EASTERN HEALTH 2022

THE STRATEGIC CLINICAL SERVICE PLAN 2012–2022

easternhealth
GREAT HEALTH AND WELLBEING

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ACKNOWLEDGMENTS

Eastern Health 2022 has been developed after feedback and comments on a draft plan that was presented to and circulated amongst the staff of Eastern Health, healthcare partners and the broader community. All contributors are sincerely thanked for their input and feedback.

In addition, the following people are acknowledged for their work in research, data collection, analysis and writing of this Plan:

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Director, Quality Planning & Innovation (Strategy, Planning & Risk Management), Eastern Health

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FOREWORD

It is with great pleasure that we present Eastern Health 2022 – the Strategic Clinical Service Plan for 2012 – 2022. We have developed Eastern Health 2022 consistent with our mission 'to provide positive health experiences for people and communities in the east.

We acknowledge and thank the hundreds of people who were involved in the development of *Eastern Health 2022* Their experience, expertise and wisdom have been invaluable in the identification of innovative strategies which will ensure that Eastern Health continues to serve the health needs of people in the east over the next decade.

At Eastern Health, we are excited to articulate a comprehensive plan that will ensure we can deliver on our promise – our vision – of Great Health and Wellbeing by providing a broad range of health services to our communities in conjunction with our healthcare partners.

We are particularly proud that the initiatives mapped out in *Eastern Health 2022* focus not only on the bricks and mortar of our health services but also, what we do within our hospitals and increasingly, outside our hospitals. We have thought carefully about how we can do things differently to provide the best possible patient outcomes and value for our health system. *Eastern Health 2022* outlines Eastern Health's aspirations to provide health services in our communities over the next decade. Furthermore, it describes the important role that we play in achieving substantial reforms within the broader Victorian health system, as described in the Victorian Government's Victorian Health Priorities Framework 2012–22: Metropolitan Health Plan.

We are keen to begin the substantial work which is now needed to implement *Eastern Health 2022* and look forward to working with our people, our healthcare partners and the broader community in its implementation.

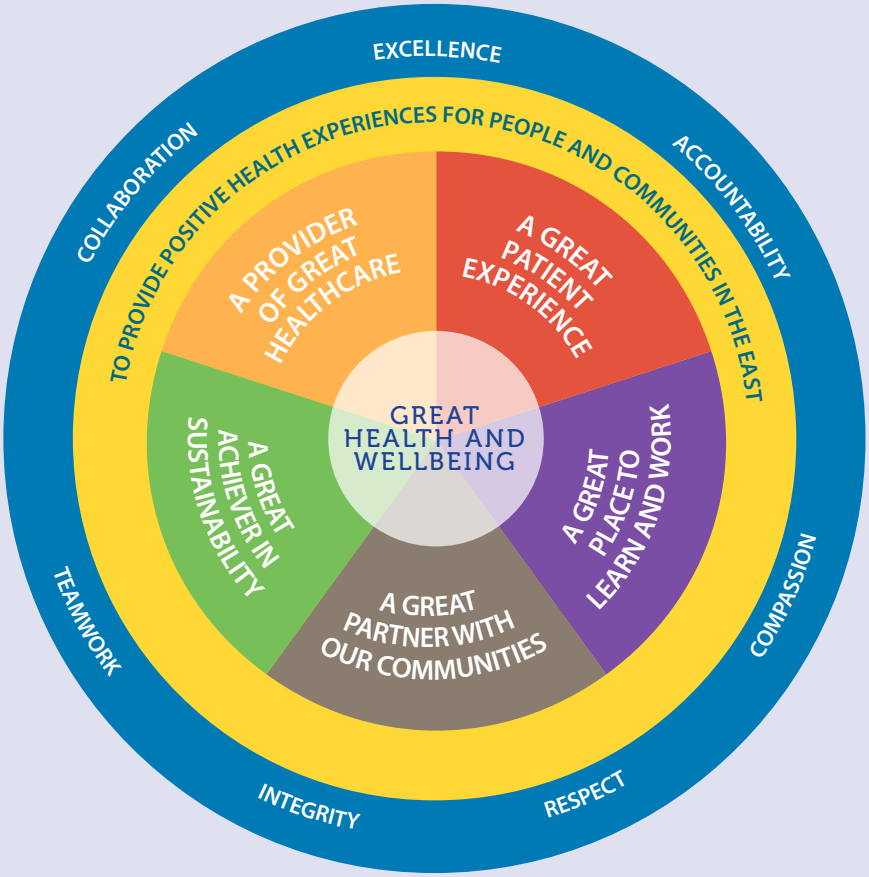
We commend *Eastern Health 2022* to you as we begin this exciting journey.

Dr Joanna Flynn, AM
Chair, Eastern Health

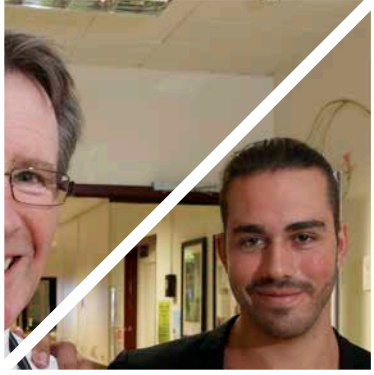
Mr Alan Lilly
Chief Executive

CONTENTS

STRATEGIC PLAN 2015



STRATEGIC DIRECTIONS	1.A PROVIDER OF GREAT HEALTHCARE	2. A GREAT PATIENT EXPERIENCE	3. A GREAT PLACE TO LEARN AND WORK	4. A GREAT PARTNER WITH OUR COMMUNITIES	5. A GREAT ACHIEVER IN SUSTAINABILITY
STRATEGIC GOALS	1.1 Meeting or exceeding all required standards of service and care.	2.1 Taking a person-centred approach which actively involves patients in decision-making.	3.1 Ensuring flexible, highly-skilled and capable workforce and volunteer networks.	4.1 Delivering models of care with our community partners that provide a seamless patient journey and deliver the right service in the right place.	5.1 Ensuring optimal utilisation of resources across the organisation.
	1.2 Delivering models of care and treatment that are based on evidence.	2.2 Aligning our services and resources to meet the changing needs of our communities.	3.2 Communicating and consulting with our staff and providing feedback, reward and recognition.	4.2 Partnering with other hospitals and community partners to provide a comprehensive and integrated range of services.	5.2 Building flexible, sustainable environments and technologies.
	1.3 Monitoring, repairing and continuously improving the quality and safety of clinical care.	2.3 Ensuring services are easy to access and navigate.	3.3 Identifying leaders and providing learning opportunities for our staff.	4.3 Embracing technologies that enhance our partnerships.	5.3 Measuring the things that matter.
	1.4 Tailoring services around the needs of a diverse population.	2.4 Ensuring access to health services for the most disadvantaged within our community.	3.4 Partnering with education and training organisations to drive research and education.	4.4 Being socially responsible and active in our community.	5.4 Living within our means minimising waste.




1 INTRODUCTION

Good health will always be valued by Australian society. Doctors, nurses, midwives, allied health professionals, clinical support staff and other care givers will always play a pivotal role in caring for people in need. However, the way we deliver the healthcare of tomorrow will be different to that of today.

The health system faces enormous challenges. Community expectations are increasing, the burden of chronic disease is increasing and the population is growing and ageing. Public health services will need to respond to these challenges. Hospitals will always have an important role to play in the management of illness and injury, acute exacerbation of chronic illness and surgical intervention of disease, however, their role in the continuum of health will shift. Rather than being the 'starting point' in a patient's journey, the hospital admission will be but one option for health services to be provided. Where possible and appropriate, services will be provided in the home and community. An important role of health services will be to ensure people have the services and support they need to remain at home – receiving care that is increasingly becoming their choice.

Eastern Health 2022 (the Plan) responds to these issues by considering the service, activity and physical profile that will be required to ensure equity of access to health services for people in Melbourne's east by providing clinical services to our community at the appropriate level and at the appropriate place.

In May 2011, during the development of the Plan, the Victorian Government released the Victorian Health Priorities Framework 2012–22: Metropolitan Health Plan which articulated the principles and priorities that will guide health service and capital planning over the next ten years within a broader, statewide context. *Eastern Health 2022* is well-aligned with this statewide framework and, importantly, ensures that Eastern Health can deliver its services in a way that makes a substantial contribution to the broader direction for health services in Victoria.

The Plan was developed over 18 months following extensive consultation within and outside Eastern Health. Figure 1a overleaf illustrates the various mechanisms used by Eastern Health to develop an evidence-based Strategic Clinical Service Plan 2012–22 – *Eastern Health 2022*.

The project to develop the Plan was overseen by a Strategic Clinical Service Plan Steering Committee with the following members:

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Executive Director, Quality, Planning & Innovation, Eastern Health

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Figure 1a – *Consultation and evidence used to develop Eastern Health 2022*

2 EXECUTIVE SUMMARY

Eastern Health is one of the largest public health services in Australia.

We provide a comprehensive range of high quality acute, sub-acute, palliative care, mental health, drug and alcohol, residential care and community health services to people and communities that are diverse in culture, age, socio-economic status, population and healthcare needs. Our role is to provide positive health experiences for people and communities in Melbourne's east. Through our efforts and our work, we make a substantial and significant contribution to the health and wellbeing of communities in Melbourne's east and we embrace this role with enthusiasm, skill and expertise.

The configuration of health services at Eastern Health has served the community and the people of Eastern Health well for many years. But times are changing and the services at Eastern Health must also change to keep up with rising community expectations, the burden of chronic disease within the community and advances being made through evidence-based practice.

The Plan is based around nine principles that articulate what Eastern Health aims to achieve through its clinical service development in the ten years to 2022. These principles are well-aligned with the principles as outlined by the Victorian Government in the Metropolitan Health Plan. They are:

	PRINCIPLES FOR *EASTERN HEALTH 2022* – THE STRATEGIC CLINICAL SERVICE PLAN 2012–22	ALIGNMENT WITH THE GUIDING PRINCIPLES WITHIN THE VICTORIAN HEALTH PRIORITIES FRAMEWORK 2012–22: METROPOLITAN HEALTH PLAN
1	Clinical services will be provided to ensure that patients have equity of access to the full range and standard of clinical services across Eastern Health	▸ Universal access and a focus on those most in need ▸ Equitable outcomes across the full continuum of health
2	Clinical services will be patient-centred	▸ Person and family-centred
3	Changes in clinical services will be based upon evidence	▸ Evidence-based decision-making ▸ Continuous improvement and innovation.
4	Clinical Services profile will be orientated to meet population-health demand and improve Eastern Health-wide 'self-sufficiency'	▸ Universal access and a focus on those most in need ▸ Local and responsive governance
5	Configuration of services will ensure that there is adequate critical mass and appropriate clinical profiles in the interests of quality and safety, teaching and research	▸ Capable and engaged workforce
6	Clinical services will be configured to enhance timely patient flow	▸ Sustainable use of resources through efficiency and effectiveness
7	Clinical services that are encountered frequently by patients will be located close to where patients live	▸ Person and family-centred
8	Services that can safely be provided in the home or in the community will be provided in the home or the community by the most appropriate health service provider	▸ Responsibility for care spans the continuum ▸ Sustainable use of resources through efficiency and effectiveness
9	Clinical services will be configured in such a way that they are sustainable and optimise utilisation of capacity across EH (financial, environmental, workforce, infrastructure, technology)	▸ Capable and engaged workforce ▸ Maximum returns on health system investments ▸ Sustainable use of resources through efficiency and effectiveness

***Figure 2b** – Clinical Service Priority Initiatives 2012-22*

CLINICAL SERVICE PRIORITY INITIATIVES 2012–22			
1	Re-orientate inpatient (bed-based) services to be provided in ambulatory settings, including home, where appropriate to do so.	11	Establish and enhance coordinated, multi-disciplinary specialty and ambulatory clinics, providing patients with a 'one-stop-service'.
2	Maximise utilisation of all Eastern Health infrastructure and align future service expansion with forecast geographical demand for public health services in the mid-section of Eastern Health's primary catchment area – specifically Yarra Ranges (Lilydale), Maroondah (Croydon) and Knox (North-East).	12	Expand and promote Advance Care Planning protocols and procedures across all Eastern Health sites.
3	Implement rapid assessment and early intervention models of care.	13	Invest in partnerships with general practitioners, community providers and Medicare Locals.
4	Adopt and implement the Eastern Health Streams of Care as a basis for Eastern Health's patient care delivery system and ensure capacity is geared to these streams appropriately.	14	Achieve Eastern Health-wide orientation of all clinical services and access points.
5	Expand Eastern Health clinical services and progress planning for facilities to meet the current and future needs of the community and ensure a minimum 70 per cent self-sufficiency rate in the areas required.	15	Develop specific strategies for targeted groups on the elective surgical waiting list to enhance preparedness for admission, improve communication, reduce functional decline and enhance quality of life while they are waiting for admission.
6	Establish models of care that are tailored to the requirements of older people within all services.	16	Orientate Eastern Health care delivery systems around the time of day and days of week that the community demonstrates it needs healthcare.
7	Consider new models for the delivery of patient-focused maternity and paediatric services that are safe and consistent across Eastern Health.	17	Develop an active research program whereby research is translated into clinical practice at Eastern Health and clinical practice is used to inform research.
8	Consider capacity and infrastructure options for planned, short cycle streams of care and chronic disease (ambulatory) streams of care where it is not possible to deliver these services in the home or community.	18	Achieve the appropriate blend of generalist and sub-specialist clinical staff to improve self-sufficiency in particular areas of clinical practice and ensure Eastern Health provides a level of service equal to or better than other services in Melbourne.
9	Explore opportunities with St Vincent's Health and other health services to ensure timely access for Eastern Health patients to tertiary services that are not within the Eastern Health service profile.	19	Respect and value diverse communities through tailored models of care.
10	Enable our health professionals to work to their full and extended scope of practice.	20	Align Clinical Support services with the clinical service profile of each hospital.

Eastern Health 2022 provides a framework that guides Eastern Health's future decision-making. *Eastern Health 2022* is fundamentally focused around 20 Clinical Service priority initiatives which are outlined below. The priority initiatives represent major pieces of work that apply right across Eastern Health Clinical Services and are primarily about continuous improvement and driving change that will ensure Eastern Health can execute its strategy and achieve tangible outcomes based upon the principles. The priority initiatives are:

In addition to these 20 priority initiatives, *Eastern Health 2022* outlines over 400 specific and targeted improvements that relate to specific clinical service groups across the organisation. These are explored in greater detail in Part B of *Eastern Health 2022*. These improvements represent the specific ways in which our clinical services will be working to achieve the overall strategic objectives of *Eastern Health 2022*.

Orientating Eastern Health's services to address the high level of growth in service demand in the middle sections of our primary catchment area is critical for ensuring equity of access – particularly for disadvantaged members of the community whose options are more limited than others. At the time of writing this Plan, there are exciting and substantial capital developments underway at Eastern Health – the Box Hill Hospital Redevelopment, the Maroondah Hospital Inpatient Ward Expansion Project and the sub-acute redevelopment at Maroondah Hospital. Even with this terrific capital expansion, *Eastern Health 2022* identifies that there will still be additional inpatient bed capacity required across Eastern Health to manage the forecast increase in activity to 2022. A high level 'map' of the future configuration of clinical services at Eastern Health is provided in section 14.2.

According to Eastern Health clinicians, the most significant advances in healthcare over the next decade will not be through advances in technology or breakthrough research, but rather in streaming of healthcare delivery systems to focus around the needs of the patient and ensuring smooth interfaces between services (or 'flow'). Redesigning the systems, processes, structure and infrastructure to make these advances possible will be critical.

Healthcare provided by Eastern Health will address the biomedical aspects of care (dealing with abnormalities of body function and structure and activity limitations) and the bio-psychosocial aspects of care (dealing with personal care participation restrictions, environmental factors and personal factors that collectively influence quality of life).

Historically, the predominant need in health care has been for the treatment of acute disease, but nearly ten percent of hospital admissions are avoidable. (5). Most health care today and in the foreseeable future concerns the management of chronic health conditions, which have intermittent exacerbations. Health services that are now typically provided in hospital will be provided by Eastern Health in the home and community. Hospital admissions at Eastern Health will increasingly becoming 'planned' episodes of disease management.

In October 2011, Eastern Health implemented new and streamlined processes for Ambulatory and Community Services. Wherever possible, patients are cared for in their own homes which reduces the risk of injury due to falls in an unfamiliar environment or acquiring a hospital infection. Research shows that outcomes for patients cared for at home are similar to those for hospitalised patients but without the inherent risks of being in hospital and with a much higher level of patient satisfaction. This is an important direction for Eastern Health as it cares for an increasing number of older people in its catchment area.

People living in the east who are over 70 years of age will be the most frequent users of our service by 2022. In 2009–10, Eastern Health admitted almost 30,000 people over the age of 70 years (excluding dialysis) and each patient stayed, on average, over 3 days longer in hospital than those aged under 70 years of age. Whilst the number of patients over 70 years of age represented 27 per cent of all patients, they represented 45 per cent of all inpatient 'bed days' or days spent in hospital. It is imperative that elder-friendly services and environments permeate throughout the breadth and depth of Eastern Health.

3 BACKGROUND

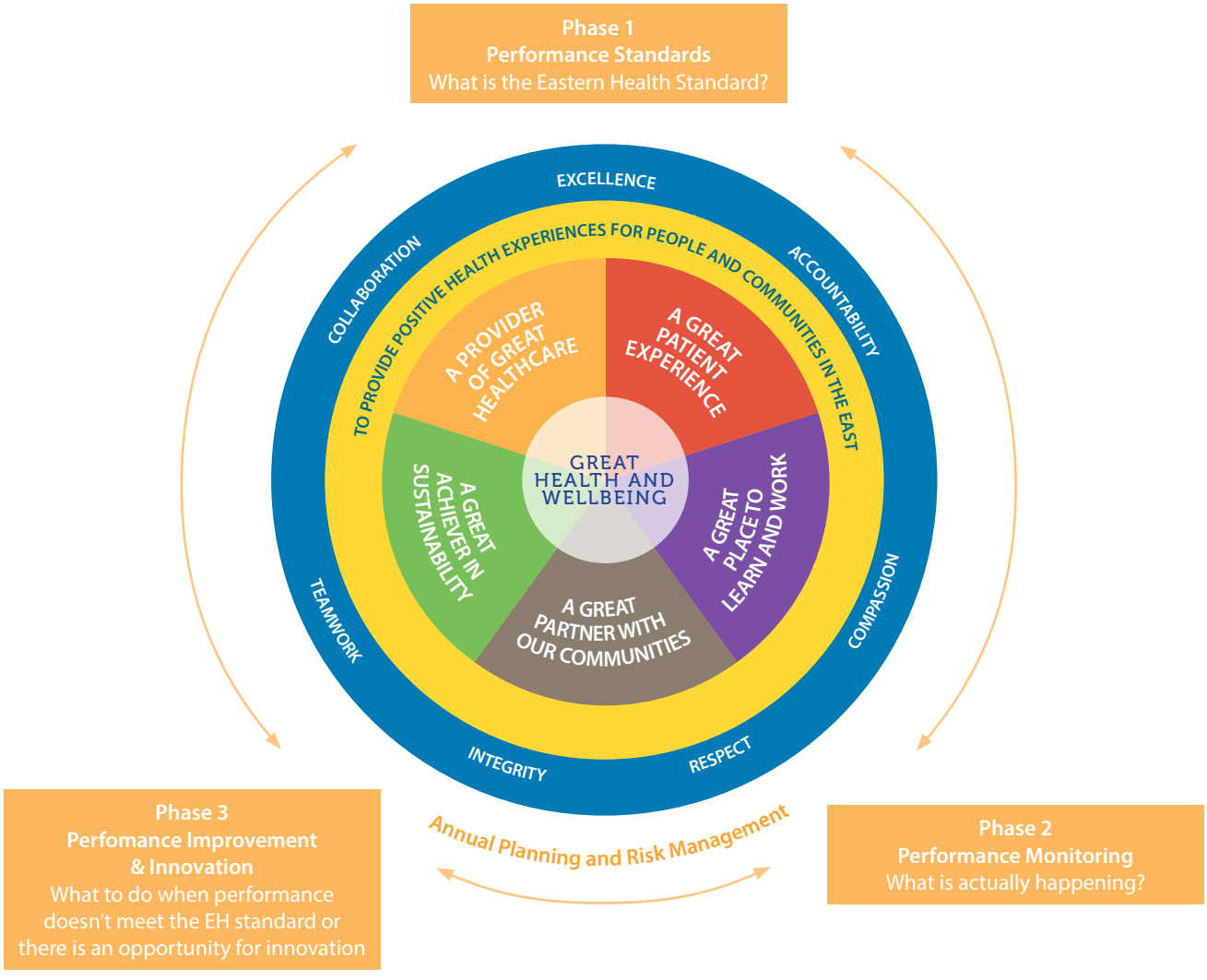
Eastern Health provides a comprehensive range of high quality acute, sub-acute, palliative care, mental health, drug and alcohol, residential care and community health services to people and communities that are diverse in culture, age, socioeconomic status, population and healthcare needs.

We deliver clinical services to more than 750,000 people through seven clinical programs from more than 29 different locations. Our services are located across 2800 square kilometres in the east – the largest geographical catchment area of any metropolitan health service in Victoria. We employ over 8300 people, deliver more than 800,000 episodes of patient care each year and manage a budget approaching $760m per year. We aspire to be GREAT in everything that we do.

We focus extensively on continuously building a high quality health care system for the people we serve and through which we can also attract and retain the best staff. We have an active education and research focus and strong affiliations with some of Australia's top universities and educational institutions. As a progressive, responsive and innovative health service, we demonstrate our commitment to excellence through external accreditation with the Australian Council on Healthcare Standards.

The primary objective of *Eastern Health 2022* is to recommend the future service profile of Eastern Health Programs and Clinical Services, at site and Eastern Health-wide levels, to best meet the needs of Eastern Health's communities over the next ten years and improve equity of access to Eastern Health services.

Figure 3a – Eastern Health Performance Excellence Framework

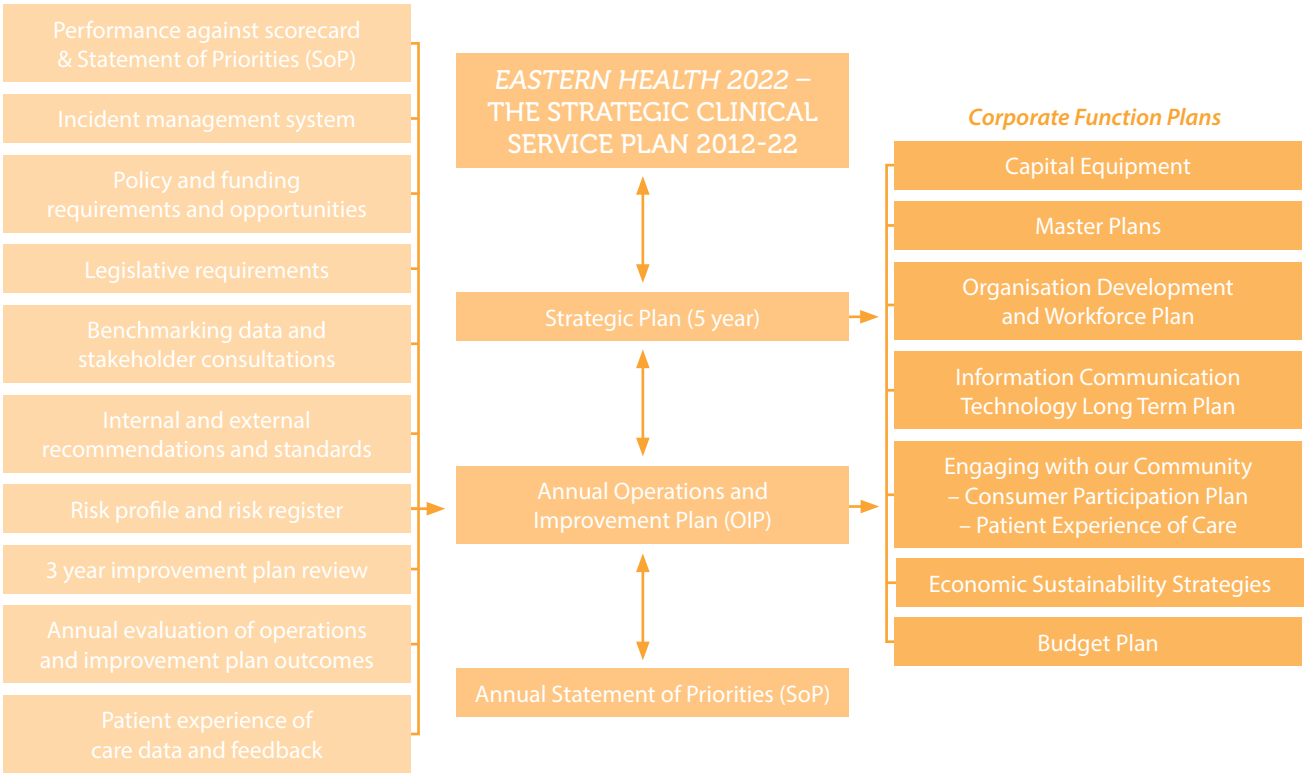


The scoping and development of the Plan was identified as a priority for the organisation in 2010–12 and goes directly to Eastern Health's Strategic goal of 'aligning our services and resources to meet the changing needs of our communities'.

Eastern Health 2022 will inform the Eastern Health Workforce Plan and a series of Master Planning projects that will be undertaken at the larger Eastern Health sites. To enable a comprehensive, longer term perspective on clinical service planning that will inform site master planning and capital investment, *Eastern Health 2022* was developed with a ten-year horizon for the period 2012–2022.

Figures 3a and 3b illustrate where *Eastern Health 2022* fits within Eastern Health's overall Performance Excellence Framework and Planning Framework. *Eastern Health 2022* is a major statement of the 'standards' Eastern Health expects and significantly influences and informs Eastern Health direction.

***Figure 3b** – Eastern Health Planning Framework*



4 THE EXTERNAL CONTEXT

Eastern Health 2022 has been developed within the context of a number of 'big picture' challenges that we face now and in the future.

These challenges were identified through research, consultation with our clinical staff and a review of clinical service plans and strategic plans at other health services in Victoria and Australia. The challenges include:

Population

Meeting the needs of an ageing population in the east, where the number of those who are over 70 years of age is growing more quickly than the rest of Melbourne. Forecast population changes in other parts of Melbourne will also have an affect on Eastern Health which manages some aspects of demand by referring patients to other health services.

Distribution of demand

Demand for public health services are not distributed equally throughout the 2800 square kilometres of Eastern Health's primary catchment area. The challenge is to align services and resources to manage a projected increased demand for public health services – particularly in the areas of Yarra Ranges, Maroondah and Knox – to improve self-sufficiency and ensure that health services are positioned where they are needed most.

Changes in disease patterns

Chronic conditions such as diabetes, heart disease, respiratory disease, obesity, dementia and mental illness are rising and now account for over two-thirds of avoidable hospitalisations. The incidence of chronic disease also increases as the population ages – a major challenge in the eastern metropolitan region.

Persistent health gaps

Inequities in health are evident in the eastern metropolitan region. The outer east areas of Eastern Health's primary catchment areas have high numbers of aboriginal people and socioeconomically disadvantaged groups which are the most severely affected and are most likely to be overweight, smoke, develop chronic illness and disability, be hospitalised for avoidable conditions and die prematurely.

Changes in the way health is delivered

There is a shift from hospital-based to more ambulatory and community-based health care. People are better informed, expect more access to services locally and increasingly want to participate in their own chronic care and that of their families. The role of Emergency Departments has changed in line with community expectations. Rather than continuing to operate the same way, a challenge exists to redesign people's experience with this 'first point of call'.

Advancing technology

Operating within our means in an industry where change and technological advancement is rapid, essential and expected. There are challenges in acquiring costly equipment and drugs to ensure that Eastern Health remains a leading health service and complacency in this area can quickly impact referral patterns.

Workforce

Finding new, innovative ways of learning and working to ensure we can attract and retain highly skilled, capable staff in an environment where there is a national healthcare workforce shortage, our workforce is ageing and there is increased globalisation (and mobilisation) of the health workforce. Role substitution will become increasingly important and there will be emergence of roles that haven't even been 'invented' yet.

Environment

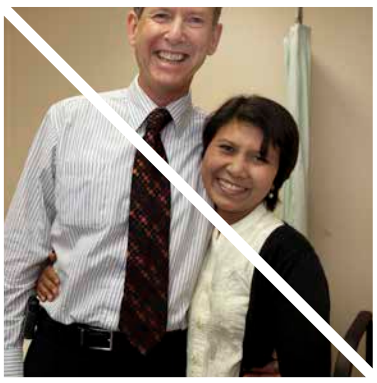
Climate change and environmental consequences of this such as bushfire, flood and water scarcity also impact health directly and indirectly. There is mounting evidence and support for all industries to use 'clean' energy, reduce energy consumption, be environmentally sustainable and be good corporate citizens.

Cost Escalation

Health care spending in Australia is growing in excess of the economy generally with most of this attributable to population, the burden of chronic disease and technology.

Government policy

Uncertainty around the further establishment and level of Government involvement in national health reforms, including Medicare Locals, Local Healthcare Networks, National Health Performance Authority, other initiatives of the National Health and Hospitals Reform Agenda and changes associated with the national Private Health Insurance Rebate.



5 POLICY CONTEXT

Eastern Health 2022 has been developed to ensure consistency with the state and national Government policy frameworks.

The following four government policy frameworks provide the primary reference points for the Plan, however there are numerous other policies that have also influenced Eastern Health's direction for particular clinical services. Details of these other government policies are contained in Appendix 1.

5.1 VICTORIAN HEALTH PRIORITIES FRAMEWORK 2012 – 2022: METROPOLITAN HEALTH PLAN

The Victorian Health Priorities Framework 2012 – 2022: Metropolitan Health Plan was released by the Department of Health in May 2011. A companion Metropolitan Health Plan – Technical Paper provides the essential data and analysis to inform implementation of these planning priorities in metropolitan Melbourne.

The seven priority areas for metropolitan, rural and regional and health capital planning into the future are:

1. Developing a system that is responsive to people's needs
2. Improving every Victorian's health status and experiences
3. Expanding service, workforce and system capacity
4. Increasing the system's financial sustainability and productivity
5. Implementing continuous improvements and innovation
6. Increasing accountability and transparency
7. Utilising e-health and communications technology

These are also aligned with ten guiding principles:

1. Universal access and a focus on those most in need
2. Equitable outcomes across the full continuum of health
3. Person and family-centred
4. Evidence-based decision-making
5. Capable and engaged workforce
6. Responsibility for care spans the continuum
7. Maximum returns on health system investments
8. Sustainable use of resources through efficiency and effectiveness
9. Continuous improvement and innovation
10. Local and responsive governance

By 2022, Victoria's health system should be:

A. Responsive to people's needs (People-focused) with the following outcomes:
   - People are as healthy as they can be (optimal health status).
   - People are managing their own health better.
   - People enjoy the best possible health care service outcomes.

B. Rigorously informed and informative (knowledge-focused) with the following outcomes:
   - Care is clinically effective and cost-effective and delivered in the most clinically effective and cost-effective service settings.
   - The health system is highly productive and health services are cost-effective and affordable.

In terms of the particular focus on communities in the east, the following are extracts from the Metropolitan Health Plan – Technical Paper (2011) relating to the Inner and Outer East regions of Melbourne.

Inner East

"It is noted that the Inner East planning area is well served with health services and facilities. It comprises relatively advantaged areas, with good health outcomes, generally above Victorian levels on health indicators measured in VPHS. While well served with health services, residents of the Inner East are relatively mobile and receive 43 per cent of their health care from areas outside the Inner East planning area. The projected population growth to 2022 is the second lowest of all the planning areas."

Outer East

"Self-sufficiency is relatively high despite the lack of a major hospital within the planning area. This may have to do with the distance and the time it takes to travel to large hospitals outside the planning area. In percentage terms, the Outer East area has the smallest growth to 2022. Given the current service availability and fair health status of residents, current facilities are likely to be suitable into the future."

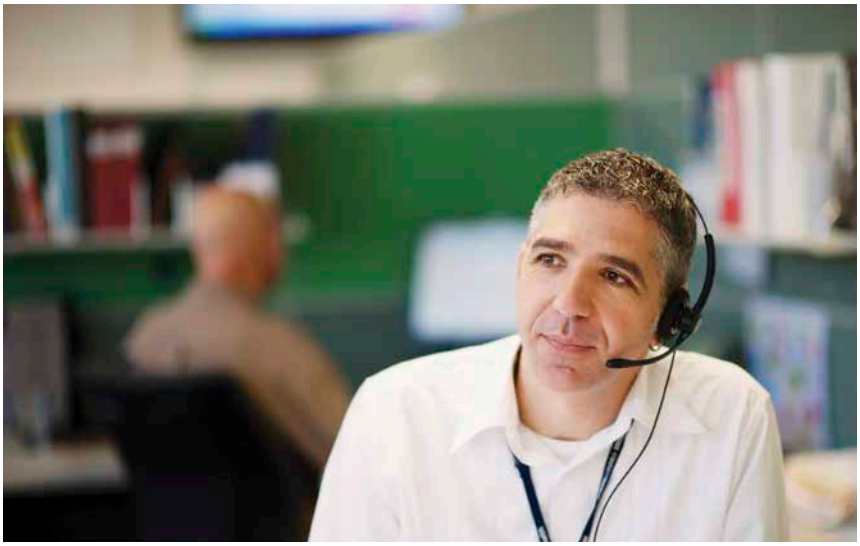
Eastern Health must consider the challenges that exist to manage very high increases in forecast population and health service demand in the broader Victorian context and design its Plan to consider this broader environmental context over the ten years to 2022.

5.2 MELBOURNE 2030 AND MELBOURNE @ 5 MILLION

Released in 2002, Melbourne 2030 provides a long-term plan for Melbourne and the surrounding region. *Melbourne @ 5 million* provides policy initiatives that are complementary to the directions of Melbourne 2030 and the two documents should be considered together.

Melbourne @ 5 million outlines the implications of the *Victoria in Future 2008* growth projections for Melbourne, which indicate that the city's population is likely to reach 5 million before 2030. Actively managing this growth and change is an important part of Melbourne's future liveability.

The Melbourne 2030 policy identifies a number of "Principal Activity Centres" and as such, outlines planning guidelines to develop these centres into major hubs of community services, transport, retail, commercial and government services. The Principal Activity Centres are major Victorian Government initiatives being delivered by the Victorian Department of Sustainability and Environment and are designed to create safe, vibrant and accessible communities. They will help link people to services, to opportunities and to each other by locating activities and development around public transport.



5.3 NATIONAL HEALTH AND HOSPITALS NETWORK AGREEMENT

On 13 February 2011, the Council of Australian Governments (COAG) agreed to sign the National Health and Hospitals Network Agreement with the Federal Government. The objective of the Agreement is to improve health outcomes and the sustainability of the Australian health system.

The Agreement sets out the architecture and foundations of the National Health and Hospitals Network, which will deliver five major structural reforms to establish the foundations of Australia's future health system in the areas listed below:

1. Public hospitals and Local Hospital Networks (LHNs)
2. Primary health care and Primary Health Care Organisations
3. Financing
4. Performance and Accountability Framework
5. National governance

The reform of Australia's health and hospital system includes:

- Improving our hospitals
- A greater focus on primary health care
- Training more doctors, nurses and allied health professionals
- Supporting aged care
- Investing in prevention
- Helping those with mental illness
- Modernising our health system

Elective surgery: National Access Guarantee and Targets

Under the Agreement, the Government will improve access to elective surgery in public hospitals by fast-tracking elective surgery for patients who have waited longer than clinically-recommended times under a new National Access Guarantee and establishing new access targets for elective surgery. States and territories will work with patients, clinicians and Local Hospital Networks to offer surgery to patients, either within Local Hospitals Networks, through another Local Hospital Network, or at a private hospital, at the state's expense.

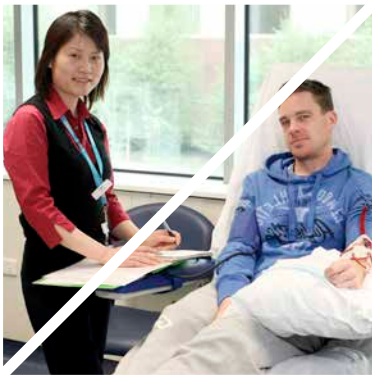
The Government will improve access to elective surgery in public hospitals by:

- Fast-tracking elective surgery for patients who have waited longer than clinically recommended times under a new National Access Guarantee, started in 2012
- Establishing new access targets for elective surgery. By December 2014, 95 per cent of patients waiting for surgery in Category 1 or Category 2 will be treated within clinically recommended times. The 95 per cent target will be extended to patients waiting for elective surgery in Category 3 by December 2015
- Providing hospitals with financial rewards, including $650 million to meet these new demands. The funding will provide the equivalent of 90,000 extra elective surgeries across Australia.

5.4 A HEALTHIER FUTURE FOR ALL AUSTRALIANS

The Final Report of the National Health and Hospitals Reform Commission, A Healthier Future for all Australians was released in July 2009 by the Commonwealth Government. The objective was to report on long term reform of the Australian Health Care System. This report emphasises four strategic reform themes:

- Taking responsibility – Individual and collective action to build good health and well-being – by people, families, communities, health professionals, employers, health funders and governments
- Connecting care – Comprehensive care for people over their lifetime
- Facing Inequities – Recognise and tackle the causes and impacts of health inequities
- Driving quality performance – Leadership and systems to achieve best use of people, resources and evolving knowledge.



6 EASTERN HEALTH ORGANISATIONAL PROFILE

Eastern Health is organised into eight directorates which are defined by clinical programs and corporate functions that run across the health service as illustrated in Figure 6a below.

The structure was implemented in February 2010 and later modified in April 2011 and August 2012 to integrate ambulatory and community health and establish a Statewide Services Program respectively. The structure supports the integration of clinical programs and corporate functions across all Eastern Health facilities.

Eastern Health 2022 identified that the full range of clinical services which are required over the next decade can be managed within Eastern Health's existing organisational profile.

***Figure 6a** – Eastern Health Organisational Profile*

FIGURE 6a

CLINICAL DIRECTORATE	PROGRAM	LARGER SITES	CORPORATE AND CLINICAL SUPPORT DIRECTORATES
Acute Health	Emergency and General Medicine Women & Children's Specialty Medicine Surgery	Angliss Hospital Box Hill Hospital Healesville & District Hospital Maroondah Hospital Peter James Centre Wantirna Health Yarra Ranges Health Yarra Valley Community Health	Corporate Projects & Sustainability Finance, Procurement and Information Services Quality, Planning and Innovation Human Resources, Fundraising and Community Relations Nursing, Access and Patient Support Services Medical Services and Research
Continuing Care, Community and Mental Health	Continuing Care Mental Health State-wide Services Ambulatory and Community Services		

7 THE CURRENT EASTERN HEALTH CLINICAL SERVICE PROFILE

In 2012, within the two Eastern Health Clinical Directorates, there are eight Clinical Programs and 42 Clinical Service Groups.

DIRECTORATE	CLINICAL PROGRAM	CLINICAL SERVICE GROUP	CLINICAL SUPPORT
Acute Health	Emergency and General Medicine	1. General Medicine 2. Emergency Services 3. Intensive Care Services	**Clinical Support Services** (Including, but not limited to Pathology, Medical Imaging, Pharmacy, Allied Health, Anaesthetics, Biomedical Engineering, Health Information Services, etc.)
	Women & Children's	4. Gynaecology 5. Maternity Services 6. Neonatology 7. Paediatric Services (includes Paediatric Medicine, Paediatric Surgery)	
	Specialty Medicine	8. Cardiology (includes invasive cardiology) 9. Dermatology 10. Endocrinology 11. Endoscopy services 12. Gastroenterology 13. Haematology 14. Infectious Diseases 15. Neurology (includes Acute Stroke and Multiple Sclerosis Services) 16. Oncology, Chemotherapy and Radiotherapy 17. Renal Medicine and Dialysis 18. Respiratory Medicine 19. Rheumatology	
	Surgery	20. Breast & Endocrine Surgery 21. Colorectal Surgery 22. Ear, Nose & Throat Surgery 23. General Surgery 24. Ophthalmology 25. Orthopaedic Surgery 26. Plastic Surgery 27. Thoracic Surgery 28. Upper Gastro-Intestinal Surgery (includes Bariatric Surgery) 29. Urology 30. Vascular Surgery	
Continuing care, community and mental health	Mental Health	31. Adult Mental Health 32. Acute Aged Persons' Mental Health 33. Child and Youth Mental Health Service (CYMHS)	
	Continuing Care	34. Geriatric evaluation and management 35. Residential Aged Care 36. Palliative Care 37. Rehabilitation	
	Ambulatory & Community Services	38. Ambulatory Services 39. Transition Care Program (TCP) 40. Community Health	
	State-wide Services	41. Turning Point, Alcohol and Other Drugs 42. Spectrum (state wide service for people who have personality disorders)	

8 PRIMARY AND SECONDARY CATCHMENT PROFILE

Eastern Health's primary catchment area is defined as the group of Statistical Local Areas (SLAs) for which Eastern Health treats the greatest number of public admitted patients of any public health service.

The secondary catchment area is defined as the group of SLAs for which Eastern Health treats the second greatest number of public admitted patients of any public health service. There are slight differences in the catchments of Eastern Health's Mental Health Programs. These relate to the outer margins of our primary catchment, as defined here. For the purposes of this Plan, unless otherwise specified, the primary and secondary catchments as defined here will be applied. Eastern Health's primary and secondary catchments include Melbourne SLAs as detailed in Figure 8a below.

***Figure 8a** – Eastern Health's primary and secondary catchments*
***Source** – Department of Health Victoria 2012*

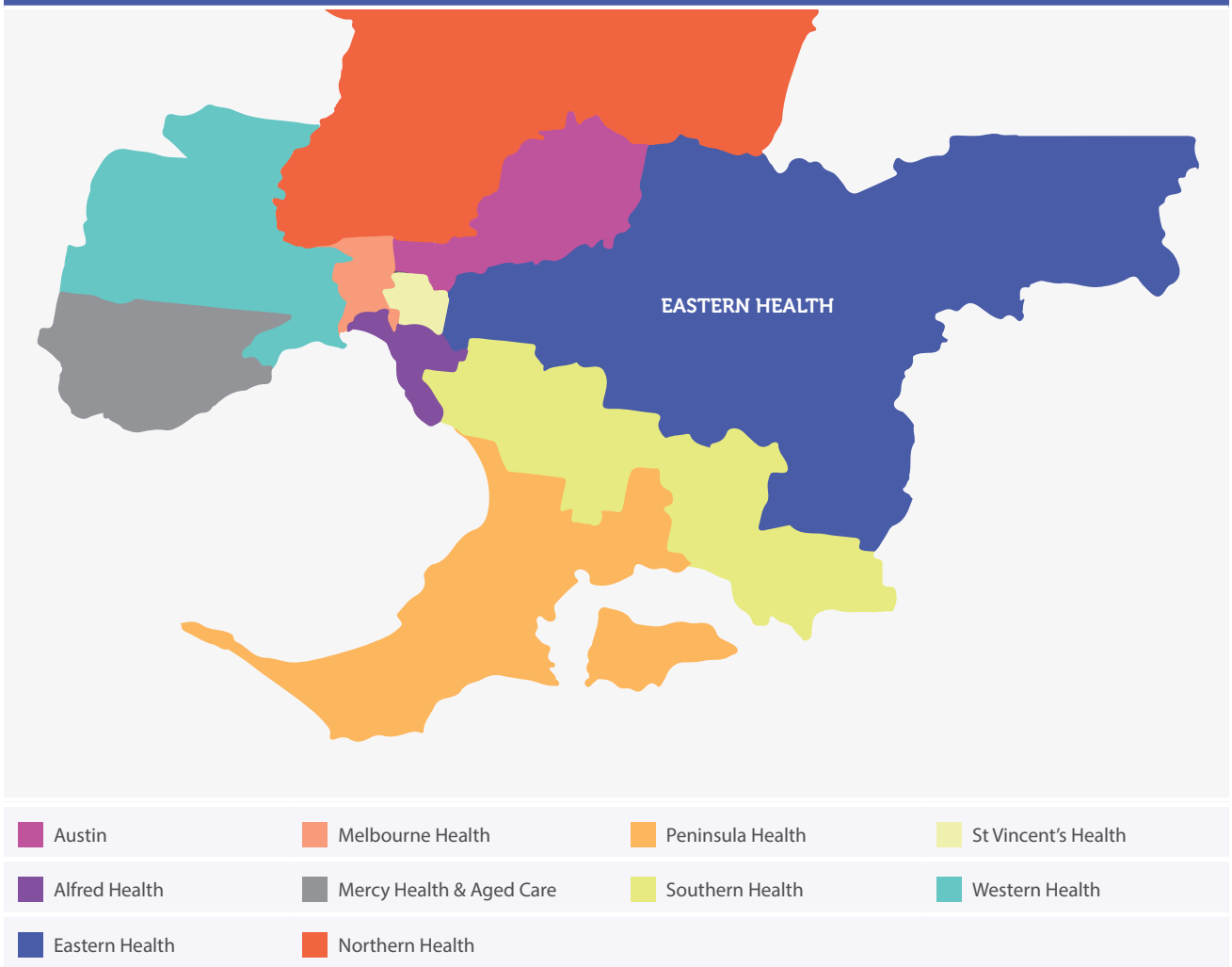
PRIMARY CATCHMENT AREA	KM²	SECONDARY CATCHMENT AREA	KM²
Boroondara (C) – Camberwell N.	17.4	Boroondara (C) – Hawthorn	9.9
Boroondara (C) – Camberwell S.	18.2	Boroondara (C) – Kew	14.5
Knox (C) – North-East	40.4	Cardinia (S) – North	713.9
Knox (C) – North-West	31.2	Knox (C) – South	42.2
Manningham (C) – East	58.0	Monash (C) – Waverley East	27.9
Manningham (C) – West	55.5	Monash (C) – Waverley West	32.1
Maroondah (C) – Croydon	37.9	Murrindindi (S) – East	2,222.1
Maroondah (C) – Ringwood	23.5	Murrindindi (S) – West	1,650.6
Whitehorse (C) – Box Hill	21.6	Nillumbik (S) – South	65.8
Whitehorse (C) – Nunawading E.	21.4		
Whitehorse (C) – Nunawading W.	21.2		
Yarra Ranges (S) – Central	421.8		
Yarra Ranges (S) – North	386.9		
Yarra Ranges – Dandenongs	147.2		
Yarra Ranges – Lilydale	102.8		
Yarra Ranges – Seville	273.6		
Yarra Ranges (S) – Pt B	1,137.5		
Total(s)	**2,816.1**		**4,779.0**

In 2008-09, 82 per cent of Eastern Health's admissions to hospital related to patients who lived within Eastern Health's primary catchment area and a further ten per cent related to patients who lived within its secondary catchment area. This supports Eastern Health's mission 'to provide positive health experiences for people and communities in the east' and confirms that it is a health service which predominantly serves communities in Melbourne's east.

Figure 8b illustrates that Eastern Health's primary catchment area is geographically the largest of any public health service in Melbourne.

Figure 8b – *Melbourne Metropolitan Primary Catchment Areas*
Source – *Department of Health Victoria 2008*

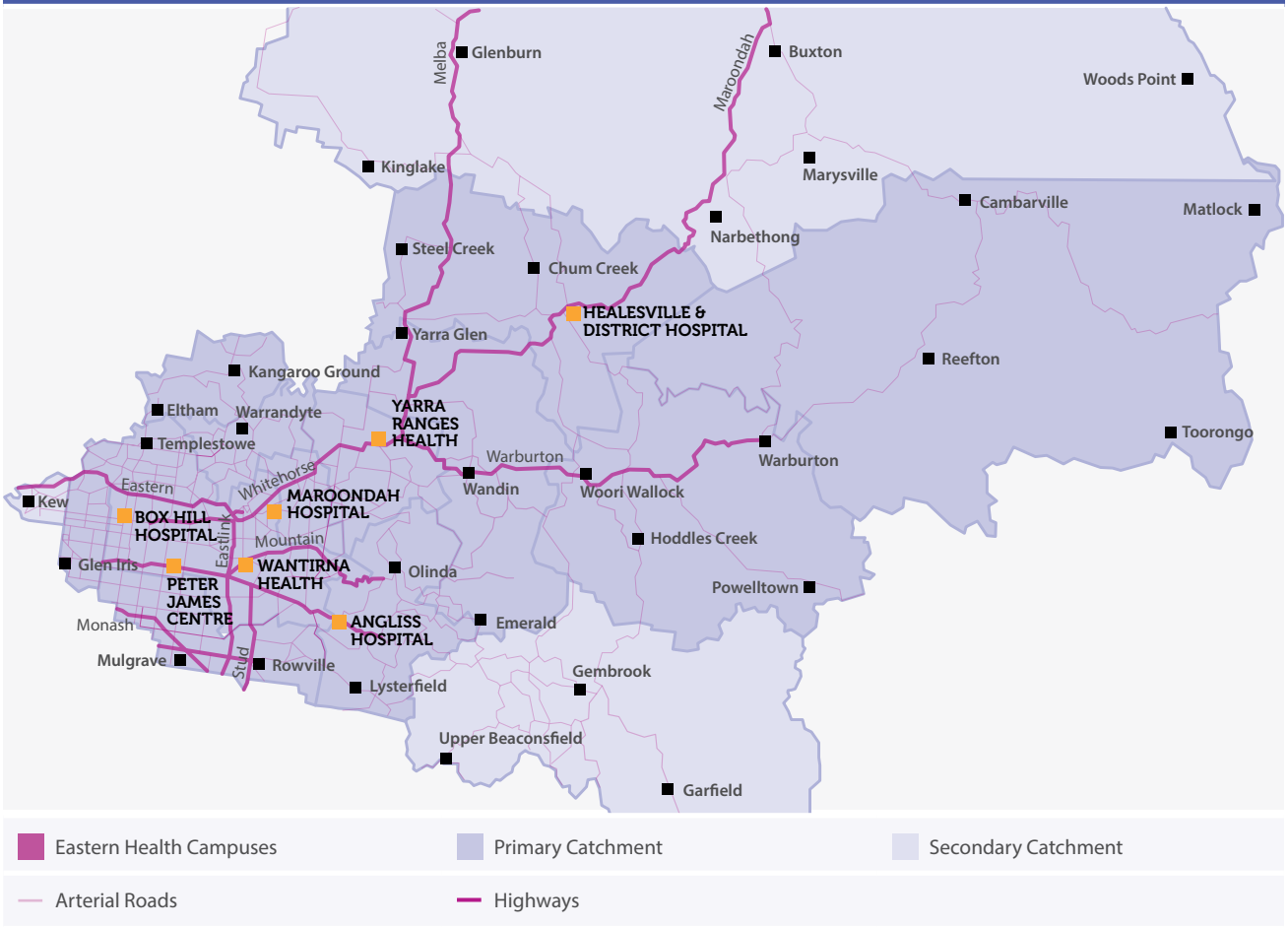
FIGURE 8b



Eastern Health's main facilities and the primary and secondary catchment areas are illustrated in figure 8c. The primary catchment stretches from Glen Iris in the inner east to the outer eastern township of Matlock. In addition to its seven larger sites, Eastern Health occupies over 60 locations across the Eastern metropolitan area, consisting of community-based mental health services, community health services and residential care. These services are detailed in the Eastern Health Sites and Services Profile within Appendix 1.

Figure 8c – *Eastern Health's main facilities, primary and secondary catchment area*
Source – *Department of Health Victoria 2010*

FIGURE 8c



9 DEMOGRAPHIC POPULATION ANALYSIS

9.1 POPULATION FORECASTS FOR EASTERN HEALTH'S PRIMARY CATCHMENT AREA

Figure 9.1a illustrates that the population in Eastern Health's primary catchment area is expected to grow at a lower rate (5.8%) than that of Victoria (15.6%) in the period 2011 – 2021.

Figure 9.1a – *Eastern Health primary catchment area forecast population growth to 2021*
Source – *Department of Planning & Community Development, Victoria in Future (VIF) 2012*

FIGURE 9.1a

STATISTICAL LOCAL AREA	POPULATION 2011	FORECAST POPULATION 2021	FORECAST POPULATION CHANGE 2011 TO 2021 (NO.)	FORECAST POPULATION CHANGE 2011 TO 2021 (%)
Boroondara (C) - Camberwell N.	47,104	48,863	1,759	3.7%
Boroondara (C) - Camberwell S.	53,993	55,379	1,386	2.6%
Knox (C) - North-East	66,871	70,097	3,226	4.8%
Knox (C) - North-West	47,259	50,714	3,455	7.3%
Manningham (C) - East	16,254	16,803	549	3.4%
Manningham (C) - West	103,185	111,089	7,904	7.7%
Maroondah (C) - Croydon	62,516	68,073	5,557	8.9%
Maroondah (C) - Ringwood	44,793	49,005	4,212	9.4%
Whitehorse (C) - Box Hill	56,168	61,181	5,013	8.9%
Whitehorse (C) - Nunawading E.	47,528	48,992	1,464	3.1%
Whitehorse (C) - Nunawading W.	53,731	54,855	1,124	2.1%
Yarra Ranges (S) - Central	15,697	16,086	389	2.5%
Yarra Ranges (S) - Dandenongs	30,746	32,003	1,257	4.1%
Yarra Ranges (S) - Lilydale	73,527	77,863	4,336	5.9%
Yarra Ranges (S) - North	13,695	14,713	1,018	7.4%
Yarra Ranges (S) - Seville	16,319	16,795	476	2.9%
Yarra Ranges (S) - Pt B	618	630	12	1.9%
TOTAL	**750,005 (13% of all Victoria)**	**793,140 (12% of all Victoria)**	**43,137 (5% of all Victoria)**	**5.8%**
Victoria	**5,621,210**	**6,500,653**	**879,443**	**15.6%**

9.2 POPULATION FORECASTS FOR EASTERN HEALTH'S SECONDARY CATCHMENT AREA

Figure 9.2a illustrates that the population in Eastern Health's secondary catchment area is also expected to grow at a lower rate (6.5%) than that of Victoria (15.6%) to 2021.

Figure 9.2a – *Eastern Health's secondary catchment area forecast population growth to 2021*
Source – *Department of Planning & Community Development, Victoria in Future (VIF) 2012*

FIGURE 9.2a

STATISTICAL LOCAL AREA	POPULATION 2011	FORECAST POPULATION 2021	FORECAST POPULATION CHANGE 2011 TO 2021 (NO.)	FORECAST POPULATION CHANGE 2006 TO 2021 (%)
Boroondara (C) - Hawthorn	37,656	42,856	568	2.0%
Boroondara (C) - Kew	31,686	33,274	5,200	13.8%
Cardinia (S) - North	25,969	27,218	1,588	5.0%
Knox (C) - South	42,958	44,846	2,581	4.3%
Monash (C) – Waverley East	60,717	63,298	3,757	5.4%
Monash (C) – Waverley West	69,465	73,222	1,888	4.4%
Murrindindi (S) – East	6,292	7,236	1,749	6.7%
Murrindindi (S) – West	7,349	9,262	944	15.0%
Nillumbik (S) - South	28,693	29,261	1,913	26.0%
TOTAL	**310,785**	**330,974**	**20,189**	**6.5%**
Victoria	**5,621,210**	**6,500,653**	**879,443**	**15.6%**

9.3 OUR AGEING POPULATION

Australia's ageing population affects us all. The median age of the population has been rising for 40 years owing to a long-term decrease in fertility. The leading edge of the "baby boomers", born in 1946, reached the age of 66 in 2012 and are either already retired or will retire soon. At the same time, our population aged 65-84 is increasing as is the number of people aged 85 and over who have an increased reliance on care and support services. (1).

Most areas within Eastern Health's primary catchment experience a higher median age than the national average. The outer eastern catchment, which includes Maroondah, Yarra Ranges and Knox, is expected to experience a higher growth in older persons than metropolitan Melbourne and Victoria. (2).

As illustrated in Figure 9.3a below, the changes associated with the ageing population are more pronounced in Eastern Health's primary catchment area than the rest of Victoria. While the rest of the state will experience a fairly normal distribution in growth across all age groups, all of Eastern Heath's growth will be aged over 50. While Eastern Health's primary catchment will always have young people, the forecast demographic changes to 2021 will see a net decrease in the number of people aged less than 50 and a substantial rise in the number of people over 50.

Figure 9.3a – *Current and forecast age distribution, Eastern Health primary catchment area and Victoria*
Source – *Department of Planning & Community Development, Victoria in Future (VIF) 2012*

FIGURE 9.3a

AGE GROUP	EASTERN HEALTH PRIMARY CATCHMENT						VICTORIA				
	Population 2011	Population within age group 2011 (%)	Forecast population 2021	Forecast population change 2011 to 2021	Forecast population change 2011 to 2021 (%)	Proportion of population change within age group by 2021 (%)	Population 2011	Forecast population 2021	Forecast population change 2011 to 2021	Forecast population change 2011 to 2021 (%)	Proportion of population change within age group by 2021
0-9	88,043	11%	85,506	-2,537	-3%	-6%	691,582	783,433	91,851	13%	10%
10-19	95,085	12%	97,066	1,981	2%	5%	698,087	758,884	60,797	9%	7%
20-29	103,969	13%	103,021	-948	-1%	-2%	854,373	903,465	49,092	6%	6%
30-39	96,627	12%	104,519	7,892	8%	18%	802,865	982,541	179,676	22%	20%
40-49	108,534	14%	101,654	-6,880	-6%	-16%	790,731	843,610	52,879	7%	6%
50-59	99,649	12%	101,489	1,840	2%	4%	697,598	782,693	85,095	12%	10%
60-69	78,793	10%	87,681	8,888	11%	21%	537,065	671,944	134,879	25%	15%
70-79	46,379	6%	69,079	22,700	49%	53%	326,720	486,193	159,473	49%	18%
>80	32,925	4%	43,125	10,200	31%	24%	222,189	287,889	65,700	30%	7%

Older people generally need more health services than younger people. Figure 9.3b illustrates that, in 2007, members of Eastern Health's community aged 70 and older required almost four times the number of hospital admissions as those aged 69 and younger. The demand for hospital admission increases as the population ages. Also, the overall demand for Eastern Health hospital admission, within every age group, increased in the four years to 2007 and this trend is forecast to continue up to 2022.

9.4 GROWTH IN DEMAND FOR HOSPITAL ADMISSION ACROSS PRIMARY CATCHMENT AREA

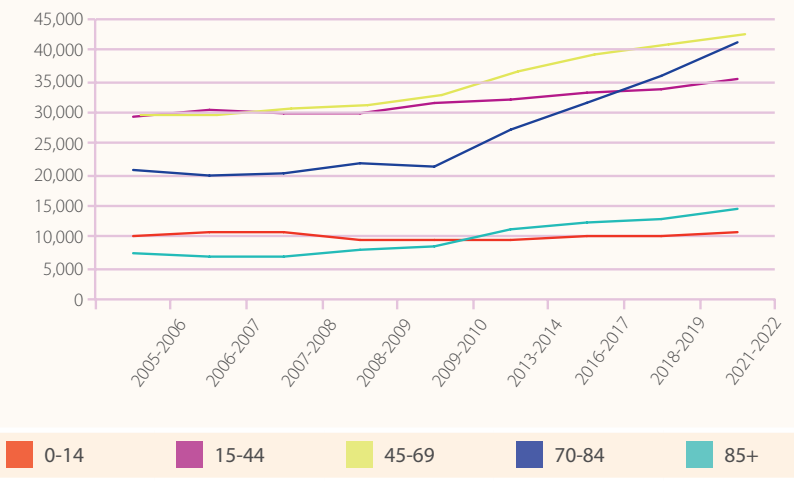
The projected increase in population, together with the marked ageing of the population in Eastern Health's primary catchment area, means that Eastern Health is expected to experience a 42 per cent increase in hospital admissions between 2008-09 and 2021-22. As Figure 9.4a illustrates, this growth will primarily relate to patients older than 70 years.

Figure 9.3b – *Eastern Health rate of inpatient admission by age grouping, actual and forecast*
Source – *Department of Health Inpatient Forecast model (2010) & Australian Bureau of Statistics Census (2001, 2006 & 2011)*

FIGURE 9.3b	0-44	45-69	70-84	85+
2003				
Eastern Health admitted patients ('000)	38.2	30.4	21.9	6.6
Primary catchment population ('000)	437.3	206.3	56.6	12.0
Ratio (EH admissions per 1,000 residents)	87.4	147.4	386.9	553.4
2007				
Eastern Health admitted Patients ('000)	42.1	36.0	26.4	7.9
Primary catchment population ('000)	433.4	216.3	58.3	13.3
Ratio (EH admissions per 1,000 residents)	97.0	166.0	453.0	589.0
2022 (Forecast)				
Eastern Health admitted Patients ('000)	45.7	42.8	41.3	14.3
Primary catchment population ('000)	439.4	241.5	89.8	22.4
Ratio (EH admissions per 1,000 residents)	104.0	177.2	460.0	638.4

Figure 9.4a – *Eastern Health Projected Hospital Admissions by Age Group 2005-06 to 2021-22 (Excluding Dialysis)*
Adapted from – *Department of Human Services Inpatient Forecast Model (2010)*

FIGURE 9.4a

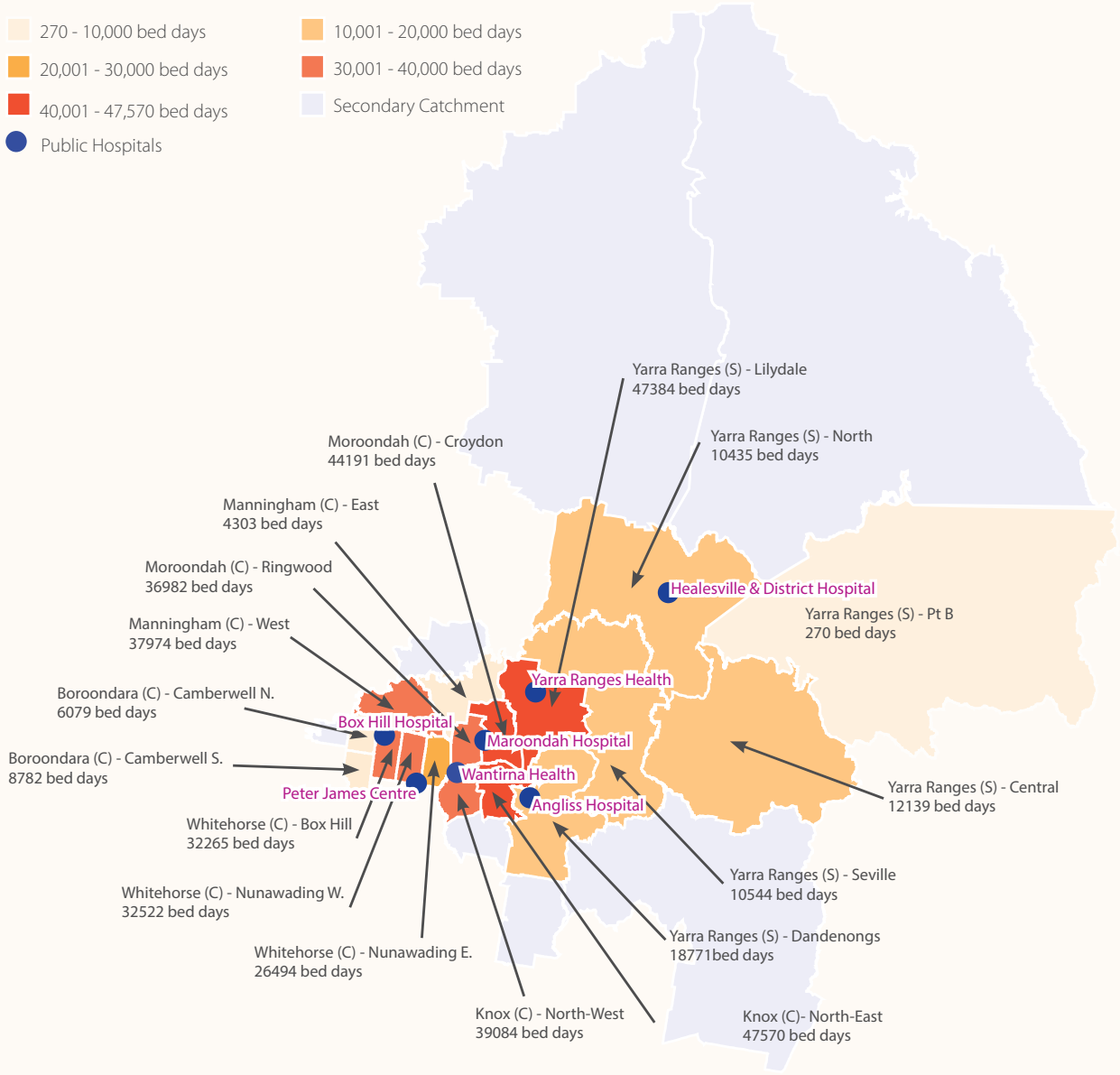


As Figure 9.4b illustrates, the demand for health services for the statistical local areas (SLAs) within Eastern Health's primary catchment area are not expected to grow at the same rate. Population change and the distribution of age groups do not occur in a geographically even manner. As the economy and society change, some areas are favoured more than others and people take advantage of new opportunities by moving into these areas. (1)

Forecast demand for public hospital bed days are highest overall in the mid-section of Eastern Health's primary catchment area – specifically Yarra Ranges (Lilydale), Maroondah (Croydon) and Knox (north-east). Even when controlled for the size and population density within each SLAs, these areas remain the highest in terms of forecast demand, as illustrated by Figure 9.4c.

Figure 9.4b – *Forecast Eastern Health bed days by 2021-22 by geographical SLA*
Adapted from – *Department of Health Public Hospital Admitted Patient Activity Projections 2008-09 to 2021-22*

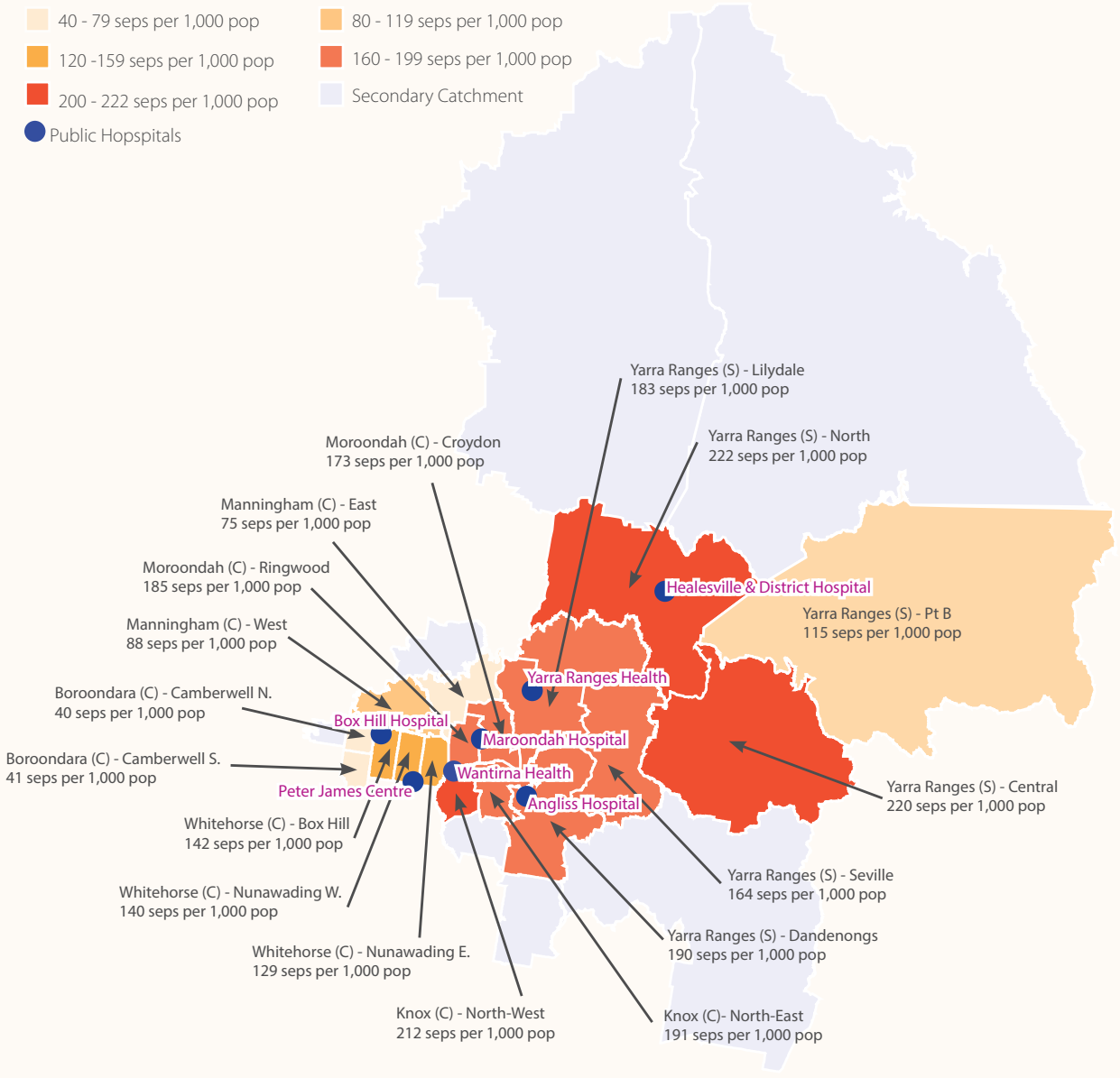
FIGURE 9.4b



It is clear that Eastern Health needs to plan for continued increased demand for services, particularly in the Yarra Ranges, Maroondah and Knox areas and work collaboratively and innovatively with other healthcare providers to meet the healthcare needs of the community and ensure services are easy to access and navigate.

Figure 9.4c – *Forecast Eastern Health separations per 1000 population by 2021-22 by geographical SLA*
Adapted from – *Department of Health Public Hospital Admitted Patient Activity Projections 2008-09 to 2021-22*

FIGURE 9.4c



9.5 OUR COMMUNITY PROFILE

Much of the following information regarding the health of our community has been extracted and adapted from the Population and Place Profile which was developed for the Inner East and Outer East Primary Care Partnerships (PCPs) in 2009. This information was essentially based upon the Australian Bureau of Statistics Census of Population and Housing (2006). Eastern Health wishes to acknowledge the PCPs for this piece of research which has been used to inform *Eastern Health 2022*.

9.5.1 RELIGION, CULTURE, ETHNICITY AND OUR INDIGENOUS POPULATION

There is a large community of Indigenous people living in Yarra Ranges (North). The closest hospital in this area is Healesville and District Hospital.

In comparison with Victoria, the eastern metropolitan region had lower proportions of people following Islam and Judaism and higher proportions of people reporting that they followed no religion. (2).

In comparison with Victoria, the eastern metropolitan region has lower proportions of people born in Australia and higher proportions of people born in non-English speaking countries. Across the entire eastern metropolitan region, there is a greater proportion of people born in Australia (71.6%) than the rest of Melbourne (69%). Of all people living in Manningham, 29.5% are born in non-English speaking countries compared with 23.5% for Melbourne.

Second to Australia, China and India are the most common birth places, with Malaysia and South Africa also being common birth places for residents in Manningham and Whitehorse.

Social cohesion and community connectedness are issues in Yarra Ranges and Maroondah.(2).

9.5.2 SOCIO-ECONOMIC STATUS

There are defined pockets of socio-economic disadvantage within Eastern Health's primary catchment areas, as defined by the Socio-Economic Indices for Areas (SEIFA) of disadvantage in the 2001 National Health Survey. These areas are:

- Knox (north-east): Bayswater, The Basin, Boronia, Ferntree Gully
- Yarra Ranges (central): Woori Yallock, Launching Place, Warburton, Yarra Junction, Millgrove.
- Yarra Ranges (north): Yarra Glen, Dixons Creek, Healesville, Maroondah.

Almost half of the postcodes in Yarra Ranges and all of the postcodes in Maroondah have a SEIFA score lower than the median. The most variation in levels of disadvantage occurs within Yarra Ranges. It includes three of the top five most disadvantaged pockets in the catchment and two of the ten least disadvantaged pockets in the catchment. Boroondara has the least concentrations of disadvantage, including five of the top ten least disadvantaged areas in the catchment. (2). There is a strong correlation between perceived health status, levels of disadvantage and the incidence of illness and hospital admissions in Yarra Ranges. (2). A reduction in family violence is a priority in the eastern metropolitan region, particularly in areas of disadvantage.(2).

Median incomes are higher in the eastern metropolitan region than for the rest of Victoria. The outer east catchment has a higher unemployment rate than the inner east catchment and the overall average unemployment is higher in the outer east in comparison to the rate for metropolitan Melbourne.

The wide variation in levels of socio-economic disadvantage across Eastern Health's wide geographical catchment area presents challenges and requires Eastern Health to ensure access to health services for the most disadvantaged within our community.

9.5.3 BURDEN OF DISEASE

Overall, people living in the eastern metropolitan region enjoy a life expectancy slightly higher than that of Victoria.

The top-ranking causes of death and disability in the eastern metropolitan region are ischaemic heart disease, diabetes, stroke, mental illness (depression, generalised anxiety disorder, suicide and dementia), cancer (lung, prostate, colon, rectum and breast) and chronic obstructive pulmonary disease (emphysema and chronic bronchitis). Other main causes of death and disability include asthma, road and traffic accidents, dental caries, arthritis and other mental illnesses such as schizophrenia and borderline personality disorders.

Yarra Ranges has the lowest perceived health status within Eastern Health's primary catchment area. It has the highest incidence of all causes of ill health and disability, communicable diseases and injuries in the eastern metropolitan region and also has the highest rate of emergency admissions in the 15-24 and 25-54 year old age groups.(2).

Maroondah has a relatively low health and wellbeing status and a high rate of accidents, injuries, suicide, poisonings, substance abuse and problem gambling.

Tobacco is the leading risk factor amongst males and obesity is the leading risk factor amongst females within the eastern metropolitan region. Violence against women is a key risk factor, contributing to a significant proportion of the burden of disease.(2). The rates of short-term risky alcohol consumption amongst males and females in the eastern metropolitan region are higher than those of Victoria.(2).

9.5.4 DISABILITY

The inner areas of the eastern metropolitan region have more people with a disability and a higher percentage of total population with a disability than the outer areas of the eastern metropolitan region. Manningham and Whitehorse have the highest percentages of total population with a disability in comparison to other areas within Eastern Health's primary catchment. Profound disability is highest in Whitehorse and Boroondara (2). The health and welfare needs of those providing unpaid care to people with a disability is an issue in Yarra Ranges.(2).

9.5.5 TRAVEL

Travel between larger sites across Eastern Health has improved with the completion of Eastlink in 2009, however, this is a tolled carriageway. The Maroondah Highway, Burwood Highway and Mountain Highway provide good access to Eastern Health's larger sites by car without tolls.

The most common form of transport to work in the eastern metropolitan region is car (as the driver) and the rate of driving is higher in the eastern metropolitan region than in Victoria, with the majority of households owning two motor vehicles. The community feel they have less access to public transport than those living in metropolitan Melbourne or Victoria. (2).

In terms of public transport:

- There is access to Box Hill Hospital by bus, tram and train.
- There is access to Peter James Centre by tram and bus.
- There is access to Angliss Hospital, Maroondah Hospital and Wantirna Health by bus.
- There is access to Yarra Ranges Health by train.
- There is poor access to Healesville & District Hospital and Yarra Valley Community Health by any form of public transport.

Due to the socio-economic factors influencing the health of communities in the outer east areas, easy transport access to Eastern Health facilities will continue to be an important factor. Ease of transport access substantially influences the experience that patients, staff and other members of the community have with Eastern Health.

It is important that Eastern Health work with the Department of Transport and local government to improve public transport to the Angliss Hospital, Maroondah Hospital and Healesville & District Hospital, including Yarra Valley Community Health. It is also important that, in developing new facilities into the future, car parking be a key consideration.

9.6 WHAT ARE OUR PATIENTS TELLING US?

Analysis of feedback from Eastern Health patients during 2009-10 and 2010-11 reveals that there is substantial appreciation for the staff and services that are offered by Eastern Health. In terms of improvements that have been identified through this important feedback, the main issues that patients have with Eastern Health relate to:

A. Communication (30%);
B. Treatment (29%); and
C. Access to services (22%).

Eastern Health 2022 has drawn on this feedback from patients to recommend a number of initiatives and projects that will improve effective and meaningful communication with patients, families and carers. It is a core objective of the Plan to improve equity of access to Eastern Health services and reduce waiting times for care. Treatment issues will also be addressed through various recommendations surrounding our workforce and others that will expand treatment modalities and provide flexible models of care that are tailored to the needs of patients.

Eastern Health is committed to providing a great patient experience and *Eastern Health 2022*, in conjunction with the Eastern Health Strategic Plan, articulates the mechanisms through which this will be achieved.

10 MEETING THE DEMAND FOR PUBLIC SERVICES IN THE EAST

10.1 CLINICAL ACTIVITY – TOP 10

Eastern Health's top 10 Major Clinical Related Groups (MCRGs) based on separations are listed in Figure 10.1a with General Medicine, General Surgery and Orthopaedics ranking in the top five of highest number of separations and bed days (also see figure 10.1b).

Figure 10.1a – *Eastern Health Top 10 MCRGs based on separations 2009-10 (excluding dialysis and unqualified neonates)*
Adapted from – *Department of Human Services Inpatient Forecast Model (2010)*

FIGURE 10.1a	
MCRG	2009-10 SEPARATIONS
Non Subspecialty Surgery	9,614
Orthopaedics	7,960
Clinical Cardiology	7,555
Chemotherapy & Radiotherapy	7,005
Non Subspecialty Medicine	6,148
Obstetrics	5,624
Respiratory Medicine	5,707
Neurology	4,984
Diagnostic GI Endoscopy	4,426
Gastroenterology	3,314

Figure 10.1b – *Eastern Health Top 10 MCRGs based on bed days 2009-10 (excluding dialysis)*
Adapted from – *Department of Human Services Inpatient Forecast Model (2010)*

FIGURE 10.1b	
MCRG	2009-10 BED DAYS
Mental Health	35,775
Orthopaedics	28,239
Geriatric Evaluation and Management (GEM)	32,515
Rehabilitation - Non-Acute	29,747
Respiratory Medicine	24,444
Non Subspecialty Surgery	23,762
Non Subspecialty Medicine	15,125
Clinical Cardiology	19,051
Neurology	15,777
Obstetrics	14,523

FIGURE 10.2a - EASTERN HEALTH STREAMS OF CARE

DURATION	PREDICTABILITY	CYCLE TIME	PATIENT REQUIREMENTS/CHARACTERISTICS
EPISODIC (Defined period of care)	Unplanned	Very Short	▸ Arrive in an unplanned manner ▸ Requires care for a maximum of six hours ▸ Condition can be managed in an ambulatory setting ▸ May require follow up through specialist consulting services or chronic disease management programs ▸ May require access to community support services or other substitution options
		Short cycle	▸ Arrive in unplanned manner ▸ Require inpatient care for more than six hours and maximum of 72 hours ▸ Path of care less likely to be variable ▸ Require access to diagnostics ▸ Likely to be less medically complex ▸ May require transfer to subacute or community support service
		Long cycle	▸ Likely to have multiple interacting complex problems. ▸ Likely to have personal care participation restrictions. ▸ Arrive in unplanned manner ▸ Require inpatient for more than 72 hours ▸ Require access to diagnostics ▸ Path of care likely to be more variable ▸ Likely to be more medically complex ▸ May require specialist management (transfer or by referral) ▸ May require transfer to subacute or community support services
	Planned	Short cycle	▸ Arrive in a planned manner (urgency is managed) ▸ Care is predictable (possibly protocol driven) and low complexity ▸ May require access to subacute care or community support services or specialist consulting services ▸ Length of stay is less than 72 hours
		Long cycle	▸ Likely to have multiple interacting complex problems. ▸ Likely to have personal care participation restrictions. ▸ Arrive in a planned manner (urgency is managed) ▸ Care is planned, likely predictable and complex ▸ May require specialist management (transfer or by referral) ▸ May require access to subacute care, community support services or specialist consulting services ▸ Length of stay is greater than 72 hours
NON-EPISODIC CARE (Care of continuous duration)	Highly predictable	Routine Chronic disease management	▸ Routine monitoring required ▸ Potential for it to be provided within a shared care arrangement with the primary health sector. ▸ This stream includes patients with Ambulatory Care Sensitive Conditions for which hospitalisation is thought to be avoidable with the application of Public Health interventions and early disease management, usually delivered in ambulatory setting such as primary care
	Less predictable	Chronic/ complex disease management	▸ Care is delivered over a continuous period of time in ambulatory setting with possible inpatient periods ▸ Burden of disease likely to be significantly impacting on functional ability and or quality of life ▸ Connected to ambulatory programs that focus on chronic care management, optimisation of quality or life
Health Promotion and Disease Prevention			▸ Population risk management through targeted programs

SERVICE CHARACTERISTICS
▸ Emergency department (ED) presentations not requiring admission ▸ Split at triage according to likely need for admission. ED footprint that reflects ambulatory nature of work ▸ ED with easy access to diagnostics and back up services ▸ Easy access to transport in and out ▸ Systems for access to community support
▸ Rapid assessment and early intervention systems that deliver patient to point of definitive treatment in earliest possible time ▸ Quick access to diagnostics ▸ Opportunity for substitution of roles where variation in care is low (e.g. extended scope nursing) ▸ Systems for access to community support
▸ Rapid assessment and early intervention systems that deliver patient to point of definitive treatment in earliest possible time ▸ Easy access to diagnostics ▸ Long stay management system that supports timely management of variation in patient care ▸ Systems for access to specialty services/transfer systems for access to community support ▸ Care provided by multidisciplinary teams ▸ Systems for patient-centred goal setting
▸ Short stay system with opportunity for substitution of roles where variation in care is low (e.g. extended scope nursing) ▸ Systems for access to community support
▸ Separation of planned from unplanned work ▸ Opportunity for substitution of roles where variation in care is low (e.g. extended scope nursing) ▸ Systems for access to specialty services/transfer ▸ Care provided by multidisciplinary teams ▸ Systems for access to community support ▸ Systems for patient-centred goal setting
▸ Established shared care arrangements with clearly defined roles and responsibilities ▸ Client self management focus
▸ Case Management, intensive care co-ordination functions ▸ Systems for access to case management that are streamlined ▸ System that allow for streamlined episodic inpatient care
▸ Targeted program for identified priorities and at risk groups ▸ Delivered in community settings

10.2 THE PATIENT CARE DELIVERY SYSTEM AND STREAMS OF CARE

People present to Eastern Health with many and varied health issues. These range from the severely, acutely ill to more routine, less urgent health issues. Eastern Health is committed to ensuring patient- centred, safe, high quality and efficient care. This requires that patients receive the right care, at the right time, in the right place, by the right person or team. This is particularly important given the requirements to balance the imperatives of accessibility, quality and safety, and financial and resource management. Eastern Health is also committed to ensuring its services and service delivery systems are aligned with government policy and funding directions, and take account of national and international healthcare trends.

Consistent with these commitments, Eastern Health has developed a service planning framework which is based on typical patient journeys across the health system. This is a high level patient-centred framework which provides the organisational context for service planning and development activities, known as the Eastern Health Streams of Care.

The Eastern Health Streams of Care have been derived from analysis of the patient variables which determine the appropriate patient journey and which comprise:

- Predictability of care requirements
- Urgency of care requirements
- Complexity of care requirements
- Duration of care requirements.

These factors determine how quickly patients require care, the settings in which care needs to be provided, and the duration of the episode of care.

Further analysis of these variables resulted in identification of eight high level streams of patient care, which are distinguished by the urgency, predictability, complexity and duration of a patient's health care issues and by the service system response to these health care issues.

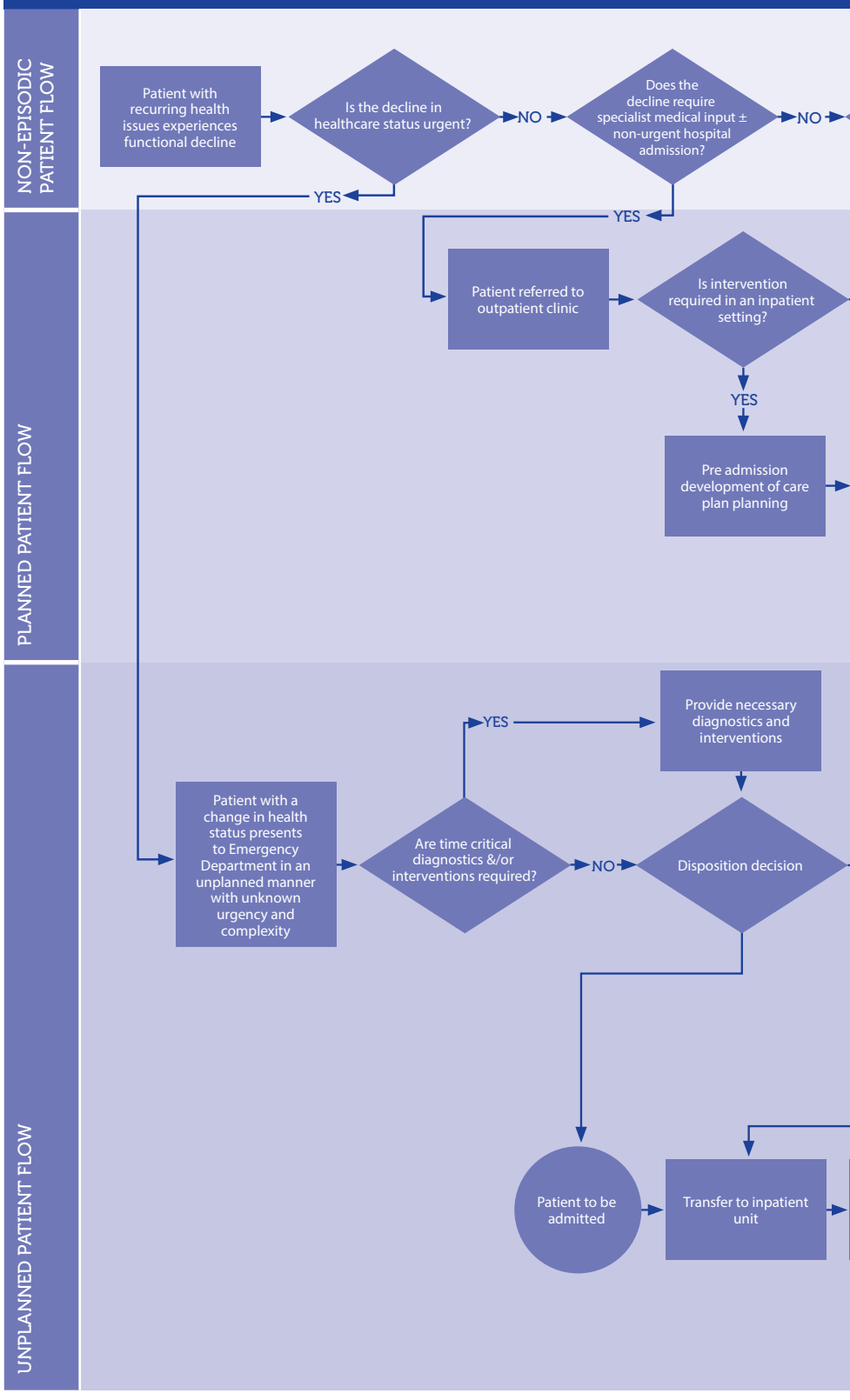
Figure 10.2a – *Eastern Health Streams of Care*

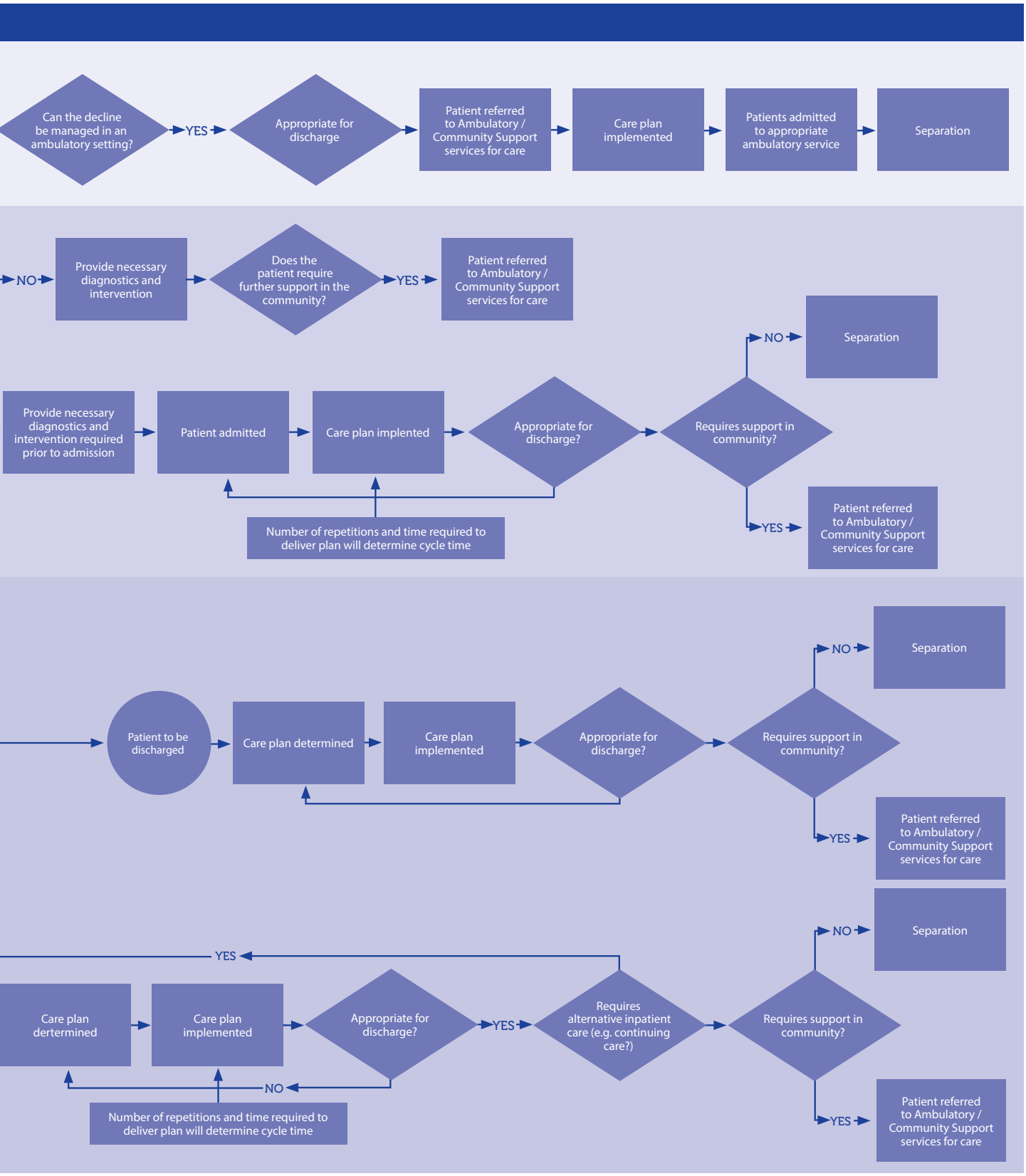
Whilst the Streams of Care are high level descriptions of typical patient journeys, they have proven to be invaluable for planning purposes as our service delivery systems need to 'line up' with these streams. Analysis of our service delivery systems provides vital information for our improvement initiatives which focus on improving access, quality and safety and resource utilisation.

Each Stream of Care can be 'mapped' at a high level as a typical patient journey. The high level patient journeys for each Stream of Care are outlined in Figures 10.2b.

Figure 10.2b – *Eastern Health high level patient Journeys*
Source: *Eastern Health*

FIGURE 10.2b




Can the decline be managed in an ambulatory setting?
YES
Appropriate for discharge
Patient referred to Ambulatory / Community Support services for care
Care plan implemented
Patients admitted to appropriate ambulatory service
Separation
NO
Provide necessary diagnostics and intervention
Does the patient require further support in the community?
YES
Patient referred to Ambulatory / Community Support services for care
Provide necessary diagnostics and intervention required prior to admission
Patient admitted
Care plan implented
Appropriate for discharge?
Requires support in community?
NO
Separation
YES
Patient referred to Ambulatory / Community Support services for care
Number of repetitions and time required to deliver plan will determine cycle time
Patient to be discharged
Care plan determined
Care plan implemented
Appropriate for discharge?
Requires support in community?
NO
Separation
YES
Patient referred to Ambulatory / Community Support services for care
YES
Care plan dertermined
Care plan implemented
Appropriate for discharge?
YES
Requires alternative inpatient care (e.g. continuing care?)
Requires support in community?
NO
Separation
NO
Number of repetitions and time required to deliver plan will determine cycle time
YES
Patient referred to Ambulatory / Community Support services for care

Eastern Health-wide analysis of separations by Streams of Care demonstrates that the fastest growing stream of care between 2005-06 and 2009-10 has been unplanned, long cycle encounters as illustrated in Figure 10.2c. This reflects the ageing of our patient population, increasing complexity of inpatients across the health service and the higher proportion of emergency presentations in the higher triage categories 1, 2 and 3.

As illustrated in Figure 10.2d, there is also a significant amount of work undertaken in the planned very short and short cycle streams, including planned same day activity, equating to over 39,000 separations in 2009-10, with the highest growth over five years in the number of planned episodes where patients stay overnight, but less than 72 hours.

Geographical separation of elective and emergency activity has long been regarded as an effective way to ensure both planned and unplanned patient activity can operate well. (7). In 2012, with the exception of Yarra Ranges Health and some surgery conducted at Healesville and District Hospital, all planned surgical activity at Eastern Health is co-located with emergency surgery services arising from the large, busy emergency departments on the larger sites at Box Hill, Maroondah and the Angliss Hospitals.

Figure 10.2c – *Eastern Health separations by Eastern Health unplanned 'Streams of Care', 2005-6 to 2009-10*
Source: *Eastern Health*

FIGURE 10.2c - UNPLANNED STREAM - ALL EASTERN HEALTH (EXCLUDING DIALYSIS)

Financial Year	Very Short Encounters	Short cycle Encounters	Long cycle Encounters
2005-2006	89,786	34,621	14,315
2006-2007	93,951	34,550	14,554
2007-2008	91,286	37,437	15,406
2008-2009	87,429	37,816	15,325
2009-2010	91,779	37,885	16,173
% growth 05/06-09/10	2%	9%	13%

Figure 10.2d – *Eastern Health separations by Eastern Health planned 'Streams of Care', 2005-06 to 2009-10*
Source: *Eastern Health*

FIGURE 10.2d - PLANNED STREAMS - ALL EASTERN HEALTH (EXCLUDING DIALYSIS)

Financial Year	Very Short Encounters	Short cycle Encounters	Long cycle Encounters
2005-2006	27,745	10,176	10,713
2006-2007	27,403	10,203	10,908
2007-2008	27,358	10,463	10,823
2008-2009	28,348	10,437	11,345
2009-2010	27,960	11,053	11,578
% growth 05/06-09/10	1%	9%	8%

Eastern Health 2022 recommends that Eastern Health service delivery systems be responsive to the different characteristics of patients presenting with planned, unplanned or chronic disease health needs. The separation of planned and unplanned streams of care and the establishment of an appropriate environment to allow for increasing demand in the highest growing streams of care will substantially contribute to this outcome. A separate environment would ideally be located centrally within Eastern Health's primary catchment and be designed to ensure capacity for planned very short cycle streams of care and chronic disease (ambulatory) streams of care where it is not possible to deliver these services in the home or community.

It is also important to note that despite significant clinical variation across the patient groups that Eastern Health cares for, all patients experience a similar step-by-step process of care. This step-by-step process of care forms the basis of Eastern Health's Patient Care Delivery System as outlined in Figure 10.2e.

10.3 SELF-SUFFICIENCY

Eastern Health has considered past and projected future growth for each of its clinical services and how well each of the clinical services is managing the public demand for inpatient services amongst people living in Eastern Health's primary catchment area. This is referred to as "self-sufficiency" - that is, the proportion of local acute public inpatient demand for clinical services that Eastern Health is meeting.

Health Service planners generally use 70 per cent as the benchmark level at which a Health Service can be considered to be "self sufficient". This recognises that up to 30 per cent of public demand for services is expected to occur outside a Health Service's local residential area for reasons which include:

A. Personal choice (by patients);
B. Higher level service requirements (e.g. for state-wide, quaternary-leve care);
C. Unavailability of specialised equipment;
D. Admission to a hospital close to where people work, visit or holiday; and
E. Established referral patterns of local general practitioners, physicians and surgeons.

In 2012, relationships exist between clinicians at Eastern Health and neighbouring health services such as Austin Health and Southern Health in particular. With the significant forecast increase in population in the north-east and south-east of Melbourne, it is anticipated that it will become increasingly difficult for other health services to accommodate the number of transfers and referrals that Eastern Health will require. It is therefore imperative that Eastern Health improve its self-sufficiency in core clinical services and reduce 'outflows' to other health services wherever possible to ensure local access to services for the community and decrease the burden on other health services.

Figure 10.3a overleaf summarises the major clinical related groups (MCRGs) and where Eastern Health self-sufficiency is good 70 per cent or above) or requires improvement (below 70 per cent). It should be noted that low self-sufficiency levels are expected in Cardiac Surgery Services, Neurosurgery Services and Transplantation Services as these services are not provided by Eastern Health. Similarly, inpatient Ophthalmology Services are provided by the Royal Victorian Eye and Ear Hospital (RVEEH) at Yarra Ranges Health, however the episodes are, by and large, counted as part of RVEEH patient activity, not Eastern Health.

Figure 10.2e – *Eastern Health's Patient Care Delivery System*

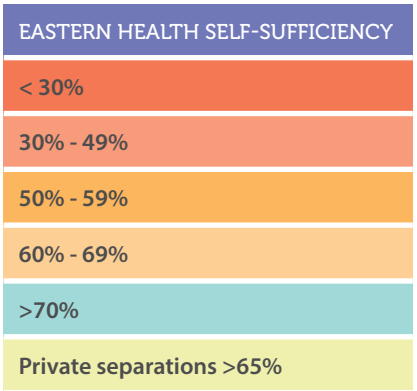
FIGURE 10.3a

MAJOR CLINICAL RELATED GROUP (MCRG)	2008-09 TO 2021/2022 % INPATIENT GROWTH WITHIN EH CATCHMENT	2008-09 % PUBLIC SEPARATIONS TREATED BY EH (SELF SUFFICIENCY)	PEOPLE LIVING WITHIN EH PRIMARY CATCHMENT				
			2008-09 TOTAL SEPARATIONS	2008-09 PRIVATE HOSPITAL SEPARATIONS	2008-09 EH PUBLIC SEPARATIONS	2008-09 % PUBLIC SEPARATIONS	2008-09 % PRIVATE HOSPITAL SEPARATIONS
Transplantation	15%	0%	27	0	0	100%	0%
Ophthalmology	66%	8%	2268	7949	179	22%	78%
Cardiothoracic Surgery	12%	24%	301	325	72	48%	52%
Neurosurgery	45%	35%	1271	1388	445	48%	52%
Extensive Burns	36%	47%	95	14	45	87%	13%
Rehabilitation - Acute	-3%	48%	23	0	11	100%	0%
Rheumatology	41%	48%	1063	700	509	60%	40%
Head and Neck Surgery	23%	48%	333	639	160	34%	66%
Medical Oncology	35%	50%	1892	2700	948	41%	59%
Tracheostomy	25%	51%	275	64	140	81%	19%
Haematology	50%	52%	4280	2674	2240	62%	38%
Renal Medicine	64%	54%	1218	709	655	63%	37%
Vascular Surgery	22%	55%	1033	1699	572	38%	62%
Ear, Nose and Throat	13%	56%	2925	3243	1641	47%	53%
Qualified Neonate	29%	58%	1284	684	739	65%	35%
Dermatology	34%	58%	674	342	388	66%	34%
Psychiatry	8%	60%	2061	262	1234	89%	11%
Plastic and Reconstructive Surgery	41%	61%	2689	6075	1641	31%	69%
Endocrinology	48%	63%	2100	960	1329	69%	31%
Chemotherapy and Radiotherapy	52%	64%	8464	8994	5375	48%	52%
Palliative Care	55%	65%	764	0	495	100%	0%
Gynaecology	5%	65%	4116	8590	2687	32%	68%
Urology	31%	65%	3582	5230	2345	41%	59%
Obstetrics	7%	66%	6701	3730	4412	64%	36%
Rehabilitation - Non-Acute	29%	66%	1846	2281	1221	45%	55%
Neurology	31%	67%	6146	1696	4107	78%	22%
Immunology and Infections	69%	67%	2610	1041	1750	71%	29%

Continued...

MAJOR CLINICAL RELATED GROUP (MCRG)	2008-09 TO 2021/2022 % INPATIENT GROWTH WITHIN EH CATCHMENT	2008-09 % PUBLIC SEPARATIONS TREATED BY EH (SELF SUFFICIENCY)	PEOPLE LIVING WITHIN EH PRIMARY CATCHMENT				
			2008-09 TOTAL PUBLIC SEPARATIONS	2008-09 PRIVATE HOSPITAL SEPARATIONS	2008-09 EH PUBLIC SEPARATIONS	2008-09 % PUBLIC SEPARATIONS	2008-09 % PRIVATE HOSPITAL SEPARATIONS
Interventional Cardiology	60%	68%	743	820	504	48%	52%
Breast Surgery	5%	69%	556	1239	382	31%	69%
GEM	39%	69%	1323	0	918	100%	0%
Non-Subspecialty Medicine	63%	70%	8681	7867	6058	52%	48%
Orthopaedics	27%	70%	9347	13457	6558	41%	59%
Diagnostic GI Endoscopy	42%	73%	5480	24041	4027	19%	81%
Renal Dialysis	90%	74%	25013	11914	18457	68%	32%
Respiratory Medicine	40%	74%	6664	4216	4946	61%	39%
Mental Health	36%	74%	2123	12864	1578	14%	86%
Non-Subspecialty Surgery	34%	75%	8622	4498	6461	66%	34%
Unqualified Neonate	0%	75%	4183	0	3156	100%	0%
Colorectal Surgery	27%	76%	1048	1688	799	38%	62%
Gastroenterology	55%	77%	4420	1817	3391	71%	29%
Cardiology	35%	78%	8573	5218	6661	62%	38%
Upper GIT Surgery	36%	80%	1835	1643	1463	53%	47%
Drug and Alcohol	26%	81%	1745	404	1405	81%	19%
Overall		**EH =68%**	**150397**	**153675**	**102104**		

Figure 10.3a – *Eastern Health self-sufficiency by Major Clinical Related Group (MCRG) 2008-09*
Source – *Department of Health Inpatient forecast model 2010*



10.4 PATIENT 'OUTFLOWS'

In terms of understanding the reasons behind Eastern Health's lower self-sufficiency in some areas, it is important to consider where patients living within Eastern Health's primary catchment area are going for their admissions to hospital. These patient admissions are sometimes referred to as 'outflows'. Figure 10.4a below outlines the number of patient 'outflows' to health services outside of Eastern Health in the five years ending 2008-09.

Eastern Health's closest neighbours, Austin Health and Southern Health, see most of Eastern Health's patient 'outflows'. Of particular note is that in the five years to 2008-09, outflows to Austin Health and Southern Health increased by 29% and 23% respectively, however, growth across Eastern Health in the same period was only 6.6% (excluding dialysis activity). With high population growth corridors forecast in the north, north-west and south-east areas of Melbourne, it will become increasingly difficult for Austin Health and Southern Health to manage routine medical and surgical activity of patients outside their own catchment areas. In the case of Austin Health, patient overflows from Northern Health are anticipated to increase in number in the short to medium term. Patient outflows to Austin Health and Southern Health are growing faster than Eastern Health services are expanding. This, combined with the forecast population growth across Melbourne, indicates that Eastern Health needs to address the issue of self-sufficiency if it is to meet the needs of its local population to 2022.

Figure 10.4a – *Patient 'outflows' from Eastern Health's primary catchment area 2004-05 to 2008-09*
Source – *Department of Health Inpatient forecast model 2010*

FIGURE 10.4a
PATIENT OUTFLOWS FROM EASTERN HEALTH'S PRIMARY CATCHMENT AREA

Health Service	2004-05	2005-06	2006-07	2007-08	2008-09
Austin Health	5,914	6,476	6,544	7,167	7,620
Southern Health	5,143	5,878	5,726	6,276	6,301
Alfred Health	3,654	3,966	3,936	4,260	4,135
Royal Children's Hospital	3,988	3,736	3,869	3,705	3,515
St Vincent's Health	3,664	3,882	3,612	3,445	3,251
Mercy Hospital group	2,020	2,821	3,050	3,011	3,108
The Royal Victorian Eye & Ear Hospital	2,090	2,156	2,244	2,442	2,148
Melbourne Health	1,686	1,800	1,873	1,978	2,018
Other non-metro	1,940	1,994	1,797	1,585	1,485
Royal Womens Hospital	1,754	1,740	1,680	1,517	1,247
Peter MacCallum Cancer Institute	1,428	1,347	1,336	1,423	1,157
Peninsula Health	316	345	349	339	336
Western Health	248	302	332	237	272
Northern Health	198	201	188	236	244
Barwon Health	122	112	110	105	135
Dental Health Service Victoria	13	12	9	19	39

Figure 10.4b outlines the top reasons for patient 'outflows' to health services outside of Eastern Health in 2008-09. This indicates that Eastern Health must consider service development in the areas of General Medicine, Neurology, Ophthalmology, Respiratory Medicine, Cancer Services, Orthopaedics and Mental Health Services to address the biggest gaps in overall self-sufficiency. These are all services that Eastern Health would rarely expect to need to refer to other health services for state-wide or quaternary-level care (unlike Neonatology and Maternity Services).

Figure 10.4b – *Patient 'outflows' from Eastern Health's primary catchment area by Clinical Related Group (CRG), where separations are more than 7500.*
Source – *Department of Health Inpatient forecast model 2010*

FIGURE 10.4b
PATIENT 'OUTFLOWS' FROM EASTERN HEALTH'S PRIMARY CATCHMENT AREA BY CLINICAL RELATED GROUP (CRG) WHERE SEPARATIONS ARE MORE THAN 7500

Clinical Related Group (CRG)	Separations 2008-09
Other Non-Subspecialty Medicine	1882
Other Neurology	1,323
Cataract Procedures	1,249
Unqualified Neonate	1,026
Other Respiratory Medicine	970
Vaginal Delivery	892
Lymphoma and Leukaemia	848
Other Orthopaedics - Surgical	826
Other Psychiatry	805
Respiratory Neoplasms	790
Red Blood Cell Disorders	782
Other Eye Procedures	728
Septicaemia, Viral and Other Infections	633
Ante-Natal Admission	618
Chest Pain	598
Other Non-subspecialty Surgery	559
Rheumatology	554
Injuries - Non-surgical	553
Oesophagitis and Gastroenterology	544
Qualified Neonate	543
Rehabilitation - Non-Acute Types	530
Other Cardiology	525
Other Endocrinology	515

10.5 PATIENT 'INFLOWS'

Eastern Health aims to provide a comprehensive public health service to people and communities in the east. In terms of understanding the reasons behind Eastern Health's lower self-sufficiency in some areas, it is important to consider how many patients Eastern Health is treating outside of its primary catchment area. These patient admissions are sometimes referred to as 'inflows'. Figure 10.5a outlines the number of patient 'inflows' to Eastern Health in the five years to 2008-09.

With minimal fluctuations between Statistical Local Areas (SLAs), the total number of patient inflows to Eastern Health in the five years to 2008-09 remained steady at just over 11,000 separations. The zero growth in Eastern Health 'inflows', combined with the 8.3% growth in 'outflows' over the same period, indicates that Eastern Health must address declining self-sufficiency if it is to meet the needs of its local population by 2022.

Figure 10.5a – *Patient 'inflows' from outside Eastern Health's primary catchment area 2004-05 to 2008-09.*
Source – *Department of Health Inpatient forecast model 2010*

FIGURE 10.5a - PATIENT 'INFLOWS' FROM OUTSIDE EASTERN HEALTH'S PRIMARY CATCHMENT AREA

SLA	2004-05	2005-06	2006-07	2007-08	2008-09
Knox (C) - South	1,954	1,654	1,834	1,773	1,768
Monash (C) - Waverley West	1,784	1,279	1,275	1,338	1,448
Monash (C) - Waverley East	1,012	1,356	1,365	1,318	1,423
Cardinia (S) - North	1,340	1,157	1,199	1,137	1,222
Casey (C) - Berwick	603	574	616	554	619
Boroondara (C) - Kew	538	488	499	516	452
Casey (C) - Cranbourne	292	340	338	345	432
Boroondara (C) - Hawthorn	395	423	487	443	389
Murrindindi (S) - East	357	380	461	509	584
Gr. Dandenong (C) - Bal	280	395	359	376	426
Stonnington (C) - Malvern	327	296	332	361	379
Casey (C) - Hallam	328	363	315	360	312
Gr. Dandenong (C) - Dandenong	314	303	248	266	294
Nillumbik (S) - South	373	280	238	204	230
Banyule (C) - Heidelberg	280	216	226	267	253
Banyule (C) - North	302	221	252	220	198
Cardinia (S) - Pakenham	149	149	155	186	216
Murrindindi (S) - West	170	216	247	261	243
Monash (C) - South-West	219	142	187	168	194
Kingston (C) - North	151	185	179	184	181

Figure 10.5b – *Patient 'inflows' from outside Eastern Health's primary catchment area by Clinical Related Group (CRG), where separations are more than 7200.*
Source – *Department of Health Inpatient forecast model 2010*

FIGURE 10.5b

Clinical Related Group (CRG)	Separations 2008-09
Other Non-Subspecialty Medicine	696
Unqualified Neonate	612
Vaginal Delivery	520
Other Neurology	459
Chest Pain	453
Oesophagitis and Gastroenterology	400
Injuries - Non-Surgical	329
Injuries to limbs - Medical	326
Other Orthopaedics - Surgical	289
Other Respiratory Medicine	280
Drug and Alcohol	257
Colonoscopy	244
Rehabilitation - Non-Acute	236
Abdominal Pain	233
Mental Health - Other	230
Other Non-Subspecialty Surgery	223
Other Cardiology	219
Other Urological Procedures	217
Other Gynaecological Surgery	214
Red Blood Cell Disorders	206

11 PRIORITISING CLINICAL SERVICE AREAS

***Eastern Health 2022* identifies a number of high priority clinical service areas that require particular focus over the next decade to reduce outflows and subsequently improve self-sufficiency and local access to these services for people living in the east.**

To identify the level 1, 2 and 3 priority clinical service areas, an analysis of the following variables was undertaken and considered as, in combination, they serve to identify current and future gaps in the required level of service to the community:

1. Identification of major clinical related groups where Eastern Health achieved below the target 70 per cent self-sufficiency rate in 2008–09;
2. Identification of major clinical related groups where Eastern Health is forecast to experience higher than average inpatient growth between 2008–09 and 2021–22 (growth in excess of 35 per cent);
3. Identification of Eastern Health Clinical Service Groups where the overnight and/or same-day bed modelling indicates a substantial (more than 10 beds) increase in required bed capacity;
4. Identification of clinical service groups where there is evidence that additions to the elective waiting list exceed the admissions from the elective waiting list in 2009–10;
5. Identification of clinical service groups where there is evidence of lengthy waiting time for planned admission;
6. Identification of outpatient clinics with the longest waiting times for an outpatient appointment (greater than one year);
7. Services that are well-placed to be provided by other health services;
8. Burden of disease and population-based health needs of communities in the east, as identified by the Inner and Outer East Population and Place Profile 2009. (2);
9. Identification of current services where the model of care impacts on Eastern Health's capacity to achieve key performance indicators (KPIs).

The above variables, in combination, provide a comprehensive indicator of current and forecast demand for clinical services within a public health system that has and will continue to operate in a constrained environment in relation to annual budget and activity targets.

Applying an analysis of the above variables, as detailed in Figure 11a, Eastern Health has identified the following level 1, 2 and level 3 priority clinical service areas for development over the next ten year period.

Figure 11a – *Eastern Health Priority Level 1, 2 & 3 Clinical Service Groups 2012 - 2022*

Level 1 Priority Clinical Service Group

Requires substantial expansion and/or model of care development

Level 2 Priority Clinical Service Group

Requires some expansion and/or model of care development

Level 3 Priority Clinical Service Group

Requires minimal expansion and/or model of care development

FIGURE 11a - EASTERN HEALTH PRIORITY LEVEL 1, 2 & 3 CLINICAL SERVICE GROUPS 2012-2022

DIRECTORATE	CLINICAL PROGRAM	EASTERN HEALTH CLINICAL SERVICE GROUP	CLINICAL SUPPORT
Acute Health	Emergency and General Medicine	1. General Medicine	Clinical Support Services (Including, but not limited to Pathology, Medical Imaging, Pharmacy, Allied Health, Anaesthetics, Biomedical Engineering, Health Information Services, etc.)
		2. Emergency Services	
		3. Intensive Care	
	Women & Children's	4. Gynaecology	
		5. Maternity Services	
		6. Paediatric Services (Paediatric Medicine, Paediatric Surgery)	
	Specialty Medicine	7. Cardiology (includes interventional cardiology)	
		8. Dermatology	
		9. Endocrinology	
		10. Endoscopy services	
		11. Gastroenterology	
		12. Haematology (will be combined with Blood & Cancer Services)	
		13. Infectious Diseases	
		14. Neurology	
		15. Blood & Cancer Services	
		16. Renal Medicine and Dialysis	
		17. Respiratory Medicine	
		18. Rheumatology	
	Surgery	19. Breast Surgery	
		20. Colorectal Surgery	
		21. Ear, Nose & Throat Surgery	
		22. Facio-maxillary surgery (new service)	
		23. General Surgery	
		24. Head and neck surgery (new service)	
		25. Ophthalmology	
		26. Orthopaedic Surgery	
		27. Pain Management Service (new service)	
		28. Plastic Surgery	
		29. Thoracic Surgery	
		30. Upper Gastro-Intestinal Surgery (including Bariatric Surgery)	
		31. Urology	
		32. Vascular Surgery	
Continuing care, Community and mental Health	Mental Health	33. Adult Mental Health	
		34. Acute Aged Persons' Mental Health	
		35. Child and Youth Mental Health Service (CYMHS)	
	Continuing Care	36. Geriatric evaluation and management	
		37. Residential Aged Care	
		38. Palliative Care	
		39. Rehabilitation	
	Ambulatory & Community Health	40. Ambulatory Services	
		41. Transition Care Program (TCP)	
		42. Community Health	
	Statewide Services	43. Turning Point, Alcohol and Other Drugs	
		44. Spectrum (state wide service for people who have personality disorders)	

12 EASTERN HEALTH-WIDE PRIORITY INITIATIVES

Through all of the consultations, analysis and gathering of evidence, the 20 priority initiatives outlined in Figure 12a have been identified as changes that will significantly contribute to the primary objective of *Eastern Health 2022* which is to meet the needs of Eastern Health's communities over the next ten years and improve equity of access to Eastern Health services. As such, they have been identified as the Eastern Health-wide priority initiatives.

The initiatives in Figure 12a are listed in order of how strongly they align with the nine principles underpinning the Plan (as detailed in section 2 – Executive Summary) and Eastern Health's Strategic Directions 2010–15. All of these initiatives are considered to be 'Eastern Health-wide' as they require a whole-of-health-service approach to implementation, impact multiple clinical services across the health service or represent considerable investment in the ten years 2012–22.

Every clinical service across Eastern Health is required to implement these priority initiatives where relevant to the services it provides.

The detailed actions contained within the priority areas are relevant and important at the time of writing this Plan. As with any long term plan, it may be necessary over time to modify or change these specific areas if the environmental context in which Eastern Health operates changes substantially.

FIGURE 12a - *EASTERN HEALTH 2022* PRIORITY INITIATIVES

	WHAT WE WILL DO	WE ARE DOING IT TO ENSURE THAT...	EASTERN HEALTH STRATEGIC DIRECTION
1	**Re-orientate inpatient (bed-based) services to be provided in ambulatory settings, including home, where appropriate to do so.** Particularly for planned same-day (medical) activity and bed-based services offered to patients during the latter part of their multi-day stays, we need to continue the work that we have started in 2011 to innovatively shift the paradigm to providing services in the home and community where possible. National reforms are moving in this direction, the State Government has articulated that it supports this direction and the evidence shows that it is what patients prefer when compared with bed-based inpatient care in hospitals. We will: ▸ Consider options for ambulatory care at all phases of the patient care delivery system (risk assessment, comprehensive assessment, care/treatment planning, care delivery, monitoring and review and discharge/transfer of care). ▸ Consider procedural and therapeutic services that can be provided in an ambulatory setting, including home. ▸ Ensure a single point of entry to ambulatory services ▸ Increase Hospital in the Home (HITH) contacts from 4 per cent to 10 per cent of multi-day separations and 12 per cent of bed days (in line with external benchmarking). ▸ Ensure Ambulatory Services interface with Emergency Department Services ▸ Provide rapid access to ambulatory medical team (MATS - for assessment of frailty, patients avoiding ED and other acute inpatient referral, nursing home in the home) ▸ Implement ambulatory models of care that are specific to each clinical service group (for example, aim to have 50 per cent of dialysis done in people's homes by 2022, management of bronchiectasis at home).	▸ Services that can safely be provided in the home or in the community will be provided in the home or the community by the most appropriate health service provider. ▸ Clinical services will be patient-centred. ▸ Clinical services will be configured to enhance timely patient flow. ▸ Clinical services that are encountered frequently by patients will be located close to where patients live. ▸ We provide additional bed-based capacity at our hospitals to meet the growing demand for services ▸ We relieve some of the increasing workforce pressures associated with staffing our hospitals and tailor jobs to suit the nature of ambulatory-based work.	A PROVIDER OF GREAT HEALTHCARE

FIGURE 12a - *EASTERN HEALTH 2022* PRIORITY INITIATIVES

WHAT WE WILL DO	WE ARE DOING IT TO ENSURE THAT...	EASTERN HEALTH STRATEGIC DIRECTION
2 **Maximise utilisation of all Eastern Health infrastructure and align future service expansion with forecast geographical demand for public health services in the mid-section of Eastern Health's primary catchment area - specifically Yarra Ranges (Lilydale), Maroondah (Croydon) and Knox (North-East).** We have some work to do to align our service capacity with projected demand from a geographical perspective, whilst maximising all existing and planned Eastern Health infrastructure to its full potential. The largest share of inpatient bed days that Eastern Health is forecast to provide by 2021-22 relates to people who live in Yarra Ranges (Lilydale), Maroondah (Croydon) and Knox (North-East). Hospitals within the mid-section of Eastern Health's catchment are Yarra Ranges Health, Maroondah Hospital, the Angliss Hospital and Wantirna Health, with Wantirna Health being most central to Eastern Health's total primary catchment area. Eastern Health must consider future clinical service expansion in these areas where they will be closer to where patients live and are forecast to be living by 2022.	▸ Clinical services will be provided to ensure that patients have equity of access to the full range and standard of clinical services across Eastern Health. ▸ Changes in clinical services will be based upon evidence. ▸ Clinical Services profile will be orientated to meet population-health demand and improve Eastern Health-wide 'self-sufficiency'. ▸ Clinical services that are encountered frequently by patients will be located close to where patients live.	A GREAT PATIENT EXPERIENCE
3 **Implement rapid assessment and early intervention models of care.** This is about timely assessment, involving the right people, to direct patients to where and what they need, every time. What we do at the beginning of each encounter with our patients is critical to their pathway, their clinical outcomes and efficiency. Some examples of what we will do are: ▸ Implement early assessment by Senior Medical Staff in the Emergency Department, early Palliative Care or GEM assessment, assessment of frailty, fast-track of acute leukaemic patients in ED, mental health client identification, timely aged care assessment, ambulatory services assessment and referral, mental health screening of maternity patients, identification of chronic disease or risk of same (e.g. drug and alcohol abuse). ▸ Fewer patients presenting to the Emergency Department for initial assessment. ▸ Provision of acute assessment clinics/environment rather than Emergency Department presentation. ▸ Eastern@Home Program to be allowed direct admission to hospital as required.	▸ Clinical services will be configured to enhance timely patient flow. ▸ Services that can safely be provided in the home or in the community will be provided in the home or the community by the most appropriate health service provider. ▸ Clinical services will be patient-centred. ▸ Changes in clinical services will be based upon evidence. ▸ Clinical Services profile will be orientated to meet population-health demand and improve Eastern Health-wide 'self-sufficiency'. Patients managed appropriately earlier have better outcomes and this also prevents chronic progression of disease. ▸ Early intervention by allied health leads to better/ faster patient outcomes (including surgery)	A PROVIDER OF GREAT HEALTHCARE
4 **Adopt and implement the EH Streams of Care as a basis for Eastern Health's patient care delivery system and ensure capacity is geared to these streams appropriately.** This is about how we organise our business to support our eight 'streams of care' which, in a marketing environment, would be known as our 'product lines'. It is about engineering service delivery systems (our workflow and the way we are organised) around what we know are predominantly our planned, unplanned and chronic disease management streams. Some examples of what we will do are: ▸ Complete implementation of the Surgery 2015 Project, the Unplanned Patient Flow Project, and the Ward Project which are currently underway at Eastern Health in 2012. These are key improvement priorities for Eastern Health. ▸ Plan for the Population Health and Prevention program to focus on tobacco use, obesity, family violence and drug and alcohol abuse.	▸ Clinical services will be patient-centred. ▸ Changes in clinical services will be based upon evidence. ▸ Clinical services will be configured to enhance timely patient flow. ▸ Clinical services will be configured in such a way that they are sustainable and optimise utilisation of capacity across EH (financial, environmental, workforce, infrastructure, technology).	A GREAT PATIENT EXPERIENCE

FIGURE 12a - *EASTERN HEALTH 2022* PRIORITY INITIATIVES

	WHAT WE WILL DO	WE ARE DOING IT TO ENSURE THAT...	EASTERN HEALTH STRATEGIC DIRECTION
5	**Expand Eastern Health clinical services and progress planning for facilities to meet the current and future needs of the community and ensure a minimum 70 per cent self-sufficiency rate in the areas required.** This is about new services at Eastern Health and stretching our target to achieve a 70 per cent self-sufficiency rate for all clinical services that we determine we are going to provide. It is also about planning for any capital redevelopments that are required to do that. The issue of self-sufficiency is important for Eastern Health. Not only is it important to clinicians who are frustrated by an inability to help more people locally, it's important because the Metropolitan Health Plan indicates that there are a number of areas outside the Eastern Metropolitan Region where population growth and health service demand are forecast to be very high. These areas will require particular focus on a State-wide level. As part of a complex health service system or network in Victoria, Eastern Health will be affected by this growth in terms of its ability to refer and move patients to other health services that will themselves be working to meet the growing demand. Within this broader environmental context, Eastern Health needs to address the barriers to improving its self-sufficiency where possible and understand the important role that other health services will play in providing a full suite of clinical services across the entire continuum of care. Some examples of what we will do are: ▸ Complete the funded upgrade of the Healesville and District Hospital, including Yarra Valley Community Health. ▸ Expand clinical services (inpatient, outpatient, ambulatory) in patient areas that have been identified as level 1 priority clinical service groups (please refer to section 11). ▸ Complete the funded redevelopment of Box Hill Hospital, expanding acute capacity by 194 beds and sub-acute capacity by 30 beds. ▸ Complete the funded redevelopment of Maroondah Hospital (Stage 2B), expanding acute capacity by 28 beds and sub-acute capacity by 20 beds. ▸ Explore further capital upgrade and redevelopment of Box Hill Hospital, Maroondah Hospital, Angliss Hospital, Yarra Ranges Health and Wantirna Health to increase clinical service capacity in-line with this Plan by 2021-22. ▸ Provide renal dialysis services at Healesville and District Hospital. ▸ Establish a Prevention and Recovery Care (PARC) service for young people in partnership with PDRSS and Spectrum. ▸ Establish an Eastern Health Child and Adolescent Eating Disorders service. Inpatient services are ideally co-located within a Paediatric Ward with close liaison with Child and Youth Mental Health Services. *Continued...*	▸ Clinical services will be provided to ensure that patients have equity of access to the full range and standard of clinical services across Eastern Health. ▸ Changes in clinical services will be based upon evidence. ▸ Clinical Services profile will be orientated to meet population-health demand and improve Eastern Health-wide 'self-sufficiency'. ▸ Configuration of services will ensure that there is adequate critical mass and appropriate clinical profiles in the interests of quality and safety, teaching and research. ▸ Clinical services will be configured to enhance timely patient flow.	A GREAT PATIENT EXPERIENCE

FIGURE 12a - *EASTERN HEALTH 2022* PRIORITY INITIATIVES

WHAT WE WILL DO		WE ARE DOING IT TO ENSURE THAT...	EASTERN HEALTH STRATEGIC DIRECTION
5	▸ Explore options to ensure that Residential Aged Care facilities are the most comfortable, attractive and well resourced facilities based on best-practice standards. This will involve reviewing the feasibility of separate smaller units within facilities for residents with challenging behaviours who have a core functional illness and the same for those with challenging behaviours associated with cognitive illness ▸ Explore the establishment of inpatient Rehabilitation and Palliative Care units at the Box Hill Hospital site. This will relieve additional projected demand on Peter James Centre and Wantirna Health, whilst optimising utilisation of what will be existing infrastructure at Box Hill Hospital. ▸ Establish an Eastern Health Bariatric Service, incorporating all aspects of obesity management (medical, surgical, allied health, capital equipment, standards for appropriate treatment and management, etc) ▸ Relocate the acute aged person's mental health (APMH) inpatient unit to either Box Hill Hospital or Maroondah Hospital and establish a second unit at the other site to increase total capacity. ▸ Enhance geographical co-location of community-based adult mental services within a hub in the Maroondah (Ringwood or Croydon) area. This could include ACAS, specialist mental health services, primary health and private-sector psychiatry. ▸ Establish an Eastern Health Pain Management Service, incorporating all aspects of pain management (medical, anaesthetic intervention, allied health, self management, psychological, SACS, standards for appropriate treatment and management, etc). This must be accessible across all Eastern Health sites. ▸ Develop an Eastern Health comprehensive Ophthalmology Service that is accessible from all larger sites and considers both planned and unplanned streams of care. ▸ Explore the co-location of Turning Point Alcohol and Drug Centre and Spectrum to optimise synergies that exist between the two services which both have a statewide role/function, and a focus on training, research and waiting lists. ▸ Establish an anorectal physiology laboratory within an Endoscopy suite and commission (already purchased) equipment at Maroondah Hospital. ▸ Develop formalised arrangements with Peter MacCallum Radiotherapy Services regarding expansion of capacity in the east, particular in and around Box Hill Hospital. ▸ Explore the feasibility of establishing a mother-baby unit in the outer east area of the primary catchment. ▸ Provide appropriately configured and well-lit procedure rooms adjacent to all outpatient services to allow for immediate, minor procedures and avoid unnecessary delays to treatment (and additions to waiting lists). ▸ Consider the establishment of a stand-alone, community-based surgical centre for same-day excisions, flexible cystoscopies and endoscopies. ▸ Explore the acquisition of medical equipment in Urology, including cystoscopes, rigid and flexible uretoscopes , a laser machine, and ongoing laser fibre. ▸ Develop a business case for robotic-assisted equipment to be used to enhance surgical outcomes and reduce length of stay (Urology, Colorectal Services). ▸ Explore the establishment of a 'hybrid operating theatre' at Box Hill Hospital which enables radiological and operating procedures to be undertaken concurrently. ▸ Ensure that there is a non-invasive vascular laboratory as close to the inpatient ward as possible (at Box Hill Hospital). ▸ Consider the design of physical environments to promote informal meetings and discussion amongst clinical staff.		A GREAT PATIENT EXPERIENCE

FIGURE 12a - *EASTERN HEALTH 2022* PRIORITY INITIATIVES

	WHAT WE WILL DO	WE ARE DOING IT TO ENSURE THAT...	EASTERN HEALTH STRATEGIC DIRECTION
6	**Establish models of care that are tailored to the requirements of older people within all services.** This is about working to establish Eastern Health as a centre for excellence in the management of acutely ill older people. It is about embedding care of older people into what we do right across our health service – acute medicine, surgery, ambulatory - and requires a whole-of-health-service approach. It is about co-locating acute geriatric medicine within acute settings and developing new standards for our services that are consistent with evidence-based management of older people. We will develop an 'Eastern Health way' to care for older people and it will be the way we all do it - not just something geriatricians do. Some examples of what we will do are: ▸ Selection of appropriate 'mix' of staff to understand and support the needs of older patients in all streams of care. ▸ Geographical co-location of multi-disciplinary Geriatric Evaluation & Management teams at Maroondah, Angliss and Healesville & District hospitals and rotation of medical, nursing and allied health staff. ▸ Building environments and facilities that are elder-friendly. ▸ Standard assessment of frailty for all patients over 65, regardless of complexity, and developing care plans appropriate to their level of frailty. ▸ Organisation-wide assessment of personal care participation restriction and appropriate care plans to ensure no deterioration or harm in this critical element. *Please note that this priority initiative is closely related to priority initiative number 18.*	▸ Clinical services will be provided to ensure that patients have equity of access to the full range and standard of clinical services across Eastern Health. ▸ Clinical services will be patient-centred. ▸ Changes in clinical services will be based upon evidence. ▸ Services that can safely be provided in the home or in the community will be provided in the home or the community by the most appropriate health service provider.	A PROVIDER OF GREAT HEALTHCARE

FIGURE 12a - *EASTERN HEALTH 2022* PRIORITY INITIATIVES

WHAT WE WILL DO	WE ARE DOING IT TO ENSURE THAT...	EASTERN HEALTH STRATEGIC DIRECTION
7 **Consider new models for the delivery of patient-focused maternity and paediatric services that are safe and consistent across Eastern Health.** This is about critically analysing how and where we provide maternity and paediatric services across our large catchment area, to ensure that they are geared to what patients want and are where they need them. Some examples of what we will do are: ▸ Consistent models of care offered to women and children across Eastern Health's primary catchment area, improving equity of access, range of service options and standards of service. ▸ Reduce fragmentation of maternity services that may be initially commenced in the private sector. ▸ Development of a midwifery-led practice model of care, delivered closer to where women are living. ▸ Ensure a feasible clinical service profile with sufficient critical mass to ensure the best clinical outcomes and attraction of the very best medical, nursing, midwifery and allied health staff.	▸ Clinical services will be provided to ensure that patients have equity of access to the full range and standard of clinical services across Eastern Health. ▸ Changes in clinical services will be based upon evidence. ▸ Clinical Services profile will be orientated to meet population-health demand and improve Eastern Health-wide 'self-sufficiency'. ▸ Configuration of services will ensure that there is adequate critical mass and appropriate clinical profiles in the interests of quality and safety, teaching and research. ▸ Clinical services that are encountered frequently by patients will be located close to where patients live.	A PROVIDER OF GREAT HEALTHCARE
8 **Consider capacity and infrastructure options for planned, short cycle streams of care and chronic disease (ambulatory) streams of care where it is not possible to deliver these services in the home or community.** This promotes improved patient experience of care for planned short cycle patients and chronically ill patients. It Is consistent with contemporary evidence which supports the geographical separation of planned and unplanned hospital activity for optimal patient flow and efficiency. (7). Separating the planned and unplanned streams of care reduces inefficiencies associated with infrastructure that is geographically dispersed. It would provide a centre for education, training and teaching in ambulatory services and other clinical areas. It would also assist in freeing-up space at Angliss and Maroondah hospitals in particular, but also Box Hill Hospital, for further and/or improved multi-day inpatient bed expansion. This initiative will require further analysis to confirm feasibility. Eastern Health will consider the establishment of a centre for chronic disease management, ideally located separately from any of its predominantly acute sites. This initiative could provide a platform for close collaboration between Eastern Health and Medicare Locals within the Eastern Metropolitan Region. From an Eastern Health perspective, the initiative could ultimately involve all Clinical Programs, however leadership from the Specialty Medicine and Ambulatory and Community Health Programs would provide most substantial gain in the short to medium term. In 2006-07, admissions to hospital due to ambulatory sensitive conditions accounted for more than 1 in 10 of all hospital admissions in Victoria.(19). For all age groups combined, the top 5 conditions with the greatest number of admissions in the metropolitan area were: 1. Diabetes complications 2. Dehydration and gastroenteritis 3. Pyelonephritis 4. Dental conditions; and 5. Chronic obstructive pulmonary disease (COPD). In addition, for children aged 0-14, the following additional conditions were identified: 6. Asthma 7. Ear, nose and throat infections; and 8. Convulsions and epilepsy. Eastern Health will prioritise chronic disease management across the above 8 areas.	▸ Clinical services will be provided to ensure that patients have equity of access to the full range and standard of clinical services across Eastern Health. ▸ Clinical services will be patient-centred. ▸ Changes in clinical services will be based upon evidence. ▸ Clinical Services profile will be orientated to meet population-health demand and improve Eastern Health-wide 'self-sufficiency'. ▸ Configuration of services will ensure that there is adequate critical mass and appropriate clinical profiles in the interests of quality and safety, teaching and research. ▸ Clinical services will be configured to enhance timely patient flow. ▸ Clinical services that are encountered frequently by patients will be located close to where patients live. ▸ Services that can safely be provided in the home or in the community will be provided in the home or the community by the most appropriate health service provider. ▸ Clinical services will be configured in such a way that they are sustainable and optimise utilisation of capacity across EH (financial, environmental, workforce, infrastructure, technology).	A GREAT PATIENT EXPERIENCE

FIGURE 12a - *EASTERN HEALTH 2022* PRIORITY INITIATIVES

	WHAT WE WILL DO	WE ARE DOING IT TO ENSURE THAT...	EASTERN HEALTH STRATEGIC DIRECTION
9	**Explore opportunities with St Vincent's Health and other health services to ensure timely access for Eastern Health patients to tertiary services that are not within the Eastern Health service profile.** This is about strategic, formalised arrangements with St Vincent's Health and other health services where required to enhance the certainty through which Eastern Health provides its clinical service delineation. Where a type or level of clinical service is not provided by Eastern Health, it needs to be clear where and when those services are available within the broader metropolitan health system. Current referral and transfer arrangements between Eastern Health and other health services are likely to change when the demand for health services in neighbouring population catchments increases over the next ten years. This is particularly relevant in the north and north-west areas of Melbourne. Eastern Health needs to continue to develop its relationship with St Vincent's Health which, due to its position and role within the Victorian health system, is less susceptible to the growth corridors than Eastern Health's nearest neighbouring health services. Some examples of what we will do are: ▸ Establish formalised Memorandum of Understanding (MOU) with key health service partners for the appropriate and timely referral and transfer of patients. Where particular services cannot be provided by St Vincent's Health (e. g major burns, spinal surgery) or where other health services are well-positioned to provide the service, we will work with those health services to provide formalised access and referral mechanisms that are supported by MOUs. ▸ Collaborate with Epworth Eastern and Knox Private Hospitals for reciprocal transfer arrangements that ensures appropriate and timely access to inpatient care for patients (e.g. critical care, access to specialised equipment, residential care, etc.)	▸ Clinical services will be provided to ensure that patients have equity of access to the full range and standard of clinical services across Eastern Health. ▸ Changes in clinical services will be based upon evidence. ▸ Configuration of services will ensure that there is adequate critical mass and appropriate clinical profiles in the interests of quality and safety, teaching and research. ▸ Clinical services will be configured to enhance timely patient flow. ▸ Clinical services will be configured in such a way that they are sustainable and optimise utilisation of capacity across EH (financial, environmental, workforce, infrastructure, technology).	A GREAT ACHIEVER IN SUSTAINABILITY
10	**Enable our health professionals to work to their full and extended scope of practice.** This is about using our staff to their full capacity, implementing advanced practice roles and removing non value-adding components of work for highly qualified doctors, nurses, midwives, allied health and clinical support staff. It is about investing in expansion of our staff capacity and designing our service delivery systems to support that. Some examples of what we will do are: ▸ Nurse-led clinics and provision of pre-procedure assessments, with scope of practice tailored to specific clinical service groups and patient cohorts. ▸ Nurse practitioners or advanced practice roles (for example, in management of hepatitis, multiple sclerosis, irritable bowel syndrome and other gastroenterological conditions, breast care, etc). ▸ Allied health practitioners (for example, in management of orthopaedic patients). ▸ Providing options for substitution of medical staff time and resource (for example, national maternity reforms and midwife-led birthing services, primary management of acute general medical patients as appropriate, endoscopy nurses, modification of insulin medication for diabetics, etc.) ▸ Specialist nurses or allied health staff to coordinate patient journeys and ensure appropriate patient management at the right time and the right place. This includes the episodic phase of care and safe exit from Eastern Health services (for example, interface with general practitioners and community-based healthcare providers for smooth and safe transfer of care). ▸ Considering the role and relationship of theatre nursing staff and theatre technicians.	▸ We provide the best quality and standard of care. ▸ Clinical services will be patient-centred. ▸ Changes in clinical services will be based upon evidence. ▸ Clinical services will be configured to enhance ▸ timely patient flow. Clinical services will be configured in such a way that they are sustainable and optimize utilization of capacity across EH (financial, environmental, workforce, infrastructure, technology).	A GREAT PLACE TO LEARN AND WORK

FIGURE 12a - *EASTERN HEALTH 2022* PRIORITY INITIATIVES

WHAT WE WILL DO	WE ARE DOING IT TO ENSURE THAT...	EASTERN HEALTH STRATEGIC DIRECTION
11 **Establish and enhance coordinated, multi-disciplinary specialty and ambulatory clinics, providing patients with a one-stop-service.** This is about bringing all of the necessary experts and services together for the sake of large groups of patients who need all of them – but who currently need to navigate multiple appointments over weeks at different geographical locations. By doing this, Eastern Health will become increasingly patient-centred and less orientated around its sites, services or staff, which has been historically derived. Some examples of what we will do are: ▸ Evidence-based practice for an effective, holistic and multidisciplinary approach to chronic, complex disease management where teams come together for a short period of time to provide the full suite of patient services to 'common' patient groups. Examples include musculoskeletal clinic, whereby a Rheumatologist, Orthopaedic Surgeon, Pain specialist and Rehabilitation team come together to see patients with related but different medical issues. ▸ Utilisation of telemedicine to provide accessibility to specialist consultation. ▸ Integrated Eastern Health scheduling system. ▸ Implement improvements identified through the Specialist Clinic Redesigning Care Project which is underway in 2012. ▸ Explore partnerships with private healthcare providers, community health and other not-for-profit providers for complementary services co-located with Eastern Health services.	▸ Clinical services will be patient-centred. ▸ Changes in clinical services will be based upon evidence. ▸ Configuration of services will ensure that there is adequate critical mass and appropriate clinical profiles in the interests of quality and safety, teaching and research. ▸ Clinical services will be configured to enhance timely patient flow.	A GREAT PATIENT EXPERIENCE
12 **Expand and promote Advance Care Planning protocols and procedures across all Eastern Health sites.** Eastern Health needs to sharpen its focus on Advance Care Planning protocols that will help patients achieve their care goals, as distinct from 'our' goals for them. Some examples of what we will do are: ▸ Early identification of patients who would potentially benefit from advance care planning. ▸ Early referral to palliative care team ▸ Information sharing and transfer between service providers, sites and services. ▸ Working to influence Eastern Health staff and community perceptions and understanding of Advance Care Planning. ▸ Collaboration and engagement with primary care providers within Eastern Health's primary catchment to achieve a consistent advance care planning strategy across hospital and community settings.	▸ Clinical services will be provided to ensure that patients have equity of access to the full range and standard of clinical services across Eastern Health. ▸ Clinical services will be patient-centred. ▸ Changes in clinical services will be based upon evidence. ▸ Services that can safely be provided in the home or in the community will be provided in the home or the community by the most appropriate health service provider. ▸ Clinical services will be configured in such a way that they are sustainable and optimise utilisation of capacity across EH (financial, environmental, workforce, infrastructure, technology).	A GREAT PATIENT EXPERIENCE

FIGURE 12a - *EASTERN HEALTH 2022* PRIORITY INITIATIVES

	WHAT WE WILL DO	WE ARE DOING IT TO ENSURE THAT...	EASTERN HEALTH STRATEGIC DIRECTION
13	**Invest in partnerships with general practitioners, community providers and Medicare Locals.** This is about establishing a centre for General Practitioner training and development and working with Medicare Locals on joint collaborative ventures. It's about working with GPs as 'part' of one team and requires us to actually invest in this area for real changes to be made. Some examples of what we will do are: ▸ Work with general practitioners regarding their role in early identification and intervention;-Establishing a centre for general practitioner training and development (preferably co-located with Eastern Health ambulatory services). ▸ Working with Medicare Locals to establish collaborative joint ventures that ensure optimal service delivery and minimised duplication of services. This will include exploring investment in 'health pathways' to ensure safe and appropriate management of common health issues in the eastern region. ▸ Lead and actively participate in programs with community partners which reduce unnecessary emergency department presentations. ▸ Provide direct access to schedule outpatient appointment or acute assessment clinics where agreed criteria are met (for example, blood and cancer services) ▸ Embed capacity for early identification and intervention to reduce hospitalisation and acute exacerbations of chronic conditions. ▸ Work with general practitioners and community providers for early and comprehensive post-discharge handover and 'outpatient discharge' handover. ▸ Focus upon adequate referral documentation (to EH and from EH). ▸ Enhance information provided to general practitioners, Ambulance Victoria and other community providers regarding EH Services and locations and actively promote these services with these groups. ▸ Improve consultation services for the management of alcohol and drug conditions in general practice. ▸ Expand nurse and allied health outreach programs (for example, plaster management)	▸ Clinical services will be provided to ensure that patients have equity of access to the full range and standard of clinical services across Eastern Health. ▸ Clinical services will be patient-centred. ▸ Changes in clinical services will be based upon evidence. ▸ Clinical Services profile will be orientated to meet population-health demand and improve Eastern Health-wide 'self-sufficiency'. ▸ Configuration of services will ensure that there is adequate critical mass and appropriate clinical profiles in the interests of quality and safety, teaching and research. ▸ Clinical services will be configured to enhance timely patient flow. ▸ Clinical services that are encountered frequently by patients will be located close to where patients live. ▸ Services that can safely be provided in the home or in the community will be provided in the home or the community by the most appropriate health service provider. ▸ Clinical services will be configured in such a way that they are sustainable and optimize utilization of capacity across EH (financial, environmental, workforce, infrastructure, technology).	A GREAT PARTNER WITH OUR COMMUNITIES
14	**Achieve an Eastern Health-wide orientation of clinical services and access points.** This is about Eastern Health-wide leadership of clinical service groups, single waiting list management, scheduling systems and single point of referral. This is about better access and equity across Eastern Health and breaking down the barriers that lead to otherwise similar patients waiting inequitable lengths of time for treatment, simply based upon the site they present to. Some examples of what we will do are: ▸ Appoint Eastern Health Heads of Unit in clinical service groups where these do not already exist and empower these positions to implement a 'chain of command' and consistent models of care which encompass all sites across Eastern Health. ▸ Develop a single surgical waiting list and consolidate disparate waiting lists to promote equity of access to Eastern Health services. Improve systems for Scheduling and waiting list management across Eastern Health. ▸ Develop a single outpatient scheduling system and work to eliminate outpatient waiting lists. ▸ Develop and implement a single point of referral, with expertise provided to navigate Eastern Health services seamlessly 'back-of-house'. ▸ Maintain and build partnerships with key transport providers within the community to ensure appropriate access to health services for the most disadvantaged within our community (e.g. Ambulance Victoria and other non-urgent private, volunteer and community-based providers).	▸ Clinical services will be provided to ensure that patients have equity of access to the full range and standard of clinical services across Eastern Health. ▸ Clinical services will be patient-centred. ▸ Clinical Services profile will be orientated to meet population-health demand and improve Eastern Health-wide 'self-sufficiency'. ▸ Configuration of services will ensure that there is adequate critical mass and appropriate clinical profiles in the interests of quality and safety, teaching and research. ▸ Clinical services will be configured to enhance timely patient flow. ▸ Clinical services will be configured in such a way that they are sustainable and optimize utilization of capacity across EH (financial, environmental, workforce, infrastructure, technology).	A PROVIDER OF GREAT HEALTHCARE

FIGURE 12a - *EASTERN HEALTH 2022* PRIORITY INITIATIVES

WHAT WE WILL DO	WE ARE DOING IT TO ENSURE THAT...	EASTERN HEALTH STRATEGIC DIRECTION
15 **Develop specific strategies for targeted groups on the waiting list to enhance preparedness for admission, improve communication, reduce functional decline and enhance quality of life while they are waiting for admission.** Where patients are on the elective surgery waiting list, Eastern Health must do all we can to see they don't deteriorate whilst waiting. There are great examples of where this is working well and this could be translated to other types of patients. Some examples of what we will do are: ▸ Consider how the osteoarthritis of the hip and knee service (OAHKS) model can be applied more broadly. ▸ Explore supportive models of care that are best provided in the community.	▸ Clinical services will be provided to ensure that patients have equity of access to the full range and standard of clinical services across Eastern Health. ▸ Clinical services will be patient-centred. ▸ Changes in clinical services will be based upon evidence. ▸ Clinical services will be configured to enhance timely patient flow. ▸ Services that can safely be provided in the home or in the community will be provided in the home or in the community by the most appropriate health service provider.	A GREAT PATIENT EXPERIENCE
16 **Orientate Eastern Health care delivery systems around the time of day and days of week that the community demonstrates it needs healthcare.** This is about critically evaluating our '9 til 5, Monday – Friday' health service. Our clinicians tell us that patients who are admitted on a Monday have a different standard of care to those admitted on a Friday. Lack of access to allied health, ambulatory care services and diagnostic services makes the journey of a weekend or evening patient very different to that of a weekday or daytime patient. This initiative is about 'smoothing' the lumps and bumps that lead to this variation and taking a closer look at our after hours and weekend services. Some examples of what we will do are: ▸ Focus on weekend allied health & clinical support services (for example, pharmacy for chemotherapy services, etc) ▸ Focus on access to diagnostic services out of hours (pathology, CT scans, MRI, etc). ▸ Focus on emergency and planned theatre access and anaesthetic cover after hours and weekends. ▸ Out of hours access to clinical services tailored to working families that cannot take time from work to attend appointments (particularly for chronic illness). ▸ Clarify expectations and standards for healthcare staff who are 'on-call' and when 'recall' is required.	▸ Clinical services will be provided to ensure that patients have equity of access to the full range and standard of clinical services across Eastern Health. ▸ Clinical services will be patient-centred. ▸ Changes in clinical services will be based upon evidence. ▸ Clinical Services profile will be orientated to meet population-health demand and improve Eastern Health-wide 'self-sufficiency'. ▸ Configuration of services will ensure that there is adequate critical mass and appropriate clinical profiles in the interests of quality and safety, teaching and research. ▸ Clinical services will be configured to enhance timely patient flow. ▸ Clinical services will be configured in such a way that they are sustainable and optimise utilisation of capacity across EH (financial, environmental, workforce, infrastructure, technology). ▸ Minimises delay in discharges, decreases ALOS, improves patient satisfaction and provides equity of service quality at all times.	A PROVIDER OF GREAT HEALTHCARE

FIGURE 12a - *EASTERN HEALTH 2022* PRIORITY INITIATIVES

WHAT WE WILL DO	WE ARE DOING IT TO ENSURE THAT...	EASTERN HEALTH STRATEGIC DIRECTION
17 **Develop an active research program whereby research is translated into clinical practice at Eastern Health and clinical practice is used to inform research.** Eastern Health aims to be a leading health service in the implementation of evidence-based research at the point of service delivery. Eastern Health will be a leader in embedding research outcomes into standard work practices every day. Eastern Health will change the way we identify and manage people with health issues, based on what we are learning through our own local research. We will also invest in research that will help overcome known challenges in population health in the eastern region and overall health service delivery systems. Eastern Health will increase our focus on research, education and training that is associated with: ▸ Population-based health service planning and evaluation; ▸ Evaluation of new models of care that are recommended within the Plan. Examples of these include the streams of care approach to clinical service delivery and the increasing ambulatory care models; and ▸ Evaluation of the effectiveness of quality and safety management systems in improving the quality of care and clinical outcomes.	▸ Clinical services will be provided to ensure that patients have equity of access to the full range and standard of clinical services across Eastern Health. ▸ Changes in clinical services will be based upon evidence. ▸ Clinical Services profile will be orientated to meet population-health demand and improve Eastern Health-wide 'self-sufficiency'.	A GREAT PLACE TO LEARN AND WORK
18 **Achieve the appropriate blend of generalist and sub-specialist clinical staff to improve self-sufficiency in particular areas of clinical practice and ensure Eastern Health provides a level of service equal to or better than other services in Melbourne.** There is a trend for sub-specialisation in surgery which is well-recognised by the Royal Australasian College of Surgeons (RACS) and the role of a general physician is becoming increasingly blurred as medical sub-specialisation also increases. Eastern Health needs to pay particular attention to getting the balance right between sub-specialisation and generalisation. Patients today don't come to us with 'one thing wrong' – they often have multi-system chronic and complex illnesses that require holistic care - arguably this is best achieved through generalist physicians or geriatricians with specialists called upon as needed. Likewise, the critical role of general surgeons, particularly in emergency surgical management, cannot be underestimated. Some examples of what we will do are: ▸ Increasing the proportion of patients primarily managed by general physicians and geriatricians with specialty medicine and surgery utilised as required. ▸ Promoting and investing in general surgery as a specialty in its own right. ▸ Women's health physiotherapy ▸ Emergency medicine-specialist clinical support (pathology, imaging) ▸ Hepatitis psychiatry liaison ▸ Cancer specialist radiologists ▸ Interventional radiologists	▸ Clinical services will be provided to ensure that patients have equity of access to the full range and standard of clinical services across Eastern Health. ▸ Clinical services will be patient-centred. ▸ Changes in clinical services will be based upon evidence. ▸ Clinical services will be configured to enhance timely patient flow. ▸ Clinical services will be configured in such a way that they are sustainable and optimise utilisation of capacity across EH (financial, environmental, workforce, infrastructure, technology).	A GREAT PLACE TO LEARN AND WORK

FIGURE 12a - *EASTERN HEALTH 2022* PRIORITY INITIATIVES

WHAT WE WILL DO	WE ARE DOING IT TO ENSURE THAT...	EASTERN HEALTH STRATEGIC DIRECTION
19 **Respect and value diverse communities through tailored models of care.** Research has shown that "providing culturally responsive health care may be viewed as a viable strategy to improve the links between access, equity, quality and safety, better health outcomes for culturally and linguistically diverse populations and as a strategy to enhance the cost effectiveness of health service delivery."(Cultural responsiveness framework – Guidelines for Victorian health services). At Eastern Health, this priority initiative is about identifying where we have gaps in our standard models of care that do not consider the needs of particular groups in our diverse population – for instance culturally and linguistically diverse communities, Aboriginals, gay and lesbian patients and people with disabilities. This is about doing things differently (and in some cases all of the time) that will make a difference to these groups. Some examples of what we will do are: ▸ Skilled liaison personnel for people of Aboriginal and other backgrounds with values and beliefs that impact on their healthcare management. ▸ Building service systems to take into account demographic and culturally-related health issues. For example, there is a higher incidence of diabetes and renal disease amongst the Sri Lankan population; the rate of diabetes in Aboriginals is higher than non-Aboriginals. ▸ Expand and integrate interpreter services across Eastern Health. ▸ Ensure that Eastern Health staff are aware of the Human Rights Charter and deliver care that is always consistent with it. ▸ Expand the depth and breadth of community participation, engagement and advice. ▸ Consistent with Eastern Health's Community Participation and Responsiveness Plan 2010-13, Eastern Health will review its current performance in relation to the following Department of Health policies and design and implement initiatives to improve performance where gaps are identified: ▸ Cultural Responsiveness Framework ▸ Disability Action Plan ▸ Aboriginal and Torres Strait islander policy ▸ DHS Language Services Policy ▸ Gay, lesbian, bisexual, transgender and intersex inclusive practice for health and human services guide	▸ Clinical services will be provided to ensure that patients have equity of access to the full range and standard of clinical services across Eastern Health. ▸ Clinical services will be patient-centred. ▸ Clinical Services profile will be orientated to meet population-health demand and improve Eastern Health-wide 'self-sufficiency'.	A PROVIDER OF GREAT HEALTHCARE

FIGURE 12a - *EASTERN HEALTH 2022* PRIORITY INITIATIVES

WHAT WE WILL DO	WE ARE DOING IT TO ENSURE THAT...	EASTERN HEALTH STRATEGIC DIRECTION
20 **Align Clinical Support services with the clinical service profile of each hospital.** This is about making sure that we have the infrastructure and expertise in our clinical support areas to make the rest of this Plan possible. Eastern Health needs to provide the right environment for excellence in clinical practice. Presently, clinical practice in some areas is limited only by the absence of diagnostic services and other clinical support services. Clinical Support services are not an optional extra in being more self-sufficient as a health service – in many cases, they are pre-requisites and as such, Eastern Health must keep this priority area top of mind. Some examples of what we will do are: ▸ Progress the establishment of an MRI shell and the acquisition of an MRI at Maroondah Hospital and explore the acquisition of an MRI at the Angliss Hospital. This will improve access to diagnostic services at Maroondah Hospital for General Medicine, Oncology, Urology and numerous other clinical services at a site that is expanding and where patient complexity is increasing. It will improve access to diagnostic services at the Angliss Hospital and support the expanded acute geriatric and general medical service and critical care services at the site. ▸ Explore the expansion of pathology and medical imaging services to Peter James Centre and Wantirna Health, in recognition of the increasing complexity of patients at these sites. ▸ Establishment of an Eastern Health interventional radiological service at Box Hill Hospital, supported by a hybrid operating suite, with a Mini C-arm, that combines radiological and operative procedures. This would be well utilised by Vascular Surgery, Thoracic Surgery, Orthopaedics, Urology, Endoscopy (ERCPs), Plastics and others who utilise image intensifiers during procedures. ▸ Investigate the establishment of a Vascular Laboratory at Maroondah Hospital. ▸ Improve Eastern Health self-sufficiency in Nuclear Medicine capability at Box Hill Hospital. This service must meet the growing demands and requirements of this tertiary level hospital (Breast & Endocrine Surgery, thyroid scans for Endocrinology, etc). ▸ Explore the acquisition of imaging technologies (e.g PET). ▸ Investigate the expansion of tertiary-level ultrasonographers and consider requirements to attract this expertise to Eastern Health. ▸ Expand ambulatory-based, non-invasive cardiac investigative services such as stress testing, echocardiograms, Holter Monitor, ECG, Thallium and Dobutamine stress testing. ▸ Explore specialised investigative services to support an expanding cardiology service at Eastern Health, specifically cardiac CT and coronary MRI services. ▸ Improve capacity for interventional pulmonology, including endobronchial ultrasound (EBUS) to enhance the management of lung cancer. ▸ Develop on-site lung function testing capacity at the Angliss Hospital to enhance inpatient consultation services and outpatient management of respiratory patients. ▸ increased pharmacy support for Haematology patients. ▸ Work together with private providers to enable linkage of patient investigation results. ▸ Enhance service capacity and capability in image-intensifier (Imaging) services at Box Hill Hospital and Maroondah Hospital. ▸ Review access arrangements for angiography at Box Hill Hospital with a view to ensuring appropriate, timely access for treatment of time-critical vascular patients. ▸ Establish clinical support services at Wantirna Health to ensure capacity to implement the Eastern Health Chronic Disease Management Centre.	▸ Clinical services will be provided to ensure that patients have equity of access to the full range and standard of clinical services across Eastern Health. ▸ Changes in clinical services will be based upon evidence. ▸ Clinical Services profile will be orientated to meet population-health demand and improve Eastern Health-wide 'self-sufficiency'. ▸ Configuration of services will ensure that there is adequate critical mass and appropriate clinical profiles in the interests of quality and safety, teaching and research. ▸ Clinical services will be configured to enhance timely patient flow.	A PROVIDER OF GREAT HEALTHCARE


EMERGENCY

13 NEW AND PLANNED INVESTMENT IN OUR BUILDINGS

Since 2006, Eastern Health has undergone an extensive building program which has seen capital improvement and expansion of the following areas:

- Angliss Hospital Community Rehabilitation Centre
- Angliss Hospital Education Precinct
- Angliss Hospital sub-acute service expansion
- Healesville Learning Centre
- Maroondah Hospital Expansion project
- Maroondah Hospital Emergency Department
- Maroondah Hospital Medical Imaging Department
- Maroondah Hospital Inpatient Units 1 & 2 (Adult Mental Health)
- Maroondah Hospital Education Precinct
- Box Hill Hospital Adolescent Inpatient Unit
- Box Hill Hospital Enabling Works (upgrade of essential infrastructure)
- Camberwell Community Care Unit
- Prevention and Recover Care (PARC) Bona Street, Ringwood
- Ringwood Distribution Centre (Eastern Health Supply and Clinical office areas)
- Peter James Centre, South Ward redevelopment (Aged Persons Mental Health)

Eastern Health 2022 has been developed within the context of several major capital developments that are either underway or have been planned and funded at Eastern Health. These developments will provide substantial additional capacity to meet the increasing demands on our health service and will also ensure that the physical environment in which so much of our work is undertaken is of an excellent standard and in line with the community's expectations.

The key developments where funding has been confirmed are detailed as follows:

13.1 BOX HILL HOSPITAL REDEVELOPMENT

At the time of writing this Plan, a major redevelopment of the Box Hill Hospital was well underway, having commenced in November 2011. The new Box Hill Hospital is scheduled to be completed in 2014–15.

Most significantly, this $447.5million redevelopment project will deliver 224 additional beds at Box Hill Hospital, which consist of:

- 101 additional adult multi-day beds
- New emergency department
- 6 additional ICU beds
- 3 additional paediatric beds
- 4 additional newborn nursery cots
- 18 additional unplanned short stay and medical assessment beds
- 2 additional chest pain evaluation beds
- 14 additional maternity beds
- 14 additional day medical beds
- 5 additional day surgery beds
- 8 additional day oncology beds
- 5 additional foetal medicine beds
- 12 additional renal dialysis chairs
- 2 additional procedural beds (cardiac catheterisation, shared, recovery, etc)
- 30 additional sub-acute beds

13.2 MAROONDAH HOSPITAL EXPANSION PROJECT (STAGE 2B)

At the time of writing this Plan, a $22m capital expansion of the Maroondah Hospital was also well underway.

This project will deliver 48 additional beds at Maroondah Hospital, consisting of:

- 6 additional intensive care/critical care beds
- 22 additional acute beds (including 4 oncology beds)
- 20 additional sub-acute beds

13.3 HEALESVILLE & DISTRICT HOSPITAL SITE (INCORPORATING YARRA VALLEY COMMUNITY HEALTH SERVICE)

There are plans to commence a $3m upgrade of the facilities at the Healesville and District Hospital site, including the Yarra Valley Community Health Service.

13.4 WANTIRNA HEALTH

At the time of writing this Plan, planning for a substantial capital development is underway to expand Eastern Health's learning facilities in partnership with Deakin and La Trobe Universities. The new centre, to be located at Wantirna Health, will be available to all staff at Eastern Health and its academic and education partners.


Family Birthing Centre
Outpatients / 3 West
Special Care Nursery
COUNTDOWN TO
85,000TH ANGLISS HOSPITAL BA
85001
Hospital

14 CONFIGURATION OF CLINICAL SERVICES BY SITE BY 2022

14.1 CURRENT CONFIGURATION OF CLINICAL SERVICES BY SITE

The following tables outline the current role of each Eastern Health Clinical Service Group by site. The current service levels are defined using the New South Wales Health Department *Guide to role delineation of health services (2002) unless otherwise indicated.*

***Figure 14.1** – Eastern Health Clinical Service Role Delineation 2011-12*

FIGURE 14.1

DIRECTORATE	CLINICAL PROGRAM	CLINICAL SERVICE GROUP	ROLE DELINEATION (2011/12)						
			BHH	MH	AH	WH	PJC	YRH	HH
Acute Health	Emergency and General Medicine	General Medicine	6	5-6	4	-	-	1	2
		Emergency Services	5	5	3	-	-	-	-
		Intensive Care	6	5	3-4	-	-	-	-
	Women & Children's	Gynaecology	5	1	4	-	-	2	2
		Maternity Services	5[V]	-	4[V]	-	-	1[V]	2[V]
		Paediatric Services							
		- Paediatric medicine	3-4	2-3	3	-	-	-	-
		- Paediatric surgery	4	3	3	-	-	-	-
		- Neonite	5[V] 3-4	- -	5[V] 3	- -	- -	- -	- 2[V]2
	Specialty Medicine	Cardiology	5-6	4-5	4-5	-	-	-	-
		Dermatology	5	-	-	-	-	-	-
		Endocrinology	6	6	5	4	4	-	2
		Endoscopy Services [Q]	3	2-3	1	-	-	1	1
		Gastroenterology	6	6	4	-	-	-	-
		Haematology	6	5	-	-	-	1	-
		Infectious Diseases	5-6	5-6	5-6	-	-	-	-
		Neurology	6	4-5	3	-	-	1-2	-
		Oncology, Chemotherapy and Radiotherapy	6	4-5	2	-	-	3	-
		Renal Medicine and Dialysis	6	3	1-2	-	Dialysis	-	-
		Respiratory Medicine	6	4-5	4	-	-	-	-
		Rheumatology	5	3	-	-	-	-	-
	Surgery	Breast Surgery	5	5	3	-	-	2	-
		Colorectal Surgery	6	4-5	4	-	-	-	-
		Ear, Nose, & Throat Surgery	5	3	4	-	-	-	-
		General Surgery	6	4	3	-	--	2	2
		Ophthalmology	-	-	-	-	-	3	-
		Orthopaedic Surgery	5	4	2	-	-	2	-
		Plastic Surgery	5-6	5-6	3-4	-	-	3-4	-
		Thoracic Surgery	5	-	-	-	-	-	-
		Upper Gastro-Intestinal Surgery	6	4	3	-	-	2	2
		Urology	6	1-2	3	-	-	3	-
		Vascular Surgery	6	-	-	-	-	-	-
Continuing Care, Community and Mental Health	Mental Health, Turning Point, Alcohol & Drugs	Adult Mental Health	5	5	-	-	-	-	-
		Ages Person's Mental Health	-	-	-	-	3	-	-
		Turning Point, Alcohol & Other Drugs	NSW role delineation definition not applicable – Provide statewide services						
		Child and Youth Mental Health Service (CYMHS)	5	-	-	-	-	-	-
		Spectrum (statewide service for people who have personality disorders)	No NSW role delineation definition Provide statewide services						
	Continuing Care	Geriatric evaluation and management	2	2	6	5	5	-	4
		Residential Aged Care	No NSW role delineation definition – Provide services at eastern region						
		Palliative Care	Consultative			5	Consultative		
		Rehabilitation	-	-	4	-	4	-	-
	Community Health	Community Health	General = 4; Community Nursing =2; Aboriginal Health=3 ; Sexual Health =1; Women's Health=3						
	Ambulatory Services	Ambulatory Services	No NSW role delineation definition – Provide services to all site						

[V]= Victorian Department of Health (2010) Capability Framework for Victorian Maternity and Newborn Service Framework

14.2 FUTURE CONFIGURATION OF CLINICAL SERVICES BY DIRECTORATE, PROGRAM AND SITE

Figure 14.2 outlines the future configuration of each Eastern Health Clinical Service Group by Directorate, Program and site, by the year 2022.

Major Centre (Level 5 or 6 Service)

Impatient services on-site, and integrated with a Major (level5-6) Centre

Planned short cycle inpatient services on-site, and integrated with a Major (Level 5-6) Centre

Inpatient consultation available, ambulatory/outpatient service only on-site, integrated with a Major Centre

No inpatient/outpatient services on site, but integrated with a Major Centre

Statewide Service

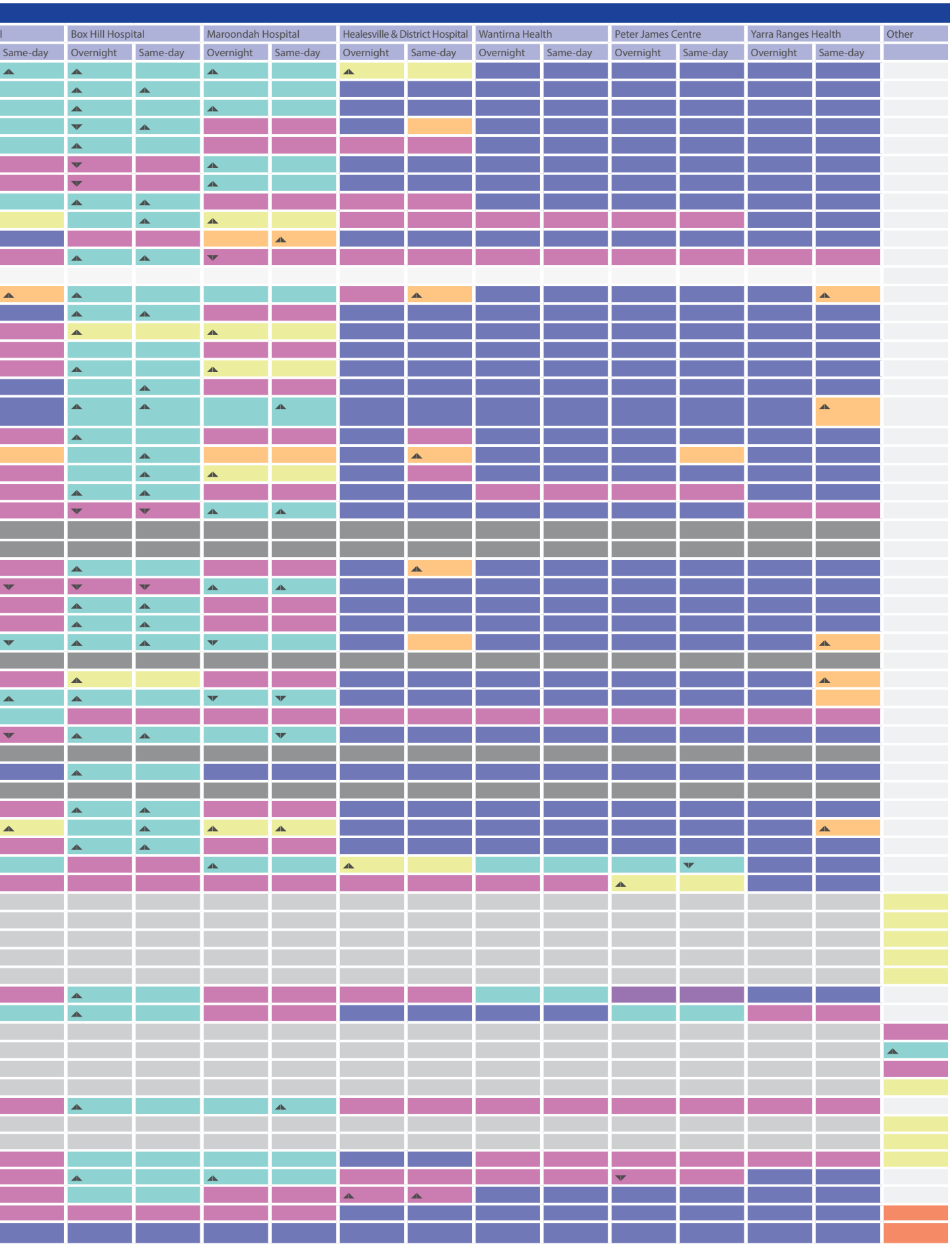
Service provided by another public health service consistent with formalised arrangements

▲ Increased bed capacity at this site compared with 2010

▼ Decreased bed capacity at this site compared with 2010

FIGURE 14.2

		Eastern Health Clinical Service Group	Total Eastern Health		Angliss Hospita
		Bed Capacity	Overnight	Same-day	Overnight
ACUTE HEALTH DIRECTORATE	Emergency & General Medicine	General Medicine	▲	▲	▲
		Emergency Services	▲	▲	▲
		Intensive Care/Critical Care Service	▲		▲
	Women & Children's	Gynaecology	▼	▲	
		Maternity Services	▲		
		Paediatric medicine	▲		▼
		Paediatric surgery	▲		▼
		Neonatology ('qualified' newborns)	▲	▲	
	Specialty Medicine	Cardiology (including invasive cardiology)	▲	▲	▲
		Dermatology (including Paediatric)		▲	
		Endocrinology	▲	▲	
		Endoscopy Services (beds distributed through other CSGs)			
		Gastroenterology and Hepatology Service	▲	▲	▲
		Haematology (will be integrated with EH Blood & Cancer Service)	▲	▲	
		Infectious Diseases	▲		
		Neurology	▼	▼	
		- Acute Stroke Units	▲		
		-Multiple Sclerosis (MS) Service		▲	
		Blood and Cancer Services (incorporating Oncology, Chemotherapy & Radiotherapy)	▲	▲	
		Renal Medicine (inpatient multi-day)	▲		
		Renal Medicine (same-day dialysis)		▲	
		Respiratory Medicine	▲	▲	
		Rheumatology	▲	▲	
	Surgery	Breast & Enodcrine Surgery	▲		
		Burns (major)			
		Cardiac Surgery			
		Colorectal Surgery	▲	▲	
		Ear, Nose and Throat Surgery	▲		▼
		Facio-maxilliary Surgery	▲		
		Head and neck Surgery	▲		
		General Surgery	▲	▲	▲
		Neurosurgery			
		Ophthalmology	▲	▲	
		Orthopaedic Surgery	▲		▲
		Pain Management Service	▲		▲
		Plastic Surgery	▲	▲	
		Spinal injury/surgery			
		Thoracic surgery	▲		
		Trauma (major)			
		Upper Gastro-intestinal Surgery (including bariatric surgery)	▲	▲	
		Urology	▲	▲	▲
		Vascular Surgery	▲	▲	
CONTINUING CARE, COMMUNITY AND MENTAL HEALTH	Continuing Care	Geriatric evaluation and management	▲		▲
		Acute Medical Care			
		Residential Aged Care			
		- Edward Street Nursing Home			
		- Mooroolbark			
		- Monda Lodge			
		- Northside			
		Palliative Care	▲		
		Rehabilitation	▲		
	Ambulatory & Community	Community Health			
		Ambulatory Services	▲		
		- Transition Care Program (community)			
		- Transition Care Program (bed-based)			
	Mental Health	Adult Mental Health	▲	▲	
		- Community Care Unit - Canterbury Rd			
		- Community Care Unit - Maroondah			
		- Prevention and Recovery Care (PARC) - Linwood & Maroondah			
		Acute Aged Persons' Mental Health	▲		
		Child and Youth Mental Health Service (CYMHS)			
	State-wide Service	Turning Point, Alcohol & Other Drugs			
		Spectrum			


Box Hill Hospital
Maroondah Hospital
Healesville & District Hospital
Wantirna Health
Peter James Centre
Yarra Ranges Health
Other
Same-day
Overnight
Same-day
Overnight
Same-day
Overnight
Same-day
Overnight
Same-day
Overnight
Same-day
Overnight
Same-day

15 WHAT DOES THIS MEAN FOR EASTERN HEALTH'S LARGER SITES?

ANGLISS HOSPITAL

Angliss Hospital will support low-to-medium complexity inpatient and outpatient healthcare needs across an expanded range of general and specialty clinical services. These include emergency medicine, general medicine, general surgery, orthopaedic surgery, urology, maternity, cardiology, gastroenterology, renal dialysis, geriatric evaluation and management, and rehabilitation as well as programs to care for patients in their own homes.

The hospital will include a critical care service that supports the expanded range of clinical services required at the site and a busy emergency service. As the new services are established, Angliss Hospital will be positioned to accommodate more complex patients.

Inpatient accommodation is a priority and the site will undergo revised master planning to ensure its buildings and infrastructure are able to meet future demands.

BOX HILL HOSPITAL

Box Hill Hospital will support medium-to-high complexity inpatient and outpatient healthcare needs across a broad range of clinical services that include maternity, general and specialty medicine and surgery, emergency medicine and intensive care services.

Mental health services will be continued, expanded and established for people of all ages – children, adults and older persons.

The hospital will expand its sub-acute focus, with new services established in palliative care and rehabilitation to address an increasing demand for these services within the community and in particular, in the areas surrounding the hospital.

By 2014–15, the Box Hill Hospital redevelopment will be completed. This $447.5m redevelopment of emergency, surgery and critical care services will enhance inpatient and ambulatory services, and provide additional capacity to care for people living in the east. The redevelopment will be supported by training, research and state-of-the art diagnostic services.

HEALESVILLE & DISTRICT HOSPITAL (INCLUDING YARRA VALLEY COMMUNITY HEALTH SERVICES)

Healesville and District Hospital, including the services of Yarra Valley Community Health, will support low complexity inpatient, ambulatory and community health services to the outer east community. Due to its geographical location within Eastern Health's primary catchment area, it is ideally situated to provide services that are utilised most frequently by the local community.

The expanded suite of clinical services will include general medicine, renal dialysis, geriatric evaluation and management, community health and a suite of specialist and ambulatory services that are tailored to the needs of the local population. Based on strong support by the local community, the hospital will also continue to provide endoscopy services and low complexity surgery.

In 2012, faced with declining demand for birthing services at the site and serious concerns regarding the lack of availability of an appropriately skilled mix of staff to support a safe, high quality birthing service, a decision was made to move birthing services from Healesville & District Hospital to Box Hill Hospital and Angliss Hospital. As part of a substantial capital upgrade of the site (and with strong support by the local community for birthing services to recommence at the site) provision will be made for a birthing suite to accommodate birthing services at the Healesville & District Hospital. This is to ensure that there are appropriate facilities available to local women and families when and if the demand for birthing services at the site increases and if the appropriately skilled mix of staff becomes available to support a safe, high quality birthing service.

The site will support innovative maternity services which will increase the hospital's capacity to provide antenatal and postnatal care to women closer to where they live.

MAROONDAH HOSPITAL

Maroondah Hospital will support medium to high complexity inpatient and outpatient needs across a broad range of expanded clinical services. These include emergency medicine, intensive care, general and specialty surgery and medicine, and adult mental health. The site will accommodate an integrated inpatient paediatric service, with paediatric medicine and surgery being substantially expanded at the hospital. New services will be established for acute aged persons mental health and geriatric evaluation and management.

As a result of its location within Eastern Health's catchment area, the hospital will play an increasingly important role in the management of more complex patients, particularly in relation to emergency and other unplanned patient activity.

While the constraints of the site are challenging in 2012, Eastern Health is working with the Department of Health and local government to plan for the future expansion of the site in a substantial way.

PETER JAMES CENTRE

Peter James Centre will provide inpatient, outpatient and ambulatory healthcare services that will include rehabilitation, geriatric medicine, renal dialysis, post acute care and residential care. Eastern Health will enhance the capacity of Peter James Centre to manage more acutely unwell patients, including the investigative, allied health and other services that are required to appropriately manage the increased acuity of patients located at the site.

Managing accessibility of health services for our communities is inextricably linked with our ability to move patients to the most appropriate facility for their needs. Peter James Centre will become increasingly important in ensuring Eastern Health is capable of achieving this.

WANTIRNA HEALTH

Wantirna Health will support inpatient and outpatient healthcare needs across clinical services that include geriatric evaluation and medicine, palliative care and rehabilitation.

Due to its central location within Eastern Health's primary catchment area and available land around it, the site is considered to be most suitable for future accommodation of planned, short cycle streams of care and chronic disease (ambulatory) streams of care when it is not possible to deliver these services in the home or community.

The development of an Eastern Health centre for education and research is also planned for the Wantirna Health site.

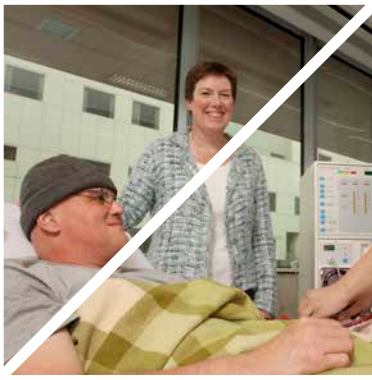
YARRA RANGES HEALTH

Yarra Ranges Health will support low complexity inpatient and ambulatory healthcare needs across clinical services that include specialist day rehabilitation and outreach services, day surgical services, chemotherapy, antenatal, postnatal and a youth mental health service.

The site will substantially expand its capacity for day surgery and endoscopy services that are in high demand in the areas surrounding Lilydale and further east across the Shire of Yarra Ranges.

OUR OTHER SITES

Eastern Health provides a comprehensive range of residential, bed-based, ambulatory and community based services through smaller sites which are located throughout the eastern metropolitan area. Each of these sites and the staff who work in them plays an integral role to ensure that quality health services are accessible in locations where patients need them – close to home.



16 KEY ENABLERS

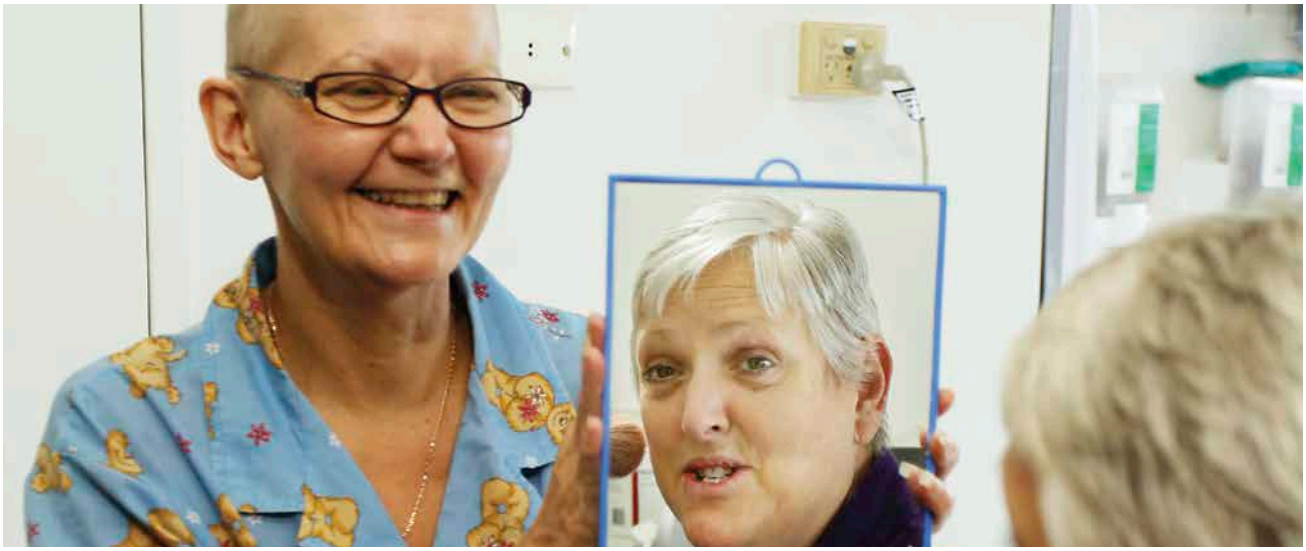
Following all of the consultations to develop Eastern Health 2022, a number of key enablers have been identified as pre-requisites for the successful implementation of Eastern Health 2022. Eastern Health will need to explore each of these areas in greater detail through more focused planning, however a brief outline of their strategic significance to the execution of this Plan has been provided below.

16.1 AN EASTERN HEALTH WORKFORCE THAT SUPPORTS THE PLAN

Eastern Health will develop a comprehensive Workforce Plan that is completely aligned with *Eastern Health 2022*. The Workforce Plan will articulate what is required in terms of a workforce that is geared around achieving the desired clinical service configuration by 2022 and the priority initiatives that are outlined within *Eastern Health 2022*.

Eastern Health's workforce configuration in 2011 is unsustainable over the medium to long term if Eastern Health is to be able to respond to future challenges. The Workforce Plan will need to explore and analyse the following strategic areas, related to workforce, that have been identified through the process of developing *Eastern Health 2022*.

- Maximising scope of practice, implementing advanced practice roles and removing non value-adding components of work amongst highly qualified doctors, nurses, midwives, allied health staff and clinical support.
- A requirement to target known and forecast skills shortages, for example, pathologists, sonographers, cardiac technologists, general surgeons, general physicians and geriatricians.
- The need for comprehensive clinical leadership succession planning.
- Sustainable organisational capability for ensuring that our staff have the skills, knowledge and expertise to execute the initiatives outlined within the Plan.
- Development of strategies that will attract a higher number of full-time medical staff to Eastern Health. In terms of being able to implement consistent patient management standards relevant to each clinical service group and to engender a culture of positive change, it is desirable for Eastern Health to attract a higher number of substantially full-time medical staff. Whilst Eastern Health expects all medical staff to demonstrate behaviours that are consistent with Eastern Health's values, during the SCSP consultation process, clinical staff expressed views that, by and large, full time medical staff are more likely to be engaged in the overall development and continuous improvement of the organisation than others who may only be engaged with Eastern Health for a few hours each week. The more substantive the appointment to Eastern Health, the more highly engaged medical staff will be in positive change and the more likely they are to provide a dynamic and sustainable environment for education, training and research. Whilst part-time medical staff will always play an important role at Eastern Health and bring substantial diverse experience with them, with competing demands on their time, it is recognised that they have limited availability to invest in the improvement of systems at Eastern Health.
- Over 25 per cent of healthcare workers in Australia are aged over 55. (6). Notwithstanding the point above, Eastern Health must explore innovative, part-time staffing rosters across nursing, allied health and clinical support areas to ensure that older, experienced staff remain in our health service for as long as they can, without compromising their changing needs as they near retirement.



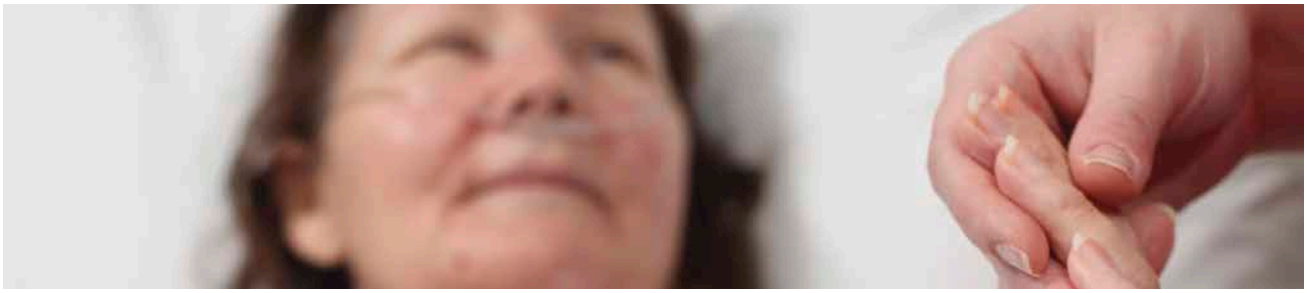
16.2 INFORMATION AND COMMUNICATIONS TECHNOLOGY (ICT) AS A VEHICLE FOR EXCELLENCE IN CLINICAL PRACTICE

Eastern Health has successfully implemented Release 1a and 1b of the Cerner Millennium Clinical System at the Angliss Hospital, Box Hill Hospital, Healesville and District Hospital, Maroondah Hospital, Peter James Centre, Wantirna Health and Yarra Ranges Health . The roll out was successfully completed in August 2011. Release 1 provided a number of benefits in relation to pathology, imaging (PACS) reporting and discharge medication management including allergy and alerts notification and decision support on drug interactions for discharge medications. Eastern Health, the Department of Health and Cerner are now in the process of introducing Release 2 of the clinical system across Eastern Health which will address a number of issues identified in Release 1 and include additional functionality such as Pathology, Medical Imaging and Inpatient Medication ordering.

Release 2 provides significantly improved functionality and has major benefits in patient safety, appropriate ordering of diagnostic tests, medications safety and clinical accountability. The Release 2 project will deliver wireless technology primarily to Angliss Hospital and Maroondah Hospitals and a whole of Eastern Health implementation of the software, which includes the much anticipated MPages. The MPages will allow clinical staff to customise the look and feel of their Cerner Millennium session to improve efficiency and workflow. Finally, the implementation will also introduce single sign-on smart card access to clinical applications for clinicians. This means that a clinician can log in at the start of the day and move from computer to computer and access their clinical desktop using the smart card in a fraction of the time it takes to log in using the current system. The system will "remember" where the clinician was up to and allow for seamless continuity of workflow between devices. The implementation of Release 2 will be yet another step in Eastern Health's journey to a paperless health service. The system will be used in conjunction with the Clinical Patient Folder (or scanned medical record) as the core repositories of clinical information for Eastern Health. This is a multimillion dollar commitment and a very exciting initiative which builds on Eastern Health's current capability and places Eastern Health at the leading edge of this technology in Victoria.

In addition to the implementation of Cerner Clinicals, Eastern Health needs to explore the following strategic areas related to ICT, that have been identified through the process of developing *Eastern Health 2022*.

- Explore technologies that enhance direct patient contact. ICT will be pivotal to provide additional options for communication between clinicians, but also communication between clinicians and patients. Examples are teleconferencing, telemedicine, tele-rehabilitation and even Skype that could be explored within patients' own homes. Such technologies can be used for cognitive intervention for certain patient groups (for instance, multiple sclerosis patients).
- Expand the use of social media to convey messages and support patients via the web and mobile phone (for example Twitter, Facebook messaging, etc.).
- Explore the application of technology for patient self-monitoring in the home (for example renal dialysis patients at home, diabetes monitoring, falls, cardiac monitoring, etc).
- Enhance the range and access to mobile technology that supports a mobile workforce that will be working more often, for longer, within the community.
- Remote (off-site) review of pathology and medical imaging results to facilitate case meetings between Eastern Health and other public, private hospitals or rural hospitals.
- Invest in technologies that enhance our partnerships. This includes but is not limited to:
  - Implementing access to the Shared Health Summary and the Personally Controlled Electronic Health Record (PCEHR).
  - Facilitating e-referral from general practitioners.
  - Providing general practitioners with secure electronic access to Cerner Clinicals.
  - Enabling direct referrals to outpatient clinics and ambulatory services by general practitioners and key healthcare partners with which Eastern Health has a Memorandum of Understanding (MOU).
  - Video link-up with high referral general practices and space within specialist clinics to facilitate this.
  - Electronic systems for applications and approvals to use biological agents (Pharmacy).
- Implement key directions, as detailed in the ICT Long Term Plan, that support clinical practice. This Plan is currently for the period 2010–15, but will be reviewed to 2020. The key directions include:
  - ICT support for evidence-based practice
  - Implement internal and external collaboration tools
  - Systematise and automate patient workflow
  - Implement Clinical Medication Management
  - Move toward a consolidated view of the Electronic Health Record
  - Provide access points and computers at the point of care
  - Increase accessibility to networks and systems
  - Implement Document Management and Data Warehousing Capability



- Introduce Enterprise Rostering and Resource Management Tools
- Enhance the e-directory and Service Framework to deliver 'right person, right area' practices across the organisation
- Introduce RFID or similar technologies for staff and patient tracking/alarm
- Introduce single sign-on roaming profiles (CTI)
- Review and improve existing change management, particularly training
- E-learning and HRIS training register and credentialing
- Infrastructure refresh
- Upgrade legacy systems to enhance data accessibility, analysis and decrease risks associated with storage capacity and security.

16.3 RESEARCH, EDUCATION AND TRAINING THAT SUPPORTS THE PLAN

Eastern Health is committed to research, education and training that is relevant and informs the care of our community. We are dedicated to building a culture of research in that it becomes embedded in everyday clinical practice. We have an active research, education and training focus and strong affiliations with some of Australia's top universities and educational institutions including Monash, Deakin and La Trobe universities providing undergraduate, postgraduate and research training. We have long standing affiliations with a number of other universities including the University of Melbourne and increasing collaborations with other groups including RMIT and Ambulance Victoria.

The Office of Research and Ethics provides research governance and infrastructure support to the Eastern Health research community in addition to providing administrative support to the Eastern Health Research and Ethics Committee.

Eastern Health supports research in its many forms including literature reviews, survey research, action research, experimental research, evaluation and performance measurement, clinical trials, epidemiological research using qualitative and quantitative methodologies with the ultimate objective of ensuring our patients and the broader community are afforded the latest technologies, therapies and practices in support of great health and wellbeing.

In 2011, Eastern Health articulated its Research Strategy. The Strategy highlights that Eastern Health's current strengths in research are in the fields of:

- Oncology
- Drug and Alcohol
- Endocrinology
- Neurology
- Care of the Aged
- Gastroenterology.

The Strategy also highlights that the opportunity exists to enhance research by increasing collaborations across Eastern Health and with partners such as the universities in these areas of strength and those areas with clinical expertise such as:

- Mental Health
- Renal medicine
- Haematology
- Community and acute care interface.

Research activities can include clinical trials, multi-professional training and clinical service delivery and health services research. In particular, it has been identified that Eastern Health could position itself as a key leader in health services research.

Within the context of the *Eastern Health 2022*, there will need to be an increasing focus on research, education and training that is focused on:

- Population-based health service planning and evaluation;
- Evaluation of new models of care that are recommended within the Plan. Examples of these include the 'streams of care' approach to clinical service delivery and the increasing ambulatory care models;
- Research translating into practice and practice influencing research (known as translational research);
- Evaluation of the effectiveness of quality and safety management systems in improving the quality of care and clinical outcomes;
- Progressing the development of an Eastern Health centre for education and research at Wantirna Health.

17 IMPLEMENTATION, REVIEW AND NEXT STEPS

***Eastern Health looks forward to working with Government, the Department of Health, its healthcare and community partners and its staff to implement* Eastern Health 2022.**

Eastern Health has aligned this Plan with the Victorian Government's Victorian Health Priorities Framework 2012-22: Metropolitan Health Plan and the Eastern Health Strategic Plan 2010-15. Each year, Eastern Health will identify elements of *Eastern Health 2022* that need to commence or be implemented in the following year as part of its Planning Framework (as described in Section 3 of this Plan). These elements will form part of the annual Operations and Improvement Plan and, in many cases, the Statement of Priorities.

The Operations and Improvement Plan is the mechanism through which Eastern Health will deploy, cascade and execute *Eastern Health 2022*. This mechanism will also ensure that progress on the objectives are monitored and reported on a quarterly basis and reviewed annually.

Eastern Health 2022 has been developed with the benefit of the most current information available to health services. As new information is made available, or our circumstances change over the life of the plan, *Eastern Health 2022* will be reviewed. There will also be a formal refresh of *Eastern Health 2022* in 2017.

Our health service is changing. Through our implementation of *Eastern Health 2022*, we will enhance equity of access to health services for people in Melbourne's east and provide clinical services to our community at the appropriate level and at the appropriate place. This is positive for Eastern Health, positive for the health system more broadly and positive for people and communities in the east. It will help us realise our vision of Great Health and Wellbeing.

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19 APPENDICES

APPENDIX 1 – GOVERNMENT POLICY FRAMEWORKS

Because Mental Health Matters

Because Mental Health Matters was released in March 2009 and outlines the reform strategy for mental health services 2009–2019. The strategy builds on the leadership and innovation previously demonstrated by Victoria in mental health service delivery and was developed through wide consultation with service providers, consumers and carers. The strategy will shape policies and services affecting the mental health and wellbeing of the population. The vision is for all Victorians to have the opportunities they need to maintain good mental health and wellbeing, while those who experience mental health problems can access timely, high quality care and support to live successfully in the community.

Strengthening Palliative Care: A Policy for Health and Community Care Providers 2004–09

Victoria's approach to palliative care is based on the definitions provided by the World Health Organisation, which classify specialist palliative care services as those based on a high level of expertise in complex symptom control, loss, grief and bereavement. However, the palliative approach should be incorporated into all health-care provision, based on the non-specialist palliative care provided by general practitioners, community and hospital-based doctors, nurses and allied health staff, as well as other specialist service providers. Care and treatment should be co-ordinated across all settings, and people should receive specialist palliative care when needed.

Care in Your Community – A Planning Framework for Integrated Ambulatory Health Care

Care in your Community aims to maximise access, quality and continuity of care, service flexibility, opportunity for service substitution and diversion, as well as optimal use of scarce resources.

Care in your Community builds on current policy directions for the delivery of integrated community-based health-care. For the purposes of this framework, community-based health-care refers to any healthcare that does not involve an overnight or multi-day stay in hospital, including:

- Same-day medical and surgical services;
- Emergency department services; and
- Outpatient services.

Care in your community planning principles identify that services provided in hospital settings will complement community-based services and that planning will identify which services, in the specific local context, can be provided safely, effectively and efficiently in community-based settings, and which services should be provided in hospitals.

Care in your community sets out a framework for a consistent approach to the development of an integrated healthcare system, building on existing strengths and trends. The framework is formulated on the vision that the Victorian healthcare system will increasingly offer person and family-centred healthcare in community-based settings, reducing the need for inpatient hospital care and improving health outcomes for Victorians.

By removing some of the systemic barriers, it is anticipated that enhanced ambulatory care services will enable improved demand management across the whole system by facilitating a right care, right time, right place approach to service delivery.

Victorian Public Hospital Specialist Clinics Strategic Framework 2009

The Victorian Public Hospital Specialist Clinics Strategic Framework was released in February 2009. It was developed to deliver high impact system improvements that will guide transformation of specialist clinics towards high performing services that deliver optimal outcomes for patients. In 2006, the Outpatient Innovation and Improvement Strategy commenced in response to the Office of the Victorian Auditor General's Access to specialist medical outpatient care report, that highlighted the need for the department to improve its performance management and strategic planning activities in relation to outpatient services.

The framework presents the Department of Human Services (the department) expectations in relation to delivery of services to assist health services in the planning, organisation and provision of services. It also identifies key objectives for specialist clinics – patient focus, timely access and sustainable services.

The five high impact service improvements to be delivered by the Specialist Clinics Improvement and

Innovation Strategy are:

- Increased capacity for new patients
- Individualised appointments for all patients
- Patient journey standards
- Local specialist clinic telephone services Info lines
- Better monitoring of services.

The framework will need to be embedded through operational and clinical management at the health service level.

Cardiac Service Framework for Victoria

In 2007, the Victorian Department of Human Services commissioned a review of acute and sub-acute adult cardiac services. The Cardiac Service Framework for Victoria (cardiac review) was completed in April 2008 and provided 48 recommendations.

One of the recommendations was to establish a cardiac clinical network, which is currently underway. Concurrently, the Department of Health is developing a Cardiac Strategy for Victoria 2010–2015, which will set out strategies for the immediate, short and long- term priorities for the delivery of cardiac services in Victoria. These strategies will draw upon the Cardiac Services Framework for Victoria 2007 and National Service Improvement Framework 2005.

Stroke Care Strategy for Victoria

The Victorian Department of Health has developed a Stroke Care Strategy for Victoria that considers the delivery of acute and sub-acute stroke services in Victoria and recommends the implementation of an integrated state-wide approach to care for people who have suffered a stroke.

It provides a framework for the delivery of public acute and sub-acute stroke services in Victoria for the next 5–10 years. It aims to guide the future provision of care, both in the design of stroke care service organisation, the delivery of stroke services and the development of an appropriate workforce to support it. The Strategy also aims to address long-standing and emerging issues for the delivery of stroke services.

The Department has established the Stroke Clinical Network, which will be responsible for advancing the implementation of the recommendations of the Strategy.

Better Faster Emergency Care

Better Faster Emergency Care sets a policy direction to support continued reform of the health system to ensure it best meets the emergency care needs of the community in the future. It is also intended to assist health services to make the best use of available resources to deliver improved health outcomes for the Victorian community. The policy framework recognises that demand for acute care is growing and that appropriate balance needs to be maintained to meet the demand for both emergency and elective services.

The strategic aims of Better Faster Emergency Care are to:

- Ensure equitable and timely access to emergency care within Victoria's public hospitals;
- Enhance the quality of emergency care in Victoria's public hospitals;
- Support delivery of patient-centred care;
- Deliver improved outcomes for the Victorian community.

Cancer Services Framework and the Victorian Cancer Action Plan 2008 –2011

A Cancer Services Framework for Victoria identifies that patients may experience better outcomes when they attend hospitals, and/or receive treatment from clinicians, with high caseloads in a relevant specialty. However, the Framework also recognises the need for accessible services and addresses appropriateness and distribution of surgical services, radiotherapy, chemotherapy, bone marrow transplants, palliative care, and genetic services. The Framework recommends benchmark minimum levels of activity should be established for the delivery of surgical oncology and chemotherapy.

Integrated Cancer Services (ICS) have been established to address key recommendations of the Framework. The ICS are geographically-based clusters of health services, providing cancer services to their population catchment through hospitals and primary and community health services. Individual ICS work internally and collaboratively with the other ICS to develop integrated care and defined referral pathways for the populations they serve. The ICS promote more effective local coordination of care for cancer patients, and a more rational, evidence-based approach to cancer service planning and delivery.

Victoria's Cancer Action Plan 2008–2011 was launched in December 2008 and augments the current work being driven by the Cancer Services Framework. The Cancer Action Plan identifies four action areas for reform with a focus on prevention and providing the best care informed by the latest research and technological advances. The Cancer Action Plan's strategic objective is to increase cancer survival rates in Victoria by 10 per cent by 2015.

Healthy Futures: Delivering better health, research and jobs for Victorians

Healthy Futures: Delivering better health, research and jobs for Victorians takes steps to build Victoria's strengths in biomedical research, expand the State's largest medical research institute, spur new research into cancer and drive greater collaboration across Victoria's medical research precincts.

Healthy Futures outlines a strategy to create a world-leading life sciences industry in Victoria. The strategy is to:

- Build on Victoria's strengths in medical research and life sciences;
- Further build Victoria's research infrastructure to attract the best people from Australia and overseas, creating the momentum to attract further investment and achieve tomorrow's medical breakthroughs;
- Boost Victoria's capacity to translate research into practical outcomes that will benefit all Australians;
- Establish stronger links and connections between researchers and support approaches that bring together clusters of skilled people to work together on common problems;
- Create opportunities for national and international collaboration on major research projects; and
- Develop an environment that is attractive to businesses that wish to invest in the products of Victoria's life sciences research.

This strategy will be achieved through:

- Capturing new opportunities in areas of research where Victoria has critical mass and a competitive advantage;
- Attracting investment and generating high quality jobs by maintaining and expanding the international reputation of Victoria's research institutes;
- Maximising opportunities for continued growth in national and international collaborations and partnerships;
- Delivering major benefits to business and industry by encouraging the commercialisation of medical research; and
- Creating a healthier future by enabling research to translate speedily into practical health benefits for the entire community.

APPENDIX 1 – GOVERNMENT POLICY FRAMEWORKS (CONT.)

Australia: the Healthiest Country 2020 – National Preventative Health Strategy.

In September 2009, the Australian Government released the Australia: the Healthiest Country 2020 – National Preventative Health Strategy. This provides a blueprint for tackling the burden of chronic disease currently caused by obesity, tobacco, and excessive consumption of alcohol. The strategy's conceptual framework is based on four rationales: influencing markets; reducing inequities in health; developing effective policies; and, investing for maximum benefit. The Strategy identifies seven strategic directions to ensure a comprehensive approach:

1. Shared responsibility – developing strategic partnerships – at all levels of government, industry, business, unions, the non-government sector, research institutions and communities;
2. Act early and throughout life – working with individuals, families and communities;
3. Engage communities – act and engage with people where they live, work and play; at home, in schools, workplaces and the community. Inform, enable and support people to make healthy choices;
4. Influence markets and develop coherent policies – for example, through taxation, responsive regulation, and through coherent and connected policies;
5. Reduce inequity through targeting disadvantage – especially low socioeconomic status (SES) population groups;
6. Indigenous Australians – contribute to 'Close the Gap'; and
7. Refocus primary healthcare towards prevention.

Building a 21st Century – Primary Health Care System – Australia's First National Primary Health Care Strategy

This National Primary Health Care Strategy represents the first comprehensive national policy statement for primary healthcare in Australia and provides the platform on which to build a strong and efficient primary health care system into the future. The four key priority areas are:

1. Improving access and reducing inequity
2. Better management of chronic conditions
3. Increasing the focus on prevention
4. Improving quality, safety, performance and accountability.

Improving primary health care for all Australians 2011

Under the National Health Reform, the Commonwealth Government is aiming to shift the centre of gravity of the health system from hospitals to primary health care. They are committed to improving Australia's healthcare system so that all Australians can access high quality services that meet their needs and the needs of their family. Medicare Locals are a central component of the Government's primary health care reforms.

Medicare Locals will support the Government's plans to address each of the areas where Australia's primary healthcare system can be improved. The Australian Government has committed to establishing a national network of primary healthcare organisations, known as Medicare Locals.

General practitioners will remain the centre of the primary health care system and continue to work with individual patients to determine what clinical care they require – but Medicare Locals will take responsibility for the primary health care needs of each local community.

Medicare Locals – Discussion Paper on Governance and Functions 2010

The aim of this paper is to provide information to the public and other interested parties as to the proposed roles and functions specific to Medicare Locals. This paper specifically addresses the following areas:

- What will Medicare Locals do?
- What will Medicare Locals look like?
- How will Medicare Locals interact with patients and providers?

The Victorian Health Services Performance Monitoring Framework (VHSPMF) 2010–11 Business Rules

The Health Services Act 1988 formally defines public health services. In 2010–11 there are 21 public health services: 12 in metropolitan Melbourne and six in regional Victoria, as well as three denominational health services based in Victoria.

The Statement of Priorities (SoP) was introduced in 2004–05 as part of a series of governance reforms enacted in changes to the Health Services Act to improve accountability between boards of health services and the state government. The annual SoP facilitates delivery of, or substantial progress towards, the key shared objectives of financial viability, improved access and quality of service provision.

The SoP incorporates system wide priorities and statewide benchmarks set by government, but also allows for health service specific priorities. These local service specific priorities are linked to overarching and longer term strategic plans.

The department is committed to ensuring that the suite of performance indicators it uses to monitor health services provides a balanced perspective of service provision. The department will continue to work with health services to develop and refine indicators over time.

To ensure an appropriate level of accountability for these health services, a framework has been implemented, which includes:

1. A Statement of Priorities that set out the policy priorities of the government, health service specific priorities and expected levels of performance in key areas for the financial year.

2. A Performance Monitoring Framework (PMF) that enables the department to transparently monitor, analyse and evaluate a health service's performance. The PMF reflects access, financial and quality aspects of performance that are assessed on a quarterly basis. The PMF results are reported in the Victorian Health Service Performance Monitor on a quarterly basis.

Primary care partnership (PCP) Strategy

The State Government initiated the Primary Care Partnerships (PCP) Strategy in 2000 to improve the health and wellbeing of people using primary care services and to reduce avoidable use of hospital, medical and residential services. A Primary Care Partnerships strategic directions 2004 –2006, Better health – stronger communities was developed and a further three-year strategic plan 2009–2012 focusing on 2–3 strategic health and wellbeing priorities was included.

Primary Care Partnerships (PCPs) are made up of a diverse range of member agencies. All PCPs include hospitals, community health, local government and divisions of general practice as core members of the partnerships. Other types of agencies such as area mental health, drug treatment and disability services are also members of PCPs. The partners can also be specific to local issues and needs. For example, some PCPs have engaged with the police, schools and community groups.

The Primary Care Partnership Strategy and associated program logic outlines the following domains of activity:

- Partnership Development
- Integrated Health Promotion
- Service Coordination
- Integrated Chronic Disease Management

Victoria's intensive care services Future directions 2009

Demand for intensive care services in Victoria's public hospitals has grown strongly over the last decade. Victoria's intensive care services: future directions provide a framework to inform future activity and investment in intensive care services to ensure they continue to meet the increased pressures in demand for ICU beds. The agreed priority areas are:

- Building a sustainable system.
- Access: the right level of patient care when required.
- Quality: safe and effective intensive care services.

It outlines a range of strategies to further improve access and quality of care, and ensure effective management of the high-level resources needed to deliver intensive care services. This future directions framework focuses on adult and paediatric intensive care services in metropolitan, regional and rural public hospitals and the use of private intensive care services for the delivery of care to public patients. It excludes emergency departments, neonatal intensive care services and stand-alone coronary care units.

Better quality, better health care

The Victorian Quality Council (VQC) was established in 2001 to foster quality and safety in Victorian health services. The council's framework Better quality, better health care outlines the principles and practices necessary for effective monitoring, management and improvement of health services. The framework identifies six interdependent dimensions of quality:

1. Safety of health care: harm arising from care is avoided and risk minimised.
2. Effectiveness of health care: health care interventions deliver measurable benefit and achieve the desired outcome.
3. Access: there is timely, equitable access to services on the basis of need irrespective of cultural or linguistic background, gender, age or socio-demographic status.
4. Acceptability: health services meet the expectations of patients and feedback is encouraged.
5. Appropriateness: selection of health care interventions is based on the likelihood that the intervention will produce the desired outcome for a patient and on using evidence and established professional standards.
6. Efficiency: resources are utilised to achieve value for money within health settings.

The Victorian Women's Health and Wellbeing Strategy 2010–2014

The Victorian women's health and wellbeing strategy 2010–2014 aims to improve women's health and wellbeing over the next four years with a focus on identified populations with poorer health outcomes where targeted approaches are required. The strategy focuses on women's health within mainstream health services, and identifies opportunities for services to work together, to improve women's health outcomes. It:

- Highlights the importance of starting early – supporting young women from 12 years of age to develop positive health values and resilience
- Identifies differences among and between women, focusing on those with poorer health outcomes
- Addresses women's health and wellbeing across the lifespan

The strategy's four priority areas, supported by women participating in the consultation, are to:

1. Improve health and reduce illness
2. Enhance mental health and reduce poor mental health
3. Prevent violence against women and improve the health response
4. Optimise the sexual health and reproductive health of women

APPENDIX 1 – GOVERNMENT POLICY FRAMEWORKS (CONT.)

Victorian Men's health and wellbeing strategy background paper 2010

The release of the strategy provides a broad framework for understanding and responding to important gender differences in the incidence of health conditions, lifestyle risk factors, and health behaviours and attitudes.

The Men's health and wellbeing strategy is a foundation document that will guide change with the aim of delivering better health outcomes for all Victorian men and groups of men with the poorest health via three identified priority areas:

1. Reduce health inequalities and improve the quality and length of men's lives by focusing work on the six identified priority conditions that have large gender-specific impacts on men.
2. Promote and facilitate men's healthy living by supporting healthy lifestyles and strengthening men's health knowledge and behaviours.
3. Strengthen health and community service delivery to men by encouraging inclusive service models and service delivery practices.

The Future Directions for Victoria's Maternity Services

Future Directions for Victoria's Maternity Services (Future Directions) was launched in 2004 and set the 5–10 year agenda for strengthening maternity services in Victoria. The focus of Future Directions was to provide primary maternity services within local settings, provide women with greater control of their birthing experience and establish maternity service models that promote continuity of care.

Further work has been undertaken in 2008 to more clearly define the four main principles of Future Directions. Characteristics of a Future Directions maternity service have been articulated and examples from maternity services across metropolitan, rural and regional Victoria have been provided in the document, Future Directions principles in action: examples from the field.

Improving care for older people: a policy for Victorian Health Services, 2003

Improving care for older people: a policy for Health Services highlights the need to change health care practices in response to Victoria's growing and ageing population. It also emphasises the importance of integrated care for older people ensuring that people have the appropriate care in the appropriate place. Three fundamental issues have emerged in considering how to improve and integrate the care of older people, namely, the need to:

- Adopt a strong person-centred approach to the provision of care and services
- Better understand the complexity of older people's health care needs
- Improve integration within Health Service's community-based programs and between Health Services and ongoing support services available in the broader community.

It aims to address the issues faced by older people moving from one care setting to another, and informs the development of care settings that provide appropriate physical, social and environmental features. Further, this policy demonstrates the need to identify older people who have additional care needs, in order to minimise the risk of adverse outcomes. Care for these people should be multi-disciplinary in nature and based on the goals expressed by the older person and their carer/s. Additional support should be provided to bridge the person's transition from hospital to the community. Inpatient care should be provided in a setting that best meets people's needs and preferences.

The Victorian Government's role in residential aged care – Victorian Government residential aged care policy 2009

The Victorian Government's role in residential aged care – Victorian Government residential aged care policy 2009 confirms the Victorian Government's ongoing commitment to residential aged care. It is committed to the health and wellbeing of older Victorians, ensuring the availability of the right service for older Victorians when they need it. The Victorian Government is investing in initiatives that improve overall access to residential aged care by:

- Advocating to the Commonwealth Government;
- Streamlining the planning system;
- Facilitating improved supply of residential aged care places;
- Promoting innovation and leadership in Victorian residential aged care;
- Developing the aged care workforce, and
- Remaining strongly committed to ongoing public sector provision of residential aged care in this State.

The Victorian Charter of Human Rights and Responsibilities

The Charter is a Victorian Act of Parliament that protects and promotes 20 civil and political rights. Examples of rights included in the Charter are the right to vote, the right to privacy and the right to be free from discrimination. It is based on the United Nations International Covenant on Civil and Political Rights, to which Australia is a signatory.

The aim of the Charter is to protect and promote human rights by ensuring that public powers and functions are exercised in a principled way and that public power is not misused. It complements a number of other pieces of legislation that are aimed at regulating the relationship between individuals and the state.

Ageing in Victoria: A plan for an age-friendly society (2010)

The strategies outlined in this plan will achieve better outcomes for older people in three areas:

1. Good health and wellbeing
2. Age-friendly communities
3. Economic and social participation.

Positive Ageing – A strategy for current and future Senior Victorians

Positive Ageing is a strategy to maximise the quality of life and social recognition of senior Victorians, who play many vital roles in our community, as family members, carers, volunteers, neighbours, workers and consumers. Positive Ageing will strengthen recognition of these roles.

Positive Ageing contributes to the Victorian Government's new social action plan, A Fairer Victoria. Positive Ageing reaffirms our practical commitment to a better quality of life in all its aspects for our seniors.

Positive Ageing is underpinned by five principles. Senior Victorians should have:

1. Confidence that their rights will be upheld, their autonomy accepted and their dignity respected;
2. Certainty that they are valued and listened to for their past, current and future contributions;
3. Opportunities to fully participate in their communities;
4. Access to information, support and services to maximise their independence and maintain their health and wellbeing;
5. Government services and communities which are responsive to their particular needs and interests and which recognise the increasing diversity of our community.

Victorians today are living longer and healthier lives than previous generations. Positive ageing strategy creates opportunities for current and future seniors to enjoy an improved quality of life.

Home and Community Care Program

The Home and Community Care (HACC) program funds services which are targeted to frail older people, people with disabilities and carers. These services provide support to people living at home whose capacity for independent living is at risk, or who are at risk of premature or inappropriate admission to long-term residential care. The HACC Program is funded jointly by the Commonwealth, state and territory governments under the Home and Community Care Act (Commonwealth) 1985.

The HACC Program is part of a broader system of community and health services for older people and people with disabilities, including community health services, public and private hospitals, general medical practitioners, residential and community respite services, disability services, residential aged care facilities, disability support services, and community care packages.

Victorian Triennial Plan Home and Community Care Program 2008–2011 Directions and Expenditure Priorities in Victoria

The three priorities of Victorian Triennial Plan Home and Community Care Program 2008–2011 Directions and Expenditure Priorities in Victoria are:

1. Access and equity – to improve client access to services and address inequity in funding;
2. Refocus service delivery models – to improve the capacity of the service system to better maintain and improve client independence through client-centred approaches and responsiveness to particular clients' needs;
3. Capacity building – to strengthen and support the sector to understand and respond to client needs.

Active Service Model

The Active Service Model is located in the broad policy context set out in A Fairer Victoria (2005) which emphasised early intervention and prevention in all services and for older people, helping them to 'stay involved in everyday activities to maintain or rebuild their confidence and stay active and healthy'.

Some other examples which share the values of providing person-centred care; supporting care relationships and complement the principles of Active Service Model include:

- HACC Diversity Framework
- Strengthening HACC in Aboriginal Communities (SHAC) strategy
- Access Points Demonstration Project
- Early Intervention in Chronic Disease (EICD) in Community Health initiative
- Integrated Chronic Disease Management Strategy
- Make a Move – Falls Prevention
- Count us in! Social inclusion for people living in public sector residential aged care services
- Well for Life
- Primary Care Partnerships (PCPs)
- Hospital Admission Risk Program (HARP)
- Long Stay of Older Persons Program – Improving Care for Older People in Hospitals Policy Framework.

Well for Life

The Well for Life program aims to enhance the health and wellbeing of frail older people by improving nutrition and increasing levels of physical activity. Well for Life projects are being implemented among older people in public housing and with older people receiving support services through Home and Community Care.

Pathways to the Future, 2006 and Beyond – Dementia Framework for Victoria

It outlines the dementia specific policy and practice strategies for the next 5–10 years. The Pathways to the Future report focuses on flexible, individualised and person-centred care. It takes the following pathway approach to dementia care:

- Healthy and active living, which may assist in preventing or reducing the risk of dementia
- Early stages on the dementia pathway
- Middle stages on the dementia pathway
- Late stages on the dementia pathway

Preparing for Victoria's Future – Challenges and Opportunities in an Ageing Population

This document suggests that all Australian Governments work together on:

- A national program of health promotion,
- Prevention and early intervention strategies to tackle the growth in chronic diseases such as dementia, and
- An integrated national system of primary and community health care, shifting the balance of care from hospitals to community based settings, to manage future pressures on health costs and slow the growth of age-related chronic diseases.

Recognising and supporting care relationships for older Victorians

The policy framework, Recognising and supporting care relationships, identifies three overarching principles in focusing on people in care relationships, and planning and delivering care. These principles are:

- Recognition and respect
- Supporting care relationships
- Participation

Community Health Services – creating a healthier Victoria

Community health services play an important role in providing a range of health services to many Victorians, and have become a major platform for the delivery of state-funded, population-focused and community-based health services in Victoria. This policy is the key to developing and integrating community health services within the broader national and state health system. It outlines a consistent set of roles, principles and directions for community health services.

The five strategic directions for development over the next decade mean that Community Health Services will:

1. Be a major platform for the delivery of a comprehensive range of primary health care and support services through community-based models of care
2. Be a significant provider of coordinated community-based disease management and ambulatory care, both directly and in partnership with acute care providers
3. Provide primary medical care through the development of general practices integrated with other primary health care services
4. Have an increased focus on child and family primary healthcare
5. Continue to provide leadership in health promotion

Rural directions – for a stronger healthier Victoria – Update of Rural directions for a better state of health (2009)

The Rural directions for a better state of health was released in 2005. This updated version continues with the three broad directions, but now with a revised focus to update development priorities. The three directions are now:

- Improving the health of rural Victorians
- Supporting a contemporary health system
- Strengthening and sustaining rural health services.

Clinical Networks. A framework for Victoria

The clinical network program was established in Victoria in response to recommendations from the Health Options Review of 2007, where networks were identified as one of a number of strategies to manage demand for health services and escalating costs. The networks were proposed as a mechanism for strengthening clinical and service provision, by bringing together groups of individuals from different organisations and professional groups to drive system change and improvement in the operational effectiveness and efficiency of public health services.

Victoria is committed to the ongoing development of the health system, to support the objective of achieving the best health and wellbeing for all Victorians.

A number of clinical networks have been established comprising a range of stakeholders, including consumers and clinicians with the ability to influence the development and implementation of evidence-based practice. The initial focus was on high-volume, high-risk clinical services, with networks now in the specialty areas of:

- Cancer
- Cardiac
- Emergency care
- Maternity and newborn
- Palliative care
- Paediatric
- Renal
- Stroke

Planning the future of Victoria's sub-acute service system – A capability and access planning framework, 2009

A service capability framework defining the scope of practice and resources was established to guide the sub-acute service delivery in Victoria. It also allows an expected sub-acute service profile to be developed in order to deliver an appropriate and accessible service. This profile would be applied at both the regional and statewide levels.

From Hospital to home: improving care outcomes for older people 2004–2008

In response to the identified issues faced by older people in the acute-aged care continuum, the Australian Health Ministers endorsed a National Action Plan for improving the care of older people across the acute-aged care continuum, 2004–2008 – *From Hospital to Home: Improving Care Outcomes for Older People* in July 2004. What older people often require is a system that provides them with care that is integrated and flexible to ensure they are supported in the community at all times. When unwell, they require a system that supports care that is planned around their individual needs. Seven guiding principles were developed:

1. Older people have access to an appropriate level of health and aged care services that match their changing needs
2. Services are shaped around the diverse needs of older people
3. Avoidable admissions to hospitals or premature admissions to long term residential aged care are prevented where possible
4. Older people have access to transition care services within the acute-aged care continuum
5. The health and aged care sectors at both the service provider and government level operate to deliver an integrated suite of services and care for older people across the acute-aged care continuum
6. The workforce involved in caring for older people is skilled, responsive and in sufficient numbers to meet older people's needs
7. Informal carers and family members are well equipped to provide support and care

The final report on achievements under the Australian Health Ministers' Advisory Council's National action plan for improving the care of older people across the acute-aged care continuum 2004 – 2008 was produced in 2010.

Best care for older people everywhere – The toolkit: Minimising functional decline of older people in hospital

The toolkit forms part of the Victorian implementation of the Council of Australian Governments Long Stay Older Patients (COAG LSOP) initiative. It has been developed to assist health services identify tools and resources that can assist them in improving care for older people in hospital and throughout the patient's journey through the care continuum. A person-centred care philosophy – 'treating older people with respect and as equal partners in the health care relationship', underpins the overall approach to the toolkit and its accompanying tools and resources.

Victorian population is predicted to increase by 19 per cent in 2003–21. The proportion of people aged 70–84 years and 85 years and over is expected to increase by 59 per cent and 74 per cent, respectively. Hospital use increases with age, as older people are more likely to suffer from chronic illnesses and experience acute health problems. There are a high percentage of older patients (34–50 per cent) who experience functional decline in hospitals. More than 46 per cent of multi-day patient stays are for patients aged over 70 years. The majority of this hospital usage is for appropriate acute and sub-acute care. The aim of the toolkit is to assist clinical staff to minimise the functional decline of older people in hospital.

The toolkit and its accompanying resources help to address some of the problems that older people experience in hospital include:

- Under-nutrition and dehydration – due to patients' inability to manage their meals and drinks independently, unfamiliar or unpalatable hospital food, missed meals due to conflicting appointments or interrupted meals, reduced appetite due to illness or lack of activity.
- Decreased mobility and loss of independence – due to patients staying in bed, lack of incidental activity, illness or impairment.
- Pressure injuries – due to poor mobility or lack of circulation.
- Incontinence – due to lack of mobility, poor orientation to bathroom, lack of access to bathrooms, use of continence aids, constipation or effects of medication.
- Falls – due to impairment, environmental hazards or poor orientation.
- Delirium – due to infection, sleep deprivation, immobility, dehydration, pre-existing cognitive impairment or medication.
- Medication errors – due to taking incorrect medication, incorrect dosages or medication side effects.
- Depression – due to ill health, loss of function or poor recovery.

Health Independence Programs Guidelines

The Health independence programs guidelines (guidelines) have been developed to provide direction for, and facilitate the alignment of, Post-Acute Care (PAC) services, Sub-acute Ambulatory Care Services (SACS), and Hospital Admission Risk Program-Better Care for Older people (HARP-BCOP) services.

Integrated PAC, SACS and HARP guidelines have been developed to enable a better client journey across the care continuum in transition from hospital to home or preventing hospitalisation, ensuring a person receives the appropriate health care, at the right time and in the right place. Each health independence program will continue to have its particular role but will be underpinned by common processes that facilitate improved health outcomes and community integration.

Improving the environment for older people in Health Services: An audit tool

This audit tool was developed as part of an initiative of the Department of Human Services' Continuing Care and Clinical Service Development Section to support the Victorian Government's implementation of its policy, Improving care for older people: a policy for Health Services (Department of Human Services 2003). It aims to improve the physical environment for older people accessing the health services, thereby fostering a safer, more accessible and comfortable environment. This tool has considered a comprehensive review of resources relevant to the care of older people, including dementia care design and access design and the occupational health and safety needs of direct care staff.

The audit is designed to be conducted by health care practitioners (direct staff or managers) auditing existing Health Service settings, such as:

- Acute care
- Inpatient rehabilitation
- Geriatric evaluation and management and interim care
- Centre-based community rehabilitation
- Sub-acute specialist clinics.

The maximum benefits from this tool are likely to be realised when clinical, support staff and management work together to achieve sustained, positive improvements for older people. This audit tool should apply across the Health Service system because older people are the main users of the above services.

'Doing it with us not for us: Participation in your health service system 2006–09'

'Doing it with us not for us' is the Victorian government's policy on consumer, carer and community participation in the health care system. Its success has been well documented in health services' Quality of Care Reports to their communities and participation remains highly valued as an aid to improve health outcomes and the quality of health care; as an important democratic right; and as an accountability mechanism.

The new 'Strategic direction 2010–13' for 'Doing it with us not for us' builds upon the first term of the policy. New standards, indicators and targets were developed with health services, consumers, carers and community members.

Patient-centred surgery – Strategic directions for surgical services in Victoria's public hospitals 2010 – 2015

Patient-centred surgery: Strategic directions for surgical services in Victoria's public hospitals, 2010–2015 sets out to meet patient and community needs improving access, shorter waiting times for patients needing surgery, improving patients' experiences and quality of care at all stages of the surgical journey – from the time they are referred for surgical assessment to their recovery at home or in a community-based facility. The five desired outcomes of the strategic directions:

1. Informed patient choice
2. Fair and consistent prioritisation
3. Streamlined patient journey
4. Safe, effective surgery
5. Coordinated care

Strategic framework for Paediatric health services in Victoria 2009

The Framework outlines a range of key service priorities identified during consultation. Many of the issues identified have been long standing and were identified in the 2002 Review.

Five key priority areas for service development are:

1. Service planning for the development of paediatric health services should incorporate a child and family-centred approach and support integrated and coordinated care across Victoria.
2. System reform initiatives developing and implementing strategies to maximise the benefit of existing capacity, services and resources.
3. Service development and expansion to respond to priority population groups, increased demand for emergency services, elective surgery and super-specialty services and transition care for adolescents.
4. Building capacity and resources to respond to increasing demand for services driven by the increasing number of children, increasing chronicity owing to increased survival rates and reflecting the new morbidity of lifestyle-related conditions.
5. Service quality initiatives to ensure the continued provision of safe and high-quality services.

Renal Dialysis – A Revised Service Model for Victoria

The final report on renal dialysis services (Jan 2005) highlights that the projection of future demand requires the availability of a robust maintenance dialysis service delivery system. There is strong support for the further development of a hub and spoke model for managing maintenance dialysis services, including formalisation of current and future funding relationships and service agreements.

Victorian Chronic and Complex Care Program (VCCCP)

The VCCCP (previously known as HARP) was commenced in 2002–03 with a vision to provide better health for Victorians through preventing avoidable admissions to hospital. Base on its successes, from 2005–06 the VCCCP has refocused its vision on the complex and chronic patient cohorts and is now in the process of mainstreaming these projects into normal practice.

The VCCCP aims to achieve this by continuing the work developed under HARP through:

- Developing preventative models of care that involve the hospital and the community;
- Focusing on people who have a manifest health need, often where their disease/condition is chronic or complex; and
- Giving priority to high volume and / or frequent users of the acute public hospital system.

APPENDIX 2 – DATA ANALYSIS, ASSUMPTIONS AND CALCULATIONS

Eastern Health 2022 has been informed by the Victorian Government Department of Health (DH) Inpatient Forecasting Model (2010). The model uses the following datasets:

- Victorian Admitted Episodes Dataset (VAED) historical data for the years 1999–2000 to 2008–09, for public and private hospitals, back-mapped to include W15VICDRG concordances. The VAED dataset is obtained from the Funding and Information PolicyBranch of DH.
- VAED Linked Dataset for 2008–09 to determine transfer rates from acute care to subacute care in order to produce the sub-acute forecasts. The VAED Linked Dataset is obtained from the Funding and Information Policy Branch of DH.
- Australian Bureau of Statistics (ABS) Estimated Resident Population (ERP) data for Australia for 1999–2000 to 2005–06. (ABS catalogue no. 3201.0).
- Department of Planning and Community Development (DPCD) population projection data for future population for the years 2006–07, 2007–08, 2008–09, 2013–14, 2016–17, 2018–19, 2021–22, and 2026–27. The population projection product is referred to as "Victoria in Future 2008".
- Australian Bureau of Statistics (ABS) population projections (Series B) for the forecast years (for interstate populations). (ABS catalogue no. 3222.0).
- Department of Planning (NSW) statistical local area population projection (April 2010). (30).

Victoria in Future 2008 & 2012 – first release population projections are not predictions of the future, nor are they targets. They analyse changing economic and social structures and other drivers of demographic trends to indicate possible future populations if the present identified demographic and social trends continue. The fertility assumption used in these projections is the Medium assumption from the ABS national and state projections released in the publication "Population Projections Australia, 2006–2011", (ABS Catalogue No 3222.0) on 4 September 2008. In this assumption, the total fertility rate for Australia falls from 1.905 at the start of the projection period to 1.800 by 2021 and then remains constant, and from 1.851 to 1.728 in Victoria. Regional differentials in fertility have been taken into consideration in preparing the projections. (Department of Planning and Community Development, Victoria)

The methodology applied in the 2010 model is consistent to a large extent with previous years' models. The process for forecasting inpatient separations involves:

- Forming groups according to the variable combinations for each year, from the past ten years of data
- Calculating the utilisation rate (separations per 1000 population) for each forecast variable combination and each year
- Projecting the utilisation rate to each of the forecast years, using a best fit model chosen from linear trend, damped trend exponential smoothing, simple exponential smoothing and double (Brown) exponential smoothing models.
- Calculating the average length of stay (ALOS) for each forecast variable combination and each year
- Projecting the ALOS into the future using a logarithmic, linear or exponential smoothing model depending on the data distribution (the most appropriate model is automatically selected by the forecasting software)
- Review of projected utilisation rates and ALOS
- Calculation of forecast separations (by multiplying projected utilisation rates by population projections), and calculation of forecast bed days (by multiplying forecast separations by projected ALOS)
- Application of new methodology to refine the sub-acute forecasts for CRGs Level 1 Rehabilitation, Level 2–3 Rehabilitation and GEM.
- Forecasting of emergency/non-emergency proportions for each forecast variable combination
- Apportionment of state-wide forecasts to statistical local area (SLA) and hospital campus. (30).

Bed modelling calculations – Eastern Health

1. The Department of Health has a standard formula to calculate bed requirements based on overall bed days used. This calculation effectively takes the total LOS and divides by the number of days in the year and by an assumed occupancy rate of 150 per cent for same day facilities and by 200 per cent for dialysis facilities. This calculation was applied to the 2009–10 VAED dataset to get a sense of reliability of the calculation for forecasting purposes. It was necessary to modify this calculation slightly to reflect that the majority of same day facilities (emergency department patients aside) are not open seven days a week and as such the calculation was modified to reflect a 6-day week for dialysis and a 5-day week for other day patients.
2. A similar approach was taken to the multiday modelling in that an estimation was made of beds not reported to the department via AIMS (chiefly same day emergency patients in this instance) and for variations in bed requirement due to differing occupancy levels where it was possible to isolate (dialysis).

APPENDIX 2 – DATA ANALYSIS, ASSUMPTIONS AND CALCULATIONS (CONT.)

3. The bed formula was then applied to the DH Inpatient Forecast Model (2010) to get a sense of the overall bed requirement in 2021–22 by directorate and site. A number of assumptions were made at this point which include:
   - A. That the proportion of same-day separations accrued in the Emergency department would remain the same over the period.
   - B. That the occupancy levels as reported in 2010 for HITH (Eastern@Home) would remain the same. A later adjustment was made to reflect a future 'target' rate of Eastern@Home bed days as a proportion of all acute, multi-day bed days forecast at Eastern Health.
   - C. Increases in bed capacity as articulated in the option 2 of the Maroondah Hospital Expansion project, the base case bed increases from the new Box Hill Hospital Redevelopment and the sub-acute expansion at the Angliss Hospital projects would be online and that all other bed capacities would remain constant.
   - D. The DH forecast model is presented in summary form at major clinical reference group (MCRG) level which is based on a combination of care type and DRG. Whilst related, this is inconsistent with the view of specialty services at Eastern Health hence the forecast model was mapped back to clinical service groups (a roll-up of clinical units) on the basis of the split of MCRGs/age groups/LOS types and admission types to internal data so forecast results could be reflected consistent with an EH view of the data.
4. After the calculations outlined in point three were performed, the bed requirement for 2021–22 was calculated by site and by Directorate in terms of funding stream (e.g. acute, sub-acute, mental health) and compared to expected bed capacity based on point 3d. Data is also presented at clinical service group level but this data has not been put in the context of current capacity as capacity at clinical service group level is often difficult to define.
5. The above calculations were based on Eastern Health maintaining current levels of self-sufficiency. There are a number of clinical services where Eastern Health is not self-sufficient (as defined as meeting 70 per cent of public inpatient activity relating to patients living within its primary catchment area). Modelling was undertaken at the MCRG level to see which MCRGs Eastern Health was not self sufficient in. The forecast data was then adjusted to reflect what numbers of patients Eastern Health would need to treat to achieve self-sufficiency for these MCRGs. Any MCRGs where Eastern Health was currently self-sufficient were left untouched. A number of MCRGs that traditionally have not been the domain of Eastern Health should be noted. It was decided not to include cardiac surgery, neurosurgery, dentistry, transplants and major burns from the scope.

APPENDIX 3 – GLOSSARY

Acute episode
A rapid onset and/or short course of illness

Acute hospital
Short-term medical and/or surgical treatment and care facility

ACHS
Australian Council on Healthcare Standards

Allied health
Allied health professionals provide clinical healthcare, such as audiology, psychology, nutrition and dietetics, occupational therapy, orthotics and prosthetics, physical therapies including physiotherapy, speech pathology and social work

Ambulatory care
Care given to a person who is not confined to a hospital/requiring hospital admission but rather is ambulatory and literally able to "ambulate" or walk around

CAC
Community Advisory Committee

CALD
Culturally and Linguistically Diverse

Chronic condition
An illness of at least six months duration that can have a significant impact on a person's life and requires ongoing supervision by a healthcare professional

Elective surgery
Hospitals use urgency categories to schedule surgery to make sure patients with the greatest clinical need are treated first. Each patient's clinical urgency is determined by their treating specialist. Three urgency categories are used throughout Australia:

- **Urgent –** admission within 30 days or condition(s) has the potential to deteriorate quickly to the point it may become an emergency

- **Semi-urgent –** admission within 90 days. The person's condition causes some pain, dysfunction or disability. It is unlikely to deteriorate quickly/ unlikely to become an emergency
- **Non-urgent –** admission sometime in the future (within 365 days). The person's condition causes minimal or no pain, dysfunction or disability. It is unlikely to deteriorate quickly/ unlikely to become an emergency.

Emergency triage
There are five defined triage categories, determined by the Australasian College of Emergency Medicine, with the desirable time when treatment should commence for patients in each category who present to an emergency department:

- **Category 1** – resuscitation; seen immediately
- **Category 2 –** emergency; seen within 10 minutes
- **Category 3 –** urgent; seen within 30 minutes
- **Category 4 –** semi-urgent; seen within one hour
- **Category 5 –** non-urgent; seen within two hours

FOI
Freedom of information

GP
General practitioner

HARP
Hospital Admission Risk Program

HealthSMART
Victoria's whole-of-health information and communication strategy

HEWS
Hospital Early Warning System

HIPS
Hospital-initiated postponements

HITH
Hospital in the Home program

Hospital bypass
A period of time when an emergency department requests that ambulances take non-urgent patients to other hospitals

ICU Intensive care unit inpatient
A patient whose treatment needs at least one night's admission in an acute or sub-acute hospital setting

Integrated care
Care provided to a person that is co-ordinated and connected across the continuum of services and among providers in all sectors and levels

NATA
National Association of Testing Authorities

NEMICS
North Eastern Metropolitan Integrated Cancer Service

Occasions of service
Hospital contact for an outpatient, either through an on-site clinic or home visit

OHS
Occupational health and safety

Outpatient
A person who is not hospitalised overnight but who may visit a hospital, clinic or associated facility, or may be visited in the home by a clinician for diagnosis, ongoing care or treatment

PARC
Prevention and Recovery Care

PCP
Primary Care Partnership

PDU
Practice Development Unit

PGMET
Postgraduate Medical Education and Training program

QICSA
Quality Improvement Council Standards and Accreditation

Rehabilitation
Rehabilitation is the combined and co-ordinated use of medical, social, educational and vocational measures for training or retraining an individual to their highest possible level of function

SACS
Sub-acute ambulatory care services is a government program that provides person-centred, inter-disciplinary care support via flexible service delivery in a range of settings, aimed to support improving and maintaining a person's functional capacity and maximising their independence

Self-sufficiency
Is a measure of how well each of the clinical services is managing the public demand for inpatient services amongst people living in Eastern Health's primary catchment area. It is the proportion of local acute public inpatient demand for clinical services that Eastern Health is meeting.

Separations
Discharge from an outpatient service

Sub-acute illness
A condition that rates between an acute and chronic illness

Stakeholder
Any person, group or organisation that can lay claim to an organisation's attention, resources or output, or is affected by that output

VACS
Victorian Ambulatory Classification System

VICNISS
Victorian Hospital Acquired Infection Surveillance System

WIES
Hospitals are paid based on the numbers and types of patients they treat – the Victorian health system defines a hospital's admitted patient workload in terms of WIES (weighted inlier equivalent separations)

YTD
Year to date

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