Australian Government
Department of Health

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An Australian Government Initiative

Primary Health Networks Primary Mental Health Care Funding

- Annual Mental Health Activity Work Plan 2016-2017
- Annual Primary Mental Health Care Funding Budget 2016-2017

Western Sydney Primary Health Network

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 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 <name of Grant Officer> via email <email address> on or before 6 May 2016.

Introduction

Overview

In the 2015-16 financial year, PHNs are required (through the recent mental health Schedule which provided operational funding to PHNs this financial year) to prepare a Mental Health Activity Work Plan by May 2016. This Plan is to cover activities funded under two sources:

- the Primary Mental Health Care flexible funding pool (which will provide PHNs with approximately $1.030 billion (GST exclusive) over three years commencing in 2016-17); and

- *Indigenous Australians' Health Programme* - an additional $28.25 million (GST exclusive) will be available annually under this programme and further quarantined to specifically support Objective 6 (detailed below): Enhance and better integrate Aboriginal and Torres Strait Islander mental health.

This is to be distinguished from the *Regional Mental Health and Suicide Prevention Plan* to be developed in consultation with Local Hospital Networks (LHNs) and other regional stakeholders which is due in 2017 (see Mental Health PHN Circular 2/2016).

Objectives

The objectives of the PHN mental health funding are to:

- improve targeting of psychological interventions to most appropriately support people with or at risk of mild mental illness at the local level through the development and/or commissioning of **low intensity mental health services**;

- 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;

- address service gaps in the provision of psychological therapies for people in **rural and remote areas and other under-serviced and/or hard to reach populations**, making optimal use of the available service infrastructure and workforce;

- commission primary mental health care services for people with severe mental illness being managed in primary care, including clinical care coordination for people with **severe and complex mental illness** who are being managed in primary care including through the phased implementation of primary mental health care packages and the use of mental health nurses;

- encourage and promote a systems based regional approach to **suicide prevention** including community based activities and liaising with Local Hospital Networks (LHNs) and other providers to help ensure appropriate follow-up and support arrangements are

in place at a regional level for individuals after a suicide attempt and for other people at high risk of suicide, including Aboriginal and Torres Strait Islander people; and

- enhance access to and better integrate **Aboriginal and Torres Strait Islander mental health** services at a local level facilitating a joined up approach with other closely connected services including social and emotional wellbeing, suicide prevention and alcohol and other drug services. For this Objective, both the *Primary Health Networks Grant Programme Guidelines – Annexure A1 - Primary Mental Health Care* and the *Indigenous Australians' Health Programme – Programme Guidelines* apply.

Objectives 1-6 will be underpinned by:

- evidence based **regional mental health and suicide prevention** plans and service mapping to identify needs and gaps, reduce duplication, remove inefficiencies and encourage integration; and

- a continuum of primary mental health services within a person-centred **stepped care approach** so that a range of service types, making the best use of available workforce and technology, are available within local regions to better match with individual and local population need.

Activities eligible for funding

- commission evidence-based clinical primary mental health care services in line with a best practice stepped care approach;

- develop and commission cost effective low intensity psychological interventions for people with mild mental illness, making optimal use of the available workforce and technology;

- the phased implementation of approaches to provide primary mental health care to people with severe and complex mental illness which offer clinical support and care coordination, including services provided by mental health nurses;

- establish joined up assessment processes and referral pathways to enable people with mental illness, particularly those people with severe and complex mental illness, to receive the clinical and other related services they need. This will include provision of support to GPs in undertaking assessment to ensure people are referred to the service which best targets their need;

- develop and commission region-specific services, utilising existing providers, as necessary, to provide early intervention to support children and young people with, or at risk of, mental illness. This should include support for young people with mild to moderate forms of common mental illness as well as early intervention support for young people with moderate to severe mental illness, including emerging psychosis and severe forms of other types of mental illness;

- develop and commission strategies to target the needs of people living in rural and remote areas and other under-serviced populations; and

- develop evidence based regional suicide prevention plans and commission activity consistent with the plans to facilitate a planned and agile approach to suicide prevention. This should include liaison with LHNs and other organisations to ensure arrangements are in place to provide follow-up care to people after a suicide attempt.

Each PHN must make informed choices about how best to use its resources to address the objectives of the PHN mental health funding.

This document, the Mental Health Activity Work Plan template, captures the approach to those activities outlined above.

The Mental Health Activity Work Plan will help guide activity to June 2016 and outline the planned mental health services to be commissioned for the period from 1 July 2016 to 30 June 2017, although activities can be proposed in the Plan beyond this period. The Department of Health will require an update in relation to these activities in the Annual Mental Health Activity Work Plan for 2017-18.

The Mental Health Activity Work Plan template has two connected parts:

1) The Annual Mental Health Activity Work Plan for 2016-2017, which will be linked to and consistent with the broader PHN Activity Work Plan, and provide:
   a) The Strategic Vision on 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 indicative funding budget for 2016-2017 for:
   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 – see pages 2-3) (PHN: Indigenous Mental Health Flexible Activity).

Mental Health Activity Work Plan 2016-2017

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) Outline 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 2016-17 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.

Activity Planning

This initial Mental Health Activity Work Plan will be informed by a specific mental health needs assessment developed by PHNs (as a complement to the broader PHN needs assessment) which should explore mental health and suicide prevention priorities against those six areas of activity which the Government has articulated for PHNs, and in consultation with key stakeholders (refer to pages 2-6, for Objectives and Activities eligible for funding, and other requirements to be reflected in the Plan).

Measuring Improvements

Each mental health priority area has one or more mandatory performance indicators. In addition to the mandatory performance indicators, PHNs may select a local performance indicator. These will be reported on in accordance with the Primary Mental Health Care Schedule.

Mental Health Activity Work Plan Reporting Period and Public Accessibility

The Mental Health Activity Work Plan will help guide activity to June 2016 and outline the planned mental health services to be commissioned for the period from 1 July 2016 to 30 June 2017.

A mental health focussed activity work plan is to be provided to the Department annually. This mental health activity plan will complement the broader PHN Activity Plan as part of the annual reporting mechanism and will build on the initial Mental Health Activity Work Plan delivered in 2016.

Once approved, the Annual Mental Health Activity Work Plan component (Section 1(b) of this document) must be made available by the PHN on their website as soon as practicable. The Annual Mental Health Activity Work Plan component will also be made available on the Department of Health's website (under the PHN website). Sensitive content identified by the PHN will be excluded, subject to the agreement of the Department.

It is important to note that while planning may continue following submission of the Mental Health Activity Work Plan, PHNs must not commit or spend any part of the funding related to this Activity Work Plan until it is approved by the Department.

Further information

The following may assist in the preparation of your Mental Health Activity Work Plan:

- The requirements detailed in the Primary Mental Health Care Schedule;
- PHN Needs Assessment Guide;
- Mental Health PHN Circulars;
- Primary Health Networks Grant Programme Guidelines – Annexure A1 – Primary Mental Health Care; and
- Indigenous Australians' Health Programme – Programme Guidelines.

Please contact your Grants Officer if you are having any difficulties completing this document.

Strategic Vision for Mental Health and Suicide Prevention

The Strategic Vision for Mental Health and Suicide Prevention is a vital component of WentWest's overarching Strategic Vision for:

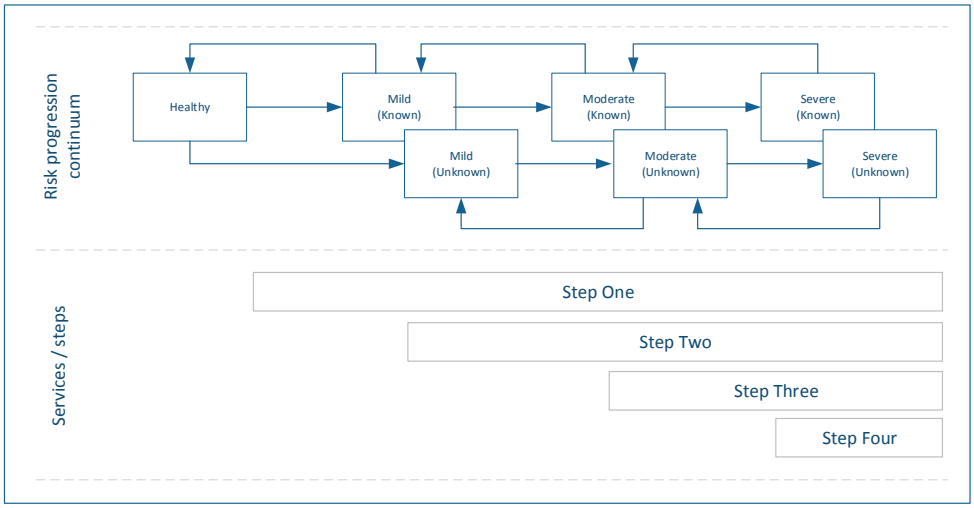
- healthier communities
- empowered individuals
- a sustainable primary health care workforce.

WentWest work in partnerships to lead better system integration and coordination, strengthening equity and empowerment for Western Sydney communities and the people who for them. We optimise all resources available, including the natural self-care capacity and resources of people themselves together with carers, families, friends, workplaces and communities who all have a vital role in contributing to their members health and wellbeing.

WentWest's overarching Strategic Vision includes a focus on the 'Quadruple Aim'. The quadruple aim refers to the simultaneous achievement of improved population health outcomes, improved user experience of care and support, efficient use of resources, and development of a sustainable and viable provider workforce. This Activity Plan draws on the quadruple aim, which provides the framing for our outcomes and the architecture for our `performance measures.

A central part of our strategic vision for Mental Health and Suicide Prevention is to apply a systems approach to the development of alcohol and drug treatment services that enables Went West and its system partners to achieve the quadruple aim.

To realise this strategic vision requires a whole of population, whole of person and whole of system perspective for service planning and commissioning across the life course. The life course continuum, shown in the diagram below, is based on a risk progression from a healthy and well population on the left-hand side through progressive states of distress or disorder to manifest mental illness and complications.



The life course continuum enables us to address all six key priorities of the department in a unified way.

- Low intensity mental health services
- Children and young people

- Rural and remote areas and other under-serviced and/or hard to reach populations
- Severe and complex mental illness
- Suicide prevention
- Aboriginal and Torres Strait Islander mental health

Our aim is that by the end of the plan period, in each of the domains of mental health and suicide prevention, we have built a platform that can support the collaborative commissioning and transformation of services across the Western Sydney.

The activity plan identifies how we will engage critical stakeholders in each domain to rethink how the system of care and support can better deliver on quadruple aim outcomes.

1. (b) Planned activities funded under the Primary Mental Health Care Schedule

PHNs must use the table below to outline the activities proposed to be undertaken in the 2016-17 financial year. These activities will be funded under the Primary Mental Health Care Schedule (PHN: Mental Health and Suicide Prevention Operational and Flexible Activity; and the PHN: Indigenous Mental Health Flexible Activity).

Note 1: Indicate within the duration section of the table if the activity relates to a period beyond 2016-17.

Note 2: PHNs must complete activities under every priority area in the tables below.

Proposed Activities	
Priority Area 1: Low intensity mental health services	This must reflect priorities as identified in Section 4 of your Needs Assessment, in line with the objectives of the PHN mental health funding: • Improve targeting of psychological interventions to more appropriately support people with or at risk of mild mental illness at the local level through the development and/or commissioning of **low intensity mental health services.**
Activity(ies) / Reference (e.g. Activity 1.1, 1.2, etc)	1.1 Develop low intensity interventions via our stepped care model 1.2. Commission community-based peer / coach workforce 1.3. Commission group sessions and peer support group meetings 1.4 Explore online support service appropriate to the western Sydney region
Description of Activity(ies) and rationale (needs assessment)	1.1 As part of the PHN's stepped care model, research and agree with local partners (including general practice) the development of low intensity interventions with a demonstrated effectiveness within stepped care approaches. Building on the UK and NZ stepped care and low intensity experience of our design support partner, Synergia, plus the emerging Australian experience base we will run a local collaborative design process to explore the range of low intensity service options that will work in our western Sydney environment. These interventions will be designed to align with the specific cultural and linguistic needs of the western Sydney population and the needs of our Indigenous population. Examples of low intensity interventions in our stepped care model are: • Within stepped care the processes of assessing and planning of people's care assume a greater importance as low intensity mental health interventions in their own right. • Integrating aspects of motivational interviewing to promote self-help and encourage self-care and support through non-service responses is another core component of low intensity interventions within stepped care • Stepped care promotes the use of 'watchful waiting', that recognises that not all mental distress needs to be medicalised with treatment, but that people in distress should be actively followed up, another low intensity intervention in its own right that is within the scope of a practice nurse if they are able to call on more specialist mental health support (e.g. mental health nurse) These activities will contribute towards addressing the identified need for more services available in the community for consumers, carers and their families to support their own mental health and wellbeing and promote recovery.

	Western Sydney PHN has substantial experience in working with general practices to improve the quality of their mental health plans. This activity will see this developed further to suit the planning needs of a stepped care environment and enable GPs to be supported in their processes and build their confidence in usage of a fuller range of low intensity options as these become available. We see this as being key to the utilisation of low intensity services. 1.2 Commission the training of a community-based peer / coach workforce to be available to provide low intensity mental health services that are easily accessible and culturally appropriate. This workforce will support all general practices, and interested practices as they transition to patient centred mental health medical homes, and facilitate consumer access to low intensity services. 1.3 Commission the delivery and supervision of group sessions and peer support group meetings relevant to specific age, sex and target groups in the region. This activity will contribute to community-based options for low intensity care, contribute towards connecting consumers to appropriate community based services, and improve their understanding of the system and how to move through it. This includes the further development of a Recovery College model in partnership with the Western Sydney Local Health District. 1.4 Explore online provider's options for online support services appropriate to the western Sydney region and our population, in parallel with the emerging direction of the Digital Mental Health Gateway, and utilising the published research base of effective online tools. These low intensity mental health services will be supported via our stepped care system (Step 2: Low Intensity Interventions – Brief Group Education Interventions / e-Therapy / Integrated physical health.
Collaboration	1.1 Joint development with the Local Health Network (LHN), general practices, NGOs and our Indigenous providers and community centres; co-design role with the PHN. 1.2 Joint development with the LHN and general practices to leverage existing workforce resources; support role 1.3 Joint development with the LHN; support role 1.4 Jointly explore options with the range of online service providers; provider role
Duration	1.1 Begin May 2016 to June 2017. Bi-monthly consultation of the Mental Health Commissioning Advisory Group. This group with key Senior managers and representatives from the region, will design strategies to operationalise a stepped care model. July 2017: Commence implementation of model. 1.2 October 2016. Identify and select appropriate training organisations to develop a peer/coach workforce. January 2017. Establish and commission peer/coach workforce with capacity to deliver low intensity services. May 2017. Develop appropriate supervision and clinical governance framework for low intensity services to be commissioned and delivered. 1.3 July 2016. Expand the service delivery model of group session, targeting specific vulnerable groups. December 2016. Begin the commissioning of mental health professional to coordinate and assist exiting and new peer support groups in the area to coordinate and deliver groups sessions.

	1.4 July 2016 In consultation with the Mental Health Commissioning Advisory Group members, identify and outline a strategy for appropriate (already existing) online mental health services that can complement Primary Health.
Coverage	1.1 Region wide approach (5 LGA's) 1.2 Blacktown LGA as potential lead/ pilot site for the development of the Peer workforce. 1.3 Region Wide approach (5 LGA's), will depend however on the availability and location of providers and facilities. SLA's may vary. 1.4 Region wide approach (5 LGA's), however may be targeted at specifically current networks, such as ATAPS & MHNIP providers and pilot specific GP practices to implement strategies
Commissioning approach	The approach to commissioning of these activities will be based on the Western Sydney Primary Health Network Commissioning Framework (WSPHNCF), a patient centred and clinically based process to enhance service delivery and patient outcomes in western Sydney. The WSPHNCF has been developed based on best practice national and international commissioning evidence. Patients and consumers form the centre of this process. The aim of the Commissioning Framework is to ensure that services are developed/ procured to meet the needs of the patients and consumers involved. The PHN will enter into a legally binding contract with all providers, where it is a commissioner of services. This will include clear metrics around payments and reporting requirements as well as clear, measurable project goals. Providers will provide regular reports on how they are progressing towards achieving the agreed goals. The reports will include outcome as well as output measures to inform evaluation. In preparation for this, an online contracts and reporting portal has been develop, which is a vital component of the PHN's commissioning role and essential for ensuring commissioned services result in better health outcomes, while being cost effective and transparent. Western Sydney PHN has built an effective clinical governance, resource management and performance development capability in mental health through our ATAPS, PIR and training programmes. A critical challenge for the future will be an active process of clinical governance, resource management and performance development that can enable safe, effective care across the stepped care system while managing the risks associated with a blended, value based reimbursement system. To address this the existing foundation will be further developed to fit the PHN co-commissioning role and the broader needs of a mental health PCMH based system of care.
Performance Indicator	As described in the strategic vision, the quadruple aim provides the framing for our outcomes and the architecture for our `performance indicators. The quadruple aim refers to the simultaneous achievement of patient experience of care, quality and population health, sustainable cost, and provider satisfaction. The mandatory performance indicators for this priority are: • Proportion of regional population receiving PHN-commissioned mental health services – Low intensity services. • Average cost per PHN-commissioned mental health service – Low intensity services.

<table>
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- Clinical outcomes for people receiving PHN-commissioned low intensity mental health services.

The mandatory indicators cover some aspects of the quadruple aim. Therefore, in addition, we include the following performance indicators:

- Consumer experience for people receiving PHN-commissioned low intensity mental health services.
- Provider satisfaction of those delivering PHN-commissioned low intensity mental health services.

These indicators, how they will be measured, monitored and used to improve system performance, will be developed in partnership with our stakeholders and local providers.
</td></tr>
<tr><td>Local Performance Indicator target (where possible)</td><td>

<table>
<tr><th>Indicator</th><th>Target</th><th>Baseline and date</th><th>Disaggregation</th></tr>
<tr><td>Proportion of regional population receiving PHN-commissioned mental health services – Low intensity services.</td><td>TBC once commissioned services are in place from 1st July 2016.</td><td>No current baseline</td><td>- Age
- Gender
- Ethnicity
- Type of service accessed (NGO, not for profit, private, etc)</td></tr>
<tr><td>Average cost per PHN-commissioned mental health service – Low intensity services.</td><td>TBC once commissioned services are in place from 1st July 2016.</td><td>No current baseline</td><td>- Type of service accessed (NGO, not for profit, private, etc)</td></tr>
<tr><td>Clinical outcomes for people receiving PHN-commissioned low intensity mental health services.</td><td>TBC once commissioned services are in place from 1st July 2016.</td><td>No current baseline</td><td>- Age
- Gender
- Ethnicity
- Type of service accessed (NGO, not for profit, private, etc)</td></tr>
<tr><td>Consumer experience for people receiving PHN-commissioned low intensity mental health services.</td><td>95% of all completed service interactions</td><td>No current baseline</td><td>- Age
- Gender
- Type of service accessed (NGO, not for profit, private, etc)</td></tr>
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	Provider satisfaction of those delivering PHN-commissioned low intensity mental health services.	95% of all staff providing PHN commissioned services as all or part of their role	No current baseline	- Workforce role - Age - Gender - Type of organisation (NGO, not for profit, private, etc)

Local Performance Indicator Data source

Indicator	Source	Collection Commencement date
Proportion of regional population receiving PHN-commissioned mental health services – Low intensity services.	National data source	1st July 2016
Average cost per PHN-commissioned mental health service – Low intensity services.	Local finance and activity data via contracts and performance management system	1st July 2016
Clinical outcomes for people receiving PHN-commissioned low intensity mental health services.	Local outcome tools such as PHQ9, K10, GAD7 as agreed with commissioned providers	1st July 2016
Consumer experience for people receiving PHN-commissioned low intensity mental health services.	Local survey	1st July 2016
Provider satisfaction of those delivering PHN-commissioned low intensity mental health services.	Local survey	1st July 2016

Proposed Activities	
Priority Area 2: Youth mental health services	This must reflect priorities as identified in Section 4 of your Needs Assessment, in line with the objectives of the PHN mental health funding: • 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.
Activity(ies) / Reference (e.g. Activity 2.1, 2.2, etc)	2.1 Commission headspace services 2.2 Early Psychosis Youth Services (EPYS) program 2.3 ATAPS child and young people program 2.4 Children and young people service improvement initiatives.
Description of Activity(ies) and rationale (needs assessment)	2.1. Continue to commission youth mental health services via headspace services in three western Sydney locations – Mt Druitt, Parramatta, Castle Hill. This will provide community-based service continuity for young people in western Sydney with, or at risk of mental illness within headspace centres, in line with the existing headspace service delivery model. The PHN will integrate and link programmes transitioning to it, such as headspace, into broader primary care activities via an approach that leverages its extensive network of primary care stakeholders and the implementation of GP led patient centred mental health medical homes (mental health PCMH) in western Sydney. Activities that will facilitate this integration and linkage include focus on team based care and leadership of multidisciplinary healthcare providers by the mental health PCMH, inclusion of wrap around support roles e.g. psychologist or mental health nurse, and continued implementation of relevant Health Pathways. This approach is underpinned by 'The 10 Building Blocks of High-Performing Primary Care', Bodenheimer T, Gharob A, Willard-Grace R, Grumbach K, AFM 2014. Implementation of the PHN's Stepped Care System will further support integration of programmes into primary care. The approach will strengthen the central role of GPs in enabling person centred integration across physical, mental and behavioural health. 2.2 Continue the funding of the Early Psychosis Youth Services (EPYS) program. This will ensure service continuity for this program and continue to deliver an early intervention service for young people at risk of severe mental illness. This is a service to detect and assist young people aged 12 – 25 who are at risk of developing a first episode of psychosis, or have experienced a first episode of psychosis and provide specialists treatment and care. 2.3 Continue commissioning mental health services for children as per service targets under the previous ATAPS child and young people program to ensure continuity of care, whilst evolving new aspects of the program to fit a more flexible, stepped care model. The ATAPS program (Access to Allied Psychological Services) allows GP's, Paediatricians and school counsellors to refer children 0 – 12 years of age who are experiencing a behavioural, or mental health issues from disadvantaged backgrounds to an appropriate, local mental health professional.

	2.4 Facilitate dialogue across the community of children and young people mental health services on the lessons learnt so far and the potential opportunities for future service improvements, including commissioning of service improvements for this population cohort by the PHN. A focus of this learning will be how to improve the integration of headspace services with other services including primary mental health care services and the region's patient centred mental health medical homes, physical health services; drug and alcohol services; and social and vocational support services. These activities address the needs of children and young people identified in the needs assessment; child and youth are identified by the PHN as a priority group for mental health services in western Sydney, the ongoing need for access to services in the community for youth, their carers and families, and a system of mental health care that is designed around the natural, normal progression of development for children and their families as a model most likely to meet client needs and enhance health outcomes in the future. The needs assessment also identified the important role schools have to promote and facilitate early intervention for children and young people with, or at risk of mental illness; local schools will be core to informing the lessons learnt and identifying improvement opportunities.
Collaboration	2.1 – 2.3 Activities will be implemented and commissioned in partnership with headspace, private mental health Professionals (previously known as ATAPS provider) and EPYS service providers e.g. Uniting Recovery – headspace and Youth Psychosis YEPS program provider. 2.4 Activity will be undertaken with a broad range of stakeholders across western Sydney, including but not limited to the LHN, NGO's, our Aboriginal and Torres Strait Islander health service providers and schools. A comprehensive list of stakeholders will be outlined in a consultation and engagement plan for this activity.
Duration	2.1 July 2016 to 30 June 2018. Continue Headspace with service delivery at current rates, with service continuity for existing clients. 2.2 July 2016 to 30 June 2017. Continue to commission the EPYS service at 75% funding levels currently indicated to WSPHN, to assist with continuity of care of existing consumers with focus on reduction of services delivery for the following year. 1 July 2017 to 30 June 2018. Continue to commission the EYPS services at 30% funding levels currently indicated to WSPHN, to provide continuity of care and reduction of service to cease program. 2.3 July 2016 to 30 June 2017. Continue to commission and ensure service continuity to clients currently engaged with the child ATAPS program. 2.4 October 2016. Network with key youth mental health providers and schools to develop a working group to guide WSPHN. January 2017. Identify and develop appropriate service delivery model in our region and commission accordingly.
Coverage	2.1 Across three LGA's Hills, Parramatta and Mt Druitt (Blacktown) 2.2 region wide approach 5 LGA's. 2.3 region wide approach 5 LGA's 2.4 Pilot Parramatta LGA initially during this planning and implementation phase

Commissioning approach	The PHN will operationalise a number of similarly delivered services across the various programs so that service continuity remains, but also begin the initial implementation of a stepped care model. For example, the ATAPS, MHNIP and headspace services currently are delivered in units of care to young people and adults. Hence the development of a structured and consistent operational process to commission service by providers within each of these programs will allow a seamless and stepped care model of service as the needs of the consumer changes. These services will have a consistent commissioning process - open to market, referral processing and invoicing and billing procedures. This will create an alignment of services and providers relevant to the consumers' presentation. The approach to commissioning for these activities will be based on the Western Sydney Primary Health Network Commissioning Framework (WSPHNCF), a patient centred and clinically based process to enhance service delivery and patient outcomes in western Sydney. The WSPHNCF has been developed based on best practice national and international commissioning evidence. Patients and consumers form the centre of this process. The aim of the Commissioning Framework is to ensure that services are developed/ procured to meet the needs of the patients and consumers involved. The PHN will enter into a legally binding contract with all providers, where it is a commissioner of services. This will include clear metrics around payments and reporting requirements as well as clear, measurable project goals. Providers will provide regular reports on how they are progressing towards achieving the agreed goals. The reports will include outcome as well as output measures to inform evaluation. In preparation for this, an online contracts and reporting portal has been developed which is a vital component of the PHN's commissioning role and essential for ensuring commissioned services result in better health outcomes while being cost effective and transparent. Western Sydney PHN has built an effective clinical governance, resource management and performance development capability in mental health through our ATAPS, PIR and training programmes. A critical challenge for the future will be an active process of clinical governance, resource management and performance development that can enable safe, effective care across the stepped care system while managing the risks associated with a blended, value based reimbursement system. To address this the existing foundation will be further developed to fit the PHN co-commissioning role and the broader needs of a mental health PCMH based system of care.
Performance Indicator	As described in the strategic vision, the quadruple aim provides the framing for our outcomes and the architecture for our `performance indicators. The quadruple aim refers to the simultaneous achievement of patient experience of care, quality and population health, sustainable cost, and provider satisfaction. The mandatory performance indicator for this priority are: • Proportion of regional youth population receiving youth-specific PHN-commissioned mental health services. The mandatory indicators cover only one aspect of the quadruple aim. Therefore, in addition, we include the following performance indicators:

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Average cost per youth-specific PHN-commissioned mental health services.
Clinical outcomes for people receiving youth-specific PHN-commissioned mental health services.
Consumer experience for people receiving youth-specific PHN-commissioned mental health services.
Provider satisfaction of those delivering youth-specific PHN-commissioned mental health services.

These indicators, how they will be measured, monitored and used to improve system performance, will be developed in partnership with our stakeholders and local providers.
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<tr><td>Local Performance Indicator target (where possible)</td><td>
<table>
<tr><th>Indicator</th><th>Target</th><th>Baseline and date</th><th>Disaggregation</th></tr>
<tr><td>Proportion of regional youth population receiving youth-specific PHN-commissioned mental health services.</td><td>TBC once commissioned services are in place from 1st July 2016.</td><td>No current baseline</td><td>- Age
- Gender
- Ethnicity
- Type of service accessed (NGO, not for profit, private, etc)</td></tr>
<tr><td>Average cost per youth-specific PHN-commissioned mental health services.</td><td>TBC once commissioned services are in place from 1st July 2016.</td><td>No current baseline</td><td>- Type of service accessed (NGO, not for profit, private, etc)</td></tr>
<tr><td>Clinical outcomes for people receiving youth-specific PHN-commissioned mental health services.</td><td>TBC once commissioned services are in place from 1st July 2016.</td><td>No current baseline</td><td>- Age
- Gender
- Ethnicity
- Type of service accessed (NGO, not for profit, private, etc)</td></tr>
<tr><td>Consumer experience for people receiving youth-specific PHN-commissioned mental health services.</td><td>95% of all completed service interactions</td><td>No current baseline</td><td>- Age
- Gender
- Type of service accessed (NGO, not for profit, private, etc)</td></tr>
<tr><td>Provider satisfaction of those delivering youth-specific</td><td>95% of all staff providing PHN commissioned</td><td>No current baseline</td><td>- Workforce role
- Age
- Gender</td></tr>
</table>
</td></tr>
</table>

	PHN-commissioned mental health services.	services as all or part of their role		- Type of organisation (NGO, not for profit, private, etc)

Local Performance Indicator Data source

Indicator	Source	Collection Commencement date
Proportion of regional youth population receiving youth-specific PHN-commissioned mental health services.	National data source	1st July 2016
Average cost per youth-specific PHN-commissioned mental health services.	Local finance and activity data via contracts and performance management system	1st July 2016
Clinical outcomes for people receiving youth-specific PHN-commissioned mental health services.	Local outcome tools such as PHQ9, K10, GAD7 as agreed with commissioned providers	1st July 2016
Consumer experience for people receiving youth-specific PHN-commissioned mental health services.	Local survey	1st July 2016
Provider satisfaction of those delivering youth-specific PHN-commissioned mental health services.	Local survey	1st July 2016

Proposed Activities	
Priority Area 3: Psychological therapies for rural and remote, under-serviced and /or hard to reach groups	This must reflect priorities as identified in Section 4 of your Needs Assessment, in line with the objectives of the PHN mental health funding: • Address service gaps in the provision of psychological therapies for people in **rural and remote areas and other under-serviced and/or hard to reach populations**, making optimal use of the available service infrastructure and workforce.
Activity(ies) / Reference (e.g. Activity 3.1, 3.2, etc)	*Note: For the Western Sydney PHN the focus is under-serviced and/or hard to reach populations.* 3.1 Commission translation and interpretation services 3.2 Promote and expand availability of culturally and linguistically diverse mental health services 3.3 Commission services for hard to reach groups previously outlined in the previous target groups under the ATAPS program. 3.4 Referrals to this service that fall outside the criteria for under-services and/or hard to reach populations will be directed to other alternative services including services to current providers under other appropriate options such as, Headpsace, Medicare or mental health nurse incentive program.
Description of Activity(ies) and rationale (needs assessment)	3.1 Continue to commission translation and interpretation services for all mental health service providers in western Sydney. Our region has a diverse community, with a high representation of people from culturally and linguistically diverse backgrounds. Over the past 10 years, approximately 16,000 people of refugee or humanitarian resettlement backgrounds have settled in western Sydney. Translation and interpretation services is one of the mechanisms to support appropriate service provision to this population but must be augmented by cultural concordance (see below). Mental health providers currently commissioned have the ability to access the Australian Government's translating and interpreting service (TIS) without cost to the provider or the consumer. 3.2 Continue to actively promote and expand the selection of mental health service providers that can offer culturally and linguistically appropriate mental health services. As above, there is a clearly defined need for these services in our region. Providers that can facilitate improved language and cultural concordance with consumers, cares and families will contribute towards more culturally sensitive care – care that produces improved patient satisfaction and outcomes. 3.3 Continue to commission services for hard to reach groups previously outlined in the ATAPS program. These groups will include consumers who experience perinatal depression, are financially disadvantaged, Indigenous, at risk of suicide and children from cultural and socioeconomic disadvantaged backgrounds. The ATAPS program will continue to provide the essential service continuity of acre, whilst beginning to develop new mechanisms of more flexible service delivery. 3.4 Develop appropriate referral criteria and identify options and work with service providers to assist with appropriate allocation of referrals.

Collaboration	These activities will be implemented in partnership with our relevant service providers including Aboriginal and Torres Strait Islander health services (e.g. Marrin Weejali and The Men's Shed at Emerton) and providers within our CALD and migrant communities. The role of these stakeholders is of co-design partner and service provider. We will also work on these activities with the LHN (co-design partner) and Western Sydney Aboriginal Health Service (co-design and provider).
Duration	3.1 July 2016 to 30 June 2018. 3.2 July 2016 to 30 June 2018. At each stage of the contract cycle (yearly contract cycle). 3.3 July 2016 to 30 June 2018. Ongoing. 3.4 July 2016 to 30 June 2018. Ongoing.
Coverage	3.1 region wide approach 5 LGA' s with consideration to specific LGA that have different cultural diversity and representation. 3.2 region wide approach 5 LGA' s with consideration to specific LGA that have different cultural diversity and representation. 3.3 region wide approach 5 LGA's. 3.4 region wide approach 5 LGA's.
Commissioning approach	The approach to commissioning for these activities will be based on the Western Sydney Primary Health Network Commissioning Framework (WSPHNCF), a patient centred and clinically based process to enhance service delivery and patient outcomes in western Sydney. The WSPHNCF has been developed based on best practice national and international commissioning evidence. Patients and consumers form the centre of this process. The aim of the Commissioning Framework is to ensure that services are developed/ procured to meet the needs of the patients and consumers involved. The PHN will enter into a legally binding contract with all providers, where it is a commissioner of services. This will include clear metrics around payments and reporting requirements as well as clear, measurable project goals. Providers will provide regular reports on how they are progressing towards achieving the agreed goals. The reports will include outcome as well as output measures to inform evaluation. In preparation for this, an online contracts and reporting portal has been developed, which is a vital component of the PHN's commissioning role and essential for ensuring commissioned services result in better health outcomes, while being cost effective and transparent. Western Sydney PHN has built an effective clinical governance, resource management and performance development capability in mental health through our ATAPS, PIR and training programmes. A critical challenge for the future will be an active process of clinical governance, resource management and performance development that can enable safe, effective care across the stepped care system while managing the risks associated with a blended, value based reimbursement system. To address this the existing foundation will be further developed to fit the PHN co-commissioning role and the broader needs of a mental health PCMH based system of care.

<table>
<tr><td>Performance Indicator</td><td>As described in the strategic vision the quadruple aim provides the framing for our outcomes and the architecture for our `performance indicators. The quadruple aim refers to the simultaneous achievement of patient experience of care, quality and population health, sustainable cost, and provider satisfaction.

The mandatory performance indicators for this priority are:
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.
The mandatory indicators cover only one aspect of the quadruple aim. Therefore, in addition, we include the following performance indicators:
Consumer experience for people receiving PHN-commissioned mental health service – Psychological therapies delivered by mental health professionals.
Provider satisfaction of those receiving PHN-commissioned mental health service – Psychological therapies delivered by mental health professionals.
These indicators, how they will be measured, monitored and use to improve system performance will be developed in partnership with our stakeholders and local providers.</td></tr>
<tr><td>Local Performance Indicator target (where possible)</td><td>
<table>
<tr><th>Indicator</th><th>Target</th><th>Baseline and date</th><th>Disaggregation</th></tr>
<tr><td>Proportion of regional population receiving PHN-commissioned mental health services – Psychological therapies delivered by mental health professionals.</td><td>TBC once commissioned services are in place from 1st July 2016.</td><td>No current baseline</td><td>- Age
- Gender
- Ethnicity
- Type of service accessed (NGO, not for profit, private, etc)</td></tr>
<tr><td>Average cost per PHN-commissioned mental health service – Psychological therapies</td><td>TBC once commissioned services are in place from 1st July 2016.</td><td>No current baseline</td><td>- Type of service accessed (NGO, not for profit, private, etc)</td></tr>
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</td></tr>
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	delivered by mental health professionals.			
	Clinical outcomes for people receiving PHN-commissioned Psychological therapies delivered by mental health professionals	TBC once commissioned services are in place from 1st July 2016.	No current baseline	- Age - Gender - Ethnicity - Type of service accessed (NGO, not for profit, private, etc)
	Consumer experience for people receiving PHN-commissioned mental health service – Psychological therapies delivered by mental health professionals.	95% of all completed service interactions	No current baseline	- Age - Gender - Type of service accessed (NGO, not for profit, private, etc)
	Provider satisfaction of those receiving PHN-commissioned mental health service – Psychological therapies delivered by mental health professionals.	95% of all staff providing PHN commissioned services as all or part of their role	No current baseline	- Workforce role - Age - Gender - Type of organisation (NGO, not for profit, private, etc)

Local Performance Indicator Data source

Indicator	Source	Collection Commencement date
Proportion of regional population receiving PHN-commissioned mental health services – Psychological therapies delivered by mental health professionals.	National data source	1st July 2016
Average cost per PHN-commissioned mental	Local finance and activity data via	1st July 2016

	health service – Psychological therapies delivered by mental health professionals.	contracts and performance management system	
	Clinical outcomes for people receiving PHN-commissioned Psychological therapies delivered by mental health professionals	Local outcome tools such as PHQ9, K10, GAD7 as agreed with commissioned providers	1st July 2016
	Consumer experience for people receiving PHN-commissioned mental health service – Psychological therapies delivered by mental health professionals.	Local survey	1st July 2016
	Provider satisfaction of those receiving PHN-commissioned mental health service – Psychological therapies delivered by mental health professionals.	Local survey	1st July 2016

Proposed Activities	
Priority Area 4: Mental health services for people with severe and complex mental illness including care packages	This must reflect priorities as identified in Section 4 of your Needs Assessment, in line with the objectives of the PHN mental health funding: • commission primary mental health care services for people with severe mental illness being managed in primary care, including clinical care coordination for people with **severe and complex mental illness** who are being managed in primary care including through the phased implementation of primary mental health care packages and the use of mental health nurses.
Activity(ies) / Reference (e.g. Activity 4.1, 4.2, etc)	4.1. Support General Practice workforce and mental health nurse workforce development and integration with practices to enable general practice to fulfil the role as a Patient centred mental health medical home (mental health PCMH). 4.2 Develop a community based peer support capacity that Mental Health PCMH practices 4.3 Explore shared care partnership models and shared care pathways that could be co-commissioned 4.4 Service continuity for mental health nurse service providers, including maintaining service continuity to current consumers and redesign commissioning requirements of the mental health nurse program (MHNP) to develop more appropriate and targeted services including developing care

	packages for consumes and flexibility in service delivery and type of services provided.
Description of Activity(ies) and rationale (needs assessment)	Overview: Our stepped care model includes commissioning a response across providers for people in our region experiencing severe and persistent mental illness (approximately 17,000 to 25,000 people of which estimates indicate only 5,100 to 7,500 people engage with mental health services). Our stepped care model will be the foundation of our activities for this priority area, in particular: Step 4 – High intensity, complex navigation support in primary / community based services Step 5 – Very high intensity – partnership with WSLHD Mental Health services. The core principle of a more effective system architecture that underpinned the national mental health review has informed our thinking for these activities - use of a general practice supported stepped care system approach that ensures that the level of care is targeted to need and can flexibly respond with integrated pathways that facilitate a seamless journey through the mental health system. Note that commissioning of a stepped system of response across providers will involve our general practices and importantly those practices interested in transitioning to patient centred mental health medical homes. Some practices in our region are already well towards the transition to patient centred medical homes and we will work with these practices to continue to build their skills and capacity, together with practices who have not commenced this transition. 4.1. Provide workforce development opportunities for our General Practice workforce that aim to support early recognition and accurate identification of people with severe and complex mental health needs, and support appropriate referral of these people to specialist services where needed. As per the above, a large proportion of our population with severe and complex needs are not engaging with any mental health services. This activity will take place simultaneously with step 4 of our model, supporting the creation of mental health capabilities in larger medical practices that have the space and capacity. This activity will utilise some of the initiatives already underway with developing our patient centred mental health medical home (mental health PCMH) model in a number of our General Practices in the region. At present there are 20 or more practices currently engaged with the PHN in developing the model, we would leverage the existing practices to partner and include a mental health component and integrate Mental Health nurse services. We plan to draw on an innovative model of general practice based 'patient centred mental health medical home' that is operating in South Auckland, New Zealand, a region which has very similar demographic and population characteristics to Western Sydney. The model includes an innovative use of a consultant psychiatry liaison role, embedded in primary care, to support GP led MH medical home practice teams, and develop their capacity to assess, plan and support people with severe and complex mental illness. The model includes support for mental health nurses, community based teams and an innovative use of peers as an integral part of the support package available (see also 4.2 below). It is noteworthy in its demonstrated success in delivering high quality community based care and reducing requirements for hospital based specialist and in-

	patient care. Dr David Codyre, the psychiatrist and clinical lead for this model has indicated his willingness, in principle, to support a process of transfer of learning from this model. We see this as an opportunity to also develop local GP mental health leadership capability and to enhance relationships with their specialist metal health colleagues. We will also commission mental health nurse services that are integrated into the general practice to provide care coordination and care facilitation between the general practice team and community services. Mental health nurses will be core to the general practice based multi-disciplinary teams (see 4.2. above) and will function as part of the community-based team to both provide care and support shared care coordination functions for this population group. 4.2. Develop a community based peer support capacity that is accessible by our mental health PCMH practices, for example peer-led self- management programs, peer-professional care planning and relapse prevention planning. Peer-led referral pathway navigation support, telephone based peer support, general practice MH medical home peer consultant liaison "team huddles" and commence design work to support the commissioning of community based peer support services for example, the availability of non-clinical roles to support clinical roles. Again, this activity is critical to supporting effective patient engagement and coordination of care by our general practices and mental health PCMH's. Community based support capacity will be part of the general practice based multi-disciplinary teams that actively manage health care to prevent hospitalisations and care for people in the community. We will utilise some the PIR consortium partnerships to engage with consumer/ peer-led services such as peer support groups, consumer consultants and establish some workforce development services to assist people who are engaged in the longer term care of the mental illness via their General Practice, but also assist people who have been discharged from hospital based services in returning to the community. 4.3 Work with our partners to explore shared care partnership models and shared care pathways that could be co-commissioned across the LHD-provided services, or LHD-commissioned providers, to better support people with severe and complex needs within general practice and improve their access to clinical support, care pathways and care packages. This activity will support steps 4 and 5 of our stepped care model where we envisage a shared care partnership operating with WSLHD to support this cohort of people in a community-setting. This activity builds on a combination of capabilities that exist in our region, including working closely with WSLHD and University research centres on development of HealthPathways for consumers, carers and referring agents and a comprehensive approach to identifying systems of care (Mental Health Atlas). This has allowed WentWest to develop a robust process to manage transition of care from the initial referral process to service delivery to consumer satisfaction and outcomes. 4.4 Service continuity to be confirmed subject to funding - while clearly indicating to service providers of the current service continuity priority, we will use the evidence based systems modelling engagement process described above to facilitate improvement, integration and alignment of these continuity services to our PHN's priorities and population needs.

Collaboration	4.1 General Practices and mental health PCMH's – co-design and providers, Australian College of Mental Health nurse to develop clear guidelines for identifying the specific skills set unique to Mental Health nurse that can assist in the multidisciplinary services of a mental health PCMH and local mental health services. 4.2 Partnerships organisations include Uniting Recovery, RichmondPRA, afterCare, CareConnect, Wise employment, Mission Australia, as well as our LHN 4.3 LHN – commissioning partner, co-design; General Practices – co-design and providers; other community and allied health providers, NGO's 4.4 General Practices and Mental Health Nurses – providers.
Duration	4.1 July 2016 to 30 June 2018. 4.2 July 2016 to 30 June 2018. 4.3 July 2016 to 30 June 2018 4.4 July 2016 to 30 June 2018.
Coverage	4.1 various Medical centres approaching and developing the mental health PCMH model throughout or region (5 LGA's) 4.2 region wide approach 5 LGA's. 4.3 region wide approach 5 LGA's. 4.4 region wide approach 5 LGA's.
Commissioning approach	The approach to commissioning for these activities will be based on the Western Sydney Primary Health Network Commissioning Framework (WSPHNCF), a patient centred and clinically based process to enhance service delivery and patient outcomes in western Sydney. The WSPHNCF has been developed based on best practice national and international commissioning evidence. Patients and consumers form the centre of this process. The aim of the Commissioning Framework is to ensure that services are developed/ procured to meet the needs of the patients and consumers involved. The PHN will enter into a legally binding contract with all providers, where it is a commissioner of services. This will include clear metrics around payments and reporting requirements as well as clear, measurable project goals. Providers will provide regular reports on how they are progressing towards achieving the agreed goals. The reports will include outcome as well as output measures to inform evaluation. In preparation for this, an online contracts and reporting portal has been developed which is a vital component of the PHN's commissioning role and essential for ensuring commissioned services result in better health outcomes while being cost effective and transparent. The envisaged approach for some of the activities outlined above is also one of co-commissioning with partners such as the WSLHD, with a shared care partnership model that will provide general practices with a funding model that enables active community based care. Western Sydney PHN has built an effective clinical governance, resource management and performance development capability in mental health

<table>
<tr><td></td><td>through our ATAPS, PIR and training programmes. A critical challenge for the future will be an active process of clinical governance, resource management and performance development that can enable safe, effective care across the stepped care system while managing the risks associated with a blended, value based reimbursement system. To address this the existing foundation will be further developed to fit the PHN co-commissioning role and the broader needs of a mental health PCMH based system of care.</td></tr>
<tr><td>Performance Indicator</td><td>As described in the strategic vision the quadruple aim provides the framing for our outcomes and the architecture for our `performance indicators. The quadruple aim refers to the simultaneous achievement of patient experience of care, quality and population health, sustainable cost, and provider satisfaction.

The mandatory performance indicators for this priority are:
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.
The mandatory indicators cover some aspects of the quadruple aim. Therefore, in addition, we include the following performance indicators:
Clinical outcomes for people receiving PHN-commissioned - Clinical care coordination for people with severe and complex mental illness.
Consumer experience for people receiving PHN-commissioned mental health service – Clinical care coordination for people with severe and complex mental illness.
Provider satisfaction of those receiving PHN-commissioned mental health service – Clinical care coordination for people with severe and complex mental illness.
These indicators, how they will be measured, monitored and use to improve system performance will be developed in partnership with our stakeholders and local providers.</td></tr>
<tr><td>Local Performance Indicator target (where possible)</td><td>
<table>
<tr><th>Indicator</th><th>Target</th><th>Baseline and date</th><th>Disaggregation</th></tr>
<tr><td>Proportion of regional population receiving PHN-commissioned mental health services – Clinical care coordination for people with severe and complex mental illness (including clinical care</td><td>TBC once commissioned services are in place from 1st July 2016.</td><td>No current baseline</td><td>- Age
- Gender
- Ethnicity
- Type of service accessed (NGO, not for profit, private, etc)</td></tr>
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	coordination by mental health nurses).			
	Average cost per PHN-commissioned mental health service – Clinical care coordination for people with severe and complex mental illness.	TBC once commissioned services are in place from 1st July 2016.	No current baseline	- Type of service accessed (NGO, not for profit, private, etc)
	Clinical outcomes for people receiving PHN-commissioned - Clinical care coordination for people with severe and complex mental illness.	TBC once commissioned services are in place from 1st July 2016.	No current baseline	- Age - Gender - Ethnicity - Type of service accessed (NGO, not for profit, private, etc)
	Consumer experience for people receiving PHN-commissioned mental health service – Clinical care coordination for people with severe and complex mental illness.	95% of all completed service interactions	No current baseline	- Age - Gender - Type of service accessed (NGO, not for profit, private, etc)
	Provider satisfaction of those receiving PHN-commissioned mental health service – Clinical care coordination for people with severe and complex mental illness.	95% of all staff providing PHN commissioned services as all or part of their role	No current baseline	- Workforce role - Age - Gender - Type of organisation (NGO, not for profit, private, etc)

Local Performance Indicator Data source	**Indicator**	**Source**	**Collection Commencement date**
	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).	National data source	1st July 2016
	Average cost per PHN-commissioned mental health service – Clinical care coordination for people with severe and complex mental illness.	Local finance and activity data via contracts and performance management system	1st July 2016
	Clinical outcomes for people receiving PHN-commissioned - Clinical care coordination for people with severe and complex mental illness.	Local outcome tools such as PHQ9, K10, GAD7 as agreed with commissioned providers	1st July 2016
	Consumer experience for people receiving PHN-commissioned mental health service – Clinical care coordination for people with severe and complex mental illness.	Local survey	1st July 2016
	Provider satisfaction of those receiving PHN-commissioned mental health service – Clinical care coordination for people with severe and complex mental illness.	Local survey	1st July 2016

Proposed Activities	
Priority Area 5: Community based suicide prevention activities	This must reflect priorities as identified in Section 4 of your Needs Assessment, in line with the objectives of the PHN mental health funding: • encourage and promote a systems based regional approach to **suicide prevention** including community based activities and liaising with Local Hospital Networks (LHNs) and other providers to help ensure appropriate follow-up and support arrangements are in place at a regional level for individuals after a suicide attempt and for other people at high risk of suicide, including Aboriginal and Torres Strait Islander people.
Activity(ies) / Reference (e.g. Activity 5.1, 5.2, etc)	5.1 Review of current suicide prevention services (primary, secondary, community) 5.2 Suicide prevention research collaboration and develop systems modelling approach 5.3 Facilitate a local partnership to both support commissioning of PHN resources and access wider resource 5.4 Service continuity to be confirmed subject to funding: • Men's Health Information Resource Centre (MHIRC), Western Sydney University - Funder for Men's Shed in Emerton (suicide prevention) • Community Connections – funder Consumer Activity Network • Hope for Life – funder Salvation Army • Mates in Construction – funder Mates in Construction • LifeForce – funder Wesley Mission
Description of Activity(ies) and rationale (needs assessment)	5.1 Commission a comprehensive review and mapping of current suicide prevention services (primary, secondary, community) and gaps in the region to inform future service planning and service continuity. The needs assessment identified a significant gap in our understanding of this sector in our region and the service gaps. The service review will draw on the evidence-based comprehensive framework developed by the Black Dog Institute. 5.2 Actively support the suicide prevention research collaboration lead by the University of Western Sydney that includes Black Dog Institute, Brain and Mind Institute and Synergia Consulting to develop a systems modelling approach to community-based suicide prevention. The PHN will act as a local implementation partner for the research collaborative enabling the systems modelling approach to be tested in real life scenarios and enable our commissioning framework to draw on the evidence of effectiveness and impact for suicide prevention. This will address the current fragmented nature of suicide prevention activities, in particular the service gaps. For example, support local dialogue to identify high value, high impact opportunities to assertively follow-up people who have attempted suicide but do not meet the requirements for secondary care, drawing on the suicide prevention system planning tool. The systems approach will contribute towards creating region-wide engagement, collaboration and collective stewardship and governance of the suicide prevention in our region.

	5.3 Leverage the systems modelling initiative to community-based suicide prevention to bring together a local partnership to both support commissioning of PHN resources and access wider resources. Building on our existing platform of dialogue across the sector using the systems modelling, support the sector in co-commissioning to leverage the PHN resources e.g. funding opportunities available via Black Dog Institute and state / LHN opportunities. This activity aligns with the understanding that activity and resources across the region is fragmented and there is a need for a shared and improved understanding of needs and service gaps. 5.4 Service continuity to be confirmed subject to funding – while clearly indicating to service providers of the current service continuity priority, we will use the evidence based systems modelling engagement process described above to facilitate improvement, integration and alignment of these continuity services to our PHN's priorities and population needs.
Collaboration	Outline if the activity will be jointly implemented with any other stakeholders, including LHNs, state and territory Government, Aboriginal and Torres Strait Islander health services, consumer organisations, NGOs? If yes, provide details including the role of all parties. The PHN will build on a unique research collaboration and suicide prevention that is focused on developing a systems model of the suicidality attempts and suicide completion continuum. The research collaboration includes University of Western Sydney, University of Sydney, Black Dog Institute, and our service design partner Synergia. Note Black Dog is currently acting as a co-commissioner in our region of suicide prevention services and is actively part of our mental health commissioning advisory council. The LHN - co-design and co-commissioner.
Duration	5.1 July 2016 to 30 June 2018. 5.2 July 2016 to 30 June 2018. 5.3 July 2016 to June 2019 the implementation of the Black Dog Institute systems based suicide prevention model 5.4 July 2016 to 30 June 2018
Coverage	5.1 Region wide approach 5 LGA's 5.2 Region wide approach 5 LGA's. 5.3 Unique to Blacktown LGA, however the model may be extended to all LGA in the region, depending on the development and utilisation of this model with the partnership organisations, such as WSLHD, Richmond PRA, Uniting Recovery, AfterCare, CareConnect and others. 5.4 Region wide approach 5 LGA's.
Commissioning approach	The approach to commissioning for these activities will be based on the Western Sydney Primary Health Network Commissioning Framework (WSPHNCF), a patient centred and clinically based process to enhance service delivery and patient outcomes in western Sydney. The WSPHNCF has been developed based on best practice national and international commissioning evidence.

<table>
<tr><td></td><td>Patients and consumers form the centre of this process. The aim of the Commissioning Framework is to ensure that services are developed/ procured to meet the needs of the patients and consumers involved.

The PHN will enter into a legally binding contract with all providers, where it is a commissioner of services. This will include clear metrics around payments and reporting requirements as well as clear, measurable project goals. Providers will provide regular reports on how they are progressing towards achieving the agreed goals. The reports will include outcome as well as output measures to inform evaluation.

In preparation for this, an online contracts and reporting portal has been developed which is a vital component of the PHN's commissioning role and essential for ensuring commissioned services result in better health outcomes while being cost effective and transparent.

Western Sydney PHN has built an effective clinical governance, resource management and performance development capability in mental health through our ATAPS, PIR and training programmes. A critical challenge for the future will be an active process of clinical governance, resource management and performance development that can enable safe, effective care across the stepped care system while managing the risks associated with a blended, value based reimbursement system. To address this the existing foundation will be further developed to fit the PHN co-commissioning role and the broader needs of a mental health PCMH based system of care.</td></tr>
<tr><td>Performance Indicator</td><td>The mandatory performance indicator for this priority is:

• Number of people who are followed up by PHN-commissioned services following a recent suicide attempt.

No additional indicators are proposed for this priority.</td></tr>
<tr><td>Local Performance Indicator target (where possible)</td><td>
<table>
<tr><th>Indicator</th><th>Target</th><th>Baseline and date</th><th>Disaggregation</th></tr>
<tr><td>Number of people who are followed up by PHN-commissioned services following a recent suicide attempt.</td><td>TBC once commissioned services are in place from 1st July 2016.</td><td>No current baseline</td><td>- Age
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<tr><td>Local Performance Indicator Data source</td><td>
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<tr><th>Indicator</th><th>Source</th><th>Collection Commencement date</th></tr>
<tr><td>Number of people who are followed up by PHN-commissioned services</td><td>National data source</td><td>1st July 2016</td></tr>
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	following a recent suicide attempt.		

Proposed Activities	
Priority Area 6: Aboriginal and Torres Strait Islander mental health services	• This has been submitted by Western Sydney PHN. Acceptance of the plan associated with priority area 6 is still to be confirmed by the Department of Health.

Proposed Activities	
Priority Area 7: Stepped care approach	This must reflect priorities as identified in Section 4 of your Needs Assessment, in line with the objectives of the PHN mental health funding: • a continuum of primary mental health services within a person-centred **stepped care approach** so that a range of service types, making the best use of available workforce and technology, are available within local regions to better match with individual and local population need.
Activity(ies) / Reference (e.g. Activity 7.1, 7.2, etc)	*Note: As per the update from the Department of Health 29th April, the below is an overview of Western Sydney PHN's intended approach to providing primary mental health services within a person-centred stepped care approach. The detail for this priority area will be worked up in detail during further planning for 2016/17.* We aim to support our Patient centred mental health medical home's and establishment of 'medical neighbourhood's' via the design and implementation of stepped care that ensures the level of care is targeted to each person's need and can flexibly respond with integrated pathways that facilitate a more joined-up journey through the mental health system of providers. Western Sydney's approach to stepped care will address the 'missing middle' of mental health care – our vulnerable populations with combinations of moderate mental illness and complexity; drug and alcohol, comorbid physical conditions and social issues such as a lack of housing. Building on experience from UK and New Zealand our preliminary commissioning design for Stepped Care in western Sydney includes: • Step 0: Entry Stage – General Practice Consultation / MH plan • Step 1: 'Self Care - Watchful Waiting' – 'Blue prescriptions' / 'green prescriptions' • Step 2: Low Intensity Interventions - Brief Group Education Interventions / e-Therapy / Integrated physical care • Step 3: Medium Intensity – similar to current Better Access • Step 4: High Intensity, complex navigation support in primary/community based service

- Step 5: Very high intensity – partnership with western Sydney LHD services

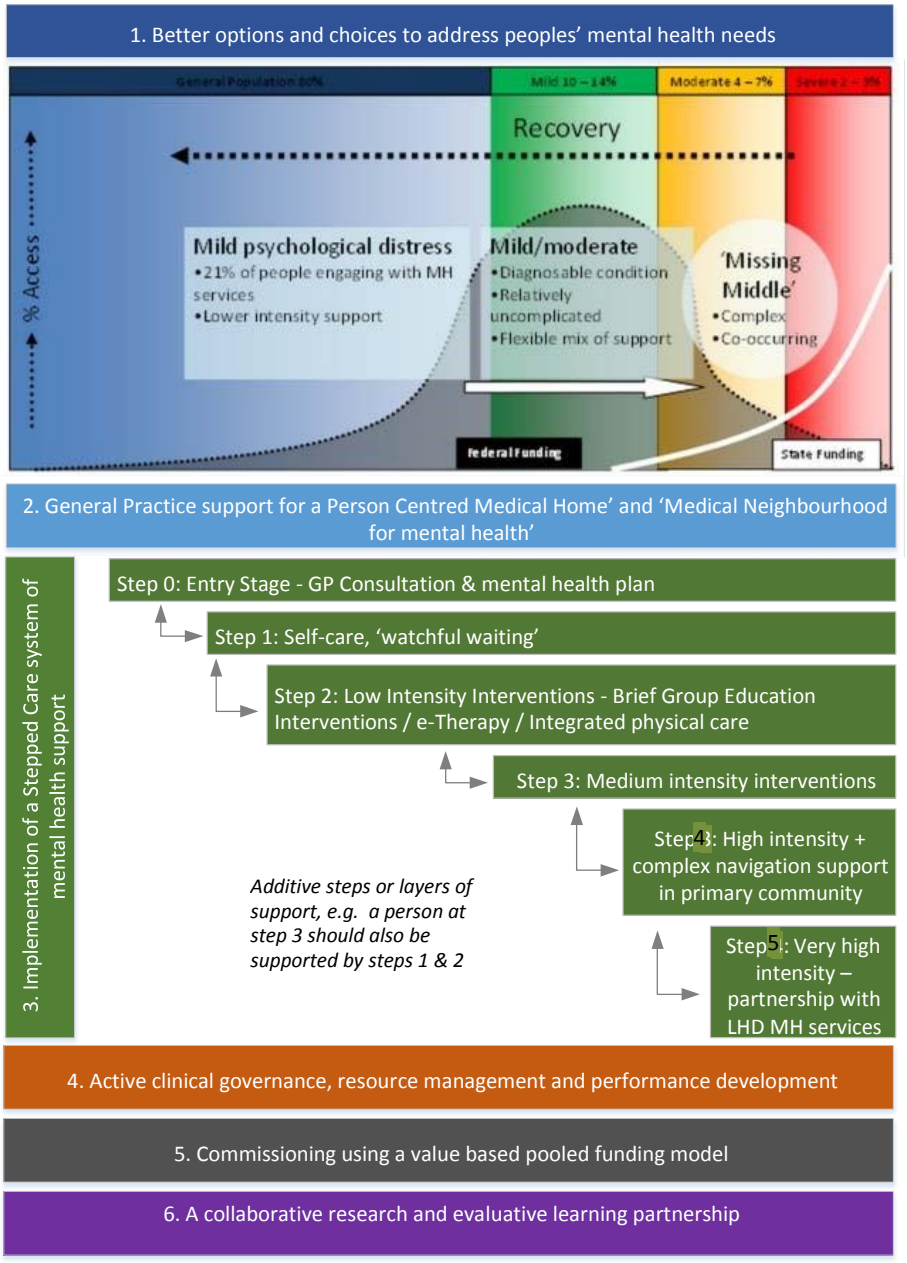

Figure 6: An integrated stepped or layered system of care

Design of a stepped care framework for Western Sydney was progressed during 2015 and summarised in the paper "High Performing Mental Health in Primary Care- Options for system and funding innovation", 5th November 2015. Implementation planning was undertaken across November/December focused on each of the 'building blocks' of the design.

For example, one planned activity was to utilise a rigorous system modelling and collaborative service design process, developed in the UK for the IAPT stepped care implementation and utilised in over 20 local stepped care implementation processes. The approach enables a collaborative engagement of primary, community and specialist mental health service and practitioners with the evidence base for a range of stepped care designs and interventions and enables modelling of their impact on patient and population level outcomes.

	Practically it would enable us to translate the conceptual design of the options paper into estimates of the real world patient flows and the clinical, operational and financial impacts of the stepped model. A second planned activity was to undertake research of key practices' population profiles to estimate the nature and capacity of the functional services within each step that would be required to enable the integration of stepped care capacity with the mental health PCMH capability that these practices have in place or are planning to develop. A third planned activity was the development of both appropriate stepped care clinical/practitioner governance functions and of a stepped care provider 'regional mental health alliance'. Subject to funding availability these activities can scaled or timed to suit but provide a basis for implementation over the plan period.
Description of Activity(ies) and rationale (needs assessment)	Provide a short description of each activity relating to the priority area. This may include, but is not limited to: aim of activity; how the activity will address the priority; target population cohort. You must also demonstrate alignment with the PHN mental health funding objectives. A description of each activity i.e. the stepped care design is outlined in detail in the paper referred to above.
Collaboration	A wide number of stakeholders will be included throughout both the design of the model, proof of concept and implementation. The success of this priority is dependent on the PHN's close collaboration with stakeholders including funders and providers. The most significant provider is our region's general practices.
Duration	Design of the stepped care framework was undertaken in 2015 Implementation design commenced in November 2015 and will continue across the first half of 2016 as the resources available are clarified. Implementation will also be policy and resource dependent however we aim to have commissioning arrangements in place aligned to the new model by 1st July 2017.
Coverage	This will be a region wide approach across 5 LGA's.
Commissioning approach (If applicable)	The approach to commissioning for these activities will be based on the Western Sydney Primary Health Network Commissioning Framework (WSPHNCF), a patient centred and clinically based process to enhance service delivery and patient outcomes in western Sydney. The WSPHNCF has been developed based on best practice national and international commissioning evidence. Patients and consumers form the centre of this process. The aim of the Commissioning Framework is to ensure that services are developed/ procured to meet the needs of the patients and consumers involved. The PHN will enter into a legally binding contract with all providers, where it is a commissioner of services. This will include clear metrics around payments and reporting requirements as well as clear, measurable project goals. Providers will provide regular reports on how they are progressing towards achieving the agreed goals. The reports will include outcome as well as output measures to inform evaluation. In preparation for this, an online contracts and reporting portal has been developed which is a vital component of the PHN's commissioning role and

<table>
<tr><td></td><td>essential for ensuring commissioned services result in better health outcomes while being cost effective and transparent.

An important building block of stepped care implementation is commissioning new value based pooled funding model. This aims to utilise the Western Sydney PHN commissioning capability and a blended value-based pooled funding resource to support the evolution of the mental health PCMH and Medical Neighbourhood as part of a both a stepped care system for mental health and an enhanced mental health PCMH in primary care.

Western Sydney PHN has built an effective clinical governance, resource management and performance development capability in mental health through our ATAPS, PIR and training programmes. A critical challenge for the future will be an active process of clinical governance, resource management and performance development that can enable safe, effective care across the stepped care system while managing the risks associated with a blended, value based reimbursement system. To address this the existing foundation will be further developed to fit the PHN co-commissioning role and the broader needs of a mental health PCMH based system of care.</td></tr>
<tr><td>Performance Indicator</td><td>The mandatory performance indicator for this priority is:

• 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.

No additional indicators are proposed for this priority</td></tr>
<tr><td>Local Performance Indicator target (where possible)</td><td>
<table>
<tr><th>Indicator</th><th>Target</th><th>Baseline and date</th><th>Disaggregation</th></tr>
<tr><td>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.</td><td>TBC once commissioned services are in place from 1st July 2016.</td><td>No current baseline</td><td>- Age
- Gender
- Ethnicity
- Type of service accessed (NGO, not for profit, private, etc)</td></tr>
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<tr><td>Local Performance Indicator Data source</td><td>
<table>
<tr><th>Indicator</th><th>Source</th><th>Collection Commencement date</th></tr>
<tr><td>Proportion of PHN flexible mental health funding allocated to low intensity services, psychological therapies and for clinical care</td><td>National data source</td><td>1st July 2016</td></tr>
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	coordination for those with severe and complex mental illness.		

Proposed Activities	
Priority Area 8: Regional mental health and suicide prevention plan	This must reflect priorities as identified in Section 4 of your Needs Assessment, in line with the objectives of the PHN mental health funding: • Evidence based **regional mental health and suicide prevention** plans and service mapping to identify needs and gaps, reduce duplication, remove inefficiencies and encourage integration.
Activity(ies) / Reference (e.g. Activity 8.1, 8.2, etc)	*Note: As per the update from the Department of Health 29th April, the below is an overview of Western Sydney PHN's intended approach to regional mental health and suicide prevention planning. The detail for this priority area will be worked up in detail during further planning for 2016/17.* The development of our PHN region-wide mental health and suicide prevention plans is a significant opportunity to drive evidence-based and effective local change in western Sydney, at a system level and regional level. This is core to the role, structure and function of PHN as an effective local change agent, within the context of the emerging mental health system reform agenda from both Commonwealth and State. The mental health and suicide prevention activities we commission will align with the Western Sydney Integrated Care demonstration site project, a partnership between western Sydney LHD and WentWest. They will be based on initiatives that demonstrably improve hospital avoidance where combinations of mental ill-health, chronic conditions and vulnerability are contributing influences. We will continue to develop and use the recently completed a 'Mental Health Atlas' services mapping process with the University of Sydney. This enables us to understand the functional mix of capacity in the region and compare this to international benchmarks using a standard taxonomy. One of the highlights of this work is that there are substantial functional capacity gaps that are required to shift from an intensely hospital focused, reactive system of care to a more community based, closer to home, planned and integrated mental health system. To enable all of the above, we will continue to build on the strong relationships with our LHD, utilising our organisational connections to our mental health provider community and Indigenous provider networks to support engagement in the co-design of an innovative system of care.
Description of Activity(ies) and rationale (needs assessment)	8.1 Develop a single mental health, AOD and suicide prevention regional plan via a highly engaged co-design process 8.2 Contract support resource to organise the co-design processes, manage data collection and analysis and lead the development of the plan
Collaboration	Outline the approach to be undertaken by the PHN in leading the development with regional stakeholders including LHNs, state and territory Governments, Aboriginal and Torres Strait Islander health services, consumer organisations,

	and NGOs, of a longer term, more substantial *regional mental health and suicide prevention plan*. 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* (see Mental Health Plan Circular 2/2016) Provide details including the role of all parties.
Duration	Design to commence in July 2016 with the plan to the complete by Jan 2017. This timeframe will enable WentWest to commission services to support the regional plan by July 2017
Coverage	This will be a region wide approach across 5 LGA's
Commissioning approach (If applicable)	The approach to commissioning for these activities will be based on the Western Sydney Primary Health Network Commissioning Framework (WSPHNCF), a patient centred and clinically based process to enhance service delivery and patient outcomes in western Sydney. The WSPHNCF has been developed based on best practice national and international commissioning evidence. Patients and consumers form the centre of this process. The aim of the Commissioning Framework is to ensure that services are developed/ procured to meet the needs of the patients and consumers involved. The PHN will enter into a legally binding contract with all providers, where it is a commissioner of services. This will include clear metrics around payments and reporting requirements as well as clear, measurable project goals. Providers will provide regular reports on how they are progressing towards achieving the agreed goals. The reports will include outcome as well as output measures to inform evaluation. In preparation for this, an online contracts and reporting portal has been developed which is a vital component of the PHN's commissioning role and essential for ensuring commissioned services result in better health outcomes while being cost effective and transparent. Western Sydney PHN has built an effective clinical governance, resource management and performance development capability in mental health through our ATAPS, PIR and training programmes. A critical challenge for the future will be an active process of clinical governance, resource management and performance development that can enable safe, effective care across the stepped care system while managing the risks associated with a blended, value based reimbursement system. To address this the existing foundation will be further developed to fit the PHN co-commissioning role and the broader needs of a mental health PCMH based system of care.
Performance Indicator	As described in the strategic vision the quadruple aim provides the framing for our outcomes and the architecture for our `performance indicators. The quadruple aim refers to the simultaneous achievement of patient experience of care, quality and population health, sustainable cost, and provider satisfaction. The mandatory performance indicator for this priority is: • Evidence of formalised partnerships with other regional service providers to support integrated regional planning and service delivery. The mandatory indicator covers one aspect of the quadruple aim. Therefore, in addition, we include the following performance indicators:

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Experience of the engagement and development process used to develop the plan across consumers, providers, peak bodies, state and federal agencies
Level of engagement with Aboriginal and Torres Strait Islander

These indicators, how they will be measured, monitored and use to improve system performance will be developed in partnership with our stakeholders and local providers
</td></tr>
<tr><td>Local Performance Indicator target (where possible)</td><td>
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<tr><th>Indicator</th><th>Target</th><th>Baseline and date</th><th>Disaggregation</th></tr>
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<tr><th>Indicator</th><th>Source</th><th>Collection Commencement date</th></tr>
<tr><td>Evidence of formalised partnerships with other regional service providers to support integrated regional</td><td>Local measurement tool/survey</td><td>1st Oct 2016</td></tr>
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	planning and service delivery.		
	Experience of the engagement and development process used to develop the plan across consumers, providers, peak bodies, state and federal agencies	Local measurement tool/survey	1st Oct 2016
	Level of engagement with Aboriginal and Torres Strait Islander	Local measurement tool/survey	1st Oct 2016