Health Service Partnership policy and guidelines

Policy for Victorian Health Service Partnerships

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VICTORIA State Government | Department of Health

Health Service Partnership policy and guidelines

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2. Executive summary

From 1 July 2021, Health Service Partnerships will be an enduring feature of the Victorian health system. These Partnerships will replace the health service 'clusters' that emerged during the COVID-19 pandemic, along with the Regional Area Health Partnerships that preceded them. All health services will be expected to fully participate in their respective Health Service Partnership in the years to come.

The *Health Service Partnership policy and guidelines* (Guidelines) detail the framework and expectations for how Health Service Partnerships will operate, following their establishment on 1 July 2021. These Guidelines supersede the Rural and Regional Health Partnership guidelines, and will cover both Health Service Partnerships and Local Area Health Partnerships, which are continuing in rural and regional Victoria.

The Health Service Partnerships model preserves the local autonomy and responsibility of health services, which remain independent entities. Health services will continue to be individually responsible for their performance against Statements of Priorities, including management of budget and finances, along with clinical service delivery and clinical governance.

While preserving local autonomy, the Health Service Partnerships model requires health services to work together on a small number of strategic system priorities, and any local priorities agreed by the Health Service Partnership, that can be enhanced by working together rather than in isolation or competition. Not all members of the Health Service Partnership need to be involved in work on additional agreed priorities, but such priorities must be selected by consensus if they require the use of Health Service Partnership resources.

Members will engage collaboratively and inclusively in their Health Service Partnership and decision-making will be by consensus. A clear and accessible escalation pathway will be available for use in exceptional circumstances that cannot be resolved within the Partnership. Each Health Service Partnership will undertake annual planning and reporting against its identified priorities. Health services will be jointly accountable for their active role in the partnership and contribution to these priorities through their individual Statements of Priorities.

There will be no change to the process for health services choosing to pursue amalgamations, which are unrelated to Health Service Partnerships. Amalgamations will remain a wholly voluntary process always instigated and led by health services. They will proceed with government support only where extensive community consultation and due diligence has occurred and where voluntary amalgamation will result in the provision of better health services in Victoria and is otherwise in the public interest.[1]

[1] *Health Services Act 1988* (Vic), s. 64A(3).

3. Purpose of the Guidelines

These Guidelines detail the framework and expectations for how Health Service Partnerships will operate, following their establishment on 1 July 2021. The Guidelines focus on:

- outlining the requirements and processes to establish the Health Service Partnerships in 2021, including transitioning from clusters, and integrating Regional Area Health Partnerships
- setting out the Department of Health's (the department's) expectations regarding membership, structure and decision making of Health Service Partnerships
- how the Health Service Partnerships should plan to demonstrate the impacts and outcomes of their work.

The Guidelines may be updated by the department in future as needed.

4. Context

The COVID-19 pandemic has impacted our system in challenging new ways, bringing to the fore the difficulty our health services can face in tackling systemic problems while working in isolation. It has also highlighted how much more resilient our system is when we work together.

We have seen examples of this emerging during the pandemic – with health services arranged into 'clusters' to plan for and manage an expected surge in demand for COVID-related critical care. As the pandemic has worn on, cluster members have also increasingly supported each other on other fronts – including aged care outbreak responses and staff furloughs.

The collaboration exhibited by clusters provides the foundations of a new and better way of working in future. The deep connections health services have with their local communities have already given Victoria one of the strongest health systems in Australia; collaborative connections between health services on pressing strategic priorities showed how our system can become stronger still.

To this end, health service collaboration, through Health Service Partnerships, will remain an enduring feature of the Victorian health system. While preserving local autonomy, the Health Service Partnerships model will require health services to collaborate on the system priorities that can be enhanced by working together rather than in isolation or competition.

This will be a significant step forward for our health system. Health services have historically had strong incentives to work independently rather than in collaboration. And while regional partnerships are longstanding for rural and regional health services, they are much newer to metropolitan health services. Recognising the collaboration model is in its genesis, the department will work closely with health services to stand up, embed and mature their Health Service Partnerships over the coming years.

5. Purpose of Health Service Partnerships

The Health Service Partnership model aims to help move the Victorian health system from competition to collaboration by requiring health services to work together on a small number of strategic system priorities (outlined in **Section 8**) that can be enhanced by working together rather than in isolation or competition.

This is intended to deliver the following benefits, outlined in **Table 1**.

Table 1: Benefits of Health Service Partnerships

Benefit	Health Service Partnerships actions
Share expertise	Bring together leadership, insight and specialised skills from across a region.
Achieve scale and coordination	Reduce implementation costs for priority initiatives through avoiding duplication of effort and enabling greater scale, specialisation and load sharing.
Create common goals	Support health services to take on collective accountability for a small number of system goals, while maintaining health service accountability for individual performance.

While Regional Area Health Partnerships will be superseded by Health Service Partnerships (see **Section 7**), Local Area Health Partnerships will continue in rural and regional Victoria. They are designed to drive local collaboration at a more operational level, while also supporting the implementation of Health Service Partnership priorities in their local area.

6. Principles of Health Service Partnerships

The principles outlined in **Table 2** should guide all Health Service Partnerships.

Table 2: Principles of Health Service Partnerships

Principle	Overview
Collaboration and consensus	All health services are members of a Health Service Partnership. Health Service Partnership members demonstrate inclusivity, partnership and collaboration in ways that are stable and enduring – not person-dependent and time limited. All members take responsibility for participating in the Partnership, reaching consensus-based decisions as a group, taking multiple points of view into consideration and compromising to move forward on broader shared aims.
Support and solidarity	Health Service Partnership members look for strategic opportunities to jointly work together to achieve consistency and reduce duplication of effort and resources on an ongoing basis, and to come to each others' aid in an emergency – offering, asking for, providing and receiving support in turn.
Rapid response	Health Service Partnerships respond rapidly to emerging issues by enabling efficient, consistent and representative engagement and decision-making in an emergency and on an ongoing basis.
Local networks	Health Service Partnerships establish and use local connections to serve their communities and meet local needs.
Better outcomes for the region	Health Service Partnerships operate in the interests of achieving better health outcomes for communities across a geographic area, with decisions on strategic priorities made at a regional level, rather than at an individual health service level. Skills and resources are shared amongst member services, seeking economies of scale to enable reinvestment of efficiencies in more and better patient care.

7. Transition from existing partnership arrangements

Health Service Partnerships will build on, expand and accelerate existing collaboration efforts between health services, including clusters and Regional Area Health Partnerships.

Transition from health service clusters

From 1 July 2021, Health Service Partnerships will replace metropolitan and regional health service clusters. The membership, work and leadership of clusters will transition to Health Service Partnerships.

Initial alignment of health services to Health Service Partnerships from 1 July 2021 is largely continuous with cluster memberships (see **Appendix A**: Initial Health Service Partnership membership and alignments).

Regional Health Service Partnerships

Rural and Regional Health Partnerships

From 1 July 2021, the regional component of Rural and Regional Health Partnerships (Regional Area Health Partnerships) will be integrated into the Health Service Partnerships. The generally subregional component of Rural and Regional Health Partnerships (Local Area Health Partnerships) will be delivered in accordance with these guidelines, with any variation from the Health Service Partnership model noted throughout.

The previous *Rural and Regional Health Partnership guidelines* will be superseded by the *Health Service Partnership policy and guidelines* from 1 July 2021.

From 1 July 2021, funding for Regional Area Health Partnerships will be provided to rural and regional Health Service Partnerships for their management and oversight.

Any reprioritisation of funded workplans following the transition from Rural and Regional Health Partnerships to Health Service Partnerships must be discussed and agreed with the department's regional office leads. In general, Rural and Regional Health Partnerships projects that have already been provided with time-limited funding for specific purposes by the department should transition from the Rural and Regional Health Partnerships to the Health Service Partnerships and continue through to completion, with delivery and reporting continuing as normal.

Further detail on reporting is detailed in **Section 12.**

Local Area Health Partnerships

Funding for Local Area Health Partnerships will continue. While Local Area Health Partnerships may work on initiatives that fall outside the Health Service Partnership priorities, workplans should be coordinated and aligned at the Health Service Partnership level to maximise impact and avoid duplication.

Local Area Health Partnerships will continue to report to the department on their work plan, as detailed in **Section 12**. To support coordination and alignment of workplans in the region, Local Area Health Partnerships are encouraged to provide workplan updates at Health Service Partnership meetings.

The department reserves the right to redirect Local Area Health Partnership funding if these Guidelines are not followed or if reporting identifies that progress and outcomes are not being achieved through current arrangements. Any funding decisions of this nature will be made following discussion with the Local Area Health Partnership.

The list of Local Area Health Partnerships is at **Appendix B**. The department will work through this transition with each partnership, including updating work plans and reporting processes.

Other local arrangements

Rural and regional health services will remain active members of their respective ICT Alliances, which may support Health Service Partnership priorities where they correspond with directions under *Victoria's Digital Health Roadmap*.

Health services will also continue to meet the requirements of the *Rural public health care agencies' ICT alliance policy* and continue to uphold obligations under ICT Alliance Joint Venture Agreements.

Local governance arrangements may be brought into their Health Service Partnership if agreed by the relevant parties, including with the department.

The Review of the Health Service Partnership model in late 2022 will also consider Health Service Partnership's alignment with other local governance arrangements.

8. Priorities for Health Service Partnerships

All Health Service Partnership will work on a small number of strategic system priorities that can be enhanced by working together, rather than in isolation or competition. These priorities consist of:

1. **System-wide reform priorities** determined annually by the Victorian Government.
2. **Local priorities** agreed by the Health Service Partnership.

System-wide reform priorities

The Minister for Health (the Minister) will write to health service Board chairs annually to convey these priorities, and they will be reflected in each health service's Statement of Priorities (see **Section 10**).

Health Service Partnerships will develop plans for priorities as identified by the Minister, to be submitted to the department, outlining activities to be undertaken to achieve outcomes and identifying how any Health Service Partnership funding will be spent.

Local priorities

Health Service Partnerships can choose to also work on locally identified priorities. These will be determined by Health Service Partnership members in collaboration with stakeholders, based on local population needs.

Not all members of the Health Service Partnership need to be involved in work on additional agreed priorities. However, such priorities must be selected by consensus if they require the use of Health Service Partnership resources.

Regional Health Service Partnerships

If agreed by the Health Service Partnership, Local Area Health Partnerships may be engaged to lead Health Service Partnership priorities. Local Area Health Partnerships may also progress their own priorities where these are aligned with the Health Service Partnership priorities and the existing Key Activity Areas (KAAs), as outlined below. Local Area Health Partnership specific priorities and workplans are to be agreed to using the consensus model within that membership group.

Key Activity Areas

17Health Service Partnership priorities will supersede the three KAAs that previously constituted the priorities of Rural and Regional Health Partnerships (see Error! Reference source not found.). However, Health Service Partnerships and Local Area Health Partnerships should strongly consider these KAAs as part of their planning processes, and actively support regional and rural members to strengthen these KAAs in the effective delivery of Partnership priorities.

Existing projects currently underway should be reviewed to determine alignment with Health Service Partnership priorities.

Table 3: Key Activity Areas to be supported and strengthened in the delivery of Health Service Partnership priorities in rural and regional settings

Key Activity Area	Outline
Clinical governance support	Health Service Partnerships will help optimise arrangements for clinical governance, to support smaller health services. They will provide additional system support to ensure the delivery of high quality and safe services to patients as an integral part of delivering priorities.
Workforce	Health Service Partnerships will provide a platform for recruiting, maintaining and retaining a healthcare workforce with the skills and capacity to deliver priorities across their region.
Corporate effectiveness	Health Service Partnerships will identify and develop efficient approaches to managing common operational needs, challenges and risks across its services.

9. Partnership structure and management

Health Service Partnership operations should be guided by the principles outlined in **Table 2**.

The Health Service Partnership model aims to strengthen health service collaboration but does not alter system governance. There will be no changes to the existing structures, roles and reporting lines of health service chief executives and their Boards, which will remain independent entities.

There will also be no change to the process for health services wishing to pursue amalgamations, which will remain wholly voluntary processes instigated and led by health services. They will proceed with government support only where extensive community consultation and due diligence has occurred and where voluntary amalgamation will result in the provision of better health services in Victoria and is otherwise in the public interest.[2]

[2] *Health Services Act 1988* (Vic), s 64A(3).

Membership

The Health Service Partnership mandated membership will comprise the Chief Executive Officers (CEOs) of all Victorian public health services, multi-purpose services, and public, metropolitan and denominational hospitals within their Health Service Partnership's geographical region. Each health service will be a member of one Health Service Partnership.

From 1 July 2021, all public health services within Victoria will be active Health Service Partnership members. Initial Health Service Partnership membership is outlined in **Appendix A**.

Public health service members (CEOs) will represent their organisations but must consider the objectives of the region and needs of communities within the region to ensure collaborative and consensus-based decision making in pursuit of these objectives is achieved.

The core membership of Local Area Health Partnerships will continue to comprise the CEOs within their designated sub-region. Local Area Health Partnership membership is outlined in **Appendix B**.

Moving Health Service Partnership

Until 31 August 2021, as part of Health Service Partnership establishment, a health service may indicate to the department its intent to explore and potentially seek formal permission to move to another Health Service Partnership, where doing so would better enable implementation of system-wide reform priorities.

Moving Health Service Partnership may be a complex process and will need to be worked through carefully over some time and require staged implementation. Agreement in principle should be reached with both Health Service Partnerships involved, based on the interests of the patient populations concerned, before a formal request is made.

Specialist Services

Specialist service providers play a critical role in Victoria's health system and need to be accessible to all Victorians requiring specialist treatment and support.

While there are unique features to each of the specialist health services, there are commonalities amongst the services that warrant a consistent approach to their involvement in Health Service Partnerships.

Recognising the active contribution they have made to clusters, specialist services will continue to be full and active members of Health Service Partnerships, with the same participation requirements and responsibilities as other members. Health Service Partnerships will provide specialist health services the opportunity to expand the collaborative practices already established and provide a platform to support and strengthen their local responsibilities.

Specialist service providers will be designated members of a Health Service Partnership based upon their geographic location. Membership will not impact the role or service provision responsibilities of statewide specialist services, or their relationships with referring services.

Specialist services are also encouraged to continue meeting as a separate group to collaborate and develop advice on statewide issues and can engage directly with the department on this as required.

Health Service Partnership Structure

Each Health Service Partnership will have a leadership group comprising member CEOs. One will act as a lead or chair, with responsibility for coordination between member health services.

Other health services within a Partnership may take on the leadership of specific reform priorities, by agreement amongst the members. These arrangements may be recorded in the Health Service Partnership's Terms of Reference.

Metropolitan Health Service Partnerships

Metropolitan Health Service Partnerships will have a two-year rotating chair. On establishment, existing metropolitan cluster chairs will continue as Health Service Partnership chairs for two years (until 30 June 2023). The Partnership will nominate a proposed successor, by consensus, to the department for endorsement at least three months before the two-year tenure expires.

Regional Health Service Partnerships

Existing regional cluster leads will continue in their role as leads of the new Health Service Partnerships.

Regional Health Service Partnerships can elect to have a Deputy Lead from a health service other than the Health Service Partnership lead health service. Deputy Leads can be rotated biennially. The Partnership will nominate a proposed successor, by consensus, to the department for endorsement at least three months before the two-year tenure expires.

For Local Area Health Partnerships, the Lead remains unchanged and is noted in **Appendix B**. The Local Partnership may choose to change their Lead or the department may instigate Lead change discussions if outcomes are not being achieved in accordance with agreed workplan.

Health Service Partnership Management

Health Service Partnership members must agree a Terms of Reference (a template is provided at **Appendix C**) which may include:

- clear documentation of the membership, responsibilities and expectations of members
- governance, consensus decision-making and dispute resolution arrangements
- a committee and accountability structure for designated reform priorities
- agreed mechanisms for monitoring, measuring and reviewing progress of the partnership development, activity and outcomes.

Decision making

All members of the Health Service Partnership are expected to participate meaningfully and effectively in meetings and to collectively achieve decision-making by consensus.

For the purposes of these Guidelines and expectations of Health Service Partnership members, consensus-based decision-making is defined as:

Decisions must be made with the active involvement, input and consideration of all member health services, and involve all reasonable efforts to achieve universal agreement. In circumstances where this is not possible, decisions may be made on a majority basis but will be subject to dispute and escalation processes described in these Guidelines (detailed in **Appendix D**).

Meetings

Existing CEO forums, Board Chair meetings, and performance meetings across all layers of the system will remain in place, enabling ongoing direct engagement between all services and the department. The Health Service Partnership Chairs and Leads Forum (HSP Forum) with the department will provide an additional forum for strategic decision-making specifically in relation to defined priorities, with Health Service Partnership Chairs/Leads accountable for transparent communication with, and effective representation of, all their members' views.

A twice-yearly Statewide Health Service Partnership Forum (Statewide HSP Forum) will be established, succeeding the existing quarterly RRHP Forum and complementing the Health Service Partnership Chairs and Leads Forum. The Statewide HSP Forum will be opt-in, and open to participation from all health service CEOs and Health Service Partnership executive and project leads. Its purpose will be to support collaboration and sharing of learnings on Health Service Partnership priorities across Victoria.

10. Establishment and resourcing

The department has taken a long-term approach of providing funding to support collaboration in the interests of achieving better outcomes and a more efficient health system, through Rural and Regional Health Partnerships. In 2021-22 and 2022-23, dedicated establishment funding will be provided to support the stand up of Health Service Partnerships statewide.

Health Service Partnership -related roles and functions can be distributed across the Health Service Partnership to support the growth of skilled people in services across the local region.

Decisions on Health Service Partnership funding beyond 2022-23 will be made following the Review of the Health Service Partnership model in late 2022, with the Review to evaluate delivery and outcomes of funding to date, and appropriate levels of funding going forward.

Health Service Partnerships may receive dedicated funding for certain specific initiatives and will be required to progress others within internal resources. For specified priorities, funding for clinical activity will typically be allocated to individual health services within Health Service Partnerships, with funding for redesign and improvement flowing to a nominated health service to administer on behalf of all members.

Regional Health Service Partnerships

Regional Area Health Partnership funding will continue; however, funding will be provided to the local Health Service Partnership for their management and oversight. Local Area Health Partnership funding will continue unaffected, as detailed in **Section 7.** Regional Area Health Partnership and Local Area Health Partnership funding will be additional to the establishment funding for Health Service Partnerships provided in 2021-22 and 2022-23. This is in recognition of the ongoing need for collaboration to address the significant challenges distinct to rural and regional health, including greater workforce shortages, less infrastructure and reduced access to health services than people in metro areas.

Regional Area Health Partnership and Local Area Health Partnership funding spent not for the purpose stated in these Guidelines is subject to recall.

Health Service Partnerships can choose to aggregate their Health Service Partnership and Local Area Health Partnership funding with the consent of all members. Aggregation of funding should not

displace the role of subregional and other health services taking up leadership roles in delivery of Health Service Partnership priorities. The department does not require funding to be aggregated, but considers such a decision, where taken locally, to be well-aligned with the broader principles of Health Service Partnerships in improving scale and coordination of priorities.

11. Roles and responsibilities

The roles and responsibilities of health services, the Health Service Partnership chair/lead, and the department are detailed in **Table 4** below.

As stated in **Section 4**, the Health Service Partnerships model preserves the local autonomy and responsibility of health services. There will be no changes to the existing roles and reporting lines of health service chief executives and their Boards, which will remain independent entities. Health services will continue to retain responsibility for their performance against Statements of Priorities, including management of budget and finances, along with clinical service delivery and clinical governance.

Table 4: Roles and responsibilities

Entity	Summary of responsibilities
Health Service Partnership members	• Leadership of priorities, where those priorities have been identified and their leadership approach has been agreed upon by members. • Actively participate and collaborate with all members of the Partnership. • Support consensus decision-making. • Participate in the development of joint priority plans. • Partner with relevant organisations on relevant priorities of interest. • Engaging other stakeholders and relevant interested parties for specialist projects that require specific knowledge, expertise and input depending on the priorities being pursued. • Support the Health Service Partnership to deliver on shared objectives.
Additional roles and responsibilities of the Health Service Partnership Chair/Lead	• Overarching coordination of the Partnership in accordance with the agreed Health Service Partnership Plan. • Proactively engage all Partnership members and ensure that all members' voices are included within the Health Service Partnership. • Build collaboration within the Partnership and forge consensus. • Advance the collective interests of members. • Facilitate two-way information sharing between the department and members on Partnership issues and priorities. • Lead planning and reporting requirements, including submitting Health Service Partnership annual plans and annual reports to the department on behalf of the collective membership. • Provide leadership and guidance to project management staff. • Share knowledge and learning between Health Service Partnerships through the Health Service Partnership Leads/Chairs Forum, and other mechanisms that may be determined collectively by Leads. • Mediate disputes within the Partnership.

Entity	Summary of responsibilities
Additional roles and responsibilities of the Rural and Regional Health Service Partnership Deputy Lead (where appointed)	• Assume the role of the Partnership Lead in the event they are unable to fulfil their duties. • At the request of the Partnership Lead, support them in their performance and responsibilities.
Department of Health	• Assign system-wide priorities on behalf of the Victorian Government and define universal requirements in health service Statements of Priorities. • If requested by the Health Service Partnership, attend Health Service Partnership meetings as an observer. • Oversee Health Service Partnership progress towards identified priorities. • Administer the *Health Service Partnership policy and guidelines* and undertake periodic review and updates as required. • Convene Health Service Partnership Chair and Leads Forum meetings that specifically focus on progress against defined priorities, and ensure that these meetings are not used as channels for communication with health services on broader issues. • Establish and maintain a clear and accessible escalation pathway for issues that cannot be resolved within a Partnership, as defined in **Appendix D**. • Manage individual health service performance in relation to Health Service Partnership accountabilities.

Escalation pathway

All entities will be responsible for fostering collaboration and decision-making by consensus within Health Service Partnerships. The department will also be responsible for maintaining a clear and accessible escalation pathway with clear escalation thresholds (as detailed in **Appendix D**), which Health Service Partnership members will be able to activate under exceptional circumstances should they feel that consensus-based decisions are not being reached, and which remain unresolved following trouble shooting and peer mediation efforts within the Health Service Partnership.

12. Planning, reporting and accountability

Work Planning

Each Health Service Partnership is required to develop an annual rolling work plan for endorsement by the Secretary, Department of Health by 30 September each year. The work plan will detail:

- the strategies and actions the partnership will undertake against each of the system-wide priorities
- local priorities identified and agreed at the time of plan completion
- the responsible health service or partnership sub-committee (or other mechanism) responsible for leading each action

- the responsibilities of members in relation to progressing these actions, including actions to strengthen the Key Activity Areas for rural and regional members (clinical governance support; workforce; and corporate effectiveness)
- the quantifiable measure by which the Partnership will evaluate progress and success
- how Health Service Partnership funding is expected to be allocated.

Reporting

The rolling annual work plan will form the basis of reporting to the department. Reporting will involve submission of the Health Service Partnership endorsed work plan and six-monthly reporting against the identified actions on or before the dates noted in **Table 5**. Updates on specific initiatives will also form discussions with health services as part of performance meetings with the department.

A Work Plan Reporting template is included at **Appendix E**. This report is a high-level summary of the priorities the partnership has identified.

Table 5: Reporting Schedule

Reporting Schedule	Due Date (annual)
Health Service Partnerships: Annual Work Plan Partnership endorsed work plan provided to the **Secretary, Department of Health**.	30 September
Half Year Report Progress report to **Deputy Secretary, Commissioning and System Improvement, Department of Health** against Work Plan. This report should include: • key activities and outcomes achieved • a short (1/2 page) narrative describing the progress and evolution of the Partnership over the past 6 months • financial report • any Health Service Partnership related staffing and FTE.	28 February
Annual Report Annual Report to **Deputy Secretary, Commissioning and System Improvement, Department of Health**. This report should include: • summary and actions from Partnership assessment (recommended) • key activities and outcomes achieved • additional funding or other resources attracted through the Partnership • a short (1 page) narrative describing the progress and evolution of the Partnership over the preceding financial year. • financial report • any Health Service Partnership related staffing and FTE.	31 July

Completed reports are to be submitted to the Department of Health Deputy Secretary, Commissioning and System Improvement by the dates indicated. Health Service Partnership Chairs/Leads may seek prior approval to extend a specific submission deadline, which the department Health Services Lead (metropolitan Partnerships) or the Regional Manager, Rural

Health Performance (rural Partnerships) may grant at their discretion where exceptional circumstances exist that would prevent a complete and timely submission.

Local Area Health Partnership reporting requirements are the same as those outlined for the Health Service Partnership. Local Area Health Partnerships are encouraged to provide updates to their Heath Service Partnership on their workplan to support coordination and alignment with their Health Service Partnership.

Accountability

The members of each Health Service Partnership are jointly accountable to the department for the development and timely submission of Health Service Partnership annual plans and reports.

All health services are accountable to each other and to the department for their active and meaningful participation in the Health Service Partnership.

Health services are also individually accountable through their Statement of Priorities for their active participation in Health Service Partnerships, including joint accountability for meeting the planning and reporting requirements set out in this document.

13. Engagement and consultation

System partners

Health Service Partnerships will need to engage and collaborate with other organisations and agencies (**Table 6**), in order to deliver system-wide reform priorities and identify local priorities.

These parties can be formal members of the Partnership participating in decision-making, but they are not required to be. The Health Service Partnership should engage them in relevant meetings, activities or initiatives as required.

Table 6: Potential interested parties

Aboriginal Controlled Community Health Organisations (ACCHOs)	ACCHOs play an important role in the delivery of equitable and patient-centred care. Health Service Partnership collaboration with them is important to drive alignment and collaboration on shared population health priorities across sectors.
Community health (registered standalone community health services)	Community health brings local community knowledge and ensures the needs of vulnerable populations are reflected in population health priorities To deliver the best continuity of care for patients, community health will be fundamental to partnership-based models that integrate hospital care with community services.
Health services from other Health Service Partnerships	Some health services may have existing relationships with a Health Service Partnership of which they are not members, or have patient flows, or catchments that are not aligned with their current Health Service Partnership. Health Service Partnerships are encouraged to stay engaged with these health services to ensure that any priorities identified, or changes implemented do not adversely affect their operations. On occasion, they may request or be invited to attend meetings in an

	observer capacity and/or have access to meeting papers and minutes with the Partnership's permission.
ICT Alliances	Rural and regional health services will remain active members of their respective ICT Alliances and continue to meet the obligations under the Alliance JVAs, which may support Health Service Partnership priorities where they correspond with directions under *Victoria's Digital Health Roadmap*.
Local government	Health Service Partnerships can engage with local governments within their region to help identify potential priorities for their local communities, and appropriate opportunities to collaborate in addressing social determinants of poor health and delivering holistic service responses.
Local Public Health Units (LPHUs)	LPHUs are an important and evolving part of regional service arrangements alongside the developing Health Service Partnerships. Whilst the LPHU is the responsibility of one or two of the Health Service Partnership members, it is expected that the LPHU will work with Health Service Partnerships, in close liaison with the department, on relevant priorities.
Interim regional bodies/Regional Mental Health and Wellbeing Boards	The Royal Commission into Victoria's Mental Health System (RCVMHS) has outlined a vision for a completely different mental health system in Victoria, with fundamental reforms to governance, across all services, new service types, changes to planning, funding, monitoring and delivery. Implementing the recommendations of the RCVMHS is by necessity a shared priority for government and service providers. As implementation planning for RCVMHS recommendations progresses, further advice will be provided on the sequencing and staging of reforms. In particular, the relationship between Health Service Partnerships and the interim regional bodies (which will be replaced by future legislated Regional Mental Health and Wellbeing Boards) will evolve, and these guidelines will need to be updated accordingly. The interim regional bodies are being established from mid 2021, and Health Service Partnerships will be engaged as these bodies are established, to ensure alignment and a coordinated approach to mental health reform.
Primary Health Networks (PHNs)	PHNs represent primary healthcare providers and aim to better integrate service delivery across primary, secondary and tertiary healthcare providers. Health Service Partnerships are not required to include PHNs, due to their focus on hospital collaboration. However, the inclusion of PHNs is encouraged as key stakeholders for Health Service Partnerships given the critical commissioning role that they play in the primary care sector and health system overall.
Private hospitals	Within Health Service Partnerships, private hospitals will contribute increased capacity when urgently required as part of the pandemic response, and also work with the public health system to address ongoing inequities in access, such as elective surgery, and drive better population health outcomes.

Consumer engagement

Health Service Partnership members are expected to engage with consumer representatives throughout planning and implementation of priority responses, as well as on strategic directions of the Partnership. Existing consumer engagement mechanisms can be used for this purpose, and the Health Service Partnership may invite consumer representative/s to participate in relevant meetings.

Clinician engagement

Health Service Partnership members are expected to engage with clinician representatives throughout the planning and implementation process, and on strategic directions. The Health Service Partnership can use existing local clinician engagement mechanisms to achieve this, and may also invite clinician representative/s to participate in relevant Partnership meetings.

14. Measuring partnership effectiveness

Measuring the strength and development of a partnership is important to ensure the development of a systematic and sustainable platform for collaboration for the long term.

As part of annual planning and reporting, all partnerships are encouraged to complete *The partnerships analysis tool*, developed by VicHealth for organisations entering into or working in a partnership to assess, monitor and maximise its ongoing effectiveness, in order to measure their overall strength and effectiveness: see *The partnerships analysis tool* <https://www.vichealth.vic.gov.au/media-and-resources/publications/the-partnerships-analysis-tool>.

Health Service Partnership Leads are encouraged to include a summary of the results and agreed actions arising from the partnership analysis in their Health Service Partnership's annual plan, and a summary of progress against these actions in the Health Service Partnership's annual report.

15. Review of the Guidelines

The Health Service Partnership model will be reviewed during 2022-23. The rural and regional Local Area Health Partnerships will be reviewed in parallel. These Guidelines and related policy documentation will be updated to reflect improvements and changes to the model arising from this, and any future, reviews.

16. Appendix A: Initial Health Service Partnership membership and alignments

Metro HSPs *Chair agency			Rural and Regional HSPs *Lead agency				
Northeast Metro	**Southeast Metro**	**Western Metro**	**Barwon South West**	**Grampians**	**Loddon Mallee**	**Hume**	**Gippsland**
Austin Health*	Monash Health*	The Royal Melbourne Hospital*	Barwon Health*	Ballarat Health Services*	Bendigo Health*	Goulburn Valley Health*	Latrobe Regional Hospital*
Eastern Health	Alfred health	Peter MacCallum Cancer Institute	Casterton Memorial Hospital	Beaufort & Skipton Health Service	Boort District Health	Albury Wodonga Health	Bairnsdale Regional Health Service
Mercy Hospital for Women	Calvary Health Care Bethlehem	The Royal Children's Hospital	Colac Area Health	Central Highlands Rural Health	Castlemaine Health	Alexandra District Health	Bass Coast Health
Northern Health	Peninsula Health	The Royal Women's Hospital	Great Ocean Road	East Grampians Health Service	Cohuna District Hospital	Alpine Health	Central Gippsland Health Service
St Vincent's Hospital		Werribee Mercy Hospital	Hesse Rural Health	East Wimmera Health Service	Echuca Regional Health	Beechworth Health Service	Gippsland Southern Health Service
Royal Victorian Eye and Ear Hospital		Western Health	Heywood Rural Health	Edenhope & District Memorial Hospital	Heathcote Health	Benalla Health	Kooweerup Regional Health Service
			Moyne Health Services	Maryborough District Health Service (TBC)	Inglewood & Districts Health Service	Corryong Health	Omeo District Health
			Portland District Health	Rural Northwest Health	Kerang District Health	Kilmore & District Hospital	Orbost Regional Health
			South West Healthcare	Stawell Regional Health	Maldon Hospital	Kyabram & District Health Service (TBC)	South Gippsland Hospital
			Terang & Mortlake Health Service	West Wimmera Health Service	Mallee Track Health and Community Service	Mansfield District Hospital	West Gippsland Healthcare Group
			Timboon & District Healthcare Service	Wimmera Health Care Group	Mildura Base Hospital	NCN Health	Yarram & District Health Service
			Western District Health Service		Robinvale District Health Services	Northeast Health Wangaratta	
					Rochester & Elmore District Health Service	Seymour Health	
					Swan Hill District Health	Tallangatta Health	
						Yarrawonga Health	
						Yea & District Memorial Hospital	

17. Appendix B: Local Area Health Partnerships

The table below summarises the specific requirements for the regional and rural Local Area Health Partnerships, where different to the Health Service Partnership model. It also details which aspects of the Guidelines apply across both models.

Theme	Alignment or variation to Health Service Partnership model
Purpose	To drive local collaboration at a more operational level, while also supporting the implementation of Health Service Partnership priorities in their local area.
Principles	No variation.
Priorities	Align with Health Service Partnership priorities and KAAs.
Structure and management	Core membership as outlined below. Existing MoU can be retained. Health services may be a member of more than one Local Area Health Partnership where this has been agreed by members.
Establishment and resourcing	No additional establishment funding. The department reserves the ability to alter funding arrangements if the Guidelines are not followed and outcomes are not being achieved.
Roles and responsibilities	No variation.
Planning, reporting and accountability	No variation.
Engagement and consultation	No variation.
Measuring partnership effectiveness	No variation.

Local Area Health Partnerships *Lead agency				
Barwon South West	**Grampians**	**Loddon Mallee**	**Hume**	**Gippsland**
Barwon Barwon Health* Colac Area Health Great Ocean Road Hesse Rural Health **Great South West** South West Healthcare* Casterton Memorial Hospital Heywood Rural Health Moyne Health Services Portland District Health Terang & Mortlake Health Service Timboon & District Healthcare Service Western District Health Service	**Central Highlands** Ballarat Health Services* Beaufort & Skipton Health Service Central Highlands Rural Health East Grampians Health Services East Wimmera Health Services Maryborough District Health Service Stawell Regional Health **Wimmera Southern Mallee** West Wimmera Health Service* Edenhope & District Memorial Hospital Rural Northwest Health Wimmera Health Care Group	**Loddon** Bendigo Health* Maldon Hospital Castlemaine Health Central Highlands Rural Health Heathcote Health Boort District Health Inglewood & Districts Health Service East Wimmera Health Services Maryborough District Health Service **Murray** Echuca Regional Health* Cohuna District Hospital Swan Hill District Health Kerang District Health Kyabram & District Health Services Rochester & Elmore District Health Service **Mallee** Mildura Base Hospital*	**Goulburn** Goulburn Valley Health* Alexandra District Health Kilmore & District Hospital Kyabram & District Health Services NCN Health Seymour Health Yea & District Memorial Hospital **Upper Hume** Albury Wodonga Health* Beechworth Health Service Corryong Health Tallangatta Health Service **Hume Central** Northeast Health Wangaratta* Alpine Health Benalla Health Mansfield District Hospital Yarrawonga Health	**Central Gippsland** Latrobe Regional Hospital* Central Gippsland Health Service West Gippsland Healthcare Group Yarram and District Health Service **East Gippsland** Bairnsdale Regional Health Service* Omeo District Health Orbost Regional Health **South Coast Gippsland** Bass Coast Health* Gippsland Southern Health Service South Gippsland Hospital Kooweerup Regional Health Service

		Mallee Track Health and Community Service Robinvale District Health Services Swan Hill District Health		

19. Appendix C: Template Health Service Partnership Terms of Reference

The following can be altered by the Health Service Partnership to best suit the needs of the group. Agreement by all members is required before finalisation of the Terms of Reference.

Membership

Members of:	*< name of Health Service Partnership>*
Name of Health Service Partnership Chair/Lead:	*xx*

List of members

Name of CEO:	**Name of Health Service:**
Xx	*xx*
Xx	xx

Other stakeholders and interested parties may be invited to participate in the work of the Health Service Partnership or attend on a meeting-by-meeting basis in relation to agenda items of relevance, should members agree.

Meetings

All meetings are to be chaired by the Health Service Partnership Chair/Lead unless otherwise delegated prior to the meeting.

The Health Service Partnership will meet <*how often*> for <*specify time*> at <*specify location*>. If required, subgroup meetings will be arranged outside of these times at a time and location convenient to subgroup members.

Other stakeholders are expected to attend Health Service Partnership meetings upon invitation if relevant.

A meeting quorum will be *<insert number>* members of the Health Service Partnership group.

Where group agreement or endorsement of an Agenda item is required, decision making will be on a consensus basis. In the event where consensus cannot be achieved, a majority of members will suffice.

Meeting agendas minutes will be provided by <*secretariat*>. This includes preparing and distributing agendas, supporting papers, meeting notes and information.

Approval of the previous meeting's minutes will be an agenda item for each meeting. The draft minutes of a meeting shall be distributed to all members no later than five working days after the meeting (noting that these minutes will only be endorsed at the subsequent meeting). Meeting minutes are to be shared with the Department of Health once approved by members.

An agenda and other relevant documents will be circulated at least two days prior to each meeting.

All paid employees of an organisation will be attending as representatives of their organisation and as such, will not receive payment or reimbursement.

Secretariat

The Health Service Partnership may choose an alternate secretariat process

An Action Log and Meeting schedule will be recorded and managed by the Secretariat.

Secretariat functions will be provided by the Health Service Partnership Chair/Lead's health service.

Proxy

Members are required to notify the Secretariat when there is an intention for a proxy or substitute to represent the member at any Health Service Partnership Chairs meeting or to undertake any delegate Health Service Partnership Chair/Lead role or responsibility.

Observers

A Department of Health employee may attend Partnership meetings as an observer, if requested and agreed by the Health Service Partnership.

Dispute resolution

The Health Service Partnership recognises and values the diversity of members and seeks to anticipate and resolve differences in this spirit. The Health Service Partnership will operate in a manner whereby members are encouraged to openly express and discuss their concerns as part of the overall decision-making process.

Members will make shared decisions aimed at improving system level responses and health outcomes across the region, rather than at an individual health service level.

Health Service Partnership members must demonstrate inclusivity, partnership and collaboration in ways that are stable and enduring – not person-dependent and time limited. All members take responsibility for reaching consensus-based decisions as a group, taking multiple points of view into consideration and compromising to move forward on shared aims.

The Health Service Partnership Chair/Lead has overarching responsibility for advancing collective interests and resolving disputes within the Health Service Partnership, consistent with the Escalation Pathway defined in the *Health Service Partnership policy and guidelines*.

Tenure

The Terms of Reference is effective from <*insert start date*> and continues until replaced or terminated by agreement between Health Service Partnership members.

20. Appendix D: Escalation pathway

The escalation pathway outlined in the table below should be followed if:

- A member feels they were not appropriately included in planning or decision making;
- Consensus decision-making cannot be reached due to non-participation, obstruction or delays caused by one or more members; or
- A member fails to deliver on accountabilities previously agreed by the Health Service Partnership.

Step	Action	Responsibility	Timing
Attempt to resolve	Relevant Member CEO takes initiative to raise and attempt to resolve any issues inhibiting consensus decision-making	Initiating member CEO, and all relevant member parties	As soon as possible after issue has arisen
Within- Health Service Partnership peer mediation	The Health Service Partnership Chair/Lead may take any unresolved points to a meeting of the full representative membership for discussion to reach a consensus position	Chair/Lead	As soon as possible after initial attempt to resolve
Notification	Member CEO notifies Chair/Lead in writing (and copies Department of Health) of nature of concern, steps taken to resolve it, and precise issues which can't be resolved	CEO of aggrieved member service	As soon as possible after attempt to resolve through peer mediation is unsuccessful
Advice-seeking	If appropriate, Chair/Lead seeks advice from the Department of Health on any issue of departmental policy or procedure that may resolve the issue	Chair/Lead Department of Health – Director, Metro Performance and Improvement (metropolitan Partnerships) or the Directors, Rural and Regional Health (rural and regional Partnerships)	Within 3 working days of notification

Step	Action	Responsibility	Timing
Negotiation	Chair/Lead undertakes negotiation between aggrieved parties to reach a consensus position	Chair/Lead Where the Chair/Lead is a party to the dispute, the Health Service Partnership may agree to nominate another member CEO to lead the negotiation	Within 3 working days of notification OR response to advice-seeking
Cross- Health Service Partnership peer mediation	The Chair/Lead may take any unresolved issues to a meeting of the Health Service Partnership Forum (HSP Forum) to seek guidance and advice, to then take back to within-Health Service Partnership peer mediation	All member CEOs	Next HSP Forum (subject to timing and potential impact of delays)
Escalation	Any unresolved issues may be escalated in writing to the Department of Health Deputy Secretary, Commissioning and Service Improvement. To include the nature of dispute, a record of steps taken and the progress or outcomes achieved at each step, and precise points which can't be resolved	Chair/Lead	Within 3 working days of unsuccessful peer mediation
Support	The Department of Health will provide information, guidance, or a policy position as appropriate for members to use to reach a consensus position.	Deputy Secretary, Commissioning and Service Improvement. The Chair/Lead may also request support to facilitate of a further discussion between the parties.	Within 5 working days of escalation
Resolution	If the issue still remains unresolved, it may be submitted to the Deputy Secretary, Commissioning and Service Improvement, and a determination will be made by the Department of Health about how the situation is to be resolved.	Deputy Secretary, Commissioning and Service Improvement	Within 10 working days of re-submission

21. Appendix E: Work Plan and Reporting template

Health Partnership Work Plan and Reporting template 20XX-20XX

Partnership Name	<Name of partnership>		
Membership	<List all partnership members>		
Partnership Assessment – summary and actions		Assessment score*	
Partnership Priorities • Use the rows below to identify the agreed priorities of the partnership. Supporting documentation should be included where relevant; i.e. detailed project plans, implementation reports etc			
Priorities	**Key Activities** Activities undertaken during reporting period	**Agreed outcome / impact, target and measure** (to be agreed with DH Regional Manager) Annual report to include progress made	**Supporting Documentation** **(List attachments)**
System priority 1	<To be completed each reporting period>		<Background Info; Project Plans; Budget allocation; Implementation Reports; Other relevant info>
System priority 2			
System priority 3			
Local priority 4			

*As part of annual planning and reporting, Health Service Partnerships are encouraged to complete ***The partnerships analysis tool*** <https://www.vichealth.vic.gov.au/media-and-resources/publications/the-partnerships-analysis-tool> to assess monitor and maximise the Partnership's ongoing effectiveness. Further detail on The partnerships analysis tool is provided in the *Health Service Partnership policy and guidelines*.