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PROJECT NAME

Trial of Integrated Area–based Planning – *Care in your community* Implementation

1.BACKGROUND

Care in your community sets out a framework for conducting area-based planning for the delivery of integrated community-based health care. It identifies three high level areas of need and sets out a structural framework for community-based health care, defined according to modes, settings and levels of care.

Care in your community does not provide a detailed methodology for the conduct of integrated area-based planning.

This project will test the planning framework set out in *Care in your community* by conducting a real planning exercise in selected locations and deliver a detailed planning methodology to be considered for use in other areas.

2.OBJECTIVES

The objectives of the trials as described on page 42 of *Care in your community* are:

- Develop partnerships between key stakeholders (building on existing partnership work)
- Provide a focus for the further development of program planning parameters by individual DHS programs
- Develop and refine the detailed area based planning methodology for broader application.

This project will specifically focus on the first and third point by:

- testing the integrated area-based planning approach as set out in *Care in your community*; and
- developing a detailed methodology for conducting area-based planning using the approach, which can then be adapted for use in other areas.

3.DESCRIPTION

3.1 Integrated Planning Areas

One of the key elements of the integrated area-based planning framework is the use of standard areas as a basis for conducting planning. In *Care in your community* these are known as Integrated Area-based Planning Catchments. These will now be referred to as Integrated Planning Areas. In each Integrated Planning Area planning considers the needs of the population within the area, need for access to services in the area by people outside the area, the configuration and integration of services in the area to meet the needs of the area population, and the need for people living within the area to access services outside the area.

The Integrated Planning Areas adopted for *Care in your community* are sub-regional areas made up of between 2 and 5 local government areas. The areas align with DHS (Whole of Victorian Government) Regions. A map of the Integrated Planning Areas is provided at

Appendix 1 to this project brief.

DHS programs and health services are based on a range of differing planning areas. Integrated Planning Areas do not replace these existing areas. Rather, adopting a single set of Integrated Planning Areas means that there will be one agreed reference point for planning for *Care in your community* that is common across all relevant programs. This will support the development of an integrated planning cycle within the Department, informed by the external area-based planning process and linked to the annual budget cycle.

3.2 Selected Locations

Three locations will be selected to trial integrated area-based planning in 2006-07; two metropolitan and one rural.

The following criteria provides the framework for selection of integrated area-based planning locations:

- Potential for strong partnerships between Health Services, CHSs, Divisions of General Practice and local government, building on, for example, PCP, HARP, Integrated Cancer Services, ICT Alliances, or Primary Care and Population Health Advisory Committees.
- Demonstrated advanced PCP service coordination practices
- Significant service and/or capital planning proposed or underway
    - Including locations where local service planning has implications for state-wide services
- Strong established focus on planning for delivery of ambulatory care services (based on Health Service strategic plans)
- Strong local capacity to manage trial activity in addition to core business and to provide operational support to the project.
- Site selection should be supported by data on local population characteristics, including:
    - Ambulatory Care Sensitive Conditions as determined by ACSC data
    - Social disadvantage as determined by the Index of Relative Socio-Economic Disadvantage (IRSED) data

Locations will be selected using these criteria on the basis of discussions with Regional Directors and MHACS and RRHACS service and capital planning and service development areas.

3.3 Planning Network Composition

Planning in each location will be facilitated by the DHS Region and conducted through a planning network comprised of representative key stakeholders in the planning process. The planning network will at a minimum include representation from:

- Department of Human Services
- Health Services (including hospitals and community health services)
- Local Government
- Nursing Services
- Divisions of General Practice
- Consumer Representatives

Agencies delivering services in each of the program areas listed on p.2 in *Care in your community* should be represented where possible including:

- Day medical and surgical procedures and treatments
- Outpatient services
- Emergency departments
- Post Acute Care
- Sub-acute Ambulatory Care Services
- Community Mental Health services and psychiatric disability rehabilitation and support services

- Community Health services
- Home and Community Care services
- Alcohol and other drug services
- Maternity services

3.4 Planning Principles

Care in your community outlines a number of principles that should guide the planning for the development of future health care service delivery capacity (p 9):

- We will build up and consolidate health care services in community-based settings, improving the range, level and quality of services delivered.
- Services delivered in hospital settings will complement community-based services. Planning will identify which services in the specific local context can be delivered safely, effectively and efficiently in community-based settings, and which services should be delivered in hospital settings.
- Planning for delivery of health care services will start from the preferred options of providing services at people's homes or close to where people live, work, shop, meet or relax (for services currently in or proposed for hospital settings, the first question will be 'can it be delivered at home or in the community?').
- Planning will maximise equitable distribution of services, based on the characteristics and needs of local populations, with a focus on addressing disadvantage (including the needs of socioeconomically disadvantaged communities, Kooris, people with a disability and people with a mental illness).
- Planning will maximise ease of access to services, co-locating services where possible and undertaking service development/redevelopment in locations that people can easily get to.
- Planning will deliver collaborative outcomes, based on partnerships focused on a population health approach.

These principles will be used in Phase Two to guide the assessment and plan any changes to the service system (see 3.8 below).

3.5 Project Establishment

Regions will be responsible for establishing and facilitating planning. The establishment of the area planning network will acknowledge and where appropriate build upon already existing networks, partnerships and/or planning processes to minimise duplication and strengthen the overall process. Existing partnership arrangements to be considered include: Primary Care Partnerships (PCPs); Integrated Cancer Services; ICT alliances; and in metropolitan areas Population Health and Primary Care Advisory Committees.

The first task, once the network is established will be for Region's to clearly define their trial area network the objectives and key components of the trial. This project brief will assist in this process as well as the *Care in your community* document. Regions may also want to set some local priorities or key goals.

Regions will have a key role in ensuring the planning undertaken by the network is in line with DHS goals and priorities and ensuring, where necessary, that program parameters are adhered to eg commonwealth/state agreements.

3.6 Planning Approach

The approach to integrated area-based planning as outlined in *Care in your community* incorporates four elements:

- Population health planning: including demography, burden of disease, psycho-social, economic and environmental factor analysis. This should be incorporated

into area-based planning using Municipal Public Health plans as the base. LGA profiles can be aggregated into area profiles.
- Integration planning: working with other partners as required, planning networks should work collaboratively to plan for service system integration and service coordination across a range of areas including workforce development and quality. This should build on existing activity undertaken by PCPs in the areas of service coordination and integrated health promotion.
- Community-based service configuration planning: building on current strategic planning processes where they exist such as Strategic Plans for Metropolitan Health Services and other program planning processes such as triennial and annual planning for allocating HACC growth funds this element should take a collaborative partnership approach to combine individual agency perspectives into a joint agreed plan.
- Regional and statewide planning: DHS both centrally and regionally has a key role in planning and decision making to support equitable resource distribution and the development of service system capacity. The department will have a role in providing data and analysis to support community based service configuration planning and population health planning.

This planning approach is described in more detail on pages 11 to 13 of *Care in your community*.

3.7 Phase 1

Outcome: A demographic and service profile for the Integrated Planning Area.

Following establishment of planning networks, Phase One of the planning trials will be to undertake a demographic and service profile for each Integrated Planning Area. This may initially be completed at the LGA level and aggregated to planning area level.

In metropolitan areas, this phase is dependent on the data analysis that is being conducted as part of *Metropolitan Health Strategy Refresh*.

Trials will be expected to include a large range of demographic, social and health utilisation data. For example:

- Health indicators: ambulatory care sensitive conditions, life expectancy, disability adjusted life years, years of life lost and years lived with a disability.
- Population: projections, birth rates, household type and family makeup, cultural and linguistic diversity;
- Economic status: relative disadvantage, electronic gaming machine prevalence, income status, unemployment data, Centrelink assistance, housing, rent stress and assistance; and
- Social indicators: education levels, social connectedness, child protection reports, crime rates, drug offences and family violence.

Community based service profiles including Community and Dental Health and services funded through the Home and Community Care Program will also be developed for each area.

Outside the *Metropolitan Health Strategy Refresh* process, the Primary Health Branch together with Rural and Regional Health Services Branch will compile all the same demographic data and service profiling for the Gippsland trial area.

As noted above at 3.6 Municipal public health plans should be used as a key source of information about local communities. Population planning data such as population projections should be based on the statewide data produced by the Department of Sustainability and Environment (DSE) as the whole of Government recognised data source

for this information.

In addition to the provided information, Regions will need to facilitate planning network access to data that will not be included in the information provided, and any other useful data sources. Regions with assistance from MHACS and RRHACS will also need to profile the existing service system on the basis of the schema for configuration of community based health care services set out in *Care in your community* pages p18 – 22:

- Modes of care - described as inpatient admission, same day admission, specialist care, primary care, group program or self care;
- Settings of Care – including hospitals, community based health care facilities and outreach; and
- Levels of Care – levels 1 through to 4 depending upon type of services provided for the facility.

3.8 Phase 2

Outcome: Assessment of priorities for service provision and service system changes.

This phase will involve the application of the integrated planning approach to assess priorities and determine action. The assessment will involve the following key elements:

- Assessing priorities in terms of the three areas of need (chronic and complex, episodic and urgent, integrated health promotion and illness prevention).
- Determine how the planning principles and program planning parameters apply to the local service system

Planning for the future shape of the health care system has to focus on what is needed to improve the health outcomes of people in community and home-based settings. The three areas of need provide a way of focusing on key areas. A consistent, planned approach to the management of chronic disease and complex care draws in DHS activities focussed on substitution and diversion, intensive case management, community based care coordination and early intervention (refer p14-15 *Care in your community*). The health care system also needs to be able to effectively meet the needs of those people who, while generally healthy, may occasionally need access to a number of health care services due to short term illness or injury (refer p 15 *Care in your community*). And improving the health and wellbeing of whole populations through health promotion and illness prevention is a key element in the planning of quality, efficient and equitable health systems (refer p 16-18 *Care in your community*).

It is envisaged that the data collected in Phase One will reveal priority areas to focus on and that it will be necessary to limit these to two or three in the first instance.

The next step will be to conduct an assessment of the local service system based on the identified local needs and the application of the planning principles and program parameters to the local service system. The planning principles are outlined at 3.4 above and together with the integrated area-based planning approach (at 3.6 and p 10-13 in *Care in your community*) provide the context for this phase of planning work. Consultant support will be available during this phase (described in more detail below).

There are some programs, such as the HACC Program, that have reasonably well developed population based program planning parameters. Further development of program planning parameters will occur in parallel with the trials, including looking at ways that program planning guidance can better support the principles of *Care in your community*. Where available program planning parameters should be applied to the planning process in this phase. Issues that arise in applying program planning parameters during this phase should be brought directly to the Implementation Group meetings for discussion and resolution. The consultant may also facilitate this process.

The outcome of this phase will be a detailed plan for service system changes that would be required for the Integrated Planning Area in order to implement *Care in your community*.

3.9 Phase 3

Outcome: Priority Action Plan with targets for implementation over 3 years.

This phase will determine priority actions from the detailed plan developed in phase 2 to be implemented. The Priority Action Plan will set 3 year targets, with annual priorities in line with the Planning Cycle described on p12 of *Care in your community*. Again using the service system configuration planning schema: modes of care; settings of care; and levels of care (p18–22 *Care in your community*) the Plan will specify goals to move towards future service system integration.

These plans will be used to inform decision making on capital development priorities for community based health care and service growth and new funding across a selected group of departmental programs. Impact of plans on service growth and new initiative funding will initially be limited to renal dialysis, dental services, HARP CDM, chronic disease early intervention in CHS's and community health counselling services. This will apply to the 2006/07 and 2007/08 financial years. From 2007, coverage will gradually be extended to the full range of community based health care services. This staged process will build upon work on program planning parameters and related work such as the review of outpatient funding arrangements.

Priority actions should be achievable within existing funding plus average rates of growth in program funding. Plans should not set unrealistic targets for service or capital growth and service development.

3.10 Consultant Support

Outcome: The delivery of a detailed planning methodology to be adapted for use in other areas.

Description: Planning activity will be supported and evaluated by an independent consultant working across the three sites. The consultant's role will be to support area-based planning by assisting the trial sites to implement the planning principles documented in *Care in your community*. The consultant will resource planning networks with information about best practice and other key achievements in area-based planning. The consultant will also evaluate the development processes and outcomes of the trials using "action learning" methodology designed to proactively address issues as they arise and enable the trials to learn through the experience. At the end of the process, the consultant will be responsible for delivering a detailed planning methodology to be adapted for use in other areas. Another key role of the consultant will be to identify program barriers to area-based planning that arise in individual program areas during Phase Three.

4. LINKS TO KEY POLICY DOCUMENTS, DIVISIONAL PLANS & KEY STRATEGIES

This project is based on the framework set out in *Care in your community* and is one of the actions for development specified in that document. *Care in your community* has adopted the principles established by the government in *Victoria: a better state of health.* Specifically these principles are:

- Principle one: The best place to treat
- Principle two: Together we do better
- Principle Three: Technology to benefit people
- Principle four: A better health experience
- Principle five: A better place to work.

These principles will inform the development of the health care system under integrated

area-based planning.

An Enabler Report will monitor work being undertaken across the Department on the enablers and key actions listed in *Care in your community*. Progress being made in these areas will be reported to the *Care in your community* Steering Committee each quarter. Refer to the most recent Enabler Report.

Links to policy documents include:

- *Rural Directions for a Better State of Health* talks about implementing an integrated area-based configuration for rural health services (p31).
- The *Metropolitan Health Strategy Refresh* will complement *Care in your community* particularly in metropolitan trials during Phase One.
- The *Care in your community* policy implementation will feed into *Health Options* part two.

Ultimately *Care in your community* is part of the bigger picture of planning and coordination in DHS and State Government. Policy decisions related to *Care in your community* will be made within this broad context.

5. COMMENCEMENT OF PROJECT	COMPLETION OF PROJECT
April 2006	August 2007

6. KEY TASKS, DELIVERABLES & TIMEFRAMES		
Key Deliverables – DHS	**Key Deliverables - Consultant**	**Dates**
Confirm Integrated Planning Areas to participate (Regions)		April 2006
Provide advice to key agencies (Regions)		May 2006
Finalise consultants brief (PHB)		June 2006
Establish area planning network (Regions)		End August 2006
	Consultant commences	End October 2006
	Consultant provides practical support to implement *Care in your community* planning principles	Beginning November 2006
	1st Workshop on Assessment and Analysis Conducted	January 2007
	Develop and facilitate a workshops around emerging themes across the three sites for regional and central office staff	By August 2007
	Attendance at monthly project working group meetings	January 2006 – August 2007
Phase One: Area Profile Complete		February 2007
Phase Two: Assessment and analysis Complete		May 2007
Phase Three: Area Priority Action Plan Complete	Prepare detailed generic planning methodology	August 2007

7. CLIENT OF PROJECT DELIVERY

Executive Director Metropolitan Health and Aged Care Services Division and
Executive Director Rural and Regional Health and Aged Care Services Division

8. STAKEHOLDERS & POTENTIAL PARTNERSHIPS

Internal Stakeholders
Access and Metropolitan Performance Branch
Aged Care Branch
Budget, Planning & Review Branch
DHS Metropolitan and Rural Regions (relevant to each planning location)
Drugs Policy and Services
Funding, Health and Information Policy
Mental Health Branch
Planning and Resources
Primary Health Branch
Programs Branch
Rural and Regional Health Services Branch
Service and Workforce Planning Branch

External Stakeholders
Community Health Services
Divisions of General Practice
Key peaks and professional bodies (eg. GPDV, MAV)
Local Government
Metropolitan Health Services
NGO's delivering Drug and Alcohol or Mental Health Services eg
Nursing Services
Other Health Services
Primary Care Partnerships

Planning Networks
As per the *Care in your Community* document (p.10), each planning network to include at least representation from:

- Department of Human Services
- Health Services (including hospitals and community health services)
- Local Government
- Nursing Services
- Divisions of General Practice

Other agencies include Drug and Alcohol agencies and Psychiatric Disability Rehabilitation and Support Services.

9. CONSULTATION

Consultation will be a key component of this project. A governance structure will facilitate consultation and guide the implementation of *Care in your community.* See Appendix 2.

Integrated area-based trials – Planning Networks
It will be important to continually and effectively consult with service providers that cannot for various reasons be active members of the planning network. In addition the planning decisions about local healthcare should involve the people that use them. Area planning networks and Regions will need to demonstrate how they have consulted with a broad range of stakeholders throughout the planning process. This can be done through already existing networks such as PCPs and consumer advisory committees that are already in operation, or through broader consultation set up specifically for the purpose of the planning trial.

The Steering Committee will be responsible for endorsing the direction of the implementation of *Care in your community.*

The Implementation Group will plan internal consultation as required.

The Advisory Group will be a consultative body that will advise both the Steering Committee and the Implementation Group on implementation issues from the view of the sector.

10. COMMUNICATION PLAN/STRATEGY

Communication about the overall implementation of *Care in your community* and the progress of the trial projects will be the responsibility of the Primary Health Branch. This will be achieved through a communications strategy. The Communication strategy aims to:

- disseminate information on the overall implementation and progress of *Care in your community* to stakeholders;
- consult with stakeholders; and
- help maintain the interest/enthusiasm in the policy.

As part of the communications strategy, the Ambulatory Care website will be maintained and updated to help provide easier access to information and updates on *Care in your community.*

The web site will also be utilised to facilitate communication between the trial sites and the *Care in your community* project team.

Individual trial sites will be responsible for communications directed at the agencies and stakeholders in their trial area.

11. RISKS AND THEIR MANAGEMENT (CONTROL)

The consultant's role is crucial to ensuring the outcome of this process.
The individual/organisation selected will need to have a proven track record for delivering to government on this type of project. In addition the contract should be actively managed to ensure that key milestones are met.

Project will not meet timelines.
Project scope has been developed to support the timeframe available

Expectations of area planning networks to support the project are unmet.
DHS project staff and other resources will support the network as required.

Project will not be able to source adequate / appropriate data to support data analysis.
Project scope is based on data primarily from existing sources. DHS project staff andother resources will support the network as required.

Data analysis will not provide clear or useful recommendations about priorities.
A range of data and analysis techniques will be undertaken to minimise this risk.

Service configuration or service system integration goals will set unrealistic targets.
Working in close partnership with external stakeholders through Planning Networks and maintaining focus on achievable 3 year planning targets will minimise this risk.

As the trials gain momentum there is a possibility that inconsistent communication might cause confusion amongst stakeholders.
Stakeholders are kept informed and engaged of Care in your community principles and developments through a communications strategy.

12. EVALUATION PLAN

The evaluation plan will be developed by the consultant. An approach to identify successful planning methodologies will focus on:

– **inputs**, for example resources, data, skills etc
– **processes**, for example stakeholder engagement, clarity of roles and scope of responsibilities etc

- **outputs**, for example demographic/service analysis, priority action plan, etc
- **outcomes**, for example consistency of recommendations with *Care in your community* planning principles/directions, population health outcomes, commitment of stakeholders/networks to the plan etc

13. CONSULTANT'S ROLE

The role of the consultant will be to tie the three trials together, identify barriers and issues relating to the trials and extract key findings. The consultant will provide a recommended methodology to support integrated area-based planning in other areas of Victoria.

14. PROJECT COSTS

The cost of this project is being shared by RRHACS and MHACS divisions.

15. PROJECT MANAGER & TEAM MEMBERS (including roles)

Each Region has nominated someone responsible for overseeing the outcome of the trial for their region. This will usually be the senior health manager for the region. A project manager working under the senior regional health manager will be the main contact person for information about progress of the trial.

Project resources will be given to Regions to manage and determine the way they structure their project to meet the outcomes required for the trial. For Example, regions may contract out the management of the project to the health service or some other suitable body or may retain project management internally.

16. PROJECT ORGANISATION & CONTROL

The Primary Health Branch is responsible for coordinating the project. This will include engaging the consultant and monitoring and evaluating the overall progress of the regional trials. This will be undertaken in partnership with the MHACS programs branch as joint sponsors of the overall implementation of *Care in your community*.

The Primary Health Branch will contract each of the three Regions to deliver on the outcomes for the trial sites. Regions will be responsible for managing the trials and delivering on these outcomes.

A working group of project managers and the Primary Health Branch will be established for the trials. The role of this group will be to resolve project issues and ensure that the project can continue to move forward. This project working group will report to the Implementation Group on overall progress. Regions will be responsible for reporting accurately on progress of their individual trials.

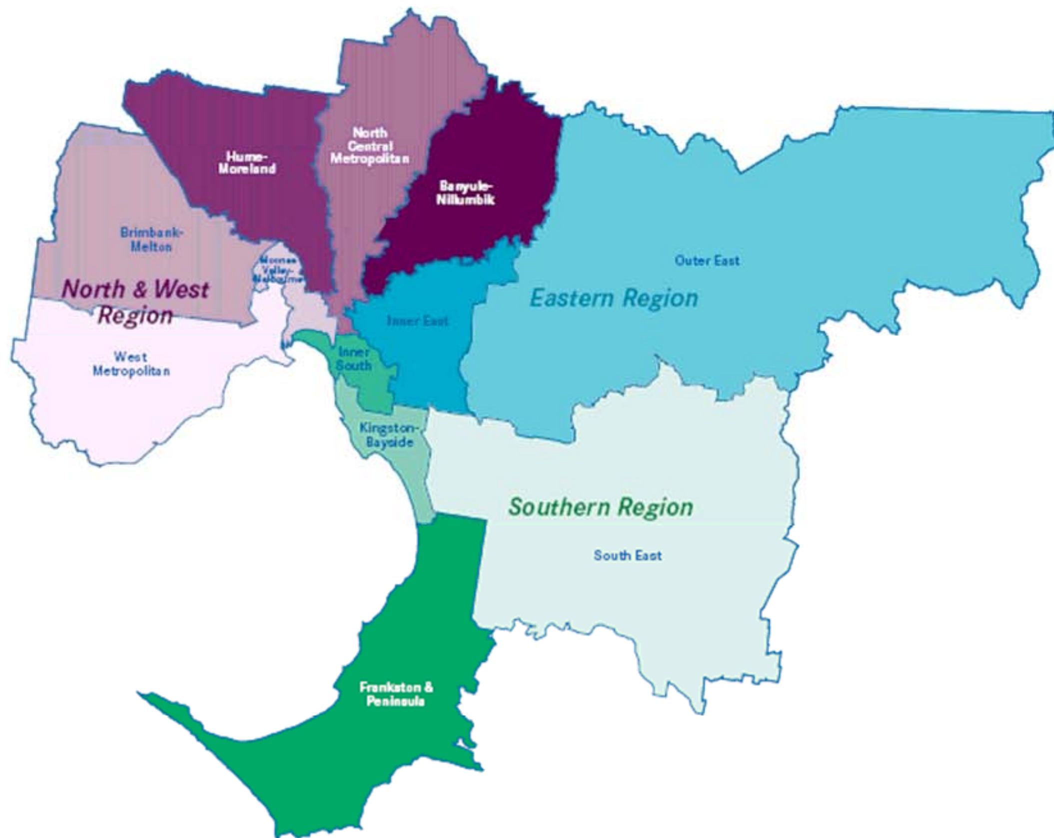
Membership of the working group will include the Primary Health Branch and all the Regions responsible for the trial and key stakeholders.

The consultant will report on progress to the Implementation group and seek direction from the working group.

Refer Appendix 2 for further detail on the whole of *Care in your community* implementation governance.

Appendix 1: Integrated Planning Areas

Integrated Planning Areas – Metropolitan Melbourne

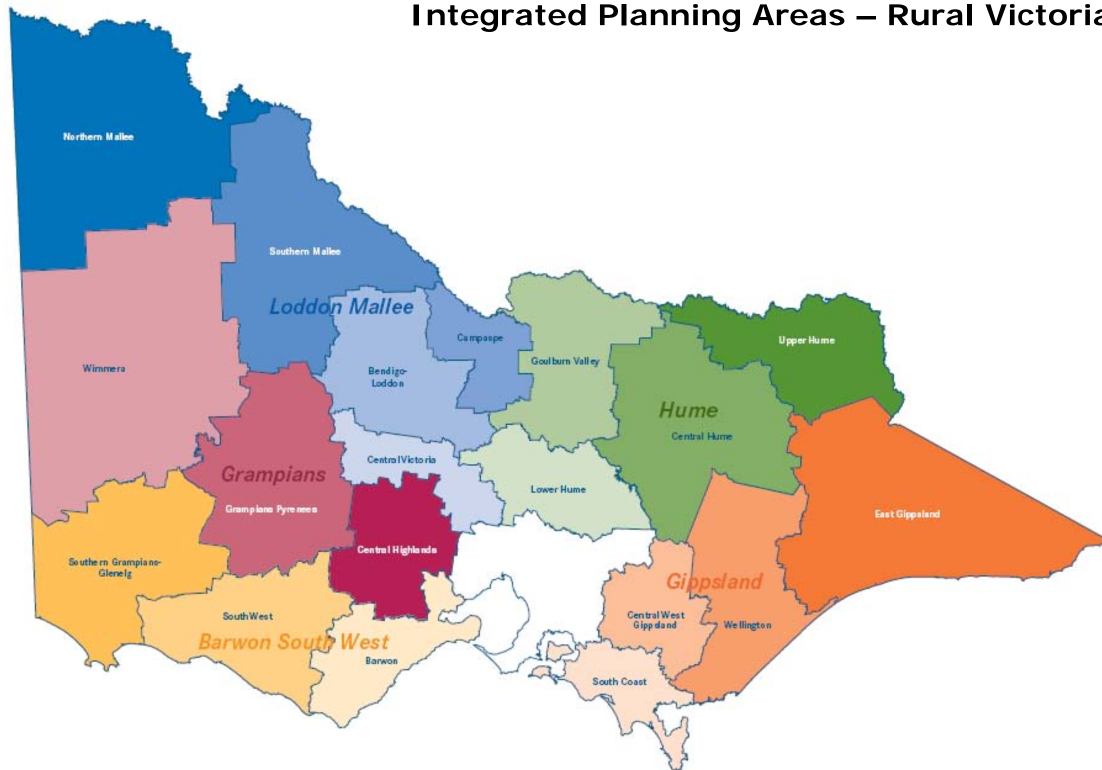


Integrated Planning Area		Local Government Area
North & West Region		
	Banyule-Nillumbik Pop. 177,946 Area: 493km²	Banyule Nillumbik
	Hume-Moreland Pop. 284,038 Area: 555km²	Hume Moreland
	North Central Metropolitan Pop. 323,567 Area: 564km²	Darebin Whittlesea Yarra
	Brimbank-Melton Pop. 245,776 Area: 651km²	Brimbank Melton
	Moonee Valley - Melbourne Pop. 170, 835 Area: 78km²	Melbourne Mooney Valley
	West Metropolitan Pop. 253,121 Area: 637km²	Hobsons Bay Maribyrnong Wyndham

Integrated Planning Area		Local Government Area
Southern Region		
	Frankston & Peninsula Pop. 257,724 Area: 853km²	Frankston Mornington Peninsula
	Inner South Pop. 296,661 Area: 86km²	Glen Eira Port Phillip Stonnington
	Kingston-Bayside Pop. 225,916 Area: 128km²	Bayside Kingston
	South East Pop. 392,162 Area: 1,822km²	Cardinia Casey Greater Dandenong
Eastern Region		
	Inner East Pop. 578,689 Area: 318km²	Boroondara Monash Whitehorse Manningham
	Outer east Pop. 394,215 Area: 2,647km²	Knox Maroondah Yarra Ranges

Population numbers are based on Estimated Resident Population 2004 by LGA.

Integrated Planning Areas – Rural Victoria



Integrated Planning Area	Local Government Area
Barwon South Western Region	
Barwon Pop. 249,793 Area: 6,271km²	Colac Otway Greater Geelong Queenscliffe Surf Coast
South West Pop. 63,886 Area: 10,334km²	Corangamite Moyne Warrnambool
Southern Grampians-Glenelg Pop. 37,122 Area: 13,033km²	Glenelg Southern Grampians
Gippsland Region	
East Gippsland Pop. 40,826 Area: 20,945km²	East Gippsland
Central West Pop. 108,252 Area: 5,440km²	Baw Baw La Trobe
South Coast Pop. 55,400 Area: 4,163km²	Bass Coast South Gippsland
Wellington Pop. 41,450 Area: 10,990km²	Wellington
Grampians Region	
Grampians Pyrenees Pop. 30,820 Area: 13,045km²	Ararat Northern Grampians Pyrenees
Central Highlands Pop. 144,433 Area: 7,027km²	Ballarat Golden Plains Hepburn Moorabool
Wimmera Pop. 38,063 Area: 27,908km²	Hindmarsh Horsham West Wimmera Yarriambiack

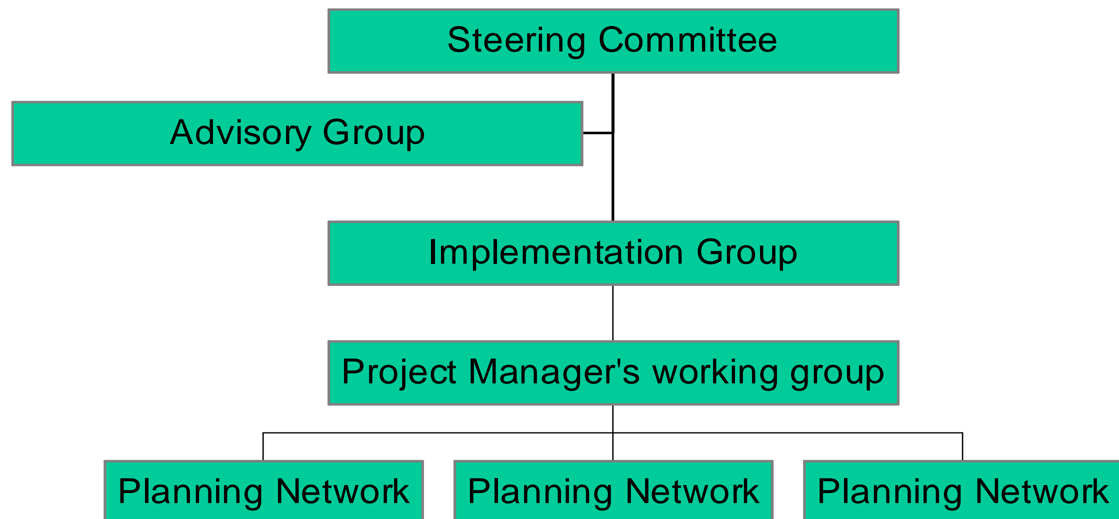
Integrated Planning Area	Local Government Area
Loddon Mallee Region	
Bendigo Loddon Pop. 103,021 Area: 9,693km²	Greater Bendigo Loddon
Campaspe Pop. 37,193 Area: 4,526km²	Campaspe
Central Victoria Pop. 70,210 Area: 4,809km²	Central Goldfields Macedon Ranges Mount Alexander
Southern Mallee Pop. 36,306 Area: 17,876km²	Buloke Gannawarra Swan Hill excl Robinvale SLA
Northern Mallee Pop. 55,313 Area: 22,245km²	Mildura incl Robinvale SLA
Hume Region	
Central Hume Pop. 60,873 Area: 17,245km²	Alpine Benalla Mansfield Wangaratta
Upper Hume Pop. 56,126 Area: 9,164km²	Indigo Towong Wodonga
Lower Hume Pop. 45,482 Area: 6,749km²	Mitchell Murrindindi
Goulburn Valley Pop. 97,105 Area: 9,803km²	Greater Shepparton Moira Strathbogie

Population numbers are based on Estimated Resident Population 2004 by LGA.

Appendix 2: Governance arrangements

A new project governance structure will guide the implementation of *Care in your community.*

Care in Your Community Implementation Governance Arrangements



Steering Committee

The Steering Committee is the group that will be responsible for endorsing the direction of the implementation of *Care in your community*. The Executive Director, Rural and Regional Health and Aged Care Services will convene the Steering Committee. It is expected it will meet quarterly as the implementation progresses.

Implementation Group

The Implementation Group is responsible for the management of the implementation of *Care in your community*. It is co-chaired by the Director, Primary Health, RRHACS division and Director Programs, MHACS division. Primary Health is the lead program area responsible for the implementation of the project. It is expected to meet monthly throughout the initial implementation phase of the project and will report to the Steering Committee on the progress of *Care in your community* and implementation issues which need addressing.

Advisory Group

The Advisory Group is proposed as a consultative body that will advise both the Steering Committee and the Implementation Group on implementation issues from the view of the sector. The Advisory Group will also contribute to an understanding of the implementation of *Care in your community* in the external sector. The Advisory Group will be convened by the Secretary of the Department of Human Services and will meet quarterly and on an issue basis if needed between meetings.

Planning Networks

Planning will be conducted within each integrated area-based trial by an area-based planning network, made up of local stakeholders and involving, at a minimum, health services (including hospitals and community health services), local government, nursing services, General Practice Divisions, consumer representatives and the Department of Human Services.