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| Local Health Service Network  policy framework |
| Version 1.1 |
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Purpose and principles

## Background

The Health Services Plan (the Plan) was commissioned to provide recommendations for a more connected and equitable health services system. The Plan was developed by an expert advisory committee and released in August 2024, with Government accepting 26 of the 27 recommendations in full or in principle.

A key pillar of the reform is Local Health Service Networks (Networks) – geographic groupings of health services responsible for planning and managing care across their region.

## Purpose

Victoria has a high number of independent health services, working largely independently or in ad hoc partnerships to meet the needs of patients in their region. The Plan found this fragmented structure leads to significant challenges for patients, workforce and communities.

Networks are designed to build on previous collaboration structures, such as Health Service Partnerships, with greater accountability and more robust monitoring and oversight.

Each Network will have accountability for its defined catchment population, ensuring that their healthcare needs are met as close to home as possible. Health services within each Network will work together to comprehensively meet the needs of communities in their region, addressing issues which existing health services, working independently, can find challenging to deliver effectively on their own.

By enabling deeper collaboration across each region, Networks will support:

* equitable and consistent care for patients across their geography
* a consistent and coordinated approach to optimising workforce planning and management
* effective utilisation of health resources to deliver value for Victorians.

## Principles

The Plan outlined the following nine principles to guide the design, establishment, operation and oversight of Networks:

* People have choice to receive care as close to home as possible, taking into account safety and complexity.
* Care is easy to navigate and provided equitably along logical pathways, understanding how communities travel and interact.
* Health service sites have clear roles and responsibilities for different levels of service provision, aligned to their scale and capability.
* Engagement with patients and the local community is enhanced to support local customisation and responsiveness to community need.
* A skilled and diverse workforce is attracted, retained and supported, including through collaboration on recruitment, training and research.
* Care pathways are seamless, with greater integration across primary, acute and aged care, Aboriginal health, mental health and alcohol and other drug services.
* The health services system is accountable, collaborative, transparent and informed, to support the outcomes that matter to patients.
* Resources are used effectively, minimising unnecessary duplication and administration to deliver value for Victorians.
* The health services system continuously improves and is flexible and adaptable in response to change.

# Design and configuration

## Design approach

Networks will group health services together within a geographical region and are responsible for delivering better care, as close to home as possible – including coordinating clinical services and attracting and retaining the right workforce.

Each Victorian public health service will retain its name, local leadership, identity and connection to its community. Health services will work together in a Network to provide greater access to services, closer to home.

Within each Network, health services should collaborate in the planning and delivery of care and share resources wherever appropriate to better meet the needs of their communities. If patients require routine care, it should be delivered as close to home as possible, in a timely way and under consistent governance for quality and safety.

If patients have more complex care needs, they should have easier access to high complexity and specialist services, including the most appropriate technology and treatments from hospitals and specialist staff capable of providing for these needs, by design.

## Groupings

Network groupings were informed by a range of factors including population scale and growth, community need, clinical capability, transport routes and distance between services.

Networks are designed to enhance patient access and navigation. Groupings take into account population and geography to ensure that most residents can access the majority of their care within a 60-minute travel time.

Networks have been grouped with the aim of each Network achieving at least 85% self-sufficiency and provide a broad range of care through robust clinical governance arrangements. Additionally, Networks should improve patient flow and establish formalised referral processes to minimise the need to refer patients outside the Network.

Network groupings will also enhance operational scale to improve the efficiency and sustainability of shared services and reduce duplication. These groupings will support opportunities to improve recruitment and retention of skilled staff and support education, training and research programs and opportunities. A full list of the design considerations used to inform network groupings is provided in the **Appendix**.

Table 1 Local Health Service Network groupings

|  |  |
| --- | --- |
| Local Health Service Network | Health services |
| Barwon | Barwon Health, Colac Area Health, Great Ocean Road Health, Hesse Rural Health Service |
| Bayside | Alfred Health, Bass Coast Health, Calvary Health Care Bethlehem, Gippsland Southern Health Service, Kooweerup Regional Health Service, Peninsula Health |
| East Metro and Murrindindi | Alexandra District Health, Eastern Health, St Vincent’s Health, Yea and District Memorial Hospital |
| Gippsland | Bairnsdale Regional Health Service, Central Gippsland Health Service, Latrobe Regional Hospital, Omeo District Health, Orbost Regional Health, South Gippsland Hospital, West Gippsland Healthcare Group, Yarram & District Health Service |
| Grampians | Beaufort & Skipton Health Service, Central Highlands Rural Health, East Grampians Health Service, East Wimmera Health Service, Grampians Health, Maryborough District Health Service, Rural Northwest Health, West Wimmera Health Service |
| Hume | Albury Wodonga Health, Alpine Health, Beechworth Health Service, Benalla Health, Corryong Health, Goulburn Valley Health, Kyabram District Health Service, Mansfield District Hospital, NCN Health, Northeast Health Wangaratta, Tallangatta Health Service, Yarrawonga Health |
| Loddon Mallee | Bendigo Health, Boort District Health, Cohuna District Hospital, Dhelkaya Health, Echuca Regional Health, Heathcote Health, Inglewood and Districts Health Service, Kerang District Health, Mallee Track Health and Community Service, Mildura Base Public Hospital, Robinvale District Health Services, Rochester & Elmore District Health Service, Swan Hill District Health |
| North Metro and Mitchell | Austin Health, Mercy Health (Mercy Hospital for Women), Northern Health, Seymour District Health |
| Parkville | Oral Health Victoria, Parkville Youth Mental Health and Wellbeing Service, Peter MacCallum Cancer Centre, The Royal Children’s Hospital, The Royal Melbourne Hospital, The Royal Victorian Eye and Ear Hospital, The Royal Women’s Hospital |
| South Metro | Monash Health |
| South West | Casterton Memorial Hospital, Heywood Rural Health, Moyne Health Services, Portland District Health, South West Healthcare, Terang and Mortlake Health Service, Timboon and District Healthcare Service, Western District Health Service |
| West Metro | Mercy Health (Werribee Mercy Hospital), Western Health |

## Role delineation framework

One of the three pillars of reform included in the Plan isa Victorian role delineation framework.This will support collaboration across the system through setting out the roles and responsibilities of every health service site, aligned to their operational scale and capability – supporting clear pathways for care.

Role delineation will be further informed by an expanded suite of clinical capability frameworks that will define the minimum workforce, infrastructure and equipment requirements of each health service site, and play a pivotal role in creating a more connected and coordinated system.

## Relationships with a tertiary or regional tertiary, a women’s and a children’s hospital

Each Network will have a formalised relationship with a tertiary or regional tertiary hospital, a women’s hospital and a children’s hospital, where the Network does not include these kinds of complex care provider within their membership.

Formalised relationships should ensure each health service has timely access to tertiary, complex women’s and neonatal, and paediatric care for their patients. They should also support patients’ journeys which are clearer, better coordinated and less demanding on the patient and their families. ​

Once implemented, the relationship with a tertiary or regional tertiary hospital, a women’s hospital and a children’s hospital should support access to (subject to the specific needs of each Network):

* specialist expertise both virtually and physically, including to support care in place
* high complexity care, including a bed if needed, with the tertiary, regional tertiary, women’s or children’s hospital responsible for coordinating care if it does not have capacity
* step closer (step-up and step-down) care, with jointly agreed roles and responsibilities as patients’ care needs change
* advanced training and development, and joint arrangements for rotations and sharing of clinical staff
* clinical trials, clinical registries and research opportunities
* adoption of best practice, evidence-based care.

Policy and guidelines for relationships between Networks and tertiary or regional tertiary hospitals, women’s hospitals and children’s hospitals will be provided separately.

# Priority areas

Networks will be responsible for improving access to care and patient flow within their region, reducing variation in care quality and safety, and delivering consistent and coordinated workforce support. They should drive research and clinical excellence and deliver clinical and non-clinical support services efficiently. Networks will coordinate approaches for integration across the sector, support population health and address health inequities.

To meet these objectives, Networks will focus on priority areas. These are set by the Department of Health (the department) and will be implemented in tranches as Networks mature.

Initially, all Networks will focus on four priority areas:

* + - access, equity and flow
    - workforce
    - safety and quality
    - shared services.

These four priority areas were selected to align with the Plan’s design principles as well as the Institute for Healthcare Improvement’s quintuple aim of: enhancing patient experience, improving population health, strengthening workforce, advancing health equity and boosting efficiency.

Other priority areas involve broader networking across the system and will therefore be a focus for Networks as they mature. Priority areas for subsequent implementation include population health, integration, and research and innovation.

The department has set mandatory common initiatives to be delivered by all Networks, aligned with the objectives under each priority area. In addition, each Network will deliver local initiatives for each priority area. These initiatives and their parameters are outlined in each Network’s Statement of Expectations.

The objectives under each of the priority areas are provided in the following sections.

## Access, equity and flow

### Access and equity

Networks will aim to facilitate high-quality, connected care across logical pathways, to make it easier for communities to interact with, and navigate, the health services system.

Networks should allow health services to understand and address the health care needs of their defined catchment populations through comprehensive needs assessment, and development of regionally appropriate interventions in collaboration with other population health and public health providers.

Formalised connections should support communities with diverse needs to access care across the care continuum, with consistent and effective transitions of care. To do so, health services should coordinate with other elements of the broader health care system including primary care, non-acute mental health and alcohol and other drugs care, aged care and Aboriginal health.

### Patient flow

Logical patient flow is critical to ensuring timely access to care and reducing bottlenecks across the acute health system. Networks will play a key role in improving patient flow across their region and ensuring the great majority of care needs are met within region.

Networks will:

* improve patient access to care, with timelier transfers and more coordinated pathways
* undertake clinical service planning for their region, informed by population health data on the health needs of their community, as well as develop and implement region-wide mechanisms to better manage patient access and flow
* strengthen collaboration within their region to increase local access to care
* establish clear patient pathways, consistent transitions of care, and smoother inter-hospital transfers, to better manage chronic health needs and improve the use of existing capacity across the system
* review approaches to sharing patient information, enabling technology and workflows for opportunities to standardise approaches and improve care transitions.

In addition, Networks will be expected to develop regional mental health collaboration plans to improve coordination and integration with the non-acute mental health system. Prioritising this work early is driven by the ongoing imperative to reduce pressure on acute mental health and emergency departments and prioritise implementation of reforms following the Royal Commission into Victoria’s Mental Health System.

## Workforce

Networks will aim to take coordinated approaches to attract, develop and retain a skilled health workforce, including clinical and non-clinical staff. They should provide consistent region-wide workforce support through common approaches to recruitment, teaching, training, retention and resource sharing, such as staff rotations or pools.

Networks will establish consistent workforce data capturing, analytics and planning practices that support collaborative approaches to:

* attract and retain a skilled clinical and non-clinical health workforce
* reduce competition across the system for the same workforce
* support availability of workforce across health services and sites
* decrease reliance on locums and improve sustainability of workforce costs​
* provide consistent, region-wide support for training, professional development and career progression​.

## Safety and quality

Networks will aim to strengthen oversight of quality and safety through aligned and robust clinical governance models, as per the Victorian Clinical Governance Framework, to facilitate the delivery of accessible, high-quality care to Victorians, while ensuring services are closer to home and more effectively coordinated.​

Networks will:

* demonstrate and support collaborative and consistent clinical governance leadership at a Network level
* develop and implement shared clinical governance models and processes across all sites
* develop consistent approaches for managing safety, quality and risk at a health service and Network level
* support a coordinated approach to continuous quality improvements to clinical service delivery across the Network
* support a collaborative approach to sharing resources and learnings to expedite the translation of improvements and reduce unwarranted variations in clinical practice across the region.

## Shared services

Health services should improve the efficiency of resource utilisation and prioritisation within a Network. Networks will aim to decrease duplication of services and prevent unnecessary administration for health services and workforce. Shared services will ensure better use of available resources and minimise wasteful impacts. Shared resources should provide staff with wider access to clinical and research opportunities. Hospitals Victoria will work with health services to identify back-office functions that can be consolidated and streamlined to improve efficiency.

## Future priorities

As Networks mature, their priority areas will expand to include population health, integration, and research and innovation, in line with the recommendations of the Plan. Subsequent priority areas are outlined below.

### Population health

Networks will play an increasing role in population health, including understanding the care needs of priority populations and addressing these in collaboration with local organisations such as Primary Health Networks and Aboriginal Community Controlled Organisations. Networks will also have an increasing focus on early intervention for their population, both early in life and early in disease progression.

### Integration

#### Networks will improve integration with other parts of the health system, including primary health, Aboriginal health, community health, non-acute mental health, alcohol and other drugs, home and community care providers, aged care and private health. This will make the system easier for patients to navigate and strengthen care provision through more consistent and effective transitions of care.

### Research and innovation

Networks will improve collaboration and coordination across health services and with research institutes and universities. This will allow more patients from a broader range of clinical settings and geographies to participate in clinical trials, and more clinicians to engage in research programs. It will also improve translation of research into practice, allowing more patients to benefit from evidence-based care and healthcare improvement activities.

# Collaborative arrangements

## Partnership structure and design

Network collaboration arrangements should support authentic collaboration between partnering health services, enabling health services to work together to deliver benefits for their patients and community that could not be achieved by health services acting alone.

Collaboration arrangements are expected to build upon the strong foundations established through Victoria's existing partnerships and collaborative structures, with the opportunity to better align structures and area-based initiatives to be progressed over time. Arrangements should further foster the constructive working relationships, transparency and trust that exist across many regions.

Arrangements should enable timely and effective decision-making that is focused on benefits for the entire community serviced by the Network, recognising its diversity and geographic breadth. As part of this, decision-making should balance the needs of the broad population, taking into account the needs of patients in lower population density, socially disadvantaged and geographically dispersed areas.

Collaboration arrangements should have mechanisms to facilitate the contribution of consumers, including those with lived experience of mental illness or psychological distress, and carers, families and supporters, to ensure patients are at the centre of Network decision-making, as outlined in Victoria’s partnering in healthcare framework.[[1]](#footnote-2) Importantly, Aboriginal communities should also shape decision-making to promote culturally safe care.

## Network collaboration arrangements

The department has set clear objectives and expectations for Networks. As part of this, the department has established parameters for Network collaboration arrangements. Core features of collaboration arrangements have been designed to ensure all health services have a say in Network activities, promote effective and timely decision-making and enable efficient Network functioning.

However, noting that Networks will vary in composition and number of member services, Networks can make some design decisions to tailor arrangements to their specific circumstances, ensuring that arrangements support delivery of Network objectives.

### Leadership committee(s)

All Networks with partnering health services must have mechanisms to ensure CEOs and board chairs of all member services are adequately engaged or represented. As Networks will differ in their composition and number of members, the precise mechanisms to achieve this can be determined by each Network, but need to ensure there is effective operational and strategic oversight of the Network. Approaches could include:

* Networks convening two separate committees: a committee of CEOs focused on shared planning and decision-making, and a committee of board chairs serving an oversighting role.
* Networks convening one committee including both CEOs and board chairs of health services forming the Network. This committee serves functions of shared planning, decision-making and oversight.
* Networks convening a CEO committee for operational decisions and a combined committee of CEOs and board chairs to provide strategic oversight.
* Networks convening a CEO committee which provides regular reports to boards and invites board members to meetings at least annually.

Under all options, the Network may choose to have an inclusive model – including all CEOs and board chairs on the committee(s) – or a representative model, in which a subset of CEOs and board chairs are formal committee members.

Irrespective of the structure adopted, the department will hold Network leadership committees accountable for meeting the roles and responsibilities outlined further below. CEOs and board chairs will commit their health services to collectively deliver against a Network strategy and annual implementation plan – as outlined in their statement of expectations – in line with commitments in each of their individual health service Statement of Priorities.

### Chairing arrangements

All Networks with more than two partnering health services will have a chair (or co-chairs) of their leadership committee(s). The chair’s role is to convene Network meetings and to facilitate communications, including being a conduit for information flow between the Network and department, and representing the Network at relevant meetings with the department. For Networks adopting separate CEO and board chair committees, the chair of the CEO committee will also act as conduit between the committee of CEOs and the committee of board chairs. For Networks with two or fewer health services, no chair is required and the department will communicate directly with all parties.

The Network should decide whether to nominate a chair (or co-chairs) from among their health services or an independent chair. The Network should also determine how the chair is appointed and their term of appointment. For Networks that decide to have a rotating chair, the role should be held for a minimum of a 12 month period to enable consistent information flow, and the responsibilities outlined above will rotate along with the chairing role.

### Decision-making

All Networks will be required to strive towards consensus decision-making. Networks must articulate alternative decision-making arrangements and escalation processes to use in the event that consensus cannot be reached. These may include voting processes with an agreed threshold for the decision to pass, escalation to board chairs or involvement of an independent chair.

Decision-making arrangements must be designed to promote fair, effective and timely decisions and should be documented in the Network’s underpinning agreement.

### Resourcing and staffing

A single health service must hold core Network funding and employ staff on behalf of the Network. The Network will have flexibility to decide which health service takes on these roles. This health service will be responsible for a number of functions on behalf of the Network:

* appropriate, accountable and transparent management of core Network funding, with timely reporting to all Network members. The frequency and manner of financial reporting should be agreed with the members.
* employment of Network staff, including all aspects of Network staff employment arrangements such as performance management and professional development of those staff.

All Networks with three or more health services must engage an executive lead and appropriate staff to coordinate Network activities. Networks with less than three health services must agree a responsible executive to coordinate Network activities. These Network executives and staff are responsible for:

* oversight and management of Network activities, as agreed by the Network. Depending on the priorities and resourcing of the Network, Network staff may be responsible for the design and planning of Network initiatives; coordination of implementation; change management associated with Network initiatives and project management of Network initiatives.
* Network administration and secretariat, including reporting on the progress of Network initiatives to all Network members as agreed by the Network leadership committee(s).

Irrespective of which health service employs Network staff, their role is to work for the Network as a whole. The executive lead is equally accountable to all health services in the Network, must act in a neutral and impartial manner and work for the collective interests of all members. Network staff should be organisationally positioned so that they are able to drive change and accountability for the entire Network, including when projects are led from a different health service (see below). Care should be taken to ensure that Network staff remain dedicated to working on Network priorities. The Network leadership committee(s) should have visibility and oversight of the executive lead and Network staff. They must agree and document reporting lines for the executive lead and Network staff.

Individual project funding may be allocated to other health services upon agreement by the Network. In this situation, the health service holding the project funding will be responsible for the following project functions on behalf of the Network:

* appropriate, accountable and transparent management of project funding, with timely reporting to all Network members. The frequency and manner of financial reporting should be agreed with the members.
* employment and management of project staff, including all aspects of Network staff employment arrangements such as performance management and professional development of those staff.
* management of project activities, as agreed by the Network, including design and planning of the project, implementation, change management and project management
* project administration, including monthly or quarterly financial reporting to all Network members as agreed by the Network leadership committee(s), and regular milestone updates.

All Networks must have mechanisms to ensure transparency of budgeting, decision-making, allocation and spending of Network funding. Networks must ensure regular reporting to the leadership committee(s) regarding financial position and expenditure. Network budgets and forecasts must be approved by all members, with the Network leadership committee(s) agreeing and documenting an appropriate process for this.

Where a Network provides a joint activity or service for which health services need to pay a contribution, Networks should ensure pricing mechanisms are transparent and agreed by all parties; and that both ‘customer’ and ‘host’ health services’ interests are treated equitably.

Where a health service provides a joint service for Network partners and needs to include an overhead in pricing partner contributions, there should be transparency in how this is calculated and this should be agreed to by the Network.

### Underpinning agreement

All Networks will be required to have an underpinning agreement that is at least as robust as that of their preceding Health Service Partnership, with a Memorandum of Understanding at a minimum. Given that there is variation in Network composition and complexity, and a range of existing arrangements across the system, Networks may select the underpinning arrangement that best supports the effective delivery of their initiatives while complying with any existing agreements. Networks should consider and decide if they wish to adopt more formal approaches such as a Joint Venture Agreement.

Networks must also have appropriate information sharing agreements to facilitate data sharing among member health services, while maintaining data privacy and security.

The Network must share its underpinning agreement with the department for visibility.

### Consumer engagement

All Networks must establish mechanisms to incorporate consumer voice in alignment with the Victorian Partnering in healthcare framework. Mechanisms should capture views from a diverse range of consumer groups, including those outlined in the Victorian Partnering in healthcare framework. Networks will be expected to engage with consumers and Consumer Advisory Committees to design an appropriate approach for their Network. Engagement with consumers should recognise and value lived experience as experience that makes them valuable leaders and active partners.

### Additional stakeholders

Networks can include additional stakeholders as affiliate members, such as Primary Health Networks, non-acute mental health services, bush nursing centres, community health organisations or Aboriginal Community Controlled Organisations.

In the longer term, Networks are intended to be a platform to enable greater collaboration across the health system, including with other sectors such as primary and community care. As Networks mature, it is expected they will increasingly engage with additional stakeholders to drive integration of care across sectors.

## Subnetwork collaboration arrangements

A Network may agree to establish a subnetwork, if the Network has a geographic subregion with distinct characteristics such as distinct natural patient flows or a more remote location. Any subnetwork arrangements must be agreed to by the Network as a whole and approved by the department.

Subnetwork collaborative arrangements will be subordinate to Networks, with subnetwork members remaining accountable to the overarching Network leadership committee(s), and for meeting overarching Network priorities and objectives, as articulated in the Statement of Expectations. Subnetwork arrangements must not come at the expense of broader Network benefits.

The subnetworks will be governed by a subcommittee of the Network leadership committee(s) and will comprise representatives from health services participating in the subnetwork.

The Network leadership committee(s) may delegate specific activities, projects, initiatives or funding to the subnetwork subcommittees to support collaborative arrangements at a sub-regional level, such as local workforce sharing or coordinating step closer (step up and step down) care.

Subnetwork arrangements must be documented in the three-year Network strategy and their activities set out in Network annual implementation plans.

## Reviewing Network collaborative arrangements

Networks are expected to change and mature over time. The collaborative arrangements suitable when Networks are first established may no longer be appropriate once they take on more initiatives and deepen their collaboration. Networks will therefore have the opportunity to review and update their collaborative arrangements from 12 months after establishment and thereafter, with opportunities for collaborative arrangements to evolve.

# Roles and responsibilities

The roles and responsibilities of Networks, health services, and the department are detailed below.

## Network

Through collaboration between member health services, each Network will:

* develop a Network strategy, annual implementation plans and clinical service plans in accordance with the Network’s Statement of Expectations
* deliver Network objectives, including shared functions and priority initiatives set out in the Statement of Expectations
* demonstrate collective progress against a Network outcomes framework, once implemented
* collaborate with Network partners and stakeholders, such as Primary Health Networks, community health providers, including non-acute mental health services, and Aboriginal Community Controlled Organisations, where priority initiatives extend across the care continuum and require input from system partners
* meet reporting requirements set by the department
* convene a leadership committee(s) with mechanisms to engage all board chairs and all CEOs for Network stewardship as per an underpinning formal Network agreement between member health services
* coordinate development and sign off on annual implementation plans and a three-year Network strategy that is aligned with a Networks outcomes framework, to meet the Network’s Statement of Expectations
* in collaboration with a partner tertiary or regional tertiary, a women’s and a children’s hospital, establish and participate in formalised relationships as outlined in the relevant policy, to be provided by the department.

## Individual member health services

Member health services will continue to be individually responsible for their performance against Statements of Priorities, including management of budget, clinical service delivery and clinical governance. Network functions and activities will not supersede legal and regulatory obligations for individual member health services.

Individual member health services will:

* sign their Network’s underpinning agreement and abide by agreed conventions
* through their CEO as a representative:
  + participate in Network leadership committee(s) either as full committee member, or through active engagement in matters
  + demonstrate collaborative behaviours and work effectively with other Network leaders towards common goals
* where nominated, lead the delivery of Network priority initiative projects and proactively engage Network members
* contribute to the development of a three-year Network strategy and annual implementation plans
* actively participate in priority initiative projects in accordance with the agreed Network strategy
* prioritise meeting collective targets as well as individual targets set in Statement of Priorities
* communicate and promote the Network in their individual health service, including providing updates to executives as relevant to prevent duplication and ensure cohesive planning and fiscal management
* share data with Network members and the department to support benchmarking, planning and reporting, underpinned by appropriate information sharing agreements.

One health service will be required to hold core Network funds and employ staff on behalf of the Network. Other health services may hold funds for discrete projects upon agreement of the Network.

The health service nominated to hold core funding will:

* formally employ, manage and host staff that are employed on behalf of the Network, with these staff working for the Network as a whole to support network operations and strategic functions
* manage Network funding, ensuring they are transparent and accountable to all Network health services over disbursement and expenditure of Network funds, and pricing of any activities they undertake on behalf of the Network, and report in a timely manner to all members.

Health service(s) allocated individual project funding on behalf of a Network must:

* manage the use of project funds appropriately to deliver the relevant initiative, including being accountable to all Network health services and maintaining transparency over pricing, expenditure and reporting
* manage project staff, activities and administration.

## Department of Health

As system manager, the department will:

* oversee Network implementation and makes necessary amendments to the Network policy framework as the Network model matures
* continue to fund clinical service activity at individual health services level
* signal and consistently reinforce the strategic importance and purpose of Networks
* clearly define collective Network priorities, initiatives and targets in collaboration with Network members
* assign shared Network priorities and accountabilities through Network Statement of Expectations and common health service Statement of Priorities clauses
* monitor and manage Network performance against performance measures in each Statement of Expectations and Statement of Priorities, including enforcing consequences to uplift performance if the Network is not meeting expectations
* mandate individual health service collaboration in Statement of Priorities and the Performance Management Framework
* convene Network performance meetings
* develop a Network outcomes framework, to monitor Network performance in future performance cycles
* if requested by the Network, attend Network meetings to observe or share insights and innovation from other Networks
* establish and maintain escalation pathways for issues that cannot be resolved through Network dispute resolution mechanisms where required
* support Networks through:
  + development and sharing of data tools
  + development and provision of complementary policies and guidelines
  + promotion of a collaborative leadership culture
* evaluate the Network model to drive continuous improvement

# Establishment and resourcing

## Transition from existing partnership arrangements

### Health Service Partnerships

Networks will supersede Health Service Partnerships (HSPs), with HSPs ceasing on 1 July 2025. The department is committed to a seamless transition from existing HSP to the new Network arrangements.

#### HSP staff

Networks must agree on their staffing profile and resourcing allocated to managing the administrative aspects of the Network. Consideration should be given to whether and how existing HSP teams can be transitioned into the new arrangements, taking into consideration which health service will hold the core funds and employ staff for Networks.

The nominated fund-holding health service will be responsible for ensuring any changes for existing HSP staff that are transitioned to Networks are undertaken in accordance with the requirements set out under relevant Enterprise Agreements and the *Fair Work Act 2009*.

#### HSP initiatives

HSPs have been delivering both strategic initiatives set by the department and local initiatives selected by the HSP.

##### Strategic initiatives

The department will work with Networks to determine whether HSP strategic initiatives should become Network responsibilities, taking into consideration factors such as the remaining length of the program, funding and cost implications, and the overall value of change.

For those programs that are transitioned to become the responsibility of Networks (such as Residential In-Reach and the Safer Together Program), the department will adjust funding allocations to reflect the Network model. Interim governance and reporting arrangements for project teams should be made while Network collaboration arrangements are established.

It may be necessary to continue to deliver some programs – such as the Residential In-Reach program – based on the original HSP boundaries due to the nature of the program. The department will work with Networks to agree how these programs will continue to be delivered to ensure agreed outcomes are met, including which health services will be responsible for coordinating the programs once HSPs cease to exist.

##### Local initiatives

Networks may decide to continue projects that were commenced by HSPs, should these be agreed to by all participating health services and appropriately resourced.

Networks should consider the impact on and alignment of these projects with the common Network priority initiatives and local Network priority initiatives outlined in their individual Statement of Expectations.

### Local and Regional Area Health Partnerships

Networks will also supersede both the Regional Area Health Partnerships (RAHPs) and Local Area Health Partnerships (LAHPs) in regional areas.

The funding for these partnerships will be provided to Networks to support delivery of Network priorities, noting the similarity in their objectives. Networks should maintain existing RAHP and LAHP activities for at least 12 months from Network establishment, during which time each Network can assess these activities and consider where they should continue or be redirected, in line with Network objectives.

### Other partnerships and programs

There are a range of other partnerships and collaborative structures across the system that will continue to maintain their current state, geographic configurations, governance and partnering arrangements and reporting structures. This includes Integrated Cancer Services, Palliative Care Consortia and Rural ICT Health Alliances.

There are also a number of programs that are coordinated at a regional level. This includes the Local Public Health Units, Palliative Care Consultancy Services, the Workforce Training and Development programs delivered by consortia or partners (such as the Victorian Rural Generalist Program) and mental health services that are delivered by area mental health services.

There are no changes at this time to the provision of these programs and services, including their geographic configuration, as a result of the establishment of Networks.

Networks should operate alongside and in collaboration with existing partnerships and programs for at least their first 12 months of operation. During this time, Networks should focus on implementing agreed collaborative arrangements, establishing relationships and implementing agreed local and common initiatives.

As Networks mature, the department’s strategic intention is to improve alignment of other partnerships and programs with Networks. The department will work through future changes carefully, taking into consideration the effectiveness of existing arrangements, the opportunities from greater consistency and simplification, the benefits and costs of realignment and change, and funding and capacity issues.

The department will consult with other partnerships, Networks and health services to inform consideration of any potential realignments. Any change will need to be justified and demonstrate value to communities, existing partnerships, health services and the Network.

The department will also explore the opportunities for greater consistency between reporting and monitoring arrangements for Networks and other partnerships and regional programs. Even where partnerships may have different arrangements and configurations, there may be some opportunities for streamlined and consistent approaches to management and monitoring, with best practice models shared between different partnerships and regional programs.

It is recommended that Networks establish relationships with all relevant partnerships and with coordinators of regional programs to collaborate and share information. There may also be opportunities to utilise the new Network governance arrangements to inform CEOs and boards of the activities of other partnerships and regional programs. Any changes to existing governance arrangements for other partnerships or other regional programs will need to be agreed with the department.

### Rural and regional specific programs

There are some specific programs that are targeted just to health services that are designated as rural and regional health services. This includes programs initiated and funded by the department and other programs that may be funded by the Commonwealth or other funding bodies.

Rural and regional designated health services that are members of Networks that include metropolitan health services will continue to be eligible for these programs.

## General funding model

Networks will receive funding to engage core staff to establish and administer the Networks, including facilitating Network-led initiatives. Core Network funding will flow through to each Network’s nominated fund holding health service. Specific terms outlining core Network funding conditions will be outlined in Local Health Service Network Core Network funding terms.

Funding may also be allocated to Networks to deliver specific initiatives or projects. This will include funding to support clinical planning and change management. The funding may flow through to each Network’s nominated fund holding health service, or to other health services in the Network, upon agreement of all parties. Conditions for initiative specific funding will be outlined in dedicated funding terms.

# Reporting and accountability

Network accountability arrangements are detailed below. These arrangements complement and do not replace individual health service accountability requirements such as Statements of Priorities (SOPs).

## Network expectations

The Minister for Health will issue an individualised Statement of Expectations to each Network.

Each Statement of Expectations will include:

* the core purpose and expectations for Networks
* Network collaborative arrangements
* core resourcing and funding arrangements.

An initial Statement of Expectations will be provided in June 2025 and updated as required. The Statement of Expectations will be accompanied by a list of mandatory common initiatives (Schedule A) and a list of locally agreed initiatives (Schedule B). The department and Networks may add schedules for further initiatives over time. The Statement of Expectations may be signed by all health service board chairs within the Network, or the chair of the Network board chair committee may sign on behalf of all members.

The Statement of Expectations will be aligned with and linked to individual health service SOPs, enabling Network actions to complement individual health service actions, and avoiding conflict with individual health service accountabilities.

SOPs will require that health services meaningfully and actively participate in Networks, and meet targets outlined in their Statement of Expectations. In time, individual health service SOPs will detail common clauses that establish joint Network targets and expectations.

Network funding letters will detail specific terms and conditions attached to funding to operationalise Networks or support discrete projects.

## Network strategy and annual implementation planning

Each Network will be required to develop a three-year Network strategy for endorsement by the Secretary, Department of Health. The strategy must be aligned with the Network outcomes framework (see further below) and set out the Network’s objectives for the next three years.

Each Network will also be required to develop an annual implementation plan for endorsement by the Secretary, Department of Health each year. The annual implementation plan should set out the activities and milestones to achieve objectives in the Network’s Statement of Expectations.

The department will communicate the timing and format for Network strategies and annual implementation plans and will support Networks through provision of templates and relevant data.

## Network performance monitoring

The department will monitor each Network’s progress towards milestones outlined in annual implementation plans. This will occur via routine Network wide reporting and Network performance meetings. Performance monitoring will be structured against an outcomes framework.

### Reporting

Networks will complete routine reporting to provide visibility and accountability of progress in meeting milestones in annual implementation plans. Once the outcomes framework is established, the department will provide Networks with area level performance data across a range of indicators, to enable Network benchmarking and tracking of progress towards joint targets.

### Performance meetings

Network performance meetings will be held with the department to track progress towards milestones in Network annual implementation plans. Meetings will typically be held six monthly provided Networks are functioning at or above the expected level. In the early phases of Network implementation, meetings will be attended by all CEOs of the Network to drive collective accountability for Network outcomes. Once Networks have matured, Networks meeting or exceeding expectations may elect to have only the chair of their leadership committee attend some meetings, provided all Network CEOs attend at least annually. Senior department representatives will also attend, joined by specific department project team leaders for discussions about individual initiatives where necessary, and individual health service performance leads to ensure alignment between Network and individual health service performance monitoring.

Similar to the Performance Management Framework for individual health services, Networks will be assigned to tiers as outlined in the table below. Decisions on which tier Networks are assigned to will be made by senior department leaders based on feedback from program areas engaging with Networks, Network formal reporting and discussions at Network performance meetings. Decisions will also consider individual health service performance to ensure health services balance their individual and collective responsibilities.

Table 2 Performance management framework for Networks

| Tier | Purpose | Criteria | Level of oversight and monitoring |
| --- | --- | --- | --- |
| Exceeding expectations | Incentivise and reward excellence | Consistently high performance:   * Network functioning effectively, as demonstrated through partnership assessment scores * Network meeting targets for common and local initiatives * effective financial management.   Collaborative leadership: Network leaders promoting a shift towards systems thinking both within their Network and across the state. | * Standard oversight and monitoring * Prioritisation for piloting new initiatives * Prioritisation for innovation funding |
| Meeting expectations | Standard oversight and support to stay on track | Operating within acceptable parameters:   * Network functioning at an acceptable level, with credible plans for improvement * Network targets on track, or with credible plans in progress.   Collaborative leadership: Network leaders demonstrating a shift towards collective thinking. | * Standard oversight and monitoring * Targeted management of issues as they arise |
| Not meeting expectations | Assist early to prevent extended decline | Significant support needed in one or more domains:   * Network targets off track and without credible plans underway to remedy this * poor partnership functioning, with no credible plan underway to improve this. | Increased oversight until common priorities and partnership functioning are on track:   * more frequent meetings with the department * board chairs engaged in Network performance meetings * must identify drivers of poor performance and establish an improvement plan with clear timeframes and agreed criteria for transitioning back to standard oversight * option to engage an independent mediator to assist in resolving underlying partnership issues. |
| Significant performance issues | Intensive support, hard accountabilities and transparent triggers | Additional complex and serious issues, e.g.   * longstanding and/or complex barriers to tangible improvement (e.g. one full year on performance support without improvement) * failures of Network leadership and/or integrity. | Significantly increased oversight as above, potentially also including:   * appointment of a ministerial representative or chair to the Network coordinating committee * independent review/audit of Network activities * use of Minister or Secretary direction powers to compel health services to comply with Network plans. |

## Network wide performance indicators

Network performance indicators will be designed to focus on improving outcomes for patients and communities. To promote action towards Network objectives and ensure robust oversight of Network activities, Network performance indicators should be:

* balanced, fostering focus on the full range of outcomes desired through Networks
* measurable, ideally without creating additional reporting and analysis burden for health services
* associated with outcomes desired through Networks, noting that Networks will initially focus on collaboration across health services to improve access, equity and flow; workforce; safety and quality; and shared services
* consistent with principles of continuous improvement, encouraging health services to constantly seek ways to uplift their performance
* amenable to change through the levers which Networks, and their member health services collectively, have
* draw from existing data sets wherever possible and minimise additional reporting burden.

Meaningful performance indicators will be developed in consultation with Networks. Networks will determine any specific indicators for their local initiatives. The department will measure the impact of these local initiatives through its monitoring of outcomes and progress towards meeting Network objectives. The department will set indicators for common Network initiatives, based on available data and with input from Networks. Having an overarching outcomes framework (below) will ensure indicators are aligned with Network objectives.

## Outcomes framework

The department will develop an outcomes framework for Networks identifying the long-term outcomes intended through Networks as well as medium- and short-term measures. Measures will be structured to foster collective accountability. Measures will focus on Network priority areas – tracking progress in each priority area, as well as collaborative behaviours – monitoring how effectively health services are working together.

The outcomes framework will be developed in the first quarter of 2025-26 and will build a foundation for reporting on Network activities. Measures in the outcomes framework will be included in Network strategies and in future years, annual implementation plans. Measures will inform and align with health service SOPs, Network Statements of Expectations and funding letters. The outcomes framework will also underpin an evaluation and monitoring framework, allowing the department to demonstrate the effectiveness and value of Networks over time.

## Roles and responsibilities of health services towards their partnership

Alongside accountability for meeting Network objectives, health services have responsibilities towards each other for working effectively in partnership. This accountability will be reflected in Network Statements of Expectations and will be supported by collaborative arrangements, decision-making processes and underpinning agreements which each Network will agree by consensus.

Working effectively in the partnership will also support health service boards to meet their obligation to act in the best interests of their health service and community: pooling resources, knowledge and experience to address common challenges ultimately provides greater value.

These formal mechanisms must be reinforced by a culture that fosters collaboration. Networks will need to create and nurture an environment where health service partners support and challenge each other to deliver progress towards their shared objectives. Leaders will need to shift their mindset from a predominant focus on their individual entity, to the population health needs of their broader community.

A collaborative leadership style will be critical, with the ability to bring diverse views together, foster effective interpersonal relationships, build a collective vision and motivate shared actions. Health service CEOs with a collaborative leadership style could provide support, guidance and peer review to strengthen the culture and capability for collaboration in other Networks.

The department will support Networks to establish a collaborative culture through setting clear expectations regarding behaviours; attracting and rewarding leaders that are collaborative, inclusive, trusting and empowering; and aligning individual health service and Network accountabilities. The department will cultivate this through designing processes in ways that promote system collaboration over competition; recruiting sector leaders who demonstrate collaborative ways of working and public sector values; and supporting agreed dispute resolution processes, if required.

# Appendix

## Design considerations for Network groupings

The design of Network groupings was informed by the following design considerations, noting some are more relevant than others for different groupings, and there may be trade-offs between considerations.

#### Geography and demography

* Natural geographic boundaries (such as mountain ranges), established travel and care access routes and communities’ sense of culture and connection to country are respected.
* Groupings give rise to a unified, contiguous geographic area that services a defined community and are aligned with other established structures.
* Most residents can access most of their care needs within 60 minutes travel time.
* Population scale gives rise to adequate clinical volumes to support safety and sustainability across the entire Network.
* Geographic scale is manageable for staff to work across at least some sites within reasonable travel times if this is required.

#### Services

* Patients can access whole-of-person and whole of life care within the grouping.
* Clinical services can be distributed across the Network to balance local access to care, safety, sustainability and efficiency.
* Optimised patient flows enable formalised referral pathways for care escalation and   
  step closer care.
* Access and navigation for patients is enhanced, minimising the need to refer outside of the Network.

#### Capability and scale

* The network grouping can achieve 85% self-sufficiency.
* Each Network includes at least one tertiary hospital (or a minimum of principal hospital or major hospital where the distance to a tertiary hospital exceeds two hours’ drive time).
* Sufficient scale is achieved across the Network to provide a broad range of high-quality, safe, sustainable services overseen by robust clinical governance arrangements.

#### Operations

* Service, regulatory and support duplication is minimised.
* Scale is adequate to ensure efficient and sustainable delivery of shared support services.
* Scale of Network enhances recruitment and retention of skilled staff and supports education, training and research programs and opportunities.

1. Safer Care Victoria, *Partnering in healthcare: a framework for better care and outcomes*, Victorian Government, 2019. Available at https://www.safercare.vic.gov.au/publications/partnering-in-healthcare [↑](#footnote-ref-2)