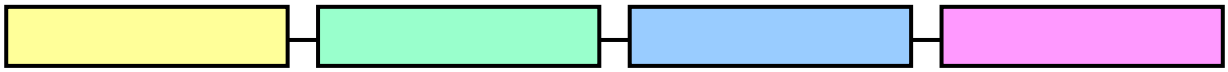
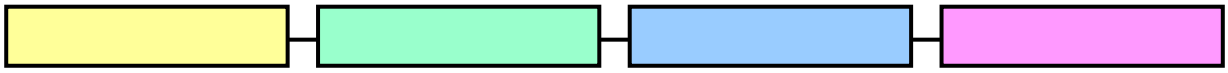


NT Regionalisation of Aboriginal Primary Health Care Guidelines

Supporting a Pathway to Regional Aboriginal Community Control



Version 6.2: September 2010
Review Date 14 February 2011

These guidelines are designed to help representatives of Aboriginal communities and homelands and service providers in the Northern Territory to work through the process of regionalisation of primary health care services.

These guidelines describe the steps to increase community control and participation in health service delivery by establishing a regional community controlled advisory group or health board; and
improve health services across regions by increasing coordination and integration of services.

This will result in better health outcomes for Aboriginal people in the Northern Territory.

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Section One

Section Two

SECTION ONE

This section:

- Explains the **key terms** used in these guidelines.
- Explains the **purpose** of these guidelines, the policy setting and the roles of the governments and the community controlled sector.
- Defines **regionalisation** and describes the two goals of regionalisation.
- Describes the **five models** for governance of regional primary health care services.
- Describes the **four stages** that will need to be followed to progress through regionalisation
- Describes the **principles** to be considered when working through the steps of regionalisation.

1. Key Terms and Definitions

Acronym	Key Term
	Auspice: to administer funding for Project on behalf of another organisation or entity.
ACCHS	**Aboriginal Community Controlled Health Service (also known as Aboriginal Medical Service {AMS})**
AMSANT	**Aboriginal Medical Services Alliance Northern Territory**
	Community Control: as defined in the Pathways to Community Control framework "refers to the principle that Aboriginal communities have the right to participate in decision making that affects their heath and wellbeing."
CQI	**Continuous Quality Improvement:** framework to measure and monitor improvement in primary health care services and ultimately health outcomes.
Core PHC Services	**Core Primary Health Care (PHC) Services:** a standard set of primary health care services developed by the NT AHF partners for use across the NT, refer to list in the Regionalisation Support Kit.
DoHA	**Australian Government Department of Health and Ageing**
	Economies of scale: efficiencies that occur in larger organisations due to larger purchasing and recruitment capacity.
HSDA	**Health Service Delivery Areas:** the 14 regions across the NT with a population of at least 2500 Aboriginal people.
EHSDI	**Expanding Health Service Delivery Initiative:** program which is funded to support regionalisation, see further information in the Policy Context section 1.3.
NT AHF	**Northern Territory Aboriginal Health Forum** a strategic planning partnership between NT health care providers and the funding bodies (DoHA, DHF and AMSANT) to achieve better coordination, allocation of health resources and outcomes for Aboriginal and Torres Strait Islander peoples in the Northern Territory.
NT DHF	**Northern Territory Department of Health and Families**
NT KPI	**NT Key Performance Indicators:** a defined set of standard indicators used to measure activities and/or performance.
OATSIH	**Office for Aboriginal and Torres Strait Islander Health,** a division of the Australian Government Department of Health and Ageing.
	Partners: NT DHF, DoHA and AMSANT.
	Pathways to Community Control ("Pathways"): key document supporting regionalisation and increased community control and participation -
PIRS	**Patient Information Recall Systems**
PHRG	**Primary Health Reform Group:** a collaborative working group reporting to the NTAHF. The PHRG consists of representatives from OATSIH, DHF and AMSANT.
	Regional Health Model: a structure for regional primary health care service that shows the governance, health service delivery and funding information.
	Regionalisation: Working together to improve health outcomes for all Aboriginal people in the Northern Territory through health system reform and the development of Aboriginal community controlled primary health care services which provide safe, high quality care and facilitate access to specialist, secondary and tertiary care (refer to *Section 1 Part 5*).
RAHC	**Remote Area Health Corps:** provides short-term health staffing for remote Indigenous communities in the Northern Territory.
	Steering Committee (*also known as Interim Health Board*)**:** group established to support regionalisation made up of the partners and community representatives.

2. Guidelines Context

The guidelines for NT Regionalisation of Aboriginal Primary Health Care have been developed by the Northern Territory Aboriginal Health Forum (NTAHF) partners, namely the Department of Health and Ageing (DoHA), NT Department of Health and Families (NT DHF) and Aboriginal Medical Services Alliance of the Northern Territory (AMSANT). The three agencies are referred to in these guidelines as **the partners**.

The guidelines provide a framework to enable a consistent approach across the NT towards regionalisation of Aboriginal primary health care services.

Objectives of the Guidelines

The major objectives of the guidelines are:

1. To define regionalisation of primary health care in the NT;
2. To describe the process to establish a regional health service and different models of community control;
3. To detail the requirements for regionalisation; and
4. To provide templates and guidelines to support regionalisation across the NT.

Audience

The target audiences of the guidelines are:

- Communities and service providers within the NT that are working towards regional reform of primary health care services; and
- The partners (DoHA, NT DHF and AMSANT).

3. Context of Regionalisation

Policy context

The NTAHF has had a long-term vision for regionalisation of primary health care services in the NT and that vision has been supported by a number of past national programs, including the Coordinated Care Trials and the Primary Health Care Access Program. The Expanded Health Service Delivery Initiative (EHSDI) has provided the most recent opportunity to implement this vision through the partnership.

The EHSDI commenced on 1 July 2008 with a commitment from the Australian Government of $99.7 million over two years. It evolved from the Northern Territory Emergency Response and the initial focus on roll out of child health checks into a program to support expansion and improvements of

the NT primary health care system. Detailed information in relation to EHSDI, including a full list of EHSDI program goals, is included in the *Regionalisation Support Kit*.

The Australian Government has committed $92.7 million[1] over the next three years commencing in 2009-10 to extend the EHSDI in the Northern Territory. This funding provides for:

- increased primary health care services for Aboriginal people;
- reform of remote primary health care services through regionalisation; and
- increased workforce through the Remote Area Health Corp.

These guidelines focus on **regionalisation** of primary health care services within the broader NT health system.

Role of the Partners

Each of the partners, through the NTAHF, provides strategic direction for progressing regionalisation in the NT and has primary carriage for the development and implementation of these guidelines. The Primary Health Care Reform Group (PHRG), which has representatives from each of the partners, has been established under the NTAHF to support the reform of primary health care in the NT, including regionalisation.

The Australian Government, through DoHA, has overall responsibility for the funding and accountability of EHSDI, and has responsibility for drafting these guidelines, under NTAHF.

The NT Government, through NT DHF, has responsibility to deliver primary health care services and implementing a change management strategy towards regionalisation.

AMSANT represents the Aboriginal community controlled health sector and provides support Aboriginal communities to working towards regionalisation.

4. The Health System

Being Part of the Broader Health System

Primary health care in the NT is currently delivered in communities by a mix of Aboriginal community controlled and NT government service providers. Some service providers work independently at the local level, while others work across a number of communities through regional models.

Currently, NT DHF delivers services in 59 remote communities, and the Aboriginal community controlled sector delivers services to 24 remote communities.

[1] This is part of the 2009-10 Budget measure Closing the Gap – Northern Territory – Indigenous health and related services that allocated $131.1m over three years. The remaining funds will be utilised for the continuation of dental services, Sexual Assault Mobile Outreach Services and the completion of ENT services in 2009-10.

The Aboriginal primary health care system in the Northern Territory is a sub-set of the broader NT and Australian health systems. The NT Aboriginal primary health care system is linked by service population and referrals to the broader health systems which include sub-acute (secondary) and acute (hospital-based) services.

In addition to the community-based primary health care centres, the Aboriginal primary health care system is supported by a range of hub-based services, including "on-call" rural Medical Practitioners, visiting specialist outreach services and other support services.

Any reforms being undertaken in the NT as part of regionalisation must take into account the broader health system and operate effectively within this system.

The Building Blocks of the Health System

The World Health Organisation has defined six basic functions that all health systems carry out. These are known as the **building blocks** and have informed implementation of systems reform in the NT. The six building blocks are:

- Leadership and Governance
- Service Delivery
- Information
- Access to Medicines, Vaccines and Technology
- Financing
- Workforce

Changes or reforms to one building block impact other blocks and also the broader health system. A change to one building block requires thinking about the impact on the other building blocks. Improving this system as a whole is necessary to achieve more equitable, sustainable and effective health services. Further information on the building blocks can be found in the *Regionalisation Support Kit*.

5. What is Regionalisation?

Definition of Regionalisation

The partners have developed a shared vision for **regionalisation** which is:

> *"Working together to improve health outcomes for all Aboriginal people in the Northern Territory through health system reform and the development of Aboriginal community controlled primary health care services which provide safe, high quality care and facilitate access to specialist, secondary and tertiary care."*[2]

[2] This vision was developed at the NT Regionalisation Workshop held in November 2009 and was endorsed by NT Aboriginal Health Forum in December 2009.

Regionalisation involves:

- Delivery of agreed **core primary health care services** (*Regionalisation Support Kit*) to all people residing in a region, with a population of at least 2500 Aboriginal people;
- Increased Aboriginal community control and participation through development of **regionalised governance models** consistent with the "*Pathways to Community Control*" framework (*Regionalisation Support Kit*);
- Moving towards **about 14 regions** across the NT, these regions are known as Health Service Delivery Areas (HSDAs), with improved coordination and integration of services within each of these HSDAs (*Regionalisation Support Kit*);
- Moving towards **a single primary health care service provider in each HSDA**; and
- Developing a **NT-wide health system** based on a consistent level of quality services being delivered and maintained.

Past national programs such as the Coordinated Care Trials and the Primary Health Care Access Program (PHCAP) have supported regionalisation and community control in the NT. These programs led to the successful establishment of the Katherine West and Sunrise Health Boards, who are responsible for the delivery of regional primary health care services and have provided valuable lessons that have assisted in preparing these guidelines.

Regionalisation aims to improve the health and well-being of Aboriginal people in the Northern Territory through:

1. **Community Control and Participation:** to increase the involvement of Aboriginal communities in health decision making; and

2. **Regional Health Service Reform:** to improve service delivery and outcomes through better coordination and integration of services.

6. The Goals of Regionalisation

Community Control and Participation

AMSANT describes 'community control' as the ability for the people who are going to use health services to determine the nature of those services, and then participate in the planning, implementation and evaluation of those services[3].

A key document supporting regionalisation and increased community control and participation is ***"Pathways to Community Control" (Pathways)***[4] which was endorsed by the NTAHF in 2008 (refer to

[3] AMSANT Internet Site: http://amsant.com.au/site/index.php?option=com_content&task=view&id=67&Itemid=75

[4] *Pathways to Community Control An agenda to further promote Aboriginal community control in the provision of Primary Health Care services*, NT Aboriginal Health Forum 2008.

the *Regionalisation Support Kit*). This document recognises that Aboriginal community control of health services can result in more responsive services, improved quality, cultural security of services and improved levels of family and community functioning. Together, these benefits all contribute to improved levels of health and well-being.

Pathways provides a framework to help Aboriginal communities think about planning, developing and managing primary health care services. It is based on the principle that Aboriginal communities have the right to participate in decision-making that affects their health and well-being. However, the framework also accepts that not all communities will want to, or be capable of, managing their own health services, and that community participation can take different forms and may change over time. *Pathways* describes different models that reflect this.

The partners have agreed that community controlled governance of health services is the strongest form of Aboriginal participation in decision making.

Regional Health Service Reform

At a regional level, the current number of different primary health care services operating within many HSDAs can make it difficult for clients and providers to work their way through the system and achieve the best outcomes. Regional Health Service Reform aims to improve coordination and integration of services.

Improved integration and coordination of services can be achieved through a number of different potential measures as detailed in the following tiered scale:

- **Tier 1**: Sharing information – between service providers in and outside a HSDA and with the Steering Committee (e.g. NT Key Performance Indicators, core services, electronic health records)
- **Tier 2:** Working together – establish networks e.g. clinical and public health advisory group, develop partnerships, undertake joint planning and monitoring of effectiveness to reduce duplication and fill gaps, focus on working together in key areas such as chronic disease management or prevention;
- **Tier 3:** Integration of services through one regional service provider.

The optimal level of integration and coordination is likely to be achieved through moving to a single regional service provider in each HSDA (Tier 3). However, through regionalisation existing service providers are requested to consider ways in which improvements could be made to current service arrangements to take progressive steps towards better coordination and integration of services within a HSDA (Tiers 1 and 2).

Improvements to the delivery of services within a HSDA are being supported by introduction of systems reform elements across the NT. These systems reform elements include:

- Core primary health care services
- Patient Information Recall Systems
- Continuous Quality Improvement
- NT Key Performance Indicators

The aim of systems reform is to improve the quality of services at a local, regional and NT wide level. Further details relating to systems reform elements are included in the *Regionalisation Support Kit.*

Options to Support Regionalisation Goals

A range of support options will be available to HSDAs to work towards these major goals. Support will be available in a number of ways, including:

- The partners will be available to help communities and community representatives understand the goals of regionalisation and the requirements of governments in relation to progressing regionalisation.
- Support for community consultation and establishment of steering committees.
- Support to develop proposals for increased community control and participation and regional health service reform.
- Support for broad consultation in relation to developing a proposed regional governance model.
- Experts will be available to support health planning in HSDAs.
- Support for the establishment of clinical and public health advisory groups.

DoHA will consider funding requests for support in line with the steps identified in these guidelines. Further details of support available are included in Section Two of these guidelines.

7. Principles Guiding Regionalisation

The partners have agreed to principles that will guide the regionalisation process in the NT. The principles will define the minimum standards that will be required to be met during each stage of regionalisation.

Principles

- All Aboriginal communities, homelands, language and cultural groups within the HSDA are encouraged to participate in information sharing and decision-making on regionalisation, and that a broad range of views and options are thoroughly explored.
- Consultation and two-way feedback continues through each stage of the regionalisation process.

- Participants have information in a form that they can understand, so that they can participate meaningfully in discussions. The use of interpreters is encouraged.
- Participants understand how their input will be used.
- There is enough time for people and groups to think things through and weigh up alternatives.
- Membership of the steering committees will include representatives of major Aboriginal communities, homelands, board members from existing primary health care services in the region and each of the partners.
- Steering committees will be made up of a mix of gender, age groups and Aboriginal cultural groups.
- Steering committees will only be asked to make major decisions once representatives have had time to talk the decisions through with the community or group they represent and feed back to the steering committee.
- Steering committees will be provided with all the necessary information in relation to governance and primary health care models to empower members to make informed decisions.
- The Final Regionalisation Proposal must contain a governance model for health services that is broadly supported by the major stakeholders in the HSDA.

8. Regionalisation Models

There are a number of different models of primary health care operating at a remote community level in the NT. The approach is often determined by history, the size of the community, the type of service provider, the distance of the community to regional centres and particular health issues in the community.

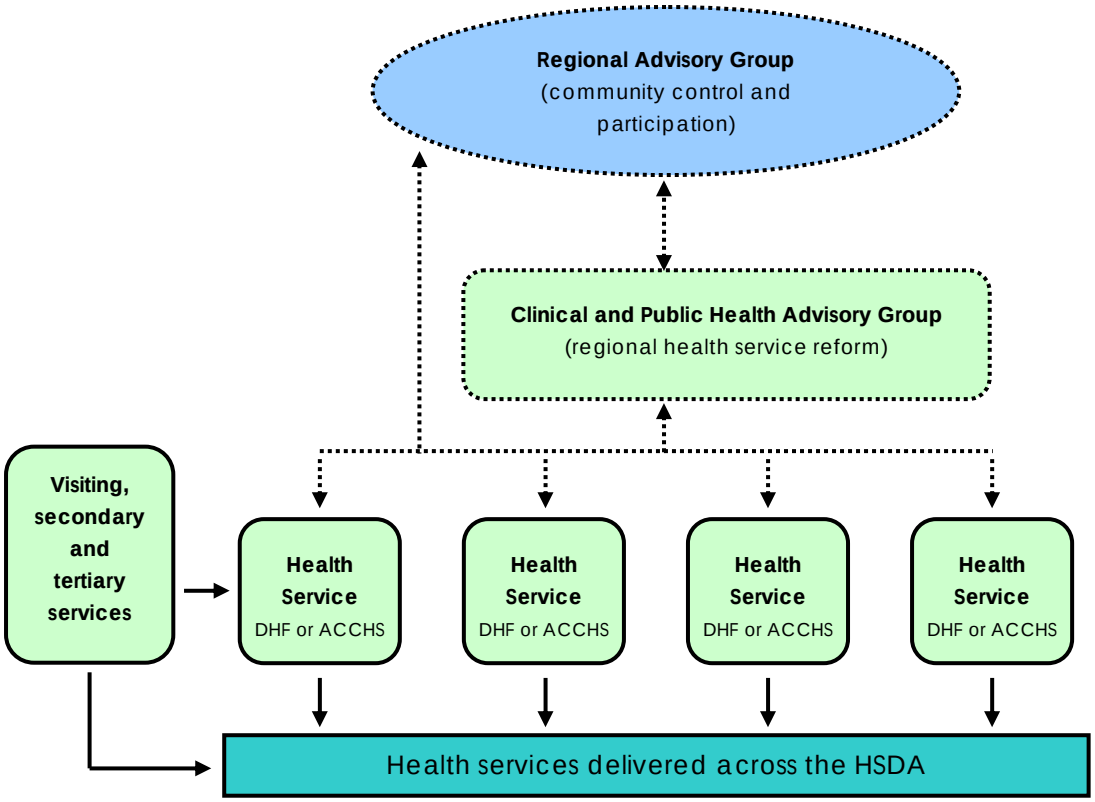
A key issue for consideration in any primary health care service delivery arrangement is the governance model and its relationship to the level of community participation. The two types of service delivery most common in remote communities are the Aboriginal Community Controlled Health Service and the NT Government run service. Each of these service types may include varying levels of community participation.

Currently, primary health care services in most HSDAs are delivered by a range of service providers, at times with little or no coordination. The role of primary health care services to coordinate health services and link with services at a jurisdictional and sometimes national level is essential to improve the continuity of care for the patient. It is also important to recognise that primary health care services are part of a broader health system and that not all health services can or should be delivered at the local level. Regional governance structures that integrate local service delivery with other health services provide the optimal opportunity for improved coordination of services for the client.

At a minimum, undertaking regionalisation activities in HSDAs will increase community control and participation and improve coordination of existing services. This will result in improvements to the

patient journey. The following diagram describes the changes to service coordination through establishment of regional advisory groups and clinical and public health advisory groups. The regional advisory groups will allow for increased community participation across the HSDA and the clinical and public health advisory groups will enable improved coordination of health services across the HSDA.

Service Model with Community Control and Participation and Regional Health Service Reform Mechanisms



Core Requirements for Regionalisation Models

As part of regionalisation, there is a need to consider the service models described in *Pathways* within a regional context. These guidelines describe five models for governance and service delivery based on the models in *Pathways* but amended to reflect the goals of regionalisation. There are other models for governance and health service delivery that are not included in these guidelines. The HSDA might develop a different model that will be better suited.

NTAHF will consider any proposed models that include the following core requirements:

Core Requirements for Community Control and Participation

- A regional group representative of all communities and major groups within the HSDA is established and maintained;
- Service providers across the HSDA work with the regional group to provide information and seek views relating to delivery of health services; and
- Service providers engage with the regional group in the planning, prioritising and monitoring effectiveness of service delivery.

Core Requirements for Regional Health Service Reform

- Core primary health care services are delivered;
- Strategies are in place to improve integration and coordination of services across the HSDA, including the establishment of a Clinical and Public Health Advisory Group;
- Service providers engage in data development at a local and regional level and interpret community health data needs and community preferences to identify priorities and plan activities at a regional and local level;
- Implementation of Continuous Quality Improvement measures consistent with systems reform requirements; and
- Systems in place to support reporting against NT Key Performance Indicators.

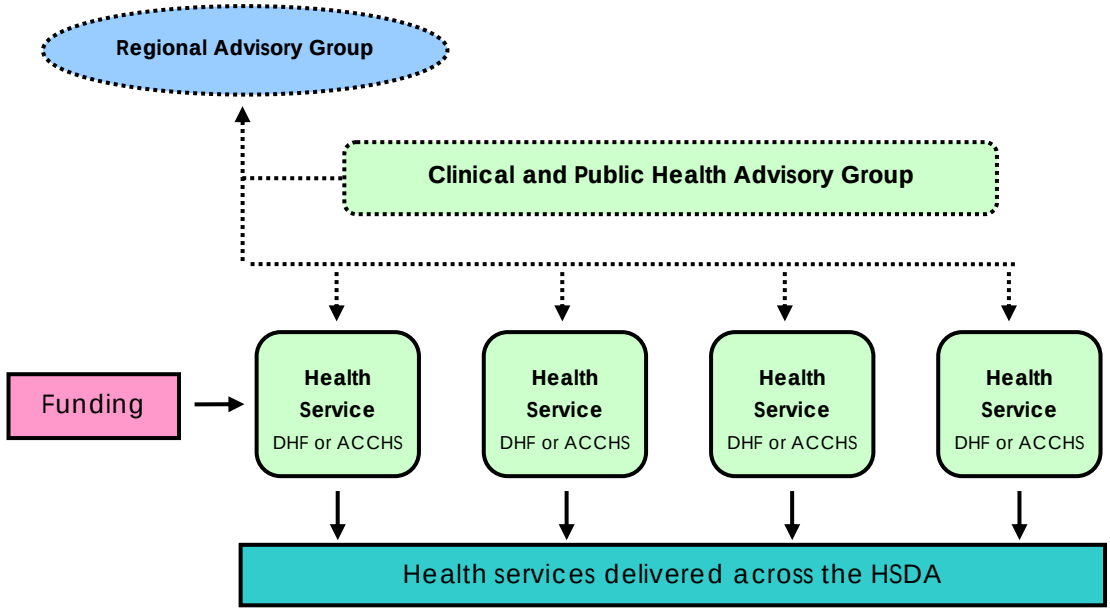
Moving Through the Models

The models illustrated on the following pages cover three key elements:

- Governance (community control and participation);
- Service delivery (who provides the services in the communities); and
- Funding arrangements (who receives funding to deliver the services).

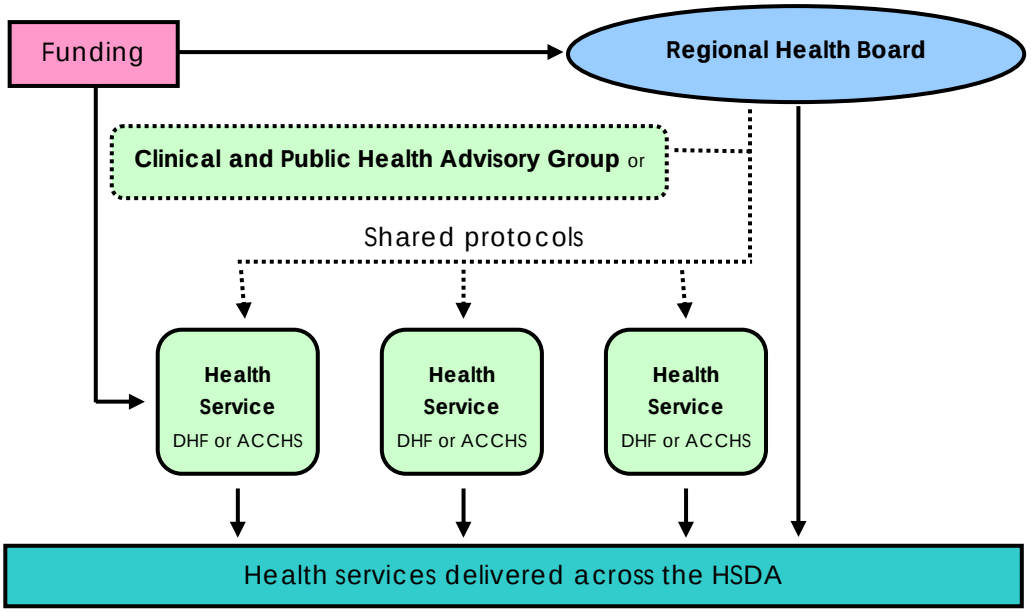
It should be noted that the models may be used as stepping stones on the pathway to community control. For example, a HSDA may have a long term goal to move to a regional Aboriginal community controlled health service, but may consider another model would be a good option for the short to medium term. A number of case studies on how to move through the models are included on page 24 of these guidelines.

Model 1: Primary Health Care Centres with regional advisory structure



Community control and participation	• A regional advisory group provides guidance to existing primary health care centres across the HSDA. The group represents all communities and major groups within the HSDA.
Health services	• Delivered by NT DHF and/or local Aboriginal Community Controlled Health Service(s) • Clinical and public health advisory group established to improve information flow and guide Regional Health Services Reform.
Funding	• Provided to the existing primary health care service providers
Reporting	• Primary health care services report to funding bodies and regional advisory group
Staff management	• Staff are managed by existing service providers i.e. staff working in NT DHF services are managed by NT DHF and staff working in ACCHS are managed by ACCHS
Benefits	• Some community participation in health services planning and decision making • Information sharing between services across the HSDA • Increased service links across the HSDA
Challenges	• Ensuring the various service providers support the two-way communication with the regional advisory group • Potential for disagreement on priorities and activities between health service providers
Example	• In Central Australia, NT DHF works with a number of regional advisory groups who provide advice on community priorities and have input into services delivery.

Model 2: Coordinated Service Delivery between NT DHF Primary Health Care Centres and Regional Aboriginal Community Controlled Health Service

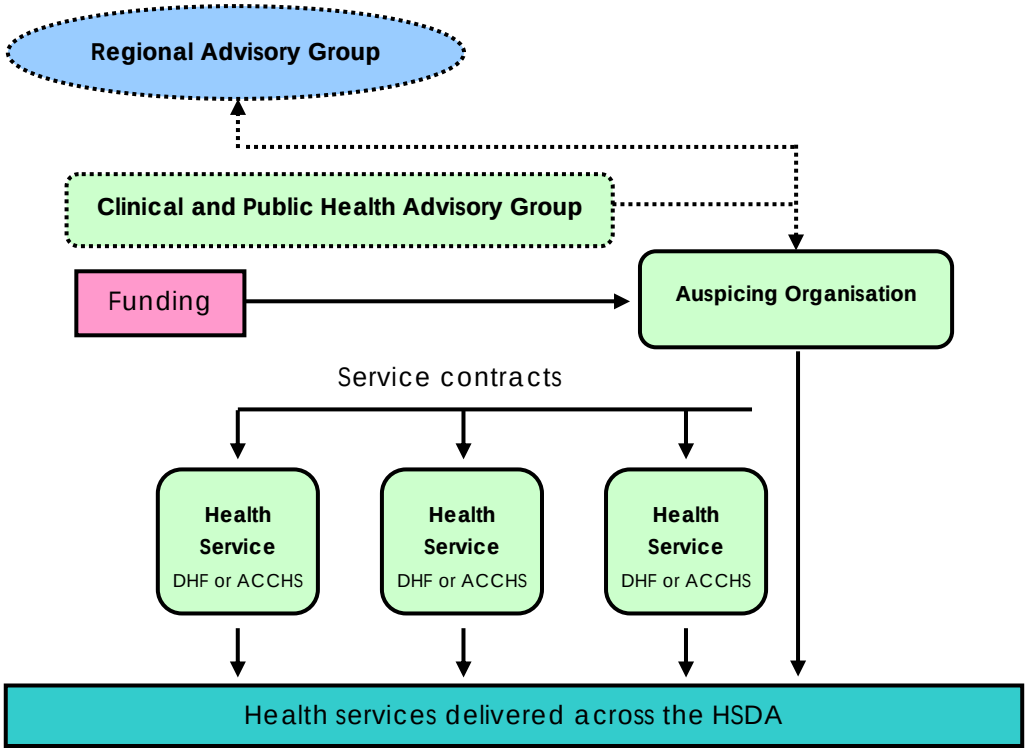


Community control and participation	• Regional Aboriginal Community Controlled legal entity with a Health Board representative of all communities and major groups within HSDA provides guidance to service providers and takes responsibility for delivery of some services or programs.
Health services	• Core primary health care services continue to be delivered by existing service providers, working closely with Regional Health Board. • Shared protocols are agreed across the HSDA to ensure a collaborative and consistent approach to service delivery. • Regional Health Board takes on responsibility for delivery of some services and/ or programs to complement NT DHF services in attempt to build capacity and increase community control. • Clinical and public health advisory group established to improve information flow and guide Regional Health Services Reform.
Funding	• Provided to NT DHF and the Regional Aboriginal Community Controlled Health Service
Reporting	• NT DHF and the Regional Aboriginal Community Controlled Health Service report to funding bodies and communities
Staff management	• Staff are managed by existing primary health care services (NT DHF or ACCHS) • Regional Health Board manages some staff who are engaged to deliver services or programs that the Regional Health Board is responsible for.
Benefits	• Increased community engagement through legally incorporated organisation • Capacity building of Regional Health Board • Information sharing between services across the HSDA • Increased coordination of services and resources across the HSDA • Improved experience for patients
Challenges	• Ensuring service providers implement shared protocols • Potential for disagreement on priorities between service providers • Potential for dual service providers in a single community • Staff managed by the Regional Health Board operating out of local clinics managed by existing service providers

Example

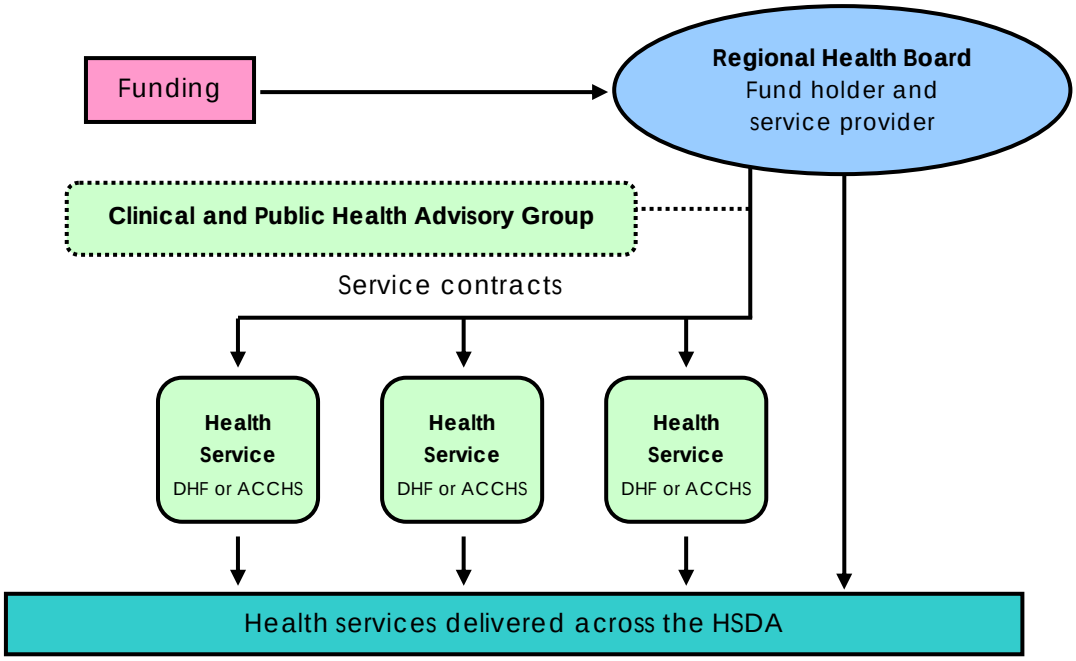
- An example of this model is the Maningrida HSDA, where NT DHF manages the primary health care service and Malabam Health Board is the Aboriginal community controlled health board that has a community advocacy role, as well as delivering a number of complementary services.

Model 3: Auspice model with regional advisory structure



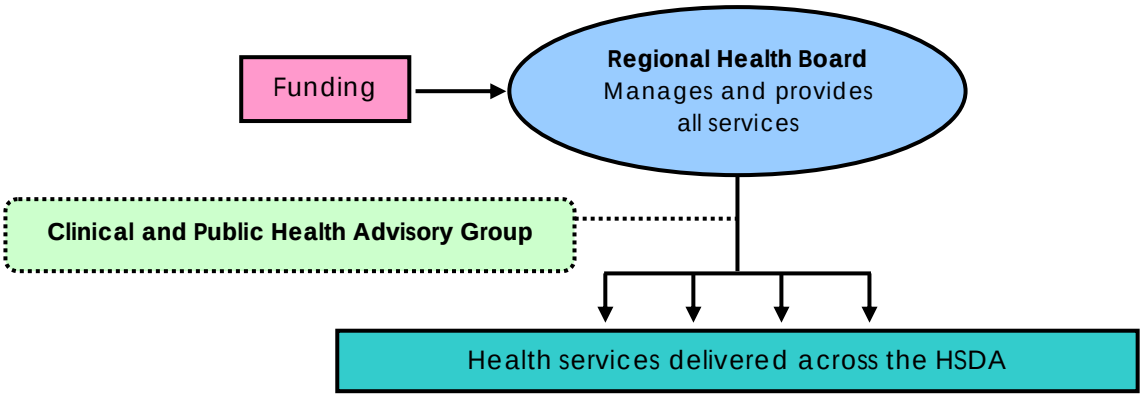
Community control and participation	• A competent and viable Aboriginal Community Controlled Health Service has contractual arrangements for funding and service delivery in the HSDA • A regional health advisory group representative of all communities and major groups within the HSDA is established and maintained to work with Aboriginal Community Controlled Health Service
Health services	• Services delivered by an Aboriginal Community Controlled Health Service that may or may not be located within HSDA and/or NT DHF (services are provided at a community and regional level)
Funding	• Provided to Aboriginal Community Controlled Health Service and/or NT DHF
Reporting	• Aboriginal Community Controlled Health Service and/or NT DHF reports to funding bodies and to the Regional Advisory Group
Staff management	• Staff are managed by the Aboriginal Community Controlled Health Service
Benefits	• Any existing Aboriginal Community Controlled Health Service with capacity can support regionalisation in a HSDA • Information sharing between services across the HSDA
Challenges	• The Aboriginal Community Controlled Health Service may not provide adequate support and resources to capacity building of the community based services or the Regional Advisory Group • The Regional Advisory Group may not be able to influence priorities or change practices at the community or regional level
Example	• Central Australian Aboriginal Congress currently auspices a number of health services in Central Australia who have their own community control and participation mechanisms.

Model 4: Regional Aboriginal Community Controlled Health Service purchases primary health care services from a competent provider (or providers)



Community control and participation	• Regional Aboriginal Community Controlled legal entity with a Health Board representative of all communities and major groups within HSDA purchases services through a funds holding model and guides service delivery
Health services	• Regional Aboriginal Community Controlled Health Service purchases services through one or more providers • Some services may be directly provided by the Regional Aboriginal Community Controlled Health Service
Funding	• Provided to the Regional Aboriginal Community Controlled Health Service, who purchases services from existing providers through service agreements
Reporting	• Service providers report to the Regional Aboriginal Community Controlled Health Service as part of the service agreement • Regional Aboriginal Community Controlled Health Service reports to funding bodies • Service providers and the Regional Aboriginal Community Controlled Health Service provides information to the communities
Staff management	• Staff are managed by existing arrangements • Regional Aboriginal Community Controlled Health Service manages some staff
Benefits	• High level of community control and participation • Opportunity for regional health service provider to build capacity • Allows for a transition period for staff and management and workforce stability
Challenges	• Ensuring that service agreements are complied with • Ensuring opportunities for capacity building of the new entity • Understanding the roles of the Regional Aboriginal Community Controlled Health Service and existing providers in relation to staff management, decision making and setting direction
Example	• This model is likely to be used as an interim step to build capacity of a new organisation prior to taking on responsibility for all service and staffing. Sunrise Health Service operated under this model prior to becoming the regional health board.

Model 5: Regional Aboriginal Community Controlled Health Service



Community control and participation	• Regional Aboriginal Community Controlled legal entity with a Health Board representative of all communities and major groups within HSDA takes responsibility for service delivery and funding
Health services	• Delivered by the Regional Aboriginal Community Controlled Health Service
Funding	• Provided to the Regional Aboriginal Community Controlled Health Service
Reporting	• Regional Aboriginal Community Controlled Health Service reports to funding bodies and communities
Staff management	• Regional Aboriginal Community Controlled Health Service will manage all staff
Benefits	• High level of community control and participation • Single service provider simplifies funding, staffing, service delivery and community control and participation • Opportunity to manage staff availability and vacancies across the region • 'Economies of scale' enable a broader range of staff to be employed and services to be delivered • Optimal level of service integration and coordination through one single service provider across HSDA • Improved experience for clients through better coordination of services
Challenges	• Ensuring services are delivered effectively across a large population and region • Ensuring the management has the skills to manage a large organisation • If services are not being delivered effectively, or the organisation is in difficultly, it impacts a large service population
Example	• Examples of this model include the Katherine West Health Board and Sunrise Health Service

9. Case Study

Katherine West Health Board

The Katherine West Health Board was established through the first round of Coordinated Care Trials. The process of setting up the Board involved lengthy and detailed consultations with all communities of the region. The intensive and time consuming consultation process was a key factor in the Board gaining support from the Commonwealth and Northern Territory Governments.

Under the terms of the legal agreement governing the trial the KWHB, as funds holder for all service delivery, could choose to either directly provide health services itself or purchase such services from any provider. For the first year or so of its existence the Board chose to purchase most health services from NT DHF.

The Board implemented a step-by-step transition to becoming the provider after this initial period. During this transitional period the Board employed people with public health, clinical and management expertise to work with them to plan and develop the health service.

Through training and exposure to the administrative activities and details of the organisation, elected Board members have over ten years, come to understand the complexities of managing a health board. Board members underwent training in finances utilising the "money story", a pictorial method of presenting accounts.

They have also had to familiarise themselves with the intricacies of government and its many demands. The Board emphasises a "community development" view of health, characterised by increased community participation and a many-faceted (holistic) view of health.

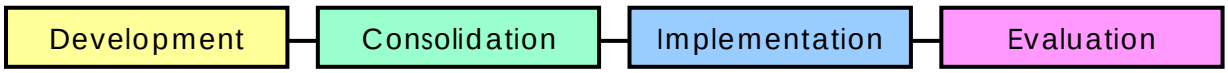
Ref: http://kwhb.org/3-brief-history-of-kwhb.html

Sunrise Health Service is another health service in the NT which has become an independent community controlled health service

Ref: http://www.sunrise.org.au/sunrise/home.htm

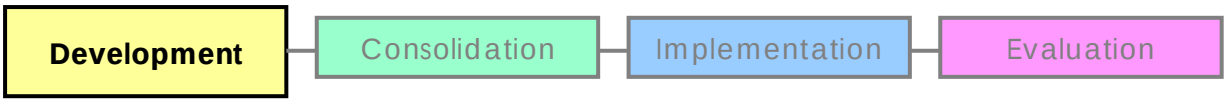
10. Stages towards Regionalisation

Pathways details a four stage process through which community participation and control can occur. These are:



A description of each of these stages follows. The description of each stage is largely informed by *Pathways* but slight amendments have been made to reflect the key goals of regional health service reform and community control and participation. In addition to the information provided below, each of the stages will be explored in detail in later sections of this document. The sections will identify the steps and the requirements to progress through the pathway to community participation and control. Tools are also provided to assist in completing this work.

Although the four stage process is detailed throughout these guidelines, it is acknowledged that activities may overlap across stages. Evaluation is identified as one of the four stages, however, it will be important to include evaluation strategies in each of the first three stages, to review progress against each stage.



The **Development Stage** is primarily focussed on community engagement, developing community capacity, identifying aspirations at a regional level and introducing health services reform elements. To progress the goals of regionalisation, it is expected that in each HSDA a steering committee consisting of representatives from each community and major group will be established to progress community control and participation and a clinical and public health advisory group will be established consisting of clinical representatives from each primary health care service to guide regional health service reform.

Key aspects of this stage against the two major goals of regionalisation are:

Community Control and Participation

- Sharing information about regionalisation;
- Engaging with communities and key stakeholders (such as service providers) across the HSDA;
- Establishing a regional community representative group (i.e. Steering Committee);
- Considering models and evaluating options for regional reform of health services and governance arrangements;
- Setting directions for community engagement and governance development; and
- Developing a proposal detailing the preferred governance model (part of *Final Regionalisation Proposal* requirement).

Regional Health Service Reform

- Current service providers aim to implement measures to improve services through systems reform elements;
- Service providers engage through establishment of a clinical and public health advisory group (or through an existing group) to develop strategies to improve coordination and integration of existing services within the HSDA; and
- Developing a proposal for better coordination and integration of existing services (part of *Final Regionalisation Proposal* requirement).

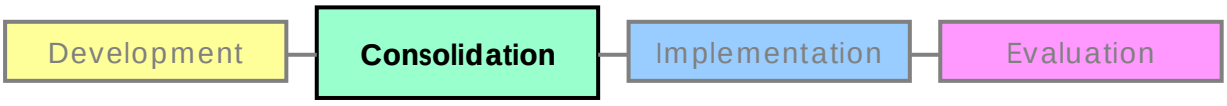
Evaluating this Stage

NT DHF has developed a *Competency and Capability Support Framework* which identifies the elements that need to be addressed prior to moving on to the next stage. Which includes addressing the criteria in Steps A to D of the Development Stage.

At the completion of the Development Stage:

- A proposed governance model, showing how communities and cultural groups are represented, will be developed, based on community preferences.
- A plan for implementing the proposed governance model will be developed.
- A plan for better coordination and integration of existing services will be developed.
- Governments will endorse the plans.

Further details on this stage, including the requirements and the expected outcomes are provided at Section Two of these guidelines.



The **Consolidation Stage** commences following approval of the *Final Regionalisation Proposal* and includes:

- Formally establishing the PHRG endorsed regional governance model;
- Detailed planning for legally transitioning the existing health services to Aboriginal community control and/or increased integration or coordination at HSDA level (depending on model); and
- Continuing to build the capacity of communities, steering committee and/or legal entity and service providers to bring about improved health services.

The major elements of this stage are described below against the two major goals of regionalisation:

Community Control and Participation

- Implement plans to establish the approved model of governance (referred to as the Regional Advisory Group or Health Board);
- Build capacity of the Regional Advisory Group or Health Board:
  - regular meetings to provide direction to those working towards regional reform;
  - implement training and capacity support in accordance with a governance training plan;
  - involvement in planning and delivery of services
- Community engagement – the Regional Advisory Group or Health Board to demonstrate effective two way community engagement throughout planning and implementing reform activities;
- Build networks – the Regional Advisory Group or Health Board forms networks and partnerships with key stakeholders in the region, including health service providers;
- Governance capacity (depending on model) – the legal entity demonstrates capability to achieve effective strategic management and corporate performance; puts in place the corporate framework necessary to support identified service models; demonstrates financial expertise by meeting all funding compliance requirements; and
- Independent formal assessment of the competence and capability of the leadership or governance group – the leadership or governance group must be assessed as having demonstrated the competence and capability necessary to continue with the consolidation process – i.e. **before** the preparation of a formal *Transition Plan for Health Services* (depending on model).

Regional Health Service Reform

- Existing service providers commence implementing integration and coordination plan as approved through *Final Regionalisation Proposal* of Development Stage;

- Existing services to report progress of integration and health services reform through the Clinical and Public Health Advisory Group to the Regional Advisory Group or Health Board;
- Develop a *Transition Plan for Health Services* with existing service providers and the Regional Advisory Group (or Health Board) and Clinical and Public Health Advisory Groups (depending on the model).
- Submit *Transition Plan for Health Services* for approval; and
- Following approval, commence implementation of a change management strategy (which will form part of the *Transition Plan for Health Services),* to prepare major stakeholders for implementation.

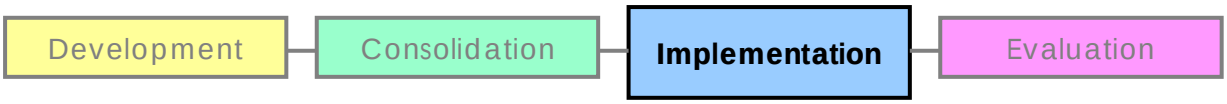
Evaluating this Stage

NT DHF has developed a *Competency and Capability Support Framework* which identifies the elements that need to be addressed prior to moving on to the next stage.

The *Competency and Capability Support Framework* will form the basis of the independent assessment undertaken during this stage.

At the completion of the Consolidation Stage:

- The Regional Advisory Group or Health Board will be established (depending on the model) and a governance training plan will be implemented.
- A legal entity will be established (depending on the model) and will have met the defined requirements of competence and capability.
- A detailed plan for transition of existing services will be developed.
- Governments will endorse the plan.



The **Implementation Stage** commences when transition plans for health services are approved and all relevant stakeholders are ready for implementation.

At this stage, existing service providers continue to work with the Regional Advisory Group or Health Board to implement agreed reform of health services. The way in which service management is affected will depend on identified model. Regardless of the identified model, services will be reformed to meet goals of regionalisation – including better coordination and integration of services.

Formal arrangements between the Regional Advisory Group or Health Board and service providers will also be implemented in this stage to ensure there is commitment to on-going community participation in the delivery and planning of health services.

Key elements of this stage include:

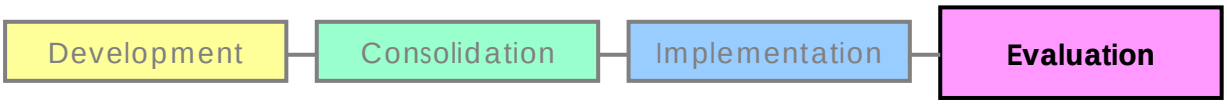
- Implementing transition plan;
- Reforming health services;
- Working closely with funding agencies and governments to monitor change and minimise risks;
- Business Planning;
- Building and maintaining confidence of community through increased participation and control;
- Building confidence of funders by ensuring accountability and reporting requirements are met;
- Building confidence of corporate regulators by meeting regulatory requirements; and
- Data collection and analysis.

Evaluating this Stage

NT DHF has developed a *Competency and Capability Support Framework* which identifies the elements that need to be addressed prior to moving on to the next stage. Ongoing evaluation will occur throughout the transition.

At the completion of the Implementation Stage:

- Existing services will transition to the new regional service provider (depending on the model).
- Regional health system reform will be implemented and ongoing.



The **Evaluation Stage** will monitor progress towards regionalisation undertaken at HSDA level and monitor the effectiveness of new service models. It will inform ongoing improvements within the HSDA. Any monitoring done at a local level will feed into an overall evaluation of regionalisation of NT Aboriginal primary health care services. The evaluation will aim to consider learnings and inform future reform activity in the NT and elsewhere in Australia.

Key elements will include:

- Stakeholder engagement;
- Setting clear objectives and logic; and
- Use of evaluation report.

SECTION TWO

This section:

- Describes the **four steps** that make up the Development Stage.
- Explains the **work** that needs to be done under each of the steps and **who** will do the work.
- Explains what will be **achieved** and any **decision** that will be made at the end of each step.
- Lists what is **required** by governments to complete each step.
- Lists the **principles** that need to be considered when doing the work.
- Describes the **support** available to do the work under each step.
- Includes **criteria and templates** for any proposals or reports that need to be completed.
- Defines **regionalisation** and describes the two goals of regionalisation.

STAGE ONE

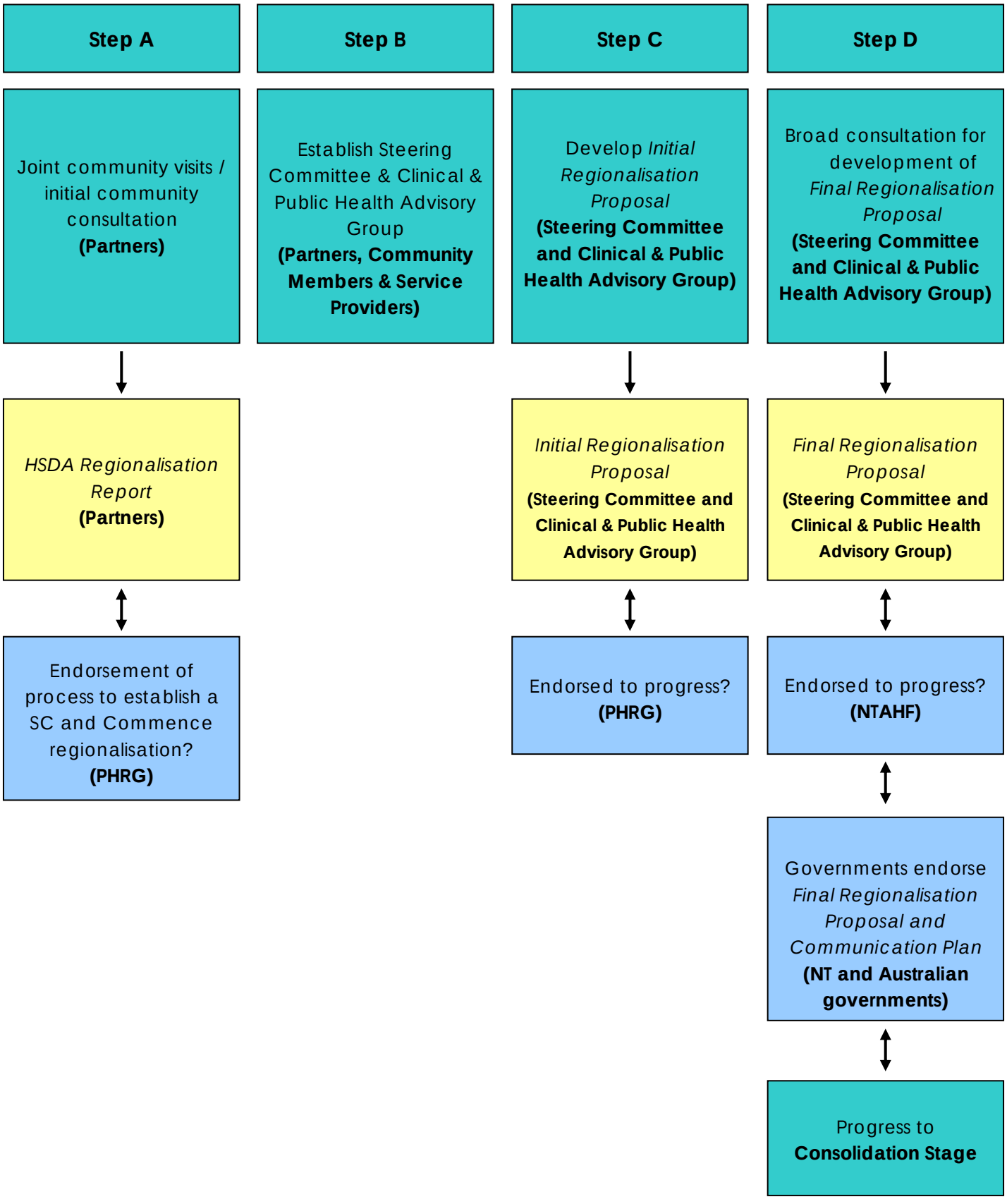
DEVELOPMENT STAGE

The Development Stage is primarily focussed on community engagement, developing community capacity, identifying aspirations at a regional level and introducing health services reform elements. There are four major steps within the Development Stage:

A. Initial Community Consultation
B. Establish Steering Committee and Clinical and Public Health Advisory Group
C. Develop *Initial Regionalisation Proposal*
D. Broad Consultation for development of a *Final Regionalisation Proposal*

A diagram explaining the Development Stage is on the following page and each of the four steps are explained in further detail in this section.

The Steps in the Development Stage



STEP A
Initial Community Consultation

This step will:

- **Ensure community members and health service providers are informed about regionalisation and related processes.**
- **Explore whether communities are interested in being involved in regionalisation.**
- **Identify people who may want to be local champions or part of a steering**

Process

- The ***partners*** will visit major communities and existing health service providers to introduce regionalisation.
- ***Community members*** will provide input into how they want to participate in the goals of regionalisation (increasing community control and participation and regional health service reform).
- The ***partners or a person with relevant skills*** will write up the outcomes of each of the community visits (*Community Consultation Report)* and compile the outcomes for all visits in the HSDA (*HSDA Regionalisation Report)* and present the reports to PHRG.
- ***PHRG*** will consider, endorse and feed back plans to progress regionalisation within the HSDA.
- Interested communities from HSDA's where regionalisation is not currently underway should approach the AMSANT Reform and Development Unit (RaDU) in the first instance.

Achievements

The ***Community Consultation Report*** will be completed after each community visit.
The ***HSDA Regionalisation Report*** will be completed and provided to PHRG.

Both reports will be made available to the communities in the HSDA.

Outcome

By the end of this step:

- ***PHRG*** will consider the *HSDA Regionalisation Report*, including the outcomes from the initial visits, community feedback, capacity of communities and the partners to commence regionalisation, and initial plans for steering committee and clinical and public health advisory group establishment.
- ***PHRG*** will endorse the next steps for community control and participation and regional health service reform.

Requirements

- Regionalisation goals and process are clearly explained to communities and key stakeholders.
- Consistent messages are delivered by each of the partners in relation to regionalisation.
- Consultations occur with communities and existing health service providers in HSDA to inform *HSDA Regionalisation Report.*
- This step will comply with the principles of regionalisation.

Support Available to Progress this Step

RaDU or a person with relevant skills will organise the community visits, in collaboration with partners, health services and community members. Costs for the community visits will be met by the partners.
Resources are available to support the following types of activity:

- External expertise to assist in facilitation community consultations.
- Eyeglasses (magnification type reading glasses for use by participants in community consultations) and microphones.

Tools

The following tools are included in the Regionalisation Guidelines for use in this step;

- Key messages for regionalisation
- Criteria: *Community Consultation Report*
- Criteria – *HSDA Regionalisation Report*

Key Messages for Regionalisation

- The NTAHF partners are working towards having a single service provider in each Health Service Delivery Area (HSDA) under community control.
- The movement towards a single service provider will be a negotiated process between community leaders, all existing primary health care providers and the partners.
- The 14 HSDA boundaries were agreed at the NT AHF, recognizing that there may be some changes in the future related to the size, cultural affiliations and other considerations. Accordingly, some HSDA boundaries are still being finalised.
- HSDAs will be more sustainable in the delivery of primary health care services when there is a regional Aboriginal population of no less than 2500 people.
- A regional health service needs around 2500 people to be sustainable and changes to the current boundaries will need to take this into consideration.
- Changes to HSDA boundaries must be approved by the NT AHF.
- EHSDI funding is for expanding and improving Aboriginal primary health care services.
- Access to primary health care services will be available to all people resident or visiting the HSDA.
- *Pathways to Community Control* is a framework to guide the development of regional PHC services under community control.
- This process will take time and involves 4 main stages:
    - Development
    - Consolidation
    - Implementation
    - Evaluation
- The speed of the regionalisation process will vary greatly in different HSDAs.
- Funding is available from DoHA to help community representatives move towards community control.
- AMSANT has been funded to assist with regionalisation and community control processes.
- All existing primary health care providers must be fully engaged in this process so that all views are fully considered.
- Final agreement about establishment and funding of a single regional primary health care provider requires separate approval of both the NT and Australian Governments.

Criteria: Community Consultation Report

This is a record of each of the community visits. The information collected during the community visits and included in this report will inform the HSDA Regionalisation Report. This document is to be completed after each community visit and kept as a record for the communities and the partners.

1. **Date of community visit**

2. **Name of community, communities or homelands visited**

3. **Describe the type of visit (e.g. community meeting, consultation with cultural groups, service providers, etc)**

4. **Who was involved in the consultation (which of the partners, steering committee members, groups in the community)?**

5. **What was the focus of the consultation and what were the key themes?**

6. **Was there any opposition to the ideas that were raised at the consultations? If so, provide details.**

7. **Outcomes of consultation**

8. **Are there any existing community health advisory groups or forums?**

9. **Is there any other relevant information that was gathered at the consultations?**

Report compiled by
Date

Endorsement (by steering committee or partners)
Date

Criteria - HSDA Regionalisation Report

*This is an analysis of information gathered and details of discussions at community visits. The document will reflect the partners' and relevant expert views on the HSDA's capacity to progress regionalisation. This document is to be completed by **a relevant expert** (with input from the partners) after all community visits are completed.*

Part 1: Community Control and Participation

1. Identify the level of community interest in health decision-making.
- *What were the communities interested in doing (e.g., setting up a regional health advisory group; setting up a steering committee to assist in progressing towards a regional Aboriginal community controlled health service; or strengthening participation in some other way)?*
- *Is there an existing group or groups who could carry out the role?*

2. Were any local community members identified as potential community representatives?
- *Provide details of any potential local champions, steering committee or regional advisory group members identified throughout the initial consultations. List the names, communities and/or cultural group they would represent.*

3. How will the communities, homelands and cultural groups within the HSDA be represented in a steering committee or regional advisory group?

4. What is the proposed process for identifying community representatives and gaining community endorsement for the representatives?

5. Did the communities identify other ways to strengthen community participation?

Part 2: Regional Health Service Reform

6. Were any strategies identified to improve coordination and integration of existing services in the HSDA?

Part 3: Endorsement

Report compiled by	**Date**
Signature of partners	**Date**
PHRG Endorsement and Comments on Recommendations	**Date**

STEP B
Steering Committee and Clinical and Public Health Advisory Group

This step identifies the process for establishing a steering committee and a clinical and public health reference group. The steering committee will support increased community control and participation through the development of a new model of governance for health services in a region. The clinical and public health reference group will support regional health service reform. The process identified in this step can also be adapted to support the development of a regional advisory group.

Purpose

This step will:

- Ensure that relevant Aboriginal communities, homelands and cultural groups are represented in strengthening the community participation their HSDA through the establishment of a steering committee.
- Ensure that existing service providers are represented in the clinical and public health advisory group.
- Nominate AMSANT, NT DHF and OATSIH staff to work with the steering committee.
- Agree on the terms of reference and protocols for the steering committee and clinical and public health advisory group.
- Agree to the roles of each of the partners in the steering committee.
- Provide information to the steering committee on the HSDA, the two goals of regionalisation and the governance models for health services.
- Ensure all steering committee members understand the purpose of the committee and the expectations of the partners.
- Ensure all steering committee members understand all of the steps to progress regionalisation.
- Ensure all steering committee members understand their roles and the roles of all partners.
- Ensure all clinical and public health advisory group members understand the purpose of the group and the expectations of the partners.
- Agree on who will develop the *Initial Regionalisation Proposal*.

Process

- The ***partners*** will work with the communities to identify representatives from communities and major groups to participate in a steering committee.
- The ***partners*** will nominate representatives from their agencies to participate in a steering committee.
- The ***steering committee*** will develop terms of reference and meeting protocols (the minimum requirements for these are included in Step B of the *Regionalisation Guidelines)*.

- The ***steering committee*** will identify support required to fulfill their role and progress regionalisation and the ***partners*** will identify how this support will be provided to the steering committee.
- The ***partners*** will provide information to the steering committee on the HSDA, including maps, demographic information, health information and any other relevant information.
- The ***partners*** will explain these guidelines for regionalisation to the steering committee and explain the steps that need to be taken and the guiding principles.
- The ***partners*** will explain the models for health service governance that have been developed.
- The ***steering committee*** will develop their workplan to identify what work needs to be done and who will do it. A template for the workplan is included in these guidelines.
- The ***current health service providers*** will nominate representatives from their organisations to participate in the clinical and public health advisory group.
- The ***clinical and public health advisory group*** will develop terms of reference, meeting protocols and a workplan for the group.
- The ***steering committee*** and ***clinical and public health advisory group*** will agree on protocols for working together.

Achievement

Once the steering committee has been established, a formal report will be provided to PHRG outlining the membership of the steering committee and the process for selecting the members. The report will also be provided to the steering committee for their records.

Requirements

- Steering committees must be representative of all major Aboriginal communities and homelands in the region.
- Clinical and public health advisory groups must be representative of all primary health care service providers in the region.
- This step will comply with the principles of regionalisation.
- The establishment of the steering committees and clinical and public health advisory groups must be accordance with the relevant terms of reference.

Support Available to Progress this Step

- Representatives from each of the partners will provide support to the development of the Steering Committee. The partners will cover the costs of their own participation in the meetings.

- The AMSANT Reform and Development Unit are available to provide support in drafting Terms of Reference, protocols and workplan development.
- The AMSANT Reform and Development Unit will write membership reports for PHRG. under the guidance of the Steering Committee.
- OATSIH will fund costs of steering committee via AMSANT who will hold the funds.
- The costs incurred by *employees of health service providers within the HSDA* attending Clinical and Public Health Advisory Group meetings will be covered by their employer. Health Service providers will also make arrangements for travel and accommodation for their representatives.

Tools

The following tools are included in the Regionalisation Guidelines for use in this step;

- Criteria – *Community Consultation Report*
- Criteria – *Steering Committee Membership and Orientation Report*
- Criteria – *Steering Committee Terms of Reference*
- Template – *Steering Committee / Clinical and Public Health Advisory Group Workplan*
- Template – *Steering Committee / Clinical and Public Health Advisory Group Meeting Agenda*
- Template – *Steering Committee / Clinical and Public Health Advisory Group Meeting Minutes*
- Criteria – *Clinical and Public Health Advisory Group Terms of Reference*

Resources

OATSIH will consider funding requests to support the selection of community representatives for the steering committee.

The costs associated with convening of a steering committee meeting will be covered by OATSIH.

The partners will cover the costs of their own participation in the meetings.

Additional funding for the clinical and public health advisory group may be considered.

Criteria: Community Consultation Report

This is a record of each of the community visits. The information collected during the community visits and included in this report will inform the steering committee membership. This document is to be completed after each community visit and kept as a record for the communities and the partners.

1. **Date of community visit**

2. **Name of community, communities or homelands visited**

3. **Describe the type of visit (e.g. community meeting, consultation with cultural groups, service providers, etc)**

4. **Who was involved in the consultation (which of the partners, steering committee members, groups in the community)?**

5. **What was the focus of the consultation and what were the key themes?**

6. **Was there any opposition to the ideas that were raised at the consultations? If so, provide details.**

7. **Outcomes of consultation**

8. **Are there any existing community health advisory groups or forums?**

9. **Is there any other relevant information that was gathered at the consultations?**

Report compiled by
Date

Endorsement (by steering committee or partners)
Date

Criteria: Steering Committee Membership and Orientation

*This report can be used as a record for the steering committee. It will identify the membership of the committee and how they were selected. This document is to be completed by **AMSANT** and provided to PHRG.*

1. **Name of Steering Committee and HSDA**

2. **Names, contact details and details of community/homeland or cultural group represented by each of the Steering Committee members**

3. **How were the members selected?**

Orientation Program

4. **Date of Orientation Program**

5. **Name of Participants**

6. **Areas of Orientation Program delivered**

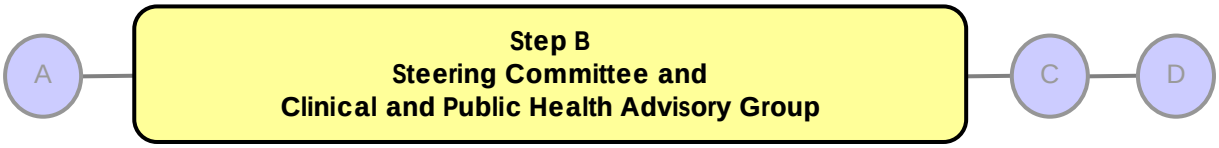
7. **Areas that may require further orientation**

8. **Who will write the Initial Regionalisation Proposal?**

   - Did the steering committee identify who will be involved in developing the Initial Regionalisation Proposal?
   - How will the Initial Regionalisation Proposal be endorsed by the steering committee before being submitted for approval?

9. **Support for the steering committee**

   - What support (if any) did the steering committee identify might be required to carry out any of the work?
   - Did the steering committee identify who might provide the support, or how it might be provided?



Part 4: Endorsement

Report compiled by
Date

Signature of partners
Date

PHRG Endorsement and Comments on Recommendations
Date

Criteria: Steering Committee Terms of Reference

The Terms of Reference are to be developed at the first Steering Committee meeting ***– by the Steering Committee.*** *This document can be adapted to meet the needs of the steering committee. The Terms of Reference below demonstrate a minimum requirement.*

Introduction

The Office for Aboriginal and Torres Strait Islander Health (OATSIH), Northern Territory Department of Health and Families (NT DHF) and the Aboriginal Medical Service Alliance of the Northern (AMSANT) ("the Partners") have committed to working with NT communities on **regionalisation**.

The purpose of regionalisation is to strengthen health services, enhance community control and establish regional health service models. Through regionalisation, we are working towards:

- Aboriginal community controlled primary health services
- Services that deliver primary health care on a regional basis
- Stronger organisations that provide accessible quality health care
- Better coordination of existing services, with an aim to integrating existing health services into a single service in each region

The guiding principles of regionalisation are:

- Aboriginal community involvement in decision making
- No forced amalgamations of existing health services
- No reduction of existing services

Steering Committees made up of the partners and community representatives will be established to support regionalisation.

1. Role of the Steering Committee

The Steering Committee will:

- Guide the regionalisation process and participate in decision making
- Inform planning for regional reform
- Support health planning in the region

- Link the communities into the regionalisation process and feed information back to communities

2. Terms of Reference

Support and participate the regionalisation process and decision-making:

- By representing the views of the groups the members represent (Aboriginal communities, government)
- By maintaining the partnership between community and government

Inform planning for regional reform:

- Represent the diverse interests of the stakeholders the members represent (government, township and homeland community members and health services)
- Identify the goal of the region, and the steps to achieving that goal
- Develop a regionalisation plan for the region

Support and participate in the health planning in the region:

- Working with the health services, identify health priorities for each community

Link the communities into the regionalisation process and feed information back to communities

- Provide information to communities on regional reform and activities.
- Provide the steering committee with feedback from the communities.

3. Composition

The Steering Committee will include representatives of:

- Relevant Aboriginal communities
- NT DHF
- AMSANT
- Health Services, and
- OATSIH

When deciding on membership, it is important to consider:

- Aboriginal communities are represented fairly
- Both male and female community representatives
- Age groups (e.g., youth)
- Size of the Steering Committee (not too big)
- Mechanisms for input from the non-Indigenous population

Once established, any changes to composition of the Committee must be agreed to in writing by existing members.

4. Conflict of Interest

Where members identify a Conflict of Interest this needs to be declared to the Committee

5. Duties and Responsibilities

The members agree to:

- Prepare for and participate in Steering Committee meetings
- Listen respectfully to the views and opinions of other members
- Represent the views, positions and ideas of the groups they represent
- Consider multiple points of view, keeping in mind the goal of regionalisation
- Promote collaboration and team work
- Facilitate timely decision making
- Participate in dissemination and communication activities.

6. Communication Protocols

The Committee should develop communication protocols, which will cover communication with Steering Committee members, communities, media, etc.

7. Terms and Method of Appointment

Members from AMSANT, DHF and OATSIH will be nominated by their respective agencies.

The process for nominating Aboriginal community representatives must be endorsed by the people attending community meetings.

People who have an interest in health and are able to participate should be encouraged to represent their communities.

Committee member appointments will generally be for a period of twelve (12) months.

Members may resign from the Committee at any time formally in writing to the Chair of the Steering Committee.

8. Proxies

Where a committee member is unable to attend a meeting, proxies are allowed if nominated prior to the meeting and accepted by the Chair.

9. Chair

The Chair will be:

- An Aboriginal community member
- Appointed by a majority of Steering Committee members (including agreed by the Partners)
- Either ongoing or rotating, as decided by the Steering Committee

The Chair will:

- Ensure meetings are purposeful and in line with the agenda
- Allow open discussion by all participants
- Support a culture of respect
- Represent the Steering Committee as required

10. Meetings

Quorum

A quorum is achieved when:

- 51% of Committee members are present
- Each of the partners are represented.

Frequency

The Steering Committee will meet as often as the nominees determine. The frequency of meetings should be determined around the activities and milestones identified by the Committee.

Minutes, papers and reporting

The agenda and all relevant papers will be circulated to members at least one week prior to the meeting and available in hard copy at the meeting.

Major decisions and agreements of the Committee will be formally minuted. The Minutes will identify a summary of the meeting, focusing on outcomes and actions agreed at the meeting. Minutes will be distributed to the nominees within two weeks of the meeting occurring.

11. Decision Making

Decisions will be made firstly by consensus, by agreement of all Steering Committee members that either support the decision or at least not block it from going forward.

If a consensus cannot be achieved a vote will be taken from members present and a majority (51%) will move the decision forward.

Decisions made by the Steering Committee represent the views of members and may be subject to further decision making by the NT Aboriginal Health Forum, NT Government and Australian Government.

12. Support for Committee

The following support will be provided to the Committee, if required:

- developing, in consultation with the Chair and the Partners, agendas for Committee meetings and other business involving the Committee;
- distributing of agenda and associated material;
- taking minutes and circulate to members after the meetings in a timely manner;
- ensuring all members are kept informed of issues and information relevant to the work of the Committee,
- arranging venues and catering for meetings;
- arranging appropriate travel and accommodation, and
- verifying reimbursement of eligible expenses.

13. Travel Allowance

Note: the costs of travel to and from meetings, accommodation and meals will be covered. This section applies to additional expenses.

Committee members traveling on official committee business may receive travel allowance.

Where the committee member receives travel allowance or reimbursement of traveling expenses from any other source for the same travel, no additional payment of travel allowance or expenses will be paid.

Where travel on official business does not require an overnight absence, no travel allowance will be paid.

Committee members attending an event where meals are provided will not receive the component of the travel allowance in respect of those meals.

Committee members will be paid travel allowance in accordance with agreed arrangements.

Reimbursement for loss of income for members will be considered if appropriate supporting evidence of the loss of income is provided.

14. Steering Committee Membership

Name of Member	Representative from the Government Community or Organisation	Contact Details

Template: Steering Committee Work Plan

*This plan can be used by the steering committee and **clinical and public health advisory group**. It will identify what tasks need to be done and who will do it. This document can be completed by the **steering committee** and reviewed at each steering committee meeting to check on progress.*

What needs to be done?	Who is going to do it?	When is it going to be done?

Template: Steering Committee Agenda

The steering committee agenda and any standing agenda items are to be developed and agreed in consultation with the Chair and the Partners. The agenda template can also be used for the ***clinical and public health advisory group.***

Steering Committee
Date/Time:
Location:

Present:
Apologies:

1. Welcome

2. Confirmation of previous minutes and Actions Arising
Moved:
Seconded:

3. Business arising

4. Item 1

5. Item 2 etc.

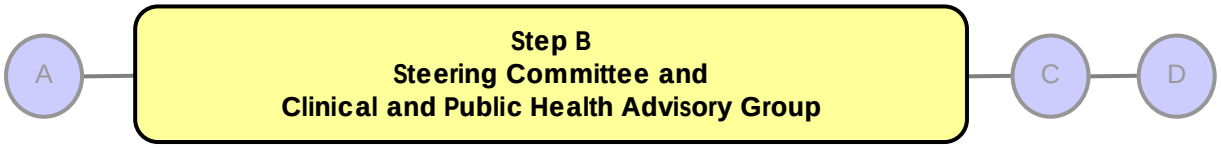
6. Other Business

7. Summary of the meeting

8. Confirmation of Actions Arising

9. Details of next meeting

10. Meeting Close



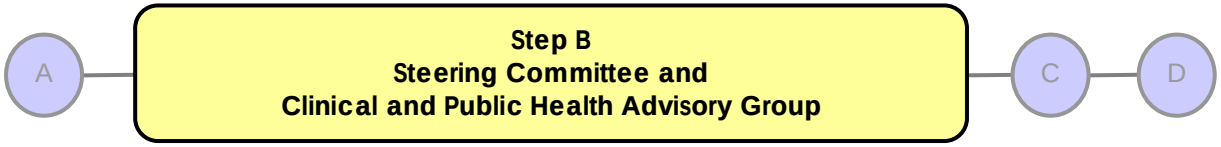
Template: Minutes of Steering Committee Meeting

*The steering committee minutes template can also be used for the **clinical and public health advisory group.***

Steering Committee
Time:
Date:
Location:

Present:
Apologies:

No.	Agenda Item	Record of Discussion	Action/decision	Person	Date
1.		Description (who spoke about what):	To…		
		Papers or Presentations (to be attached):			
		Key discussion points (general summary, dot points):	Moved by…… Seconded by……		
		Description (who spoke about what):			
		Papers or Presentations (to be attached):			



		Key discussion points (general summary, dot points):	Moved by…… Seconded by……		
3		Description (who spoke about what):	To…		
		Papers or Presentations (to be attached):			
		Key discussion points (general summary, dot points):	Moved by…… Seconded by……		

List of Current Actions

Date:

No.	Action	Date by	Responsible
1.			
2.			
3.			
4.			
5.			

Criteria: Clinical and Public Health Advisory Group Terms of Reference

The NT *Regionalisation of Aboriginal Primary health Care Guidelines,* endorsed by the NTAHF partners, describe the development of *Clinical and Public Health Advisory Groups,* (originally referred to as *Clinical Leadership Groups)* in all HSDAs that are in transition towards a single Community Controlled provider.

The (insert HSDA name) Clinical and Public Health Advisory group will provide a mechanism through which professional expertise from health service providers within the HSDA can be provided to the Steering Committee and to health service providers to improve service delivery and to assist progress of regionalisation of primary health care services within that HSDA.

The Advisory Group will also provide a mechanism through which health service providers within an HSDA will be able to share expertise with the aim of providing better coordinated services and consistent quality primary health care services across the HSDA. The role and focus of the Clinical and Public Health Advisory Group is likely to evolve as the HSDA progresses through stages of Regionalisation. The initial focus of this Group will be to assist Steering Committees in the planning in relation to health services reform to be undertaken in the Development Stage.

(Within HSDAs with an established health board as a single provider, the functions of the Advisory Group will be provided within the health service management structure of that provider).

1. Role of the Clinical and Public Health Advisory Group will be to:

   a. Provide advice to the Steering Committee/Health Board on key clinical and public health issues within the HSDA;
   b. Identify key gaps in service delivery within the HSDA;
   c. Provide advice on efficient coordination of services between providers within the HSDA;
   d. Undertake annual joint service delivery planning against Core Primary Health Care Services;
   e. Provide advice on health workforce needs within the HSDA;
   f. Provide advice on health service management issues including CQI, service delivery protocols, equipment needs and Clinical Governance;
   g. Provide advice on information management issues;
   h. Provide advice on health service performance, including Key Performance Indicators;

i. Provide advice if and as requested to the Steering Committee and planning units to assist in the development of Initial and *Final Regionalisation Proposal*s within the Development Stage of regionalisation, this advice will include consideration of:

- Existing relationships and linkages between health service providers;
- what needs to be included in a Regional Health Service Reform plan to assist the transition towards regional health services through better integration and coordination of existing services;
- resources required to support implementation of this Regional Health Service Reform plan;
- risks associated with implementing this plan.

j. Provide advice on research proposals and reports to the Steering Committee.

2. Composition.

The size of the Reference Group will be determined by the Steering Committee. Membership of the advisory group will include:

- A minimum of two (2) Steering Committee/Health Board members, nominated by the Steering Committee/Health Board;
- Health Professionals and/or Health Service Managers drawn from provider organisations delivering health services within the HSDA;
- Representation from each of the health service providers within the HSDA;
- CQI Facilitator for HSDA where applicable;
- A balance of Clinical, Public Health and Health Service Management expertise and experience;
- May include other nominees at the discretion of the Steering Committee/Health Board including support from AMSANT and other external expertise where needed.

Membership of the group will be approved by the steering committee, taking into account:

- All members will be committed to the principles of community control and community input into health service planning, and to the progression of health service management to community control as detailed in the document "*Pathways to Community Control";*
- All members will recognise the authority of the HSDA steering committee, Interim Health Board or Health Board in leading the regionalisation process;
- The Advisory Groups needs to represent the major professional disciplines within the HSDA including Aboriginal Health Workers;
- The Advisory Group should have the capacity to provide high level clinical and public health advice and leadership;

- The Advisory Group will operate in a manner that is culturally safe and accepts cultural guidance.

3. Operational Protocols

- The Chair will be appointed by the HSDA Steering Committee/Health Board;
- The frequency of meetings will be decided through discussion with the Steering Committee/Health Board;
- The Steering Committee/Health Board and Advisory Group will jointly decide standing agenda items for the group;
- The Advisory Group will provide a report back to each steering committee meeting on standing agenda items and other business arising;
- Meeting minutes will be promptly circulated after each meeting for approval and then made available to Steering Committee/Health Board members and Service Providers within the HSDA;
- Decisions of the Advisory Group will be ***recommendations*** to the Steering Committee/Health Board and Health Service Providers.

4. Support for the Advisory Group

- Health Service Providers within the HSDA will decide, in discussion with the Steering Committee/Health Board, who will provide secretarial support for the Advisory Group;
- The secretarial support will include arranging meetings, arranging with the Chair to circulate an agenda, taking and distributing minutes, organising a venue for meetings and arranging accommodation and travel for members (except as below);
- Costs incurred by *employees of health service providers within the HSDA* attending Advisory Group meetings will be covered by their employer. Health Service providers will also make arrangements for travel and accommodation for their representatives.

STEP C
Initial Regionalisation Proposal

This step will:

- **Identify the steps, the expertise and the funding required to develop a *Final Regionalisation Proposal*.**
- **Identify the process for consulting with communities and other stakeholders to develop a *Final Regionalisation Proposal.***
- **Identify which models are likely to be explored through community consultation.**
- **Seek funding to progress to the next steps.**

Process

- The ***steering committee*** will develop, or guide development of, the *Initial Regionalisation Proposal*.
- The ***Clinical and Public Health Advisory Group*** will develop the regional health service reform section of the proposal for endorsement by the steering committee.
- The ***partners*** will provide ongoing guidance and support to the steering committee during the development of the proposal.
- The ***steering committee*** will endorse the proposal and submit it to OATSIH.
- ***OATSIH*** will assess the proposal if any funding is being requested.
- If OATSIH supports the proposal, it will be submitted to ***PHRG*** for endorsement.
- If the proposal is endorsed by PHRG, ***OATSIH*** will seek funding approval.
- The steering committee will develop the regional health service reform section of the proposal with the advice and support of the Clinical and Public Health Advisory Group.

Achievement

The ***Initial Regionalisation Proposal*** will be developed by or under the guidance of the steering committee. The *Initial Regionalisation Proposal* will form the basis of a work plan for regional reform activities in the HSDA and will include activities, communication and consultation plan and budget (if funding is being requested).

Outcome

By the end of this step:

- ***The Steering Committee*** will be satisfied that the *Initial Regionalisation Proposal* is correct and complete to a standard for submission to PHRG.
- ***OATSIH*** will assess the proposal and any funding implications.
- ***PHRG*** will assess the proposal to ensure it meets the requirements under these guidelines.

- If the proposal is endorsed by PHRG, ***OATSIH*** will seek approval for funding identified in the proposal.
- If the proposal is not endorsed, ***PHRG*** will identify what further work is required and it will be referred back to the steering committee.

Requirements

- Community consultations should be conducted in accordance with the requirements of Step A Initial Community Consultations Principles page
- This step will comply with the principles of regionlisation15.
- Community Consultations Reports and Initial Regional Proposal are completed.
- The Initial Proposal submitted by the Steering Committee must contain the content outlined in the Criteria: Community Consultation Report.
- The Steering Committee must endorse the Initial Proposal.
- Where funding is identified as a requirement or funding is requested a detailed budget must be provided.

Support Available to Progress this Step

- Representatives from each of the partners will provide support to the development of the Initial Proposal. The partners will cover the costs of their participation in the meetings and consultations.
- The AMSANT Reform and Development Unit will provide support in planning community consultations for the initial round of consultations.
- The AMSANT Reform and Development Unit will draft the Initial Proposal under the guidance of the Steering Committee.
- OATSIH will consider funding requests identified in the Initial Regionalisation Proposal for regional level support (i.e. HSDA level planning unit and experts).
- PHRG may provide assistance upon request.

Resources

It is anticipated that Steering Committees may require additional resources to develop the Initial Regional Proposal. Additional resources may be sought to support the following types of activity:

- external expertise to assist facilitate community consultations;
- workshops, meetings;
- production of written material;
- eyeglasses (magnification type reading glasses for use by participants in community consultations) and microphones.

Tools

The following documents are included in the Regionalisation Guidelines for use in this Step;

- Criteria – *Community Consultation Report*
- Criteria – *Initial Regionalisation Proposal*

Criteria: Community Consultation Report

This is a record of each of the community visits. The information collected during the community visits and included in this report will inform the Initial Regionalisation Proposal. This document is to be completed after each community visit and kept as a record for the steering committee and the partners.

1. **Date of community visit**
2. **Name of community, communities or homelands visited**
3. **Describe the type of visit (e.g. community meeting, consultation with cultural groups, service providers, etc)**
4. **Who was involved in the consultation (which of the partners, steering committee members, groups in the community)?**
5. **What was the focus of the consultation and what were the key themes?**
6. **Was there any opposition to the ideas that were raised at the consultations? If so, list them.**
7. **Outcomes of consultation**
8. **Are there any existing community health advisory groups or forums?**
9. **Is there any other relevant information that was gathered at the consultations?**

Report compiled by
Date

Endorsement (by steering committee or partners)
Date

Criteria: Initial Regionalisation Proposal

This proposal will show in detail what the steering committee would like to do to progress regionalisation in their HSDA and how they will do it. The Initial Regionalisation Proposal is to be completed by the steering committee (or under the guidance of the steering committee) with input from the Clinical and Public Health Advisory Group.

The Initial Regionalisation Proposal should describe the health and governance activities that are planned to develop a governance model and the improved coordination of health services. This planning should be based on and have reference to the six health system building blocks:

- **Leadership and Governance**
- **Service Delivery**
- **Information**
- **Access to Medicines, Vaccines and Technology**
- **Financing**
- **Workforce**

http://whqlibdoc.who.int/publications/2009/9789241563895_eng.pdf
http://www.who.int/healthsystems/strategy/everybodys_business.pdf

The following criteria are intended to assist comprehensive planning covering all the basic information that the partners require to be able to understand and consider an Initial Regionalisation Proposal.

Executive Summary	
Executive Summary	• What is proposed? • How it will be implemented? • How long it will take? • How much it will cost? • The Executive Summary should contain all the main points of the Initial Regionalisation Proposal and be short (preferably no more 1 page).
PART 1 - COMMUNITY CONTROL AND PARTICIPATION	
The HSDA *Information about the population and geography of the*	• Describe the region to be considered for *Initial* and *Final Regionalisation Proposal* development. • Does this proposal cover the HSDA region? If the Steering Committee is proposing a different area, describe the area and why changes are

HSDA	being made.
The Process to Date *Feedback about the regionalisation process so far.*	• Has the Steering Committee started discussions with communities about regionalisation? If so, describe who has been consulted and how the consultations took place. • What was the focus of these consultations? • What was the feedback from these consultations? Include both positive and negative feedback. • Are there any key stakeholders or groups who do not support progressing regionalisation? • Describe the process used to develop the *Initial Regionalisation Proposal*. • Has the Steering Committee undertaken an analysis of a governance model or models for further consideration in the Final Regionalisation Proposal development? ***Option(s)*** **Description** | **Advantages** | **Disadvantages** | | | • Has the Steering Committee identified a preferred governance model or models to explore further through *Final Regionalisation Proposal* development?
Future Consultations *Describe purpose of consultations to inform Final Regionalisation Proposal Development*	• Identify Aboriginal communities, cultural groups and key stakeholders to be engaged in future consultations. • How do you plan to undertake consultations? • What information are you going to provide at the consultations? • What key questions do you plan to ask at the consultations? • What is your timeframe for the consultations? • How will you ensure that there are on-going two-way discussions with the stakeholders throughout the Development Stage? • How will the feedback from the consultations inform the *Final Regionalisation Proposal*? • How will you ensure that all cultural groups have an opportunity to discuss their ideas in a culturally safe environment? • Are there any conflicts of interest? If so, how will these be managed?
Resources And Support For Final Regionalisation Proposal Development *Details about how*	• Who will undertake the consultations and development work? Describe their skills and experience in community consultation. • What support does the Steering Committee require for consultations and *Final Regionalisation Proposal* Development? • How will the Initial Regionalisation Proposal be implemented? *Is staffing*

the Final Regionalisation Proposal will be developed.	*required?* • How progress of the Initial Regionalisation Proposal will be managed? • Timetable, key dates and milestones. • Provide a budget for *Final Regionalisation Proposal* development (see Budget template below).
PART 2 - REGIONAL HEALTH SERVICE REFORM	
The HSDA *Describe existing health services and relationships within the HSDA.*	• List health service providers who contributed to development of *Initial Regionalisation Proposal – Regional Health Service Reform*. • List health service providers within HSDA that were not included in development of *Initial Regionalisation Proposal – Regional Health Service Reform*. • Identify existing relationships and linkages between health service providers.
The Process to date	• Are health service providers in HSDA aware of the regionalisation agenda? • Have health service providers been involved in regionalisation consultations to date? • Has a Clinical and Public Health Advisory Group been established? • If yes, who are the members of the Clinical and Public Health Advisory Group and what services are members from? • Describe planned activities to improve coordination and linkages of services. • The process developed to an annual HSDA level health plan.
Risk Management	• Are there any risks in undertaking planned consultation? If yes, how will these risks be managed? • **Risk title** • **Risk description**: *Describe the risk- that is, what could happen if this event actually occurs?* • **Likelihood**: Rate how likely it is that this will occur (Unlikely; Moderately likely; Very likely) • **Impact:** Rate the impact if it does occur (Low; Medium; High) • **Classification:** *Classify the risk (as Low Risk, Medium Risk or High Risk).* • **Treatment:** *What will you do to eliminate the risk, or to reduce the likelihood of it happening or its impact if it does happen?*
Attachments	• Budget • List any attached documents that support this proposal (e.g., letters from existing service providers supporting this approach, letters of support from other community groups, other planning documents, etc)

Endorsement

Proposal compiled by
Date

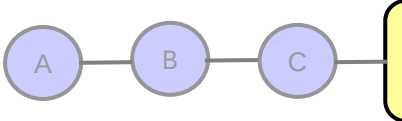
Endorsed by Steering Committee
Date

PHRG Endorsement and Comments
Date

Preferred Budget Format

The budget should only include costs specifically associated with the regionalisation activities and refer only to income and expenditure associated with the EHSDI program.

STEP D
Final Regionalisation Proposal



Step D
Final Regionalisation Proposal

This step will:

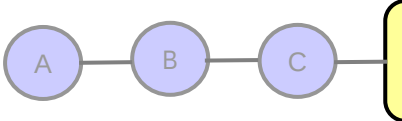
- **Seek the views of stakeholders in relation to a governance model for health services in the HSDA.**
- **Develop a proposed model for governance of health services in the HSDA, taking into account the views of stakeholders.**
- **Develop a *Final Regionalisation Proposal* for endorsement by PHRG and governments. The proposal will include governance of health services and improved integration and coordination of health services in the HSDA.**

Process

- The ***steering committee*** will undertake, or guide the broad consultation of stakeholders, as identified in the endorsed *Initial Regionalisation Proposal*.
- The ***steering committee*** will develop, or guide the development of a proposed governance model taking into account the views of all stakeholders.
- The ***steering committee*** will undertake, or guide further consultation on the proposed governance model and incorporate feedback from stakeholders.
- The ***steering committee*** will develop, or guide the development of the *Final Regionalisation Proposal*, outlining the proposed governance model and the process undertaken to develop this model.
- The ***Clinical and Public Health Advisory Group*** will develop a proposal for integration and coordination of existing health services.
- The ***steering committee*** will endorse the *Final Regionalisation Proposal* and submit to PHRG for endorsement.
- ***PHRG*** will assess the *Final Regionalisation Proposal* to ensure it meets the requirements and principles identified in these guidelines.
- If PHRG endorses the *Final Regionalisation Proposal*, ***OATSIH*** will seek funding approval to commence consolidation activities.
- If the proposal is not endorsed, ***PHRG*** will identify what further work is required and it will be referred back to the steering committee.

Achievement

The ***Final Regionalisation Proposal*** will be developed by, or under the guidance of, the steering committee. The *Final Regionalisation Proposal* will identify governance development and regional health service reform for the HSDA and will include activities and budget (if funding is being requested).



Step D
Final Regionalisation Proposal

Outcome

By the end of this step:

- ***The Steering Committee*** will be satisfied that the *Final Regionalisation Proposal* is correct and complete to a standard for submission to PHRG.
- ***OATSIH*** will assess the proposal and any funding implications.
- ***PHRG*** will assess the proposal to ensure it meets the requirements under these guidelines.
- If the proposal is endorsed by PHRG, ***OATSIH*** will seek approval for funding identified in the proposal.

Requirements

- The Final Proposal submitted by the Steering Committee must contain the content outlined in the Criteria: *Final Regionalisation Proposal*.
- The Steering Committee must endorse the Final Proposal.
- That the *Final Regionalisation Proposal* contains details for integration and coordination of existing health services.
- Where funding is identified as a requirement or funding is requested a detailed budget must be provided.
- This step will comply with the principles of regionalisation.

Support Available to Progress this Step

- The support required to progress this stage will be outlined in the Initial Regionalisation Proposal.
- Representatives from each of the partners will provide support to the development of the Final Regionalisation Proposal. The partners will cover the costs of their participation in the meetings and consultations.
- The AMSANT Reform and Development Unit will provide support to steering committees, clinical and public health advisory groups and planning units, where in place.
- The AMSANT Reform and Development Unit will draft or support the regional support mechanism, if any, to draft the Final Regionalisation Proposal under the guidance of the Steering Committee.

Tools

The following tools are included in the Regionalisation Guidelines for use in this Step;

- Criteria – *Community Consultation Report*
- Criteria – *Final Regionalisation Proposal*

Criteria: Community Consultation Report

This is a record of each of the community visits. The information collected during the community visits and included in this report will inform the Final Regionalisation Proposal proposals. This document is to be completed after each community visit and kept as a record for the steering committee and the partners.

1. **Date of community visit**
2. **Name of community, communities or homelands visited**
3. **Describe the type of visit (e.g. community meeting, consultation with cultural groups, service providers, etc)**
4. **Who was involved in the consultation (which of the partners, steering committee members, groups in the community)?**
5. **What was the focus of the consultation and what were the key themes?**
6. **Was there any opposition to the ideas that were raised at the consultations? If so, list them.**
7. **Outcomes of consultation**
8. **Are there any existing community health advisory groups or forums?**
9. **Is there any other relevant information that was gathered at the consultations?**

Report compiled by
Date

Endorsement (by steering committee or partners)
Date

Criteria: Final Regionalisation Proposal

The Final Regionalisation Proposal will show in detail the process of the steering committee to develop and implement a regional governance model in their HSDA. The Proposal is to be completed by the steering committee (or under the guidance of the steering committee) with input from the Clinical and Public Health Advisory Group.

The Final Regionalisation Proposal should describe the health and governance activities that are planned to develop a model and support improved integration and coordination of services in the HSDA. This planning should be based on and have reference to the six health system building blocks:

- **Leadership and Governance**
- **Service Delivery**
- **Information**
- **Access to Medicines, Vaccines and Technology**
- **Financing**
- **Workforce**

http://whqlibdoc.who.int/publications/2009/9789241563895_eng.pdf
http://www.who.int/healthsystems/strategy/everybodys_business.pdf

The following criterion is intended to be a comprehensive planning tool, covering all the basic information that the partners require to be able to understand and consider an Initial Regionalisation Proposal.

Executive Summary	
Executive Summary	• What is proposed? • How it will be implemented? • How long it will take? • How much it will cost? • It is suggested that you complete this section last. The Executive Summary should contain all the main points of the Initial Regionalisation Proposal and be short (preferably no more 2-3 pages).
Part 1: Community Control and Participation	
The HSDA *Describe the*	• Describe the HSDA, including the geography, the communities, the cultural groups and the population.

demographics of the HSDA.	• Identify all the different groups (stakeholders – cultural groups, community groups, service providers, non-Indigenous population) *that will be affected by any changes to the health services.* • Is there any additional information you would like to include about the region and the people that may support your application?
The Process *How was the governance model decided?*	• Describe the process used to develop the governance model. • Who was consulted? • Are there any communities or key stakeholders who do not support these proposed arrangements? Please describe their issues, and how their concerns may be addressed if the proposed regionalised governance model is approved and implemented. • How can you show that the proposed governance model has the support of the majority of Aboriginal people living in the HSDA?
Health Service Model and Governance Plan	• Which one of the models best describes the communities' vision for health service delivery in the HSDA? • What is the communities' decision about arrangements for governance for the HSDA? (Describe how the proposed model for health service delivery would be governed). • Describe the membership and structure of the Regional Advisory Group or Health Board. • Describe how all stakeholders are represented on the Regional Advisory Group or Health Board. • How will the members of the Regional Advisory Group or Health Board be selected? • Describe how the Regional Advisory Group or Health Board will function. • How will the Regional Advisory Group feedback to the communities and homelands? • If a legal entity will be formed as part of the governance model, how will the organisation be incorporated? • What are the implications of the proposed regional governance model for existing service providers?
One Year Governance Plan *How will the model be implemented in the short term?*	• Identify the steps and timeframes that need to be taken in order to implement the proposed governance model, including any interim arrangements. • If it is agreed that an existing service provider is to become a regionalised service provider, describe the legal and constitutional changes that will need to occur. • What resources will be needed to support this work?

Part 2: Regional Health Service Reform	
Current Service Providers	• Who are the existing service providers and what kind of governance arrangements are currently in place? • Describe the relationships and linkages between existing service providers • What works well with the existing arrangements? • What could be improved with the existing arrangements? • What are the existing service providers currently doing to support coordination and integration? • What can be done to improve coordination and integration? • Provide details on progress of health system reform against the following health system building blocks: o Service Delivery (including Core Primary Health Care Services and Continuous Quality Improvement) o Information (including Patient Information and Recall Systems and NT Key Performance Indicators) o Access to Medicines, Vaccines and Technology o Financing o Workforce
The Process	• Describe the process used to develop the regional health service reform plan. • Who was consulted? • Are there any key stakeholders who do not support the regional health service reform plan? Please describe their issues, and how their concerns may be addressed if the proposed regional health service reform plan is approved and implemented. • How can you show that you have engaged the Steering Committee in developing the Regional Health Service Reform proposal?
One Year Regional Health Service Reform Plan	• Identify the steps and timeframes that need to be taken in order to implement the regional health service reform plan, including any interim arrangements • What resources will be needed to support this work?
Risk Management	• Are there any risks in undertaking planned consultation? If yes, how will these risks be managed? • **Risk title** • **Risk description**: *Describe the risk- that is, what could happen if this event actually occurs?* • **Likelihood**: Rate how likely it is that this will occur (Unlikely; Moderately likely; Very likely)

	• **Impact:** Rate the impact if it does occur (Low; Medium; High) • **Classification:** *Classify the risk (as Low Risk, Medium Risk or High Risk).* • **Treatment:** *What will you do to eliminate the risk, or to reduce the likelihood of it happening or its impact if it does happen?*
Attachments	• Budget (see Initial Regionalisation Proposal above) • List any attached documents that support this proposal (e.g., letters from existing service providers supporting this approach, letters of support from other community groups, other planning documents, etc)

Endorsement

Proposal compiled by **Date** **Endorsed by Steering Committee** **Date** **PHRG Endorsement and Comments** **Date**