Australian Government
Department of Health

phn NORTH COAST
An Australian Government Initiative

North Coast Primary Health Network
Mental Health
Activity Work Plan 2016 - 2018

Contents

Introduction

Overview

This Activity Work Plan is an update to the 2016-18 Activity Work Plan submitted to the Department in May 2016.

Strategic Vision

NCPHN's vision is "people and communities on the North Coast with mental health concerns are on a seamless journey of recovery, towards lives characterised by meaning, connection and contribution, served by a network of integrated and coordinated services."

NCPHN adopts— and will continue to adopt—a collaborative approach to work towards this vision. NCPHN will lead an inclusive process, engaging our partners in the sectors in regional mental health and suicide prevention planning and reform.

The vision for North Coast's stepped-care approach is that it will be a recovery-orientated, person-centred model. Key tenets of the model are:

1. Services are both accessible and easily navigable for all - consumers, carers and clinicians
2. Services are appropriate to each person's (changing) need and transition between these services is seamless allowing for continuity of care
3. Services are integrated within the stepped-care model and encompass the complexity of a person with mental health needs
4. Services are provided by an appropriately skilled workforce who understand their roles and responsibilities within the mental health system, and those of their colleagues.

NCPHN will engage people with a lived experience of mental illness, clinicians, Local Health Districts, Aboriginal services (both clinical and community services), youth organisations and other community partners to ensure planning meets the mental health priorities and the needs of the community.

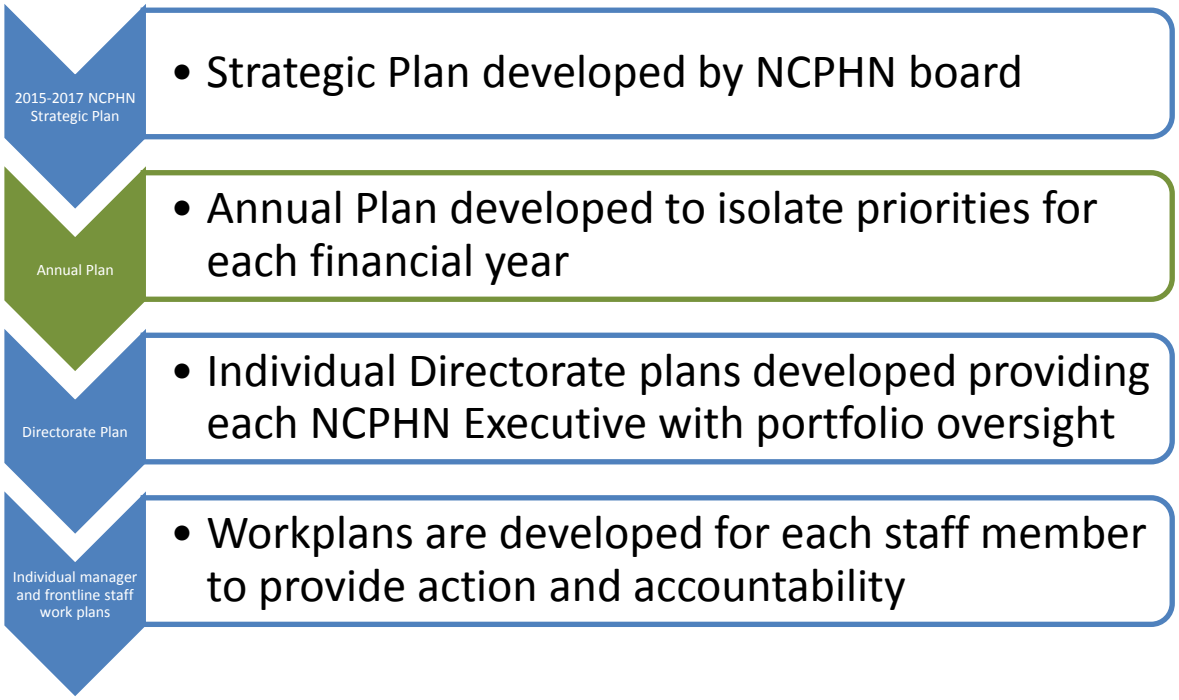
A systems approach to suicide prevention will be adopted that incorporates the whole spectrum of intervention points - prevention, early intervention, treatment and continuing care. Postvention support will also be explored.

Efficient and effective reforms will be made possible through broad consultation and engagement. Appropriate data will be collected from all commissioned services to provide quality assurance, including ongoing monitoring and evaluation and to inform service planning. Additionally, commissioned services will have consumer feedback procedures to facilitate quality improvement and complaint management.

A Mental Health Clinical Quality Committee will be established with Terms of Reference consistent with Section 1.3 of Primary Health Network Guidelines. The Council will be responsible for the safety and quality of commissioned services, including approving quality schedules and KPIs for procurement contracts, as provided by relevant commissioning groups. The council will receive reports and monitor the quality of services. The Council will be advised by NCPHN clinical councils, NCPHN community reference groups, mental health collaboratives and consumer groups.

Strategic Implementation

This Activity Work Plan represents the second phase in the NCPHN planning process. To ensure all elements of the NCPHN Strategic Plan become operationalised, a cascading implementation plan structure is used. This enables a direct line of sight between the organisation's strategic objectives and work plan actions for individual front line staff. All teams report on their progress monthly to the Executive Team.



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

Proposed Activities	
Priority Area	**Priority Area 1: Low intensity mental health services** MH(1) Develop and trial low-intensity interventions in selected LGAs, refine the intervention/s with a view to expansion across the region, page 66. MH(2) Support the ongoing delivery of New Access on the North Coast, page 67.
Activity(ies) / Reference	1.1 Ongoing delivery of established low intensity mental health service 1.2 Provide consumer and service provider (both clinical and non-clinical) education regarding low intensity services and the Digital Mental Health Gateway (when operational)
Existing, Modified, or New Activity	Modified Activity
Description of Activity	The activities listed below are expected to improve access to mental health support and promote recovery for people with mild to moderate depression and anxiety. 1.1 Low intensity mental health service is delivered to provide early intervention for anxiety and depression using low intensity CBT and guided self-help. Services can be accessed by self-referral. It aims to improve access to services and promote recovery for people experience mild symptoms. NCPHN has participated as a pilot site for the low intensity mental health service since early 2013. NCPHN has secured a continuation of the program. The low intensity mental health service will continue to be available to North Coast residents until 30 June 2017. The pilot has been successful with positive outcomes for people with low to moderate mental health challenges on the North Coast using a low-intensity Cognitive Behavioural Therapy approach. The service will transition from direct service delivery. 1.2 Provide education on the availability and evidence for low intensity services, both delivered locally and online, and to encourage uptake and referral.

	Amendments to 2016-17 AWP: • Adjusted numbering system for sub-activities to increase clarity of description • Removed reference to former 'New Access' low intensity services branding • Removed strategy to trial low-intensity interventions. Delivery of this activity is still scheduled however will be delivered through lead site funding. • Added strategy for providing education on availability and evidence for low intensity services
Target population cohort	1.1 People over 18 years of age experiencing mild to moderate anxiety and depression. 1.2 Consumers (direct marketing) and service providers (both clinical and non-clinical) who have contact with people with mild to moderate anxiety and depression
Consultation	Nil
Collaboration	Nil
Duration	1.1 June2016-July 2018 1.2 June 2016-ongoing
Coverage	Entire NCPHN region
Commissioning method	1.1 Direct service delivery transitioned to contracted services 1.2 Joint delivery - direct service delivery and contracted
Approach to market	Depending on the outcomes of the co-design process, either a select or open tender process will be used to procure services
Decommissioning	Transition of NCPHN pilot low intensity service Continuity of care will be supported as low intensity service transitions
Performance Indicator	Priority Area 1 -Mandatory performance indicators: • Proportion of regional population receiving PHN-commissioned mental health services – Low intensity services • Average cost per PHN-commissioned mental health service – Low intensity services • Clinical outcomes for people receiving PHN-commissioned low intensity mental health services

Local Performance Indicator target	1.1 Output indicator: Services delivered Outcome indicator: Recovery rates >80% 1.2 Increase in low intensity services delivered in the region
Local Performance Indicator Data source	PC-MIS (existing low intensity database) 1 July 2016 to 30 June 2017 PMHC MDS 1 July 2017 to 30 June 2017

Proposed Activities	
Priority Area	**Priority Area 2: Youth mental health services** MH(3) Work with Lismore, Tweed Heads, Coffs Harbour and Port Macquarie headspaces to ensure service continuity and that services are meeting the needs of the young people in other smaller towns on the North Coast, page 67. MH(4) Develop and implement models of care within prioritised/identified communities for children and young people with (or at risk of) severe mental illness, page 67.
Activity(ies) / Reference	**MH2 – Youth Mental Health** 2.1 Transition Lismore and Tweed Heads headspaces to a new lead agency 2.2 Work with 4 local headspace centres for the provision of coordinated youth mental health in smaller towns on the North Coast 2.3 Develop and implement models of care within Bellingen, Nambucca and Kempsey Local Government Areas for children and young people with (or at risk of) severe mental illness, and refine the intervention/s with a view to expansion across the region 2.4 Facilitate increased child mental health services in Grafton
Existing, Modified, or New Activity	Modified Activity
Description of Activity	2.1 Transition of all headspaces to be managed to ensure continuity of service provision and the ongoing collection of data for the purposes of quality improvement, monitoring and evaluation. Target population: 12-25 year olds.

	2.2 The NCPHN Needs Assessment highlights the need for youth services in Kyogle, Casino, Byron Bay, Grafton, Ballina, Murwillumbah, Bellingen, Kempsey and Nambucca. Working with headspace lead agencies, roll-out a regionally consistent model service delivery for youth mental health in smaller towns. 2.3 Working with stakeholders and using the commissioning process, NCPHN will develop and implement models of care within Bellingen, Nambucca and Kempsey Local Government Areas for young people with (or at risk of) severe mental illness. Services to be inclusive, youth friendly and support early intervention. Commissioned services to include care coordination, psychological therapies (over and above what is available under Better Access), monitoring physical health and medication management. Service development is with a view to expansion across the region. 2.4 In response to youth suicides in Grafton increase access to child and adolescent psychiatry using fly-in-fly out model and telehealth. Advocate for the establishment of headspace centre in Grafton. Amendments to 2016-17 AWP: • Adjusted numbering system for sub-activities to increase clarity of description • Additional information on commissioned services in sub-activity 2.3 • Added sub-activity relating to child and adolescent psychiatry and advocacy for headspace in Grafton.
Target population cohort	2.1-2.2 12-25 year olds 2.3 0-25 year olds 2.4 Young people and their families in the Clarence Valley
Consultation	Youth Planning Forums with representation from young people, NGOs including headspace and NNSW LHD held 30 June 2016 Co-design forum for youth services on MNC planned for April 2017
Collaboration	2.1 headspace National Office 2.2 Broad community consultation 2.3 Clinical Quality Committee, clinicians, consumers

	2.4 Joint advocacy, working together with Our Healthy Clarence Steering Committee
Duration	2.1 Completed 31 December 2016 2.2 Commenced 1 January 2017 2.3 Co-design to commences April 2017; Service delivery to commence 1 October 2017 2.4 February 2017-June 2018
Coverage	2.1 Tweed and Lismore LGAs 2.2 Kempsey, Richmond Valley, Clarence Valley, Nambucca 2.3 Kempsey, Bellingen, Nambucca, Clarence Valley 2.4 Clarence Valley
Commissioning method	Wholly commissioned
Approach to market	Depending on the outcomes of the co-design process, either a select or open tender process will be used to procure services.
Decommissioning	N/A
Performance Indicator	Priority Area 2 - Mandatory performance indicator: Support region-specific, cross sectoral approaches to early intervention for children and young people with, or at risk of mental illness (including those with severe mental illness who are being managed in primary care) and implementation of an equitable and integrated approach to primary mental health services for this population group
Local Performance Indicator target	2.1 Headspaces transitioned without disruption to service delivery 2.2 Volume and nature of services delivered to youth residing in Kempsey, Nambucca, Clarence Valley Richmond Valley, reported by post code and age; outcome measure of recovery 2.3 Volume and nature of PHN commission services delivered to youth residing in Bellingen, Nambucca, and Kempsey reported by post code and age; outcome measure of recovery; patient experience measures (Community YES Survey) 2.4 Volume of MBS psychiatry items delivered in the Clarence Valley.
Local Performance Indicator Data source	2.1 NA

	2.2 MBS data, PHMC MDS 2.3 PMHC MDS 2.4 MBS data PMHC MDS Data collection commences 1 July 2017

Proposed Activities	
Priority Area	**Priority Area 5: Community based suicide prevention activities** MH(9) Using the LifeSpan model, implement a region wide approach to suicide, page 69.
Activity(ies) / Reference	5.1 Using the LifeSpan model, implement a region wide approach to suicide in Clarence Valley, Tweed/Byron, Lismore and Kempsey 5.2 Using the Lifespan model, build capacity within the communities and the health system to effectively support people at risk of suicide 5.3 Build capacity among Aboriginal communities and within the mental health system to deliver culturally appropriate, evidence based suicide prevention services (using the Lifespan model where applicable) 5.4 Implement a suicide prevention follow-up service 5.5 Commission culturally appropriate suicide prevention services for Aboriginal people
Existing, Modified, or New Activity	Modified Activity
Description of Activity	5.1 Commence planning and implementation of the LifeSpan approach to suicide prevention in Clarence Valley, Lismore, Tweed, Byron and Kempsey LGAs, including the development of local suicide prevention plans. In response to recent suicides in Grafton, NCPHN will prioritise the implementation of a regional wide approach to suicide prevention in the Clarence Valley in line with Our Healthy Clarence Plan. Activity will include: • Follow-up service for people after a suicide attempt

	• Development of local postvention plans and guidelines, including communication protocols for the community following a suicide or major suicide attempt • Development of local resource packs / information that can be provided to families • Improving access to psychiatry (see Priority Area 4) • Improving access to psychological therapies (see Priority Area 3) Additionally, implementation will commence in Lismore, Tweed, Byron and Kempsey LGAs - LGAs with some of the highest suicide rates in our region. Local Steering Groups will oversee locally responsive plans to suicide prevention. Local services to provide secretariat support to steering groups with NCPHN funding support. The approach will then be refined with a view to later expansion across the region. 5.2 Using the Lifespan model, commission evidenced-based training to build workforce capacity to support people at risk of suicide and community capacity to support people at risk of suicide. 5.3 Build capacity within the mental health system to deliver culturally appropriate, evidence based mental health services for Aboriginal and Torres Strait Islander people, thereby improving access, and complementing/linking to existing services including suicide prevention. Additionally, build capacity among Aboriginal communities to support Aboriginal people at risk of suicide. 5.4 Co-design an appropriate suicide prevention follow-up service based on best-practice principles. 5.5 Co-design Aboriginal and Torres Strait Islander suicide prevention activities targeted to populations and regions with the greatest need. Amendments to 2016-17 AWP: • Adjusted numbering system for sub-activities to increase clarity of description • Consolidated former MH5d and MH5e activities into new sub-activity 5.3
Target population cohort	5.1 Whole of community 5.2 Clinicians and community gatekeepers

	5.3 Clinicians working with Aboriginal people and Aboriginal community gatekeepers 5.4 People who have presented at an Emergency Department after a suicide attempt 5.5 Aboriginal people
Consultation	5.1 Multi-agency suicide Prevention Steering Committees, including Our Healthy Clarence 5.2-5.3 A discussion paper was shared widely throughout the sector and input invited 5.4 beyondblue, NGOs co-design forum 1 March 2017; Clinical Councils – regular consultation; Clinical Expert Committee (planned from March 2017) 5.5 Meeting with Aboriginal Community Controlled Organisations (14 February 2017)
Collaboration	Members of local Steering Groups: development of local suicide prevention plans beyondblue: expert input in the development and implementation of local follow-up service
Duration	5.1 June 2016 – ongoing 5.2-5.3 January 2017 – March 2018 5.4 Service commences 1 July 2017 5.5 1 July 2017 – 30 June 2018
Coverage	5.1 Communities in the LGAs of Clarence Valley, Lismore, Tweed, Byron and Kempsey 5.2-5.3 Entire NCPHN region 5.4 Tweed Valley, Byron, Ballina, Kyogle, Lismore, Clarence Valley, Richmond Valley 5.5 Entire NCPHN region
Commissioning method (if relevant)	5.1 Partly commissioned (secretariat support) 5.2-5.5 Wholly commissioned
Approach to market	5.1 Direct service delivery and select tender 5.2-5.3 Open tender

	5.5 Depending on the outcomes of the co-design process, either a select or open tender process will be used to procure services
Decommissioning	NA
Performance Indicator	Priority Area 5 - Mandatory performance indicator: Number of people who are followed up by PHN-commissioned services following a recent suicide attempt.
Local Performance Indicator target (where possible)	5.1 Development of LifeSpan informed suicide plans for communities of focus; Operational suicide prevention steering committees for communities of focus 5.2 % of NCPHN population trained by NCPHN in gate keeper training and the LGAs of those individuals; % of NCPHN clinicians completed suicide prevention training 5.3 % of Aboriginal population completed gate keeper training; number of clinicians working with Aboriginal people who have undertaken suicide prevention training 5.4-5.5 The co-design process will identify targets for number of people accessing the service and outcome measure
Local Performance Indicator Data source	5.1 Output indicator 5.2-5.5 Reports from contracted organisations

Proposed Activities	
Priority Area	**Priority 6: Aboriginal and Torres Strait Islander mental health services** MH(10) Support the development of a stepped care model across the NCPHN region for Aboriginal and Torres Strait Islander people, page 69.
Activity(ies) / Reference	6.1 Build capacity within the mental health system to deliver culturally appropriate, evidence based mental health services for Aboriginal and Torres Strait Islander people, thereby improving access, and complementing/linking to existing services including drug and alcohol services, social and emotional wellbeing services and mainstream services

	6.2 Approaches to support mental wellbeing of Aboriginal people with a particular focus on programs that work within an Aboriginal cultural framework, including holistic service delivery 6.3 6.3Development of an Aboriginal mental health model of care
Existing, Modified, or New Activity	Modified Activity
Description of Activity	These activities will deliver culturally appropriate and culturally safe mental health services that address health needs and service gaps for Aboriginal people. A focus will be on developing Aboriginal models of care that support: • the delivery of holistic care • the integration of mental health services with social and emotional wellbeing, drug and alcohol and suicide prevention services • the implementation of stepped care that meets the needs of Aboriginal people Amendment to 2016-17 AWP: • Adjusted numbering system for sub-activities to increase clarity of description • Changes reflect a change in focus in this Priority Area following consultation with our Aboriginal partners. The 2016-17 Priority Area 6 activities continue under mainstream activity where there will be a continued focus on meeting the needs of Aboriginal people.
Target population cohort	Aboriginal people
Consultation	Consultation with ACCHOs held on 14 February 2017. Consultations are ongoing with the Northern NSW and Mid North Coast LHDs, Black Dog Institute, Non-Government Organisations focused on Aboriginal mental health; the Many Rivers Alliance (representing AMS from across NCPHN region: Bulgarr Ngaru MAC (Grafton, Casino, and Bugalwena/Tweed Heads) , Bullinah AMS (Ballina), Jullums Rekindling the Spirit (Lismore), Galambila AMS (Coffs Harbour), Durri AMS (Kempsey & Nambucca Heads), Werin AMS (Port Macquarie)), Aboriginal Health Authority (representing AMSs in Mid North Coast: Galambila AMS (Coffs Harbour), Durri AMS (Kempsey & Nambucca Heads), Werin AMS (Port Macquarie)) and the Ngayundi Executive Committee. NCPHN Clinical Councils will advise on the development and implementation of these initiatives.

Collaboration	NA
Duration	January 2017 – March 2018
Coverage	6.1-6.2 Entire NCPHN region 6.3 Mid North Coast
Commissioning method	Wholly commissioned
Approach to market	Open tender with a possibility of select tender for 6.6 in 2017-18
Decommissioning	NA
Performance Indicator	Priority 6 - Mandatory performance indicator: Proportion of Indigenous population receiving PHN-commissioned mental health services where the services were culturally appropriate
Local Performance Indicator target	% of Aboriginal population receiving mental health first aid and training of local trainers Development of model of care and its uptake across diverse organisations including MNC Aboriginal Medical Services and MNC LHD
Local Performance Indicator Data source	Reports from contracted organisations

Proposed Activities	
Priority Area	**Priority 7: Stepped care approach** MH(1)-MH(10), page 66-69.
Activity(ies) / Reference (e.g. Activity 1.1, 1.2, etc)	Develop the framework for the implementation of stepped care in mental health services on the North Coast
Existing, Modified, or New Activity	Modified Activity
Description of Activity	7.1 Form Clinical Expert Committee to support the development of eligibility criteria for different steps based on functional assessment and motivation (stages of change).

	7.2 Establish a single point of intake for PHN commissioned services that: • is supported by a digital information management system • allows self-referral for low intensity services • facilitates step-up and step-down to PHN commissioned services and other services as appropriate; facilitates step-across (within blended low intensity service), • manages demand and funding for suicide prevention services, packages of care funding and psychological therapies. 7.3 As outlined in other priority areas, develop and implement the service models of the various 'steps' of a stepped care model, in order to develop a menu of options for referring clinicians, consumers and carers. Amendments to 2016-17 AWP: • Adjusted numbering system for sub-activities to increase clarity of description • Expanded detail on approach.
Target population cohort	NA
Consultation	Clinical Councils, community reference groups, mental health collaboratives
Collaboration	NA
Duration	7.1 Commencement February 2017 7.2 Commencement July 2017 7.3 Various, as described above
Coverage	Region wide
Commissioning method (if relevant)	7.1 Direct service delivery (in-house consultation and expert reference group) 7.2 Direct service delivery (held in-house until established and able to be commissioned out) 7.3 Various, as described above
Approach to market	7.1-7.2 NA 7.3 Various, as described above

Decommissioning	NA
Performance Indicator	Priority 7 - Mandatory performance indicator: Proportion of PHN flexible mental health funding allocated to low intensity services, psychological therapies and for clinical care coordination for those with severe and complex mental illness.
Local Performance Indicator target (where possible)	Number of clients receiving services at appropriate 'step' as classified by assessment tool
Local Performance Indicator Data source	PMHC-MDS

Proposed Activities	
Priority Area	**Priority 8: Regional mental health and suicide prevention plan** MH(1)-MH(10), page 66-69.
Activity(ies) / Reference	Develop a Regional Plan for Mental Health and Suicide Prevention
Existing, Modified, or New Activity	Modified Activity
Description of Activity	NCPHN will consult widely in the development of our Regional Mental Health and Suicide Prevention Plan to ensure that there is broad agreement and support from all stakeholders on the regional mental health and suicide prevention priorities and the approaches to address those priorities. Existing consultation forums such as Clinical Councils will be used to inform this process. These include the established mental health collaboratives in Northern NSW and Mid North Coast (Mental Health and Wellbeing Collaborative and IMHpact MNC), consumer forums (NNSW Mental Health Forum, MNC Consumer Reference Group), NCPHN Clinical Councils and Community Reference Groups. Dedicated forums will be convened as required. Regional stepped care model will be documented as part of the regional mental health plan. Amendments to 2016-17 AWP • Adjusted numbering system for sub-activities to increase clarity of description • Expanded detail on approach.

Target population cohort	Whole regional population, with a focus on organisations delivering mental health services or connecting with mental health services
Consultation	See below
Collaboration	Mental health collaboratives in NNSW and Mid North Coast NCPHN will work collaboratively with: the Northern NSW and Mid North Coast LHDs, Aboriginal Medical Services, NNSW Mental Health and Wellbeing Collaboration, IMHpact MNC, NNSW Mental Health Forum, MNC Consumer Reference Group, NCPHN Clinical Councils and Community Reference Groups, Suicide Prevention Australia, Black Dog Institute. NCPHN Clinical Councils will advise on the development and implementation of these initiatives.
Duration	July 2016 - September 2017
Coverage	Entire NCPHN region
Commissioning method	Partly commissioned
Approach to market	TBC
Decommissioning	NA
Performance Indicator	Priority 8 - Mandatory performance indicators: Evidence of formalised partnerships with other regional service providers to support integrated regional planning and service delivery.
Local Performance Indicator target	Diverse regional engagement of the development of the plan
Local Performance Indicator Data source	Consultation Forum attendance Discussion paper respondents

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

Proposed Activities	
Priority Area	**Priority 3: Psychological therapies for rural and remote, under-serviced and / or hard to reach groups** MH(5) Service continuity for Healthy Minds which provides services to hard-to-reach groups, page 67. MH(6) Develop and trial approaches to delivering psychological services to underserviced groups in selected areas and refine the intervention with a view to expansion across the region, page 68.
Activity(ies) / Reference	3.1 Service continuity for Healthy Minds which provides services to hard-to-reach groups 3.2 Priority access to psychological services for people at risk of suicide 3.3 Trial approaches to deliver psychological therapies to the communities of Kempsey and Port Macquarie 3.4 Implement strategies to incentivise or increase mental health professional workforce in identified rural and remote towns, starting with Grafton and Kempsey
Existing, Modified, or New Activity	Modified Activity
Description of Activity	3.1 Aim: Service continuity for NCPHN's Healthy Minds program. Healthy Minds facilitates the delivery of psychological services to under-serviced and hard-to-reach groups including using co-location with community organisations; facilitating providers to deliver psychological therapies in under-service areas (rural and remote regions); use of home visits; use of telephone CBT. Healthy Minds will be transitioned to a prime contractor model to enable service continuity while reformed areas of the program are trialled.

	3.2 An incentive system will be developed to encourage mental health clinicians to provide priority access to people at risk of suicide. Service design will include defining eligibility criteria and modelling to consider demand within budget constraints. This activity aims to provide timely access to psychological services for people at risk of suicide. The model will be developed and trialled in Port Macquarie and Kempsey will a view to expansion across the region. 3.3 This activity aims to improve access to psychological therapies for groups that are hard to engage or underserviced by the MBS. Using co-design methodology and input from the Expert Clinical Panel, a service model will be designed whereby clinicians are incentivised to partner with organisations and utilise Better Access within those services. The incentive will take into account the need for an increased rate of bulk-billing of those clients and a reduced attendance rate. 3.4 Aim: increase availability of access to psychological therapies in regions with low rates of clinicians delivering psychological therapies. The communities of highest priority are Grafton, Bowraville and Kempsey. Working together with the communities and clinicians (local and in neighbouring regions) identify and implement the most appropriate option(s). The work in Bowraville will be coordinated with the local Solution Brokerage Group. Amendments to 2016-17 AWP: • Adjusted numbering system for sub-activities to increase clarity of description • Added approach to provide priority access for those at risk of suicide • Separated former MH3b activity 'develop and trial approaches to delivering psychological services to underserviced groups in Clarence Valley, Kempsey and Port Macquarie LGAs, and refine the intervention with a view to expansion across the region' into two separate activities: 3.3 and 3.4.
Target population cohort	3.1 People experiencing financial hardship, people at risk of suicide, Aboriginal people, children, people at risk of homeless 3.2 People at risk of suicide and people with need for psychological therapies

	3.3 People experiencing or at risk of homelessness; people with a disability; Aboriginal people; People with substance misuse disorder; People in contact with the justice system; Children and youth 3.4 People residing in Grafton, Bowraville and Kempsey
Consultation	• Our Healthy Clarence Steering Committee meetings: ongoing • Solution Brokerage Bowraville: ongoing • Consultations will be held with the LHDs, Healthy Minds providers and referrers, NGOs where existing co-location arrangements are in place ; Clinical Councils, Consumers and Clinical Quality Committee
Collaboration	3.1 Organisations supporting hard-to-reach populations where existing Healthy Minds co-location arrangements are in place 3.2 NA 3.3 Local organisations providing services to listed hard-to-reach populations, including those with existing Healthy Minds co-location arrangements 3.4 Rural Doctors Network; professional bodies for registered mental health professionals; local Council and Chamber of Commerce; universities training mental health professionals
Duration	3.1 TBC 3.2 Commencement of co-design: January 2017; Commencement of service delivery 1 July 2017 3.3 Commencement of service delivery 1 July 2017 3.4 Clarence Valley: response commissioned 1 July 2017 Bowraville: response commissioned 31 December 2017 Kempsey: response commissioned 31 December 2017
Coverage	3.1 Entire NCPHN region 3.2-3.3 Port Macquarie and Kempsey, initially 3.4 Bowraville, Kempsey and Clarence Valley

Continuity of care	• Healthy Minds to be transitioned to prime contractor model and, overtime, blended into alternative models of delivery for psychological services • Timing to be managed to ensure service continuity. Services to be modified (and where necessary reduced) as new service models are introduced • Psychological services with independent contractors managed by NCPHN • 2016-17 funding: $2.5million • Prime contractor not yet identified
Commissioning method	3.1 Contracted service delivery, managed directly by NCPHN transitioning to prime contractor model 3.2-3.3 Wholly commissioned 3.4 Direct service delivery or commissioned (TBC)
Approach to market	3.1 Open tender for prime contractor model 3.2 Depending on the outcomes of the co-design process, either a select or open tender process will be used to procure services 3.3 Open tender, delivered from prime contractor model 3.4 If commissioned, open or select tender, delivered from prime contractor model
Decommissioning	See continuity of care
Performance Indicator	Priority 3 - Mandatory performance indicators: • Proportion of regional population receiving PHN-commissioned mental health services – Psychological therapies delivered by mental health professionals • Average cost per PHN-commissioned mental health service – Psychological therapies delivered by mental health professionals • Clinical outcomes for people receiving PHN-commissioned Psychological therapies delivered by mental health professionals
Local Performance Indicator target	3.1 Increase in service delivery by 5% compared with 2015-16 baseline (Aboriginal, Children and people at risk of homeless), and outcome measures collected on activity by 100% of practitioners 3.2 Number of people eligible for the service seen within specified timeframes

	3.3 Number of partnerships formed where an clinician is delivering psychological services with support from an organisation; diversity of partnership organisations by target groups; 3.4 Increase in billing of psychological services under the MBS for people residing in the Clarence Valley, Bowraville and Kempsey
Local Performance Indicator Data source	3.1 ATAPS MDS data 3.2 N/A 3.3 Provided by prime contractor 3.4 MBS Data

Proposed Activities	
Priority Area	**Priority 4: Mental health services for people with severe and complex mental illness including care packages** MH(7) Service continuity for existing mental health nursing services, page 68. MH(8) Develop and implement models of care (including care packages) for adults with sever and complex mental illness who can be safely managed in the primary care setting, page 69.
Activity(ies) / Reference	4.1 Service continuity for exiting mental health nursing services 4.2 Develop and implement models of care (including care packages) within Lismore, Richmond Valley, Clarence, Coffs Harbour and Nambucca LGAs for adults with severe and complex mental illness who can be safely managed in the primary care setting, and refine the intervention/s with a view to expansion across the region. 4.3 Develop and trial approaches to delivering psychological services to underserviced groups (people at risk of suicide and people with a mental illness for whom the 10 Better Access sessions is inadequate) in Kempsey and Port Macquarie LGAs, and refine the intervention with a view to expansion across the region. 4.4 Regional NDIS readiness for people with psychosocial disability. 4.5 Improving access to psychiatry.
Existing, Modified, or New Activity	Modified Activity

Description of Activity	4.1 NCPHN to transition mental health nursing services from Medicare to NCPHN ensuring service continuity then transition services to a prime contractor. Liaise with providers of mental health nursing services to (a) ensure quality of services provided, (b) understand models of care, approach to care coordination and risk management and (c) identify quality improvement opportunities, including any barriers to delivering best practice. This quality assurance process will inform broader severe and complex mental health reform work. 4.2 Implement models of care for the delivery of mental health services to people with severe and complex mental illness in the primary care setting with provision for funding care coordination and monitoring physical health and medication management. Activity includes; • identify the optimal clinicians to deliver services • identify criteria for when people can be safely managed In the primary care setting • develop infrastructure for the provision of packages of care Models of care to be initially trialled in the Richmond Valley, Clarence Valley and Coffs Harbour LGAs with a view for expansion across the regions. 4.3 Within the packages of care, develop a model of service delivery for people whose need for psychological therapies exceeds what Better Access can deliver to ensure services are commensurate with an individual's need. Service development to include defining eligibility and modelling to consider demand within the constraints of the budget. The models will be developed and trialled in Port Macquarie and Kempsey will a view to expansion across the region. 4.4 NCPHN will work with stakeholders, including Family and Community Services and Mission Australia (PIR), Social Futures and GPs, to prepare for the roll-out of the NDIS to eligible individuals with psychosocial disability from July 2017. 4.5 Explore and implement options for improving access to psychiatry including increasing the uptake of tele-psychiatry, implementing consultation-liaison psychiatry models, partnering with LHD to attract psychiatrists to the region who may work in both the private and public sector and incentivising travel to priority locations. Focus Kempsey, Nambucca Valley and Clarence Valley. Amendments to 2016-17 AWP:

	• Adjusted numbering system for sub-activities to increase clarity of description • Added sub-activity regarding the development and trial of approaches to delivering psychological services for people with severe and complex needs where their needs exceed what Better Access can deliver in Kempsey and Port Macquarie • Added sub-activity regarding improving access to psychiatry
Target population cohort	People with severe mental illness and complex needs who can be safely managed in the primary care setting
Consultation	Consultations will be held with the LHDs, Healthy Minds providers and referrers, NGOs where existing co-location arrangements are in place ; Clinical Councils, Consumers and Clinical Quality Committee NCPHN intends to consult with the Royal Australian and New Zealand College of Psychiatry, Rural Doctors Network, NSW Health Agency for Clinical Innovation (Mental Health Group), and Consumer Reference Groups (Mental Health Forum and Consumer Reference Group), College of Mental Health Nurses, Australian Psychological Society and Family and Community Services.
Collaboration	Nil identified at present
Duration	4.1 1 July 2016 – ongoing 4.2 1 October 2017- ongoing 4.3 1 July 2017 – ongoing 4.4 1 July 2016 – ongoing 4.5 1 July 2017 – ongoing
Coverage	4.1 Region wide 4.2-4.3 Lismore, Richmond Valley, Coffs Harbour and Nambucca 4.4 Region wide 4.5 Focus Kempsey, Nambucca and Clarence Valley
Continuity of care	NCPHN Mental Health Nursing services to be transitioned to prime contractor model and, overtime, blended into alternative models of delivery for people with severe mental illness and complex needs. Funding unchanged

	Prime contractor not yet identified
Commissioning method (if relevant)	4.1-4.3 Wholly commissioned 4.4 Direct Service Delivery 4.5 Wholly commissioned
Approach to market	4.1 NA for existing services; open tender for any expanded services and transition to prime contractor 4.2-4.3 Select tender (Prime Contractor) 4.4 NA 4.5 Open tender
Decommissioning	NA
Performance Indicator	Priority 4 - Mandatory performance indicators: • Proportion of regional population receiving PHN-commissioned mental health services – Clinical care coordination for people with severe and complex mental illness (including clinical care coordination by mental health nurses). • Average cost per PHN-commissioned mental health service – Clinical care coordination for people with severe and complex mental illness.
Local Performance Indicator target (where possible)	4.1 >90% utilisation rate for mental health nursing sessions 4.2-4.3 Number of people accessing services and occasions of service delivered 4.4 Number of people with a psychosocial disability accessing services via the NDIS 4.5 Increase in billing of psychiatry under the MBS for people residing in the Clarence Valley, Nambucca and Kempsey
Local Performance Indicator Data source	Contracted service data PMHC-MDS MDS data