Australian Government
Department of Health

phn
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Updated Activity Work Plan 2016-2019: 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 2016-2019, 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 2016-2019 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 and/or suicide prevention trial sites will be managed separately.

The Mental Health Activity Work Plan must be lodged via email to your Grant Officer on or before 17 February 2018.

Overview

This Activity Work Plan is an update to the 2016-18 Activity Work Plan submitted to the Department in February 2017. However, activities can be proposed in the Plan beyond this period.

Mental Health Activity Work Plan 2016-2019

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 2016-19 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

Our Vision – Healthy People and Healthy Communities

Our Purpose – To deliver innovative, locally relevant solutions that measurably improve the health outcomes of our communities.

Our Values – Respect – Innovation – Accountability – Integrity – Cooperation – Recognition

Our Principles – We will deliver better health outcomes that are efficient, effective, equitable and sustainable by:

- having a whole of system focus that puts people and communities first
- being responsive to the diversity of, and differences in, our communities and address health inequalities
- helping people understand and care for their own health, and supporting them as partners in a better health system
- supporting and being guided by GPs and other clinicians as leaders in a better health system
- aiming for the best use of health resources, with locally relevant services that are high quality and cost-effective collaborating with other to enable and coordinate timely and appropriate health care, so that people can stay well in their communities

Our Business Fitness – We will:

- focus organisational performance on Flagship Innovation, Local Relevance, Leading Delivery, and Strong Evaluation
- underpin performance with agile, innovative, efficient, cost effective and robust internal administrative and governance functions
- ensure that operations are underpinned by organisational values, clear team- based objectives, staff training and development, effective communication and leadership, and a positive team culture
- utilise Community Advisory Committees and GP-led Clinical Councils that effectively enhance the performance and primary care engagement of the organisation

HNECC PHN'S 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 focus' of HNECC PHN's Primary Mental Health Care Services are:

Visibility – services are known to other health professionals, other service providers (e.g. 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 can 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. Design and commissioning activities will be underpinned by collaborative regional needs assessment and planning alongside population health data to ensure PHN activity is in line with demonstrated needs of local communities and consumers.

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

Proposed Activities	
Priority Area	**Priority Area 1: 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 Commissioning and management of low intensity mental health services. 1.3 Development and capacity building within the low intensity workforce.
Existing, Modified, or New Activity	1.1 Modified 1.2 Modified 1.3 New
Description of Activity	1.1 HNECC PHN will continue to support and promote the Mental Health digital gateway (Head to Health) 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 will also build on existing partnerships with EveryMind (Formally Hunter Institute of Mental Health) and the Centre for Rural and Remote Mental Health to engage in research and frameworks to improve consumer participation in low intensity interventions. 1.2 HNECC PHN will continue to manage commissioned low-intensity services and work with providers to support integration of these services within the overall stepped care system. HNECC will also ensure commissioned low-intensity services are utilising existing digital resources to enhance commissioned service activity.

	1.3 HNECC PHN will work with education providers and the growing low-intensity workforce to grow and strengthen the workforce with particular emphasis of building growth and development of the peer work component of the sector.
Target population cohort	1.1 Whole of population 1.2 Whole of population 1.3 Low-Intensity workforce (Including Peer workers and those with lived experience)
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. 1.3 Consultation will be conducted with education providers, low intensity service providers and peer and sub-clinical workforce.
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. The PHN will also strengthen existing partnerships with EveryMind and the Centre for Rural and Remote Mental Health to ensure all activity within the low intensity space is coordinated and supports an integrated and collaborative approach to system change. 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. 1.3 The PHN will collaborate with providers and education providers to ensure activity is targeted to the emerging needs of the workforce.

Duration	1.1 01/07/2018 – 31/06/2019 1.2 01/07/2018 – 31/06/2019 1.3 01/07/2018 – 31/06/2019
Coverage	1.1 Whole PHN Region 1.2 Whole PHN Region 1.3 Whole PHN Region
Commissioning method (if relevant)	1.1 N/A 1.2 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. 1.3 N/A
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. 1.3 N/A
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.

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 (e.g. 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? (e.g. 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 Expenditure **2016-17** (GST Exc) – Commonwealth funding	$325,000
Planned Expenditure **2016-17** (GST Exc) – Funding from other sources	$0
Planned Expenditure **2017-18** (GST Exc) – Commonwealth funding	$750,000
Planned Expenditure **2017-18** (GST Exc) – Funding from other sources	$0
Planned Expenditure **2018-19** (GST Exc) – Commonwealth funding	$455,000
Planned Expenditure **2018-19** (GST Exc) – Funding from other sources	$0
Funding from other sources	N/A

Proposed Activities	
Priority Area	**Priority Area 2: Child and 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 including four new outreach centres for Tamworth headspace. 2.2 HNECC PHN will co design and commission 4 x new youth complex mental health services as part of Phase 2 roll-out of youth complex funding. 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 Build and develop better networks across the sector and increase capacity to engage in early intervention and low-intensity support, including developing capacity within the Primary Care sector to respond effectively to the early intervention of eating disorders in children and young people.
Target population cohort	2.1 Young people aged 12-25 years within the HNECC Footprint 2.2 Young people aged 12-25 years within the HNECC Footprint 2.3 Young people aged 12-25 years within the HNECC Footprint

Consultation	2.1 Consultation will occur with other PHN's, lead agencies and hNO with the establishment of new outreach centres. 2.2 For new services within the youth complex space, consultation will occur with internal and external stakeholders, with co design workshops conducted with all stakeholders, targeting young people and vulnerable population groups. Consultation will also occur through social media outlets, including our online engagement platform (PeopleBank) and Facebook page. 2.3 Consultation will occur with internal and external stakeholders, subject matter experts, local health districts, and targeted population.
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, Orygen, 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 01/07/2018 – 30/06/2019 2.2 Ongoing 01/07/2018 – 30/06/2019 2.3 Ongoing 01/07/2018 – 30/06/2019
Coverage	2.1 Tamworth, Armidale, Moree, Narrabri, Gunnedah, 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: co-design, validation of data, select request for tender, evaluation of submissions, and contract

	negotiation and execution with successful tenderers will be used in the commissioning of any new 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 N/A
Approach to market	2.1 N/A 2.2 Open Tender 2.3 N/A
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. Is this a process, output or outcome indicator? a) 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 (e.g. 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? (e.g. 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. • Primary Mental Health 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 Expenditure **2016-17** (GST Exc) – Commonwealth funding	$5,191,271
Planned Expenditure **2016-17** (GST Exc) – Funding from other sources	$0
Planned Expenditure **2017-18** (GST Exc) – Commonwealth funding	$5,069,286
Planned Expenditure **2017-18** (GST Exc) – Funding from other sources	$0
Planned Expenditure **2018-19** (GST Exc) – Commonwealth funding	$6,015,154
Planned Expenditure **2018-19** (GST Exc) – Funding from other sources	$0
Funding from other sources	N/A

Proposed Activities	
Priority Area	**Priority Area 3: 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 Commissioning of new mental health clinical (allied health/psychology) services. 3.2 Implementation of change process to move from previous service model to model developed from co-design process.

Existing, Modified, or New Activity	3.1 3.2	Modified New
Description of Activity	3.1 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. These new services will have an increased focus on patient centred, GP inclusive care as well as stronger links with mental health nursing workforce to ensure patient access to multidisciplinary collaborative care. Once clinical redesign of nursing and psychological services is complete, HNECC will engage in supporting GPs and service providers to move from the previous model of service delivery to the new model. This will be based on feedback from providers and GPs and may include workshops, in-services and development of new referral pathways. The PHN will also ensure smooth transition of consumers between providers as current contracts are replaced by new services.
Target population cohort	3.1 3.2	Consumers with mild to moderate mental health issues who are otherwise unable to engage in psychological services. Current consumers at the time of transition to redesigned service model.
Consultation	3.1 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). 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 3.2	The PHN will work in collaboration with consumers and subject matter experts to ensure quality in commissioning. The PHN will collaborate with existing and new providers as well and GP practices to ensure the smooth transition into the new clinical services system.
Duration	3.1	01/07/2018 – 01/11/2018

	3.2 02/11/2018 – 31/06/2019
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 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. 3.2 N/A
Approach to market	3.1 Open Tender 3.2 N/A
Decommissioning	Existing Mental Health Psychological Services (Formally ATAPs and MHSRA) will be decommissioned as of the 01/02/2019. These will be replaced by a redesigned clinical mental health service with improved linkages to general practice and mental health nurses. Existing providers will be encouraged to submit tenders within the open tender process, and sole providers will be encouraged and supported to form consortia to strengthen their competitiveness within this proves. Based on the outcome of commissioning activity some transitional funds may be provided to support continuity of care for those consumers caught in the transition process between providers.
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 to be integrated in service redesign 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 (e.g. from activity commencement for 12 months for reporting in September 2018). To be confirmed at the conclusion of co-design process.
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? • Primary Mental Health MDS • PHN Quarterly Reports To be confirmed at the conclusion of co-design process.
Planned Expenditure **2016-17** (GST Exc) – Commonwealth funding	$6,805,529
Planned Expenditure **2016-17** (GST Exc) – Funding from other sources	$0

Planned Expenditure **2017-18** (GST Exc) – Commonwealth funding	$5,250,000
Planned Expenditure **2017-18** (GST Exc) – Funding from other sources	$0
Planned Expenditure **2018-19** (GST Exc) – Commonwealth funding	$6,907,657
Planned Expenditure **2018-19** (GST Exc) – Funding from other sources	$0
Funding from other sources	N/A

Proposed Activities	
Priority Area	**Priority Area 4: 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 Commissioning of new primary mental health nursing services and coordination of smooth transition from MHNIP to new service model. 4.2 Management of Transitional care package program and expansion of service locations. 4.3 Collaboration with NSW PHN Network to continue commissioning of GP psychiatry consultation Service. 4.4 Continue work in collaboration with LHDs to strengthen Primary Health Sector Capacity to provide effective services for the treatment of eating disorders.
Existing, Modified, or New Activity	4.1 Modified 4.2 Modified 4.3 New 4.4 New
Description of Activity	4.1 Following completion of clinical redesign work in previous year, new mental health nursing services will be commissioned for commencement on the 1/02/2019. Once procurement has been completed, the PHN will work with providers to ensure a smooth transition for consumers from existing MHNIP providers to new providers of mental health nursing services. 4.2 Four sites will be commissioned as part of stage one roll-out of this program from 1/06/2018. The PHN will work collaboratively with both Local Health Districts to identify four further inpatient units most at need of transitional support for complex consumers. Once identified the PHN will commission a further four providers to undertake transitional care packaging support for consumers of these identified sites. 4.3 The PHN will co-commission psychiatry consultation services for GPs in collaboration with other interested NSW PHNs. 4.4 The PHN will work collaboratively with local health districts and the butterfly foundation to develop models of care for the early intervention of eating disorders in the primary care space.

		The PHN will collaborate with GPs, local health districts and other key stakeholders to commission models of care which fit within the area eating disorders plan.
Target population cohort	4.1	Consumers with GP managed mental health conditions who require nursing services.
	4.2	Consumers with complex mental health presentations who are at risk of becoming high volume tertiary services users.
	4.3	General Practitioners and consumers with mild to moderate mental health diagnosis.
	4.4	Consumers with mild to moderate diagnosis which can be described as an eating disorder.
Consultation	4.1	Consultation will occur with GPs, providers and consumers to ensure smooth transition of services
	4.2	Consultation will occur with Local Health Districts, consumers, and primary service providers.
	4.3	Consultation will occur with General Practitioners, Practice Managers, partner PHNs and Consumers.
	4.4	Consultation will occur with Local Health Districts, General Practitioners and other key stakeholders.
Collaboration	4.1	The PHN will work in collaboration with consumers and subject matter experts to ensure quality in commissioning. HNECC will collaborate with providers to ensure the smooth transition of consumers in areas when new providers will commence mental health nursing programs.
	4.2	The PHN will work in collaboration with consumers Local Health Networks and subject matter experts to ensure quality in commissioning.
	4.3	The PHN will collaborate with participating PHN, particularly Coordinaire who will take the lead in commissioning activities.
	4.4	The PHN will work collaboratively with LHDs, peak bodies and consumers to ensure quality in commissioning.
Duration	4.1	01/07/2018 - 30/06/2019
	4.2	01/07/2018 - 30/06/2019

	4.3 01/07/2018 - 30/06/2019 4.4 01/07/2018 - 30/06/2019
Coverage	4.1 Whole of PHN region 4.2 Whole of PHN region 4.3 Whole of PHN region 4.4 Whole of PHN region
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. 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. 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

	4.3 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. 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 4.4 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. 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 4.3 Open Tender 4.4 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 01/02/2019. 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)	• 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 01/02/2019.
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 Commencing 01/02/2019
Planned Expenditure **2016-17** (GST Exc) – Commonwealth funding	$1,609,456
Planned Expenditure **2016-17** (GST Exc) – Funding from other sources	$0
Planned Expenditure **2017-18** (GST Exc) – Commonwealth funding	$3,040,000
Planned Expenditure **2017-18** (GST Exc) – Funding from other sources	$0
Planned Expenditure **2018-19** (GST Exc) –	$2,797,120

Commonwealth funding	
Planned Expenditure **2018-19** (GST Exc) – Funding from other sources	$0
Funding from other sources	Nil

Proposed Activities	
Priority Area	**Priority Area 5: Community based suicide prevention activities**
Activity(ies) / Reference (e.g. Activity 1.1, 1.2, etc)	5.1 Recommission existing Suicide prevention services. 5.2 Implementing Regional Suicide Prevention Plan. 5.3 Continue to support LifeSpan Consortiums.
Existing, Modified, or New Activity	5.1 Modified 5.2 Modified 5.3 Modified
Description of Activity	5.1 The PHN intends to recommission current services with amendments to scope and target populations based on outcomes upcoming regional planning process. 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 continued 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 June 2018. Further details will be able to be provided in future updates upon completion of the plan. 5.3 The PHN will continue to work collaboratively as a key stakeholder within LifeSpan consortiums within the Hunter and Central Coast Areas. This includes being the lead agency responsible for the management of QPR training licence procurement and continued roll-out of the Black Dog Step Care program through GP practices.
Target population cohort	5.1 Whole of population 5.2 Whole of population 5.3 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) and through local community consultation program.
	5.3	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) and through local community consultation program.
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.
	5.3	The PHN will collaborate with Black Dog and participating General Practices to ensure effective implementation of the StepCare Program. The PHN will also collaborate with LifeSpan Project officers to ensure all communities and key stakeholders are able to access QPR training licences.
Duration	5.1	01/07/2018 - existing providers to commence on renewed contracts.
	5.2	01/07/2018 – 30/06/2019
	5.3	01/07/2018 – 30/06/2019
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 PHN region
	5.3	Whole of PHN region

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 5.3 N/A
Approach to market	5.1 Direct approach to existing contracted providers, open tender for any new services commissioned. 5.2 N/A 5.3 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 (e.g. from activity commencement for 12 months for reporting in September 2018). 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 networks per year What level of disaggregation will apply to this target and be reported to the Department? (e.g. 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 Expenditure **2016-17** (GST Exc) – Commonwealth funding	$756,715
Planned Expenditure **2016-17** (GST Exc) – Funding from other sources	$0
Planned Expenditure **2017-18** (GST Exc) – Commonwealth funding	$1,200,522
Planned Expenditure **2017-18** (GST Exc) – Funding from other sources	$0

Planned Expenditure **2018-19** (GST Exc) – Commonwealth funding	$1,350,522
Planned Expenditure **2018-19** (GST Exc) – Funding from other sources	$0
Funding from other sources	N/A

Proposed Activities	
Priority Area	**Priority Area 6: 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 to improve cultural safety of existing programs.
Existing, Modified, or New Activity	6.1 Existing 6.2 Existing 6.3 Modified
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 (e.g. 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. Results of recent cultural audits will be used to implement capacity building within provider agencies to improve the cultural safety of the services being provided.
Target population cohort	6.1	Aboriginal people across the lifespan
	6.2	Aboriginal people across the lifespan
	6.3	AMS, ACCHO providers and other providers providing services to Aboriginal communities.
Consultation	6.1	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 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.
	6.2	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 addition to local Aboriginal controlled organisations and local elders.
	6.3	Consultation will be conducted with AMS and ACCHO providers and with local Aboriginal Community Representatives.
Collaboration	6.1	The PHN will work in collaboration with consumers, service providers and subject matter experts to ensure successful execution of services contracted.
	6.2	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.
	6.3	The PHN will collaborate with AMS, providers 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	01/07/2018 – 30/06/2019
	6.2	01/07/2018 – 30/06/2019
	6.3	01/07/2018 – 30/06/2019
Coverage	6.1	Whole of PHN region
	6.2	Whole of PHN region
	6.3	Whole of PHN region
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)	Increase of 10 Social Emotional Wellbeing Projects
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 Collection to occur throughout the year
Planned Expenditure **2016-17** (GST Exc) – Commonwealth funding	$380,088
Planned Expenditure **2016-17** (GST Exc) – Funding from other sources	$0

Planned Expenditure **2017-18** (GST Exc) – Commonwealth funding	$250,000
Planned Expenditure **2017-18** (GST Exc) – Funding from other sources	$0
Planned Expenditure **2018-19** (GST Exc) – Commonwealth funding	$250,000
Planned Expenditure **2018-19** (GST Exc) – Funding from other sources	$0
Funding from other sources	Nil

Proposed Activities	
Priority Area	**Priority Area 7: 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 Existing 7.2 Existing 7.3 Existing
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 regard 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	01/07/2018 – 30/06/2019
	7.2	01/07/2018 – 30/06/2019
	7.3	01/07/2018 – 30/06/2019
Coverage	7.1	Whole of PHN region
	7.2	Whole of PHN region
	7.3	Whole of PHN region
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. 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 (e.g. from activity commencement for 12 months for reporting in September 2018). 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? (e.g. 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. To commence on commissioning of services.
Planned Expenditure **2016-17** (GST Exc) – Commonwealth funding	$Nil
Planned Expenditure **2016-17** (GST Exc) – Funding from other sources	$0
Planned Expenditure **2017-18** (GST Exc) – Commonwealth funding	$750,000
Planned Expenditure **2017-18** (GST Exc) – Funding from other sources	$0
Planned Expenditure **2018-19** (GST Exc) – Commonwealth funding	$106,000
Planned Expenditure **2018-19** (GST Exc) – Funding from other sources	$0
Funding from other sources	Nil

Proposed Activities	
Priority Area	**Priority Area 8: Regional mental health and suicide prevention plan**
Activity(ies) / Reference (e.g. Activity 1.1, 1.2, etc)	8.1 Promotion and Implementation of Regional Mental Health and Suicide Prevention Plan
Existing, Modified, or New Activity	8.1 Modified
Description of Activity	8.1 On Completion of the HNECC PHN Regional Mental Health Suicide Prevention Plan focus will shift to the promotion and implementation of the completed plan.
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. The PHN will also work with key stakeholders to ensure planned implementation schedule is produced.
Duration	8.1 01/07/2018 – 30/06/2019
Coverage	8.1 Whole of PHN region
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. N/A

	Is this a process, output or outcome indicator?
Local Performance Indicator target (where possible)	N/A
Local Performance Indicator Data source	N/A
Planned Expenditure **2016-17** (GST Exc) – Commonwealth funding	$0
Planned Expenditure **2016-17** (GST Exc) – Funding from other sources	$0
Planned Expenditure **2017-18** (GST Exc) – Commonwealth funding	$0
Planned Expenditure **2017-18** (GST Exc) – Funding from other sources	$0
Planned Expenditure **2018-19** (GST Exc) – Commonwealth funding	$0
Planned Expenditure **2018-19** (GST Exc) – Funding from other sources	$0
Funding from other sources	N/A

Proposed Activities		
Priority Area	**Priority Area 9: 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	01/07/2018 – 30/06/2019
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 (e.g. 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? (e.g. 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.
Planned Expenditure **2016-17** (GST Exc) – Commonwealth funding	$538,800
Planned Expenditure **2016-17** (GST Exc) – Funding from other sources	$0
Planned Expenditure **2017-18** (GST Exc) – Commonwealth funding	$543,200
Planned Expenditure **2017-18** (GST Exc) – Funding from other sources	$0
Planned Expenditure **2018-19** (GST Exc) – Commonwealth funding	$280,000
Planned Expenditure **2018-19** (GST Exc) –	$0

Funding from other sources	
Funding from other sources	If applicable, name other organisations contributing funding to the activity (i.e. state/territory government, Local Hospital Network, non-profit organisation).