Health Services Plan

Report of the Expert Advisory Committee

April 2024

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Executive summary

In July 2023, the Secretary of the Victorian Department of Health commissioned the Expert Advisory Committee to lead a process to examine the design and governance of Victoria's health services system. We were asked to develop a Health Services Plan (the Plan), for a future system that will improve equity and access to healthcare for all Victorians.

Over the past 10 months, we have engaged with health service leaders and explored many of the challenges experienced by patients, communities and our health workforce. Historically the Victorian health services system has performed well, and our health workforce continues to be committed to providing the best care for their patients. However, our system is under increasing strain, exacerbated by the enduring impacts of the COVID-19 pandemic. We have heard about how our health services system leads to inconsistent access to high-quality and safe care, disconnected and fragmented care, difficulties for patients and clinicians in navigating a complex system, and challenges in engaging and retaining our essential health workforce. We have learnt about how Victoria's 76 separate health services have unclear roles and responsibilities, and undertake duplicated effort. It is clear our health services and workforce are under pressure, and that now is the time for change.

We have found many of these challenges are exacerbated by the system's structure, with the siloed nature of Victoria's health services creating obstacles to seamless, integrated patient care. Our precious health resources are not aligned to best meet the needs of patients now and into the future. Increasing demand for services and changing disease and demographic trends require integrated models of care that the current system is not designed to deliver.

To find solutions to these challenges, we have consulted extensively with health service leaders about their experiences serving local communities, considered lessons from other jurisdictions and sought expert insights to develop a Plan for a system that will better serve all Victorians.

In this Plan we describe a roadmap for a more connected system with clear roles and responsibilities outlined in a Victorian role delineation framework, enabling collective strengths to be harnessed, and innovation and best practice to be spread.

Under our recommended health services system, all health services will become part of Local Health Service Networks (Networks): geographically defined, formal groupings that will be accountable for meeting the care needs of their community as close to home as possible. These Networks will address issues that existing health services find challenging to manage on their own: ensuring equity of access to care, creating consistent pathways for patients across the system, supporting quality and safety of care, and engaging and supporting workforce more consistently.

We recognise health services are the bedrock of many communities, particularly in rural areas, with many people deeply committed to their long-established local hospitals. These connections must be valued and strengthened. All individual health services will become part of a Network, to improve the care that can be provided locally and strengthen workforce support. There must be continuing local leadership within each Network, informed by local community voices. In recognition of the importance health services have to communities, we recommend they all retain their individual identities and brands.

Within each Network, there will be clearer definitions of the roles and responsibilities of different types of health service site, ranging from very small sites to major tertiary hospitals, and women's, children's and specialist hospitals. These definitions will set out what types of care can safely be provided where, and what communities can reasonably expect. Clearer, more logical pathways will be established between different hospital sites, so that as patients' care needs change, they receive timely and appropriate care in the right location.

Every Network will have a formal relationship with a major tertiary, a women's and a children's hospital. These hospitals will support each Network by offering expertise and sharing specialist workforce, and will be responsible for coordinating timely access to more complex care. Our specialist hospitals will continue to have a unique leadership role in our system, with responsibility for care and expertise across the state as well as to their local communities. Through each being part of a Network, specialist hospitals will strengthen their participation in multidisciplinary and whole-of-life care and research, while providing connections across Victoria to their expertise and skills.

Establishing Networks will be a vital foundational step to deepen integration with sector partners in primary care, community and non-acute mental health, alcohol and other drugs, and aged care, so patients can experience more seamless and connected care. In this Plan we outline future directions to connect care across the continuum.

The Victorian Department of Health must work in partnership with, and support the sector, to implement the Plan. The government must hold the department to account for implementation, and the new role it plays in the system.

We believe the Health Services Plan, enabled through the consolidation of health services into Local Health Service Networks, will shape a system that better meets the needs of Victorians now and into the next decade. The system will need to continue to learn and adapt to meet the fast-changing healthcare needs of Victorian communities as they age and grow.

While our health services system has served us well in the past, it is no longer fit for purpose to meet current and future challenges. Change is needed now, and this Plan will create a more equitable, consistent, high performing health services system, for patients, our essential health workforce, and our community.

Our consultations and the formal and informal submissions we received, have convinced us that Victoria's health service leadership – across the length and breadth of our state – understands the need for reform and is committed to working with their communities to achieve it. We applaud their vision and urge all those charged with implementation to work together to achieve it.

Findings and recommendations

The Committee makes 27 recommendations to reform Victoria's health services system so that it is better designed and structured to deliver the right care, in the right place, at the right time for all Victorians. These recommendations – along with the key findings from each chapter that have driven the recommendations – are brought together in this section.

Chapter 1: The case for change

Finding: The following problem statement outlines the key issues we seek to address: *Depending on who you are, and where you live, Victorians have variable experiences of and inequitable access to timely, safe, high-quality care, which means health outcomes vary across the state*.

Finding: While Victoria's health services system has performed well in the past, its design is no longer fit-for-purpose and impedes best efforts to meet current and future challenges.

- Victoria's health system is coming under increasing pressure, with an ageing population, increasing chronic disease, increasing costs of service delivery, workforce challenges and enduring impacts of the COVID-19 pandemic.
- Depending on who you are, and where you live, Victorians' access to care varies. While those in inner metropolitan areas tend to have greater access and choice of services, others experience service gaps, longer waitlists, further travel and less consistency in the appropriateness of the care they receive. These inequities are exacerbated for priority populations and vulnerable groups, such as Aboriginal Victorians, refugees and asylum seekers, and culturally diverse Victorians.
- Victorians' experience of care varies, with many finding the system complex and difficult to navigate. Referral pathways are inconsistent, often relying on relationships between clinicians rather than a consistent, logical and seamless approach.
- Not all patients receive the right care, and some experience avoidable harm during their care. We have unexplained variation across the state because the current system structure does not support all health services to deliver care as safely as possible.
- Health services face severe workforce challenges. While clinical workforce shortages are a worldwide phenomenon, these challenges are amplified here by uncoordinated recruitment processes and competition for staff between multiple health services in a geographic region. This ultimately impacts patient access to care. Health workers also have inconsistent access to professional development, peer support and research opportunities, depending on where they work.

- Because health services share geographies, it is unclear which services are accountable for ensuring the care needs of a local population are met. Health services should be responsible for designated communities, to clarify accountability for population health outcomes.
- The fragmented structure of Victoria's health services system hinders integration with other sectors, such as aged care, non-acute mental health, community health and primary care. It also hinders Victoria's ability to implement reforms arising from the next National Health Reform Agreement addendum that is being negotiated in response to the recommendations of the 2023 Mid-Term Review.
- The role of the Department of Health (the department) as system steward is also hampered by existing arrangements. While other Australian health departments work with a maximum of 16 networks to ensure the right health care is delivered at the right time and in the right place, our department has 76 individual services – more than the rest of the nation put together.
- Victoria's health services system does not make the best use of our vital healthcare resources due to duplication of activities across the 76 services and a lack of scale efficiencies. This reduces the resources available for direct patient care.
- Existing arrangements, such as Health Service Partnerships, are not sufficient to drive the collaboration required to meet current and future challenges facing the system.

Recommendation 1: Government undertake fundamental reform to address current and future challenges and build a health services system that delivers the right care, in the right place, at the right time, for all Victorians now and for the future.

Chapter 2: System design principles

Finding: Victoria's health services system should be reformed in line with the following design principles:

- people have choice to receive care as close to home as possible taking into account safety and complexity
- connected high-quality care is easy to navigate and provided equitably along logical pathways, understanding how communities travel and interact
- improved clarity of roles and responsibilities of the different levels of service provision
- engagement with patients and the local community is enhanced to achieve evidence-based local customisation and responsiveness to community need
- a skilled and diverse workforce continues to be attracted and retained, supported by teaching, training, research and collaboration across the sector
- the system is structured to achieve integration across population health, primary, aged, acute care, non-acute mental health and alcohol and other drugs, and Aboriginal community-controlled health care
- the system is accountable, collaborative, transparent and informed, to support the outcomes that matter to patients
- duplication is reduced to deliver value for the people we serve and unnecessary administration for our staff through ensuring better use of current resources, and minimising wasteful impacts
- the system continuously improves and is flexible and adaptable in response to change.

Chapter 3: Core design elements

Finding: Roles and responsibilities of each health service site in meeting patient and community needs are unclear.

- Different health services play diverse, but equally meaningful roles across the care continuum, including providing primary, community, aged and acute care services.
- However, there is a lack of clarity in which services different sites should be responsible for providing, given their scale and capability, and which services the community should reasonably expect.
- While patients often need to attend different health services for their care, the system is not designed to ensure their experiences are as smooth as they could be.
- Greater clarity in the roles and responsibilities of health service sites would help support more logical patient journeys across services, better continuity of care, and care as close to home as possible for patients.

Recommendation 3.1: Victoria adopt a role delineation framework setting out the roles and responsibilities for each health service site.

The role delineation framework will draw from the Australian Institute of Health and Welfare peer grouping framework with modifications to take into account:

- **primary, community, aged care, subacute and acute services**
- **virtual and ambulatory as well as bed-based services**
- **population, geography, and accessibility of care**
- **health service site size and capability.**

The department will define the roles and responsibilities of health service sites in accordance with the role delineation framework and in consultation with health services.

Roles will be defined as Very Small, Group D to A health service sites, and Major Tertiary sites, offering service profiles with increasing clinical complexity. Hospitals delivering the most complex and specialised care in Victoria will be defined as major tertiary where they deliver comprehensive adult care and as women's, children's or specialist hospitals where they deliver complex care for distinct patient cohorts.

The department will establish a process for these roles and responsibilities to be updated as health service site capabilities and the community's health needs evolve over time.

The department will continue to develop a comprehensive suite of clinical capability frameworks, which will support more detailed role delineation at the level of clinical specialties.

Finding: Health services have variable sizes and capabilities and face challenges delivering care if they operate independently from each other.

- Individual health services can lack the scale and capability to meet most of the care needs of their local communities, and to attract and retain a skilled workforce.
- If health services work separately, it is difficult to deliver connected, high-quality care; integrate care across population health, primary and acute settings; and maximise use of health care resources.
- Integrated health networks optimally service populations of approximately one million people in metropolitan areas and greater than 200,000 in rural areas. Some of Victoria's existing geographic health service regions do not meet these population scales.

Recommendation 3.2: Victoria's health service sites be formally organised into Local Health Service Networks representing discrete geographies of appropriate population scale.

Each Local Health Service Network should include, at a minimum, a Group A hospital to ensure that the majority of care needs are met close to home for its communities. In addition, formalised linkages will be established with major tertiary, women's, and children's hospitals to facilitate more consistent and effective connections with higher complexity care (see Recommendation 5.1).

Chapter 4: Caring for patients within their region

Finding: Victoria's fragmented health services system impacts care quality and experience, diffuses responsibility for population health outcomes, exacerbates workforce challenges and impedes integration with other sectors.

Fragmentation across health services contributes to:

- inequities in patient experience and difficulties accessing care
- quality and safety risks
- difficulty attracting and supporting health workforce
- inefficient use of resources
- barriers to coordinated improvement
- difficulties engaging with other providers such as Primary Health Networks and Aboriginal community-controlled health organisations
- poorly defined catchment geographies resulting in a lack of clear accountability for population health outcomes.

Recommendation 4.1: Local Health Service Networks comprising public and denominational health services be established in Victoria to manage each health service region with the following responsibilities:

Population health and addressing population inequities

- **Understanding and addressing 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.**
- **Increasing focus on early intervention for their population, both early in life and early in disease progression.**
- **Understanding the health and care needs of priority populations and vulnerable groups in their region, and addressing inequities in accessible and culturally safe health care, including through collaboration with local organisations, such as Primary Health Networks and Aboriginal community-controlled health organisations.**

Access to care

- **Developing a network of care for their geography that ensures that the great majority of the care needs of their population are met within region, as close to home as is safe and sustainable, using appropriate sites with capacity and capability.**
- **Network wide clinical service planning, within departmental frameworks, to define health service site roles and responsibilities aligned to the role delineation framework, and to identify service and capital development priorities consistent with local population health needs and service sustainability.**

- **Establishment of consistent Network-wide care escalation and de-escalation criteria and treatment protocols to support patient care in the lowest acuity setting, where safe and practicable.**
- **Establishing default referral pathways to support logical patient flows for step-up and step-down care, including coordinating consistent pathways to and from General Practitioner care, private hospitals, local community health, aged care and other health care providers.**
- **Reducing inequities in patient access to care across the Network, by implementing reforms such as single waiting lists and service models such as virtual care and remote support.**
- **Better linking public sector residential aged care services within the Network with the broader continuum of care.**
- **Ensuring the most effective use of resources both within and outside hospital walls to improve patient flow, including through coordinated management of ambulance ramping, emergency department and inpatient capacity, expected discharges and collaboration with ambulance services and other Networks to reduce bottlenecks across the acute health system.**
- **Better utilisation of available capacity across the Network through inter-site transfers for step-down care, site specialisation and increased options for the establishment of quarantined services.**

Safety and quality

- **Unified clinical governance leadership across the Network.**
- **Implementing a unified and consistent clinical governance framework across all sites, aligned to National Safety and Quality Health Service Standards and contemporary clinical practice, and supported by establishment of a learning network across all Network sites.**
- **Increase consistency in the quality and safety of services through common approaches to managing clinical risk and adverse events, including shared morbidity and mortality reviews to support dissemination and adoption of key learnings.**
- **Implementing a common risk management framework across the Network, across all domains of risk, enabling the mitigation of ongoing and emerging risks through a consistent and coordinated approach.**
- **Establishing benchmarking of key performance indicators and outcomes across each Network to promote improvement.**

Workforce

- **Coordinated attraction and retention of clinical and non-clinical workforce across all health service sites.**
- **Common medical workforce appointments across health service sites supported by network-wide credentialling to facilitate clinician mobility.**
- **Establishing of nursing, midwifery and allied workforce banks across the Network and at more localised levels to support vacancy management.**
- **Establishing mechanisms for clinicians with specialised skills to support workers throughout the Network, including through telehealth and secondary consultations, to build expertise and skills and support care in place at local hospitals wherever possible.**
- **Improving workforce attraction and retention across public sector residential aged care sites, through enhanced career and professional development opportunities.**
- **Deliver consistent workforce support, including common approaches to professional development and training.**

Research and Innovation

- **Improve coordination of partnerships and deepen relationships with research institutes and universities.**
- **Improve consistency of access to research opportunities for the health workforce, and access to clinical trials for patients.**
- **Improve collaboration and reduce barriers to multidisciplinary and whole-of-lifespan research opportunities, including through fostering collaboration across specialist and generalist hospital sites.**

Integration

- **Improve navigability of the health system for patients across the health and wellbeing continuum, including across primary, community and acute care, physical and mental health, and with aged care services.**
- **Facilitating efficient patient record sharing between sites, ideally through common electronic medical record platforms.**
- **Improve provision of care in the community and reduce the prevalence of preventable hospitalisations, through stronger cross sectoral collaboration with primary care, community health and Aboriginal community-controlled health organisations.**
- **Improve integration with aged care, such as through better coordinated in-reach into residential aged care.**
- **Building strengthened relationships with the private hospital sector.**

Effective use of resources

- **Establishment of shared approaches to clinical support services that benefit from enhanced scale, such as diagnostic services, remotely supported reading of medical imaging, and virtual secondary consultations with specialists.**

- **Building on the work of Rural ICT Alliances, development of a Network-wide ICT strategy, and approaches to common ICT systems, including electronic medical record systems.**
- **Establishing shared administrative, human resources and payroll functions servicing the Network.**
- **Supporting shared and more efficient approaches to compliance and accreditation processes.**

Recommendation 4.2: As well as their whole of network responsibilities, Local Health Service Networks will support coordination and collaboration for subregions within their geography where locally specific arrangements are appropriate, such as for local referral pathways or workforce sharing.

Recommendation 4.3: Where existing collaborative arrangements, such as Rural ICT Alliances or pathology networks, span a wider geography than Local Health Service Networks, these arrangements should continue where they deliver value.

Recommendation 4.4: The new responsibilities for Local Health Service Networks apply equally to Networks comprised of one existing health service and to Networks that bring together multiple health services.

Finding: Specialist health services play an important role as centres of expertise for the state, but their patients experience issues from fragmented care as much as other patients and would benefit from participation in Local Health Service Networks.

Finding: The best hospitals in the world according to credible global assessments[1] are very large-scale academic centres comprising multiple hospital sites and specialist centres that enable significant breadth of scale and depth of specialisation within a unified, collaborative structure. The organisational barriers between our health services have stymied the realisation of this model in Victoria. Formation of Local Health Service Networks will increase the scale of Victoria's academic medical centres, further enhancing their ability to attract and retain the best practitioners, researchers and leaders.

[1] Newsweek, *The world's best hospitals 2024*, Newsweek website, 2024, available at www.newsweek.com/rankings/worlds-best-hospitals-2024, accessed April 2024. Also see previous years' rankings. Newsweek is a global digital news organisation that has on six occasions ranked world hospitals, assessing some 2,400 hospitals across 30 countries.

Recommendation 4.5: Major tertiary hospitals and specialist services will be included in Local Health Service Networks to:

- **support coordinated, multidisciplinary care that integrates seamlessly across whole-of-life and complex care for patients, supports smooth care transitions and improves life-long outcomes**
- **enable sharing of workforce, expertise and research efforts across specialties**
- **facilitate multidisciplinary research and strengthen specialist hospitals' statewide role as centres of excellence**
- **provide clinicians and researchers with greater resources, relationships and cross-disciplinary research opportunities through being part of a larger organisation**
- **become more competitive with the best hospitals in the world in both care and translational research**
- **maximise economies of scale in clinical and non-clinical support services to support allocation of resources to patient care and research.**

Recommendation 4.6: Local Health Service Networks will be established for the following geographies:

Regional Victoria:

- **Barwon South West**
- **Grampians**
- **Loddon Mallee**
- **Hume**
- **Gippsland**

Metropolitan Melbourne and statewide services:

- **West Metro**
- **Parkville**
- **North Metro**
- **East Metro**
- **South Metro**
- **Bayside**

Chapter 5: Caring for patients who need higher complexity care

Finding: Many health services lack reliable and consistent connections to major tertiary, women's, children's and other specialist hospitals for higher complexity care, impacting patient experience and outcomes.

Lack of reliable and consistent connections contributes to:

- delays in patients accessing appropriate care
- difficulties for patients and clinicians in navigating the system
- patients travelling unnecessarily for care, or staying further away for longer
- poor utilisation of resources and capability, including excessive use of high capability hospitals for low or medium complexity care, and inconsistent use of other hospital sites
- inconsistent access to advanced workforce training and professional development.

Recommendation 5.1: The department will facilitate each regional and metropolitan Local Health Service Network establishing a formal relationship with a major tertiary, a women's and a children's hospital.

Formal relationships will take into account logical patient flows and geography, and balance demand across the system. These relationships will support:

- **access to specialist expertise both virtually and physically, including to support care in place and close to home wherever possible**
- **consistent and timely access to high complexity care, including a bed if needed, with the major tertiary, women's or children's hospital having responsibility to coordinate appropriate care if it does not have available capacity**
- **jointly agreed roles and responsibilities for timely access to step up and step-down care as patients' care needs escalate and de-escalate**
- **improved access to advanced teaching, training and professional development, and joint arrangements for rotations and sharing of clinical staff**
- **improved access to clinical trials and research opportunities**
- **adoption of best practice, evidence-based care.**

The department will support the establishment of consistent referral pathways for every Network to have relationships with specialist hospitals which focus on distinct clinical streams.

Chapter 6: Caring for patients who need very highly specialised care

Finding: While Victoria has a program designating very highly specialised, low volume care to a limited number of sites, some services are still delivered at a higher number of sites than comparable jurisdictions.

This creates difficulty:

- maintaining a highly specialised and skilled workforce
- ensuring sustainable, safe and high-quality care
- establishing centres of excellence in highly complex care and research.

Recommendation 6.1: The department will establish a formal process to review which health service sites provide very highly specialised, low volume care.

The process will include establishing an expert advisory committee to support the department to:

- **assess new, very highly specialised, low volume services so they are concentrated in a small number of health service sites**
- **review existing designated services to determine whether these services can safely and sustainably be delivered in a more dispersed model in the system**
- **develop options to concentrate existing designated and non-designated very highly specialised, low volume services to establish centres of excellence, improve sustainability, and support quality and safety.**

Chapter 7: Governing a connected health services system

Finding: Informal partnerships limit the depth of collaboration and have weak participation and accountability requirements, rendering them insufficient to overcome issues arising from system fragmentation.

Informal partnerships:

- are too reliant on individual personalities and willingness to participate constructively
- lack formal, shared accountability to government and the public on whether they are delivering improved care for their community
- lack mechanisms that enable deeper collaboration, such as the ability to employ staff or hold funding.

Finding: Among governance options for Local Health Service Networks, consolidation of existing health services is the optimal approach to address current and future challenges.

Compared to stronger partnership arrangements, consolidated health services:

- have the greatest potential to reduce inequities and improve consistency in care, as a single entity becomes responsible for each community's health outcomes
- best support safety and quality, through each consolidated entity having greater resources and capability to manage clinical governance
- provide a single employer in each region to coordinate recruitment and retention of staff, and offer consistent professional development and training
- enable greater efficiencies of scale and the removal of duplication, optimising use of available resources.

Recommendation 7.1: Government consolidate health services under the following model:

Each consolidated Local Health Service Network is a single entity with:

- **a new, skills-based board with membership that reflects the diversity of its region**
- **a newly recruited Network chief executive officer**
- **enduring pre-existing site identities and brands**
- **visible local leadership**
- **a single employer that can engage and deploy workforce across sites in accordance with community need**
- **unified clinical governance and clinical service planning**
- **unified financial management, corporate governance and back office**
- **consistent policies and procedures across all health sites, including quality and safety processes**
- **accountability for care across its entire Network geography.**

Within each Local Health Service Network:

- **visible local leadership will be maintained at each pre-existing health service, with site-appropriate seniority and delegated powers to deliver the following objectives:**
  - **clinical services that are responsive to local conditions and local community health needs**
  - **robust oversight of high-quality and safe care**
  - **engaged local workforce and positive workforce culture**
  - **responsible financial management consistent with the Network board's approved financial delegations**
  - **collaborative engagement with other local service providers to support local pathways and care**
  - **collaboration with local government on population and public health and wellbeing planning**
  - **fostering of local innovation**
  - **managing locally specific functions, including continuing and strengthening current community and social service functions**
  - **robust emergency management preparedness and coordination.**
- **Local Community Boards and community engagement mechanisms are established for each pre-existing health service to:**
  - **provide feedback and advice to local leadership to ensure services meet community needs, and that local perspectives are considered**
  - **include connections to and representatives of major community organisations, such as local government**
  - **support local fundraising and community engagement.**
- **chairs of Local Community Boards will form a subcommittee of the entity board**
- **existing health service identities, brands and related functions such as fundraising are maintained.**

Where a Local Health Service Network has geographic subregions, the Network will establish appropriate subregional leadership structures to deliver the following objectives:

- **coordination across health service sites within the subregion to deliver step-up and step-down care for low to medium complexity care, with the objective of keeping care as close to a person's home as possible**
- **consistent local and subregional referral pathways, including where a subregion may have distinctive flows, such as in peri-urban areas**
- **effective management of site capacity, load sharing and workforce sharing across the subregion.**

Recommendation 7.2: Where a consolidated Local Health Service Network includes a specialist health service with a statewide role, support for that specialist service is to be maintained and strengthened through:

- **visible leadership for the specialist service, with appropriate seniority and delegated powers to deliver the following objectives:**
  - **specialist clinical services that are responsive both to local and statewide health needs**
  - **positive workforce culture, and support for statewide access to specialty expertise, including for care, training and professional development, and research**
  - **in the context of Network service planning, provide specialist service planning across the state**
  - **collaboration, referral pathways and clinical networks with other service providers within their specialty**
  - **responsible financial management consistent with the Network board's approved financial delegations.**
- **a Specialist Community Board that provides advice and feedback to the specialist service leadership, and whose chair is a member of a subcommittee of the Network board**
- **maintaining existing specialist health service identities, brands and related functions such as fundraising.**

Recommendation 7.3: Where a Network includes a denominational health service and a consolidated public health service, the department will establish stronger partnership arrangements between the denominational health service and consolidated public health service so that they are jointly responsible for delivering Network objectives and outcomes.

Finding: The department does not consistently fulfil its role as system steward, with its attention and resourcing instead often focused on managing issues related to 76 separate health services and their interrelationships.

The department should play a greater role in strategic planning and direction setting – in partnership with the sector – to move the system to a new level of maturity.

Recommendation 7.4: The government will hold the department accountable for fulfilling a stronger role in setting strategic directions, monitoring and ensuring accountability.

In a consolidated system, the department will:

- **continue monitoring and holding health services accountable for performance and improvement**
- **strengthen its focus on strategic leadership and direction setting, including statewide system clinical planning, rather than day-to-day issues for individual health services**
- **set and enforce clear objectives and outcomes for each consolidated health service entity, including for meeting population health needs, reducing inequity across its geography, and incorporating local voice**
- **drive greater consistency across health services, and set clear expectations – including directions where needed – when statewide approaches are necessary, and enforce compliance**
- **refocus efforts on quality and safety of care, on continuous improvement and learning, innovation, reform and standardisation of care**
- **enable some activities currently performed by regional offices to become managed by and within Networks where appropriate and consistent with Network functions, rather than departmental functions**
- **regularly review Network boundaries and make decisions about potential adaptations taking into account changing population and demography.**

Chapter 8: Implementing the Health Services Plan

Finding: Implementation of the Plan will rely on a range of critical factors including culture, leadership, change management and improvement methodologies.

- Successful implementation will depend on workforce culture and capability.
- Other enablers out of scope for the Committee include funding models, digital tools and ICT, and broader reforms (e.g. patient transport, workforce).

Recommendation 8.1: The department invest in change management and other key skills to support consolidation of the system, taking a systematic approach to working with key stakeholders and implementing and sustaining change.

Recommendation 8.2: The department and health services promote a collaborative leadership style, developing sector and departmental leaders who take a broad view when leading teams and systems and can share this vision with staff and stakeholders.

Recommendation 8.3: Health services strengthen a learning health system through further:

- **promoting improvement activities through evidence-based frameworks**
- **nourishing innovation including through health services research cultivating links with partners including medical research institutes, and promoting uptake of evidence-based care through building workforce capability for improvement activities.**

Recommendation 8.4: The department review funding models to promote future financial sustainability and support contemporary clinical and organisational practice, including through digital transformation.

The department's review of funding models consider appropriate mechanisms to support ongoing investment in digital systems and minor capital and engineering infrastructure to ensure the system is modern, sustainable and digitally enabled.

The department review and improve budget, pricing and financial accountability mechanisms, to support more robust financial management.

Recommendation 8.5: The department implement Victoria's Digital Health Roadmap, to enable clinical information systems to share information and support interoperability across the health system.

Recommendation 8.6: The department:

- **make clear and timely policy decisions when new clinical or support services are being introduced on whether statewide or decentralised approaches should be adopted, taking into account equity, consistency, effectiveness and efficiency**
- **explore statewide approaches for existing clinical or support services where cost effective and efficient.**

Recommendation 8.7: **The department continue reforms to strengthen health workforce, improve efficiency and coordination of patient transport, establish mechanisms to manage patient flow and demand, and leverage opportunities such as virtual care.**

Chapter 9: Continuing reform

Finding: Further work is required to improve connections with primary care, community health, and across physical health, mental health and alcohol and other drug-related issues.

- A lack of clarity about the relative roles and responsibilities of community health providers and health services risks contributing to service gaps or duplication.
- Poor integration between primary and acute care leads to fragmented care pathways, impacting patient experiences and outcomes.
- Improved integration is needed to better care for those with physical, mental health and alcohol and other drug-related care needs.

Recommendation 9.1: The department clarify the relative roles and responsibilities of registered community health providers and health services, in the context of broader reforms to integrate primary and acute care.

Recommendation 9.2: The department work with the Commonwealth to establish regional governance structures that span primary, acute, non-acute mental health, alcohol and other drug and aged care services, with features including:

- **regional governance structures being responsible for planning, coordinating and commissioning services that are tailored to local health needs and address local service gaps, while remaining consistent with department-led statewide system planning**
- **maintenance of alignment of other system boundaries with new Networks, including mental health regions, Local Public Health Units and Primary Health Networks**
- **support for improving interfaces with local government, aged care, disability and social sectors.**

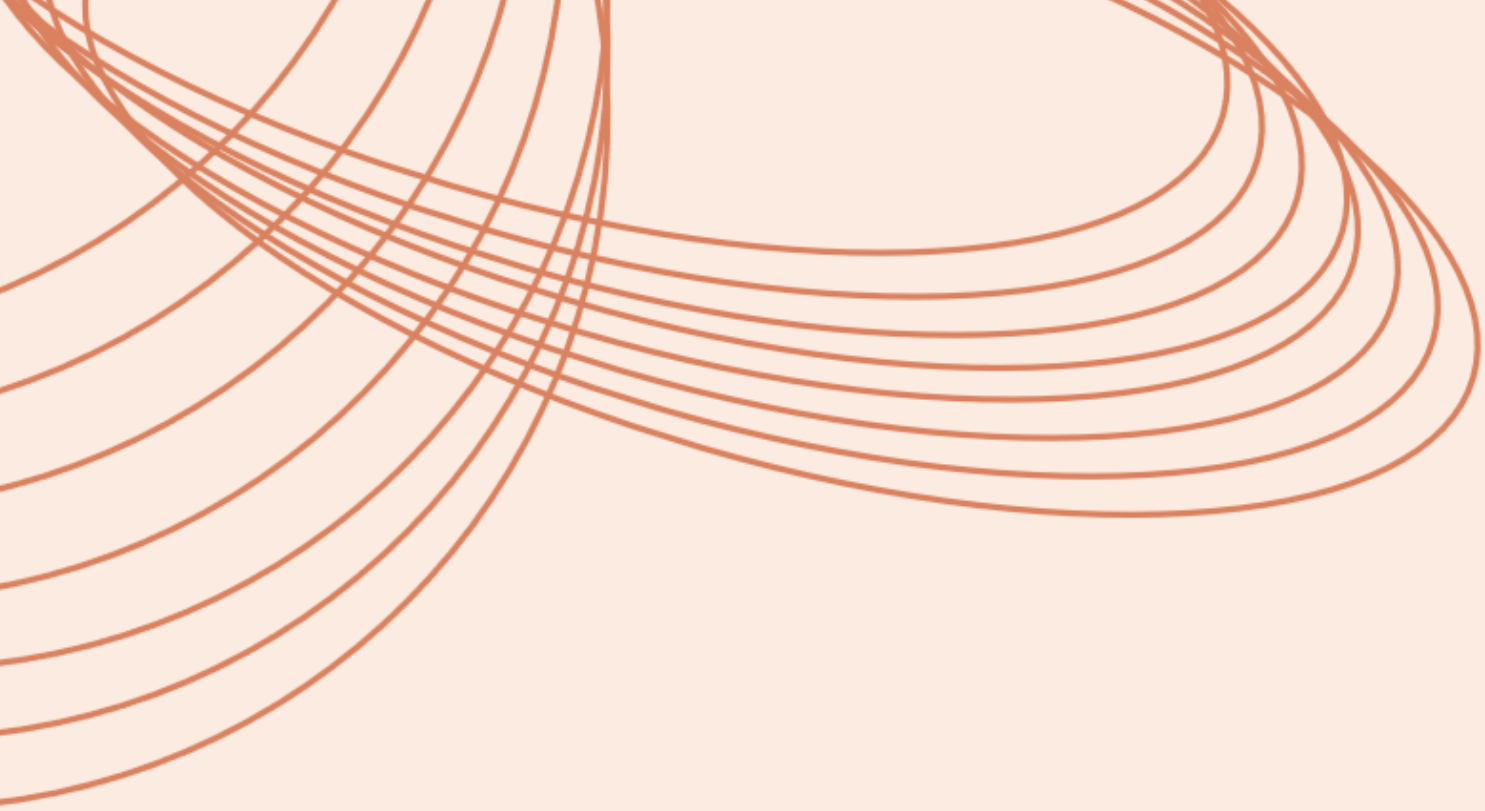
Recommendation 9.3: The department develop and incentivise new care models that promote delivery of the right care, in the right place, at the right time, including:

- **support for innovative service models that support integrated care pathways for physical and mental health across primary, acute and aged care**
- **exploration of funding models that better support patients' care pathways and reward achievement of outcomes for patients**
- **support for digital systems and technology to support information flow, and virtual care.**

Recommendation 9.4: **The department align new regional governance structures with mental health regional bodies to best support integration across physical health, aged care, mental health, and alcohol and other drugs.**

Recommendation 9.5: **The department drive continuous improvement of the health services system including through commissioning reviews of the reformed system including:**

- **a review in three years from commencement of the reform implementation to evaluate the process**
- **a review in five years from implementation to evaluate outcomes, considering services consolidated into Network groupings and those that remain separate (including denominational providers of public health services).**



Introduction

The Victorian health services system faces increasing pressure

Victoria has a high-performing health services system, but in recent years the system has come under increasing pressure.

Like other jurisdictions throughout Australia, Victorian health services face the compounding challenges of an ageing population, a growing burden of chronic disease, rising costs of service delivery and increasingly severe workforce shortages.

More patients require ongoing support for chronic conditions, rather than discrete episodes of acute illness or injury. Medical advancements are supporting the development of new treatments, technologies and models of care, such as virtual care, requiring new approaches from health services.

The role of private practice has changed, with patients in many parts of outer metropolitan, regional and rural Victoria facing extreme challenges accessing GPs or incurring high out-of-pocket costs.

These pressures are felt inequitably across the state, and our health services vary in how well equipped they are to manage these challenges. Some communities – particularly in rural Victoria – have older populations and higher rates of chronic disease than other communities. Workforce shortages are more acute in outer metropolitan, regional and rural Victoria.

These pressures impact Victoria's capable and dedicated healthcare staff, who are working harder to deliver patient care in an outdated system. And, most importantly, these pressures impact patients, with the health services system no longer supporting delivery of equitable care across the state.

The pandemic exposed issues in our health services system

Despite seismic shifts in the healthcare landscape, the design and structure of Victoria's health services system has remained almost unchanged for 20 years. The system was designed following a Ministerial Review of Health Care Networks in 2000,[2] with further changes in 2003 to strengthen governance and accountability.[3]

Victoria's health services system operates under a 'devolved governance' model, with each health service a separate legal entity overseen by a board appointed by the Minister for Health. Provided boards meet accountability requirements set out by the department, they are allowed a degree of local autonomy in how and what services they deliver.

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[2] S Duckett et al., *Victoria: ministerial review of health care networks: final report*, Victorian Department of Human Services, 2000.

[3] G Kibble, B McKay, & S Bradley, *Victorian public hospital governance reform panel report*, Victorian Department of Human Services, 2003.

There are currently 76 independently governed health services in Victoria. (This is more than any other Australian state, in fact it is more than the rest of Australia has combined.) These services differ vastly in size and role, from small rural sites that focus on primary, community and aged care services, to major tertiary hospitals that deliver highly complex acute care.

Victoria's devolved governance model has many benefits and has contributed to the strengths of Victoria's health system. Health services can use their expertise and local knowledge to tailor care for their community. Operational decisions are made locally, rather than centrally by the department, allowing greater responsiveness to local care needs. Devolved governance also fosters innovation, with leaders empowered to drive local change and improvement.

However, the system's current structure also presents challenges to care delivery. Victoria's large number of individual health services can limit collaboration and coordination across the system. Supporting continuity of care and seamless pathways for patients is more challenging when their care is fragmented across multiple providers. Variation in the size and capability of health services can result in unexplained variation in how patient care is delivered. When individual health services develop innovative programs, these cannot be readily scaled across the system – leading to pockets of excellence rather than widespread improvement. And the large number of individual services can lead to duplication, inefficiency and competition between health services, who too often find themselves vying for the same resources and workforce, rather than collaborating to jointly serve the health needs of their communities.

These strengths and weaknesses of Victoria's health services system were highlighted during the COVID-19 pandemic. The pandemic demonstrated the importance of tailoring care to local communities and the benefits of moving decision-making closer to the people it affects, with contact tracing, vaccination programs and community engagement more effective when performed locally. However, the pandemic also generated challenges that were too great for individual health services to solve on their own. Heightened demand for critically-ill-patient care, responding to the elevated threat in residential aged care and dealing with severe workforce shortages required a degree of coordination that was challenging to achieve with 76 individual health services.

In response, health service clusters were established in 2020 to drive greater collaboration. Clusters evolved to Health Service Partnerships in 2021, which established informal partnering between health services on a small number of priorities. 18 months later an independent evaluation[4] found that while these partnerships have some benefits, they cannot address all the issues facing

[4] A Cockram, J Flynn, & L Wallace, *Health service partnerships evaluation: steering committee report* [unpublished report], Victorian Department of Health, 2022.

Victoria's health system. The evaluation recommended a further review of the design and governance of Victoria's health services system to explore whether the system is optimal to meet current and future challenges.

The impacts of the COVID-19 pandemic persist today. While Victoria's workforce rose to meet the challenges, this caused tremendous strain, with health services stretched and people exhausted. Highly dedicated staff are trying their best, but too often find the system makes it harder to deliver care. Ultimately, the pandemic highlighted the need for a more responsive health services system designed to support our dedicated healthcare workforce to provide safe and quality care.

The Health Services Plan: caring for Victorians now and into the future

The department established an independent Expert Advisory Committee (Committee) in June 2023 to lead development of the Health Services Plan (the Plan). Comprised of Chair Mr Bob Cameron, Dr Alex Cockram, Professor Christine Kilpatrick, Ms Therese Tierney and Mr Lance Wallace PSM, the Committee was tasked with articulating a health services system that delivers the right care, in the right place, at the right time (scope at Appendix 2).

As a committee, we were asked to consider the optimal design of Victoria's health services, including setting out:

- a framework for the appropriate roles of different kinds of public hospitals and other health service facilities in most effectively providing the right care to people across Victoria
- appropriate organisational arrangements to support optimal health services system design, grouping health services to ensure safe, high-quality care is provided to communities, as well as to attract and retain workforce
- identifying appropriate collaboration arrangements to support optimal public health service design.

A key requirement was that community access to safe and quality services must be maintained or enhanced, including in rural areas.

Health service entities in scope

The following types of health services entities are in scope for the Health Services Plan:

- public health services[5]
- public hospitals[6]
- multi purpose services[7]

[5] For a full list of public health services, see the *Health Services Act 1988* (Vic), Schedule 5.

[6] For a full list of public hospitals, see the *Health Services Act 1988*, Schedule 1.

[7] For a full list of multi purpose services, see the *Health Services Act 1988*, Schedule 1a.

- denominational services[8]
- Victorian Institute of Forensic Mental Health
- Dental Health Services Victoria.

Although these health service entities provide a range of services – including acute care, community health, aged care, physical and mental health, alcohol and other drugs (AOD) and dental health – to deliver a timely and robust Plan we have focused predominantly on acute care, while considering interfaces with other sectors.

The following services are out of scope:

- private hospitals
- private day procedure centres
- ambulance services
- non-emergency patient transport (NEPT) services
- Youth Mental Health and Wellbeing Victoria
- early parenting centres
- bush nursing hospitals
- registered community health organisations
- public sector residential aged care provided outside of in-scope health services.

Any other health services not defined by the *Health Services Act 1988* (Vic) are also outside the Plan's scope.

To develop the Plan, the Committee developed a problem statement outlining the issues we considered needed addressing. We then drafted design principles to underpin the future system and guide decisions about individual design elements. We consulted with health service CEOs and board chairs on both the problem statement and design principles. Once these foundations were finalised, we began developing design elements and initial options to promote delivery of the right care, in the right place, at the right time. We conducted a further round of consultation with CEOs and board chairs to test these design elements and initial options for reform. The extensive feedback from health services CEOs and board chairs on these options received through this round of consultation shaped our next steps.

In addition, the Committee's secretariat met with health service CEOs and/or boards, and the outcome of these discussions was provided to the Committee. We carefully considered this extensive range of feedback and it informed further development of reform options. Once the Committee had developed a refined set of reform options for the Plan, we performed a final round of consultation with CEOs

[8] For a full list of denominational hospitals, see the *Health Services Act 1988*, Schedule 2.

and board chairs. Throughout these rounds of consultation, the Committee also received a total of 105 letters and submissions from health service leaders and other sector stakeholders.

Knowing the CEOs and board chairs were representing their staff and board colleagues, the Committee considered views from other stakeholders. Consumer perspectives were gathered through an Engage Victoria survey distributed through health services. We considered insights from the Victorian health workforce strategy consultation and engagement process, and briefings were also held with unions. We learned from Safer Care Victoria (SCV) advice and drew on departmental data and analysis. The Committee also considered reform lessons from other jurisdictions, including the New South Wales (NSW) parliamentary inquiry into rural health,[9] the NSW *Special commission of inquiry into acute care services in NSW public hospitals,*[10] *Advice on Queensland Health's governance framework*,[11] and the Western Australia (WA) *Independent review of WA health system governance*.[12] Local, national and global health system experts were consulted to provide balanced perspectives and advice.

We are grateful to everyone who participated in consultations and who provided submissions, correspondence or feedback, helping to shape the final Plan. We also thank the secretariat for the extensive support and expertise it provided in the development of the Plan.

Our health services system has served Victorians well. However, the COVID-19 pandemic highlighted significant issues with the design of Victoria's health services system that make it more challenging to deliver high-quality, equitable care. A new path is needed to meet today's fast-changing care needs and ensure our system is fit-for-purpose to meet future challenges. This Plan provides a roadmap for how we can support our dedicated healthcare workforce to deliver the right care, in the right place, at the right time for all Victorians.

[9] Parliament of New South Wales (NSW), Portfolio Committee No. 2, *Health outcomes and access to health and hospital services in rural, regional and remote New South Wales, Health Report No. 57,* Parliament of NSW, 2022.

[10] P Garling, Special Commission of Inquiry, *Special commission of inquiry into acute care services in NSW public hospitals*, State of NSW, 2008.

[11] J McGowan, P Philip & A Tiernan, *Advice on Queensland Health's governance framework*, Qld Department of Health, 2019.

[12] K Peake et al., *Independent review of WA health system governance,* State of Western Australia, 2022.

Chapter 1

The case for change

Chapter 1: The case for change

Finding: The following problem statement outlines the key issues we seek to address: *Depending on who you are, and where you live, Victorians have variable experiences of and inequitable access to timely, safe, high-quality care, which means health outcomes vary across the state*.

Finding: While Victoria's health services system has performed well in the past, its design is no longer fit-for-purpose and impedes best efforts to meet current and future challenges.

- Victoria's health system is coming under increasing pressure, with an ageing population, increasing chronic disease, increasing costs of service delivery, workforce challenges and enduring impacts of the COVID-19 pandemic.
- Depending on who you are, and where you live, Victorians' access to care varies. While those in inner metropolitan areas tend to have greater access and choice of services, others experience service gaps, longer waitlists, further travel and less consistency in the appropriateness of the care they receive. These inequities are exacerbated for priority populations and vulnerable groups, such as Aboriginal Victorians, refugees and asylum seekers, and culturally diverse Victorians.
- Victorians' experience of care varies, with many finding the system complex and difficult to navigate. Referral pathways are inconsistent, often relying on relationships between clinicians rather than a consistent, logical and seamless approach.
- Not all patients receive the right care, and some experience avoidable harm during their care. We have unexplained variation across the state because the current system structure does not support all health services to deliver care as safely as possible.
- Health services face severe workforce challenges. While clinical workforce shortages are a worldwide phenomenon, these challenges are amplified here by uncoordinated recruitment processes and competition for staff between multiple health services in a geographic region. This ultimately impacts patient access to care. Health workers also have inconsistent access to professional development, peer support and research opportunities, depending on where they work.
- Because health services share geographies, it is unclear which services are accountable for ensuring the care needs of a local population are met. Health services should be responsible for designated communities, to clarify accountability for population health outcomes.
- The fragmented structure of Victoria's health services system hinders integration with other sectors, such as aged care, non-acute mental health, community health and primary care. It also hinders Victoria's ability to

implement reforms arising from the next National Health Reform Agreement addendum that is being negotiated in response to the recommendations of the 2023 Mid-Term Review.

- The role of the Department of Health (the department) as system steward is also hampered by existing arrangements. While other Australian health departments work with a maximum of 16 networks to ensure the right health care is delivered at the right time and in the right place, our department has 76 individual services – more than the rest of the nation put together.
- Victoria's health services system does not make the best use of our vital healthcare resources due to duplication of activities across the 76 services and a lack of scale efficiencies. This reduces the resources available for direct patient care.
- Existing arrangements, such as Health Service Partnerships, are not sufficient to drive the collaboration required to meet current and future challenges facing the system.

Recommendation 1: Government undertake fundamental reform to address current and future challenges and build a health services system that delivers the right care, in the right place, at the right time, for all Victorians now and for the future.

Victoria's health services system is under increasing pressure, with an ageing population, growing prevalence of chronic disease, increasing costs of service delivery, ongoing workforce challenges and the enduring impacts of the COVID-19 pandemic.

While Victoria's health services have highly committed and dedicated staff, they have variable capacity to respond to these challenges and adopt new technologies and models of care. Moreover, our highly fragmented system does not support health services to collaborate, limiting opportunities to pool resources, share innovations and operate at scale. Victorians, in turn, have variable access to timely, safe and high-quality care, depending on who they are and where they live.

The key system challenges outlined in this chapter were distilled from a series of workshops with the board chairs and CEOs of Victorian health services. The aim of these workshops was to develop a shared understanding of the system-wide problems that exist in Victoria, and the barriers to addressing them.

Through these workshops the following problem statement was also developed, which the Health Services Plan seeks to address:

> *Depending on who you are, and where you live, Victorians have variable experiences of, and inequitable access to, timely, safe, high-quality care, which means health outcomes vary across the state.*

Our system has served Victorians well. However, a step change is now needed to meet current challenges and grasp future opportunities.

Access to care

> *Living in a remote community with lots of really small populations and ageing populations, the main barrier for us is access.*[13]

Variable access

Victorians' access to care varies, depending on who they are and where they live. This includes a range of social, political, cultural and economic factors, such as socioeconomic status, education, housing, transportation, food security, psychosocial risk factors, social environment and support networks.

Across metropolitan, regional and rural areas, some Victorians face particularly complex or multifaceted barriers to accessing care. This includes Aboriginal and Torres Strait Islanders, refugees and asylum seekers, culturally diverse Victorians, people with a disability, people experiencing homelessness or mental ill-health and people in the LGBTIQA+ community.

For example, emergency department patients with preferred languages other than English (including those who don't require an interpreter) are significantly less likely to be seen and treated within recommended timeframes than those whose preferred language is English.[14] Long emergency department wait times are associated with worse patient outcomes, including a higher risk of death.

Access also varies based on geography. Whereas people in inner metropolitan areas tend to have greater access and choice of services, others experience service gaps and further travel distances. Some patients also wait longer for services and there is variation in the appropriateness of the care they receive.[15]

Across different geographic areas, there is also significant variation in the care that communities can access within their region. For example, in Barwon South West, 93% of admitted maternity care is provided within the region, compared to only 76% in Hume.[16] Reduced access means patients in Hume are more likely to travel further for maternity care, with impacts on their families, their livelihoods and their quality of life.

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[13] Participant at workshop of health service CEOs and board chairs, Health Services Plan, August 2023.

[14] Victorian Department of Health, 2021–22 to 2023–24 Victorian Emergency Minimum Dataset (VEMD) data [internal analysis], April 2024.

[15] For example, according to the VEMD 2022–23, people attending rural and regional emergency departments are 8% less likely to be seen within the recommended times. Elective surgery and specialist outpatient wait time performance also varies significantly by health service and region.

[16] Victorian Department of Health, 2021–22 Victorian Admitted Episodes Dataset (VAED) data [internal analysis], October 2023.

Travelling for care

For some types of care, it will always be necessary for patients to travel, as not all hospitals can provide all services. Complex care, such as a transplant or neurosurgery, should be delivered at sites which are large enough – and provide this service frequently enough – to support dedicated clinical expertise in this area. In such instances, small local health services may provide initial care for the patient before they are referred to a higher capability hospital. They may also provide rehabilitation services after the patient has received treatment elsewhere.

However, patients in our system often travel further than necessary. This includes travelling to a metropolitan site rather than a nearby regional centre, or travelling across metropolitan areas for types of care that could be provided closer to home. As observed by one respondent to the department's Women's Health Survey:

> *[It's] disappointing the number of times I cannot get good rural/ regional care and get bumped to Melb [Melbourne] for issues that a major rural hospital or competent small rural hospital should be [able to] proactively help prevent.*[17]

In such circumstances, the patient may unnecessarily remain at a large health service far from their family, or delay or miss out on care due to the time, cost and inconvenience of travel.

For example, a patient requiring maintenance dialysis may begin treatment at a site far from home by necessity, due to limited capacity at their closest centre. However, due to a lack of centralised regional waitlists, patients are rarely transitioned back to their closest centre, even when a chair becomes available.[18] Given the need to travel for dialysis services multiple times per week, this can have a significant impact on a patient's quality of life.

Virtual care

If health services are well connected, it is also possible to provide some care without the need for travel at all. This could be enabled through virtual care, secondary consultation or remote supervision by a clinician at another health service. During the Committee's workshops, many health service leaders encouraged greater leverage of virtual care, noting it can ensure '*…our very skilled specialists aren't using their time to travel to all ports of the state, but neither are our consumers.*'[19]

While internet access can be a challenge, many consumers – particularly those living in rural or regional areas – value virtual care options to minimise travel and

[17] Victorian Department of Health, *Engage Victoria women's health survey 2023* [internal analysis], February 2024.

[18] Participant at workshop of health service CEOs and board chairs, Health Services Plan, August 2023.

[19] Participant at workshop of health service CEOs and board chairs, Health Services Plan, August 2023.

access specialist expertise.[20] Reflecting on their use of telehealth, one respondent to the Committee's consumer survey explained, '*I needed follow up services and did not want to travel 400km for [a] 15-minute appointment.*'[21]

Disconnected care

Unfortunately, none of these functions is consistently supported by the current system. Health services are not always well connected, with fragmentation and poor coordination often limiting access to expertise across the state and leading to delays in patient transfers.

For example, if a lower capability health service has a deteriorating patient, the onus is on them to find an available bed elsewhere for the patient. They may need to contact multiple tertiary hospitals, often relying on ad-hoc or personal relationships with other health services. These tertiary hospitals do not have clear accountabilities for deteriorating patients, and can refuse to provide any assistance for these patients if they do not have capacity at the time.

The impact on patients can be life-threatening, with delays sometimes extending over 50 hours before they are transferred to a hospital with appropriate expertise.[22] The same is true of step-down care, with poor connections between health services creating barriers to timely discharge back to a patient's local health service where appropriate.

Fragmentation can also make it challenging to establish clear and coordinated pathways for patients who transition between services. Increasing rates of ongoing chronic and complex conditions mean that many patients need multidisciplinary care, beyond what a single hospital or specialist facility can provide.

For example, it can be challenging to coordinate between services when teenagers at the Royal Children's Hospital are ready for adult services, or could receive surgery in an adult hospital, such as the Royal Melbourne. It is difficult for these transfers to be seamless, and they create an administrative burden for health services.

Despite their proximity to one another, hospitals in Parkville have no shared visibility of demand and capacity across sites.[23] If a patient requires care from another service in the precinct, staff must call that hospital to find a bed and negotiate the patient's transfer. Once the patient has received treatment, staff at the hospital who accepted them must again call around to negotiate transfer back to the appropriate service for ongoing care. In the period when a patient is receiving

[20] Victorian Department of Health, Results from consumer survey undertaken for the Expert Advisory Committee [internal analysis], 2024.

[21] Victorian Department of Health, Results from consumer survey undertaken for the Committee.

[22] West Gippsland Healthcare Group, *Interhospital patient transfers* [presentation to the Victorian Perioperative Consultative Council], August 2021.

[23] Victorian Department of Health, Internal advice, 2024.

care from another hospital in the precinct, they become less visible to their treating specialist, and this can delay timely access to appropriate specialist care should their condition deteriorate. In addition, the manual processes to manage transfers are time-consuming, inefficient and do not reflect the best use of health resources.

Experience of care

> *People can be prepared to travel, but if you undertake a seven hour round trip for a 15-minute appointment and they don't even know your name, it breaks your heart.*[24]

Variable experience

While many patients are satisfied with their care, there is variation across the state, with smaller and specialist hospitals tending to perform better than larger ones on patient self-reported metrics.[25] These trends in variable experience are consistent with the findings of the Committee's consumer survey.[26]

Culturally safe care

Variable patient experience is particularly apparent for Aboriginal and/or Torres Strait Islander patients, who do not have consistent access to culturally safe care. In Victoria, Aboriginal patients are three times more likely to leave hospital against medical advice than non-Aboriginal patients.[27] They are also around twice as likely to leave an emergency department without being seen.[28] While patients may choose not to access care for many reasons, this can be an indicator that they did not feel safe or that the care was not culturally appropriate.

The proportion of Aboriginal and/or Torres Strait Islander patients who leave hospital against medical advice varies from an average of 3.4% at tertiary hospitals to an average of 0.5% in small rural health services, with significant variation within peer groups.[29] This suggests that the current system does not support health

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[24] Participant at workshop of health service CEOs and board chairs, Health Services Plan, August 2023.

[25] Victorian Agency for Health Information, *Victorian healthcare experience survey – adult inpatient survey,* March-January 2023 data. Statewide, 92% of surveyed patients discharged from Victorian health services were satisfied with the care they received during their admission. Small rural, local and specialist health services all performed above average on this metric, with between 98% and 99% of surveyed patients indicating they were satisfied with their care.

[26] Victorian Department of Health, Results from consumer survey undertaken for the Committee. People living in major cities were less likely to feel their hospital had met their expectations (55%) compared with those living in inner regional areas (67%), outer regional areas (63%) or remote areas (63%).

[27] Victorian Department of Health, 2022–23 VAED data [internal analysis], March 2024. Only public hospitals with at least one Aboriginal patient are included. Aboriginal status is known to be underreported, which may affect the results.

[28] Victorian Department of Health, 2021–22 to 2023–24 VEMD data [internal analysis], April 2024.

[29] Victorian Department of Health, 2022–23 VAED data [internal analysis], March 2024. Only public hospitals with at least one Aboriginal patient are included. Aboriginal status is known to be underreported, which may affect the results.

services to consistently provide culturally safe care, impacting patient experience and outcomes.

Navigating the system

Regardless of where they live, Victorians often struggle to navigate the system. According to a recent survey of over 2,000 Victorians, more than a quarter do not feel confident in their ability to find the right healthcare service for their needs.[30]

While many patients are willing to travel for some services, they expect the care pathway to be clear and well-connected.[31] During consultations, one rural health service leader noted: *'For me as a consumer, I wouldn't mind travelling a bit if it were seamless and easy, I'm not a surprise [to the health service] when I get there and it's friendly and welcoming.'*[32] Unfortunately, this does not always occur.

Referral pathways are 'messy' and 'unreliable', often based on relationships between individual clinicians rather than a standardised approach.[33] For patients, this means their care may be disconnected, their information may not follow them, and communication may be unclear. In the Committee's consumer survey, poor communication was among the main reasons identified by patients for a service not meeting their expectations.[34]

With multiple health services providing care for a patient, and with limited connection and coordination between them, there is no single point of accountability for the care and wellbeing of individual patients. In many cases, this places the onus on patients to advocate for and coordinate their own care in a system that is confusing to navigate. Ultimately, this contributes to inequity in how patients access and experience care.

Speaking about the difficulty of navigating the health system, one respondent to the department's Women's Health survey commented:

> *This was a huge emotional and financial strain on my family and had they not stepped up to fill this role, I would not be alive today. Services were simply not available, inconsistent or inadequate.*[35]

Wait times

According to feedback from the Committee's consumer survey, wait times are what matters most when people reflect on their experience of the public health services

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[30] The Source, *Right care, right place, right time* [research commissioned by the Victorian Department of Health], 2023.

[31] Victorian Department of Health, Results from consumer survey undertaken for the Committee. Most patients are willing to travel for some hospital services, particularly inpatient and specialist care.

[32] Victorian Department of Health, Results from consumer survey undertaken for the Committee.

[33] Participant at workshop of health service CEOs and board chairs, Health Services Plan, August 2023.

[34] Victorian Department of Health, Results from consumer survey undertaken for the Committee.

[35] Victorian Department of Health, *Engage Victoria women's health survey 2023*.

system.[36] It is also the most common reason for expectations of care not being met, and one of the areas most commonly identified by consumers as requiring improvement.[37] Given that patients are not balanced evenly across health services (see 'Outcomes for community', below), there are opportunities to improve patient experience by making better use of capacity across the system.

Quality and safety

> *Take a small town whose community is propped up by the GP service. We'll let them have their 30 births per year and do surgery, even though in our right minds we would not design it like that.*[38]

Variable quality and safety

While the average quality and safety performance of Victorian health services is good, Victoria is not the best performer nationally and there continues to be problematic variation across the state.[39] Not all patients receive the right care, and some are exposed to avoidable harm through their interaction with health services.

The current system structure does not support all health services to deliver care as safely as possible. According to Victorian data, the likelihood of a patient experiencing a hospital-acquired complication varies depending on the kind of hospital they attend. For example, the rate of the most common complication, healthcare-associated infection, is different across the state with the highest variation in small rural hospitals. While some hospitals in that group have low rates, others do not, and the average rate is 56% higher in small rural hospitals than in larger regional health services, even after adjusting for risk.[40]

Similarly, the likelihood of a stillbirth or baby dying within 28 days of being born is more variable in rural, regional, and outer metropolitan hospitals, with significant variation across different hospitals.[41] This level of variation indicates that some

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[36] Victorian Department of Health, Results from consumer survey undertaken for the Committee.

[37] Victorian Department of Health, Results from consumer survey undertaken for the Committee.

[38] Victorian Department of Health, Results from consumer survey undertaken for the Committee. While GPs deliver highly valuable care in their communities, providing complex services in low volumes can pose a risk to patient safety.

[39] S Duckett, M Cuddihy & H Newnham, Review of Hospital Safety and Quality Assurance in Victoria, *Targeting zero: supporting the Victorian hospital system to eliminate avoidable harm and strengthen quality of care*, Victorian Government, 2016, pp 11–12. For national comparisons see the Steering Committee for the Review of Government Service Provision's R*eport on government services 2023 – Health (Part E)* and Australian Institute of Welfare's (AIHW) *Australia's health performance framework – Health System: effectiveness.*

[40] Victorian Agency for Health Information, *Risk-adjusted hospital acquired complications report (Feb 2023–Jan 2024) [unpublished report]*, April 2024. Patients transferred directly to residential aged care following their hospital admission were excluded from this analysis.

[41] Safer Care Victoria, *Victorian perinatal services performance indicators 2021*, Victorian Government, 2024, p 72. The indicator referred to is the 'gestation standardised perinatal mortality ratio. It takes into account gestation – or length of time since conception – which is a key risk factor. However, it does not take into account other risk factors, such as differences in patients' socioeconomic status, which impact on risk of death. Note: only hospitals with at least 5 stillbirths or deaths within 28 days in total across the 5-year period are included.

health services experience suboptimal conditions for delivering the safest possible care.

Variable capability and capacity

To minimise risk, it is essential that health services have consistent and rigorous oversight of patient care. This means having the systems and processes in place to monitor, report on and respond to incidents, and continuously improve quality and safety of care.

Currently, health services have variable ability to meet these needs, linked to their size and the resources available to them. For example, small health services are not always able to employ dedicated clinical safety staff, which can contribute to variable clinical standards.

This variation is reflected in hospital accreditation and board data. Over the last four years, one in seven Victorian health services required remedial action to achieve accreditation. Of these, most were smaller health services challenged by limited scale and resources, as well as one metropolitan hospital. [42] Furthermore, over the past three years, at any given time, between three and six Victorian health services have had a ministerial delegate assigned to their boards to support them with clinical, financial and corporate governance, particularly on complex issues. While the reasons they require this support can be varied, it highlights the challenges within the current system of ensuring that all health service boards have the required skills and expertise at all times.[43] This typically impacts boards in non-metropolitan areas with reduced access to the breadth of skills required for effective board governance.

Clinical governance

Since 2016, multiple independent reports have linked quality and safety issues and clinical governance limitations to the way our health services system is structured and governed.[44] Similar observations have been made more recently by SCV. In a statement to the Committee, SCV observed:

> *SCV-led reviews in the past five years have shown that poor quality and safety governance in hospitals has led to unnecessary patient harm and differences in the ways patients have been treated across the system.*

[42] Australian Commission on Safety and Quality in Health Care, National Safety and Quality in Health Services Standards data [internal analysis], June 2023. Inclusion criteria: Victorian public hospitals, assessments completed between January 2019 and May 2023.

[43] Victorian Department of Health, Internal advice, January 2023.

[44] Duckett, Cuddihy & Newnham, *Targeting zero;* Victorian Auditor General's Office (VAGO), *Clinical governance: health services,* Victorian Government, 2021; and VAGO, *Clinical governance: Department of Health,* Victorian Government, 2021.

SCV is concerned that health services' governance vary in their ability to prevent harm. This means we cannot always guarantee safe care across the system or that patients aren't being harmed when they shouldn't be.

One reason for these differences is the large number of independent health services in Victoria. Each has its own governance leaders accountable for patient safety, which makes it challenging to have the right care quality and safety governance skills across the system to keep patients safe.

SCV runs programs to help hospital governance leaders improve their quality of care and patient safety skills, but because there are so many hospitals and leaders, it's tough to meet everyone's needs. Plus, everyone comes into these roles with different levels of knowledge and experience.

To make sure all hospitals in Victoria consistently keep patients safe, we need to address the number and configuration of health services across the system. This will help reduce the risk of patients being unnecessarily harmed when receiving medical care in the future.

Workforce

> *I worry about the competition, about us all competing for the same workforce. If we collaborated, we could all be working together to get better outcomes.*[45]

Attraction and retention

While there are workforce challenges across the state, attraction and retention difficulties are particularly pronounced in rural, regional and outer metropolitan areas. For example, rural health services lose staff at a 30% higher rate than metropolitan services and devote more resources to recruitment, spending 3.6 times more on recruitment per head than metropolitan services.[46]

A range of factors contribute to these challenges and while some are outside of the health system, others are related to health service scale.[47] For example, smaller health services with low service volumes may have fewer opportunities for professional development and career progression, which can impact staff retention. They may also need to offer fractional rather than fulltime clinical roles, which can be more challenging to fill.

For example, at one small Victorian health service, it had been difficult to attract a clinician to a 0.1 full-time equivalent role. This meant the community had to travel

[45] Participant at workshop of health service CEOs and board chairs, Health Services Plan, August 2023.

[46] Victorian Department of Health, 2021–22 health service financial data [internal analysis], September 2023.

[47] Victorian Department of Health, *Victorian health workforce strategy: A 10-year strategy for a modern, sustainable and engaged healthcare workforce*, Victorian Government, 2024. For example, health workers may be less likely to relocate rurally due to limited schooling and employment opportunities for their families.

for care which could have been provided closer to home. When the health service later merged with others in the region, the larger organisation was able to appoint to a full-time role, with a condition of employment to work one day per fortnight at the smaller campus.[48]

While workforce shortages are a worldwide phenomenon, these challenges are amplified by uncoordinated recruitment processes and competition between multiple health services in a geographic region. For example, a large recruitment drive at one metropolitan hospital can draw workers away from other nearby health services.[49] The system also does not readily support health services to share workforce or jointly appoint clinicians to work across a larger catchment area. This impacts patients' access to care close to home, as well as costs to health services.

Overall, smaller health services tend to face higher relative workforce costs, compared to larger organisations.[50] Some of these elevated costs are driven by a reliance on fractional appointments of Visiting Medical Officers and locums. In 2022, a third of health services, largely in regional and rural areas, used sessional medical officer services at a rate more than three times what it would cost to employ a salaried staff specialist.[51]

Training and peer support

Workers' access to training and professional development also depends on the size and capability of their health service. Specialist health services invest an average of $1,207 in each staff member's training and development. This is more than double that of regional and rural health services, at just $560 per year.[52]

Moreover, health services with low volumes of care can often only employ one or two health workers per professional group. This is particularly true for medical officers and scientists at local and small rural hospitals, while hospitals from other peer groups are able to employ multiple health practitioners.[53]

For those working in more isolated settings, support and supervision arrangements are often ad-hoc or reliant on informal professional networks, rather than being

[48] Advice from a health service leader involved in a previous Victorian amalgamation, 2023.

[49] Advice from Victorian health service leader.

[50] Victorian Department of Health, 2022–23 and 2023–24 health service funding data, Trial Balance data and data from the VAED, Victorian Integrated Non-Admitted Health dataset and the VEMD [internal analysis], April 2024. Compared to metropolitan health services, local and sub-regional health services spend around 17% more on average for each National Weighted Activity Unit they deliver, with local health services spending the most. Note – data is not available for small rural health services.

[51] Victorian Department of Health, 2021–22 Victorian Public Sector Commission data [internal analysis], August 2023.

[52] Victorian Department of Health, 2021–22 Trial Balance dataset [internal analysis], September 2023.

[53] Victorian Department of Health, 2021–22 Victorian Public Sector Commission data [internal analysis], August 2023. Inclusion criteria: casual, ongoing and fixed-term employees. For example, 16 medical scientists, 13 medical officers (including sessional) and 4 hospital pharmacists were sole practitioners, all in local and small rural health services. Please note, those practitioners might work across multiple providers part-time.

supported by the system in a structured way. This has implications on worker wellbeing as well as the quality and safety of the service. As observed in the *Targeting zero* report, without consistent access to peer support and senior expertise, clinicians can become disconnected from contemporary best practice.[54]

Research and clinical excellence

While Victoria is highly respected for its clinical research, the system does not support our specialist and major tertiary hospitals to reach their full potential on an international scale. Research is spread across multiple, fragmented health services, making it harder to conduct whole-of-lifespan and multidisciplinary research. Clinical trials are often spread across multiple competing organisations, reducing their ability to achieve the power required for robust clinical findings.[55]

Advanced research increasingly requires both deep specialisation but also multidisciplinary and interdisciplinary connections. The five highest ranked hospitals in the world are structured to support this by including multiple speciality centres within one organisation.[56] Top ranked hospitals in the United Kingdom's National Health Service are also structured in this way, with multiple hospitals and speciality centres jointly led under one Foundation Trust. While there are many factors which impact a hospital's overall performance, it is noteworthy that this is a feature of the top ranked hospitals globally.

More broadly, access to research opportunities varies across the system. Smaller health services may not have a sufficient patient pool with unified standards of care, or the necessary relationships with research institutes and universities, to participate in clinical trials and advanced research. The effectiveness and validity of translational research is also impacted if a range of service settings, across different geographies and types of hospital, is not covered by the research. Greater access to research opportunities across health services would benefit both clinicians and patients, enabling access to innovative trials and faster translation of new knowledge into practice.

High complexity, low volume care

Some very low volume, highly complex services are delivered across a large number of health services in Victoria compared to other jurisdictions. Examples include bone marrow transplants, kidney transplants, extracorporeal membrane

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[54] Duckett, Cuddihy & Newnham, *Targeting zero,* p 45.

[55] A Bowen, S Tong & J Davis, 'Australia needs a prioritised national research strategy for clinical trials in a pandemic: lessons learned from COVID-19', *The Medical Journal of Australia,* 2021, 215(2):56–58, doi: 10.5694/mja2.51143.

[56] Newsweek, The World's Best Hospitals 2024, available at www.newsweek.com/rankings/worlds-best-hospitals-2024. The top five ranked hospitals are Mayo Clinic – Rochester (USA), Cleveland Clinic (USA), Toronto General Hospital (part of the University Health Network – Canada), Johns Hopkins Hospital (USA) and Massachusetts General Hospital (part of Mass General Brigade – USA).

oxygenation (ECMO), cardiothoracic surgery and complex interventional cardiology.

Whilst this can make it easier for patients to access services, it also results in lower volumes of the service being delivered at each site. This can challenge service quality and sustainability. It can result in competition between health services for the limited numbers of clinicians skilled in these highly specialised services. And limited scale at each site makes it more difficult to develop significant centres of clinical, research and training excellence in each of these highly specialised areas.

Local voice

> *There is power in engaging the consumer and taking them along on the journey. We don't tell the consumers enough about the system.*[57]

Variable engagement

Through consultation, the Committee heard that local voice is essential to health service provision, particularly in non-metropolitan areas where the local health service is often the key employer and a long-term community institution.

Unfortunately, our system does not provide a consistent way for health services to capture or share the valuable insights of their local patients and communities. Moreover, health services' scale impacts their ability to implement the structures and processes required to facilitate local input into decision making.

Existing structures

While health service boards can include directors from the local area, this is not always possible. To ensure quality, safety and sound governance, each board must have a mix of skills including clinical, legal and financial skills, as well as health service user perspectives.[58] Local representation is also important. But with approximately 700 board members required across the state – the vast majority of whom are on regional and rural health service boards – it can be challenging to achieve an adequate skill mix and maintain sufficient local representation on every board. In particular, some health services in more geographically rural areas struggle to attract sufficient applicants with the skill, knowledge and experience mix needed for an effective board. This is particularly the case for smaller health services which are competing for talent against other government boards, and means that in rural and regional Victoria 54% of board members are not local.[59]

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[57] Participant at workshop of health service CEOs and board chairs, Health Services Plan, August 2023.

[58] Duckett, Cuddihy & Newnham, *Targeting zero,* p 29.

[59] Victorian Department of Health, 2023 health service board residency data [internal analysis], August 2023. A Board Member is considered local if they reside closer to a campus of the board they were appointed to than the campus of another health service.

Conversely, some larger health services with a statewide footprint don't necessarily have members with a strong regional perspective. Overall, this suggests it is questionable whether existing board governance is an appropriate or effective mechanism for ensuring local input into decision making.

Community Advisory Committees are one mechanism which can provide a local voice to boards. However, only 19 of the 76 health services in Victoria are required to have one under current legislation.[60] The remaining health services may choose to voluntarily organise a group with a similar function, but oversight over both mandated and voluntary committees is limited.

Outcomes across the community

> *We don't have a system design. We have an incremental hodge podge.*[61]

Diluted responsibility

Population health refers to the health outcomes of a group of individuals, including the distribution of outcomes within the group.[62] In the current system, the role of health service boards and leadership teams is to serve their own health service and patients, rather than the wider community across their region – including community members both inside and outside hospital walls. Responsibility for population health is diluted between multiple health services of varying capabilities who service overlapping geographies. Ultimately, this makes it unclear who is accountable for meeting the community's care needs within any given geographic area. This includes a lack of clear accountability for addressing access barriers and services gaps for disadvantaged populations.

Fragmented planning

In some instances, health services within a geographic area will collaborate on service plans for the wider region. However, region-wide service planning is the exception not the rule and most planning currently occurs at an individual health service level. This approach has often led to service maldistribution, with some clinical services unnecessarily duplicated across multiple hospitals, while others are lacking or not aligned to community need.

For example, bariatric surgery, as a treatment for people with obesity, is currently provided at two metropolitan sites and one rural site. There is no rational plan underpinning where this procedure is delivered and the distribution is not necessarily aligned to population need, given that obesity is widely distributed across the state rather than concentrated in any one specific region.

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[60] *Health Services Act 1988*, s 65.

[61] Participant at workshop of health service CEOs and board chairs, Health Services Plan, August 2023.

[62] D Kindig and G Stoddart, 'What is population health?', *American Journal of Public Health*, 2003, 93(3):380–3.

While the department has a role in stewarding the system, this role is challenged by the number of independent entities, their varying capability and capacity and the lack of clear accountability for health outcomes in a geographic region.

Patient demand

Fragmentation and poor coordination across the system make it challenging to balance patient demand effectively and make the best use of capacity and capability across the state. Some high capability hospitals are overloaded with patients from other catchment areas seeking general care, which can contribute to service delays for those who live locally or require more complex services.[63] Others have spare capacity and may or may not have a suitable workforce to treat more patients and potentially provide care closer to home.

For example, across the state, average bed utilisation is 106% in major tertiary hospitals but 91% in other large hospitals.[64] There is also variation among metropolitan hospitals, with utilisation ranging from 83% to 113%.[65] Utilisation is even lower at small local health services with an average occupancy rate of 40%.[66] Similar trends are seen in operating theatres, with a recent census finding that operating rooms had an 88% occupancy rate in metropolitan sites, compared to only 58% for small rural hospitals.[67]

If the system were more connected, some patients who would currently be transferred to busy hospitals could be cared for at a hospital closer to home. Staff and workload could also be better shared across health services, resulting in better utilisation of rural and regional operating theatres and shortening regional waitlists.

Integration with other sectors

> *How do we better fit the work of the PHNs [Primary Health Networks] into our system, rather than sitting outside of it?*[68]

[63] Victorian Department of Health, 2020–21 VAED data [internal analysis], August 2023. A high proportion of care delivered by major tertiary and specialist hospitals is non-local general inpatient activity.

[64] Victorian Department of Health, 2022–23 VAED data [internal analysis], April 2023, and 2021 hospital bed audit. 'Other large hospitals' refers to AIHW Group A and B hospitals. Data only includes surgical and medical bed and activity data to allow comparisons between hospitals.

[65] Victorian Department of Health, 2022–23 VAED data and 2021 hospital bed audit. Includes all non-specialist hospitals in metropolitan Melbourne.

[66] Victorian Department of Health, 2022–23 VAED data and 2021 hospital bed audit. Refers to AIHW hospital peer groupings Group D and Very Small Hospitals.

[67] Open Advisory, *Victorian Department of Health operating room metrics* [research commissioned by the Victorian Department of Health], 2024, p 8.

[68] Participant at workshop of health service CEOs and board chairs, Health Services Plan, August 2023.

Wider health system

The health services system does not work in isolation; rather, it operates alongside other providers of primary care, aged care, community health, Aboriginal health, non-acute mental health and AOD services. While our scope focused on health services, we also considered how health services interface with the broader system to ensure communities can access appropriate, connected care across the full spectrum of care needs. In doing so, we found that the structure of the Victorian health services system impacts not only integration between health services, but also integration with other sectors. For example, the existence of 76 health services creates additional challenges in achieving integration between primary and acute care. The lack of clarity of the role of health services compared with registered community health providers can also lead to uncoordinated and overlapping service provision.

National reforms

Australian states and territories are working towards increased collaboration between primary care and hospital services. For example, the Mid Term Review of the National Health Reform Agreement recommended increased collaboration between Primary Health Networks (PHNs) and Local Hospital Networks,[69] with an ambition of improving patient pathways and outcomes through joint planning and commissioning.

In its current fragmented state, Victoria's health system is not well placed to meet these ambitions, or to benefit from future reforms to integrate primary and acute care. This is because Victoria's six PHNs would need to interface and jointly plan and commission services with 76 independently governed health services. In contrast, PHNs in NSW and Queensland would only need to engage with between 16 and 18 Local Hospital Networks.

Sustainability

> *There's a massive amount of duplication. We all do things 76 times differently. That's a lot of wasted effort and energy.*[70]

Duplication

The Victorian health system includes 76 independently governed health service entities – more than all other states and territories combined. These health services differ vastly in size, from small rural sites delivering fewer than 20 admitted episodes

[69] Local Hospital Networks are one of a number of separate legal entities established by each Australian state/territory government in order to devolve operational management for public hospitals, and accountability for local service delivery, to the local level.

[70] Participant at workshop of health service CEOs and board chairs, Health Services Plan, August 2023.

a year, to enormous multi-campus organisations, with the largest delivering over 280,000.[71]

This results in a significant amount of duplication. Each health service has its own board, meaning 700 board directors are engaged across health services on a rolling basis. While some health services have collaborated on shared services, many back-office functions, such as payroll and finance, remain duplicated across the state.

There is also overlapping activity for each individual hospital to meet all the compliance requirements associated with delivering hospital services. Examples include maintaining hospital accreditation, credentialling, meeting financial and legal obligations as a public entity, and reporting requirements to the department and SCV. While such compliance is important to ensure quality, safety and sustainability of services, it can be difficult, duplicative and inefficient for health services to manage these requirements. This is especially true of small health services who may lack the scale to be able to employ dedicated staff to manage these requirements.

As observed by one health service leader during consultations: *'It always baffles me when we're all doing so many different things. There's got to be a better way to be spending less money in this space so that everyone's on similar systems.'*[72]

Implications for patient care

The Committee's scope does not encompass a comprehensive financial analysis of Victoria's health services. However, the Committee observes that duplication across multiple health services, and subscale clinical and non-clinical support services, all contribute to poor use of precious health resources which could be better invested in patient care.

For example, the amount it costs health services to deliver care varies significantly across the state – with smaller health services tending to spend more than larger health services.[73] While there is variation among health services of all sizes, there is much greater difference among the smallest health services, with some spending over 50% more than others to deliver the same kinds of care.[74]

As well as variation in the costs of care delivery, health services across the state also spend varying proportions of their budgets on administration. This variation is evident even at similar-sized health services, but on average, the variation is higher

[71] Victorian Department of Health, 2022–23 VAED data [internal analysis], December 2023.

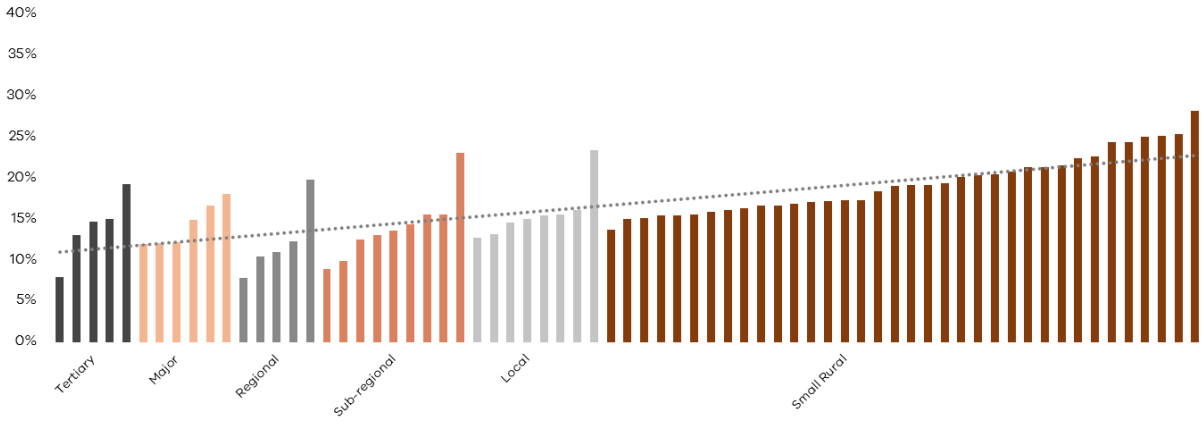
[72] Participant at workshop of health service CEOs and board chairs, Health Services Plan, August 2023.

[73] Victorian Department of Health, Linked 2020–21 Victorian Cost Data Collection and VAED data [internal analysis], September 2023. Calculation based on cost per National Weighted Activity Units.

[74] Victorian Department of Health, Linked 2020–21 Victorian Cost Data Collection and VAED data [internal analysis], September 2023.

in sub-regional, local and small rural peer groups (Figure 1).[75] This means that in many less efficient health services, a smaller amount of funding is available for direct patient care and clinical services.

Figure 1 – Proportion of administrative and back-office costs in health service budget by peer group



Source: Department of Health, analysis of cost data from HeART dataset 2022–23, March 2024.

Barriers to collaboration

> *It's the elephant in the room. We say we want collaboration but in practice it's not the way the system works.*[76]

Health services across Victoria face significant challenges which are difficult to address while working independently, or in informal partnerships. As such, health services are increasingly recognising the benefits of collaboration to better meet the needs of their wider region and Victoria as a whole. For example, reflecting on workforce recruitment difficulties, one health service leader observed:

> *We should be collaborating on workforce… In a perfect world, we'd love to have a partner arrangement with metros where their new recruits rotate through regions. This would help with our workforce difficulties and give more health workers exposure to the regions.*[77]

Existing collaboration structures

The Victorian system includes multiple structures to promote collaboration and partnership. This includes Health Service Partnerships, Local Area Health

[75] Victorian Department of Health, 2022–23 HeART dataset [internal analysis], March 2024. Note – data might be affected by variability in cost centres to which health services report administrative and back-office expenses, particularly at specialist hospitals, which are not included here.

[76] Participant at workshop of health service CEOs and board chairs, Health Services Plan, August 2023.

[77] Participant at workshop of health service CEOs and board chairs, Health Services Plan, August 2023.

Partnerships, integrated cancer services, ICT Alliances and Mental Health and Wellbeing Interim Regional Bodies.

While current collaborative structures are somewhat helpful in addressing variation and inequity across the system, the following factors limit their effectiveness.

Optional and ad hoc – current partnerships are largely optional and depend on the willingness of health service staff and leaders to participate. There is limited governance or oversight on the right partnerships for individual services to pursue to meet their community and clinical needs. Instead, many arrangements are established ad hoc, driven by individual services and relationships rather than a more systematic evaluation of the community's needs.

Limited accountability, trust and transparency – when collaboration does occur, it can be challenged by a lack of clearly articulated shared accountabilities and limited mechanisms to hold participants to account. Partnerships also rely on trust between participants and can be undermined by a perceived lack of transparency between parties. For example, health services have raised concerns about whether pricing for shared services reflects the true cost of delivery, and whether purchasers have sufficient influence over the service quality.

Consensus decision-making – above all, most collaborative arrangements operate by consensus decision-making, where reforms can be supported by a majority of participants but blocked or stalled by a small minority. Some participants have described the process of seeking agreement in this environment across multiple health services as 'excruciating'.[78]

Health services have also raised concerns about how well their interests are supported by decision-making processes. For smaller health services, there are concerns their needs will be overlooked by larger players. Larger health services, on the other hand, have raised concerns that the agenda for an area can be distorted by health services with a smaller breadth of financial and clinical responsibilities.

The need for change

Given the wide-ranging challenges facing the health services system, there is a need for fundamental change.

The structure of our healthcare system has remained largely unchanged for 20 years.[79] Our health services vary significantly in size and capability and are often not well connected with each other. And while Victoria's devolved structure can

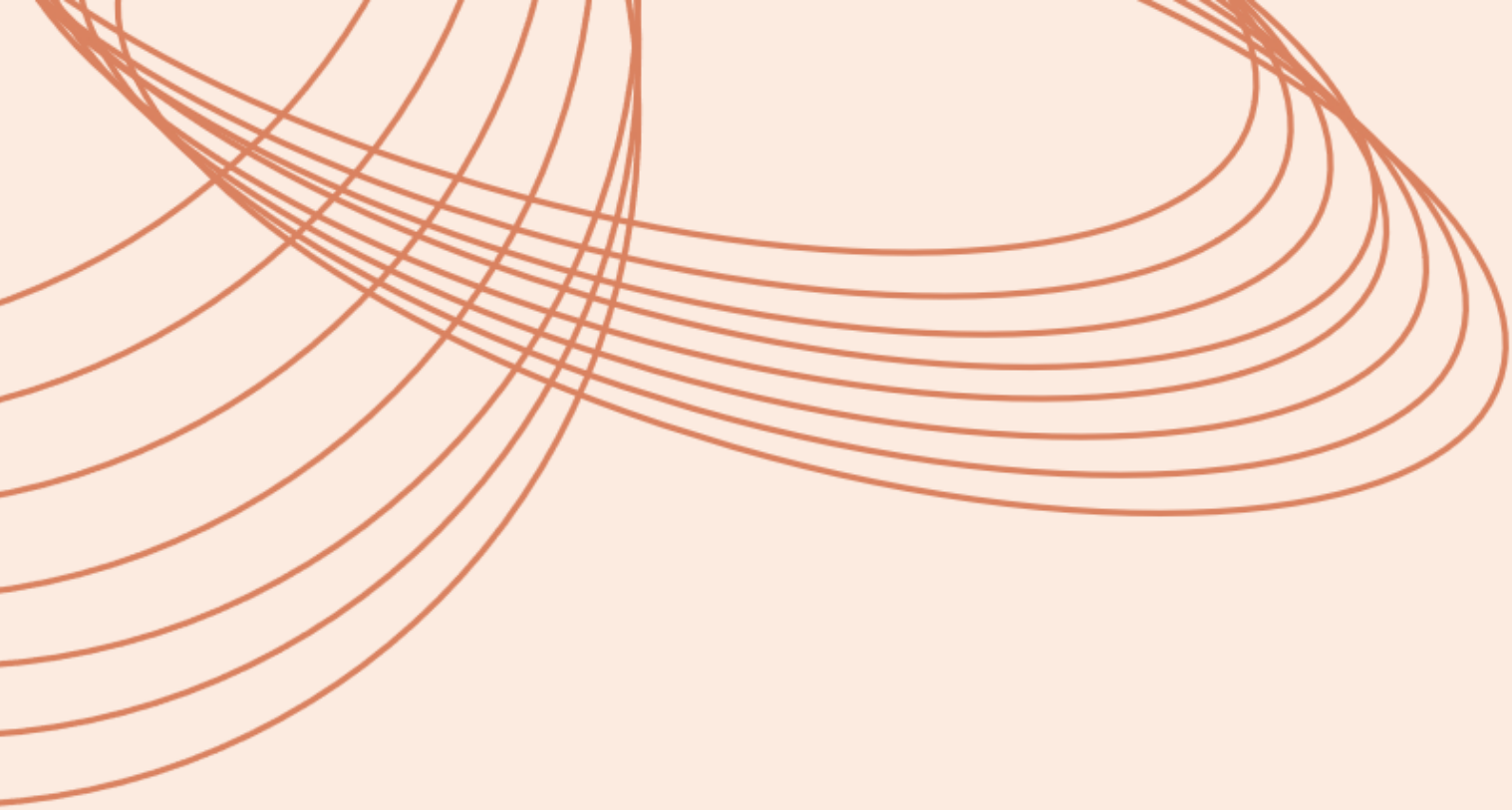
[78] Participant at workshop of health service CEOs and board chairs, Health Services Plan, August 2023, and through health service interviews.

[79] C Ham & N Timmins, *Managing health services through devolved governance: a perspective from Victoria, Australia*, The King's Fund, 2015, p 21. Note that the last major structural changes to Victoria's health system occurred in 2003.

facilitate local flexibility and responsiveness, it can also result in fragmentation, limit coordination and collaboration across the system, and contribute to duplication.

In discussions with the Committee, health services leaders spoke of a needlessly complex system that hampers patient access, experience and outcomes across the state. While views on the specifics of reform differed, health service leaders were overwhelmingly supportive of a more connected and cohesive system – one that will be fit-for-purpose now and into the future.

We must not miss this opportunity for reform and risk the system continuing without correction on a deteriorating trajectory. A step change is now needed to build a health services system that delivers the right care, in the right place, at the right time for all Victorians.



Chapter 2

System design principles

Chapter 2: System design principles

Finding: Victoria's health services system should be reformed in line with the following design principles:

- people have choice to receive care as close to home as possible taking into account safety and complexity
- connected high-quality care is easy to navigate and provided equitably along logical pathways, understanding how communities travel and interact
- improved clarity of roles and responsibilities of the different levels of service provision
- engagement with patients and the local community is enhanced to achieve evidence-based local customisation and responsiveness to community need
- a skilled and diverse workforce continues to be attracted and retained, supported by teaching, training, research and collaboration across the sector
- the system is structured to achieve integration across population health, primary, aged, acute care, non-acute mental health and alcohol and other drugs, and Aboriginal community-controlled health care
- the system is accountable, collaborative, transparent and informed, to support the outcomes that matter to patients
- duplication is reduced to deliver value for the people we serve and unnecessary administration for our staff through ensuring better use of current resources, and minimising wasteful impacts
- the system continuously improves and is flexible and adaptable in response to change.

In consultation with health service leaders, the Committee developed nine design principles to shape the development of the Health Services Plan.

Principle 1: People have choice to receive care as close to home as possible taking into account safety and complexity.

When patients receive care close to home, they remain nearer to family and loved ones, and experience less disruption to their lives. While not all care – particularly more complex care – can be provided everywhere, referral pathways should support the delivery of patient care at the health service site that is closest to their home, and which has the capability to deliver the care safely and sustainably.
This supports a high proportion of care being received in each region, minimising the need for patients to travel further than they need to. However, the system should continue to support patient choice, noting that some may choose to receive care at an alternative site.

Principle 2: Connected high-quality care is easy to navigate and provided equitably along logical pathways, understanding how communities travel and interact.

Many patients, particularly those with chronic conditions, need to receive care from multiple different health service sites along their care journey. Health services should coordinate this journey so that patients receive care in the right place at the right time. These pathways should foster ease of movement for both staff and patients, considering major roadways, public transport routes and geographical landmarks such as mountain ranges and waterways.

Principle 3: Improved clarity of roles and responsibilities of the different levels of service provision.

Currently, the roles and responsibilities of different health service sites are unclear, leading to service gaps and overlaps, and inconsistent patient pathways. Clarifying the types of health services and the complexity of care different health service sites can safely deliver will support the design of connected referral pathways to high-quality care, and clearer journeys for patients.

Principle 4: Engagement with patients and the local community is enhanced to achieve evidence-based local customisation and responsiveness to community need.

Health services should tailor the services they deliver from their sites and their models of care to best meet the needs of their unique communities. Communities can strongly identify with their local health service, which often has deep social, cultural and economic links with its broader community. These connections should be valued and strengthened. Planning should be informed by best available evidence and strong engagement with local communities to ensure responsiveness to evolving needs.

Principle 5: A skilled and diverse workforce continues to be attracted and retained, supported by teaching, training, research and collaboration across the sector.

Attracting and retaining a skilled workforce is one of the largest challenges currently faced by the health sector. Competition between health services for scarce workers exacerbates this challenge and leads to uneven distribution of clinicians across the state. More coordinated approaches to attract and retain workers are required, along with more consistent opportunities for clinicians to grow their skills through teaching, training, professional development and research.

Principle 6: The system is structured to achieve integration across population health, primary, aged, acute care, non-acute mental health and AOD, and Aboriginal community-controlled health care.

Patients – particularly those with or at risk of chronic conditions – often need to access care from preventive, primary and acute care providers. However, fragmentation across these sectors results in disjointed or disconnected care. To develop more seamless care pathways, the system should support greater integration across population health, primary and acute care, physical and mental health, aged care, the AOD sector, and with Aboriginal health.

Principle 7: The system is accountable, collaborative, transparent and informed, to support the outcomes that matter to patients.

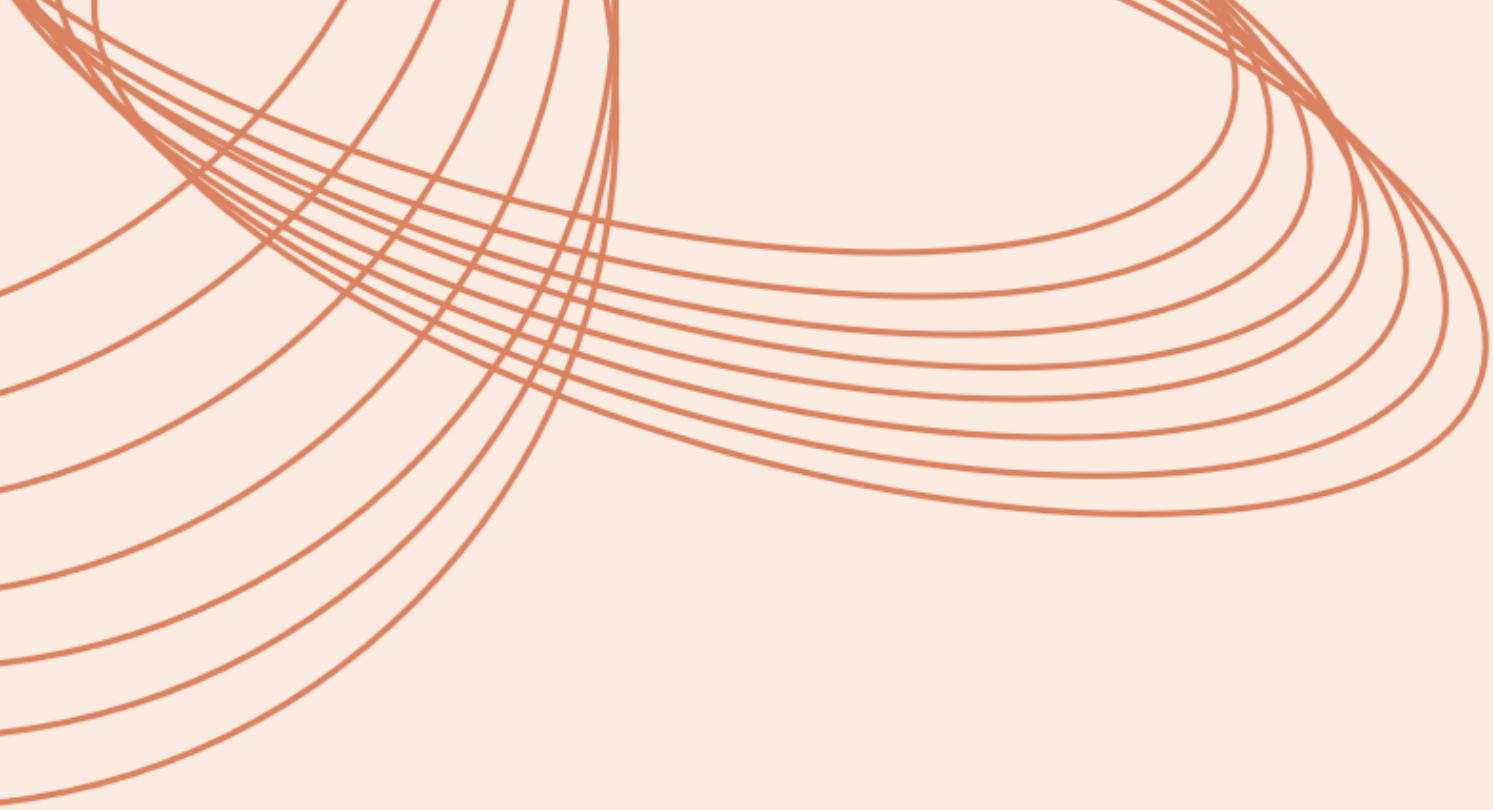
System fragmentation results in unclear accountability for patient health and wellbeing across their individual care journeys, and unclear accountability for population health outcomes. Key to enhanced accountability is a clearer sense of who is responsible for what, for which community. In addition, accountability should be informed by transparent data, information sharing and timely access to best available evidence.

Principle 8: Duplication is reduced to deliver value for the people we serve and unnecessary administration for our staff through ensuring better use of current resources, and minimising wasteful impacts.

Currently many administrative, compliance and clinical and non-clinical support functions are duplicated in each health service, resulting in inefficiencies that divert precious health resources away from patient care. System design should minimise this duplication, optimising use of current resources and concentrating skill sets to reduce the burden of complex compliance processes.

Principle 9: The system continuously improves and is flexible and adaptable in response to change.

Change is a constant in health care delivery. Shifting consumer demographics, evolving population health needs and emerging therapies and technologies mean that the health system needs to be flexible and able to rapidly adapt to changing circumstances. Achieving this will require a learning health system in which evidence is efficiently gathered, shared and adopted into practice.



Chapter 3

Core design elements

Chapter 3: Core design elements

Finding: Roles and responsibilities of each health service site in meeting patient and community needs are unclear.

- Different health services play diverse, but equally meaningful roles across the care continuum, including providing primary, community, aged and acute care services.
- However, there is a lack of clarity in which services different sites should be responsible for providing, given their scale and capability, and which services the community should reasonably expect.
- While patients often need to attend different health services for their care, the system is not designed to ensure their experiences are as smooth as they could be.
- Greater clarity in the roles and responsibilities of health service sites would help support more logical patient journeys across services, better continuity of care, and care as close to home as possible for patients.

Recommendation 3.1: Victoria adopt a role delineation framework setting out the roles and responsibilities for each health service site.

The role delineation framework will draw from the Australian Institute of Health and Welfare peer grouping framework with modifications to take into account:

- **primary, community, aged care, subacute and acute services**
- **virtual and ambulatory as well as bed-based services**
- **population, geography, and accessibility of care**
- **health service site size and capability.**

The department will define the roles and responsibilities of health service sites in accordance with the role delineation framework and in consultation with health services.

Roles will be defined as Very Small, Group D to A health service sites, and Major Tertiary sites, offering service profiles with increasing clinical complexity. Hospitals delivering the most complex and specialised care in Victoria will be defined as major tertiary where they deliver comprehensive adult care and as women's, children's or specialist hospitals where they deliver complex care for distinct patient cohorts.

The department will establish a process for these roles and responsibilities to be updated as health service site capabilities and the community's health needs evolve over time.

The department will continue to develop a comprehensive suite of clinical capability frameworks, which will support more detailed role delineation at the level of clinical specialties.

Finding: Health services have variable sizes and capabilities and face challenges delivering care if they operate independently from each other.

- Individual health services can lack the scale and capability to meet most of the care needs of their local communities, and to attract and retain a skilled workforce.
- If health services work separately, it is difficult to deliver connected, high-quality care; integrate care across population health, primary and acute settings; and maximise use of health care resources.
- Integrated health networks optimally service populations of approximately one million people in metropolitan areas and greater than 200,000 in rural areas. Some of Victoria's existing geographic health service regions do not meet these population scales.

Recommendation 3.2: Victoria's health service sites be formally organised into Local Health Service Networks representing discrete geographies of appropriate population scale.

Each Local Health Service Network should include, at a minimum, a Group A hospital to ensure that the majority of care needs are met close to home for its communities. In addition, formalised linkages will be established with major tertiary, women's, and children's hospitals to facilitate more consistent and effective connections with higher complexity care (see Recommendation 5.1).

The Health Services Plan is based on three core design elements, which are detailed in this and following chapters:

- establishing a Victorian role delineation framework that clarifies the roles and responsibilities of each health service site in the Victorian system (this chapter)
- organising health service sites into geographic regions – Local Health Service Networks – which have responsibility for ensuring that their community's health care needs are met as close to home as possible (see Chapter 4)
- establishing formal linkages between Local Health Service Networks and providers of high complexity care, including major tertiary, women's, and children's hospitals (see Chapter 5).

We believe these design elements will support a more consistent, equitable, networked system of care in Victoria, that delivers the right care, in the right place, at the right time, both now and into the future.

Defining the roles of health service sites

Different health service sites meet diverse community needs

Victorian health services play different roles across the care continuum, including providing primary, community, aged and acute care services. This is appropriate to meet the diverse care needs of communities, which vary by demography, geography, socioeconomic status and population health status.

Health service sites in remote centres with low or dispersed populations typically focus on primary, community and aged care and provide a limited range of low complexity acute services. These health service sites play a key role in meeting lower complexity care needs for communities close to home. When required, they should link patients into more complex care that may be further from home.

Health service sites in large rural and urban communities, such as metropolitan growth areas and rural cities, typically provide care for patients with medium to high complexity needs, including most medical and surgical conditions (e.g. joint replacements, appendectomies, kidney failure, congestive heart failure, chronic respiratory conditions) and critical care when required. To deliver this care safely and sustainably, these sites need to treat enough patients each year to maintain the skill sets of their clinicians. These health service sites may therefore be further from home for some communities, however, their presence within a given region ensures that most care needs can be met reasonably close to home.

Some health service sites in metropolitan Melbourne provide care for their local communities as well as patients across Victoria who need the highest complexity care, such as open-heart surgery, organ transplantation or rare cancer treatment. The proportion of patients who require this level of care is relatively low, hence very large populations are required to ensure sufficient volumes for safe, sustainable and high-quality care. These services are therefore provided from a small number of sites across metropolitan Melbourne, typically on a statewide basis.

Lack of clarity about roles and responsibilities creates issues for patient care

The types of care different health service sites provide should be linked to the site's scale, the types of communities that they serve and their clinical capability. The types of care also need to be matched to population scale to ensure clinical volumes are sufficient to support safe and high-quality care and allow the clinical workforce to maintain their skills and experience. However, unlike other jurisdictions, Victoria currently lacks a framework outlining how the roles of health services correspond to their scale, capability and population.

We have heard that this lack of clarity creates challenges for patients and clinicians in understanding which types of care can reasonably be expected at health service sites close to home or within their region. It means that some patients are referred into higher capability sites than necessary when care could have been safely

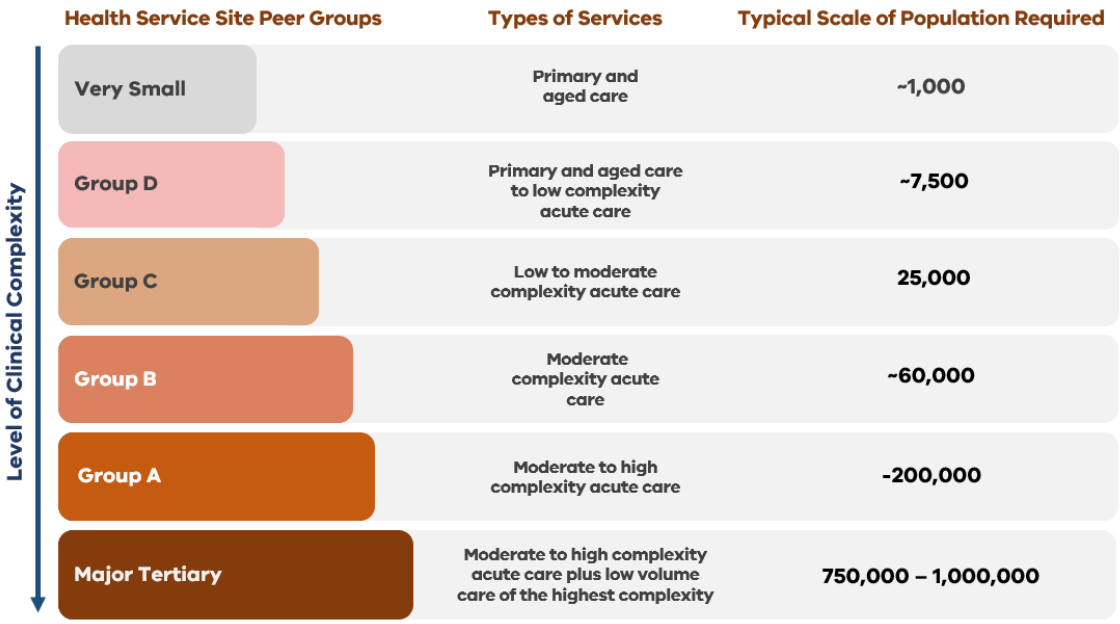
delivered at a local health service site closer to home. It can also result in delays to patients accessing the right care.

A Victorian role delineation framework

The Committee proposes Victoria adopt a role delineation framework describing the roles and responsibilities of different health service sites. A role delineation framework provides a common language to describe the different roles and responsibilities of health service sites to support patients in accessing care at the right time, in the right place and at the most appropriate level of clinical complexity to optimise safety and outcomes. By outlining the minimum services communities can expect from their local health service, the framework will strengthen connections between health services, supporting regions to better plan appropriate referral pathways to ensure that as much care as is safe can be delivered locally for patients.

We recommend a role delineation framework that draws on but modifies the Australian Institute of Health and Welfare (AIHW) hospital peer groupings, which are based on a range of characteristics outlined in Appendix 4. Under this framework, health service sites are categorised as very small, Group D, Group C, Group B, Group A and major tertiary, as outlined in Figure 2, each offering a spread of service profiles at different levels of clinical complexity. As hospital peer groups move from very small to major tertiary, the level of clinical complexity that can be delivered increases. This correlates with an increasing scale of population required to support the clinical volumes necessary for the safe delivery of increasingly complex care. It also correlates with the increasing proportion of acute care needs that can reasonably be met for the populations that they serve.

Figure 2 – Health service site role types and key characteristics



In addition to peer groups outlined in Figure 2, the framework also includes hospital peer groups focused on women's services, children's services and specialist hospitals, which typically provide deep expertise in a discrete clinical stream. The key characteristics of these hospitals are outlined in Appendix 4.

Clinical capability frameworks will strengthen role delineation in Victoria

The framework presented here describes the types of health service sites in Victoria based on service profile, population, and geography. We note that detailed role delineation in other jurisdictions also includes clinical capability frameworks defining the minimum workforce, infrastructure and equipment requirements each health service site must meet in order to provide safe, high-quality services in a particular clinical specialty or service stream.

Victoria currently has two published capability frameworks that assess adult and paediatric perioperative capability and maternity and newborn capability. We recommend the department expand the suite of Victorian capability frameworks into other core areas of clinical practice including emergency and urgent care, medicine, critical care, cancer, pharmacy and diagnostic services.

Once complete, the Victorian role delineation framework along with the suite of clinical capability frameworks will articulate different roles of Victoria's health service sites based on the services that they offer, the communities that they serve and the complexity of care that they can safely deliver.

The department will define the roles and responsibilities of health service sites in accordance with the Victorian role delineation framework and existing clinical capability frameworks, in consultation with health services. It is important to note that role delineation is not static and can shift over time with population and demographic changes. On this basis, the Committee recommends the department establish a process to update roles and responsibilities as health service site capabilities and the community's health needs evolve over time.

Grouping health services into Local Health Service Networks

Individual health services, particularly in areas of low population density, may not have the scale and capability to meet most of the care needs of their local communities. As outlined in Figure 2, these health services may have a key role in community and aged care but may not have the service volumes required to deliver more complex acute care safely and sustainably. Patients in these communities therefore need to visit other health services when they require more complex care.

While patients often need to visit multiple health services, Victoria's fragmented health services system makes it difficult to coordinate care across different providers. It also impedes connection and coordination with other elements of the broader health system including primary care, non-acute mental health and

AOD care, aged care and Aboriginal health. Overall, this results in a lack of accountability for the management and improvement of population health.

To address these issues, the Committee recommends Victoria's health service sites are organised into formal, geographic regions called Local Health Service Networks (Networks), described further in Chapter 4. The purpose of these Networks, in both metropolitan and regional/rural Victoria, is to support more equitable and consistent care for patients across their geography and provide more consistent workforce support. Each Network has clear accountability for its defined catchment population. Component health service sites will work together to comprehensively meet the needs of communities in their region, addressing issues which existing health services, working independently, lack the scale and capability to deliver effectively on their own.

A region- or place-based approach seeks to ensure that most care needs can be met relatively close to home. The role delineation framework outlined above identifies that a region should include, at a minimum, a Group A health service in order to deliver 85% of care needs for most patients. The framework will also help define referral pathways between health service sites to support efficient care escalation and step-down.

Based on similar regional place-based structures in other national and international jurisdictions, we recommend that regions service populations of about one million within metropolitan Melbourne and populations greater than 200,000 in rural areas. At this scale the health services within each Network, in partnership with other structures like PHNs and Mental Health and Wellbeing Interim Regional Bodies, will be able to take on accountability for the population health outcomes for the defined geographies that they serve.

Linking Local Health Service Networks with high complexity care

As outlined above, complex care can only be provided at sites with sufficient service volumes to ensure safe and sustainable care. High complexity care is delivered in metropolitan Melbourne by a small number of major tertiary, women's, children's and specialist hospitals. Victoria currently has five major tertiary hospitals,[80] which provide the most comprehensive care at the highest level of complexity. Victoria also has four women's hospitals[81] providing complex women's and maternity care, two children's hospitals[82] providing complex paediatric care, and four specialist hospitals[83] providing deep clinical and research expertise in particular specialties.

[80] Alfred Hospital, Austin Hospital, Monash Medical Centre, Royal Melbourne Hospital and St. Vincent's Hospital.

[81] Joan Kirner Women's and Children's, Mercy Hospital for Women, Monash Women's and the Royal Women's Hospital.

[82] Monash Children's Hospital and the Royal Children's Hospital.

[83] Peter MacCallum Cancer Centre, the Royal Dental Hospital of Melbourne, the Royal Victorian Eye and Ear Hospital and the Victorian Heart Hospital.

In our current health services system, many health services have unclear and uncoordinated referral pathways to the high complexity and specialist care provided by these hospitals. The Plan will establish clear and consistent referral pathways between Networks and major tertiary, women's, children's and specialist hospitals, connecting them with the complex and specialist care that they require. It will also set out the roles within each service, including responsibilities for determining when a referral is required, and the urgency of the request. These connections – detailed in Chapter 5 – will strengthen the statewide role of Victoria's major tertiary, women's, children's and specialist hospitals, and benefit patients, the community and the health workforce as outlined below.

Timely patient and clinician access to specialist expertise

Formalised connections between each Network and their providers of high complexity and specialist care will support timely access to care for patients. Clinicians in each region will have confidence they can readily access specialist expertise when they need it. Telehealth and virtual care models will allow specialists to support care in place, where clinically appropriate, minimising patient transfers to major tertiary, women's, children's and specialist hospitals. Where patients do require transfer, formal connections will facilitate ease of step-down back to local hospitals for the lower complexity phase of their treatment and ongoing care.

Workforce mobilisation and enhanced access to professional development

Formal connections will foster collaboration on workforce supports. Highly specialised clinicians will work across Network geographies, and clinicians in each region will have greater access to teaching, training, professional development and education. Together, this will support capability uplift across the system over time.

More equitable access to clinical research

Formalised connections between Networks and major tertiary, women's, children's and specialist hospitals will also facilitate more equitable access to ground-breaking clinical research for all Victorians. Currently this access is challenging for patients living in rural centres, with most research undertaken in metropolitan Melbourne. Connections with Networks will allow more patients to participate in clinical trials and more clinicians to engage in research programs. In addition, clinical trials and translational research activities will be strengthened through drawing on larger patient populations from a broader range of clinical settings and geographies.

Chapter 4

Caring for patients within their region

Chapter 4: Caring for patients within their region

Finding: Victoria's fragmented health services system impacts care quality and experience, diffuses responsibility for population health outcomes, exacerbates workforce challenges and impedes integration with other sectors.

Fragmentation across health services contributes to:

- inequities in patient experience and difficulties accessing care
- quality and safety risks
- difficulty attracting and supporting health workforce
- inefficient use of resources
- barriers to coordinated improvement
- difficulties engaging with other providers such as Primary Health Networks and Aboriginal community-controlled health organisations
- poorly defined catchment geographies resulting in a lack of clear accountability for population health outcomes.

Recommendation 4.1: Local Health Service Networks comprising public and denominational health services be established in Victoria to manage each health service region with the following responsibilities:

Population health and addressing population inequities

- **Understanding and addressing 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.**
- **Increasing focus on early intervention for their population, both early in life and early in disease progression.**
- **Understanding the health and care needs of priority populations and vulnerable groups in their region, and addressing inequities in accessible and culturally safe health care, including through collaboration with local organisations, such as Primary Health Networks and Aboriginal community-controlled health organisations.**

Access to care

- **Developing a network of care for their geography that ensures that the great majority of the care needs of their population are met within region, as close to home as is safe and sustainable, using appropriate sites with capacity and capability.**
- **Network wide clinical service planning, within departmental frameworks, to define health service site roles and responsibilities aligned to the role delineation framework, and to identify service and capital development priorities consistent with local population health needs and service sustainability.**

- **Establishment of consistent Network-wide care escalation and de-escalation criteria and treatment protocols to support patient care in the lowest acuity setting, where safe and practicable.**
- **Establishing default referral pathways to support logical patient flows for step-up and step-down care, including coordinating consistent pathways to and from General Practitioner care, private hospitals, local community health, aged care and other health care providers.**
- **Reducing inequities in patient access to care across the Network, by implementing reforms such as single waiting lists and service models such as virtual care and remote support.**
- **Better linking public sector residential aged care services within the Network with the broader continuum of care.**
- **Ensuring the most effective use of resources both within and outside hospital walls to improve patient flow, including through coordinated management of ambulance ramping, emergency department and inpatient capacity, expected discharges and collaboration with ambulance services and other Networks to reduce bottlenecks across the acute health system.**
- **Better utilisation of available capacity across the Network through inter-site transfers for step-down care, site specialisation and increased options for the establishment of quarantined services.**

Safety and quality

- **Unified clinical governance leadership across the Network.**
- **Implementing a unified and consistent clinical governance framework across all sites, aligned to National Safety and Quality Health Service Standards and contemporary clinical practice, and supported by establishment of a learning network across all Network sites.**
- **Increase consistency in the quality and safety of services through common approaches to managing clinical risk and adverse events, including shared morbidity and mortality reviews to support dissemination and adoption of key learnings.**
- **Implementing a common risk management framework across the Network, across all domains of risk, enabling the mitigation of ongoing and emerging risks through a consistent and coordinated approach.**
- **Establishing benchmarking of key performance indicators and outcomes across each Network to promote improvement.**

Workforce

- **Coordinated attraction and retention of clinical and non-clinical workforce across all health service sites.**
- **Common medical workforce appointments across health service sites supported by network-wide credentialling to facilitate clinician mobility.**
- **Establishing of nursing, midwifery and allied workforce banks across the Network and at more localised levels to support vacancy management.**
- **Establishing mechanisms for clinicians with specialised skills to support workers throughout the Network, including through telehealth and secondary consultations, to build expertise and skills and support care in place at local hospitals wherever possible.**
- **Improving workforce attraction and retention across public sector residential aged care sites, through enhanced career and professional development opportunities.**
- **Deliver consistent workforce support, including common approaches to professional development and training.**

Research and Innovation

- **Improve coordination of partnerships and deepen relationships with research institutes and universities.**
- **Improve consistency of access to research opportunities for the health workforce, and access to clinical trials for patients.**
- **Improve collaboration and reduce barriers to multidisciplinary and whole-of-lifespan research opportunities, including through fostering collaboration across specialist and generalist hospital sites.**

Integration

- **Improve navigability of the health system for patients across the health and wellbeing continuum, including across primary, community and acute care, physical and mental health, and with aged care services.**
- **Facilitating efficient patient record sharing between sites, ideally through common electronic medical record platforms.**
- **Improve provision of care in the community and reduce the prevalence of preventable hospitalisations, through stronger cross sectoral collaboration with primary care, community health and Aboriginal community-controlled health organisations.**
- **Improve integration with aged care, such as through better coordinated in-reach into residential aged care.**
- **Building strengthened relationships with the private hospital sector.**

Effective use of resources

- **Establishment of shared approaches to clinical support services that benefit from enhanced scale, such as diagnostic services, remotely supported reading of medical imaging, and virtual secondary consultations with specialists.**

- **Building on the work of Rural ICT Alliances, development of a Network-wide ICT strategy, and approaches to common ICT systems, including electronic medical record systems.**
- **Establishing shared administrative, human resources and payroll functions servicing the Network.**
- **Supporting shared and more efficient approaches to compliance and accreditation processes.**

Recommendation 4.2: As well as their whole of network responsibilities, Local Health Service Networks will support coordination and collaboration for subregions within their geography where locally specific arrangements are appropriate, such as for local referral pathways or workforce sharing.

Recommendation 4.3: Where existing collaborative arrangements, such as Rural ICT Alliances or pathology networks, span a wider geography than Local Health Service Networks, these arrangements should continue where they deliver value.

Recommendation 4.4: The new responsibilities for Local Health Service Networks apply equally to Networks comprised of one existing health service and to Networks that bring together multiple health services.

Finding: Specialist health services play an important role as centres of expertise for the state, but their patients experience issues from fragmented care as much as other patients and would benefit from participation in Local Health Service Networks.

Finding: The best hospitals in the world according to credible global assessments[84] are very large-scale academic centres comprising multiple hospital sites and specialist centres that enable significant breadth of scale and depth of specialisation within a unified, collaborative structure. The organisational barriers between our health services have stymied the realisation of this model in Victoria. Formation of Local Health Service Networks will increase the scale of Victoria's academic medical centres, further enhancing their ability to attract and retain the best practitioners, researchers and leaders.

[84] Newsweek, *The world's best hospitals 2024*, Newsweek website, 2024, available at www.newsweek.com/rankings/worlds-best-hospitals-2024, accessed April 2024. Also see previous years' rankings. Newsweek is a global digital news organisation that has on six occasions ranked world hospitals, assessing some 2,400 hospitals across 30 countries.

Recommendation 4.5: **Major tertiary hospitals and specialist services will be included in Local Health Service Networks to:**

- **support coordinated, multidisciplinary care that integrates seamlessly across whole-of-life and complex care for patients, supports smooth care transitions and improves life-long outcomes**
- **enable sharing of workforce, expertise and research efforts across specialties**
- **facilitate multidisciplinary research and strengthen specialist hospitals' statewide role as centres of excellence**
- **provide clinicians and researchers with greater resources, relationships and cross-disciplinary research opportunities through being part of a larger organisation**
- **become more competitive with the best hospitals in the world in both care and translational research**
- **maximise economies of scale in clinical and non-clinical support services to support allocation of resources to patient care and research.**

Recommendation 4.6: **Local Health Service Networks will be established for the following geographies:**

Regional Victoria:

- **Barwon South West**
- **Grampians**
- **Loddon Mallee**
- **Hume**
- **Gippsland**

Metropolitan Melbourne and statewide services:

- **West Metro**
- **Parkville**
- **North Metro**
- **East Metro**
- **South Metro**
- **Bayside**

As outlined in Chapter 1, Victoria's current health services system design leads to a range of challenges for patient care and our health workforce, including:

- patients experiencing poorly coordinated, fragmented care
- unclear accountability for a patient's care and for population health more broadly
- inconsistent governance of the safety and quality of patient care
- difficulties in attracting and retaining skilled workforce
- unnecessary duplication of administrative and support functions.

In this chapter we detail how grouping health services into Local Health Service Networks will overcome these issues and achieve benefits for patients, workforce and community.

Establishing Local Health Service Networks

Victoria has 76 separate health services, each working largely independently to meet the health needs of the residents in often-overlapping local areas. While this has fostered strong local engagement with communities and local tailoring of services, these benefits are being eroded by the challenge of providing appropriate, safe and comprehensive care across multiple health service sites of widely varying scale, capability and resourcing. To address these challenges a more connected, structured and joined up approach is required.

We frequently heard about this need for greater connection from health system leaders through our consultation process. We also note that in 2023 a group of Victorian health service CEOs identified that health service sites need to work together in a connected network of services, arguing this would support planned and dependable referral pathways that offer access to higher level services when required, and maximise the use of lower acuity services close to patient's homes.[85]

The Committee recommends organising Victoria's health service sites into formal, geographic networks – Local Health Service Networks (Networks). Networks will support more equitable and consistent care for patients across their geography, provide coordinated, targeted responses to identified health needs within their region, and strengthen workforce support to deliver those services. They will be established in both metropolitan and regional/rural Victoria and cover both public and denominational health services. Networks will address issues which existing health services, working independently or in loose partnership arrangements, lack the scale, capability and authority to deliver effectively on their own.

[85] Health service CEO workgroup, *From Competition to collaboration: The acute referral pathway: how this group of Victorian health services' chief executives want to collaborate to improve the system* [prepared as part of the Victorian Health Service CEO Collaboration and Partnerships Workstream in collaboration with the Department of Health – unpublished], June 2023.

Each Network will have responsibility for ensuring that the great majority of acute care needs of their local population are met within the Network through care provided as close to home as possible (recognising that patients can continue to choose where they go for care).

Core objectives of each Network will include:

- supporting population and public health interventions, and addressing population health inequities, in collaboration with relevant providers in their region
- improving access to care and patient flow across their region
- reducing variation in the quality and safety of care
- delivering consistent and coordinated workforce support
- driving research and clinical excellence
- providing a coordinated approach to integration across sectors
- delivering clinical and non-clinical support services efficiently at scale.

Recommended functions for Local Health Service Networks are outlined in the following section.

Supporting population health and addressing inequities

Each Network will have a defined catchment population (using standard Australian Bureau of Statistics geographical areas) and will be responsible for meeting most of this population's health needs. To support improvement of population health outcomes, Networks will be required to work with the department and other local public and population health providers to ensure that appropriate planning and prioritisation of service development is in place across the full spectrum of care.

Key Network functions to support population and public health will include:

- understanding and addressing the health care needs of their defined catchment population through comprehensive needs assessment, and developing regionally appropriate interventions in collaboration with population health and other public health providers
- increasing the focus on early intervention for their population, both early in life and early in disease progression.

A particularly important responsibility of Networks in supporting the health of their population will be to understand and address the care needs of priority populations and vulnerable cohorts. In particular, those who experience barriers to accessing culturally safe and appropriate care, such as Aboriginal peoples. In Victoria's current, fragmented system, it is often not clear who is responsible for addressing the care needs of marginalised groups – especially those who have limited contact with the formal care system due to culture, language and ethnicity, socioeconomic or other factors – exacerbating inequities in health outcomes. Small health services

may also lack scale to address the complex needs of small but highly vulnerable groups within their catchment population.

Networks will overcome these issues and improve equity in population health outcomes in collaboration with other relevant providers in their region. Networks will have clear accountabilities for addressing inequities for priority populations and vulnerable cohorts within their catchment population, extending beyond hospital walls. With significantly larger scale than existing health services, Networks will have greater capability and capacity to address needs of vulnerable groups. Within Victoria's current system design, small health service organisations are challenged by insufficient scale to address the complex needs of vulnerable groups in their local catchments, who might comprise very small subsets of the catchment population. Networks will have sufficient scale in their capabilities and the geographies and populations that they serve to develop strategic, targeted and effective interventions for vulnerable cohorts.

Key Network functions to address population inequities will include:

- understanding the health and care needs of priority populations and vulnerable groups in their region.
- addressing inequities in accessible and culturally safe health care, including through collaboration with local organisations, such as ACCHOs and PHNs.

Improving access to care and patient flow within their region

A key role for Networks will be to improve access to care across their region. They will be responsible for clinical service planning for their region as well as developing and implementing region-wide mechanisms to better manage patient access and flow. The Networks will support local flows and strengthen collaboration within their component geographic subregions to increase local access to care.

This responsibility of improving access to care will not only be for episodic conditions. Networks will be responsible for developing approaches to managing health conditions that endure across the lifespan, as people transition from childhood through adulthood and into older age. With increasing rates of chronic conditions across our communities, Networks will also be responsible for clear pathways to manage chronic health needs.

Networks will work in partnership with the department to plan for improved access to care and management of patient flows. Key Network functions will include:

- developing a network of care for their geography that ensures that the great majority of the care needs of their population are met within region, as close to home as is safe and sustainable, leveraging appropriate sites with the necessary capacity and capability
- Network-wide clinical service planning, within departmental frameworks, to define health service site roles and responsibilities aligned to the role

delineation framework, and to identify service and capital development priorities consistent with local population health needs and service sustainability

- establishing default referral pathways to support logical patient flows for step-up and step-down care, including coordinating consistent pathways to and from GP care, private hospitals, local community health, aged care and other health care providers
- reducing inequities in patient access to care across the Network, by implementing reforms such as single waiting lists for planned care and service models such as virtual care and remote support.

Networks will improve connections between health service sites across the patient journey, from initial planned or emergency presentation through to step down care and discharge to community, as well as throughout the lifespan. These connections will allow flexible use of capacity within the Network at times of high demand, improving management of patient flows in to and out of hospital services. Improved connection will also streamline communication with Ambulance Victoria regarding system capacity constraints, optimising the distribution of ambulances and the timely handover of patients arriving by ambulance.

Key Network functions in managing capacity and demand will include:

- ensuring the most effective use of resources both within and outside hospital walls to improve patient flow and ensure early and pre-emptive actions to minimise delays to care. This will include coordinated management of ambulance ramping, emergency department and inpatient capacity, expected discharges, and collaboration with ambulance services and other Networks to reduce bottlenecks across the acute health system
- better utilising available capacity across the Network through inter-site transfers for step-down care, site specialisation and increased opportunity for better segregation of planned and unplanned care.

Networks, due to their size, will also be able to establish stronger partnerships with the private sector. Private hospitals and other private providers play an important role in meeting the demand for health services in Victoria and have a history of working in close collaboration with the public sector during times of high surge demand, for instance during the COVID-19 pandemic. The public sector has also been able to leverage arrangements with private service providers to sustainably meet community demand for services such as radiation therapy and diagnostics. The scale of Networks will drive stronger and more efficient partnerships with the private sector that will support demand management and efficient patient flow.

More robust management of safety, quality and risk

Networks will develop greater breadth and depth of expertise in clinical governance that will be applied across the Network to reduce clinical risk and support continuous improvements to clinical service delivery.

Key Network functions to manage safety, quality and risk will include:

- unifying clinical governance leadership across the Network
- implementing a unified and consistent clinical governance framework across all sites, aligned to National Safety and Quality Health Service Standards and contemporary clinical practice, and supported by establishment of a learning network across all Network sites
- increasing consistency in the quality and safety of services through common approaches to managing clinical risk and adverse events, including shared morbidity and mortality reviews to support dissemination and adoption of key learnings
- establishing benchmarking of key performance indicators and outcomes across each Network to promote improvement.

Networks will also allow common risk management frameworks to be established on issues beyond clinical risk, including strategic, operational, financial, compliance, legal, technological, data, reputational and environmental risks.

Attraction, retention and support of workforce

Local Health Service Networks will have greater capacity and capability than existing, independent health services to implement coordinated approaches to addressing workforce challenges.

Networks will have greater common resources to enhance recruitment, retention and development of skilled staff and support sharing of expertise. They will also be able to mobilise workforce both physically and virtually across a large-scale network, better addressing workforce gaps and providing network-wide support.

Networks will enable a broader scope of clinical service provision, opening up opportunities for professional development to a wider workforce cohort.
For example, staff working at small hospital sites in rural Victoria will have better access through their Network to training and development opportunities at larger hospitals. This will provide a depth and breadth of experience that is currently unavailable at a smaller health service site. Equally, staff at metropolitan health services will have more equitable access to highly specialised expertise, supported by the greater scale and more consistent capability of all metropolitan Networks.

Key Network functions to strengthen workforce will include:

- coordinating attraction and retention of clinical and non-clinical workforce across all health service sites in collaboration with multiple university partners
- implementing common medical workforce appointments across health service sites supported by Network-wide credentialling to facilitate clinician mobility
- establishing nursing, midwifery and allied workforce banks across the Network and at more localised levels to support vacancy management
- establishing mechanisms for clinicians with specialised skills to support workers throughout the Network, including through telehealth and secondary consultations, to build expertise and skills and support care in place at local hospital wherever possible
- improving workforce attraction and retention across public sector residential aged care sites, through enhanced career and professional development opportunities
- delivering consistent workforce support, including common approaches to professional development and training.

Driving research, innovation and clinical excellence

Networks will improve integration of research efforts to drive clinical innovation and excellence. Victoria is home to 18 high calibre medical research institutes and multiple universities, which collaborate broadly with many different health services to develop cutting-edge health and medical research. Networks will provide scale to facilitate more effective and coordinated partnerships between Victorian health services and research institutes and universities. This will be instrumental to further strengthening the international profile of Victoria's existing research precincts and centres of excellence such as the Melbourne Biomedical Precinct, Melbourne Children's, the Clayton Health and Education Research Precinct, the Alfred Research Alliance and the Aikenhead Centre for Medical Discovery. In turn, this will support the attraction of global leaders in research and competitiveness for grants and funding.

A hallmark of the world's pre-eminent academic health institutions – such as the Mayo Clinic and Mass General Research Institute in the United States and University College London Hospitals in England – is that they leverage the scale of multiple hospital sites to support research efforts. These institutions operate highly multidisciplinary research programs that encompass the full spectrum of care across all life stages and disease states. The development of Networks will enable Victoria to further adopt similar world-leading academic health models.

Partnering between research bodies and Networks will enable broadening of research efforts and provide new opportunities:

- In the existing system, many patients cannot access clinical trials that may make a significant difference for their condition or illness. Partnering at scale between research bodies and Networks will provide opportunities for wider groups of staff and patients to participate in research and clinical trials that are currently unavailable at sites less connected to research networks.
- Several research institutes and universities in Victoria undertake rural health research with the aim of improving health services and supporting rural residents to live healthy lives. Networks will continue to work with multiple universities, and the partnerships between research programs, universities and the Networks will accelerate gains in rural health outcomes and improve translation of research into best practice care.
- Networks will improve collaboration and reduce barriers to multidisciplinary and whole-of-lifespan research opportunities, including through fostering collaboration across specialist and generalist hospital sites.

Local integration

Networks will facilitate coordinated engagement with other key structures such as PHNs, Mental Health and Wellbeing Boards (currently Mental Health and Wellbeing Interim Regional Bodies), ACCHOs, local governments, and aged care and disability service providers, and better respond to recommendations from the National Health Reform Agreement Mid-Term Review.

Networks will be accountable for working to achieve integration across primary and acute care as well as physical and mental health care to support a holistic approach to optimising population health outcomes. Opportunities for stronger alignment and integration of regional governance are discussed in Chapter 9.

Improved coordination between these structures has the potential to:

- improve how readily patients can navigate across the health and wellbeing continuum, including across primary, community and acute care, physical and mental health, and with aged care services
- facilitate efficient patient record sharing between sites, ideally through common EMR platforms
- improve the provision of care in the community and reduce the prevalence of preventable hospitalisations, through stronger cross sectoral collaboration with primary care, community health and ACCHOs
- build strengthened relationships with the private hospital sector.

Particularly in rural and regional areas, health service sites play an important role in providing public sector residential aged care services, and supporting access to care in thin markets where there are few or no alternatives. However, small sites with

limited scale can find it challenging to adopt contemporary models of care or connect aged care residents effectively with broader clinical services. Networks will be able to manage public sector residential aged care with greater scale and capability, and better integrate these services with the broader continuum of care. Consistent with the intent of current Commonwealth aged care reforms, the Networks will drive adoption of contemporary person-centred models of residential aged care. In addition, they will create greater capability to improve access to clinical services for aged care residents, such as geriatricians, allied health and psychologists.

Networks will support a greater emphasis on early needs identification, intervention, and care coordination across services for older people in the community, with the aim of improving population outcomes. Networks will also support older people with very complex care needs who struggle to access appropriate care outside the public system and who are at greater risk of hospital admission.

Effective use of resources

Networks will consolidate clinical and non-clinical support services to facilitate standardisation, reduce duplication and reduce competition for skilled support staff.

Key Network functions will include:

- establishing unified approaches to clinical support services that benefit from enhanced scale, such as diagnostic services, remotely supported reading of medical imaging, and virtual secondary consultations with specialists
- developing a Network-wide ICT strategy, and approaches to common ICT systems, including EMRs, building on the work of Rural Health ICT Alliances
- establishing unified administrative, human resources and payroll functions servicing the Network
- supporting common and more efficient approaches to compliance, safety and quality, and accreditation processes.

Supporting coordination across other geographies

The Committee does not intend Networks to drive centralisation of care that could be provided locally. Rather, Networks ought to enhance local service provision through providing greater structural support. Networks must ensure that the unique needs of geographic subregions within their broader catchment are met. This will require strategies such as common workforce employment across sites and local referral pathways to ensure that necessary operational arrangements are in place to sustain clinical service delivery and emergency management at a local level.

While Networks will be the primary structure for delivering health objectives for a geographic region, there will be some functions which deliver greater benefits if

structured either at a subregional level or across a greater geographic span than Networks. Accordingly, Networks will be required to:

- support appropriate functions at whole of network and geographic subregional levels
- ensure that existing collaborations that span areas beyond the defined geography of the Network continue to deliver value. For example, those areas with existing ICT alliances which extend over large geographic areas should continue, where they deliver value. Similarly, Networks should continue to support the recent establishment of public pathology networks.
- absorb the existing roles of Health Service Partnerships. As the constituent health services within most Networks reflect the members of existing Health Service Partnerships, the initiatives developed and implemented by Health Service Partnerships should be continued where they offer enduring value. This includes the strategic directions or recently developed Health Service Partnership Strategic Service Plans.

Whether formed from multiple existing health service organisations or a single existing organisation, all Networks will have increased accountability to realise all Network functions and responsibilities.

Networks will also collaborate with neighbouring Networks and statewide services to ensure patients receive the right care in the right place in a seamless and timely manner. The department will drive consistency in service delivery across the Networks, where there are benefits, ensuring equitable health outcomes for all Victorians regardless of where they live.

Design considerations for Local Health Service Networks

Our considerations about Network design were underpinned by the design principles presented in Chapter 2 and informed by lessons from other public health systems such as NSW[86] regarding the size and scale of groupings.

Our recommended Network design is based on a range of factors including natural patient flows, geography, transport networks, population scale, and the characteristics of communities and the health service delivery challenges they face. For instance, patients in a small rural community adjacent to a metropolitan area may travel toward the metropolitan centre for acute care. However, the local health service still faces the challenges of rural health service delivery, and the community may therefore benefit from a Network structure experienced in managing those challenges. In this context, there will be some sensible outflows from Networks to neighbouring Networks (e.g. from peri-urban areas towards metropolitan rather

[86] Garling, *Special commission of inquiry into acute care services in NSW public hospitals*.

than regional hospitals), and Networks must provide a consistent approach to supporting outflows to other Networks where logical and appropriate.

Our decisions regarding Network size were informed by the NSW experience of consolidations over the last 20 years, which demonstrated the importance of striking a balance between having areas that are large enough to realise the benefits of scale and capability, while retaining effective management and local responsiveness.

In 2005, NSW reduced from 17 to eight area health services.[87] In 2008, following a series of high-profile issues, a Special Commission of Inquiry found the organisational or geographic size of health services was in many cases too large for effective governance and decision making informed by local clinical experience. At the same time, the Inquiry found that more sparsely populated areas '*need to be part of larger area health services to ensure that they have a capital base and patient numbers to function on a fair basis'* and that the creation of larger area health services enabled deeper clinician involvement across the network.[88] Connecting smaller hospitals to major hospitals promoted improved standards in hospitals across the area health service and improved sharing of clinical expertise and clinicians. Following this advice, NSW restructured to 15 Local Health Districts (and two specialty networks) in 2011, with average populations of approximately 1 million for metropolitan districts and 350,000 for regional/rural districts.

Design considerations are detailed below. Some are more relevant than others for different groupings, and there may be trade-offs between considerations.

Table 1: Design considerations for Local Health Service Networks

Area	Considerations
Geography & Demography	• Natural geographic boundaries (such as mountain ranges) established travel and care access routes, and the communities' sense of culture and connection to country are respected. • Scale and geographies of Networks are aligned with other established structures (e.g. public health, PHNs, Mental Health Regions, Health Service Partnerships). • 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.

[87] M Foley, *Future arrangements for governance of NSW Health: report of the Director-General*, NSW Department of Health, 2005.

[88] Garling, *Special commission of inquiry into acute care services in NSW public hospitals*.

Area	Considerations
Services	• Clinical services can be distributed across the Network to balance local access to care, safety, sustainability and efficient utilisation of resources. • Optimised patient flows enable formalised referral pathways for care escalation and step-down. • Access and navigation for patients is enhanced minimising the need to refer outside of the Network.
Capability and Scale	• At least one major tertiary or Group A hospital is included in each Network to ensure that greater than 85% of acute care needs are met locally. • 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, and 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.

The Committee's recommended Networks are of comparable size and capability both within metropolitan Melbourne and across regional Victoria, so that communities living in different geographies are served by Networks with similar abilities to deliver care effectively.[89] We consider this important as current disparities in the size and capability of different health services contribute to inequities in patient access and outcomes across Victoria.

Each Network should include, at a minimum, a Group A health service site operating at peak of practice, to ensure that the majority of patients can receive most of their care locally. Currently there is variation in complexity of care that can be safely delivered by Victoria's Group A health service sites. The Committee recommends the department works with Networks to identify where current capability gaps exist and support these areas to improve clinical service provision over time.

Network design accommodates changes in population as projected by *Victoria in future*.[90] Population is expected to increase in the western, northern and southeastern growth corridors of metropolitan Melbourne, while decreasing or stabilising in some remote regional areas. Apart from the proposed Parkville

[89] Health services and Primary Health Networks in other jurisdictions typically serve populations of 0.2–0.4 million in rural areas and 1–1.2 million in metropolitan areas.

[90] Victorian Department of Transport and Planning, *Victoria in future*, Victorian Department of Transport and Planning website, 2023, available at www.planning.vic.gov.au/guides-and-resources/data-and-insights/victoria-in-future, accessed April 2024.

Network, the metropolitan Networks are projected to continue to be of balanced and comparable size of between 1.2 and 1.4 million residents each by 2036, while the decrease in some areas of regional and rural Networks will be offset by greater increases in population elsewhere within the same Network.

We have heard from a range of stakeholders with proposals for smaller scale groupings, particularly from areas currently supported by subregional services. We recognise that highly localised groupings can provide benefits for geographically specific functions, such as engagement with local primary care providers, or day-to-day workforce sharing of staff within travel constraints. Given this, the Committee recommends that Networks facilitate subregional and local collaboration within their geography where this is beneficial and appropriate. However, for the broader range of functions which Networks will deliver, the Committee considers that greater scale and capability is required.

Specialist hospitals' role within Local Health Service Networks

The Committee has carefully considered whether hospitals that provide specialist services for the state should be included within geographic networks or within a separate specialist network. These specialist hospitals focus on either particular clinical specialties (e.g. Dental Health Services Victoria, the Peter MacCallum Cancer Centre and the Royal Victorian Eye and Ear Hospital), or particular patient cohorts (e.g. the Royal Women's Hospital and the Royal Children's Hospital).

We note that several hospitals or services that provide specialist statewide functions are situated within generalist health services (e.g. the Victorian Heart Hospital within Monash Health, or trauma services at the Royal Melbourne Hospital and Alfred Hospital). It is therefore difficult to design a distinct and coherent grouping of 'statewide specialist' health services, and it is not clear what functions or benefits such a grouping would deliver collectively. Specialist hospitals that are part of generalist health services derive a range of patient and workforce benefits from these arrangements, including access to multidisciplinary care within the one organisation, better integration of care for patients with complex care needs, and sharing of workforce expertise and collaboration. These arrangements support holistic care of patients that treats them as whole individuals rather than organs or conditions.

For these reasons, we recommend including specialist services within broader geographic networks that provide generalist care. This approach supports improved care pathways for the many patients that may need specialised care but also have broader health concerns. It also supports multidisciplinary collaboration across clinicians, research and workforce sharing and coordination.

At the same time, it is important to the Victorian health system that these specialist hospitals continue to play and enhance their statewide role. This role includes establishing clear referral pathways from Local Health Service Networks across the

state to statewide specialist care, establishing mechanisms for statewide access to specialist expertise, and providing a locus for advanced research and training within their specialty.

The Committee also notes the intent since 2000 to create an integrated Biomedical Precinct at Parkville to provide integrated comprehensive children's, women's, specialty and general hospital services, teaching and research. This proposal supported the relocation of the Royal Women's Hospital (Women's) and Frances Perry House in 2008, the Royal Children's Hospital (Children's) redevelopment in 2011, the relocation of Peter MacCallum Cancer Centre (part of the Victorian Comprehensive Cancer Centre) in 2016, and the creation of the Doherty Institute in 2014. All hospitals within the precinct provide a statewide role.

Despite this intent, and the implementation of infrastructure to support connectivity between three of these hospitals on a single site, they continue to be independently governed with disconnected organisational processes and procedures that create barriers for staff and patient transitions. In addition, there are currently many intra-precinct service dependencies and transition pathways which rely more on individual clinician brokerage than formal integrated processes, and which are often not supported due to operational differences between the four sites.

For example, many children who are patients at the Children's have conditions that will require lifelong management. While the Children's manages a program to assist these children and their families transition to adult care pathways over several years, the Committee understands that service coordination across child to adult pathways could be strengthened, made more consistent and clarified. A more embedded integrated and coordinated approach would help achieve this, which would be facilitated by a unified Network across the hospitals.

The ability of Peter MacCallum Cancer Centre (Peter Mac) and the Women's to provide highly complex care is strengthened by current strong connections with the Royal Melbourne Hospital (Royal Melbourne) to provide trauma, critical care, emergency surgery, diabetes, endocrinology, rehabilitation, neurosurgery and cardiology support. For example, the Royal Melbourne provides the intensive care unit (ICU) for patients of the Women's and Peter Mac. This ensures that women experiencing high-risk pregnancies have access to critical care on site if and when they need it. It is also used by cancer surgery patients at Peter Mac who require ICU care as part of their planned recovery pathway. However, while this shared critical care approach has been supported by stringent process and pathway development, a range of processes supporting shared patient care are stymied by organisational and clinical governance variances.

While the hospitals often engage in shared care arrangements for patients, there can be limited visibility of these patients across the different hospitals. This can lead to situations where, for example, Peter Mac cancer patients present to the Royal Melbourne emergency department during an episode related to their cancer,

and when stable, are not able to automatically transfer to Peter Mac for care. Timely access to highly specialised expertise can be hindered when a complex patient is in one Parkville hospital and the relevant clinical specialists are in another Parkville hospital. A more unified model would support patient visibility across sites. Greater integration across the hospitals would facilitate visibility of emergency department and bed capacity across sites that could enable the right care, in the right place, at the right time for patients.

The highest performing hospitals globally overcome these challenges by bringing together multiple specialty centres and institutes within a single organisation. This includes both cohort- and condition-specific specialties.

According to credible global assessments of the best hospitals in the world, of the 15 top-ranked hospitals globally:

- most are, or are part of, a large, multi-campus organisation
- many have a specific hospital, centre or institute for women's health
- almost all have a children's hospital and/or a research centre or institute for children's healthcare
- all have at least one campus, centre or institute for specific conditions or treatments, such as cancer, cardiovascular disease and transplants.[91]

This approach enables multidisciplinary care and research both within and across particular specialty streams. It enables greater sharing of workforce and expertise across specialities. Furthermore, in each specialty, clinicians and researchers benefit from the resources, relationships and scale available as part of a larger organisation. Patients also benefit from more coordinated care across different specialties, as well as access to the latest treatments and innovations.

Significant infrastructure investment over the last decade has enhanced physical connections across the Parkville precinct and has delivered state-of-the-art health, research and education facilities. However, the organisational barriers between the constituent health services continues to preclude the realisation of a fully integrated care model for patients, clinicians and researchers.

As such, the Committee believes that bringing together services in the Parkville Network will strengthen the statewide roles of the constituent hospitals as centres of clinical and research excellence, and support their ambition to be amongst the best hospitals in the world. A single Network in Parkville will be the most effective enabler to fully realise the specialised clinical service integration, workforce collaboration and world-leading research and teaching potential of this unique precinct in Australia.

[91] Newsweek, The world's best hospitals 2024, available at www.newsweek.com/rankings/worlds-best-hospitals-2024.

Proposed Local Health Service Networks for Victoria

Applying the above design considerations, we propose 11 Local Health Service Networks. These have been designed following extensive consideration of possible groupings of existing health services and represent the Committee's recommended configuration. Three alternative groupings are noted in Appendix 5, however these are not recommended by the Committee as they would reduce some of the benefits for patients and workforce achievable under the Plan. In addition, the Committee considers that any further changes to the 11 recommended groupings, would be likely to undermine the principles and intent of the design and would hinder realisation of the anticipated benefits.

Forensicare has not been included within a Network due to its unique role and need to integrate with the justice health system. However, we note that Forensicare will continue to require robust connection with health service partners to ensure access to comprehensive physical care for its patients.

Rural and Regional Networks

Barwon South West

Health services: Barwon Health, Casterton Memorial Hospital, Colac Area Health, Great Ocean Road Health, Hesse Rural Health Service, 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.

Population served (2026): 490,000

The geography of this Network, spanning from Glenelg on the South Australian border to Geelong, aligns with the existing Health Service Partnership, the historic rural region of Barwon South West. This Network has the highest population of all the proposed regional Networks, approaching 500,000 people by 2036, with the greatest population density in Geelong, followed by Warrnambool. Established referral patterns across the Network, fostered by a lengthy history of health service collaboration, have resulted in 90% of care being delivered locally in the region with most care received at University Hospital Geelong and Warrnambool Hospital. Noting that University Hospital Geelong is the provider of the most complex care in the Network, there is well-established escalation of patient care from Warrnambool to Geelong, as clinically required.

Given the population density in Geelong and its high proportion of medical and surgical specialists, the Committee recommends grouping the Barwon region with the South West region into a single Network to facilitate the provision of greater clinical supports to the service sites in the South West and to support the growing capability of Warrnambool Hospital.

An alternative grouping for this region, which, on balance, the Committee does not recommend, is in Appendix 5.

Grampians

Health services: Beaufort & Skipton Health Service, Central Highlands Rural Health (excluding Kyneton Hospital), East Grampians Health Service, East Wimmera Health Service, Grampians Health, Maryborough District Health Service, Rural Northwest Health, West Wimmera Health Service.

Population served (2026): 250,000

This Network reflects the existing Grampians Health Service Partnership and previous Grampians rural health region. The region has a lengthy history of service consolidations to support service efficiency and viability. East Wimmera Health Service (five sites), West Wimmera Health Service (four sites) and Central Highlands Rural Health and Rural Northwest Health (both three sites) have all previously consolidated formerly disparate health sites into single health service networks. More recently Grampians Health was established, consisting of Ballarat Health, Wimmera Base Hospital, Edenhope District & Memorial Hospital, Stawell Regional Health and Dimboola District Hospital, which spans from the east to the west of the region.

This proposed grouping across the entire Grampians region would consolidate these eight health services together. It respects the natural flows of patients between local hospitals to the higher capability sites within the region. Ballarat Base Hospital would continue to be the provider of the most complex care in this Network.

Loddon Mallee

Health Services: Bendigo Health, Boort District Health, Cohuna District Hospital, Dhelkaya Health, Echuca Regional Health, Heathcote Health, Inglewood and Districts Health Service, Kerang District Health, Kyneton Hospital, Mallee Track Health and Community Service, Mildura Base Public Hospital, Robinvale District Health Services, Rochester & Elmore District Health Service, Swan Hill District Health

Population served (2026): 334,000 (Victoria) + 9,305 (NSW)[92]

The geography of this Network spans from the more densely populated Macedon Ranges Shire in the south to the remote and sparsely populated Mallee Region in the far northwest. This grouping reflects the existing patient flows which follow the main transport routes along the Murray River and down towards Bendigo and Melbourne. It aligns with the pre-existing Health Service Partnership and rural

[92] Based on NSW bordering local government areas (LGAs) immediately adjacent to Network area (Balranald, Murray River, Wentworth).

health regions. The Bendigo Hospital is proposed to continue being the provider of the most complex care in the Network.

Due to the higher density of medical and surgical specialists in Bendigo, the Mallee Region is recommended to be grouped with Loddon Region to achieve organisational sustainability and support clinical uplift to the more remote areas. This proposed Network structure aligns Mildura Base Public Hospital, Mallee Track Health and Community Service and Robinvale District Health Services with Bendigo Health to reduce the isolation of these health services and the need for patients to be flown to Melbourne for higher complexity care. The proposed Network supports the scale necessary to achieve efficiencies in non-clinical support functions and builds on the strong existing ICT Alliance.

An alternative grouping for this region, which, on balance, the Committee does not recommend, is in Appendix 5.

Hume

Health services: Albury Wodonga Health, Alexandra District Health, Alpine Health, Beechworth Health Service, Benalla Health, Corryong Health, Euroa Health, Goulburn Valley Health, Kyabram District Health Service, Mansfield District Hospital, NCN Health, Northeast Health Wangaratta, Seymour Health, Tallangatta Health Service, Yarrawonga Health, Yea and District Memorial Hospital

Population served (2026): 291,898 (Victoria) + 93,452 (NSW)[93]

The geography of this proposed Network reflects the existing transport routes, community-connections and patient flows. It also reflects the Hume Health Service Partnership and is aligned to the historical rural health regions of Goulburn and Oven's Murray. Therefore, health services within this Network have longstanding pre-existing connections.

Goulburn Valley Health (Shepparton) and Albury Hospital are proposed to continue as the providers of the most complex care in this Network.

This Network includes health services on the fringe of metropolitan Melbourne which were considered for possible grouping with North Metro Network: Alexandra District Health, Yea and District Memorial Hospital, and Seymour Health. Although some patients flow to Melbourne from these areas, these communities have a strong cultural connection to rural Victoria, rather than metropolitan Melbourne, and many of the service delivery issues they experience have more in common with the challenges faced by other rural communities than with metropolitan areas. Accordingly, the Committee concluded on balance that they are

[93] Based on NSW bordering LGAs immediately adjacent to Network area (Albury, Berrigan, Federation, Greater Hume Shire, Murrumbidgee, Snowy Valleys)

better grouped with the Hume Network on the basis that, collectively, the proposed Hume Network would better understand and address the challenges of rural health service delivery inherent at these sites.

In addition, the Committee carefully considered the most appropriate arrangements for Albury Wodonga Health, given the complexities of cross border arrangements, natural patient flows within the Hume region, and the benefits for the region of having sufficient scale in its Network to improve patient care and support workforce. Following consideration of multiple options, the Committee concluded that the optimum arrangements for the Albury Wodonga community and broader Hume region, would be for Albury Wodonga Health to become part of a Hume Local Health Service Network, with the Network board to establish specific governance arrangements and executive leadership structures to manage cross-border issues.

Gippsland

Health services: Bairnsdale Regional Health Service, Bass Coast Health, Central Gippsland Health Service, Gippsland Southern Health Service, Latrobe Regional Hospital, Omeo District Health, Orbost Regional Health, South Gippsland Hospital, Yarram & District Health Service

Population served (2026): 250,000

The Gippsland Network is proposed to serve a population exceeding 250,000 people, which meets the threshold scale to meaningfully support population health outcomes. The geography of this proposed Network, spanning from Bass Coast Shire in the west to the large East Gippsland Shire, aligns well with that of the Gippsland PHN and the Gippsland Mental Health and Wellbeing Region.

Latrobe Regional Hospital is proposed to be the provider of the most complex care in the Network, supporting the delivery of greater than 85% of care locally over time. We recognise that the western portion of the Network, notably Bass Coast Shire, has significant patient flow patterns to metropolitan Melbourne health services for higher capability care. However, many of the service delivery issues experienced in Bass Coast Shire have more in common with the challenges faced by other rural communities than with metropolitan areas. Accordingly, the Committee concluded on balance that Bass Coast Health is better grouped with the rest of Gippsland.

Metropolitan Networks

West Metro

Health services: Western Health in partnership with Mercy Werribee Hospital (denominational)

Population served (2026): 1.1 million

This Network's geography encompasses populations in the rapidly growing western suburbs of Melbourne, which are experiencing major changes in demographics and health care needs. The Network reflects the existing primary catchments of Western Health and Werribee Mercy Hospital with which it would require a partnership. This Network will include three new health service sites when completed – Footscray Hospital, Melton Hospital and Point Cook Community Hospital – and the effective incorporation of these new health service sites will be fundamental to the Network providing increased scope and access to care locally.

Sunshine Hospital is proposed to be the provider of the most complex care in this Network, noting that it already accommodates one of four statewide Level 6 maternity services at the Joan Kirner Women's & Children's Hospital.

Parkville

Health services: Peter MacCallum Cancer Centre, Royal Children's Hospital, Royal Melbourne Hospital, Royal Women's Hospital

Population served (2026): 0.44 million (local population) plus population for statewide services.

Collectively, these four health services provide highly specialised care at a statewide level, as well as local care to residents of their immediate catchment. The co-location of these four health services within the Parkville Precinct, with three of them accommodated on the one site, has fostered strong clinical interdependencies between the services. For instance, the Royal Melbourne Hospital, the Royal Women's Hospital and the Peter MacCallum Cancer Centre leverage shared emergency department and ICU models. Newborns needing complex care transition from the Royal Women's to the Royal Children's for ongoing paediatric care and those who continue to have chronic illness into adulthood transition to the Royal Melbourne Hospital. Despite these deep clinical connections, the separate legal status of the organisations precludes seamless transitions of patients between hospitals, who have to be discharged and readmitted as they move across the site for care. Separate organisational arrangements also hinder patient-centred multidisciplinary care for those with complex conditions.

The Committee proposes these four health services consolidate into a central Network to facilitate seamless care for patients across the entire lifespan from birth to old age, and for patients with complex conditions. Consolidation will also create

an academic and research health institution of sufficient scale and capability to be highly competitive with major international institutions, and provide greater opportunities to drive innovative, translational research in partnership with universities and eminent research institutes co-located in this unique precinct.

An alternative grouping for Parkville, which, on balance, the Committee does not recommend, is in Appendix 5.

In addition, work is currently underway to establish Parkville Youth Mental Health and Wellbeing Service as a public health service entity. The relationship of that entity with the Parkville Local Health Service Network should be considered in the future.

North Metro

Health services: Austin Health and Northern Health, in partnership with Mercy Hospital for Women (denominational)

Population served (2026): 0.97 million

This Network encompasses the northern suburbs of Melbourne from the City of Darebin in the inner city to the fringe areas of Whittlesea and Nillumbik Cities, and the southern regions of Mitchell Shire. It includes the northern growth corridor, which has Victoria's largest projected population growth over the next 15 years.

Given its location in a growth corridor, Northern Health is required to focus its resources on managing very high volumes of emergency presentations and admissions, leaving little residual capacity to delivery elective care. Consolidation of Austin Health and Northern Health, and partnership with Mercy Hospital for Women will provide robust referral pathways for moderate and high complexity care, increasing the overall efficiency of this Network. As a consolidated service, this Network would also be effective in reducing unnecessary flows from the northern growth areas to the Parkville Precinct, relieving pressure on Royal Melbourne Hospital and Royal Women's Hospitals and enhancing their ability to focus on highly complex care.

Austin Hospital, as a major tertiary hospital, is proposed to be the provider of the most complex care in the Network, supporting the delivery of greater than 85%–90% of care locally over time. In addition, the network will continue to support system innovations such as Northern Health's work to establish the Victorian Virtual Emergency Department (VVED), as well as open up professional development opportunities for staff across the Network.

East Metro

Health services: Dental Health Services Victoria, Eastern Health, and the Royal Victorian Eye and Ear Hospital, in partnership with St Vincent's Health (denominational)

Population served (2026): 1.2 million

This Network respects the community's existing service flows from the middle and outer east towards the central business district along the major transport routes of the Maroondah and Burwood Highways and Eastern Freeway, from the Yarra Valley and Dandenong Mountains to Box Hill and the city centre. It reflects the existing Eastern Health and St Vincent's Health's primary catchments and strengthens the access by residents of these areas to higher level specialist care at St Vincent's Hospital.

On this basis, St Vincent's Hospital, as a major tertiary hospital, is recommended to be the provider of the most complex care in the Network.

We propose Dental Health Services Victoria and the Royal Eye and Ear Hospital, although focused on specialist clinical streams, are consolidated with the East Metro Network. This is recommended based on their physical locations and to maximise the benefits of connection for multidisciplinary care, coordination of workforce, and consolidated clinical, non-clinical and corporate support services. Both Dental Health Services Victoria and the Royal Eye and Ear Hospital would continue to play their statewide roles as providers of specialist care and expertise.

South Metro

Health service: Monash Health, West Gippsland Healthcare Group

Population served (2026): 1.2 million

This Network builds on the existing primary catchment of Monash Health in the southeastern suburbs and extends into western Gippsland. The Network will consist of the four metropolitan hospitals and numerous other sites in the southeast of Melbourne and will provide a mature networked service delivering care to a large and growing population across the region. Consolidating West Gippsland Healthcare Group with Monash Health reflects the strong flows from the Warragul-Drouin District of Baw Baw local government area towards metropolitan Melbourne. Consolidating these services will boost South Metro Network's self-sufficiency, which is expected to continue increasing as Warragul Hospital's clinical capability is improved through its connection with Monash Health.

Monash Medical Centre Clayton, as a major tertiary hospital, would be the provider of the most complex care in the Network, supporting the delivery of greater than 85% of care locally over time.

Bayside

Health services: Alfred Health, Kooweerup Regional Health Service and Peninsula Health, in partnership with Calvary Health Care Bethlehem (denominational)

Population served (2026): 1.1 million

This Network groups the primary catchments of Alfred Health, Kooweerup Regional Health Service and Peninsula Health into a single bayside Network. The Alfred Hospital has a central role in the Victorian health system, providing many highly complex services at a statewide and national level, as well as providing care for its local catchment. This Network also reflects existing patterns of patient flows from Frankston and Mornington Peninsula to The Alfred Hospital for complex care which is unable to be managed safely by Peninsula Health. Formalising these arrangements will further support the Alfred Hospital's role in the system by increasing the scale of its catchment and enhancing the sustainability of its highly complex services.

Calvary Health Care Bethlehem (denominational) is proposed to operate in partnership with this Network due to its physical location within the Network and the synergies that exist with Alfred Health for specialty neurological services.

The Alfred Hospital, as a major tertiary hospital, is proposed to continue as the provider of the most complex care in the Network, supporting the delivery of greater than 85%–90% of care locally over time.

Chapter 5

Caring for patients who need higher complexity care

Chapter 5: Caring for patients who need higher complexity care

Finding: Many health services lack reliable and consistent connections to major tertiary, women's, children's and other specialist hospitals for higher complexity care, impacting patient experience and outcomes.

Lack of reliable and consistent connections contributes to:

- delays in patients accessing appropriate care
- difficulties for patients and clinicians in navigating the system
- patients travelling unnecessarily for care, or staying further away for longer
- poor utilisation of resources and capability, including excessive use of high capability hospitals for low or medium complexity care, and inconsistent use of other hospital sites
- inconsistent access to advanced workforce training and professional development.

Recommendation 5.1: The department will facilitate each regional and metropolitan Local Health Service Network establishing a formal relationship with a major tertiary, a women's and a children's hospital.

Formal relationships will take into account logical patient flows and geography, and balance demand across the system. These relationships will support:

- **access to specialist expertise both virtually and physically, including to support care in place and close to home wherever possible**
- **consistent and timely access to high complexity care, including a bed if needed, with the major tertiary, women's or children's hospital having responsibility to coordinate appropriate care if it does not have available capacity**
- **jointly agreed roles and responsibilities for timely access to step up and step-down care as patients' care needs escalate and de-escalate**
- **improved access to advanced teaching, training and professional development, and joint arrangements for rotations and sharing of clinical staff**
- **improved access to clinical trials and research opportunities**
- **adoption of best practice, evidence-based care.**

The department will support the establishment of consistent referral pathways for every Network to have relationships with specialist hospitals which focus on distinct clinical streams.

In the last chapter we outlined how Local Health Service Networks will support local delivery of most patient care needs. At least 85% of care needs will be delivered locally in Networks that include a Group A hospital.

However, some complex or highly specialised care will still need to be provided by higher capability or more specialised hospitals, if they are to be provided in sufficient volume to support safe, high-quality and sustainable care. Complex care should be delivered at sites which are large enough – and provide these services frequently enough – to support dedicated clinical expertise in this area.
This chapter outlines how connections will be formalised between Networks and major tertiary hospitals, women's, children's and specialist hospitals to ensure patients can access specialised care when they need it.

What are major tertiary hospitals?

Major tertiary hospitals serve two significant roles in the Victorian healthcare system: they provide health care to their local communities, and they provide complex care for the entire state.

Major tertiary hospitals typically provide the most comprehensive care at the highest level of complexity. They are equipped with the most advanced medical facilities and technology and are distinguished by a very broad cross-section of specialised clinical staff. They have well established partnerships with universities and medical research centres to foster continuous learning.

Key roles of major tertiary hospitals include:

- providing services for statewide catchments which are generally not available at other hospitals such as multidisciplinary services, neurosurgery, and designated services (for example organ transplants)
- providing clinical advice and supports to allow patients to be cared for at many hospitals across the system
- leading a network of training and education for the next generation of clinicians
- striving to be centres of excellence for clinical research
- providing clinical advice and supports to allow patients to be cared for at many hospitals across the system.

In addition to providing overall complex and comprehensive care, some major tertiary hospitals provide highly specialised, low volume services such as organ transplants for the state (see Chapter 6).

These characteristics position major tertiary hospitals as an important support for Networks.

The location of major tertiary hospitals

To support the safety, quality and sustainability of high complexity care, it is important to have a limited number of major tertiary hospitals within the state, as this ensures each site sees a sufficient volume of highly complex patients to maintain the skills of their highly specialised workforces. This approach also concentrates workforce expertise across highly complex clinical services and medical research.

In Victoria there are currently five major tertiary hospital sites:

- Alfred Hospital
- Austin Hospital
- Monash Medical Centre Clayton
- Royal Melbourne Hospital
- St Vincent's Hospital.

These hospitals are in metropolitan Melbourne where they provide the full range of care for their local communities along with providing complex and comprehensive care to Victorians from regional and rural areas.

Women's, children's and specialist public hospitals

Victoria also has several public hospitals that provide high complexity and/or specialised care for certain clinical streams or specific patient cohorts.

These hospitals comprise, for women's and maternity services:

- Joan Kirner Women's and Children's
- Mercy Hospital for Women
- Monash Women's (at Monash Medical Centre)
- Royal Women's Hospital.

For children's services:

- Monash Children's Hospital
- Royal Children's Hospital.

And for specialist clinical streams:

- Peter MacCallum Cancer Centre
- Royal Dental Hospital of Melbourne
- Royal Victorian Eye and Ear Hospital
- Victorian Heart Hospital.

These hospitals maintain concentrated workforce expertise and are often clinical and research leaders in their field. They provide an important service at a regional and statewide level by ensuring the community can access specialised healthcare.

Challenges in accessing highly complex care

Currently many health services have unclear and uncoordinated connections to high complexity care provided by major tertiary, women's, children's and other specialist hospitals. Instead, pathways are highly dependent on informal relationships and historical patterns. This means:

- some health services have limited access to specialised expertise and advice, including secondary consultation services from senior clinicians. Without access to this advice, some health services refer patients unnecessarily to major tertiary and specialist hospitals, when it may be possible for them to be cared for locally with appropriate specialist advice.
- there is a lack of clear protocols for access to high complexity care when a patient deteriorates, which may result in junior medical staff negotiating with multiple major tertiary or specialist hospitals. This can lead to delays in regional patients being transferred and accessing the care they need where and when they need it. Regional health services frequently have to contact multiple tertiary hospitals to find a bed for deteriorating patients, with cases of life-threatening delays extending to more than 50 hours for patients to be transferred to hospitals with appropriate expertise.[94]
- there is a lack of clear protocols for returning patients back to local hospitals for step down care after the highly complex or specialised phase of their care. This means patients may be staying unnecessarily in major tertiary or specialist hospitals when it could be possible for them to be recovering in a local hospital closer to home, while another patient could be using their bed in a major tertiary hospital.
- there is inconsistent access to advanced workforce training and development, and to research networks and clinical trials across the health services system. This means that patients and clinicians across Victoria have inequitable access to advances in clinical care and expertise. It also means that translational research is often only undertaken in a limited range of geographies and settings, and risks not being informed by the diversity of service settings that exist across the state.

The challenges described above result not just in poor experience for individual patients, but also contribute to broader challenges in providing timely care across the health services system. Some major tertiary hospitals are overloaded with general patients, while other hospitals have spare capacity to manage more patients. For example, major tertiary hospitals experience average bed utilisation of 106%, while Group A hospitals have an average of 91%.[95] This variation in the

[94] West Gippsland Healthcare Group, *Interhospital patient transfers*.

[95] Victorian Department of Health, 2021–22 VAED and 2021 multiday and same-day surgery and medical bed audit data [internal analysis], April 2024.

distribution of care across the system needs to be addressed if we are to provide more consistent access for all patients.

To ensure patients and families have consistent access and that services are equitably and safely shared across the system, formal relationships are required between major tertiary, women's, children's and specialist hospitals, and all Local Health Service Networks.

Formalised relationships for high complexity care

The department will facilitate formal relationships between each Network and a major tertiary hospital to support better coordinated and collaborative access to services and ensure step-up and step-down care pathways for patients.

These formalised relationships will ensure that all health services in a Network have access to major tertiary care for their patients in a seamless and timely manner. Referral to the partnered major tertiary hospital can be made directly by any hospital within a Network and will not be reliant on the local Group A hospital to facilitate referral. However, local Group A hospitals will be well positioned to support other hospitals to determine whether escalation to a major tertiary hospital is clinically required, or whether care can be provided locally with or without remote support from the major tertiary hospital. This approach means that the patients' journey within the system is clearer and less demanding on the patient and their family.

In addition, each Network will have a formalised relationship with a women's and a children's hospital to support clear pathways to access high complexity women's and paediatric care and to support management of regional and statewide demand across these services.

These formalised relationships will focus on key areas:

- Each hospital partnering with a Network will be responsible for providing access to specialist expertise. This will include direct access to workforce, as well as secondary consultations with senior clinicians and virtual outreach, with the aim of supporting regional hospitals to uplift their skills and care for patients in place wherever possible.
- Each hospital partnering with a Network will be responsible for providing appropriate care, including a bed if needed, where a patient's care needs have escalated beyond the capability of hospitals within the Network per the role delineation framework. Where the major tertiary, women's or children's hospital does not have capacity available in its own facility, it will be responsible for finding appropriate care elsewhere.
- Each hospital partnering with a Network will agree roles and responsibilities for timely access to step up and step-down care as patients' care needs escalate and de-escalate. Step-down protocols will ensure that patients are

transferred back to a non-tertiary hospital following the complex component of their care, releasing capacity at the major tertiary hospital and supporting patients to recover closer to home.

- Each hospital partnering with a Network will collaborate on workforce supports, including access to teaching, training, professional development and education. These collaborations will aim to provide more equitable workforce access to senior clinical expertise and training across the system.
- Each hospital and Network will collaborate on research opportunities such as access to clinical trials and translational research, so that access to advanced and innovative care is more equitable across the state, and research is better informed through having been undertaken across a broader range of populations, geographies and settings.
- Partnerships will support sharing of best practice, evidence-based care.

Overall, the aim of these relationships will be to provide more equitable and consistent patient access to complex care, where patients can remain close to home wherever safe and practicable rather than be transferred to a major tertiary, women's or children's hospital.

Where patient transfers are required, the formalised relationships will support more consistent referral pathways, ensuring clarity for clinicians and reducing the time spent locating available beds across the system in time critical situations. Importantly, the model will shift accountabilities, so that senior clinicians at major tertiary, women's and children's hospitals become responsible for ensuring that deteriorating patients have access to appropriate care, rather than junior medical staff having to search across the system.

In implementing this model within their area, each major tertiary, women's and children's hospital and Network will need to work closely with patient transfer services including Ambulance Victoria, Adult Retrieval Victoria, Paediatric Infant Perinatal Emergency Retrieval and NEPT services. These services play a key role in transferring patients across the state and will be integral stakeholders to the success of the model.

The relationships between major tertiary, women's and children's hospitals and Networks will help balance the distribution of complex care across the system. Group A and B hospitals in many parts of Victoria have the capability and capacity to provide more services for moderately complex patients. Better distributing moderately complex care across hospital Networks will support Group A and B hospitals to deliver at the top of their scope of practice, whilst reducing demand on major tertiary and women's and children's hospitals so they can focus on higher complexity care. Formalised relationships will allow major tertiary, women's and children's hospitals to redirect lower complexity care and step-down care to Group A and B hospitals where clinically appropriate. This enables patients to be

closer to home sooner, rather than spending extended periods of time in major tertiary, women's or children's hospitals.

Access to other specialist hospitals and their expertise

Hospitals such as the Peter MacCallum Cancer Centre, Royal Dental Hospital, the Royal Victorian Eye and Ear Hospital and Victorian Heart Hospital, specialise in distinct clinical streams and play statewide roles. The Committee recommends referral pathways are in place for every Network to access these specialist services. As these hospitals engage extensively in clinical research, clear pathways from each Network will also support access to clinical trials for Victorians.

In addition, the Committee recommends specialist hospitals continue their existing approaches that support the sharing of highly specialised expertise broadly across the sector, leveraging outreach and virtual models.

The Committee also recommends that Statements of Priorities (SOPs) for specialist hospitals include expectations for the sharing of expertise on a statewide basis, as well as development of robust referral pathways to these sites for patients who cannot be provided care in place through virtual or outreach modalities.

Establishing relationships

Building stronger relationships between major tertiary, women's and children's hospitals and Networks to improve patient care means establishing trusting, collaborative relationships across staff, fostering open communication and information sharing, and aligning values and goals.

Each regional Network will be expected to have a formal relationship focused on a single major tertiary hospital, a women's hospital and a children's hospital. While there will be occasions when patients need to be referred to other tertiary hospitals (e.g. because of highly specialised care needs or family connections), focusing on a relationship with a single hospital will support greater consistency in referral pathways, and a more seamless, less fragmented patient experience. It will also enable workforce and training connections to be built more consistently and comprehensively, and deeper, more trusting relationships across staff.

In metropolitan areas, it will most often be the case that a Network will have a major tertiary hospital within its Network. In those circumstances, the kinds of relationship and responsibilities between a major tertiary hospital and other hospitals would be established within that Network.

The Committee recommends the department supports and guides the development of formalised relationships between each Network and a major tertiary, a women's and a children's hospital applying the following criteria:

- the relationship considers how consumers and staff flow across geography

- the major tertiary, women's or children's hospital has capability and capacity to provide senior clinical advice and care to patients from the partnering Network
- there is strong alignment of leadership and organisational cultural and values between partners
- the relationship supports load sharing across the major tertiary, women's and children's hospitals to optimise utilisation of these hospitals
- the relationship supports a balanced approach to ensure each major tertiary, women's and children's hospital can meet the needs of their local communities as well as statewide demands.

Enablers

Chapter 8 outlines broad success factors for Plan implementation, including shared goals and well-defined accountabilities, roles and responsibilities, community and workforce engagement, organisational culture and leadership style, workforce culture and capability, resourcing, and digital infrastructure. Specific enabling arrangements between each Network and their partnering major tertiary, women's and children's hospitals should include the following:

- agreed financial arrangements between each Network and the partnering hospital
- clear governance, roles, and responsibilities
- escalation and de-escalation protocols for the management of patients as their care needs change
- development of clinician trust and understanding of each other's capabilities
- care models and technology to support virtual care, including secondary consultations, and patient transfer
- joint arrangements for rotations and sharing of clinical staff
- communication protocols and systems between hospitals, including for seeking expert advice and transfer of patient information
- support for clinical staff to work effectively across services, including seamless credentialling, shared employment arrangements and appropriate terms and conditions.

Chapter 6

Caring for patients who need very highly specialised care

Chapter 6: Caring for patients who need very highly specialised care

Finding: While Victoria has a program designating very highly specialised, low volume care to a limited number of sites, some services are still delivered at a higher number of sites than comparable jurisdictions.

This creates difficulty:

- maintaining a highly specialised and skilled workforce
- ensuring sustainable, safe and high-quality care
- establishing centres of excellence in highly complex care and research.

Recommendation 6.1: The department will establish a formal process to review which health service sites provide very highly specialised, low volume care.

The process will include establishing an expert advisory committee to support the department to:

- **assess new, very highly specialised, low volume services so they are concentrated in a small number of health service sites**
- **review existing designated services to determine whether these services can safely and sustainably be delivered in a more dispersed model in the system**
- **develop options to concentrate existing designated and non-designated very highly specialised, low volume services to establish centres of excellence, improve sustainability, and support quality and safety.**

Some patients require highly specialised care for relatively rare and complex conditions such as rare cancers, genetic disorders or complex medical or surgical disorders. These services are not available in every hospital because they need to be delivered by highly specialised teams of clinicians who have the necessary skills and experience. Limiting the number of hospitals that offer these services supports clinicians and teams to optimise their skills and minimise patient complications through higher volumes of practice. For this reason, Victoria and other jurisdictions have limited the number of hospitals at which very low volume, highly complex treatments are delivered.

Many of Victoria's very low volume, highly complex services are concentrated in three or fewer major tertiary or specialist hospitals to ensure that these services are provided in a consistent, high-quality, sustainable manner. Hospitals that deliver this cutting-edge care are often a catalyst for innovation, supporting pioneering clinical practice.

In Victoria, examples of services which have been designated by the department and Nationally Funded Centres to a limited number of sites[96] include Major Trauma Services at the Alfred Hospital, the Royal Melbourne Hospital and the Royal Children's Hospital,[97] the heart-lung transplant centre at the Alfred Hospital, and the liver transplant unit and spinal cord services at the Austin Hospital (see Appendix 7 for a list of established designations).

These highly specialised services do not exist in isolation. Patients and their families will contact different parts of the system at different times for parts of their care – often many times. Key to streamlining the care journey for patients and their families is the coordination of episodes of care received at highly specialised centres and the other, related episodes of care ideally provided by local health services closer to home.

Challenges and opportunities for highly specialised care

Some very highly specialised services continue to be delivered from multiple sites

Despite arrangements to concentrate certain services in a limited number of sites, some very highly specialised, low volume services are delivered from a comparatively large number of hospitals in Victoria, including ECMO, bone marrow transplants, kidney transplants, complex cardiothoracic surgery and complex interventional cardiology. For example, cardiothoracic surgery is delivered from twice as many hospitals per capita in Victoria compared to England.[98]

While the current distribution of these services in Victoria may support ease of access for patients, it results in very low volumes at each site, which may challenge service quality and sustainability. It also leads to competition between sites for highly specialised clinicians, who are relatively scarce in Victoria's public hospital system. There are relatively low rates of co-appointments of these expert clinicians, and the current system constrains collaboration between them.

Taken together, these factors hinder services from achieving sufficient scale to develop statewide and national Centres of Excellence. Centres of Excellence could provide a higher concentration of expertise delivering comprehensive, interdisciplinary care, seamlessly integrated with strong translational research programs and high-level training and education.

The United Kingdom has been developing Centres of Excellence for specific high complexity care such as stroke, cardiac and cancer services over many years, which

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[96] Victorian Department of Health, *Statewide design, service and infrastructure plan for Victoria's health system 2017–2037,* Victorian Government, 2017.

[97] Victorian Department of Health, *Trauma services*, Victorian Department of Health website, 2023, available at www.health.vic.gov.au/victorian-state-trauma-system/trauma-services, accessed April 2024.

[98] D Richens, *Cardiothoracic surgery: getting it right first time (GIRFT) programme national specialty report,* National Health Service (UK), 2018.

have provided demonstrable benefits to patient care. For instance, consolidated stroke centres in London have reduced mortality rates for patients following an acute stroke by 25% at three months post event, while the cost of treating each stroke patient was also reduced.[99] Similarly, designation of major trauma centres in Victoria over 20 years ago reduced mortality rates by 15–25%.[100]

The suite of highly specialised, low volume procedures requires ongoing review

As novel, highly specialised, very low volume treatments and new health technologies emerge in Victoria, they will need to be strategically allocated to a limited number of sites. Concentrating these services in a small number of sites will maximise the impact of these innovations, ensure sustainability and maintain the highest standards of care and training.

The distribution of very high complexity, low volume services will be regularly reviewed and revised to determine the extent of concentration required for both current and future procedures and therapies, and where these services are best delivered. Consideration will also be given to the elements of a given course of treatment that must be delivered at a small number of concentrated sites, as opposed to those lower acuity elements that could safely be delivered closer to home in partnership with a local hospital.

Ongoing monitoring and regular review of these services will be informed by population health requirements, advances in clinical practice, workforce, service and capital planning, and funding requirements. In some cases, over time, it may be possible to relax the concentration of these services as case volumes grow and technology advances to better support safety and sustainability.

Experts within the sector will be engaged to support such monitoring and review processes, to encourage a collaborative approach on how very highly specialised, low volume services are delivered across the sector. The arrangement of services will support load balancing across the system, given resource and capacity constraints, so that each major tertiary hospital plays a significant role in the provision of some, but not all, very highly specialised, low volume services. This may support the development of multiple Centres of Excellence across Victoria.

In addition, building relationships across services will support clinician mobility between major tertiary hospitals to enable clinicians to continue practising their field of expertise and supporting the right care for the patient in the right service. Such mobility may also allow clinicians with specialist training from elsewhere in the

[99] C Davie et al., *London's hyperacute stroke units improve outcomes and lower costs*, Harvard Business Review website, 2013, available at https://hbr.org/2013/11/londons-hyperacute-stroke-units-improve-outcomes-and-lower-costs, accessed April 2024.

[100] K Lansink & L Leenen, 'Do designated trauma systems improve outcome?', *Current Opinion in Critical Care*, 2007, 13(6):686–90, doi: 10.1097/MCC.0b013e3282f1e7a4.

system to practice at major tertiary and specialist hospitals, supporting skills development and maintenance more broadly.

Concentrating highly specialised clinical services

Concentrating very highly specialised, low volume services requires transparent and effective processes and governance to ensure the optimal outcomes for patients, staff and the whole community.

The Committee recommends the department embed a consistent assessment and review process to ensure the distribution of services remains current and fit for purpose, and that patients are receiving care in the most appropriate setting.

We have considered both competitive and managed approaches to identifying which sites can deliver very highly complex, low volume services. Competitive processes create incentives for excellence and avoid perceptions of favouritism. However, competitive processes also risk fragmenting an already scarce workforce, and undermining collaboration across the sector. Managed design processes risk being perceived as lacking transparency but can result in a more integrated and collaborative system design.

Given these considerations, we recommend the department establish a formalised process leveraging expertise within the sector to review and advise on how very highly specialised services should be distributed across the state. This approach will ensure equity and transparency for the Victorian health sector.

The Committee recommends the Secretary of the Department of Health hold accountability for decisions on where services should be concentrated, advised by a multidisciplinary expert advisory group, comprising clinicians and CEOs from the sector, consumer representation and chief clinicians from SCV. Where needed, working groups should be established to ensure each clinical area has the relevant subject matter expertise.

The Committee recommends the following framework for concentrating the delivery of very highly specialised, low volume clinical services:

- The department establish an expert advisory group consisting of both clinicians and health service CEOs, supported by the department, with a respected independent chair.
- The department and expert advisory group identify, based on system wide needs analysis, treatments and therapies to be considered for concentration.
- Services to be concentrated, the number of sites needed and their geographic dispersion to yield an optimum network, and capabilities required to host a service, are endorsed by the advisory group and approved by the department.

- Health services with an interest and the necessary capability to deliver the service apply to the department to be one of the selected sites.
- Applications are assessed by the advisory group, taking into account capability, workforce and location to support an optimum service network. Where appropriate, external clinical advice (potentially interstate or international) is sought to ensure efficacy and independence in the assessment process.
- Health services recommended by the advisory group for selection are requested to develop a joint proposal for how they will collaboratively provide the service and manage the specialist workforce in a networked approach for the state. The independent chair may play a role in helping to broker a networked solution across health services.
- Joint proposal is assessed by the advisory group and recommended to the Secretary for approval.

Principles to concentrate highly specialised care

The underlying principles for concentrating specified treatments or procedures into a small number of selected sites are that:

- concentrating services to specific sites will lead to improved outcomes for patients, through focusing expertise and facilities that would not otherwise be available for very low volume therapies or interventions
- sites selected to host these services will have strong and formal relationships across the Victorian health care system to ensure equitable access to care, with clear referral pathways for eligible patients across Victoria
- concentrating services to selected sites will be informed by evidence of volume-outcome relationships, or other evidence that supports improved patient outcomes through increased quality, safety, sustainability and/or efficiency
- the selection of sites will also be informed by the opportunity to create Centres of Excellence that integrate care with world class translational research and education, that can be recognised at a national and international level
- financial, workforce and technical viability of highly specialised services will be enhanced through concentration (reduced duplication) of resources
- specialist workforce for highly specialised care will be supported to work across different health service sites to ensure they can continue to provide this care regardless of where it is delivered
- new health technologies which are high cost and have low population uptake can be implemented via a strategic and staged approach under a defined framework while the evidence base is still evolving

- sites selected to host very highly specialised services will have active research, training, and education programs to ensure continuous improvement and dissemination of knowledge
- the process for appointment of services will be formally established, equitable, and transparent to health services and clinical stakeholders.

Chapter 7

Governing a connected health services system

Chapter 7: Governing a connected health services system

Finding: Informal partnerships limit the depth of collaboration and have weak participation and accountability requirements, rendering them insufficient to overcome issues arising from system fragmentation.

Informal partnerships:

- are too reliant on individual personalities and willingness to participate constructively
- lack formal, shared accountability to government and the public on whether they are delivering improved care for their community
- lack mechanisms that enable deeper collaboration, such as the ability to employ staff or hold funding.

Finding: Among governance options for Local Health Service Networks, consolidation of existing health services is the optimal approach to address current and future challenges.

Compared to stronger partnership arrangements, consolidated health services:

- have the greatest potential to reduce inequities and improve consistency in care, as a single entity becomes responsible for each community's health outcomes
- best support safety and quality, through each consolidated entity having greater resources and capability to manage clinical governance
- provide a single employer in each region to coordinate recruitment and retention of staff, and offer consistent professional development and training
- enable greater efficiencies of scale and the removal of duplication, optimising use of available resources.

Recommendation 7.1: Government consolidate health services under the following model:

Each consolidated Local Health Service Network is a single entity with:

- **a new, skills-based board with membership that reflects the diversity of its region**
- **a newly recruited Network chief executive officer**
- **enduring pre-existing site identities and brands**
- **visible local leadership**
- **a single employer that can engage and deploy workforce across sites in accordance with community need**
- **unified clinical governance and clinical service planning**
- **unified financial management, corporate governance and back office**
- **consistent policies and procedures across all health sites, including quality and safety processes**
- **accountability for care across its entire Network geography.**

Within each Local Health Service Network:

- **visible local leadership will be maintained at each pre-existing health service, with site-appropriate seniority and delegated powers to deliver the following objectives:**
  - **clinical services that are responsive to local conditions and local community health needs**
  - **robust oversight of high-quality and safe care**
  - **engaged local workforce and positive workforce culture**
  - **responsible financial management consistent with the Network board's approved financial delegations**
  - **collaborative engagement with other local service providers to support local pathways and care**
  - **collaboration with local government on population and public health and wellbeing planning**
  - **fostering of local innovation**
  - **managing locally specific functions, including continuing and strengthening current community and social service functions**
  - **robust emergency management preparedness and coordination.**
- **Local Community Boards and community engagement mechanisms are established for each pre-existing health service to:**
  - **provide feedback and advice to local leadership to ensure services meet community needs, and that local perspectives are considered**
  - **include connections to and representatives of major community organisations, such as local government**
  - **support local fundraising and community engagement.**
- **chairs of Local Community Boards will form a subcommittee of the entity board**
- **existing health service identities, brands and related functions such as fundraising are maintained.**

Where a Local Health Service Network has geographic subregions, the Network will establish appropriate subregional leadership structures to deliver the following objectives:

- **coordination across health service sites within the subregion to deliver step-up and step-down care for low to medium complexity care, with the objective of keeping care as close to a person's home as possible**
- **consistent local and subregional referral pathways, including where a subregion may have distinctive flows, such as in peri-urban areas**
- **effective management of site capacity, load sharing and workforce sharing across the subregion.**

Recommendation 7.2: Where a consolidated Local Health Service Network includes a specialist health service with a statewide role, support for that specialist service is to be maintained and strengthened through:

- **visible leadership for the specialist service, with appropriate seniority and delegated powers to deliver the following objectives:**
  - **specialist clinical services that are responsive both to local and statewide health needs**
  - **positive workforce culture, and support for statewide access to specialty expertise, including for care, training and professional development, and research**
  - **in the context of Network service planning, provide specialist service planning across the state**
  - **collaboration, referral pathways and clinical networks with other service providers within their specialty**
  - **responsible financial management consistent with the Network board's approved financial delegations.**
- **a Specialist Community Board that provides advice and feedback to the specialist service leadership, and whose chair is a member of a subcommittee of the Network board**
- **maintaining existing specialist health service identities, brands and related functions such as fundraising.**

Recommendation 7.3: Where a Network includes a denominational health service and a consolidated public health service, the department will establish stronger partnership arrangements between the denominational health service and consolidated public health service so that they are jointly responsible for delivering Network objectives and outcomes.

Finding: The department does not consistently fulfil its role as system steward, with its attention and resourcing instead often focused on managing issues related to 76 separate health services and their interrelationships.

The department should play a greater role in strategic planning and direction setting – in partnership with the sector – to move the system to a new level of maturity.

Recommendation 7.4: The government will hold the department accountable for fulfilling a stronger role in setting strategic directions, monitoring and ensuring accountability.

In a consolidated system, the department will:

- **continue monitoring and holding health services accountable for performance and improvement**
- **strengthen its focus on strategic leadership and direction setting, including statewide system clinical planning, rather than day-to-day issues for individual health services**
- **set and enforce clear objectives and outcomes for each consolidated health service entity, including for meeting population health needs, reducing inequity across its geography, and incorporating local voice**
- **drive greater consistency across health services, and set clear expectations – including directions where needed – when statewide approaches are necessary, and enforce compliance**
- **refocus efforts on quality and safety of care, on continuous improvement and learning, innovation, reform and standardisation of care**
- **enable some activities currently performed by regional offices to become managed by and within Networks where appropriate and consistent with Network functions, rather than departmental functions**
- **regularly review Network boundaries and make decisions about potential adaptations taking into account changing population and demography.**

Over previous chapters, the Committee has described a range of collaborative solutions that the health services system should adopt to deliver more accessible, equitable and consistent care for patients, and improve support for our healthcare workforce.

As health services move to deliver shared functions and work as Networks, they will require more effective governance arrangements that support: clarity of roles and responsibilities; transparency; responsiveness and effective use of resources.

Current governance arrangements create risks to patient care

As described in earlier chapters, Victoria's health services system operates under a devolved governance model with 76 discrete health services, each with its own board. Several independent reports have highlighted issues with this model.[101]

We believe the siloed nature of the system drives many challenges highlighted in Chapter 1 of this Plan, and limits health services' ability to coordinate, share and collaborate to bring about better experiences for the health workforce, and better outcomes for patients and communities.

Informal partnerships limit the depth of collaboration possible

Many different collaborative arrangements have been established to address inherent challenges of Victoria's fragmented system. For example, Local Area Health Partnerships were established in 2016 to drive local collaboration at an operational level in subregional areas. Regional ICT Alliances were established in rural and regional Victoria to support health services to implement Victoria's Digital Health Roadmap.

In July 2021, Health Service Partnerships were established to drive collaboration between health services. In 2022 an independent evaluation[102] found the informal nature of Health Service Partnerships limits their ability to improve patient and system outcomes. While Health Service Partnerships promote coordination, planning and knowledge sharing, they play a limited role in areas such as strengthening clinical governance, and jointly managing or sharing resources and workforce due to their inability to employ staff or hold funds. The evaluation also found Health Service Partnerships lack formal, shared accountability to government and the public on whether they are delivering improved care for their community. Noting the current system design had been in place for over 20 years, the evaluation recommended a broader process to examine the design and governance of Victoria's health services system, which has led to this Plan.

Consistent with the Health Services Partnership evaluation, we have heard that the effectiveness of informal partnerships between health services is highly dependent upon individuals' willingness and ability to collaborate. Lack of trust and poor

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[101] In 2015, the King's Fund identified that devolved governance is both a strength and weakness of Victoria's health system: while it can facilitate local flexibility and responsiveness, it can also limit coordination and collaboration. Noting the large number of independent health services, the King's Fund suggested reviewing the number of boards and promoting greater collaboration between them. It also recommended the department have greater involvement in the planning and oversight of clinical services. However, the King's Fund did not make explicit recommendations about the design of the system.

Following a cluster of perinatal deaths at Djerriwarrh Health, *Targeting zero* was released in 2016. Focused on strengthening statewide and health service governance of quality and safety, the report found that health services have variable ability to ensure safe and high-quality care, with unacceptable risk of patient harm. Five years later, the Victorian Auditor General's Office found that health services' systems and processes still did not consistently ensure provision of high-quality and safe patient care.

[102] Cockram, Flynn, & Wallace, *Health service partnerships evaluation.*

interpersonal relationships can hamper collaboration, particularly when collaborating services vary in size, influence and capability. These relationships can be fraught, with wariness about sharing information, and concerns about how shared funding is used when the cost of shared services is not visible to all health services, and it is unclear if one service is benefitting more than another. There are also challenges to decision making: the current consensus approach means one or two can disrupt change that would benefit the whole.

In our view, informal partnerships (including Health Service Partnerships) are insufficient to realise the full benefits of collaboration. Formal mechanisms are required to better integrate and connect care across regions and to deliver the step-change that Victoria's health system needs.

Determining the optimum collaborative arrangement

We have considered a range of approaches to integrate health services and facilitate deep collaboration across Networks. In making our recommendations, our key priorities were to ensure all patients receive the most appropriate, safe and high-quality care, and to support our health workforce. We have also been mindful to avoid introducing unnecessary duplication and complexity and to ensure the system has robust accountability, efficient decision-making mechanisms, and clear participation mandates, roles and responsibilities.

We have extensively considered two options for formalising collaborative arrangements: government consolidating health services, or strengthening partnerships. In our view, consolidation offers significantly greater benefits for patients, workforce and community, and creates the best possible foundation to meet the needs of patients now and into the future. The strengthened partnership model is a far weaker alternative that nevertheless offers benefits above the current informal approach if consolidation is not possible.

Consolidating health services

We recommend government consolidate Victoria's 76 existing health service entities into 11 new entities – one for each Local Health Service Network.

Each pre-existing health service will maintain their individual identities and brands within the new entities, preserving the community's connection to their local health services, and maintain visible local leadership, to support local operational management and responsiveness to local communities' health needs.

In short, this means the names and identities of existing health services will not change.

A model for government to consolidate health services

Consolidating health services aims to achieve clear accountability for population health, unambiguous governance, consistent high-quality care, and ability to

attract and deploy health workers across a geography in accordance with the community's needs and the workers' willingness. At the same time, we note that regions are not homogenous and often span large areas – creating a need for locally tailored arrangements. Consolidation needs to maintain local pathways and leadership to foster responsiveness to community need. Consolidation also needs mechanisms to strengthen local community engagement within a broader regional structure. Below we describe a consolidation model to realise each of these desired outcomes.

Unified governance and accountability

Health services are consolidated into a single legal entity in each region. The consolidated Network will have a new skills-based board with members reflecting the diversity of its region. The consolidated health service will recruit a new Network CEO.

The new board and Network CEO will be accountable for care across their entire Network geography, including for reducing health inequities across the region, and will be held to account for this by the department. Networks have operational flexibility in how these outcomes are met, given their differing operating environments and diverse community needs.

The consolidated entity will be responsible for all Network functions outlined in Chapter 4. It acts as a single employer for its region, with a workforce plan to ensure appropriate engagement and deployment of staff to meet the clinical and operational needs of every site across its geography.

The entity will have a unified structure for governance and accountability across consolidated sites including clinical governance, service planning, financial management, corporate governance and common back-office functions. Consolidated entities will have consistent policies and procedures across all sites, including quality and safety processes. The overarching entity, having visibility of all sites within the region and population needs, will be responsible for clinical service planning. To ensure that each consolidated entity is effective in managing all its health service sites equitably, we encourage, as much as operationally possible, consolidated entity executives being based – or spending designated working time – across entity sites.

Maintaining pathways close to home

Many Networks include subregions – logical groupings of hospitals linked by patient flow and geography. Some functions, such as local referral pathways and day-to-day workforce sharing, may need to be organised at this subregional level, given geographic scale and distances. These functions should be managed at a subregional level, coordinating around local communities, transport routes and connections between hospitals.

To achieve this, the consolidated entity will be accountable for establishing subregional leadership and pathways to support people staying close to home for work and care. The consolidated entity will be responsible for appointing executive leaders who are skilled at maintaining a positive workforce culture, have demonstrated ability to maintain high standards of quality and safety, are adept at stakeholder management and can manage their budget within a delegated authority set by the overarching Network board.

Local leadership and responsiveness

At a local level, there will be visible leadership at each pre-existing health service. Within each consolidated entity's structure of delegations, these leaders will be accountable for managing:

- local operational issues
- local clinical services, consistent with the overarching entity's clinical services plan
- local workforce and culture
- local budget within financial delegations approved by the Network board
- emergency management
- engaging with other service providers in the area (e.g., primary, community, aged care)
- fostering local innovation
- local functions, including continuing and strengthening the broad range of critical health and social service activities currently undertaken by services at the local level (for example, the continuation of child care or Men's Sheds in the rural services that provide them).

Community engagement

Victoria's health services have deep connections to community, and we recommend building on this to strengthen the consolidated system. We have considered lessons from the NSW parliamentary inquiry into *Health outcomes and access to health and hospital services in rural, regional and remote New South Wales*.[103] It is critical that local communities are meaningfully engaged to ensure services are responsive to their needs.

To achieve this, we recommend establishing Local Community Boards for each pre-existing health service. Chairs of Local Community Boards will form a subcommittee of the overarching consolidated entity board. Local Community Boards will provide advice and feedback to both local leadership and the

[103] Parliament of NSW, *Health outcomes and access to health and hospital services in rural, regional and remote New South Wales*.

overarching entity board to ensure services meet community needs, and that the perspectives of the community, patients and providers are considered in board decisions. Local Community Boards will also support effective links between the consolidated entity and other local health and community services.

The Local Community Board will advise on key issues including:

- strategic community and health service initiatives, including on initiatives and policy changes to support consumer-centred care and improve population health and wellbeing.
- health equity and population health, including reviewing population health data, ensuring priorities are aligned with local need, and identifying initiatives to improve health equity.
- research and evaluation, including determining appropriate outcomes and measures to support continuous improvement in line with population trends and emerging community needs.
- community and stakeholder engagement, including building partnerships with local stakeholders to improve access to and coordination of services, and engaging with the community on local fundraising. Local Community Boards would also have oversight of their Network's collaborative work with local government on population health plans.

Comprehensive and authentic engagement with local consumers – and an approach that responds to local needs – will also be supported by:

- selecting leaders who are actively engaged with, and deliver for, all health service sites and communities within their region
- maintaining existing health service identities and brands
- brand related functions including fundraising continuing, with funds continuing to be committed to local sites.

Arrangements for specialist health services within a consolidated entity

Victoria's statewide specialist health services focus on either specific clinical streams (such as the Royal Eye and Ear Hospital, and the Peter MacCallum Cancer Centre) or particular patient cohorts (such as the Royal Children's Hospital and the Royal Women's Hospital). They play a unique role in the system: providing expert clinical skills and knowledge to the sector on a large scale, building local clinical capability through education and training to support patients to receive care closer to home, and leading bench to bedside research.

However, specialist services face the same challenges shouldered by all health services, with increasing demand and workforce shortages straining their capacity to provide valued care for patients statewide.

Consolidation will strengthen specialist services, protecting their role and the care they provide for all Victorians. These services will be able to draw on broader

multidisciplinary care teams, to provide care that is both tailored and holistic where required – recognising that, increasingly, patients are presenting with multiple or complex conditions, that need to be managed through multidisciplinary teams rather than single specialties. Specialist services will be better supported to collaborate and improve their already high calibre multidisciplinary research in larger entities. They will be able to leverage shared back of house expertise, systems, and processes, enabling them to better focus their attention on their core business and statewide functions. Importantly their provision of statewide training, and expert care for all Victorians will be preserved and extended.

Specialist health service leadership and Specialist Community Boards

Specialist services will require visible leaders who deeply understand their nuanced role, including their dual responsibility for the care of patients across the entire state, as well as for their local communities. Their leadership will be responsible for managing the specialist service's strategic and operational issues within the consolidated entity's leadership team and promote and advance the pre-existing service's local and statewide functions.

Specialist Community Boards will also be established for each pre-existing specialist service. Specialist Community Board members will represent the views of specialist care consumers across the state, ensuring this care remains patient-centred, and advise on the specific challenges and opportunities for provision of statewide specialist care. These Boards, like the Local Community Boards representing other pre-existing services, will report into the new entity's overarching board, ensuring the needs of their specialist patient cohorts are met, and the unique strengths and capabilities of pre-existing specialist services are maintained and grown in the consolidated organisation.

Proposed consolidated entities

As outlined in Chapter 4, new, consolidated entities will be established for each Local Health Service Network across the state. Membership and rationale for each grouping is outlined in Chapter 4.

The ongoing productive work of existing collaborative arrangements (for example ICT Alliances and Health Service Partnerships) will be rolled into the new entities. Collaboration arrangements that span geographies greater than Networks (for example, pathology networks) and provide a collective benefit should continue.

Benefits of consolidation

More equitable access to care

The Committee considers that a consolidated system will have the greatest potential to reduce inequities and improve consistency of care. A single entity will be

responsible for each community's outcomes, with clear accountability to holistically plan for and provide services for populations within their area. They will be able to efficiently manage centralised region wide waitlists and share approaches to service models such as home based and virtual care. Larger scaled and higher capability entities will also be able to ensure patients receive care closer to home more often, providing a broader range of services in many smaller or historically lower capability sites.

This can be seen in the experience of Grampians Health – which formed from a voluntary consolidation of Edenhope, Stawell, Wimmera and Ballarat Health Services. Since this consolidation, oncology services have opened in Stawell, and in Horsham, there is now expanded access to general and orthopaedic surgery, and specialist rehabilitation services, alongside new neurology and outpatient maternity services.[104] The new entities will also have greater capacity to provide – or connect patients to – more complex care when required, fluidly transferring patients for more complex care in a timely manner through their deep relationships across higher and lower capability sites within the Network.

In metropolitan areas, consolidated Networks will bring opportunity to expand care access – including to novel, patient-centric models of care – and spread tailored, appropriate, and sensitive approaches to providing care to vulnerable groups and priority populations.

Patient experience

In a consolidated system, most patients will be able to access multidisciplinary and whole-of-lifespan care from the one entity, with more seamless and simplified care pathways. Patients will receive care from healthcare workers and entities adopting uniform approaches, policies, and procedures as they transition across sites to receive higher and lower complexity care. Patients will be spared the unnecessary administrative burden associated with discharge and readmission from one entity to another, and avoid duplicative questioning and investigations as their medical records will be accessible across sites. Clinicians will have clearer visibility of their patients and their care journey, through unified clinical records across all sites within an entity. Health service managers will have greater visibility of capacity and demand across sites in their Network, and the authority to effectively utilise available inpatient beds, theatres and ambulatory appointments to connect patients to care they need quickly.

[104] Grampians Health, *Twelve months on report*, Grampians Health website, 2023, available at https://grampianshealth.org.au/wp-content/uploads/2023/02/Grampians-Health-12-month-Report.pdf, accessed April 2024.

Improved safety and quality

The consolidated system will strengthen safety and quality. Each consolidated entity will have greater resources and capability to manage clinical governance. With clinical risk management expertise spread less thinly across the system, there will be greater potential to develop robust approaches to managing clinical risk and preventing adverse events.

Even health services with existing strong expertise in continuous improvement serve to benefit from being a part of a larger entity where ideas can be shared, and innovation spread. Across all areas in the state, including metropolitan Melbourne, regional and rural areas, there is opportunity to spread capability in improvement methodology, and to develop health services' capability and capacity to drive clinical excellence.

There is evidence linking health service consolidation to quality and safety improvements. For example, while healthcare acquired infection rates are steadily decreasing across the system, hospitals that amalgamated with other sites improved even faster after merging.[105] While the precise drivers are unclear, improved resourcing and capability as part of a larger organisation could contribute.[106]

Chief clinical officers, and senior quality, safety and risk leaders should spend time working across all sites, consistent with their responsibility to drive strong clinical governance across the entire consolidated Network.

Research and clinical excellence

A consolidated system will bring together multiple specialty centres, institutes and universities into a more unified structure, mirroring the structure of the top ranked hospitals around the world, such as the Mayo Clinic, Cleveland Clinic and Johns Hopkins Hospital.[107] This is also the prevailing approach in England, where multiple highly rated hospitals are brought together under the leadership of a single National Health Service Foundation Trust, such as Guy's and St Thomas' and University College London Hospitals.

In jurisdictions around the world, this approach enables multidisciplinary care and research *across* as well as *within* specialities – including for women, children and specific conditions, such as cancer. Furthermore, in each specialty, clinicians and

[105] Victorian Department of Health, VAED data [internal risk-adjusted analysis], September 2023. Based on analysis of hospital acquired complications occurring before and after amalgamations of Western Health and Djerriwarrh, Grampians Health, Dhelkaya Health, Great Ocean Road Health and NCN Health.

[106] Advice from health service leaders involved in previous Victorian amalgamations, 2023.

[107] Newsweek, *The world's best hospitals 2024*, available at www.newsweek.com/rankings/worlds-best-hospitals-2024.

researchers benefit from the resources, relationships and scale available as part of a larger organisation.

Patients will benefit from more coordinated care across a broad range of specialties, as well as access to the latest treatments and innovations. This is seen, for example, at Mass General for Children, where patients benefit from complete access to the resources of Massachusetts General Hospital (one of the top five hospitals in the world) and, as they age, a smooth transition of care from paediatric to adult services at Massachusetts General Hospital.[108]

Improved workforce support

The consolidated system will support our valuable health workforce, enabling them to work smarter, not harder. A single employer in each region will reduce competition across the system for the same scarce workforce. The single employer arrangement will enable employment and sharing of often hard to recruit specialists across multiple sites, thereby reducing the number of costly fractional and visiting medical officer appointments across the system. Rather than compete, consolidated entities will be able to pool efforts across sites to drive effective recruitment campaigns. They will also be able to consistently provide the high calibre training, amenities, and professional development opportunities the health workforce needs to establish and grow their careers. In turn, providing these better supports will strengthen each entity's retention capacity and reduce the chance that the system loses experienced and skilled staff. The health workforce will have greater flexibility, only needing to complete one credentialling process to work across multiple sites in a region, reducing their administrative burden and enabling greater sharing of skills and expertise across geographical areas.

Better use of healthcare resources

The consolidated system will also bring about improved efficiencies and economies of scale. While quantifying financial benefits of a consolidated system was not within our scope, in our view there is duplication and unnecessary administrative burden associated with operating 76 separate health services. The consolidated system will enable health service leaders to make better use of limited resources and support long-term sufficiency. Streamlining and centralising systems, processes and approaches, particularly for back-office functions and compliance activities, will enable attention to be redirected to higher value activities including improvements in patient care, transfer of ideas and innovation across services.

[108] Newsweek, *The world's best hospitals 2024*, available at www.newsweek.com/rankings/worlds-best-hospitals-2024.

Partnerships with denominational services

We do not propose that denominational health services consolidate with other health services in their Local Health Service Network at this time. Instead, we propose strengthening partnerships between denominational services and their Network's consolidated public health service entity, making them jointly accountable for delivering Network objectives and outcomes. To achieve this, the strengthened partnership model will have the following features:

- the department setting and enforcing clear participation and accountability requirements
- a joint committee of the consolidated health service and denominational health service CEOs responsible for collaboratively delivering shared functions
- the CEO committee agreeing 1- and 3-year plans outlining how partnership objectives and outcomes will be met
- a joint committee of the consolidated health service and denominational health service board chairs to provide oversight of CEO committees and act as an escalation point for disputes.

We propose the department evaluate partnership arrangements within three years from implementation to explore whether these are achieving the best outcomes for patients, workforce and community, or whether alternative arrangements for denominational services would better support the community's needs.

The role of the department

Current role

Under Victoria's model of devolved governance, health services should be responsible for operational decision making while the department determines policy settings and funding, supports health services with enablers such as information technology platforms and data benchmarking, and monitors performance. However, we have heard that the department does not consistently fulfil this stewardship role, with its attention and resourcing instead focused on managing issues stemming from the large number of health services and their interrelationships.

For example, while the department has played a role in statewide planning to some degree,[109] planning is more often left to individual health services. The existence of many health services, each with separate – and often contrasting – interests, makes

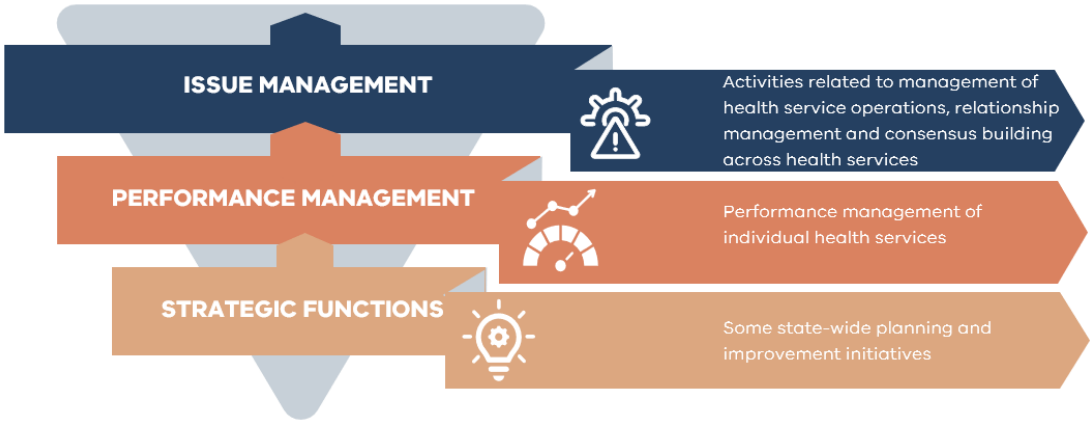
[109] For example, the *Statewide design, service and infrastructure plan for Victoria's health system 2017–2037,* and more recently through supporting the development of clinical service plans for Health Service Partnership regions, commencing with the North East Metro and Hume regions.

it challenging for the department to resolve disputes on difficult issues, or to ensure compliance.

A similar issue is seen with Health Service Partnerships: the department has not set clear expectations and faces difficulties holding a multitude of services sufficiently to account for authentic participation.

In our view, the department must play a greater role in strategic planning and direction setting – in partnership with the sector – to move the system to a new level of maturity. As outlined below, consolidation provides an opportunity to strengthen its focus on outcomes and overall system performance. Government must hold the department accountable for executing these responsibilities.

Figure 3 – The department's current core focuses



A consolidated system

In a consolidated system, the department's leadership can directly engage 11 Network leaders to focus on building a more consistent and connected system in a way not possible with 76 CEOs. Coordinated oversight of the entire health services system becomes possible, with the department and sector leaders partnering to problem solve, respond to data and move the system forward.

With 11 Network CEOs and health services, the department can reduce its direct involvement with day-to-day issues and relationship management. Consolidated health service entities will have greater capability and more effective governance, reducing the need for direct departmental involvement in operational matters. The new entities will be better equipped to face challenges, responsively meet the needs of communities, drive clinical improvement and sustainably manage resources. Networks will also manage some activities currently performed by the department's regional offices, including managing local relationships and issues.

The department will steward the system by:

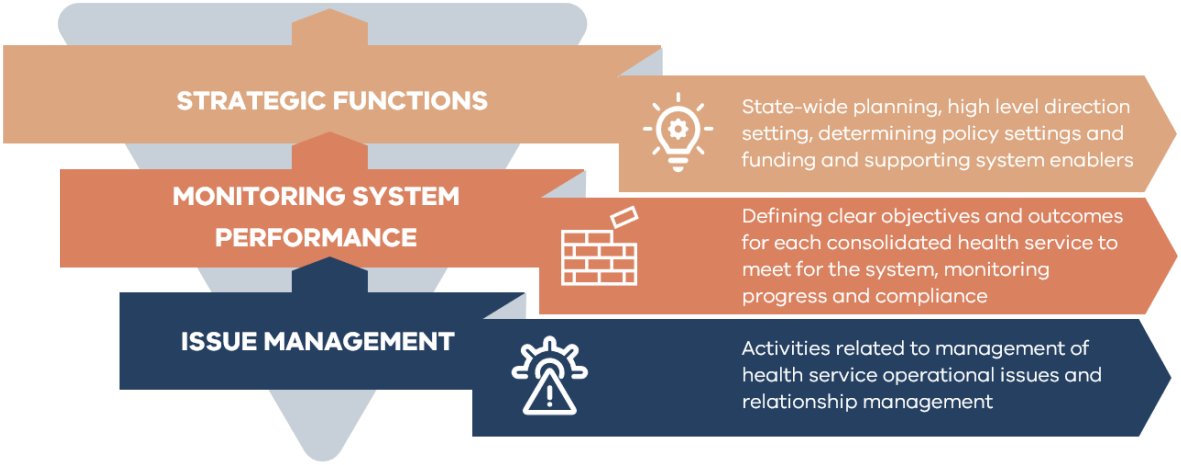
- maintaining its key role as performance manager, defining clear objectives and outcomes for each consolidated health service and monitoring their

progress. Outcomes will include health service performance targets as well as population health goals for the entity's designated population. Performance targets will cover all services across the continuum of care provided by the entity, including community health and aged care services.

- playing a stronger role in setting strategic direction, priorities, policies, and frameworks. The department will set system parameters for entity planning and make infrastructure decisions informed by Network capital plans. The department will lead statewide system clinical planning including reviewing and updating the role delineation framework based on capability and population health needs. The department must be clear when statewide, consistent approaches are necessary, for example adopting statewide capability frameworks, or statewide approaches to procurement, purchasing and supply chain, and use directions where needed to enforce compliance.
- setting clear objectives for incorporating local voice and responding to local needs. As demonstrated by the NSW parliamentary inquiry into *Health outcomes and access to health and hospital services in rural, regional and remote New South Wales*,[110] meaningful community engagement is critical to ensure services are responsive to local needs. The department must ensure that new entities' engagement with communities is comprehensive and authentic, including embedding the role of Local Community Boards.
- refocusing efforts to uplift care quality and safety across the system. SCV can spend less time addressing variation in clinical governance capability and instead partner with services to focus on continuous improvement and learning, innovation and standardisation of care.
- regularly reviewing and adapting Network boundaries considering factors including demographic and population changes to ensure the system continues to be fit-for-purpose. This could be done through establishing mechanisms and principles to guide future boundary decisions.

[110] Parliament of NSW, *Health outcomes and access to health and hospital services in rural, regional and remote New South Wales.*

Figure 4 – The department's role in a consolidated system



The department's role in supporting partnerships in the new system

As described above, denominational health services will enter strengthened partnership arrangements with the consolidated entity in their Local Health Service Network region. To ensure these partnerships are accountable for delivering joint Network outcomes, the department must:

- mandate participation by creating common clauses in SOPs outlining each service's responsibility to their partnership
- set and enforce clear accountability requirements for delivering shared objectives and outcomes
- ensure regional plans clearly articulate how objectives and outcomes will be achieved, and monitor partnerships' progress towards these
- assist in resolving issues between individual partnering health services, using direction powers as necessary to overcome any stalled decisions. This represents a shift compared to recent historical management; however, it may be necessary on occasion to avoid stifling collective outcomes
- signal the strategic importance of partnerships to health service boards so they consider partnerships with equal weight and importance as their individual health service accountabilities.

Chapter 8

Implementing the Health Services Plan

Chapter 8: Implementing the Health Services Plan

Finding: Implementation of the Plan will rely on a range of critical factors including culture, leadership, change management and improvement methodologies.

- Successful implementation will depend on workforce culture and capability.
- Other enablers out of scope for the Committee include funding models, digital tools and ICT, and broader reforms (e.g. patient transport, workforce).

Recommendation 8.1: The department invest in change management and other key skills to support consolidation of the system, taking a systematic approach to working with key stakeholders and implementing and sustaining change.

Recommendation 8.2: The department and health services promote a collaborative leadership style, developing sector and departmental leaders who take a broad view when leading teams and systems and can share this vision with staff and stakeholders.

Recommendation 8.3: Health services strengthen a learning health system through further:

- **promoting improvement activities through evidence-based frameworks**
- **nourishing innovation including through health services research cultivating links with partners including medical research institutes, and promoting uptake of evidence-based care through building workforce capability for improvement activities.**

Recommendation 8.4: The department review funding models to promote future financial sustainability and support contemporary clinical and organisational practice, including through digital transformation.

The department's review of funding models consider appropriate mechanisms to support ongoing investment in digital systems and minor capital and engineering infrastructure to ensure the system is modern, sustainable and digitally enabled.

The department review and improve budget, pricing and financial accountability mechanisms, to support more robust financial management.

Recommendation 8.5: The department implement Victoria's Digital Health Roadmap, to enable clinical information systems to share information and support interoperability across the health system.

Recommendation 8.6: The department:

- **make clear and timely policy decisions when new clinical or support services are being introduced on whether statewide or decentralised approaches should be adopted, taking into account equity, consistency, effectiveness and efficiency**
- **explore statewide approaches for existing clinical or support services where cost effective and efficient.**

Recommendation 8.7: The department continue reforms to strengthen health workforce, improve efficiency and coordination of patient transport, establish mechanisms to manage patient flow and demand, and leverage opportunities such as virtual care.

The Health Services Plan represents a fundamental shift in how health care is structured and delivered in Victoria. Successfully implementing this change will depend on concerted and enduring effort from the department, health system leaders and workforce. In this chapter we outline what we consider to be key enablers of reform. Some – such as establishing a collaborative culture and fostering a learning health system – are integral to the Plan. Other enablers – such as funding models, digital tools and ICT, workforce and patient transport – were out of scope for detailed consideration by the Committee but are nevertheless critical to successful implementation.

Collaboration and change

Realising the benefits of the Plan will demand a change in culture and capability, fostering genuine collaboration and partnership between providers.

Leadership

Implementing the Plan will depend on a shared vision, with a common understanding of the goals of the Plan and the benefits this will have for patients, workforce and community. Leadership will play a critical role, with a need for leaders who can take a collaborative approach, looking beyond their individual organisation to consider the health needs of their community. Such leaders can also foster an organisational culture that supports collaboration at all levels – including executive, clinical and non-clinical workforce. Strong relationships – underpinned by openness and trust – will promote genuine collaboration and lead to better outcomes for patients and workforce.

There are some building blocks that will promote progress towards this necessary culture and capability. Many health services have already established strong relationships with each other based on trust, honesty and transparency through participation in historical or current collaborative structures such as Health Service Partnerships. There are also examples of specialist service networks, such as Integrated Cancer Services, demonstrating ability for collaboration across entity borders for service improvement.

To cement these relationships and create a culture of collaboration and partnership, we recommend that the department and health services promote a collaborative leadership style, developing health service and departmental leaders who take a wider view when leading teams and systems and can share this vision with staff and stakeholders.

Clinical collaboration and trust

Implementing the Plan will require a clinical workforce that embraces collaboration and has the skills and capability to deliver integrated care. Alfred Health's approach to partnerships with other services offers lessons for how collaborative arrangements could be scaled through the Plan. Alfred Health supports subregional and rural health services to care for patients in their own facilities wherever possible through providing virtual support and oversight. If necessary, patients are transferred to the Alfred, which provides coordinated escalation, transfer and subsequent step-down arrangements. These partnerships are enabled by:

- strong relationships between management teams and clinical leaders at each site
- trust between partners, with clinicians understanding the service offerings, workforce skill mix, diagnostic capability and infrastructure at each site
- clinicians at the higher capability site owning and managing clinical risk wherever the patient is, not just when physically admitted
- an experienced workforce, with senior staff who are well experienced in how to manage risk appropriately and better equipped to support patients remotely.

Engaging patients and community

To achieve the best patient outcomes, the system should improve engagement with patients and the local community. This will allow the system to be customised and respond to community needs where required.

Health services already have mechanisms to capture local and patient voice, including in their health service boards and Community Advisory Committees. However, the extent of input varies between health services, with opportunity to strengthen engagement. Many communities also have strong connection to their local health service, which may be where they or their children were born, they or their partner are employed, or their elderly parent was cared for. In some, particularly smaller, communities, health services play a significant social, cultural and community role beyond the direct provision of care, as they may be the largest institution and employer in the area, and a valued bedrock of the community. These close social, economic and emotional ties may lead to significant community concerns about the risk of loss through any change, particularly in the context of historical experiences and broader social and economic structural change.

Maintaining existing health service identities and brands will help patients continue to readily recognise their trusted local services, and find the care they need through change, in a system that has been described as difficult to navigate. Each health service's reputation has been built upon over many years, contributed to by efforts of dedicated health workforce and service leaders, with many resultant positive relationships with community members. In turn, communities have supported

health services generously through fundraising initiatives. It is important that community members, the lifeblood of towns, continue to have opportunity to support their local health services.

In addition, continuing strong, locally tailored and responsive community engagement will be required to support the change journey. Bringing together diverse health services with unique histories, strengths and nuanced understandings of local needs, will provide opportunity for the region to have a stronger collective voice advocating for its population. Engaging with patients to gather insights into different local priorities, challenges and geographies will promote support for change.

Change management

As outlined above, realising benefits of the Plan will depend on creating a supportive culture and capability among leaders, workforce and community. Achieving and sustaining this substantial change will require a systematic approach to engaging key stakeholders and supporting them to implement reform. Those working in the health sector are already under significant pressure and cannot be expected to implement change on their own. Leaders will need to maintain safe and effective health service operations while also steering reform implementation. Communities must be listened to and supported on the change journey.

We therefore recommend the department invest in change management to underpin Plan implementation. Effective change management should promote a shared understanding of reform goals along with clarity of roles and accountability arrangements. It should encompass rigorous project planning to enable a smooth transition to new systems, processes and governance arrangements. The department will need to provide clear guidance, set expectations and support sector leaders with communications and engagement – helping them communicate the benefits of the Plan for patients, workforce and community. Change management should also support health services to adjust to new systems, processes and ways of working while simultaneously maintaining their core business of care delivery. Finally, support should be available both before and following initial implementation, acknowledging that change will take time to be fully embedded.

Fostering a learning health system

The change journey for the Plan's reforms will extend beyond the initial years of implementation. Indeed, we intend for these reforms to be a starting point for a more future ready system, that can meet evolving demands, adopt novel models of care and capably navigate challenges. Achieving this will require a system that can learn and be flexible and adaptable in response to change. Such a system could capitalise on opportunities (such as those arising through national reform processes, medical advances and digital technologies), cope with challenges (such

as rising chronic disease and costs) and respond to future public health crises (such as future pandemics and climate change). Achieving a learning system will require timely access to data, large scale sharing of expertise and experience, and an agile workforce that values evidence and embraces change.

There are existing agencies tasked with supporting health services towards this goal. The Victorian Agency for Health Information offers data collection and publications across health services, for certain performance metrics. SCV works with clinicians and patients on clinical improvement activities, helping health services deliver better, safer healthcare. In addition, the Commonwealth government is establishing an Australian Centre for Disease Control to improve Australia's response and preparedness for public health emergencies. However, more action is needed to realise the full benefits of a learning system for patients and workforce.

We recommend health services take specific actions to foster a learning system. Health services should build expertise in evidence-based improvement methodologies and invest in training to support this. Health services should also continue to engage with research partners to leverage Victoria's high calibre medical research platforms and build even stronger links with universities to support translational research and promote uptake of evidence-based care.

Other areas critical for Plan implementation

Funding and incentives

Victoria's health system has a complex funding mix, with a combination of contributions from both the state and the Commonwealth financing its health services. While it has not been within our scope to undertake deep analysis of funding models, we acknowledge the predominant current model of activity-based funding incentivises efficient activity rather than patient outcomes. While this has benefits in supporting technical efficiency, it does not promote allocation of resources to the most efficient and effective models of care, nor support the holistic, continuous and wrap around models of care that are required with the increasing incidence of chronic disease.

Many sector experts have highlighted the need for reform in funding models, and for a fundamental pivot to direct more funding upstream to preventative care. In our view, the department should review funding models to promote future financial sustainability. This issue will be covered in more detail in the following chapter on continuing reform.

Design of future funding models should also consider how best to support Victoria's health services to adopt contemporary clinical and organisational practice, including through digital transformation.

We note that some other Australian jurisdictions have dedicated and ongoing funding mechanisms for digital health, which enables their health services to continue to evolve and adapt to technological change. We consider there would be merit in Victoria exploring funding models that enable health services to continuously improve their digital maturity. As well as supporting flow of patient information across sites (see below), contemporary information systems enable more efficient health service operations such as back office functions. Similarly, there would be merit in exploring more effective funding models to support infrastructure maintenance and upgrades to medical equipment. An improved funding model could help sustain health services as modern and fit for purpose organisations.

The department must also improve the system's financial robustness and accountability. The department should review and update the price it pays for health service activity to reflect the true costs of providing care efficiently. It should continue its negotiations with the Commonwealth and other states to secure funding to viably support the system and allow sustainable delivery of high-quality care. The department should also strengthen health services' ability to exercise robust financial management, and the department's ability to hold health services accountable for this, through providing more timely and appropriate budget information.

Digital tools and informatics

Building a connected health care system will depend on integrated digital systems allowing information to flow smoothly between different sites – whether patient information, surgical waitlists, bed or staffing availability. Staff will also need to be trained in using new systems and approaches. Only then can the system function in a truly coordinated manner. Integrated digital systems will enable:

- clinicians to access timely and comprehensive data – including medical records, imaging and pathology results – to make informed decisions for the benefit of their patients
- clinicians to have visibility of the entire patient journey, allowing a more seamless patient experience, and less risk of errors as patients transition between sites
- more informed research, evidence and population health planning, through comprehensive data collection within privacy frameworks across populations and patient cohorts
- more efficient use of resources, with better visibility of capacity to allow load sharing across regions, and visibility of staffing availability and centralised waitlists to allow more equitable and timely access.

Victoria has some existing initiatives in place to support this. All patients have a unique patient identifier enabling linkage of records across providers.

The department is implementing a secure health information sharing system so clinicians can access critical patient health information at the point of care.[111] The system will initially provide for sharing of public pathology results, discharge summaries, patient details and diagnosis lists but will later be expanded to allow a patient's treating clinician to access a range of clinical information including allergies, alerts, medications and clinical documents such as diagnostic imaging test reports, emergency department and outpatient letters. The system is subject to strict privacy, confidentiality controls and oversight arrangements, with the department responsible for ensuring health information is kept safe, secure and protected from unauthorised access.[112]

However, more work is needed to improve information sharing and system interoperability. Across Victoria, not all health services have implemented an EMR system, and, among those who have implemented EMRs, multiple different systems are in use, with variable ability to integrate and communicate with each other. Additional work is required to roll out EMR systems at all sites and ensure sufficient interoperability.

Victoria also has uneven digital capacity, with health services having variable access to modern information systems, networks, portable smart devices and digital imaging to facilitate connectivity. Rural ICT alliances have effectively procured and maintained technology for each region in recent years. There is value in Local Health Service Networks delivering this work in geographies where their boundaries align with current ICT alliances. In areas where ICT alliances span a greater geography than the new Networks, ICT alliances should continue to progress digital capability.

Further work is also required to ensure timely access to analytics, information and data to assure quality and safety. As identified by *Targeting zero*, it is critical that the department can regularly collect, analyse and use data to glean timely and meaningful insights that highlight risk and improvement opportunities.

While digital tools and ICT are out of scope for the Plan, continuing to progress digitisation will be critical for the Plan's success. We recommend the department implement Victoria's Digital Health Roadmap, to enable clinical information systems to share information and support interoperability across the health system.

[111] Legislation to support the new system came into effect in February 2024, and the system will be progressively rolled out across Victorian public health services in the second half of 2024.

[112] A Privacy Management Framework is being developed that will articulate the roles, obligations and governance involved in protecting Victorian health consumers' information privacy in the statewide system.

Statewide services

Throughout our consultation, several stakeholders questioned whether further benefits could be realised by rolling out services statewide, rather than region-by-region. This may further reduce duplication, improve economies of scale and drive consistency in care delivery. Statewide services could include both clinical services (such as the VVED emergency ambulance responses delivered by Ambulance Victoria) and non-clinical services (such as EMRs, payroll).

Other states have centralised a number of services. Queensland Shared Services supports finance, human resource management and telecommunications functions for all public health services.[113] HealthShare NSW operates payroll, patient transport, linen, food and patient support services for the NSW health system.[114] A number of states, including NSW, Queensland and South Australia, have established statewide public pathology services.

While not within the scope of the Plan, we note that Victoria has come some way in scoping and instituting statewide services in recent years. HealthShare Victoria has been established to support statewide procurement, purchasing, supply chain surety and logistics for the public health sector.[115] Public pathology reforms are establishing a smaller number of regionalised providers.

However, we are also conscious that states which have implemented a broader range of statewide services than Victoria have had historically different governance models and institutional histories to Victoria. These different histories mean that Victoria has significant sunk costs in a diversity of systems, and that the organisational and operational changes, as well as upfront investments, required to move to statewide approaches may be more significant in Victoria than in historically more centralised jurisdictions.

In this context, the Committee recommends a twofold approach. Where new services or systems are being introduced – such as virtual care – the department should at an early stage consider the benefits and risks of statewide versus de-centralised approaches, and make clear and timely policy decisions on the most appropriate approach for the Victorian health services system, taking into account equity, consistency, effectiveness and efficiency.

For existing services or systems, we suggest that the department could explore statewide approaches where cost effective and efficient, with rigorous cost benefit analysis before making any changes. Consideration should also be given to the benefits of providing services regionally, including for economic prosperity and responsiveness to local context.

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[113] Queensland Government, *Queensland shared services*, Queensland Government website, 2024, available at www.forgov.qld.gov.au/service-delivery-and-community-support/queensland-shared-services, accessed April 2024.

[114] HealthShare NSW, *About us*, HealthShare NSW website, available at www.healthshare.nsw.gov.au/about, accessed April 2024.

[115] HealthShare Victoria was established as a Victorian public sector entity in 2021.

Alignment with other reforms

Workforce strategy

The department has recently published its Health Workforce Strategy. The Strategy is focused on workforce wellbeing, capability, supply and innovation and provides directions for Victoria to ensure a sustainable and robust health workforce into the future. The reforms under the Health Services Plan will support this Strategy and address many of the challenges highlighted by workforce throughout the consultation that informed the strategy – including isolation and variation in processes.

NEPT review

We have heard that variable access to NEPT across the state results in patients waiting in hospital or transit lounges longer than necessary, poor hospital flow reducing their ability to admit new patients, and the risk of excessive costs. In addition, when health services cannot access NEPT, patients may be transported by paramedics instead, diverting ambulances away from emergencies.

The recent NEPT review considered Victoria's existing procurement arrangements, and the most effective settings to support non-urgent transport for Victorians. Implementing recommendations from the NEPT review will improve how this service is provided and funded.

To fully realise the benefits of the Health Services Plan, further work is required to better coordinate transport across health services and regions. Connecting more patients to appropriate step-up and step-down care, along logical pathways, will depend on efficient transfer of patients between services. New approaches should be established that coordinate patient transfers within a region so that patients can be transferred in a way that is responsive to their needs, whether that be non-emergency transport vehicle, community transport, taxi or ride share services, and with their transport aligned to appointment times and bed availability. There is also opportunity to improve transport routes to better utilise existing fleets and avoid the need to rely on ambulances as a last resort.

Command centre

Victoria's future Victorian Digital Health Command Centre will enable the health system to collectively manage patient flow and demand. The Health Services Plan reforms and associated benefits – including efficient and patient-centred referral pathways, more effective load sharing and strong relationships between local, major tertiary and highly specialised statewide services – will further support demand management across the system.

Virtual care strategy

Published in 2023, Victoria's Virtual Care Strategy, has outlined a vision for virtual care across public health agencies, with the overall purpose of allowing Victorians who prefer virtual care to use it when it is appropriate and available. Bringing health services together – through Networks – to leverage collective technology, equipment and health workforce of individual entities will support this strategy.

These reforms address critical issues which will influence implementation of the Plan. We therefore recommend the department continue reforms to strengthen workforce, improve efficiency of patient transport, establish mechanisms to manage patient flow and demand, and leverage opportunities such as virtual care.

Chapter 9

Continuing reform

Chapter 9: Continuing reform

Finding: Further work is required to improve connections with primary care, community health, and across physical health, mental health and alcohol and other drug-related issues.

- A lack of clarity about the relative roles and responsibilities of community health providers and health services risks contributing to service gaps or duplication.
- Poor integration between primary and acute care leads to fragmented care pathways, impacting patient experiences and outcomes.
- Improved integration is needed to better care for those with physical, mental health and alcohol and other drug-related care needs.

Recommendation 9.1: The department clarify the relative roles and responsibilities of registered community health providers and health services, in the context of broader reforms to integrate primary and acute care.

Recommendation 9.2: The department work with the Commonwealth to establish regional governance structures that span primary, acute, non-acute mental health, alcohol and other drug and aged care services, with features including:

- **regional governance structures being responsible for planning, coordinating and commissioning services that are tailored to local health needs and address local service gaps, while remaining consistent with department-led statewide system planning**
- **maintenance of alignment of other system boundaries with new Networks, including mental health regions, Local Public Health Units and Primary Health Networks**
- **support for improving interfaces with local government, aged care, disability and social sectors.**

Recommendation 9.3: The department develop and incentivise new care models that promote delivery of the right care, in the right place, at the right time, including:

- **support for innovative service models that support integrated care pathways for physical and mental health across primary, acute and aged care**
- **exploration of funding models that better support patients' care pathways and reward achievement of outcomes for patients**
- **support for digital systems and technology to support information flow, and virtual care.**

Recommendation 9.4: The department align new regional governance structures with mental health regional bodies to best support integration across physical health, aged care, mental health, and alcohol and other drugs.

Recommendation 9.5: The department drive continuous improvement of the health services system including through commissioning reviews of the reformed system including:

- **a review in three years from commencement of the reform implementation to evaluate the process**
- **a review in five years from implementation to evaluate outcomes, considering services consolidated into Network groupings and those that remain separate (including denominational providers of public health services).**

Implementing the Plan will improve coordination across health services and lead to greater accountability for population health through improved engagement with other sectors such as PHNs, ACCHOs, aged care, disability providers and local government (Chapter 5).

While this will create foundations for a connected system, further work is required to strengthen links between health services and primary and community care, refocus the system towards early intervention and multidisciplinary care models, and improve integration across physical health, mental health and AOD-related issues.

Improving the interface with community health providers

Victoria has 24 independently managed registered community health centres, and 55 community health services integrated within public health services. Community health services deliver a range of primary health, physical and mental health, social care and community-based support. These services help keep patients with chronic conditions well in the community, avoiding or delaying their need for hospital care.

The Committee has heard there is a lack of clarity regarding roles and responsibilities between registered community health providers and health services, particularly when it comes to provision of care for people with chronic conditions outside of hospitals. This can lead to overlap, duplication and competition between providers – such as registered community health providers and health services independently operating primary care clinics in the same area. While there are examples of collaboration across health services and registered community health providers, these are often based on individual relationships rather than system design.

We recommend the department clarify the relative roles and responsibilities of registered community health providers and health services in keeping patients well in the community. This would enable more consistent and clearer patient pathways between community health and the hospital system and allow providers to collaborate more effectively. This work should be undertaken in the context of broader reforms to integrate primary and acute care (see below).

Integrating primary, acute, mental health, AOD and aged care

Over past decades our health system has been successful in treating disease, allowing increases in life expectancy. A growing number of patients are now living for long periods with chronic disease, and frequently more than one condition. These patients need ongoing care, often both physical and mental, from many different specialties across the care continuum, who are often operating independently from one another. Poor integration between services within and across sectors leads to fragmented care pathways, impacting patient experiences and outcomes. Patient centred approaches that meet holistic care needs will lead to better outcomes and ensure patients feel treated as individuals rather than component organs or conditions.

Older adults living in aged care settings can also be better supported through models allowing them to receive holistic care in their familiar environments in residential aged care facilities more often, rather than presenting to hospital. They can also be supported to return to their familiar environments with care in place sooner, more often.

Implementing integrated care models

While the current system excels at delivering episodic care to those with acute needs, it is not well equipped to support the growing number of patients with complex and chronic health care needs or those requiring input from services spread across the currently separated sectors. These patients require ongoing, integrated care models that span all their primary and acute, physical and mental health care needs, with a multidisciplinary team approach. New care models are required that are centred around the patient and support treatment from the most appropriate provider and setting to meet their needs.

Achieving this will demand greater connectivity between services and practitioners, with seamless flow of patient information to ensure all providers have timely access to relevant information to maximise patient outcomes and experience. This will require improvements to data systems and data sharing processes to ensure these capture the full patient journey (Chapter 8). New technology supporting virtual care including remote monitoring options, should also be supported.

Establishing regional governance structures

Establishing integrated care models centred around individuals can be challenged by the historic structural split between Commonwealth and state responsibilities in healthcare, which separates governance and funding of the primary and acute care sectors. More integrated, patient-centred models will require better integrated approaches to commissioning and planning across acute and primary care.

The National Health Reform Agreement Mid-Term Review makes recommendations to improve alignment and collaboration between acute and primary care, including developing joint planning and commissioning approaches. The review assumes that health services are grouped into Local Health Networks and recommends driving and enforcing integration between these Local Health Networks and PHNs. Grouping health services into Networks (as outlined in Chapter 5) will bring Victoria into line with other states and territories and allow Victoria to capitalise on integration opportunities through the next Agreement.

Building on this, we recommend the department work with the Commonwealth to establish regional governance structures that span primary and acute care. These regional governance structures would focus on integrated care pathways (e.g. for chronic disease) rather than acute, episodic care. They would be responsible for planning, coordinating and commissioning services across both primary and acute care, in line with department-led statewide planning. Regional governance structures should be tasked with improving patient pathways and outcomes and be held accountable for meeting population health needs. Integrating services at the regional level will allow care to be tailored to local health needs and service gaps. In this way, regional governance structures would promote coordinated care pathways for patients and allow care to be tailored to community need.

Regional governance structures based on Networks would also improve overall system integration. For example, regional governance structures should align with Local Public Health Units to drive a concerted focus on population health. Local Public Health Units administer programs for disease prevention and population health, using local knowledge and relationships to tailor initiatives to their community. Currently embedded within health services, Local Public Health Units should align with any new regional governance structure based on Networks, given that Networks will assume greater responsibility for population health in collaboration with the range of other population and public health providers.

Other system boundaries (e.g. mental health regions, PHNs) should also be aligned with the new Networks, with support for improving interfaces with local government, aged care, disability and social sectors.

Funding models that support integrated care

Integrated care models also need to be incentivised by appropriate funding mechanisms. Current funding models are more tailored to episodic care, rewarding delivery of volumes of hospital activity, and are not well suited to integrated care across different settings.

We recommend that the department develop and incentivise innovative service models that support integrated care pathways. The department should explore flexible funding models (e.g. bundled payments, capitation models, blended approaches) to incentivise these new service models through:

- spanning the care continuum – promoting greater investment in prevention and early intervention outside of hospital
- funding patient pathways rather than discrete episodes – incentivising integrated approaches to meet needs of those with complex and chronic conditions
- rewarding value rather than volume – ensuring health resources promote the outcomes that matter to patients, not merely the most hospital activity.

Supporting integration across physical and mental health

The current system fails to fully support integration across physical health, mental health and AOD services. This limits the ability to centre care pathways around a person's full needs, which for many includes a combination of mental health, AOD and physical health care. As a result, patients may receive care that is less effective as it does not take into account interactions between their different needs. They may have poor experiences in a system that treats them as a disparate set of conditions, rather than holistically as a person.

The Royal Commission into Victoria's Mental Health System (the Royal Commission) noted the benefits that regional approaches, including commissioning, can support joined up approaches to care delivery that respond to the needs of local populations. This includes integration of mental health and wellbeing services across the continuum of care as needs escalate and change, as well as promoting integration of physical and mental health care. The National Mental Health and Suicide Prevention Agreement also includes commitment to regional commissioning and joint planning for the mental health and wellbeing system.

Regional governance reforms within the mental health and wellbeing system have commenced as part of a phased approach to locate decision making closer to local communities, to achieve service responses that are tailored to local needs.[116] The full

[116] Interim regional bodies responsible for building local relationships and a strong information base on regional mental health and wellbeing needs and service systems commenced operation in 2022. From 1 January 2025, the

intent of the Royal Commission is for Regional Boards to assume regionalised functions of planning, funding and monitoring services within their region by 2026.

We recommend that mental health Regional Bodies align with any new regional governance structure (as outlined above) to best support integration across the continuum of care. This recommendation is consistent with the Royal Commission, which stated that any future governance structures should allow for collaboration between mental health and wellbeing and other health services, as well as other service systems, with a view to encouraging integration that centres on a person's needs and ensures that physical, mental health and AOD care is coordinated.

We recommend alignment include resource sharing between mental health Regional Bodies and new regional governance structures to promote efficiency and effectiveness – for example integration of infrastructure, administrative support and functional (ultimately commissioning) units. However, boards should remain separate to allow lived experience to be appropriately incorporated and ensure that alignment does not dilute focus on mental health and wellbeing, but rather promotes more integrated care, with less duplication of effort. We recommend that mental health and wellbeing regional governance reforms be designed in a way that enables future alignment with any broader reforms to the health system, including changes to the health services system through implementation of this Plan, and any new regional governance structures that may follow. The department will continue to provide advice to government on the pathway to mental health Regional Boards adopting full functions, and this should include consideration of the context of the Plan and broader health system reforms.

Continuous improvement

While this Plan will deliver step change reform needed for the system to face current and impending issues, we acknowledge future challenges and reform opportunities will emerge, as Victoria's demography, patient care needs and the health care landscape continue to evolve. Some geographic areas across the state – particularly those on the peri-urban fringes of Melbourne – are projected to continue to experience significant population growth. Seismic shifts are also occurring in the demographics and health needs of communities, and further capital projects are planned or underway. This Plan should not be viewed as a 'set and forget' solution. The optimal design and governance for Victoria's health system will undoubtedly change and require future refinement to suit contextual factors in years to come.

Mental Health and Wellbeing Act 2022 (Vic) enables the establishment of regional boards as statutory advisory boards, that will lead engagement with their communities to advise the Minister for Mental Health on regional service needs.

Given this, we recommend the department view the system with a continuous improvement lens and continue to refine system settings adaptively, so the system continues to be responsive to the Victorian community's needs. As part of this, we recommend the department commission a review of the reformed system in five years from the Plan's implementation date, to evaluate whether intended outcomes have been achieved. This review should consider whether services who remain standalone would benefit from being a part of the consolidated system and Local Health Service Networks. In addition, a shorter-term review should be completed in three years' time to review the Plan's implementation process and ensure there are emerging signs the system is heading towards delivering intended outcomes. Importantly, both reviews should focus on whether the voices and health needs of local consumers and communities are being appropriately heard and addressed.

Conclusion

Victoria's health system has served our state well, and our healthcare workforce is unflagging in its commitment to providing the best patient care. But our health services system is under strain – as exposed and exacerbated by the COVID-19 pandemic – and is no longer fit for purpose.

The structure of our system contributes to inconsistent and inequitable access to high-quality and safe care. Too often, particularly for patients with chronic disease, care is disconnected and fragmented. It is difficult for patients and clinicians to navigate a needlessly complex system. The system makes it challenging to engage and support our essential health workforce. Our precious health resources risk being wasted through unnecessary duplication. Ultimately, these issues impede our ability to deliver the best care and outcomes for all Victorians.

We have developed three core concepts so that Victoria's health services system is better designed to provide patients the right care, in the right place, at the right time:

- A Victorian role delineation framework will clearly set out the roles and responsibilities of health service sites across Victoria. It will create a shared understanding of what care the community can reasonably expect from their local services, and support patients being cared for at the most appropriate place for their needs.
- Local Health Service Networks will bring health services together with clear accountability to meet their communities' care needs as close to home as possible. Networks will support more consistent and equitable care across their region, delivered along logical pathways. They will engage essential health care workers more effectively, and provider greater support for training and professional development. And they will support local leadership and local voice, preserving health services as valued and responsive local institutions.
- Formal relationships between Networks and providers of high complexity care will support more timely, seamless care for patients who require more specialised care. This care will be provided close to home as much as possible, with clear pathways to complex care providers when needed.

We consider that these reforms are needed – and needed now – to create a Victorian health services system that is equipped for the future, and can learn and adapt. They will help our health workforce deliver better care for their patients. And they will support more consistent and equitable care across the state, for all Victorians.

Our consultations and the formal and informal submissions we received, have convinced us that Victoria's health service leadership – across the length and breadth of our state – understands the need for reform and is committed to working with their communities to achieve it. We applaud their vision and urge all those charged with implementation to work together to achieve it.

Appendices

Appendix 1 – Acronyms and shortened forms

For the purposes of this report, the term 'health service' includes all public health services, multi purpose services and public, metropolitan and denominational hospitals.

The following acronyms and shortened forms are frequently used in this report. Other shortened forms are explained where they are used.

Acronym/ shortened form	Explanation
ACCHO	Aboriginal community controlled health organisation
AOD	Alcohol and other drugs
AIHW	Australian Institute of Health and Welfare
CEO	Chief executive officer
the department	Victorian Department of Health
ECMO	Extracorporeal membrane oxygenation
EMR	Electronic medical record
GP	General practitioner
ICU	Intensive care unit
ICT	Information and communications technology
LGA	Local government area
LGBTIQA+	Lesbian, Gay, Bisexual, Trans and gender diverse, Intersex, Queer, and Asexual. The plus sign indicates that there are many different terms used to describe identity, which are not all covered by the letters LGBTIQA.
NEPT	Non-emergency patient transport
NSW	New South Wales
PHN	Primary Health Network
SCV	Safer Care Victoria
SOP	Statement of priorities
VAGO	Victorian Auditor General's Office
VAED	Victorian Admitted Episode Dataset
VEMD	Victorian Emergency Minimum Dataset
VVED	Victorian Virtual Emergency Department
WA	Western Australia

Appendix 2 – Health Services Plan scope

Developing a Health Services Plan that delivers the right care at the right time in the right place

Purpose

While Victoria has high-performing health services, Victorians are experiencing significant differences in access to timely, safe and appropriate care depending on where they live, and who they are. Fragmentation across Victoria's health services contributes to this variation in health care quality, with people facing challenges accessing connected care close to home.

The structure of Victoria's health system has been largely unchanged for the past 20 years, despite substantial shifts in the population's health care needs and the ways that care is delivered. With health making up one third of the state's operating budget,[117] we must use these precious resources in the best way to meet our changing health care needs.

The department will develop a Health Services Plan, based on expert advice, that will outline the optimal design of Victoria's health services to provide the right care, in the right place, at the right time. Ultimately, the Plan aims to support the delivery of outcomes that matter for local communities and improve health equity and access across Victoria.

Scope

The draft Health Services Plan will consider the optimal design of Victoria's health services.

Health service entities are defined under the *Health Services Act 1988* as public health services, public hospitals, multipurpose services, denominational hospitals, private hospitals, day procedure centres, ambulance services, non-emergency patient transport services, the Victorian Institute of Forensic Mental Health, and prescribed entities that provide health services.

For the Plan, the term 'health services' means health service entities defined by the *Health Services Act 1988*, including Dental Health Services Victoria[118] and the

[117] The 2023–24 Victorian State Budget provides $15.4 billion over five years in output initiatives, including $4.9 billion for health.

[118] While the Plan will not cover dental health in depth, DHSV performs core activities that relate to other health services. Oral and maxillofacial procedures are undertaken by both DHSV and other health services; oral health contributes to overall health and impacts on hospital demand; and there is opportunity to integrate DHSV in care pathways with other health services.

Victorian Institute of Forensic Mental Health,[119] but excluding private hospitals, private day procedure centres, ambulance services and non-emergency patient transport services. Health services not defined by the *Health Services Act 1988* are not in the Plan's scope.[120]

Health services in scope provide a range of services. To deliver a robust Plan within the available timeframe, the scope will focus predominantly on acute care, and at a high-level integrated community health and public sector residential aged care. While the Plan will take into account interfaces with other sectors, the Plan will not seek to comprehensively cover types of care (e.g., primary and community care, mental health (outside of level 5 services delivered by health services), alcohol and other drugs, aged care, forensic mental health care, dental health) that are provided by multiple kinds of service provider beyond health services.

The Plan will set out the following arrangements, and their supporting rationale, for Victoria's health system:

- a framework for the appropriate roles of different kinds of health service site[121] in most effectively providing the right care in the right place, at the right time for their local community and geography, including:
    - describing in general terms the different levels of capability for health service sites
    - describing, on an area basis, what levels of general capability can be safely, efficiently and appropriately provided[122]
    - describing the principles for appropriate referral networks across health service sites to support seamless patient experience, facilitate patient flow and support care close to home
    - principles for the provision of statewide specialised services and the connections that should be in place with other sites.
- appropriate organisational arrangements to support the optimal health services system design, that enable any future health service organisations to:
    - have clearly defined responsibilities with respect to how the care needs of their local community are equitably met

[119] While the Plan will not cover justice health or mental health care in depth, Forensicare is included in the scope as it faces similar corporate, governance and organisational challenges to other health services; shares capability, skills and expertise with other health services; and has opportunities to strengthen patient pathways to other health services, as Forensicare patients often have complex care needs requiring acute hospital treatment.

[120] The Plan will not cover early parenting centres, private hospitals, bush nursing hospitals, private day procedure centres, ambulance services, non-emergency patient transport services, registered community health organisations, or public sector residential aged care provided outside health services.

[121] Note that sites may also deliver services virtually.

[122] Note this should not involve developing a clinical services plan for the state or each region.

    - ensure the voices of their local community and consumers are heard in how health services are managed
    - provide and govern safe and high-quality, seamless patient care
    - support, attract and retain workforce effectively.
- appropriate collaboration arrangements to support the optimal public health services system design that:
    - provide a foundation for better coordination across primary and acute care in each region, and facilitate care being provided in as low acuity settings, close to home, as possible, through supporting more effective care pathways, especially for patients with chronic disease
    - support alignment and integration across physical, mental and public health
    - enable collaborative system leadership that supports the achievement of population and system goals, enables collective management of system-level issues (e.g. workforce), and facilitates longer term system planning.

The development of the draft Health Services Plan will be led by an Expert Advisory Committee, developed collaboratively with health service leaders and key health sector stakeholders.

The draft plan will:

- maintain or enhance community access, including in rural areas, to safe and high-quality services. Closures are out of scope of the plan.
- maintain a role for all current workers – including front-line, back office and executive staff
- not entail changes that result in a health service employee's terms and conditions, considered on an overall basis, being less favourable.

Appendix 3 – Plan development process

The Plan was developed between July 2023 and April 2024 and involved consultation with health service leaders and experts over three key stages.

Stage 1: Problem definition and design principles

The Committee began by examining evidence of system problems along seven themes based on the Institute for Healthcare Improvement's quintuple aim:

- patient experience
- quality and safety
- workforce and clinician experience
- health equity, including travel and access
- local and consumer voice
- population and system-level health outcomes
- delivering value.[123]

For each theme, the Committee considered performance at a state level as well as variation across health services, in the context of their size, capability and location. This analysis fed into a high-level problem statement outlining the key issues we considered needed addressing in the Victorian health system. Draft design principles were then developed to underpin the future system and inform decisions about the Plan.

Sector input was key to developing the problem definition and design principles. Seven workshops were held across late August and early September 2023 to align on system-wide problems, understand barriers and identify system design principles. 147 CEOs and board chairs attended, representing 74 health services.

Based on workshop feedback, the problem statement was refined and nine key system design principles were developed as outlined in Chapter 2.

Stage 2: Design concepts

The Committee next developed a set of design concepts to address the problems identified in Stage 1. These design concepts were guided by the design principles and informed with evidence and analysis provided by the secretariat.

A second round of workshops were held in November and December 2023 to test the initial design concepts, with CEOs and board chairs from 75 health services participating. Three design concepts were discussed:

- role delineation

[123] S Nundy, L Cooper & K Mate, 'The quintuple aim for health care improvement: A new imperative to advance health equity', *JAMA,* 2022, 327(6):521–522, doi:10.1001/jama.2021.25181.

- Local Health Service Networks
- connecting to highly complex and specialised care.

Sector insights were also sought on potential functions of Networks, with a focus on enabling timely access to safe and quality care, supporting workforce, and reducing complexity and boosting efficiency. Four potential governance options to support Networks were also tested, ranging from informal partnerships to voluntary amalgamations.

Following these workshops, the Committee received and considered 46 submissions from around 60 health services.[124]

Stage 3: Final options and recommendations

After considering sector input from Stage 2, the Committee developed a refined set of reform options, including proposed Network groupings and governance mechanisms.

A final round of in-person consultation with CEOs and board chairs occurred across March and April 2024, with 134 CEOs and board chairs from 72 health services participating.

At these workshops, the Committee shared its proposed Network groupings and tested two potential governance mechanisms: strengthened partnerships, or health service consolidations. The latter option was included as this had been raised by stakeholders during the previous workshops.

The Committee also invited written submissions during this final stage, with 62 health services providing 59 submissions.[125]

Incorporating broader health system perspectives

Throughout the Plan process, the Committee incorporated views from a broad range of partners and experts across the health system.

The Committee and/or the secretariat held 69 meetings with CEOs, board chairs, international experts, leaders from other jurisdictions, and a range of other key stakeholders to inform development of the Plan. This included thought leaders with experience in governance changes; health system experts with experience of health systems in Victoria, NSW, Queensland, Western Australia, New Zealand and Denmark; and leaders with expertise in specialist fields including women's health, disability, rural and regional healthcare.

[124] This includes individual and joint submissions. A number of health services also made multiple submissions.

[125] This includes individual and joint submissions. A number of health services also made multiple submissions.

Consumer perspectives were gathered through an Engage Victoria survey distributed through health services, surveying more than 250 health service consumers and carers. The Committee also considered insights from a survey of over 2,000 consumers on how they navigate the health system, commissioned by the department.[126]

The Committee considered insights from the Victorian health workforce strategy consultation and engagement process, which gathered a broad range of perspectives and experiences from over 5,000 people across the health sector. Data was also obtained from other Victorian organisations to inform potential impacts, including Victorian Healthcare Association pulse surveys.

Data and evidence underpinning the Plan

The secretariat undertook research and analysis using Victorian data and global literature and shared insights with the Committee, including:

- current and projected population size
- health service self sufficiency
- patient flow
- quality and safety
- workforce attraction and retention
- wait times
- patient experience
- socio-economic characteristics, and
- regional variation in disease burden.

The Committee also considered a range of reports focusing on Victorian health services, including:

- SCV – *Targeting zero – the review of hospital safety and quality assurance in Victoria*[127]
- Victorian Auditor General's Office – *Clinical governance: health services*[128]
- Health Service Partnership Expert Steering Committee –*Health service partnerships evaluation: steering committee report*[129]
- Department of Health – *Engage Victoria women's health survey*[130]

[126] The Source, *Right care, right place, right time.*

[127] Duckett, Cuddihy & Newnham, *Targeting zero.*

[128] VAGO, *Clinical Governance: Health Services.*

[129] Cockram, Flynn, & Wallace, *Health service partnerships evaluation.*

[130] Victorian Department of Health, *Engage Victoria women's health survey 2023.*

- The Kings Fund – *Managing health services through devolved governance: a perspective from Victoria, Australia*[131]
- Health service CEO workgroup – *From competition to collaboration: the acute referral pathway: how this group of Victorian health services chief executives want to collaborate to improve the system*.[132]

Reform lessons from other jurisdictions were also considered, including:

- the NSW parliamentary inquiry into *Health outcomes and access to health and hospital services in rural, regional and remote New South Wales*.[133]
- the *Special commission of inquiry into acute care services in NSW public hospitals*[134]
- the *Advice on Queensland Health's governance framework*[135]
- the *Independent review of WA health system governance*.[136]

Relevant frameworks and reforms were also considered, including the *Statewide design, service and infrastructure plan for Victoria's health system*[137] and *Victorian health workforce strategy*.[138]

Finally, international experiences also fed into our analysis, including data and case studies from Denmark, United Kingdom, Canada, Finland, New Zealand and other jurisdictions.

[131] Ham & Timmins, *Managing health services through devolved governance.*

[132] Health service CEO workgroup, *From Competition to collaboration: The acute referral pathway.*

[133] Parliament of NSW, *Health outcomes and access to health and hospital services in rural, regional and remote New South Wales.*

[134] Garling, *Special commission of inquiry into acute care services in NSW public hospitals.*

[135] McGowan, Philip & Tiernan, *Advice on Queensland Health's governance framework.*

[136] Peake et al., *Independent review of WA health system governance.*

[137] Victorian Department of Health, *Statewide design, service and infrastructure plan for Victoria's health system 2017–2037.*

[138] Victorian Department of Health, *Victorian health workforce strategy.*

Appendix 4 – A Victorian role delineation framework

What differentiates hospital types?

Most jurisdictions in Australia have a role delineation framework to describe the types of hospitals in their system.

The Committee recommends the establishment of a Victorian role delineation framework, that draws from work undertaken by the AIHW, but modified to take into account the breadth of care types that Victorian health services provide, contemporary service models, and population and community factors.

The AIHW's peer grouping framework was established in 1999 to define groups of similar hospitals based on shared characteristics to allow a better understanding of the organisation and provision of hospital services across states. This peer grouping framework has been leveraged as a basis to support role delineation in Victoria.

The AIHW peer grouping framework's definition of peer groups is based on the following parameters:[139]

- draws on data from a broad range of sources
- references the physical scale of hospital infrastructure, for instance number of beds and the presence or absence of, for instance, emergency departments and ICUs
- is defined, in addition to infrastructure characteristics, by the types, diversity and volumes of the services. These services include:
    - volume of primary, community and outpatient occasions of service
    - volume of emergency presentations
    - volume and range of acute diagnosis related groups serviced
    - volume of acute service separations, average lengths of stay and average cost weights
    - proportion of surgical separations.

Consultation with Victorian health services recommended refinement and extension of these parameters to better tailor them to the unique characteristics of Victoria's health service sites and to align with contemporary and emerging care models such as Better at Home.[140] The following changes have been included to create the Victorian role delineation framework.

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[139] AIHW, *Australian hospital peer groups,* Australian Government, 2015.

[140] Victorian Department of Health, *Better at Home initiative*, Victorian Department of Health website, 2023, available at www.health.vic.gov.au/patient-care/better-at-home-initiative, accessed April 2024.

Geography and demography

The AIHW peer grouping framework is agnostic to the locations in which health service sites reside. However, geography, demography and connection to country and culture vary significantly across Victoria and influence the types of services and models of care delivered from health service sites. The following characteristics have been incorporated into the framework to account for these factors:

- reference to the types of geographies in which health service sites reside and the scale of populations served
- the extent of geographic isolation and distance from other care providers,
- the average proportion of acute hospital care needs that can be met for the local catchment population.

Non-acute service delivery

The AIHW framework places a very strong emphasis on acute service provision, however, this is not representative of the service profiles of many of Victoria's rural health service sites, which play a strong role in primary and aged care. On this basis, the following characteristics have been incorporated into the framework to ensure that these services are recognised:

- number of residential aged care places
- volume of presentations to urgent care centres
- number of subacute and non-acute separations and patient days.

Delineation of care complexity

Whilst the AIHW framework considers the diversity of care provided at health service sites, it includes limited characteristics that delineate care complexity. To support delineation of care complexity, the following characteristics have been incorporated into the framework:

- ICU classification per the College of Intensive Care Medicine
- length of stay and average cost weight of separations including an ICU stay
- provision of high complexity services including cardiac surgery, neurosurgery, infectious diseases, bone marrow transplant, organ (kidney, liver, heart, lung or pancreas) transplant and burns
- average cost weights of cardiology, cardiothoracic surgery, neurosurgery and infectious disease separations and proportion of these requiring ICU stay.

The department is currently developing a suite of clinical capability frameworks. These will support delineation of care complexity in future iterations of this framework.

Model of care changes

With initiatives such as Better at Home, the way that services are delivered in Victoria is changing. Care is increasingly becoming non-reliant on physical infrastructure with a large volume of services delivered virtually or in the home. The AIHW framework place a strong emphasis on physical hospital beds. To ensure that non-bed-based care is accounted for, the framework has been extended to include 'bed equivalents' for care delivered outside of hospital walls.

Admissions policy variations

The volumes of acute weighted separations considered within the framework have been adapted to account for Victorian variations in admission policies. This applies predominantly to same day chemotherapy and haemodialysis services, which are admitted services in Victoria but non-admitted services in most other Australian jurisdictions.

Collectively, these characteristics modify the AIHW framework to create a Victorian role delineation framework that best aligns with the roles and responsibilities of health service sites in Victoria.

High-level peer group descriptors for a Victorian role delineation framework

The high-level descriptions of different health service site peer groups are outlined below. Over time these descriptors will be refined through synthesis with known clinical capability levels as further capability frameworks are implemented in Victoria. The descriptors below provide an indication of the levels of capability associated with the different health service site peer groups based on common analyses across other Australian jurisdictions.

Very Small

Very Small health service sites are community centred in their service delivery. They provide a tailored range of services to best meet the needs of their community, whilst also being responsive to changing needs. These services are frequently the main providers of co-located primary, community, and aged care for their local communities. Very Small health service sites may provide pregnancy and postnatal shared-care close to home for women who are registered to have their baby at another facility.

Noting that these facilities service townships with a paucity of private service provision they play an important role in the provision of primary care, health promotion and early intervention. As these sites are, on average, 50 minutes travel time away from more complex hospital care (and sometimes greater than 90 minutes), they play a vital role in referral and navigation of patients, when required, to higher level services.

Overnight care at these facilities is typically non-acute, transitional and respite care for patients from the local community for whom care in the home may be impractical or unsafe.

Contingent on workforce availability, urgent care services at these sites may draw on remote expertise including from VVED, or alternatively from expertise at emergency departments in the region.

Very Small health service sites are typically amongst the largest employers in their townships and play a role in the overall sustainability of their communities.

In other jurisdictions, Very Small health service sites typically deliver services aligned to clinical capability levels 1–2.

Figure 1 – Very Small health service site characteristics

Characteristic	Description
Service Profile	Typical types of services include, but are not limited to: • primary care • primary mental health • community health • perinatal care for low-risk pregnancies (no birthing, shared care) • community AOD services • public sector residential aged care • non-acute overnight care (transitional care, geriatric management, respite) • may have a limited hours urgent care service, which may leverage the VVED for virtual secondary consult.
Service Metrics	**Hospital separations per year:** 0–200 **Hospital beds and equivalents:** 0–16 **Average length of stay for overnight care:** 13 days **Average % local acute care needs met:** 3% **Residential aged care places:** 7 or more **Non-admitted occasions of service*:** 0–27,000
Catchment Community	**Population size:** 600–3,000 people **Age profile:** older than Victorian average distribution **Geographies:** Inner or Outer Remoteness areas of rural Victoria **Average travel time to complex hospital care:** 50 min

** Non-admitted care includes primary, community urgent and outpatient episodes of care.*

Group D

Group D health service sites play an important role in delivering co-located primary, community, and aged care as well as low complexity, predominantly day-stay acute care that is tailored to best meet the local needs of small rural communities. Many Group D services also support pregnancy care for low-risk pregnancies including birthing.

Contingent on workforce availability, urgent care services at these sites may draw on remote expertise including from the VVED, or alternatively from expertise at emergency departments in the region.

Like Very Small health services, funding arrangements for Group D health service sites provide flexibility that allow them to rapidly pivot to respond to changing community needs. Group D services may service townships that are subject to seasonal population variation that require the operational flexibility to accommodate substantial fluctuation in demand, particularly for urgent care services.

Group D facilities are typically located in rural towns that have a paucity of private services and are, on average, 50 minutes travel time away from private general practice clinics or more complex public hospital care. As such, they play an important role in linking their communities to higher complexity care and receiving these patients back following their acute episode for recovery and step-down care close to home.

Overnight care at these facilities is typically for non-acute, transitional care and respite patients for whom care in the home may be impractical or unsafe.

Group D health service sites are typically the largest employer in their townships and play a role in the overall sustainability of their communities.

In other jurisdictions, Group D health service sites typically deliver services aligned to clinical capability levels 1–3.

Figure 2 – Group D health service site characteristics

Characteristic	Description
Service Profile	Typical types of services per Very Small facilities plus: • urgent care service (limited hours or 24/7), which may leverage the VVED for virtual secondary consult. • ambulatory acute medical services, i.e., haemodialysis • same day low complexity procedures, i.e., endoscopy, cataracts, general surgery • pregnancy care for low-risk pregnancies, vaginal and planned caesarean births. • non-acute overnight care potentially providing geriatric evaluation and management.
Service Metrics	**Hospital separations per year:** 200–15,000 **Hospital beds and equivalents:** 8–63 **Average length of stay for overnight care:** 6–7 days **Average % local acute care needs met:** 15% **Residential aged care places:** 12 or more **Non-admitted occasions of service:** 0–270,000
Catchment Community	**Population size:** 800–5,300 people **Age profile:** older than Victorian average **Geographies:** Inner or Outer Remoteness areas of rural Victoria **Average travel time to complex hospital care:** 50 min

Group C

Group C health service sites are primarily located in outer regional towns with populations of less than 30,000 people. These sites are located, on average, 45 minutes' drive-time from a Group B or Group A hospital, and as such provide a range of public primary and community health services and low to moderate complexity hospital care tailored to the specific needs of the local communities. There are also a small number of Group C health service sites located in metropolitan Melbourne and part of a larger health service network.

Group C health service sites can provide up to 60% of acute care needs for their communities, including the provision of maternity care for greater than 50% of women. They play an important role in linking their communities to higher complexity care and receiving back these patients following their acute episode for recovery and step-down care close to home. Arrangements may be in place with proximate Group B and Group A hospitals for virtual access to expertise alongside

workforce sharing arrangements to support, for instance, emergency/urgent care services and overnight medical coverage.

Group C health service sites may service townships that are subject to seasonal population variation that requires the operational flexibility to accommodate substantial fluctuation in demand.

Group C health service sites typically deliver a significant portion of acute care in the home and/or via virtual modalities.

In other jurisdictions, Group C hospitals typically deliver services aligned to clinical capability levels 2–4.

Figure 3 – Group C health service site characteristics

Characteristic	Description
Service Profile	Typical types of services per Group D facilities plus: • urgent care service or small emergency department (24/7) • ambulatory acute medical services, i.e., chemotherapy may be available at some sites partnering with larger services • multiday low to moderate complexity surgery and medicine (typically general surgery and general medicine, but limited sub-specialties may be available contingent on workforce availability) • pregnancy care for normal-risk pregnancies, vaginal and planned and unplanned caesarean births • acute overnight care for general medicine, general surgery, obstetrics and rehabilitation.
Service Metrics	**Hospital separations per year:** 5,500–15,500 **Avg. Diagnostic Related Groups (>5 seps):** 212 (range 133–273) **Hospital beds and equivalents:** 33–142 **Average length of stay for overnight care:** 2–3 days **Average % local acute care needs met:** 47–60% **Proportion of acute bed days delivered in the home:** 1–20% **Residential aged care places:** 0–94 **Non-admitted occasions of service:** 0–210,000
Catchment Community	**Population size:** 6,000–26,000 people **Age profile:** older than Victorian average **Geographies:** from outer regional towns to suburbs of metropolitan Melbourne **Average travel time to complex hospital care:** 45 min (for rural Victorian services)

Group B

Group B hospitals service large rural or urban communities with populations up to 100,000 people. These hospitals provide a range of community health and aged care services and make a significant contribution to meeting the acute care needs of their catchments (in some cases more than 70% of all acute separations). They support the retention of care within their region and limit unnecessary out flow to Group A and Major Tertiary hospitals.

These services include medium scale emergency departments and dedicated ICUs with 24/7 intensivist coverage.

These hospitals will typically support Very Small, Group D and Group C health service sites with access to clinical expertise through virtual and non-virtual modalities, and where care is escalated to a Group B hospital, patients may be repatriated back to a Group C or D hospital to facilitate recovery and step-down care close to home.

Group B hospitals typically deliver a significant portion of acute care in the home and/or via virtual modalities. In other jurisdictions, Group B hospitals typically deliver services aligned to clinical capability levels 3–5.

Figure 4 – Group B health service site characteristics

Characteristic	Description
Service Profile	Typical types of services per Group C facilities plus: • emergency department (24/7) • acute overnight care with a range of sub-specialties • pregnancy care for moderate-risk pregnancies, vaginal and planned and unplanned caesarean births • intensive care.
Service Metrics	**Hospital separations per year:** 17,000–58,900 **Avg. Diagnostic Related Groups (>5 seps):** 371 (range 288–431) **Hospital beds and equivalents:** 71–189 **Avg. length of stay for overnight care:** 3 days **Avg. % local acute care needs met:** 60–70% **Proportion of acute bed days delivered in the home:** 12–25% **Non-admitted occasions of service:** 23,000–520,000
Catchment Community	**Population size:** 60,000 – 100,000 people **Age profile:** varied **Geographies:** large rural or urban communities that are not characterised by the Victorian Government as Regional Economic Development Areas

Group A

Group A hospitals service metropolitan Melbourne growth corridors, major suburban areas and major regions in rural Victoria, with populations typically exceeding 200,000 people. They provide about 40% of all Victoria's statewide hospital separations and bed days, with a significant proportion of these delivered in patient's homes or via virtual modalities.

Group A hospitals manage most needs for acute hospital services and most emergency activity, except for the most complex care (which is referred to Major Tertiary and Specialist Hospitals). The proportion of acute needs met at Group A hospitals can vary widely due to proximity to other Group A hospitals and consumer choice, however, greater than 90% of acute care needs are met at some Group A hospitals. This is essential to limiting unnecessary out flow to Major Tertiary hospitals and supports the role of Major Tertiary hospitals in their provision of the most complex care.

Group A hospitals play a significant system role in teaching and training clinicians. In addition, these hospitals will typically support Very Small, Group D, Group C and Group B hospitals with access to clinical expertise through virtual and non-virtual modalities, and where care is escalated to a Group A hospital, patients may be repatriated back to a Group B, C or D hospital to facilitate recovery and step-down care close to home.

In other jurisdictions, Group A hospitals typically deliver services aligned to clinical capability levels 4–5.

Figure 5 – Group A health service site characteristics

Characteristic	Description
Service Profile	Typical types of services per Group B facilities plus: • acute overnight care with most sub-specialties • large ICUs with high level of critical care • maternity service, cardiology service, oncology service and other general specialty acute hospital services operating at a high level.
Service Metrics	**Hospital separations per year:** 28,500–93,700 **Avg. Diagnostic Related Groups (>5 seps):** 514 (range 379–643) **Hospital beds and equivalents:** 164–511 **Avg. length of stay for overnight care:** 3–4 days **Avg. % local acute care needs met:** 70–90% **Proportion of acute bed days delivered in the home:** 10–20% **Non-admitted occasions of service:** 51,000–570,000
Catchment Community	**Population size:** 200,000+ **Age profile:** varied **Geographies:** metropolitan Melbourne growth areas and major suburban areas, and major regional cities statewide

Major Tertiary Hospital

Major Tertiary Hospitals provide over 20% of the state's activity. They typically serve large metropolitan regions, extending into regional Victoria. Major Tertiary Hospitals provide medium complexity care for their proximate communities, supporting the sustainability of service delivery and maintenance of workforce capability. In addition, they also provide the highest complexity care across all disciplines and specialties (except maternity and paediatrics in most cases) for their broader regional metropolitan and rural catchments, including in some cases, designated statewide or national services.

These hospitals will typically support most other hospitals in the system with access to clinical expertise through virtual and non-virtual modalities. Where care is escalated to a Major Tertiary hospital, patients may be repatriated back to a hospital closer to home for recovery and step-down care.

Major Tertiary Hospitals typically deliver an increasing proportion of acute care in the home and/or via virtual modalities. Alongside Group A and Specialist Hospitals, Major Tertiary Hospitals play a fundamental role in the provision of teaching, training, and research.

In other jurisdictions, Major Tertiary hospitals typically deliver services aligned to clinical capability level 6.

Figure 6 – Major Tertiary health service characteristics

Characteristic	Description
Service Profile	Typical types of services per Group A facilities plus: • statewide lead hospitals • large emergency departments • large ICUs with highest level of critical care • all sub-specialties • multi-disciplinary acute hospital specialty services staff co-located on site include cardiac surgery, neurosurgery, bone marrow and organ transplant, and infectious diseases • research, education and training, performed on site.
Service Metrics	**Hospital separations per year:** 67,000–109,000 **Avg. Diagnostic Related Groups (>5 seps):** 618 (range 588–644) **Hospital beds and equivalents:** 503–802 **Avg. length of stay for overnight care:** 4.2 days **Avg. % local acute care needs met:** >95% **Proportion of acute bed days delivered in the home:** 15–20% **Non-admitted occasions of service:** 250,000–1,800,000
Catchment Community	**Population size:** > 1,000,000 **Age profile:** varied **Geographies:** major metropolitan Melbourne regions with direct service provision and referral pathways extending across most of regional Victoria

Women's and Children's Hospitals

Women's and Children's Hospitals provide a comprehensive range of services for women and children. Often these hospitals provide the highest complexity care across obstetrics, gynaecology, and paediatrics for their broader regional metropolitan and rural catchments, including in some cases, designated statewide or national services.

Figure 7 – Women's and Children's health services characteristics

Characteristic	Description
Service Profile	Typical types of services: • emergency care services (24/7) • comprehensive range of ambulatory acute paediatric services and women's services mainly supporting obstetrics, gynaecology, and midwifery specialty areas • obstetrics, gynaecology, midwifery, and paediatric specialty workforce incorporating primary through highest level hospital bed-based care • pregnancy care for normal risk through to highest at-risk pregnancies, vaginal and planned and unplanned caesarean births • acute overnight and multi day care for paediatric medical and surgical services, and rehabilitation • acute overnight and multi day care for women, mainly supporting obstetrics, gynaecology, and midwifery specialty services.
Service Metrics	**Hospital separations per year:** 17,500–51,000 **Avg. Diagnostic Related Groups (>5 seps):** 223 (range 96–459) **Hospital beds and equivalents:** 33–322 **Average length of stay for overnight care:** 2–3 days **Average % local acute care needs met:** not applicable **Proportion of acute bed days delivered in the home:** 0–25% average 6% **Residential Aged Care Places:** not applicable **Non-admitted occasions of service:** >500,000
Catchment Community	**Population:** women and/or children **Age profile:** younger than Victorian average (profile is mainly children and women of child-bearing age) **Geographies:** statewide service providers with most patients being residents of metropolitan Melbourne **Average travel time to complex hospital care:** average travel time to these hospitals is 34 minutes

Victoria also accommodates a number of specialist hospitals. These are not described further here due to the diverse nature of these services in Victoria and the range of roles that they play.

Appendix 5 – Alternative groupings

In the course of consultations, the Committee received many submissions from health service leaders proposing alternative groupings, affiliations and designs of the Networks. The Committee has considered these at length and assessed each against the principles of the Plan and the criteria that the Committee believes would determine the success of any proposed Network.

The Committee has recommended 11 Networks and considers that variation, alteration or reduction in the scale and configuration of these would detract from the anticipated benefits of the Plan.

There are three variations, however, that we acknowledge may be viable and necessary when other factors, such as community opinion, are taken into account. These are the division of the Barwon South West Network, the division of the Loddon Mallee Network, and the separation of the Royal Children's Hospital from the Parkville Network.

Barwon South West alternative configuration

An alternative option is to create two separate Networks: Barwon Network and South West Network. This option recognises the large scale of the population of the Barwon South West region, and that Geelong is a metropolitan centre in its own right with distinctive characteristics compared with the largely rural south west region. On balance, this option is considered sub-optimal as the single Network option yields significant scale and supports the necessary patient flows from the south west to Barwon Health for complex care.

Were this alternative option to proceed, we recommend that existing connections between the Barwon and South West Networks are actively strengthened to support clinical flows, as the forecast population of the south west region is unlikely to be adequate to support the development of South West Healthcare's capability with sufficient scale to achieve the proposed benefits of a Network. In addition, strong connections between the Barwon and South West Networks will create opportunities for shared clinical support, administrative, and ICT services, which will benefit from economies of scale across the two Networks.

Barwon Network

Health services: Barwon Health, Colac Area Health, Great Ocean Road Health, Hesse Rural Health Service

Population served (2026): 383,000

South West Network

Health services: 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.

Population served (2026): 110,000

Loddon Mallee alternative configuration

Recognising the remoteness of the Mallee region and the particular flows of patients with complex care needs from this region to Melbourne by air travel rather than to Bendigo by road, an alternative option is to separate this region from the Loddon Network. This is not the Committee's preferred option as it reduces the scale of the benefits to local communities and workforce.

Under this option, the Mallee Network, comprising Mildura Base Public Hospital, Robinvale District Health Service and Mallee Track Health would service a population of 71,305. Mildura Base Hospital would be the provider of the most complex care in this Network.

Loddon Network (comprising Bendigo Health and nine other health services) would service a population of 293,110, and Bendigo Hospital would be the provider of the most complex care in this Network.

Should this alternative option proceed, we recommend that existing connections are actively strengthened between the Mallee and Loddon Networks to maintain and expand opportunities for shared clinical support, administrative and ICT services, which provide economies of scale across the two Networks.

Mallee Network

Health Services: Mallee Track Health and Community Service, Mildura Base Public Hospital, Robinvale District Health Service

Population served (2026): 61,800 (Victoria) + 9,300 (NSW)[141]

With a self-sufficiency of 88%, Mallee Network provides the majority of care to the residents of the region, with escalated care accessed through established pathways to Bendigo and metropolitan Melbourne.

Loddon Network

Health Services: Bendigo Health, Boort District Health, Cohuna District Hospital, Dhelkaya Health, Echuca Regional Health, Heathcote Health, Inglewood and Districts Health Service, Kerang District Health, Kyneton Hospital, Rochester & Elmore District Health Service, Swan Hill District Health

Population served (2026): 280,000 (Victoria) + 13,110 (NSW)[142]

Although Loddon has a low self-sufficiency of 72%, this is largely due to outflows from the southern populous areas into metropolitan Melbourne. Separating Loddon from Mallee allows Bendigo Hospital, as the provider of the most complex care in

[141] Based on NSW bordering LGAs immediately adjacent to Network area (Wentworth).

[142] Based on NSW bordering LGAs immediately adjacent to Network area (Balranald, Murray River).

the region, to focus on developing referral pathways and service supports to other hospitals in the region, thereby improving local access to care.

Parkville alternative configuration

While there are significant benefits for the Royal Children's Hospital to be consolidated with the Parkville Network due to patient, clinical and research linkages, given its unique status with the community, its consolidation with other Parkville health services may be challenging. Therefore, a variation to the Parkville Network would be one in which the Royal Children's Hospital remains a separate standalone entity.

There remain significant benefits from the consolidation of Peter MacCallum Cancer Centre, Royal Melbourne Hospital and Royal Women's Hospital into a Parkville Network, given their strong clinical interdependencies and their co-location on the one site.

Health Services: Royal Children's Hospital

Population served (2026): Statewide

Health Services: Peter MacCallum Cancer Centre, Royal Melbourne Hospital, Royal Women's Hospital

Population served (2026): Statewide

Appendix 6 – Alternative governance

Strengthened partnerships approach

Should it not be possible to implement health service consolidations, an alternative approach, which the Committee does not recommend, would be to establish strengthened partnerships across existing health services.

The model will build on the current Health Service Partnerships and bring about greater accountability and more robust monitoring and oversight. However, the Committee considers this approach is inferior to consolidations as a system-wide approach to governance.

Setting expectations and objectives

Health services will be mandated by government to develop and sign on to a common three-year plan to deliver objectives, leaving no uncertainty about whether health services can opt out of partnerships and activities. Objectives will be linked to collaborative functions set by the department (see Chapter 4 for shared Networks functions) and be concrete, measurable and time bound. Health services will also be mandated to develop annual plans identifying how they will make progress and deliver the objectives over the three-year period. There can be some flexibility across Networks, allowing Networks to select shorter- and longer-term functions for focus from set options, according to local need and maturity.

Plans will identify which health services will provide the services on behalf of the Networks. Partnerships can decide where it is practical and effective to host functions, and different functions can be hosted by different health services. Distributing leadership across multiple capable services will build collective ownership and lead to more tailored designs that serve local areas. Cross service working groups can be established within each Network to gain collective input and endorsement. Given health services will remain separate entities, there will be no mechanism to collectively hold funds or employ staff. Therefore, health services nominated to host functions will need to hold the relevant budget and employ skilled workforce to drive that work.

Partnership structure

CEO committee

A committee of CEOs will be responsible for delivering the functions outlined in Chapter 4, in line with well-defined objectives and outcomes. The CEO committee will comprise CEOs of all health services within the Network, ensuring representative membership, collective visibility of the group's decision making, along with shared ownership of objectives and actions.

CEO committees may vary in size. For larger CEO committees, projects or tasks could be delegated to smaller working groups. CEO committees may be chaired by any health service CEO within a Network.

Board chair committee

Board chair committees will include chairs of all partnering health services and provide an oversight mechanism for CEO committees. Establishing these committees will signal the strategic importance of the CEO committees and promote a sense of board ownership. The board chair committees will also act as an escalation point for disputes and provide another avenue for conflict resolution.

Ministerial facilitator

A ministerial facilitator will be appointed to support effective functioning of Networks where there are four or more partnering health services, given the complexities of timely and effective group decision making. Where three or fewer health services are partnering (such as a consolidated public health service with a denominational health service) a ministerial facilitator may not be required. The ministerial facilitator will attend both the CEO committee and the board chair committee meetings to support timely decision making, resolve any disputes, and provide insights to the department. This includes instances where it may be necessary for the department to direct a service to agree to a committee decision when escalation to a board chair committee for resolution has failed.

To ensure the ministerial facilitator has sufficient authority and can work effectively in the facilitator role, they should:

- be appointed by the government, signalling the gravitas of the position
- be a highly skilled, experienced and respected sector leader
- be impartial
- have a personality and leadership style that is consensus building, conciliatory and diplomatic in nature.

Decision making and dispute resolution

Partnership decisions will be made via consensus, with CEOs asked to consider shared regional interests and come to a timely and binding agreement. In our view, a consensus-based approach will result in the greatest buy in and give the greatest legitimacy to decisions impacting all services. The ministerial facilitator will support timely decisions by assisting in negotiations, consensus building and helping the CEO committee establish a way forward when decision making stalls. Focusing on agreeing annual and three-year plans at the outset will reduce the chance of frequent and ongoing disagreement between services.

If proposed decisions are challenged by individual health services, the ministerial facilitator will begin dispute resolution, if necessary, escalating to the board chair committee for resolution. If a solution to the impasse still cannot be reached, the

ministerial facilitator will escalate the issue to the department, with the option of using Secretarial or Ministerial direction to compel health services to comply with the majority view informed by the ministerial facilitator's advice. The ministerial facilitator may also advise the department on committee dynamics, including any challenging behaviours or non-collaborative working styles.

Accountability

The department will regularly monitor progress against plans through reporting and performance meetings, with accountability reinforced via common clauses in individual health service SOPs, strategic plans and funding terms. For example, SOPs could include details of the CEO committee and accountability targets, to be performance managed by the department. The department could also use funding as a lever to incentivise accountability.

Health service CEOs will continue to report and be accountable to their respective boards. Boards will be accountable for delivering shared functions in line with common collective objectives outlined in individual health service SOPs. CEO committees will also be overseen by their board chair committee, whose individual members have authority (as board chairs) to commit their organisation to decisions.

The department will instruct health services to reinforce their partnership arrangements through a formal agreement. The agreement will include terms regarding structure, responsibilities and objectives, set out dispute resolution processes and consequences for noncompliance with committee decisions. Ideal agreements underpinning partnerships may differ depending on the number and type of partnering health services.

Geographic and specialist service variation

Nuanced approaches will be required across Networks to reflect the number of partnering health services and groupings where there is a combination of both denominational and non-denominational health services. There will be differences in scope of functions and underpinning agreements, depending on the number of members and composition of the partnership.

The challenges of the strengthened partnership model

While the strengthened partnership model will provide clearer guidance on participation requirements, and more robust accountability and dispute resolution processes compared to earlier partnership models, we still consider it has significant limitations compared to consolidation, as a system-wide approach to governance.

The model is inevitably complex due to the enduring independent governance of 76 health services. Decision making will be time intensive and cumbersome, and

there will be duplication and overheads associated with dual reporting lines and reporting to multiple committees.

Most importantly, this partnership model will deliver fewer benefits than consolidation. Health workforce across each region will continue to remain employed by separate health services, unable to be commonly engaged and deployed according to community need. Variable quality and safety performance will persist, with individual health services acting independently, unable to leverage strong clinical governance expertise and resourcing of stronger performing services. There will be a continuing lack of clear accountability for the population health needs of a region, and for each individual patient in the system, with ongoing challenges and delays in finding and connecting patients to timely care in the right setting.

Patients will continue to cross many individual health service boundaries being discharged and readmitted in inefficient processes and needing to repeat information many times. Metropolitan and specialist health services will remain siloed, unable to provide comprehensive multidisciplinary care, or whole-of-life care, in many instances. Health services will also have overlapping and ambiguous responsibilities to meet care needs of local communities. A complex landscape will persist, with many closely located metropolitan health services offering an often uncoordinated mix of services.

For these reasons the strengthened partnership model is not our recommended option for system-wide governance.

Appendix 7 – Established designated services

Currently designated services/procedures	No. of sites	Designated health service/s	Nationally funded centre?	Highly specialised therapies funding?
Acute brain injuries	2	• Alfred Health – The Alfred (Alfred) • Austin Health – the Austin (Austin)	No	No
Bone marrow transplants – adults	6	• Alfred • Austin • Peter Mac • Royal Melbourne Hospital • St Vincent's Health • University Hospital Geelong	No	No
Bone marrow transplants – children	1	• Royal Children's Hospital		No
CAR T-cell therapy, Kymriah®	3	• Alfred • Peter MacCallum Cancer Centre • Royal Children's Hospital	No	Yes
CAR T-cell therapy, Yescarta® and Tecartus®	2	• Alfred • Peter MacCallum Cancer Centre	No	Yes
Cardiothoracic surgery	6	• Alfred • Austin • Monash Health – Monash Medical Centre (Monash – MMC) • Royal Melbourne Hospital • St Vincent's Health • University Hospital Geelong	No	No
Cochlear implants	1	• Royal Victorian Eye and Ear Hospital	No	No
ECMO	7	• Alfred • Austin • Eastern Health • Monash – MMC • Royal Melbourne Hospital • St Vincent's Health • University Hospital Geelong	No	No
Endovascular clot retrievals for acute stroke	2	• Monash – MMC • Royal Melbourne Hospital	No	No
Gene therapy, Luxturna®	1	• Royal Victorian Eye and Ear Hospital	No	Yes
Heart transplants – adults	1	• Alfred	No	No
Heart transplants & complex cardiac surgery – children	1	• Royal Children's Hospital	Yes	No
Immunotherapy, Qarziba®	2	• Monash Children's Hospital • Royal Children's Hospital	No	Yes

Currently designated services/procedures	No. of sites	Designated health service/s	Nationally funded centre?	Highly specialised therapies funding?
Islet cell transplants	1	• St Vincent's Hospital	Yes	No
Kidney/pancreas transplants – children	1	• Royal Children's Hospital	No	No
Liver transplants – adults	1	• Austin	No	No
Liver transplants – children	1	• Royal Children's Hospital (supported by Austin)	Yes	No
Lung transplants – adults	1	• Alfred	No	No
Major burns unit – adults	1	• Alfred	No	No
Major burns unit – children	1	• Royal Children's Hospital	No	No
Major trauma – adults	2	• Alfred • Royal Melbourne Hospital	No	No
Major trauma – paediatric	1	• Royal Children's Hospital	No	No
Neuro-degenerative rehabilitation	1	• Calvary Health Care Bethlehem	No	No
Paediatric lung and heart-lung transplants	1	• Alfred (supported by Royal Children's Hospital)	Yes	No
Paediatrics rehabilitation	2	• Monash Childrens Hospital • Royal Children's Hospital	No	No
Pancreas transplants – adults	1	• Monash – MMC	Yes	No
Renal transplants – adults	5	• Alfred • Austin • Monash – MMC • Royal Melbourne Hospital • St Vincent's Hospital	No	No
Renal transplants – children	1	• Royal Children's Hospital		No
Transvaginal mesh complication referral centres	4	• Mercy Hospital for Women • Monash – MMC • Royal Women's Hospital • Western Health	No	No
Traumatic and non-traumatic spinal rehab	2	• Alfred • Austin	No	No