such as headspace, and the Mental Health Nurse Incentive Programme services) into broader primary care activities, and to supporting links between mental health and drug and alcohol service delivery.

d) Have a particular focus on the approach to new or significantly reformed areas of activity – particularly Aboriginal and Torres Strait Islander mental health, suicide prevention activity, and early activity in relation to supporting young people presenting with severe mental illness.

In addition, PHNs will be expected to provide advice in their Mental Health Activity Work Plan on how they are going to approach the following specific areas of activity in 2016-18 to support these areas of activity:

- Develop and implement clinical governance and quality assurance arrangements to guide the primary mental health care activity undertaken by the PHN, in a way which is consistent with section 1.3 of the *Primary Health Networks Grant Programme Guidelines* available on the PHN website at *http://www.health.gov.au/internet/main/publishing.nsf/Content/PHN-Program_Guidelines,* and which is consistent with the National Standards for Mental Health Services and National Practice Standards for the Mental Health Workforce.
- Ensure appropriate data collection and reporting systems are in place for all commissioned services to inform service planning and facilitate ongoing performance monitoring and evaluation at the regional and national level, utilising existing infrastructure where possible and appropriate.
- Develop and implement systems to support sharing of consumer clinical information between service providers and consumers, with appropriate consent and building on the foundation provided by myHealth Record.
- Establish and maintain appropriate consumer feedback procedures, including complaint handling procedures, in relation to services commissioned under the activity.

Value for money in relation to the cost and outcomes of commissioned services needs to be considered within this planning process.

1. (a) Strategic Vision

Mental Health treatment and Suicide prevention services across the Hunter, New England and Central Coast regions are visible, accessible, integrated, consumer centred and appropriately resourced to handle the service demands of the community.

Key elements of this strategic vision are:

Visibility – services are known to other health professionals, other service providers (eg social services, community services, law enforcement etc) and the community. Services will be clearly described in terms of their place within an integrated stepped care model to assist consumers and service providers to easily identify the level of service provided by mental health or suicide prevention providers.

Accessibility – services are easily accessible to those who need them and are provided in regions where individuals require treatment utilising technological solutions where there are limited human resources or isolated populations. Waiting times for access to services do not negatively impact patient outcomes nor deter individuals from seeking treatment. Referral pathways are clearly defined and facilitate patients receiving the right care at the right time and in the right place.

Integration – different providers understand and work closely with each other to ensure collaborative relationships are developed and nurtured. Region-wide planning occurs at an appropriate level to ensure:

- decisions that may impact parts of the system are fully understood by all stakeholders
- evidence-based, efficient and effective treatment services are supported
- referral pathways and service integration occurs seamlessly between providers to ensure consumers receive the most appropriate service.
- Services are mapped to an integrated stepped care model inclusive of suicide prevention services to ensure services are available across the spectrum to support prevention and early intervention as well as graduated services as part of the recovery journey.
- Services are coordinated to ensure consumers are able to seamlessly transition between services in line with an evidence based stepped care model.

Consumer Centred – Services will be reviewed or developed using a coproduction methodology to place consumers and community in the centre of service design and review. Commissioned services will contain sufficient flexibility to meet the needs of the populations in which they service. Consumers will be able to access services through a streamlined point of entry to support consumer choice and reduce barriers to efficient triage and referral.

Resourcing – services that provide treatment for population groups within the community that are most vulnerable receive the greatest support. This will be facilitated by ongoing review of population health data and engagement with consumers and key stakeholders. Rigorous use of best practice literature and other practice evidence will be applied to all resourcing decisions to ensure resourcing supports methodologies which have proven to improve health outcomes and where no evidence exists we will partner with academic bodies to engage in research and evaluation to create evidence to guide practice.

All HNECC PHN Activity Work Plans and health planning across the organisation are developed and initiated through a Quadruple Aim lens. The objectives of Quadruple Aim are presented within activity tables. A specialist reference group will provide oversight, advice and support coproduction of service delivery models to ensure locally relevant, evidenced based services within both mental health and suicide prevention.

Planned activities funded under the Primary Mental Health Care Schedule – Priority Area 1

Note 1: For Priority Area 1, 2, and 5-8 use Template 1 below.

Note 2: For Priority Areas 3 and 4, please use Template 2 on page 9.

HNECC PHN Mental Health Activity Matrix
MH1 Low intensity mental health services
MH2 Youth Mental Health Services
MH3 Psychological therapies for rural and remote, under-serviced and / or hard to reach groups
MH4 Mental health services for people with severe and complex mental illness including care packages
MH5 Community based suicide prevention activities
MH6 Aboriginal and Torres Strait Islander mental health services
MH7 Stepped Care Approach
MH8 Completion of Regional Mental Health and Suicide Prevention Plan
MH9 Response to PFAS Exposure: Additional specialised mental health counselling services

Proposed Activities - copy and complete the table as many times as necessary to report on each Priority Area	
Priority Area	**MH1 Low intensity mental health services**
Activity(ies) / Reference (e.g. Activity 1.1, 1.2, etc)	**1.1 Promotion of existing low intensity services and low intensity gateways.** **1.2 Design and commissioning of new low intensity mental health services.**
Existing, Modified, or New Activity	1.1 Modified 1.2 Modified

Description of Activity	1.1	HNECC PHN will support and promote the Mental Health digital gateway once available and facilitate use amongst key groups by way of collaboration with local organisations and health providers. HNECC PHN will support and promote the availability of validated self-help and digital mental health services as part of a Stepped Care approach to mental health service provision. This will occur in conjunction with the development of targeted information and promotion for service providers, GPs and consumers regarding the clinical efficacy of alternatives to face to face intervention. These services will be promoted via HNECC PHN across local networks. Links through the HNECC PHN website will direct users to the site as appropriate, similarly, HNECC PHN will utilise social media to promote these resources. Embedding appropriate links in HealthPathways and the use of portals will be a key activity in raising the awareness of clinicians and consumers. HNECC PHN will also aim to include resourcing and framework in all commissioned services to facilitate promotion of low intensity online services including the development of community access terminals to support the use of low intensity resources for those otherwise unable to access these services.
	1.2	HNECC will build upon existing low intensity mental health services based on data provided by the Mental Health needs analysis. This will include promoting the formation of groups and supporting the growth of the peer workforce within contracted providers. The commissioning of low intensity mental health services to provide easy access to high quality, evidence based psychological services for people with, or at risk of, mild mental illness along with quality coaching and other low intensity interventions in a variety of formats may also be considered.
Target population cohort	1.1	Whole of population.
	1.2	Whole of population.
Consultation	1.1	Consultation will be conducted with key stakeholders via the MH/D&A expert reference group as well as through provider networks. Consumer consultation will be conducted utilising PHN online consumer engagement platform (PeopleBank).
	1.2	Consultation will be conducted with key stakeholders via the MH/D&A expert reference group as well as through provider networks. Consumer consultation will be conducted utilising PHN online consumer engagement platform (PeopleBank). In the event of commissioning services, consultation with be conducted through the use of a co-production panel which will comprise of key stakeholders, consumers and community members.

Collaboration	1.1	The PHN will work in collaboration with Government and non-government providers of low intensity services and gateways to ensure resources and referral details are detailed in a logical and easy to find structure with minimal duplication of information.
	1.2	The PHN will work in collaboration with existing providers, Local Health Districts, consumers and community members to design low intensity services which are integrated into existing service structures.
Duration	1.1	Total Duration 01/07/2016 – 31/06/2018 Mapping and promotion plan: Completed by 30/10/2017 Framework for ongoing management and updating implemented by 30/11/2017.
	1.2	Total Duration 01/07/2017 – 31/06/2018 Coproduction of low intensity service completed by 01/08/2017 Commissioning of low intensity service as per design by 01/11/2017 Commencement of low intensity service 01/12/2017.
Coverage	1.1	Whole PHN Region
	1.2	Whole PHN Region
Commissioning method (if relevant)	1.1	N/A
	1.2	It is anticipated that the PHN's current commissioning model, the key stages of which are: open Expression of Interest for providers to deliver services; select request for tender issued; evaluation of submissions; and contract negotiation and execution with successful tenderers, will be used in the commissioning of any new low intensity services. When services are commissioned, they will be monitored through a comprehensive annual planning and quarterly reporting cycle. The providers will also provide an evaluation report at the completion of the program, which will include qualitative and quantitative data, clinician and consumer feedback and indicators of the benefit of the Service. This data will inform HNECC PHN's ongoing Needs Assessment and Commissioning cycle.
Approach to market	1.1	N/A

	1.2 Open and/or selective tender, with intention to explore combining suitable low intensity and stepped care related services into a single model and tender in order to drive operational efficiencies.
Decommissioning	Nil
Performance Indicator	Priority Area 1 - Mandatory performance indicators: • Proportion of regional population receiving PHN-commissioned mental health services – Low intensity services. • Average cost per PHN-commissioned mental health service – Low intensity services. • Clinical outcomes for people receiving PHN-commissioned low intensity mental health services. Priority Area 7 - Mandatory performance indicator: • Proportion of PHN flexible mental health funding allocated to low intensity services, psychological therapies and for clinical care coordination for those with severe and complex mental illness. In addition to the mandatory performance indicator, you may select a local performance indicator. What local performance indicator will measure the outcome of this activity? • Number of recognised low intensity service provider within the PHN Footprint. Is this a process, output or outcome indicator? • Output Indicator
Local Performance Indicator target (where possible)	What performance target will be used (including justification) noting that performance target reporting will cover the 12 month reporting period (eg. from activity commencement for 12 months for reporting in September 2017). a) Number of people accessing services per quarter. (Quadruple Aim – Better Health Outcomes) b) Number of occasions of service across PHN funded services per quarter. (Quadruple Aim – Lower cost of care) c) Cost per occasion of service. (Quadruple Aim – Lower cost of Care) d) Average client satisfaction score (Quadruple Aim – Improved Consumer Experience).

	e) Average change in K10 Score per quarter (Quadruple Aim – Better Health Outcomes). What is the baseline for this indicator target and what is the effective date of this baseline? a) As per agreement in contract. b) As per agreement in contract. c) As per agreement in contract. d) 60% e) 4 What level of disaggregation will apply to this target and be reported to the Department? (eg. target group, gender, age) a) Disaggregation of greater than 20% b) Disaggregation of greater than 20% c) Disaggregation of greater than 20% d) Disaggregation of greater than 20% e) Disaggregation of greater than 3 points.
Local Performance Indicator Data source	Provide details on the data source that will be used to monitor progress against this indicator. Is this indicator sourced from a national data set? If so, what national data set? • MH MDS • Quarterly PHN Reporting Where possible, data collection should cover the activity duration period. What is the commencement date of the data collection? • Upon commissioning of services.

Planned activities funded under the Primary Mental Health Care Schedule – Priority Area 2

Note 1: For Priority Area 1, 2, and 5-8 use Template 1 below.

Note 2: For Priority Areas 3 and 4, please use Template 2 on page 9.

Proposed Activities - copy and complete the table as many times as necessary to report on each Priority Area	
Priority Area	**MH2 Youth mental health services**
Activity(ies) / Reference (e.g. Activity 1.1, 1.2, etc)	**2.1 Management of existing contracts for youth mental health providers.** **2.2 Design and commissioning of new youth mental health services.** **2.3 Increase capacity within existing primary youth mental health services.**
Existing, Modified, or New Activity	2.1 Existing 2.2 Modified 2.3 Modified
Description of Activity	2.1 Continue to support commissioned headspaces at Tamworth, Gosford/Lake Haven, Maitland and Newcastle to implement Headspace Model Integrity Framework and continue to support the ongoing growth and development of headspace services across the entire HNECC footprint through satellite and stand-alone sites when opportunities arise. Support greater cooperation between headspace providers to support collaboration and resource sharing. Work with Headspace centres to prepare for contract renewals and potentially contracting of new lead agencies. 2.2 HNECC PHN will enter into coproduction of a service model for Youth with complex and severe mental health presentations and will then subsequently commission services based on the outcomes of service coproduction process. The PHN will also commission the further roll-out of low-intensity youth services (LITe Model) following the initial pilot phase. In addition to these activities the PHN will also explore opportunities to provide further services to youths experiencing or at risk of mental illness through commissioning of early intervention focused services where indicated by needs assessment. 2.3 The PHN will engage in capacity building within existing service providers with regards to development of a peer workforce model to assist with consumer engagement and early intervention within new and existing providers. In addition to this there will be resources to

		build better networks across the sector and increase capacity to engage in early intervention and low-intensity support, including supporting the LHD Eating Disorders plans, improved engagement and treatment services with specific at risk, marginalised or hard to engage demographic groups and encouraging service collaboration across the sector.
Target population cohort	2.1	Children and Young people (Under 26) within the HNECC Footprint
	2.2	Children and Young people (Under 26) within the HNECC Footprint
	2.3	Children and Young people (Under 26) within the HNECC Footprint
Consultation	2.1	Consultation will be conducted with key stakeholders via the MH/D&A expert reference group as well as through provider networks. Consumer consultation will be conducted utilising PHN online consumer engagement platform (PeopleBank).
	2.2	Consultation will be conducted with key stakeholders via the MH/D&A expert reference group as well as through provider networks. Consumer consultation will be conducted utilising PHN online consumer engagement platform (PeopleBank). In the event of commissioning services, consultation with be conducted through the use of a co-production panel which will comprise of key stakeholders, consumers and community members.
	2.3	Consultation will be conducted with key stakeholders via the MH/D&A expert reference group as well as through provider networks. Consumer consultation will be conducted utilising PHN online consumer engagement platform (PeopleBank). In the event of commissioning services, consultation with be conducted through the use of a co-production panel which will comprise of key stakeholders, consumers and community members.
Collaboration	2.1	The PHN will work in collaboration with lead agencies of established headspaces to ensure implementation of model integrity framework and ongoing performance of Headspace centres.
	2.2	The PHN will work in collaboration with existing youth mental health providers, Local Health Districts, consumers and community members to design and produce services for young people which are integrated into existing service structures and target established need.
	2.3	The PHN will work in collaboration with existing youth mental health service providers, Local Health Districts, consumers and community members to identify opportunities to build capacity and consumer choice within existing service models.

Duration	2.1	Ongoing 01/07/2017 – 30/06/2018
	2.2	Ongoing 01/07/2017 – 30/06/2018 Coproduction to be completed by 30/07/2017 Commissioning to be completed by 30/09/2017 Services to commence 30/10/2017
	2.3	Ongoing 01/07/2017 – 30/06/2018
Coverage	2.1	Tamworth, Maitland, Newcastle & Gosford/Lake Haven
	2.2	Whole of PHN Area
	2.3	Whole of PHN Area
Commissioning method (if relevant)	2.1	N/A
	2.2	It is anticipated that the PHN's current commissioning model, the key stages of which are: open Expression of Interest for providers to deliver services; select request for tender issued; evaluation of submissions; and contract negotiation and execution with successful tenderers, will be used in the commissioning of any new low intensity services. When services are commissioned, they will be monitored through a comprehensive annual planning and quarterly reporting cycle. The providers will also provide an evaluation report at the completion of the program, which will include qualitative and quantitative data, clinician and consumer feedback and indicators of the benefit of the Service. This data will inform HNECC PHN's ongoing Needs Assessment and Commissioning cycle.
	2.3	It is anticipated that the PHN's current selective commissioning model, the key stages of which are: Selective Expression of Interest for providers to deliver services; select request for tender issued; evaluation of submissions; and contract negotiation and execution with successful tenderers, will be used in the commissioning of any new low intensity services. When services are commissioned, they will be monitored through a comprehensive annual planning and quarterly reporting cycle. The providers will also provide an evaluation report at the completion of the program, which will include qualitative and quantitative data, clinician and consumer feedback and indicators of the benefit of the Service. This data will inform HNECC PHN's ongoing Needs Assessment and Commissioning cycle.
Approach to market	2.1	N/A

	2.2 Open Tender 2.3 Selective Tender
Decommissioning	N/A
Performance Indicator	Priority Area 2 - Mandatory performance indicator: • support region-specific, cross sectoral approaches to early intervention for **children and young people** with, or at risk of mental illness (including those with severe mental illness who are being managed in primary care) and implementation of an equitable and integrated approach to primary mental health services for this population group. In addition to the mandatory performance indicator, you may select a local performance indicator. What local performance indicator will measure the outcome of this activity? a) Proportion of regional youth population receiving youth-specific PHN-commissioned mental health services. b) Specialist Reference Group is established to guide the development of service models and identify local needs in the region. Is this a process, output or outcome indicator? a) Output Indicator. b) Process Indicator.
Local Performance Indicator target (where possible)	What performance target will be used (including justification) noting that performance target reporting will cover the 12 month reporting period (eg. from activity commencement for 12 months for reporting in September 2017). f) Number of Young people accessing service per quarter. (Quadruple Aim – Better Health Outcomes) g) Number of occasions of service across PHN funded services per quarter. (Quadruple Aim – Lower cost of care) h) Cost per occasion of service. (Quadruple Aim – Lower cost of Care) i) Average client satisfaction score (Quadruple Aim – Improved Consumer Experience).

	j) Average change in K10 Score per quarter (Quadruple Aim – Better Health Outcomes). What is the baseline for this indicator target and what is the effective date of this baseline? f) As per agreement in contract. g) As per agreement in contract. h) As per agreement in contract. i) 60% (Baseline taken 30/01/2017) j) 4 (Baseline taken 30/01/2017) What level of disaggregation will apply to this target and be reported to the Department? (eg. target group, gender, age) f) Disaggregation of greater than 20% g) Disaggregation of greater than 20% h) Disaggregation of greater than 20% i) Disaggregation of greater than 20% j) Disaggregation of greater than 3 points.
Local Performance Indicator Data source	Provide details on the data source that will be used to monitor progress against this indicator. Is this indicator sourced from a national data set? If so, what national data set? • Headspace Nation Minimum Data Set. • Quarterly PHN Reporting Where possible, data collection should cover the activity duration period. What is the commencement date of the data collection? Ongoing Data collection (Quarterly)

Planned activities funded under the Primary Mental Health Care Schedule – Priority Area 3

Use this template table for Priority Areas 3 and 4

Proposed Activities - copy and complete the table as many times as necessary to report on each Priority Area	
Priority Area	**MH3 Psychological therapies for rural and remote, under-serviced and / or hard to reach groups**
Activity(ies) / Reference (e.g. Activity 1.1, 1.2, etc)	**3.1 Redesign of PMHCS services.** **3.2 Recommissioning of PMHCS Services.**
Existing, Modified, or New Activity	3.1 New 3.2 New
Description of Activity	3.1 The Primary Mental Health Care Services (PMHCS) program, previously known as ATAPS/MHSRRA, will be reaching the end of its current contract period in June 2017. It is intended that PMHCS will undergo coproduction redesign to examine ways in which the program can be made more flexible and accessible to meet the psychological needs of communities across the PHN footprint with particular reference to identified hard to reach and at risk groups such as; people at increased risk of suicide or self-harm; Aboriginal and Torres Strait Islander people; women experiencing perinatal depression and/or anxiety; children and youth; people living in rural and remote areas; and people who are socio-economically disadvantaged. The Primary Mental Health Care Services model will be reviewed in the context of developing a Stepped Care model for the HNECC PHN region, and in the context of the future commissioning of low intensity population based services for people with mild to moderate mental health issues. 3.2 Once PMHCS has undergone coproduction redesign, the service will be recommissioned across the PHN with a focus on distribution of psychological interventions to improve equity in access to psychological services for at risk groups across the footprint.
Target population cohort	3.1 Whole of Population 3.2 Whole of Population
Consultation	3.1 Consultation will be conducted with key stakeholders via the MH/D&A expert reference group as well as through provider networks. Consumer consultation will be conducted utilising PHN

	online consumer engagement platform (PeopleBank). The coproduction review will also involve, consultation with the co-production panel which will comprise of key stakeholders, consumers and community members. 3.2 Consultation will be conducted with key stakeholders via the MH/D&A expert reference group as well as through provider networks. Consumer consultation will be conducted utilising PHN online consumer engagement platform (PeopleBank).
Collaboration	3.1 The PHN will work in collaboration with existing PMHCS providers, Local Health Districts, consumers and community members to design and produce a service which is integrated into existing stepped care service structures and targets established need. 3.3 The PHN will work in collaboration with consumers and subject matter experts to ensure quality in commissioning.
Duration	3.1 01/07/2017 – 01/09/2017 3.2 01/09/2017 – 31/06/2018
Coverage	3.1 Whole of PHN Area 3.2 Whole of PHN Area
Continuity of care	All providers have been asked to provide transition plans as part of the 2nd quarter reporting outlining plans for the maintenance of care should contracts change to another provider at the end of their contracts. Transitional funding will also be provided to support existing providers to extend time to facilitate consumer engagement with a new service should service changes occur.
Commissioning method (if relevant)	3.1 N/A 3.2 It is anticipated that the PHN's current commissioning model, the key stages of which are: open Expression of Interest for providers to deliver services; select request for tender issued; evaluation of submissions; and contract negotiation and execution with successful tenderers, will be used in the commissioning of any new low intensity services. When services are commissioned, they will be monitored through a comprehensive annual planning and quarterly reporting cycle. The providers will also provide an evaluation report at the completion of the program, which will include qualitative and quantitative data, clinician and consumer feedback and indicators of the benefit of the Service. This data will inform HNECC PHN's ongoing Needs Assessment and Commissioning cycle.

Approach to market	3.1 N/A 3.2 Selective tender with existing providers.
Decommissioning	Nil
Performance Indicator	Priority Area 3 - mandatory performance indicators: • Proportion of regional population receiving PHN-commissioned mental health services – Psychological therapies delivered by mental health professionals. • Average cost per PHN-commissioned mental health service – Psychological therapies delivered by mental health professionals. • Clinical outcomes for people receiving PHN-commissioned Psychological therapies delivered by mental health professionals. In addition to the mandatory performance indicator, you may select a local performance indicator for each Priority Area. What local performance indicator will measure the outcome of this activity? • PHN is currently working with providers to develop standard performance indicators at a local level derived from existing practices and the MDS. Measures will cover the entirety of Quadruple Aim methodology. Expected completion date 01/07/2017. Is this a process, output or outcome indicator?
Local Performance Indicator target (where possible)	What performance target will be used (including justification) noting that performance target reporting will cover the 12 month reporting period (eg. from activity commencement for 12 months for reporting in September 2017). • PHN is currently working with providers to develop standard performance indicators at a local level derived from existing practices and the MDS. Measures will cover the entirety of Quadruple Aim methodology. Expected completion date 01/07/2017. What is the baseline for this indicator target and what is the effective date of this baseline? What level of disaggregation will apply to this target and be reported to the Department? (eg. target group, gender, age)
Local Performance Indicator Data source	Provide details on the data source that will be used to monitor progress against this indicator.

	Is this indicator sourced from a national data set? If so, what national data set? • MDS • PHN Quarterly Reports Where possible, data collection should cover the activity duration period. What is the commencement date of the data collection?

Planned activities funded under the Primary Mental Health Care Schedule – Priority Area 4

Use this template table for Priority Areas 3 and 4

Proposed Activities - copy and complete the table as many times as necessary to report on each Priority Area	
Priority Area	**MH4 Mental health services for people with severe and complex mental illness including care packages**
Activity(ies) / Reference (e.g. Activity 1.1, 1.2, etc)	**4.1 Recommissioning of MHNIP Services.** **4.2 Commissioning of Local Transitional Care Package Program.**
Existing, Modified, or New Activity	4.1 New 4.2 Modified
Description of Activity	4.1 The Mental Health Nurses Incentive Program (MHNIP) program will be reaching the end of its current contract period in June 2017. It is intended that MHNIP will undergo coproduction redesign to examine ways in which the program can be made more flexible and accessible to meet the primary mental health nursing needs of communities across the PHN footprint with particular prior to the end of contracts. It is also hoped that review using the coproduction methodology will examine workforce development and retention within the program. The MHNIP model will be reviewed in the context of developing a Stepped Care model for the HNECC PHN region, and in the context of the future commissioning of low intensity population based services for people with mild to moderate mental health issues. MHNIP services will then be recommissioned for the duration of the activity work plan. 4.2 The PHN will be commissioning Transitional Support and Care Package Services which will focus on Primary providers partnering with local Mental Health Units and Emergency Departments to develop transitional care from tertiary to primary services supported by patient centred care packages. These services will be based on local partnerships and solutions to supporting those with complex mental health issues remaining in the primary health sector.
Target population cohort	4.1 People experiencing complex or severe mental illness who are able to be safely managed in the primary health sector.

	4.2 People with complex or severe mental health issues who can be safely managed in the primary sector, who are at risk of multiple or prolonged preventable admissions to tertiary services.
Consultation	4.1 Consultation will be conducted with key stakeholders via the MH/D&A expert reference group as well as through provider networks. Consumer consultation will be conducted utilising PHN online consumer engagement platform (PeopleBank). 4.2 Consultation will be conducted with key stakeholders via the MH/D&A expert reference group as well as through provider networks. Consumer consultation will be conducted utilising PHN online consumer engagement platform (PeopleBank).
Collaboration	4.1 The PHN will work in collaboration with consumers and subject matter experts to ensure quality in commissioning. 4.3 The PHN will work in collaboration with consumers Local Health Networks and subject matter experts to ensure quality in commissioning.
Duration	4.1 01/07/2017 – 31/06/2017 4.2 01/07/2017 – 31/06/2017
Coverage	4.1 Whole of PHN Area 4.2 Whole of PHN Area
Continuity of care	All providers have been asked to provide transition plans as part of the 2nd quarter reporting outlining plans for the maintenance of care should contracts change to another provider at the end of their contracts. Transitional funding will also be provided to support existing providers to extend time to facilitate consumer engagement with a new service
Commissioning method (if relevant)	4.1 It is anticipated that the PHN's current commissioning model, the key stages of which are: open Expression of Interest for providers to deliver services; select request for tender issued; evaluation of submissions; and contract negotiation and execution with successful tenderers, will be used in the commissioning of any new low intensity services. When services are commissioned, they will be monitored through a comprehensive annual planning and quarterly reporting cycle. The providers will also provide an evaluation report at the completion of the program, which will include qualitative and quantitative data, clinician and consumer feedback and indicators of the benefit of the Service. This data will inform HNECC PHN's ongoing Needs Assessment and Commissioning cycle.

	4.2 It is anticipated that the PHN's current commissioning model, the key stages of which are: open Expression of Interest for providers to deliver services; select request for tender issued; evaluation of submissions; and contract negotiation and execution with successful tenderers, will be used in the commissioning of any new low intensity services. When services are commissioned, they will be monitored through a comprehensive annual planning and quarterly reporting cycle. The providers will also provide an evaluation report at the completion of the program, which will include qualitative and quantitative data, clinician and consumer feedback and indicators of the benefit of the Service. This data will inform HNECC PHN's ongoing Needs Assessment and Commissioning cycle.
Approach to market	4.1 Open Tender 4.2 Selective Tender
Decommissioning	Nil
Performance Indicator	Priority Area 4 - mandatory performance indicators: • Proportion of regional population receiving PHN-commissioned mental health services – Clinical care coordination for people with severe and complex mental illness (including clinical care coordination by mental health nurses). • Average cost per PHN-commissioned mental health service – Clinical care coordination for people with severe and complex mental illness. In addition to the mandatory performance indicator, you may select a local performance indicator for each Priority Area. • PHN is currently working with providers to develop standard performance indicators at a local level derived from existing practices and the MDS. Measures will cover the entirety of Quadruple Aim methodology. Expected completion date 01/07/2017. What local performance indicator will measure the outcome of this activity? Is this a process, output or outcome indicator?
Local Performance Indicator target (where possible)	What performance target will be used (including justification) noting that performance target reporting will cover the 12 month reporting period (eg. from activity commencement for 12 months for reporting in September 2017).

	• PHN is currently working with providers to develop standard performance indicators at a local level derived from existing practices and the MDS. Measures will cover the entirety of Quadruple Aim methodology. Expected completion date 01/07/2017. What is the baseline for this indicator target and what is the effective date of this baseline? What level of disaggregation will apply to this target and be reported to the Department? (eg. target group, gender, age)
Local Performance Indicator Data source	Provide details on the data source that will be used to monitor progress against this indicator. Is this indicator sourced from a national data set? If so, what national data set? • MDS • PHN Quarterly Reports Where possible, data collection should cover the activity duration period. What is the commencement date of the data collection?

Planned activities funded under the Primary Mental Health Care Schedule – Priority Area 5

Note 1: For Priority Area 1, 2, and 5-8 use Template 1 below.

Note 2: For Priority Areas 3 and 4, please use Template 2 on page 9.

Proposed Activities - copy and complete the table as many times as necessary to report on each Priority Area	
Priority Area	**MH5 Community based suicide prevention activities**
Activity(ies) / Reference (e.g. Activity 1.1, 1.2, etc)	**5.1 Recommission existing Suicide prevention activities and commissioning of additional low intensity and early intervention activities and services for suicide prevention.** **5.2 Implementing Regional Suicide Prevention Plan.**
Existing, Modified, or New Activity	5.1 Modified 5.2 New
Description of Activity	5.1 Decisions regarding further commissioning of services will occur pending review of existing low intensity (Family Wellbeing Program formerly TATS) and medium intensity suicide prevention contracts (Farmlink and Lifeline Programs including follow-up services) which were previously funded under the Community Suicide Prevention Grant Scheme prior to contracts ending in June 2017 and completion of in depth needs analysis. More intensive Follow-Up services will be integrated into Priority areas MH3 and MH4 (PHN MHS and MHNIP). The PHN intends to recommission current services with amendments to scope and target populations based on outcomes of upcoming review. Based on the outcomes of recommissioning of current providers and completion of suicide prevention plan further services may be commissioned based on identified needs within the PHN area. PHN will also support the roll out of first responder training initiatives and screening programs to facilitate early identification and intervention. 5.2 Implementation of Regional Suicide Prevention Plan will be instigated upon completion of plan in September 2017. Further details will be able to be provided in future updates upon completion of the plan.
Target population cohort	5.1 Whole of population 5.2 Whole of population

Consultation	5.1	Consultation will be conducted with key stakeholders via the MH/D&A expert reference group as well as through provider networks. Consultation with people with lived experience will be conducted utilising PHN online community engagement platform (PeopleBank). In the event of new programs being developed coproduction methods will also involve, consultation with the co-production panel which will comprise of key stakeholders, people with lived experience and community members.
	5.2	Consultation will be conducted with key stakeholders via the MH/D&A expert reference group as well as through provider networks. Consultation with people with lived experience will be conducted utilising PHN online community engagement platform (PeopleBank).
Collaboration	5.1	The PHN will work in collaboration with people with lived experience and subject matter experts to ensure quality in commissioning.
	5.2	The PHN will work in collaboration with service providers and networks to ensure efficient implementation and engagement with the plan.
Duration	5.1	01/07/2017 - existing providers to commence on new contracts. 01/02/2018 – Any new services commissioned to commence.
Coverage	5.1	Farmlink – LGAs sitting within the New England Area Lifeline – LGAs sitting within the Hunter and Central Coast Areas Additional Services – Whole of area
	5.2	Whole of area
Commissioning method (if relevant)	5.1	It is anticipated that the PHN's current commissioning model, the key stages of which are: Expression of Interest for providers to deliver services; select request for tender issued; evaluation of submissions; and contract negotiation and execution with successful tenderers, will be used in the commissioning of any new low intensity services. When services are commissioned, they will be monitored through a comprehensive annual planning and quarterly reporting cycle. The providers will also provide an evaluation report at the completion of the program, which will include qualitative and quantitative data, clinician and consumer feedback and indicators of the benefit of the Service. This data will inform HNECC PHN's ongoing Needs Assessment and Commissioning cycle.
	5.2	N/A

Approach to market	5.1 Direct approach to existing contracted providers, open tender for any new services commissioned. 5.2 N/A
Decommissioning	Nil
Performance Indicator	Priority Area 5 - Mandatory performance indicator: • Number of people who are followed up by PHN-commissioned services following a recent suicide attempt. In addition to the mandatory performance indicator, you may select a local performance indicator. What local performance indicator will measure the outcome of this activity? • Average increase in confidence of training participants in intervening with at risk people. Is this a process, output or outcome indicator? • Outcome Indicator
Local Performance Indicator target (where possible)	What performance target will be used (including justification) noting that performance target reporting will cover the 12 month reporting period (eg. from activity commencement for 12 months for reporting in September 2017). a) Number of suicide prevention action groups created. What is the baseline for this indicator target and what is the effective date of this baseline? a) 2 new network per year. What level of disaggregation will apply to this target and be reported to the Department? (eg. target group, gender, age) a) 0 networks created.
Local Performance Indicator Data source	Provide details on the data source that will be used to monitor progress against this indicator. Is this indicator sourced from a national data set? If so, what national data set?

	MH MDS PHN Quarterly Reporting Where possible, data collection should cover the activity duration period. What is the commencement date of the data collection? 01/07/2017

Planned activities funded under the Primary Mental Health Care Schedule – Priority Area 6

Note 1: For Priority Area 1, 2, and 5-8 use Template 1 below.

Note 2: For Priority Areas 3 and 4, please use Template 2 on page 9.

Proposed Activities - copy and complete the table as many times as necessary to report on each Priority Area		
Priority Area	**MH6**	**Aboriginal and Torres Strait Islander mental health services**
Activity(ies) / Reference (e.g. Activity 1.1, 1.2, etc)	**6.1**	**Management of existing Aboriginal Mental Health contracts.**
	6.2	**Development and promotion of social and emotional health and suicide prevention initiatives.**
	6.3	**Capacity Building within Aboriginal Community Controlled Agencies (Including AMS Providers) and mainstream organisations who provide services to Aboriginal consumers.**
Existing, Modified, or New Activity	6.1	Modified
	6.2	Modified
	6.3	New
Description of Activity	6.1	Following on from successful commissioning of Aboriginal Mental Health Services the PHN will continue to manage existing contracts and work towards completing review of current services prior to the completion of contracts in June 2018.
	6.2	Develop and promote social and emotional health activities to be delivered through the footprint and implement seed grants to support establishment and ongoing promotion of these programs in ACCHOs across the region. In addition to this explore use of culturally safe e-health and low intensity services with a focus on suicide prevention for example i-Bobbly program, peer and facilitated group programs aimed at strengthening cultural ties and support networks in vulnerable communities, programs aimed at specific at risk sub-groups (eg LGBTIQ youth) and peer support services in addition to already funded suicide prevention and postvention programs.
	6.3	Engage in capacity building within local ACCHO network to increase capacity to operate within the open market as well as in the design and development of evidenced based mental health services. Further to this work with all agencies who provide services to Aboriginal consumers to provide services which are culturally safe and meet the needs of local communities in

		consultation with local Aboriginal community leaders. This activity also involves the facilitation of opportunities for Community Controlled Organisations and mainstream providers to engage and form mutually beneficial partnerships. These activities may also include providing opportunities for mainstream and Aboriginal services to come together for the purposes of knowledge development and facilitation of sharing of knowledge and practice initiatives.
Target population cohort	6.1 6.2 6.3	Aboriginal people across the lifespan Aboriginal people across the lifespan AMS and other ACCHO providers.
Consultation	6.1 6.2 6.3	Consultation will be conducted with key stakeholders via the MH/D&A expert reference group as well as through provider networks. Consumer consultation will be conducted utilising PHN online consumer engagement platform (PeopleBank) in addition to local Aboriginal controlled organisations and local elders. When the services are reviewed coproduction review methods will also involve, consultation with the co-production panel which will comprise of key stakeholders, consumers and community members. Consultation will be conducted with key stakeholders via the MH/D&A expert reference group as well as through provider networks. Consumer consultation will be conducted utilising PHN online consumer engagement platform (PeopleBank) in addition to local Aboriginal controlled organisations and local elders. Consultation will be conducted with AMS and ACCHO providers and with local Aboriginal Community Representatives.
	6.1 6.2 6.3	The PHN will work in collaboration with consumers, service providers and subject matter experts to ensure successful execution of services contracted. The PHN will work in collaboration with service providers, community representatives and other key stakeholders to ensure engagement with programs with a view to supporting community and provider ownership. The PHN will collaborate with AMS and ACCHO providers to ensure capacity building activities are targeted and support greater capacity to engage in the open market and develop evidence based services. The PHN capacity building activities will be linked to provider activity to ensure activity is meaningful and creates measurable outcomes.

Duration	6.1	01/07/2017 – 30/06/2018 Review of existing contracts to be completed by 01/02/2018. Recontracting/Commissioning for services post June 2018 to be completed by 01/06/2018.
	6.2	01/07/2017 – 30/06/2018
	6.3	01/07/2017 – 30/06/2018
Coverage	6.1	Whole of Area
	6.2	Whole of Area
	6.3	Whole of Area
Commissioning method (if relevant)	6.1	It is anticipated that the PHN's current commissioning model, the key stages of which are: Expression of Interest for providers to deliver services; select request for tender issued; evaluation of submissions; and contract negotiation and execution with successful tenderers, will be used in the commissioning of any new low intensity services. When services are commissioned, they will be monitored through a comprehensive annual planning and quarterly reporting cycle. The providers will also provide an evaluation report at the completion of the program, which will include qualitative and quantitative data, clinician and consumer feedback and indicators of the benefit of the Service. This data will inform HNECC PHN's ongoing Needs Assessment and Commissioning cycle.
	6.2	It is anticipated that the PHN's current commissioning model, the key stages of which are: Expression of Interest for providers to deliver services; select request for tender issued; evaluation of submissions; and contract negotiation and execution with successful tenderers, will be used in the commissioning of any new low intensity services. When services are commissioned, they will be monitored through a comprehensive annual planning and quarterly reporting cycle. The providers will also provide an evaluation report at the completion of the program, which will include qualitative and quantitative data, clinician and consumer feedback and indicators of the benefit of the Service. This data will inform HNECC PHN's ongoing Needs Assessment and Commissioning cycle.
	6.3	N/A
Approach to market	6.1	Plan to renew contracts in the first instance, in cases of poor performance or withdrawal of providers, approaches will be made to the open market.

	6.2 EOIs to be issues to relevant providers. 6.3 Direct approach to providers as identified.
Decommissioning	Nil
Performance Indicator	Priority Area 6 - Mandatory performance indicator: • Proportion of Indigenous population receiving PHN-commissioned mental health services where the services were culturally appropriate. In addition to the mandatory performance indicator, you may select a local performance indicator. What local performance indicator will measure the outcome of this activity? • Number of Social Emotional Wellbeing Projects within the PHN Footprint. Is this a process, output or outcome indicator? • Output Indicator.
Local Performance Indicator target (where possible)	What performance target will be used (including justification) noting that performance target reporting will cover the 12 month reporting period (eg. from activity commencement for 12 months for reporting in September 2017). What is the baseline for this indicator target and what is the effective date of this baseline? • To be determined upon commencement of commissioned of services. What level of disaggregation will apply to this target and be reported to the Department? (eg. target group, gender, age)
Local Performance Indicator Data source	Provide details on the data source that will be used to monitor progress against this indicator. Is this indicator sourced from a national data set? If so, what national data set? • MH MDS • PHN Quarterly reporting. Where possible, data collection should cover the activity duration period. What is the commencement date of the data collection?

Planned activities funded under the Primary Mental Health Care Schedule – Priority Area 7

Note 1: For Priority Area 1, 2, and 5-8 use Template 1 below.

Note 2: For Priority Areas 3 and 4, please use Template 2 on page 9.

Proposed Activities - copy and complete the table as many times as necessary to report on each Priority Area	
Priority Area	**MH7 Stepped Care Approach**
Activity(ies) / Reference (e.g. Activity 1.1, 1.2, etc)	**7.1 Develop capacity within the primary sector to operate within a patient centred stepped care model.** **7.2 Improve integration with other sectors contained within the stepped care model (e.g. Tertiary care, community services etc).** **7.3 Facilitate integration and standardising of governance, clinical information management, performance reporting and consumer/staff feedback processes to support a holistic and integrated stepped care model within primary health services.**
Existing, Modified, or New Activity	7.1 New 7.2 New 7.3 New
Description of Activity	7.1 The PHN will develop and commission a framework/service to provide support to existing providers and the community to correctly stratify and place consumers into the stepped care model inclusive of step one and low intensity options to move focus onto low intensity and illness prevention activities. In addition to this the PHN will also commission the development of a framework and subsequent support to support the consistent delivery of step one (promotion, prevention and referral) within providers operating at the higher levels of stepped care and other services who service at risk population groups. The current stepped care model will also be developed further to incorporate Suicide Prevention and Drug and Alcohol in order to drive further integration and consumer centred care delivery. Work will also focus on ensuring capacity within the local Primary Health sector to provide services across the spectrum of stepped care and identifying gaps and working with providers to find solutions to address these needs which may include service enhancement or commissioning activities. This

	work will also include finalising regional mental health and suicide intervention plan which will inform future activities. 7.2 The PHN will develop and commission a framework to ensure consumers can move efficiently between community services, tertiary services and the primary health system. The PHN will support opportunities for supporting partnerships and collaboration between providers and other parts of the stepped care model. This may be achieved through facilitating strategic partnerships or commissioning primary services in collaboration with LHDs and community organisations which include integration within the service model. Work will also include the development of resourcing and information programs aimed at increasing knowledge of available services and treatment frameworks within the Primary care sector to increase provider knowledge across the entire stepped care spectrum as well as empowering consumers to make informed choices from anywhere within the stepped care framework. 7.3 The PHN will work with providers to implement a series of standards in regards to clinical governance, clinical information storage, performance reporting and consumer and staff feedback processes. This will be further supported by continued development of electronic referral pathways and common data management processes. Once this work is completed standards will be included into PHN contracts and IT requirements will be integrated into tendering processes.
Target population cohort	7.1 All of population 7.2 All of population 7.3 Existing and future PHN contracted providers.
Consultation	7.1 Consultation will be conducted with key stakeholders via the MH/D&A expert reference group as well as through provider networks. Consumer consultation will be conducted utilising PHN online consumer engagement platform (PeopleBank). In the event of new programs being developed coproduction methods will also involve, consultation with the co-production panel which will comprise of key stakeholders, consumers and community members. 7.2 Consultation will be conducted with key stakeholders via the MH/D&A expert reference group as well as through provider networks. Consumer consultation will be conducted utilising PHN online consumer engagement platform (PeopleBank). In the event of new programs being developed coproduction methods will also involve, consultation with the co-production panel which will comprise of key stakeholders, consumers and community members.

	7.3	Consultation will be conducted with key stakeholders via the MH/D&A expert reference group as well as through provider networks. Consumer consultation will be conducted utilising PHN online consumer engagement platform (PeopleBank).
Collaboration	7.1	The PHN will work in collaboration with consumers, service providers and subject matter experts to ensure successful development and execution of services contracted.
	7.2	The PHN will work in collaboration with consumers, service providers and subject matter experts to ensure successful development and execution of services contracted.
	7.3	The PHN will work in collaboration with existing service providers and subject matter experts to ensure successful implementation of governance, information management and consumer feedback standards.
Duration	7.1	01/07/2017 – 30/06/2018 Design and commissioning to be completed by 20/12/2017
	7.2	01/07/2017 – 30/06/2018 Design and commissioning to be completed by 20/12/2017
	7.3	01/07/2017 – 01/10/2017 – Completion of standards 01/10/2017 – 30/06/2018 – Implementation into existing programs and integration into new contracting.
Coverage	7.1	Whole of Area
	7.2	Whole of Area
	7.3	Whole of Area
Commissioning method (if relevant)	7.1	It is anticipated that the PHN's current commissioning model, the key stages of which are: Expression of Interest for providers to deliver services; select request for tender issued; evaluation of submissions; and contract negotiation and execution with successful tenderers, will be used in the commissioning of any new low intensity services. When services are commissioned, they will be monitored through a comprehensive annual planning and quarterly reporting cycle. The providers will also provide an evaluation report at the completion of the program, which will include qualitative and quantitative data, clinician

	and consumer feedback and indicators of the benefit of the Service. This data will inform HNECC PHN's ongoing Needs Assessment and Commissioning cycle. 7.2 It is anticipated that the PHN's current commissioning model, the key stages of which are: Expression of Interest for providers to deliver services; select request for tender issued; evaluation of submissions; and contract negotiation and execution with successful tenderers, will be used in the commissioning of any new low intensity services. When services are commissioned, they will be monitored through a comprehensive annual planning and quarterly reporting cycle. The providers will also provide an evaluation report at the completion of the program, which will include qualitative and quantitative data, clinician and consumer feedback and indicators of the benefit of the Service. This data will inform HNECC PHN's ongoing Needs Assessment and Commissioning cycle. 7.3 N/A
Approach to market	7.1 Open Market or Selective Tender 7.2 Open Market or Selective Tender 7.3 N/A
Decommissioning	Nil
Performance Indicator	Priority Area 7 - Mandatory performance indicator: • Proportion of PHN flexible mental health funding allocated to low intensity services, psychological therapies and for clinical care coordination for those with severe and complex mental illness. Priority Area 8 - Mandatory performance indicators: • Evidence of formalised partnerships with other regional service providers to support integrated regional planning and service delivery. In addition to the mandatory performance indicator, you may select a local performance indicator. What local performance indicator will measure the outcome of this activity? • Number of commissioned within the PHN Footprint Is this a process, output or outcome indicator?

	• Output indicator.
Local Performance Indicator target (where possible)	What performance target will be used (including justification) noting that performance target reporting will cover the 12 month reporting period (eg. from activity commencement for 12 months for reporting in September 2017). What is the baseline for this indicator target and what is the effective date of this baseline? • To be determined upon commissioning of services. What level of disaggregation will apply to this target and be reported to the Department? (eg. target group, gender, age)
Local Performance Indicator Data source	Provide details on the data source that will be used to monitor progress against this indicator. Is this indicator sourced from a national data set? If so, what national data set? • MH MDS • PHN Quarterly reporting. Where possible, data collection should cover the activity duration period. What is the commencement date of the data collection?

Planned activities funded under the Primary Mental Health Care Schedule – Priority Area 8

Note 1: For Priority Area 1, 2, and 5-8 use Template 1 below.

Note 2: For Priority Areas 3 and 4, please use Template 2 on page 9.

Proposed Activities - copy and complete the table as many times as necessary to report on each Priority Area	
Priority Area	**MH8 Regional mental health and suicide prevention plan**
Activity(ies) / Reference (e.g. Activity 1.1, 1.2, etc)	**8.1 Completion of Regional Mental Health and Suicide Prevention Plan**
Existing, Modified, or New Activity	8.1 Existing
Description of Activity	8.1 Completion of the HNECC PHN Regional Mental Health Suicide Prevention Plan based on outcomes from mental health and suicide prevention needs assessment and feedback from community and key stake holders.
Target population cohort	8.1 Whole of Community
Consultation	8.1 Consultation will be conducted with key stakeholders via the MH/D&A expert reference group as well as through provider networks. Consumer consultation will be conducted utilising PHN online consumer engagement platform (PeopleBank).
Collaboration	8.1 The PHN will collaborate with key stakeholders and the community in order to facilitate engagement with the resulting plan to assist in developing ownership and commitment to the plan.
Duration	8.1 01/07/2017 – 30/09/2017
Coverage	8.1 Whole of Area
Commissioning method (if relevant)	8.1 N/A
Approach to market	8.1 N/A
Decommissioning	Nil
Performance Indicator	Priority Area 8 - Mandatory performance indicators: • Evidence of formalised partnerships with other regional service providers to support integrated regional planning and service delivery.

	In addition to the mandatory performance indicator, you may select a local performance indicator. What local performance indicator will measure the outcome of this activity? Is this a process, output or outcome indicator?
Local Performance Indicator target (where possible)	What performance target will be used (including justification) noting that performance target reporting will cover the 12 month reporting period (eg. from activity commencement for 12 months for reporting in September 2017). What is the baseline for this indicator target and what is the effective date of this baseline? What level of disaggregation will apply to this target and be reported to the Department? (eg. target group, gender, age)
Local Performance Indicator Data source	Provide details on the data source that will be used to monitor progress against this indicator. Is this indicator sourced from a national data set? If so, what national data set? Where possible, data collection should cover the activity duration period. What is the commencement date of the data collection?

Planned activities funded under the Primary Mental Health Care Schedule – Priority Area 9

Note 1: For Priority Area 1, 2, and 5-8 use Template 1 below.

Note 2: For Priority Areas 3 and 4, please use Template 2 on page 9.

Proposed Activities - copy and complete the table as many times as necessary to report on each Priority Area	
Priority Area	**MH9 Response to PFAS Exposure: Additional specialised mental health and counselling services.**
Activity(ies) / Reference (e.g. Activity 1.1, 1.2, etc)	**9.1 Response to PFAS Exposure: Specialised mental health services.**
Existing, Modified, or New Activity	9.1 Existing
Description of Activity	9.1 Briefing held for all current contracted providers of PHN MHS to alert them to supplementary funding available for eligible consumers affected by the contamination, with rates in line with current contracts. Resourcing provided and information, including provider list and reimbursement claim form and stat dec placed on website for public access. Services promoted through local meetings and community leaders. Due to transient nature of some of the workforce in the affected area and timeframe of contamination, all providers in the HNECC footprint have received resourcing and education. The PHN will maintain current arrangements and facilitate payment of sessions.
Target population cohort	9.1 People effected by the Williamtown PFAS exposure.
Consultation	9.1 Consultation will be conducted with key stakeholders via the MH/D&A expert reference group as well as through provider networks. Consumer consultation will be conducted utilising PHN online consumer engagement platform (PeopleBank) as well as the community advocacy and support group representing the Williamtown community.
Collaboration	9.1 Collaboration with other government departments in providing GP, provider and public education. Collaboration with local community leaders to promote available service pathways. Collaboration with PHN MHS providers and GPs to ensure access for affected consumers across the PHN footprint. Collaboration with other PHN and primary care providers outside HNECC footprint in cases where eligible participants have left the footprint.

Duration	9.1	01/07/2017 – 30/06/2018
Coverage	9.1	Primary focus on providers in the Hunter, with inclusion of NE and CC regions. Creation of pathways into primary care support outside the HNECC region.
Commissioning method (if relevant)	9.1	HNECC PHN has not commissioned PFAS services but has engaged directly with Mental Health Practitioners deemed to be most appropriate to respond to the specific needs of the communities most impacted by PFAS exposure. Under the PFAS program HNECC PHN utilises the funds provided by the Department to facilitate payments Allied Health providers. This is undertaken via a claim form (copies of these forms have been included as attachments to this Work Plan) submission process whereby: **Allied Health Payments** 1. Claim form will be downloaded from HNECC PHN website and completed by the Allied Health Provider. This will be one of our existing ATAPs / MHSRRA providers. 2. Claim form is emailed to HNECC PHN for approval 3. Payment will be made weekly in arrears to each provider 4. Register will be updated to track payments and required information The Allied Health Payments are based on the existing contract rates that we have with each of our providers, and the rate will therefore vary between provider and region.
Approach to market	9.1	Direct Engagement
Decommissioning	Nil	
Performance Indicator	What local performance indicator will measure the outcome of this activity? Is this a process, output or outcome indicator? 1. Increased access for non-defence personnel to mental health and counselling services for people who have lived or worked in Williamtown PFAS investigation area 2. Provision of voluntary PFAS Blood Testing Program 3. Support and education of Mental Health and General Practitioners around PFAS Exposure is available 4. Established reimbursement program for General Practice for pre and post blood test counselling consultations which ensures those seeking a PFAS blood test are not out of pocket	

	5. A tailored HNECC PHN communications strategy developed in line with government PFAS response and appropriate messaging is being distributed throughout affected HNECC PHN communities HNECC PHN has determined and established some eligibility criteria for reimbursement and has platforms and systems in place to ensure adequate responsibility
Local Performance Indicator target (where possible)	What performance target will be used (including justification) noting that performance target reporting will cover the 12 month reporting period (eg. from activity commencement for 12 months for reporting in September 2017). What is the baseline for this indicator target and what is the effective date of this baseline? What level of disaggregation will apply to this target and be reported to the Department? (eg. target group, gender, age)
Local Performance Indicator Data source	HNECC PHN will not collect patient level data. It will however, collect data around volume including the number of claims made and the number of mental health sessions accessed under the program. This data will be reported back in the appropriate 6 and 12 month reports.