

# 10 YEAR HEALTH SERVICE IMPLEMENTATION PLANNING TASKGROUPS

## Terms of Reference

### Aim

To guide the development of 1-3 year implementation plans across five geographical groupings across country South Australia.

### Roles

Provide expert advice towards the development of implementation plans across geographical groupings by:

- > Critically reviewing the directions outlined in the draft 10 year health service plans within the Taskgroup geographical area.
- > Considering the socio-demographic profile and priority health needs of populations within the geographical area or sub-areas.
- > Identifying opportunities to strengthen ties between statewide reform directions and local needs expressed through the 10 year plans.
- > Identifying opportunities for improving patient pathways across the geographical area or sub-areas.
- > Recommending priorities and timing for new or expanded clinical services across the geographic grouping.
- > Identifying workforce, infrastructure and ICT requirements to support achievement of implementation plan outcomes over 1-3 years.
- > Recommending leadership and coordination requirements to support achievement of implementation plan outcomes.
- > Contribute to formulation of evaluation strategies to assess the outcomes of implementation planning.
- > Endorsing the draft implementation plan for broader feedback from statewide service providers and HACs and analysing feedback.
- > Endorsing the final implementation plan for consideration by CHSA Chief Executive Officer.

### Membership

The following describes the membership for each of the five Taskgroups:

- > CHSA Cluster Director (Chair)
- > CHSA Executive Director
- > Community (x4):
  - o Health Advisory Council Representatives
  - o Aboriginal Health Advisory Committee Representatives
- > Clinicians (x4):
  - o GPs / Medical Specialists
  - o Nurses / Midwives
  - o Community and Allied Health

- > Other (x2)
  - o Medicare Local (*where established in timeframe*)
  - o Local Government

Nominations for community, clinicians and others will be sought from a variety of representative bodies. CHSA will select the final Taskgroups, considering factors such as:

- > Participated at a broader catchment leadership level - eg. participated in country committees or area based groups.
- > Significant experience in rural areas.
- > Good understanding about SA Health reform particularly the objectives/outcomes of the country health strategy.
- > Interested in contributing to leadership in priority setting across country SA.
- > Can commit to the terms of reference regarding meeting frequency etc.
- > Currently working or residing in geographical area.
- > Working across several clinical areas (clinical representatives).

CHSA acknowledges the geographic and clinical diversity of the five geographic groupings and that a Taskgroup of this size will require broader engagement strategies to ensure equitable contributions from community members and clinicians. Additional engagement strategies such as the use of sub-groups or workshops with broader participation will be established to best match the needs of the geographic area. As a result of feedback received during the roadshows, CHSA is developing a sustainable Medical Clinical Advisory Structure which could contribute to the broader engagement strategies of the Taskgroup.

### Timeframes

Mid June 2011	Taskgroup membership confirmed
Early July 2011	First meeting of Taskgroups
July 2011 – January 2012	Meetings of Taskgroups
End January 2012	Taskgroups to endorse final implementation plans
Early February 2012	CHSA review of status of implementation planning milestones

The final timeframes will have some flexibility and will be finalised with the Taskgroups.

### Meeting schedule

Taskgroups are anticipated to meet on approximately 5-7 occasions between June 2011 to January 2012 comprising a combination of short and long meeting / workshops as negotiated between the Taskgroup chairperson and membership at the first meeting in June 2011.

Tele-conference, web-conferencing and video-conference facilities will be utilised to enable members to participate and reduce the burden on time and travel.



## Remuneration

Remuneration will be provided for meeting time and travel as follows:

- > GPs/medical representatives as per agreed GPSA rates.
- > Community representatives (eg. HACs and AHACs) – reimbursement for travel and office sundries as appropriate, access to fleet vehicles for travel.
- > Other professional groups – attendance at meetings and other costs will be provided in-kind or as otherwise negotiated.

## Executive support

Country Health SA will provide the following executive support as follows:

- > Compilation and provision of supporting documentation including health service profiles, statistical and demographic data, and other research activities towards the development of the implementation plans as required.
- > Secretarial support for meeting arrangements and minute taking.
- > Provision of expert input and advise as required.
- > Writing and editorial support for the development of the draft implementation plans based on the deliberations of the Taskgroup.

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## Taskgroup geographical boundaries

The following map depicts the five geographical groupings represented by the five Taskgroups. The groupings align with National Health Reform for Medicare Locals and the Country SA Local Health Network boundaries.

Colour coding	Taskgroup boundaries	Medicare Local boundary alignment
Yellow	Whyalla, Port Lincoln, Port Augusta, Eyre Peninsula, Flinders Ranges and Far North	Country North
Green	Barossa, Eudunda, Kapunda, Yorke, Lower North & Mid North	Country North
Orange	Inner Country (including Gawler, Mount Barker, Victor Harbor, Kangaroo Island)	3 metropolitan Medicare Locals
Blue	Riverland / Mallee Coorong	Country South
Pink	South East	Country South

