Connecting care for a healthy tomorrow

A business case exploring a voluntary amalgamation between Alexandra District Health and Eastern Health

December 2025

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ALEXANDRA DISTRICT HEALTH

Eastern Health

Acknowledgement of Traditional Owners

Alexandra District Health, and Eastern Health acknowledge the Taungurung people and the Wurundjeri people of the Kulin Nation, the Traditional Owners of the land on which their services operate, and pay respect to their Elders past, and present. Alexandra District Health and Eastern Health also pay respect to the cultural authority of all Aboriginal and Torres Strait Islander peoples from other areas of Australia who reside in the communities they serve.

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2 Executive Summary

In 2025, the Boards of Alexandra District Health (ADH) and Eastern Health (EH) agreed to explore a voluntary amalgamation and to prepare a business case consistent with the Department of Health's draft Voluntary amalgamation of Victorian health services Guidance Note and the requirements of the *Health Services Act 1988*.

The business case assesses two options: Option 1: a base case that maintains the current organisational arrangements while continuing to build on the East Metro and Murrindindi Local Health Service Network (EMM LHSN); and Option 2: a voluntary amalgamation of ADH and EH to form a single health service. The business case analysis is structured around seven benefits:

1. Increased access to services and care closer to home;
2. Improved integration and connectivity of care;
3. Improved equity in health and wellbeing outcomes;
4. A more sustainable and strengthened workforce;
5. Improved clinical quality and safety;
6. Improved use of system resources; and
7. Improved access to research-related activity.

The case for change is grounded in persistent and unequal health needs across the shared metropolitan–rural catchment, particularly in Murrindindi and Yarra Ranges local government areas (LGAs). These communities experience higher rates of chronic disease, mental ill-health, alcohol-related harm and tobacco use than many other LGAs and Victoria overall, alongside a rapidly ageing population and constrained primary care access. Almost half of Murrindindi residents report waiting longer than acceptable to see a general practitioner (GP). Hospital admissions for Murrindindi residents are significantly higher than the state average, and a substantial proportion of the community travels 45-90 minutes for care that could be safely provided closer to home if local capability and workforce were strengthened.

At the same time, ADH's small scale limits its ability to respond to these needs, to sustain a contemporary workforce, and to invest in the enabling mechanisms required for future models of care. Addressing these challenges requires a more integrated, catchment-based approach to planning, service delivery and workforce sustainability that cannot be reliably achieved through partnership arrangements alone.

Under Option 1 (Base case), ADH and EH remain separate legal entities, each with its own Board, Chief Executive Officer, strategic plan, and clinical service plan. Service development is progressed primarily through the EMM LHSN Implementation Plan, including initiatives such as Step Closer Care pathways, sustaining residential in-reach, Hospital in the Home access, improved access to EH's Information and Communications technology (ICT) environment and a three-chair dialysis service at ADH once implemented. Whilst these steps are important, they do not create a material uplift in inpatient, procedural or specialist clinic activity at the ADH site, nor do they resolve duplicated clinical governance and corporate systems or provide a clear mechanism for ADH patients and staff to participate in EH's research program. Option 1 therefore delivers only incremental improvements across the seven benefits, with ongoing reliance on separate planning, decision-making and funding streams.

Option 2 (Voluntary amalgamation) enables a single health service to plan and deliver a more ambitious, integrated service profile across the shared catchment, with a particular focus on expanding local services at the ADH site. Under Option 2, ADH and EH would form a single health service entity with the name 'Eastern Health', with one Board, one Chief Executive Officer, and unified corporate and clinical governance, whilst retaining senior local leadership to preserve ADH identity and local accountability. Service changes enabled by the amalgamation include a

staged increase in inpatient activity, additional low-complexity theatre (procedure) activity, new specialist clinics (general medicine, geriatrics, , paediatrics and low complexity surgery), implementation of a three-chair dialysis service as part of an EH hub-and-satellite model, improved access to imaging and diagnostic capability at ADH, and clearer pathways for escalating and de-escalating care. Over time, the amalgamated health service would support a unified electronic medical record, simplified referral and transfer processes, and a more deliberate equity focus for high-priority cohorts.

Across the seven benefits, Option 2 consistently outperforms Option 1. It increases access to care closer to home through the planned uplift in inpatient, theatre and specialist clinic activity at ADH whilst maintaining safe, supported links to metropolitan campuses for higher-acuity care (Benefit 1). Integration and connectivity are enhanced by a single organisation responsible for the full pathway, from community-based care through to tertiary services, with unified clinical pathways, streamlined inter-hospital transfers and, over time, a shared Electronic Medical Record (EMR) and clearer points of entry and navigation for patients and referrers (Benefit 2).

Equity is advanced by the capacity to design and deliver targeted programs for high-incidence conditions and priority cohorts in Murrindindi and the outer east, supported by strengthened local services and rural–metro clinical collaboration (Benefit 3). Workforce sustainability is improved through broader career pathways across the amalgamated health service sites, with increased graduate and registrar rotations, access to EH's education and wellbeing programs, and reduced reliance on fragile single-supplier arrangements (Benefit 4). Clinical quality and safety benefit from unified clinical governance, consolidated policies, shared incident and risk management systems, and the ability to invest at scale in quality infrastructure (Benefit 5). Option 2 also enables more efficient use of system resources through reduced duplication of corporate and support functions and better distribution of demand across sites (Benefit 6), whilst integration into EH's research infrastructure provides ADH patients and staff with access to clinical trials and research pathways that are not achievable under Option 1 (Benefit 7).

A comprehensive stakeholder engagement program sought the views of staff in both health services, stakeholders and community members, with particular emphasis on the Alexandra district. Staff feedback from both organisations was generally positive about exploring voluntary amalgamation, with ADH staff in particular recognising the potential for expanded services, more sustainable workforce arrangements and strengthened pathways. Community feedback from Alexandra and the broader Murrindindi area showed strong support for sustainable local healthcare and expanded services (including cancer care, dialysis, imaging and specialist access), alongside clear expectations that any structural change must protect local identity, ensure rural governance voice and deliver tangible improvements in access and outcomes. Stakeholder sentiment overall can be characterised as cautiously supportive, with conditional endorsement of voluntary amalgamation where these safeguards are met, and local benefits are demonstrable.

For the purposes of modelling, the business case assumes that amalgamation will occur in 2026. Financial modelling confirms that Option 2 can deliver the expanded service profile at ADH at a manageable cost, broadly comparable with Option 1 over five years. Under Option 1, ADH remains in deficit throughout, even with the current $1.2 million "top-up" funding. Under Option 2, additional surgical and medical separations, new specialist clinics and dialysis activity increase National Weighted Activity Unit (NWAU), by 110 per cent in the fifth year, to just over 2,070 units. This growth, together with around annual risk-adjusted savings from reduced duplication of corporate functions and lower contractor and casual labour costs, improves the operating position and generates cumulative operating benefits of around $6.3 million across the five years compared with Option 1.

Implementation costs arise under both options. For Option 1, these relate to ADH's participation in the EMM LHSN work program and foundational ICT integration, estimated at around $3.0 million which is currently unfunded.   Under Option 2, amalgamation-specific project management, legal, and enabling costs bring combined EMM LHSN and amalgamation implementation expenditure to approximately $3.2 million in the first two years. These front-loaded, time-limited costs are expected to be repaid from amalgamation operating benefits by the fourth year, without additional Department of Health funding, with ongoing surpluses thereafter. The proposal is therefore not primarily a savings initiative - it applies similar or modestly higher public investment to support more activity, more integrated care and improved outcomes and experience for patients and staff, while placing ADH on a more sustainable trajectory.

Identified risks associated with voluntary amalgamation, including leadership and governance bandwidth, ICT implementation complexity, workforce recruitment and retention, and community confidence are assessed and mitigations described as part of a risk management plan. With the proposed mitigations in place, most residual risks are assessed as low to medium and are considered manageable through the staged implementation and integration approach.

When the seven benefits, catchment health needs, relative costs, risks, and stakeholder sentiment are considered together, the analysis concludes that Option 2 - Voluntary amalgamation of ADH and EH delivers greater overall value than the base case (Option 1). It is the option most likely to provide better access to specialist care closer to home, more integrated and connected care that improves health outcomes, strengthened and sustainable workforce opportunities, more effective use of system resources, and research capability, and a financially sustainable platform for future service development. Option 2 is therefore identified as the preferred option for securing a contemporary, sustainable and equitable health service for the communities of ADH and Melbourne's east.

3 Glossary

Term	Definition
ACHS	Australian Council on Healthcare Standards
ACQSC	Aged Care Quality and Safety Commission
ADTTA	Alexandra and District Traders and Tourism Association
ADH	Alexandra District Health
ANMF	Australian Nursing and Midwifery Federation
AOD	Alcohol and Other Drug
BAU	Business as usual
CCU	Community Care Unit(s)
CEO	Chief Executive Officer
DH	Department of Health
EH	Eastern Health
EMM LHSN	East Metro and Murrindindi Local Health Service Network
EMR	Electronic Medical Record
FTE	Full Time Equivalent
FY	Financial Year
GP	General Practitioner
Guidance Note	Department of Health Draft Voluntary Amalgamation of Victorian Health Service, Guidance Note, September 2025
ICT	Information and Communication Technology
LGA	Local Government Area
LHSN	Local Health Service Network
MOU	Memorandum of Understanding
NSQHS	National Safety and Quality Health Service
NSQHSS	National Safety and Quality Health Service Standards
NWAU	National Weighted Activity Unit
PARC	Prevention and Recovery Care
SCV	Safer Care Victoria
STP	Safer Together Program
VA	Voluntary amalgamation
VCDC	Victorian Cost Data Collection
VMO	Visiting Medical Officer
VVED	Victorian Virtual Emergency Department
YDMH	Yea and District Memorial Hospital

4 Introduction

4.1   Purpose of this Document

In June 2025, the boards of ADH and EH each resolved to explore the potential of a voluntary amalgamation between the organisations for the benefit of the shared communities and the workforce. This business case presents the benefits, costs and risks associated with a voluntary amalgamation and compares these to a base case of enhanced partnership, which is occurring through the work of the EMM LHSN.

4.2   Background

The Department of Health's Strategic Plan 2023-27 sets out a bold vision that Victorians are the healthiest people in the world and identifies key strategic directions such as: providing care closer to home; a stronger and more sustainable health workforce; and moving from competition to collaboration.

Like all Victorian health services, ADH and EH operate in a dynamic environment characterised by increasing and changing service demand, workforce pressures and changing government and community expectations for locally based care. In this context, health services are always considering the ways in which they may need to evolve to continue to meet the needs of their community in the short and longer term.

Against this backdrop, ADH initiated conversations with EH to explore a potential voluntary amalgamation. The purpose of the exploration was to understand whether working in a different way, (as an amalgamated health service), would lead to an improved ability to meet the needs of their respective communities, support and strengthen the workforce and underpin long-term service viability.

The work to explore a voluntary amalgamation comes two years after the development of the Victorian Health Services Plan. Directed health service amalgamations were a recommendation of the Expert Advisory Committee, the only recommendation of the Expert Advisory Committee not supported by the Government, which moved to establish the Local Health Service Networks, (LHSNs). The Government continues to strongly emphasise partnerships, scale and geographic based models.

The *Health Services Act 1988* allows for health services to voluntarily amalgamate. The decision to proceed with a voluntary amalgamation must be supported by the Boards of the amalgamating health services and be approved by the Minister for Health only if the Secretary of the Department of Health is satisfied that the amalgamation will result in: *the provision of better health services, or more effective governance of the quality or safety of health services provided, throughout Victoria or in any part of Victoria; and, the amalgamation is otherwise in the public interest. (Health Services Act 1988, S6A).*

To support ADH and EH, the Department of Health shared a draft guidance note, which sets out the context and processes to be considered when exploring voluntary amalgamation*, (Department of Health Draft Voluntary Amalgamation of Victorian Health Service, Guidance Note, September 2025).*

4.3 Method and Approach

The process to explore the potential of a voluntary amalgamation was guided by the process described in the *Department of Health Draft Voluntary Amalgamation of Victorian Health Service, Guidance Note, September 2025*.

The guidance note describes three phases, which culminate in the development of a formal business case and a further two phases for proposal approval, and implementation if relevant/required following completion of the business case.

Figure 1: Steps Towards Voluntary Amalgamation

Source: Victorian Government, Draft Voluntary amalgamation of Victorian Health Services – Guidance Note (September 2025 draft)

4.3.1 Exploratory Phase

ADH and EH have a long history of working together in partnership to support their shared communities. This strong partnership exists in addition to the newly formed EMM LHSN, which include ADH, EH, Yea and District Memorial Hospital (YDMH) and St Vincent's Hospital Melbourne.

Both ADH and EH benefit from the support provided to ADH to establish a more sustainable approach to health services and financial services at ADH. Shared service arrangements are now in place between the organisations, notably the commencement of cancer specialist clinics and chemotherapy administration (infusion) at ADH, which commenced in July 2025. There is also a successful graduate nurse program and ADH use EH's iLearn Learning Management System to support its local learning programs.

Exploring a voluntary amalgamation was viewed as a sensible next step in the partnership and as a possible way to increase the magnitude and pace of partnership benefits to the shared communities and workforce.

In June 2025, the Boards of ADH and EH each resolved to explore the potential of a voluntary amalgamation between the organisations for the benefit of the shared communities and the

workforce and to seek in principle support from the Department of Health to explore the potential of a voluntary amalgamation.

4.3.2 Intent Phase

In August 2025, the Secretary of the Department of Health provided in-principle support for ADH and EH to continue to explore a voluntary amalgamation.

A Memorandum of Understanding between the two organisations was executed outlining their commitment to explore the voluntary amalgamation. A Steering Committee comprising Board Directors, and the Chief Executives of ADH and EH was established to oversee the process to prepare this business case.

During this intent phase, leaders from ADH and EH worked together to document the case for change for change (drivers for change), the potential benefits and to consider a potential strategic services model for an amalgamated health service to support the analysis of the possible options.

4.3.3 Consideration Phase

The consideration phase included a series of activities to assess the benefits, costs, and risks of a potential amalgamation and to compare these to a base case or no change option in recognition of the service and system development that was occurring through the existing EMM LHSN.

During this phase, ADH and EH jointly commenced an engagement process with staff and volunteers, community members, and stakeholders to communicate information about the work to explore a voluntary amalgamation and help build understanding, trust, and support for a stronger, sustainable health service that benefits the community. The intensive engagement phase ran for a period of two weeks during November 2025.

Due Diligence was undertaken to provide an assessment of ADH and EH's policies, finances, and relevant non-financial matters and to satisfy each of the potentially amalgamating health services that there was no material barrier to amalgamation.

The development of a business case document commenced, which included consideration of the recommended option to ensure that any risks and interdependencies to the delivery of the identified benefits were considered and mitigated.

The Steering Committee oversaw the work during the consideration phase, meeting fortnightly initially and weekly from October to support the increasing intensity of the work. The Steering Committee monitored the progress of the work; including the stakeholder engagement program and business case development.

4.3.4 Proposal Phase

Given that the preferred option was to proceed with voluntary amalgamation, the proposal phase was commenced. During the proposal phase, the Boards of ADH and EH individually considered the business case, the draft amalgamation agreement, and by-laws.

5 Background to the Business Case

This section provides an overview of the shared catchment served by ADH and EH, including its location, demographic profile and key health and wellbeing characteristics. It also outlines the roles, service profiles and activity of ADH and EH within this catchment, to contextualise the case for change.

5.1   Catchment Location

Figure 2: Map of Alexandra District Health and Eastern Health Catchments (LGAs)
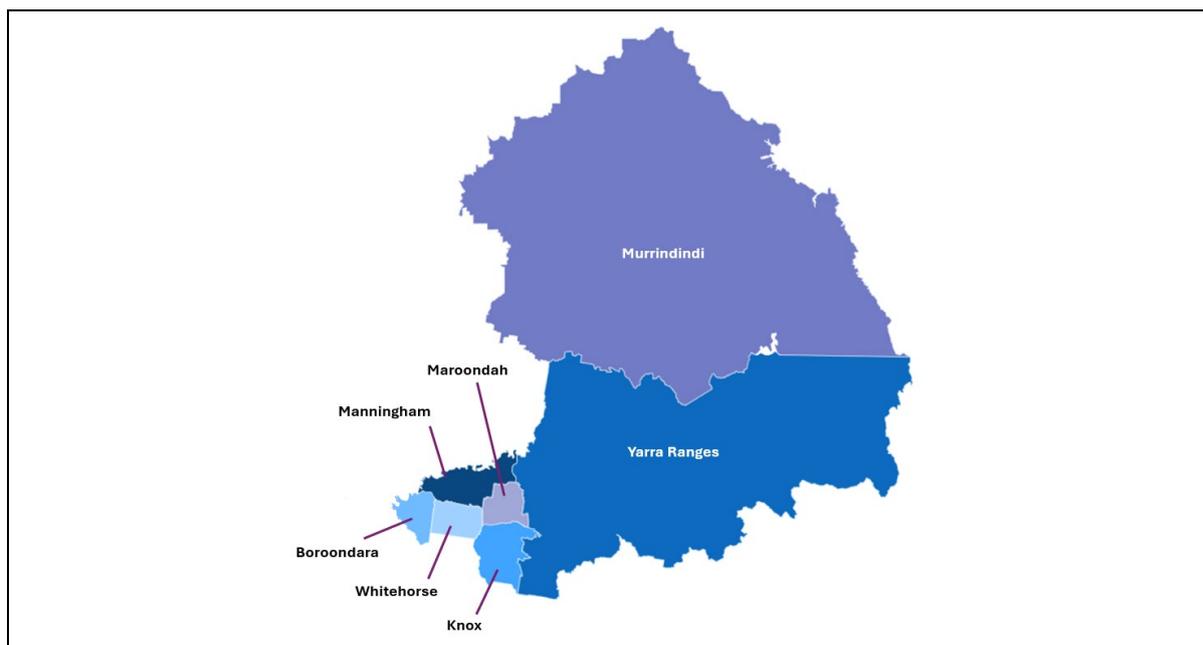
The local government areas in the consideration set for this business case are the primary catchments for ADH and EH:

- Murrindindi Shire. ADH primarily serves the eastern part of the Murrindindi Shire, with the western part served by YDMH. The most populous community is Alexandra, with the majority of the rest of the population in Yea, Kinglake, and Eildon. To assist with demographic analysis the entire LGA is included in the consideration set.
- City of Whitehorse;
- City of Boroondara. Although the City of Boroondara is included in the consideration set, it is important to note that it is primarily the community in Kew that flow to EH. To assist with demographic analysis the entire LGA is included in the consideration set.
- City of Knox;
- Yarra Ranges Shire;
- City of Manningham; and
- City of Maroondah.

5.2   Catchment Demography

ADH and EH provide health care and services to communities in a band that extends from metropolitan Melbourne's inner east through to the outer east and into the adjacent rural east communities.

5.2.1 Catchment Population Size

Catchment population size is a key consideration in planning and investment decisions, as it underpins demand forecasting, capacity planning and the scale of required resources. The number of people residing in, working in or otherwise drawing on services within the catchment directly influences activity volumes, service utilisation patterns, infrastructure, workforce and funding requirements.

5.2.1.1 Current and Forecast Population

By 2036, the shared catchment of ADH and EH is expected to reach 1.12 million people, with most of these people (circa 220,000) living in the City of Whitehorse. Although the second largest LGA is Boroondara, it is mostly those people living in the suburb of Kew and near surrounds who attend EH, with most of the other Boroondara residents receiving their services from inner city hospitals, including St Vincent's Hospital. The smallest LGA is Murrindindi, with 17,020 people forecast to live in there by 2036, with people in the eastern part of the LGA accessing services from ADH, whilst those in the western part of the LGA usually attending YDMH.

Figure 3: Population and Forecast Population for the ADH and EH Catchments.
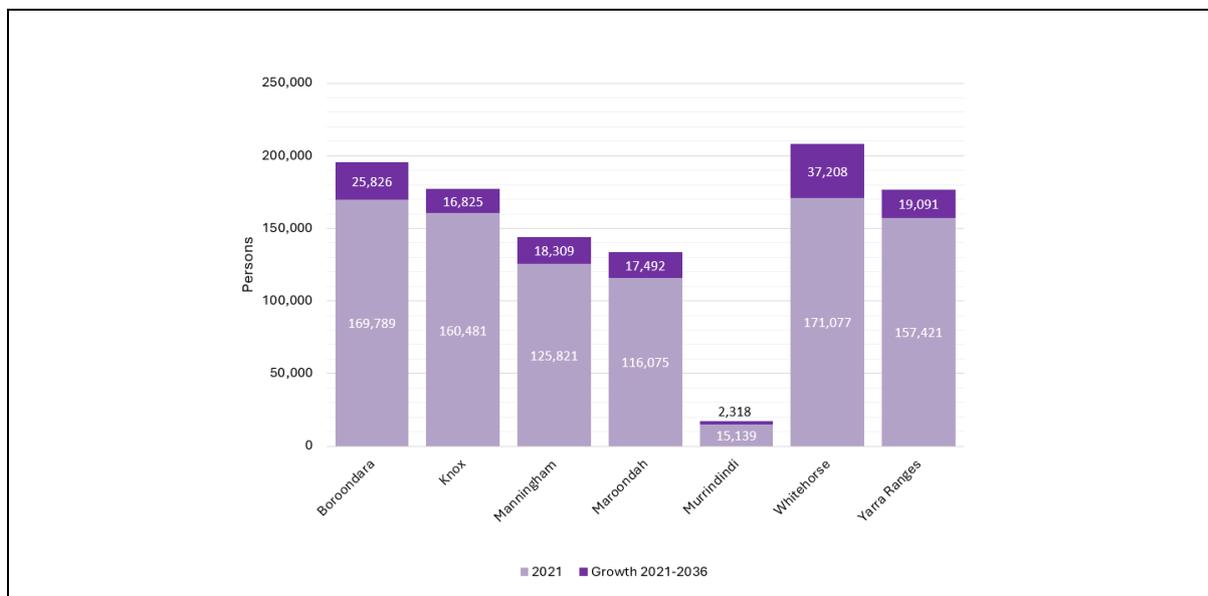
Source: Australian Bureau of Statistics, 2021 Census All persons QuickStats.

Although the catchment is relatively large for a public health service, second only to Monash Health, and eventually Bayside Health, the shared ADH and EH catchment is growing relatively slowly compared to the rest of Victoria. From 2021-2036 the population is expected to increase by 180,000 people, with around 2,300 of those living in Murrindindi.

Figure 4: Population Growth 2021 – 2036 ADH Catchments, EH Catchment and Victoria
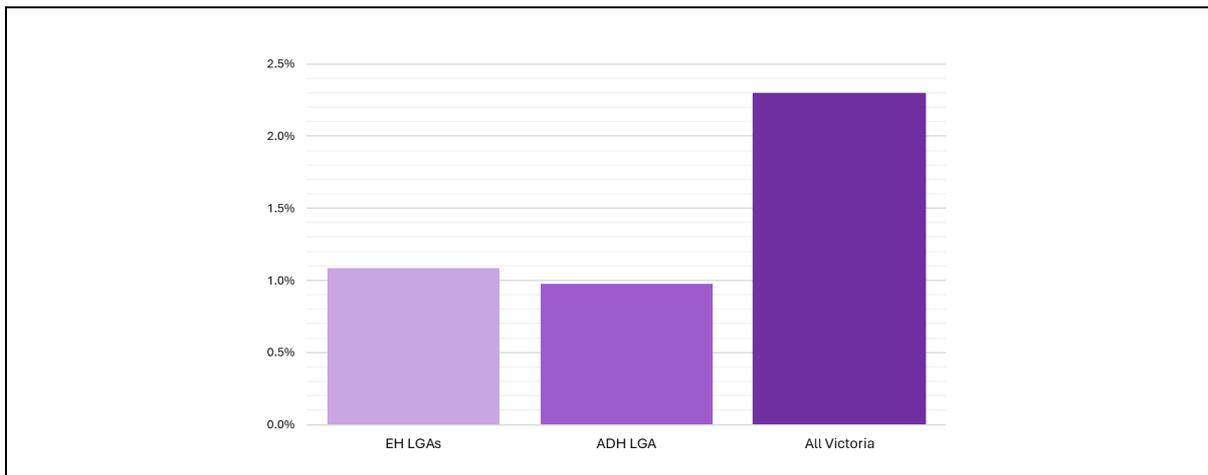
Source: Australian Bureau of Statistics, 2021 Census All persons QuickStats.

5.2.2 Catchment Age

Population ageing is relevant because it drives the type, and demand for services across the catchment. A higher proportion of older residents is typically associated with greater prevalence of chronic and complex conditions, increased need for rehabilitation and supportive care, and higher utilisation of unplanned and acute services, particularly when community-based support is insufficient.

5.2.2.1 Current Age Profile of the Catchment

Across the shared ADH and EH catchment, the largest age group is those people aged 35-39 years, closely followed by those aged 45-49 years and those aged 50-54 years. The smallest group is those aged 80-84 years, followed by those aged more than 85 years.

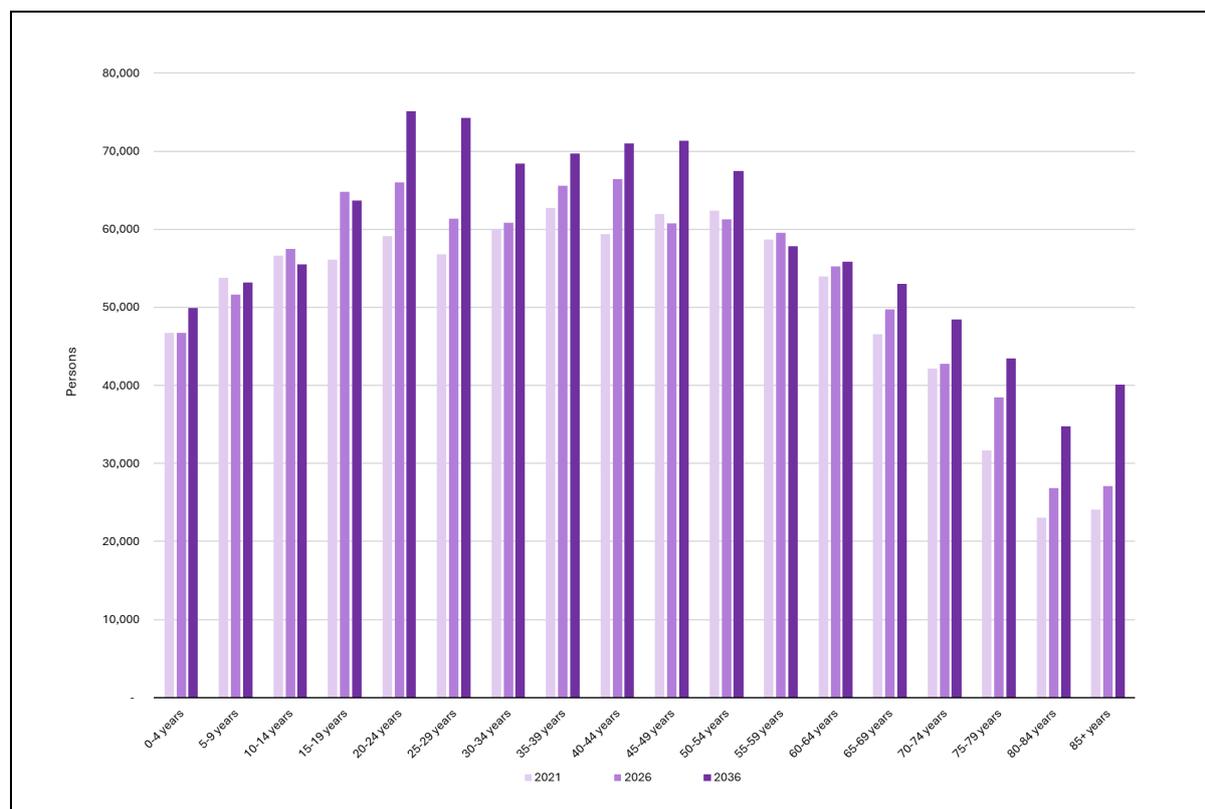**Figure 5: Age Profile Across the Shared ADH and EH Catchment (2021)**
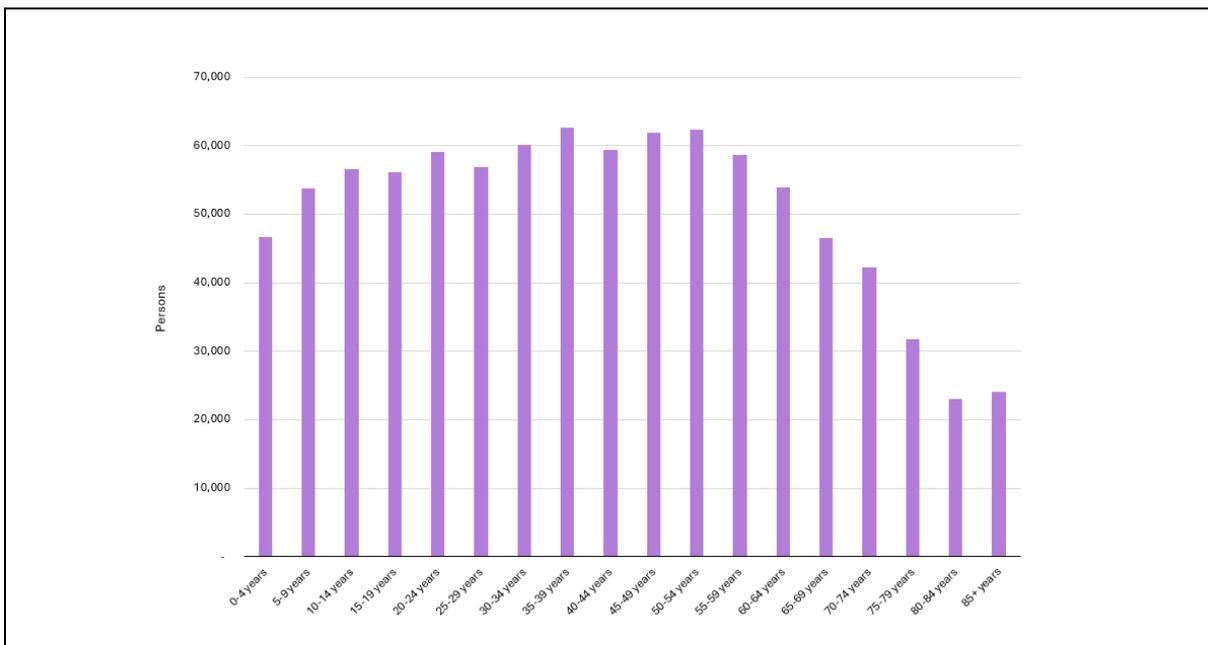
Source: Australian Bureau of Statistics, 2021 Census All persons QuickStats.

5.2.2.2   Change in Population Ageing

Understanding age structure and projected shifts in older age groups helps to anticipate pressure points in the system and indicate the types of care that will be necessary in the future.

By 2036, the largest age group will be those aged 20-24 years and those aged 25-29 years. There is also a reasonably sized increase in those aged 45-49 years and those aged 80 to 84 years and those aged more than 85 years.

Figure 6: Population Changes by Age Group 2021-2036

Source: Australian Bureau of Statistics, 2021 Census All persons QuickStats.

Consistent with this population ageing, the age group growing at the fastest rate is those aged over 85 years in Yarra Ranges and Murrindindi, where the growth rate is 159 per cent and 183 per cent, respectively.

Table 1: Catchment Population Change, 2021-2036 by Age Group and LGA for ADH and EH Catchment

Age (yrs)	Boroondara	Knox	Manningham	Maroondah	Murrindindi	Whitehorse	Yarra Ranges
0-4	23.05%	0.09%	10.03%	6.44%	-2.44%	34.40%	-6.11%
5-14	-0.91%	-3.33%	2.28%	2.38%	-9.30%	4.27%	-30.00%
15-19	9.34%	8.84%	24.45%	20.81%	-1.66%	15.97%	17.29%
20-24	34.02%	14.46%	40.94%	32.54%	9.44%	41.14%	61.04%
25-34	42.70%	7.73%	32.42%	17.86%	18.60%	43.85%	3.80%
35-44	15.51%	10.08%	14.24%	9.57%	18.57%	28.29%	17.78%

Age (yrs)	Boroondara	Knox	Manningham	Maroondah	Murrindindi	Whitehorse	Yarra Ranges
45-54	4.89%	10.29%	15.81%	17.32%	-14.92%	17.27%	12.62%
55-64	-3.37%	-5.22%	0.84%	10.42%	-7.60%	12.48%	-3.46%
65-74	15.73%	10.72%	8.68%	15.81%	24.90%	17.14%	8.55%
75-84	39.36%	68.67%	8.55%	38.73%	92.61%	17.39%	70.22%
85 +	41.53%	107.78%	51.10%	57.28%	183.14%	16.85%	159.38%

Source: Australian Bureau of Statistics, 2021 Census All persons QuickStats.

This population ageing is expected to significantly increase demand for health care and related services. As the proportion of older adults grows, so too does the prevalence of chronic disease, frailty, and multi-morbidities, all of which require more frequent, possibly longer, and more intensive episodes of care. Older people typically utilise a higher volume of hospital, primary care, allied health, diagnostic, rehabilitation, and community support services, and often require more coordinated and specialised models of care to maintain independence and quality of life. This demographic shift will place upward pressure on service capacity, workforce availability, and infrastructure, reinforcing the strategic need for proactive investment, integrated care pathways, and models that support early intervention, prevention, and safe ageing in place.

5.2.3 Catchment Health and Wellbeing

The burden of disease within the catchment shape service demand and is a key contributor to the drivers for change. Catchment health and wellbeing can be understood though the lens of different data sets.

5.2.3.1 Long-term Health Conditions

For the purposes of this business case, it is helpful to understand the incidence of long-term health conditions and use this to understand the type of health care and service that should be delivered locally so that people can experience care close to home.

The table below presents the incidence of long-term health conditions across the LGAs of the shared ADH and EH catchments. The LGAs with the highest number of people, and the LGA with the highest proportion of the population for each condition are shaded orange.

Table 2: Long-term Health Conditions in the ADH and EH LGAs and Victoria

	Incidence of condition in population (count and proportion)							
	Boroondara	Knox	Manningham	Maroondah	Murrindindi	Whitehorse	Yarra Ranges	Victoria
Arthritis	11,111 6.6%	13,186 8.3%	9,862 7.9%	9,852 8.6%	1,993 13.1%	11,911 7.0%	14,719 9.4%	518,633 8.0%
Asthma	12,417 7.4%	14,105 7.4%	7,721 6.2%	10,486 9.1%	1,447 9.5%	12,387 7.3%	14,944 9.6%	543,047 8.4%
Cancer	5,152 3.1%	4,662 2.9%	3,955 3.2%	3,581 3.1%	648 4.3%	4,777 2.8%	4,927 3.2%	179,326 2.8%
Dementia	1,542 0.9%	1,208 0.8%	1,432 1.1%	910 0.8%	94 0.6%	1,261 0.7%	876 0.6%	45,946 0.7%
Diabetes	5,119	8,534	5,776	5,041	843	7,135	6,699	303,371

	Incidence of condition in population (count and proportion)							
	Boroondara	Knox	Manningham	Maroondah	Murrindindi	Whitehorse	Yarra Ranges	Victoria
	3.0%	5.4%	4.6%	4.4%	5.5%	4.2%	4.3%	4.7%
Heart disease	5,920 3.5%	6,326 4.0%	5,074 4.1%	4,350 3.8%	801 5.3%	6,144 3.6%	6,142 3.9%	243,130 3.7%
Kidney disease	1,165 0.7%	1,358 0.9%	1,113 0.9%	982 0.9%	193 1.3%	1,351 0.8%	1,301 0.8%	57,437 0.9%
Lung condition	1,543 0.9%	2,331 1.5%	1,342 1.1%	1,739 1.5%	409 2.7%	1,832 1.1%	2,642 1.7%	97,270 1.5%
Mental health condition	11,889 7.1%	13,778 8.7%	7,281 5.8%	11,237 9.8%	1,534 10.1%	12,498 7.4%	16,047 10.3%	571,150 8.8%
Stroke	1,222 0.7%	1,522 1.0%	1,292 1.0%	1,135 1.0%	211 1.4%	1,445 0.9%	1,481 0.9%	59,844 0.9%
Any other long-term condition	13,194 7.9%	13,923 8.8%	10,243 8.2%	10,669 9.3%	1,293 8.5%	14,158 8.4%	13,838 8.9%	519,110 8.0%

Source: Australian Bureau of Statistics, 2021 Census All persons QuickStats

In all instances, except stroke, an LGA within the shared ADH and EH catchment performs more poorly than Victoria overall. In five out of the 11 condition types, Murrindindi performs worse than all other Victorian LGAs in terms of the percentage of the population experiencing that condition. In six out of the 11 conditions, Yarra Ranges has the highest number of people per LGA in the shared catchment experiencing the condition. The incidence of dementia and cancer in Boroondara is likely a reflection of the older age profile in that community. As described earlier, people living in Boroondara primarily flow to inner city hospitals for their care, with people living in Kew and the near surrounds attending EH.

5.2.3.2 Mental Health

Of the long-term health conditions, in volume, mental ill health affects the largest number of people in Victoria, and the largest number of people in the ADH and EH catchments. Comparatively speaking, a larger proportion of residents in Yarra Ranges (10.3%), Murrindindi, (10.1%) and Maroondah (9.8%) report a long-term mental health condition, compared with Victoria (8.8%). (Table 2)

Specifically, people in Yarra Ranges are estimated to be experiencing high or very high levels of psychological distress at a significantly greater rate than the rest of Victoria. Further, those people living in Yarra Ranges, Murrindindi and Knox are estimated to have experienced depression and/or anxiety in the last 12 months at higher rates than the rest of Victoria.

The rate of suicide in Murrindindi in 2018 was 20.3 per 100,000 people, almost double the rate for Victoria and 30 per cent higher than regional Victoria at 15.0.

Table 3: Psychological Distress, Anxiety and Depression, and Suicide and Self-inflicted Injuries

Boroondara	Knox	Manningham	Maroondah	Murrindindi	Whitehorse	Yarra Ranges	Victoria
High or very high psychological distress. % (Source: 1)							
12.5	15.6	16.2	20.4	20.9	14.9	25.7 *	19.1
Anxiety or depression in last year. % (Source: 1)							
10.7	16.8	11	14	16.3	8.8	19.7	14.9
Deaths from suicide and self-inflicted injuries, 0 to 74 years. Average annual ASR per 100,000. (Source: 2)							
9.8	10.6	6.7	14.0	20.3	7.9	10.8	10.9

Denotes statistical significance compared with whole of Victoria
Sources: 1. Victorian Population Health Survey, 2023.
2. PHIDU, Public Health Social Atlas – 2018 data

These indicators signal a sustained and elevated burden of mental ill-health in the region and highlight the imperative for enhanced service capacity, early-intervention models, and improved access to mental health support in a geographically dispersed metro-rural region.

5.2.3.3   Alcohol and Drug Use

The use of alcohol and tobacco are risk factors for poor health. Murrindindi is estimated to have a greater proportion of its community at increased risk of alcohol related harm. The rate is greater than all the other LGAs in the EH catchment and significantly greater than the proportion of people in Victoria. Tobacco use is estimated to be higher in Murrindindi than all the LGAs in the EH catchment and is slightly higher than the estimated proportion for all of Victoria.

Table 4: Estimated Risk of Alcohol Related Harm

	Boroondara	Knox	Manningham	Maroondah	Murrindindi	Whitehorse	Yarra Ranges	Victoria
At increased risk of alcohol related harm (%)	14.4	8.9	10	9.8	21.2*	7.7	17.2	13.1
Current tobacco smoking (%)	8.5	11.4	10.5	14.7	14.8	7.9	8.7	14.5

Denotes statistical significance compared with whole of Victoria
Source: Victorian Population Health Survey, 2023.

5.2.3.4   Incidence of Chronic Disease

Burden of disease for individuals is cumulative, with an increasing burden of disease associated with an increasing number of chronic illnesses a person experiences. People who live with several co-occurring chronic illnesses are more likely to use health resources at a higher rate. In addition, because of the way the health system is organised, their care for one of their conditions may not take account of or be coordinated with the care of their other condition(s).

Table 5: Incidence of Chronic Disease

	Boroondara	Knox	Manningham	Maroondah	Murrindindi	Whitehorse	Yarra Ranges	Victoria
Two or more chronic diseases (excl. anxiety and/or depression) %	15.4	20.9	16.4	19	29.1*	15.4	20.5	16.9

*Denotes statistical significance compared with whole of Victoria
Source: Victorian Population health Survey, 2023.

Across the shared ADH and EH catchment, the outer east communities (Yarra Ranges and Murrindindi, and to some extent Knox) experience higher rates of disease compared with other LGAs in the shared catchment and Victoria. Promotion of health and wellbeing, and management of chronic illness in primary medical care settings is further hampered by GP access, with 47.4 per cent of people in Murrindindi, estimated to wait longer to see a GP than is acceptable (compared with 33 per cent for Victoria).   Together with ageing, this disease burden will drive service demand in the catchment and will require models of care to respond to longer term chronic illness, alongside single episode acute care.

5.2.3.5   Use of Hospital Services

Use of hospital services is an indicator of underlying health and wellbeing. To account for variations in population size, a rate of admissions (or presentation) per 100,000 people is used to understand the differences in use of hospital services.

Table 6: Public Hospital Emergency Presentation and Acute Admission Rates 2022/23

Boroondara	Knox	Manningham	Maroondah	Murrindindi	Whitehorse	Yarra Ranges	Victoria
Emergency Department presentations							
15,133	24,975	18,970	25,386	22,794	18,256	26,426	25,890
Admissions, excluding same day renal dialysis. ASR per 100,000							
11,054	19,841	14,814	18,884	27,599	13,992	21,791	23,195
Admissions for same day renal dialysis							
2,094	4,305	3,670	4,967	3,396	3,777	3,612	5,272

The communities of Maroondah and Murrindindi were the largest users of emergency departments in 2022/23, although below the rate for the rest of Victoria. In terms of admissions, Murrindindi has the highest rate of admissions across the shared catchment and significantly higher than the rate for the rest of Victoria. With respect to same day dialysis, the communities of Maroondah and Knox have the highest rates of utilisation, both of which are below the Victorian rate.

Where data indicates poorer health and wellbeing, for example for the communities of Murrindindi and Yarra Ranges, which not uniformly correlated with health service utilisation, it may be that there are factors such as accessibility at play.

5.3   Alexandra District Health

The Alexandra District Hospital was officially opened in 1871 to respond to the health needs of the local community established because of the mining boom in 1866. It was a small community hospital with five beds, eventually growing to 10 beds in subsequent years. A fire in 1957 destroyed a significant section of the hospital. Reconstruction efforts and further development saw the size of the hospital increase to 30 beds, including the only nursing home beds in the local area at that time.

From the mid-1980s to the present day there has been the most rapid expansion in services. The health service now provides inpatient medical and low complexity surgical care, a range of community-based outpatient services, an urgent care clinic and support for older people to remain living in their homes. In 2014 the name was changed to ADH to reflect their broadened health service provision.

ADH is deeply rooted in its community. Over decades the community has contributed funds and other efforts to develop the facilities and support the purchase of equipment. The community continue to play a vital role in the health service, supporting volunteer and auxiliary functions and some philanthropic activity.

5.4   Eastern Health

EH provides health care and services to the eastern catchment of Melbourne, the largest geographical area of any metropolitan health service in Victoria, covering 2,816 square kilometres.

EH provides a range of emergency, surgical, medical, and general healthcare services, including maternity, palliative care, mental health, drug and alcohol, residential aged care, community health and statewide specialist services to people and communities that are diverse in culture, age, socio-economic status, and healthcare needs. EH delivers this care and service from more than 40 locations including major campuses:

- Eastern Health Angliss;
- Eastern Health Blackburn;
- Eastern Health Box Hill;
- Eastern Health Healesville;
- Eastern Health Lilydale;
- Eastern Health Maroondah;
- Eastern Health Peter James;
- Eastern Health Richmond;
- Eastern Health Ringwood; and
- Eastern Health Wantirna.

It delivers more than 1.5 million episodes of patient care annually through the following clinical services:

- Medicine;
- Surgery and anaesthetics;
- Women and children;
- Critical care and access;
- Care at home and specialist clinics;
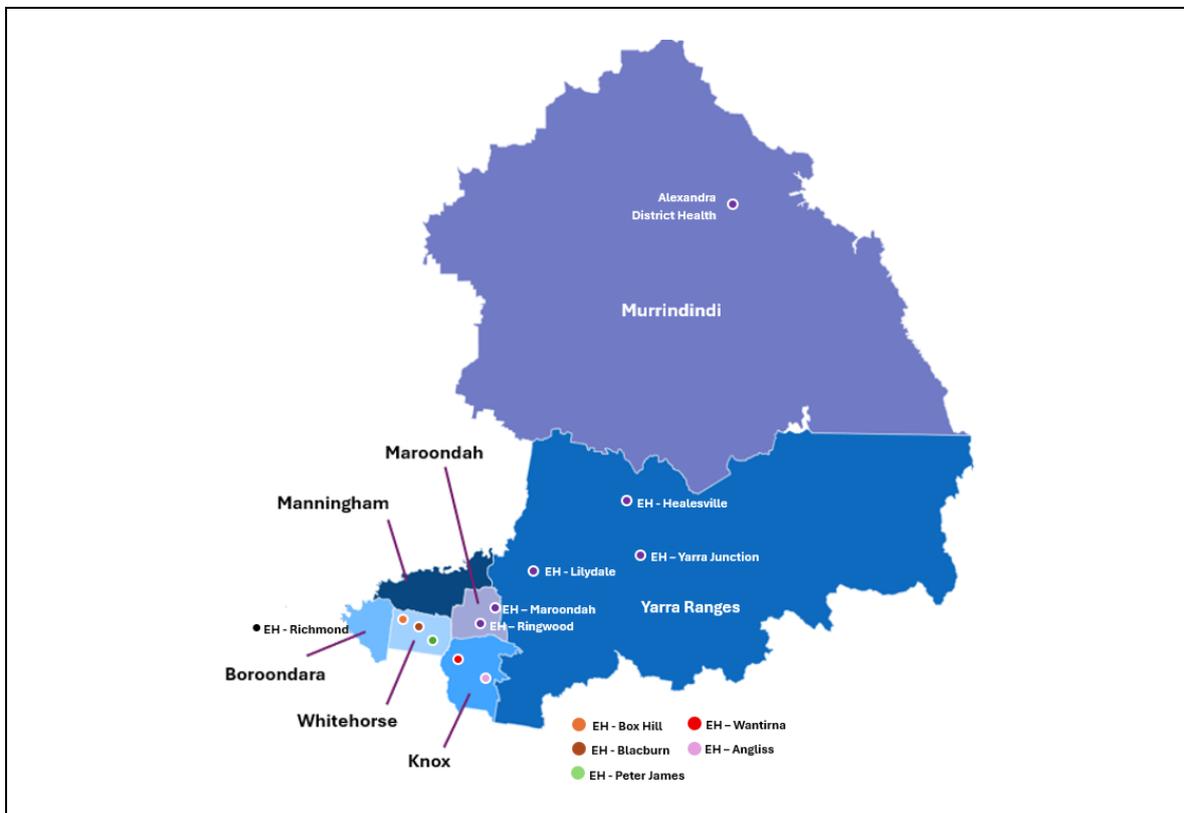- Mental health and wellbeing; and

- Statewide services, including Turning Point and Spectrum.

EH has university partnerships with:

- Deakin University;
- La Trobe University; and
- Monash University.

ADH is located in the western part of the Murrindindi LGA and is a 2 hour and 15-minute drive from Melbourne, (164 km). The campuses of EH are located across the eastern metropolitan LGAs, with one campus housing statewide services in Richmond. The closest EH campus to ADH is EH – Healesville, which is 68 km away and 56 minutes by car. The closest emergency department to ADH is EH – Maroondah, which is a 1 hour and 35-minute drive and 104 km away. Depending on traffic, travel time to EH - Angliss (which also has an emergency department and maternity services) is also around 1 hour and 35-minutes.

Figure 7: Map of ADH and EH locations

5.5 Clinical Service Profiles of ADH and EH

Table 7: Clinical Services Profile ADH and EH

	ADH	EH
Acute		
Acute beds	6 staffed beds (25 bed capacity)	714 (open beds)
Operating Ttheatres (number of theatres and days of operation)	1 operating theatre All planned care Operating 7 days each month 1 Central Sterile Services Department	25 operating theatres, across 6 sites Mix of planned and unplanned care Operating every day of the year 6 Central Sterile Services Departments
Urgent Care Centre (bays)	3 bays 2 consulting rooms and 1 resus bay, which is utilised as isolation cubicle	0
Urgent care (beds)	1 Clinical decision bed	0
ED points of care	0	110 points of care 48 Short Stay
Hospital In the Home (# of patient capacity)	Yes, contracted to the District Nursing Service	Yes
GP clinic/services	No GP practices are owned by ADH Approximately 1.2FTE Rural Generalist Anaesthetists employed by ADH to work in the Acute ward/UCC and Anaesthetics.	1 at Healesville, 7 day a week service
Access to telehealth	VVED	VVED
Dialysis chairs/points of care	0 (3 as part of a current business case)	70 (plus 62 home dialysis)
Sub-acute		
Subacute (incl. rehabilitation and geriatric evaluation and management)	0	158
Palliative care	0	28
Other bed-based services		
Mental health	0	96 Adult Acute (8 are AOD) 30 Older Adult 12 Adolescent 58 CCU and PARC
Aged care		
Residential aged care (beds)	0	120
Commonwealth Home Support Program	Yes	Yes
Ambulatory services		
District nursing	Yes	Yes
Maternity shared care (ante/post)	No	Yes, as part of a comprehensive maternity clinical service

	ADH	EH
Dental services	No	No
Allied health	Yes	Yes
Community rehabilitation	No	Yes
Cardiac rehabilitation	Yes	Yes
Pulmonary rehabilitation	Yes	Yes
Clinical Support Services		
X-ray (days per week or times per day)	No	Yes Angliss Hospital, Box Hill Hospital, Maroondah Hospital - 7 days per week: Healesville – 5 days per week
Ultrasound (days per week or times per day)	No	Yes 7 days per week Angliss Hospital, Box Hill Hospital, Maroondah Hospital

Source: ADH and EH.

5.5.1 Clinical Activity

Table 8: Summary of Clinical Activity at ADH and EH 2023–2024

	2023-2024		2024-2025	
	ADH	**EH**	**ADH**	**EH**
Emergency department presentations	0	146,855	0	148, 339
Urgent care presentations	3,839 (with 11% transfer out rate)	0	3724 (with 10.5% transfer out rate)	0
Separations including same day	938	1,549,332	828	1,569,934
Total surgeries/procedures	688	41,231	634	42,063
Total bed days	2364	439,596	1987	440,596
Staffing (Full time equivalent, monthly)	61.37	7487	58.46	7788

Source: ADH and EH.

5.5.2 Patient Flow

ADH and EH currently work as part of the connected Victorian health care system, with patients flowing between their sites to access care and service. Forty percent of the hospital separations for people who live in the ADH catchment are provided at one of the EH campuses. Of all the

Victorian health care services, EH provides the most care to people who live in the ADH catchment.

Table 9: Acute Separations for Those People Living in the ADH Catchment

Health service where acute care is provided	Proportion of separation for all the ADH catchment population (2023/24) (Excludes dialysis)
ADH	20%
EH	40%
Northern Health	3%
Austin Health	1%
Seymour Health	14%
Yea & District Memorial Hospital	1%
Other metropolitan health services	14%
Other regional health services	8%

The acute care provided by EH to residents of the ADH catchment is a mix of unplanned emergency care, which may result in an inpatient admission (around 50 per cent) with 50 per cent for planned care such as dialysis, chemotherapy and planned surgery.

6 Defining the Case for Change

In defining the case for change, clinical and administrative leaders from ADH and EH worked together, reviewing the data and sharing their experience and expertise to understand the drivers for change and their impacts. The potential options explored through this business case seek to address these impacts and in doing so create benefits that would flow to the staff, community, health services, and the system.

6.1   Drivers of Change and Impacts

The following table outlines the identified internal and external drivers and provides a description of their impact.

Table 10: Drivers of Change and Impacts

Driver	Description
Internal drivers	

Range of services delivered at ADH	• ADH has limited scale necessary to adapt and meet the local community's evolving needs, including the increasing local demand associated with population ageing.
	• The current service delivery profile at ADH is not reflective, to the extent that it should be, of the needs of the local community, meaning that the local community is needing to travel away from 'home' to care that could be expected to be provided locally. This includes:
	   o Limitations to the complexity of medical inpatient care;
	   o No access to subacute bed-based services;
	   o Limited access to low complexity surgical procedures, (despite theatre and bed availability);
	   o No local access to dialysis; and
	   o Limited access to specialist clinic (outpatient) services.
	• Murrindindi residents travel around 45 minutes to 1.5 hours to access care and service that could be provided closer to home.
	• Expanding the range of services provided at ADH sites and to better cater to the needs of the local community is needed.

Non-network and disconnected care into the outer east and into Murrindindi Shire	• Movement of patients between ADH and EH requires a formal transfer of care from one organisation to the other creating fragmented care experiences for patients, burdensome processes for clinicians and the potential for access to timely care to be compromised as EH seeks to manage their 'local' access demands. • This movement of patients (or sharing and movement of patient related information) is hampered by fragmented clinical information management systems.

Driver	Description
	• Reducing and/or removing the existing barriers to care and to more equitably distribute the combined resources of the organisations to a shared catchment is preferred.
Clinical safety and quality (outcomes and systems) is not optimal	• As a large health service, EH has capacity to make relatively larger investments in the development of its clinical workforce to support safe, high-quality care. Similarly, EH has the capacity to make relatively larger investments in the maturity of its clinical governance frameworks and supporting systems and processes. Access to a larger pool of clinical experience and expertise also provides greater opportunity for clinical review, supervision, and practice development, which support safe practice and clinical improvement. • Many quality and safety systems are duplicated across ADH and EH as each organisation works to meet their quality and safety obligations (regulatory and accreditation requirements, and similar). This duplication represents an inefficient use of precious system resources. • There is a need to find better ways to utilise shared quality and safety expertise to develop a unified and more efficient system.
Burdensome compliance and regulatory requirements	• ADH and EH are each responsible for meeting their own compliance and regulatory obligations. The work to do this is administratively burdensome and particularly so for a smaller health service such as ADH. • The work is also duplicative, with in most case the same processes being completed at each health service. • EH, because of its size and related business needs has developed more specialised expertise, (e.g.) in-house Chief Counsel, and the amalgamation provides an opportunity to leverage this expertise across a wider set of considerations. • Compliance and regulatory requirements can be managed more efficiently, by reducing the duplication that is currently occurring.
Inadequate capacity for workforce development	• Clinical workforce capacity and capability is a challenge for most public health services as they seek to respond to the changing nature of health care delivery, and regular workforce exit and renewal. Workforce capability is also a function of clinical experience and exposure, where staff working in services with greater scope and scale have greater opportunities to learn and develop, thus creating a virtuous cycle that supports capability and retention. ADH, as a smaller health service, is challenged to provide adequate scale and scope to continuously develop the capability of their workforce. In smaller scale services, a relatively small change, such as the exit of a single clinical leader can alter the scope of practice of a whole team. Smaller scale services are also challenged to be able to dedicate the time and financial support for capability development.

Driver	Description
	• The different location and service profiles of ADH and EH present opportunities for each other to learn and develop. For example, the rural location and service profile of ADH presents learning opportunities for EH staff who are interested in developing in this area. Conversely, the broader scale and scope (acuity) of clinical services that EH delivers presents opportunities for ADH staff to develop their capability.
	• Where capability development can be woven into the day-to-day work, rather than seen as additional to the day-to-day work, capability development is easier to manage. However, for this to occur between separate organisations, formal secondment agreements and similar need to be in place, making the process administratively (and possibly financially) burdensome to administer.
	• Non-clinical workforce capability and subsequent organisational capacity is easier to manage in larger organisations where there is likely to be exposure to broader set of tasks and work circumstances, and often technical experts who are able to support and coach peer learning. Similarly to clinical workforce capability development, ADH faces challenges associated with its small scale and limited exposure to a broad range of non-clinical/corporate workforce learning opportunities.

	• There is a need to build upon the existing workforce development being progressed by ADH and EH (nursing workforce) to:
	
	   o Broaden the scope of learning opportunities;
	
	   o Remove the administrative burden associated with formal agreements, etc. that need to be in place to move staff between services;
	
	   o Coordinate investment in workforce development to deliver better value; and
	
	   o Leverage the university and other educational partnership that EH has to benefit a larger workforce.

Limited access to clinical trials	• As a small health service, ADH is not able to offers its patients access locally to cutting edge care and treatment options close to home, meaning that patients need to travel, often long distances, or miss out altogether. This lack of access has the potential to exacerbate the burden of inequity experienced in the ADH catchment.
	• Local trials could also generate evidence that is more relevant to rural populations, considering different demographics, comorbidities, and access challenges.
	• For staff, involvement in research and trials supports recruitment, retention and professional development, helping to build a skilled, workforce.

Driver	Description
Expertise in service development capability is unevenly spread	• All health services are challenged to respond to increasing service demand, and to develop and implement new models of care to respond to changing needs. As a large health service, EH has know-how model of care development and there is opportunity to leverage its significant investment in Care at Home to develop models of care to support the ageing populations in Murrindindi and Yarra Ranges. Further the expertise within EH can support the development of models for care closer to home. ADH brings its rural expertise to this effort to ensure that the models of care are fit for purpose to be delivered in a rural and semi-rural setting.
External drivers	
Population is growing and ageing	• Although the populations of both the ADH and EH catchments are growing, they are growing at a much slower rate than the rest of Victoria. There are some small pockets of growth within the EH catchment associated with migration patterns and in-fill residential development, but overall, population growth will not drive significant service demand. • Critically, the catchment populations of ADH and EH are ageing, and this changing age structure will drive increased demand for services and care over the coming decades. • The increased aged profile will also drive demand for models of care that respond to the needs of an ageing population. • ADH has limited scale necessary to adapt and meet the local community's evolving needs, including the increasing local demand associated with population ageing.
Demand for health services is expected to increase	• Timely access to care and support is currently challenging. For example, EH is able to meet its activity targets for planned care, but not its timeliness targets. • Demand for services is expected to increase, raising the pressure on this already constrained system. • There is currently upward of 40,000 people waiting for a specialist clinic appointment which represents 15% of the total volume seen in a year. • Additional infrastructure and related additional capacity, particularly for planned care (procedures, surgery and outpatients) would improve access and timeliness of some services and care
Unique geographic context of the region	• The geography of the region creates a unique set of challenges for healthcare access and workforce attraction and retention. • ADH is a 2 hour and 15-minute drive from Melbourne (164 km). • The closest emergency departments to ADH are: o Maroondah Hospital, and Angliss Hospital - 1 hour and 35-minute drive (114 km); and

Driver	Description
	o Box Hill hospital - 1 hour and 49-minute drive (128 km). • The relatively small population of 15,600 people is dispersed across the LGA. • There is very low availability of public transport, with the closest train station located in Seymour.
Some communities do more poorly than others	• Whilst there are examples of mixed health outcomes across the shared catchment, there are persistent and significant issues in the outer east communities of Murrindindi and Yarra Ranges. This will challenge both ADH and EH into the future. Together with ageing, this illness profile will drive increased service demand. • Addressing health inequity requires significant investment of time and often requires health services to change their ways of working. Best practice evidence suggests the need to embed equity in policy, planning, and resource allocation to bring an equity lens to decisions. Coordination of this approach is necessary where catchments are shared. Current separate governance does not support this coordination, and this approach to equity is not a current priority for the EMM LHSN. • ADH has limited scale necessary to adapt and meet the local community's evolving needs, including the increasing local demand associated with population ageing.
Site by site (rather than catchment approach) to service planning, related service investment and service development.	• The approach to service planning is primarily driven by a site-by-site planning model rather than a catchment or population model and assumes many of historical patterns will carry forward into future years. As a result, health services undertake service planning for a site (to support a capital investment) or for their primary catchment at a health service level. Where a large health service catchment adjoins a small health service catchment (like ADH and EH) there is a risk that the planning does not adequately capture the service needs in the smaller catchment that cannot be responded to by the smaller health service and should be picked up by the neighbouring larger health service. This is compounded when there is an underlying shift in the population profile that drives changes in service type, (rather than just the volume), e.g. population ageing. • The LHSN service planning work may address this issue to a limited extent, in that it will identify clinical service and related workforce directions for nominated high-volume clinical streams. However, beyond the role delineation framework there is no clear decision-making framework for resolving issues related to overlap or gaps in service delivery capability or capacity, or further how the clinical service plan will be 'resourced' to result in more sensible service delivery.
Limitations of the current arrangements	• ADH and EH are active members of the EMM LHSN, and as such work together, and as part of the broader partnership, to advance

Driver	Description
	the health experience and outcomes of their shared communities of interest and the sustainability of the health services and system.

	• However, there are limitations with the effectiveness of the early LHSN partnership, including:
	  o Reliance on relationships between individuals;
	  o Limitations on the individual entities in pooling resources;
	  o Transaction costs of partnering across individual entities;
	  o Administrative burden associated with managing 'shared Activities' across the partnership;
	  o Inability to leverage the scale of the two large health services easily; and
	  o The newness of the partnership with a very broad set of priorities and large work program.

6.2   Benefits

A clear articulation of benefits is essential, providing a shared understanding of the value any proposed change is expected to deliver. Benefits describe the positive outcomes being sought through each of the possible options being assessed in the business case, and the extent to which they address the impact of the change drivers.

This business case nominates seven benefits. The benefits fall to one, or all of the following stakeholder groups: community, staff, health services (ADH and EH) or the Victorian health care system overall. Table 11 describes the seven benefits from the perspective of each stakeholder and outlines the measurable impact of the benefit within a five-year time horizon.

Table 11: Benefits

Benefit	Description	Measurable impact (5 years)
Benefit 1	**Increased access to service and care closer to home**	
Community	• Increased complexity of care to be managed in inpatient settings at ADH. • Increased access to (new) specialist inpatient subacute care at ADH. • Increased number of low complexity procedures available at ADH. • Increased access to specialist clinics at ADH.	a. Increase in number of multiday separations at ADH. b. Increase in number of procedures completed at ADH. c. Increase in number of specialist clinic visits at ADH. d. Reduced travel (time/distance) for ADH catchment residents.
Staff	• Improved ability to complete care for their local community in their local community. • Access to a wider range of clinical learning and development opportunities with more support.	

Benefit	Description	Measurable impact (5 years)
Health service	• Improved utilisation of existing infrastructure. • More efficient cost structures.	e. Increased staff satisfaction. f. Improved staff retention.
System	• Improved utilisation of existing system resources.	
Benefit 2	**Improved integration and connectivity of care and service**	
Community	• Community is able to access services locally and do not need to navigate unfamiliar services away from home.	a. Improved patient experience. b. Improved staff satisfaction. c. Improved access performance (timely transfers).
Staff	• Easier transfers of care.	
Health service	• Patients are in the right place for their care. • More appropriate use of health service resources.	
System	• More efficient use of system resources (removal of non-value adding activity).	
Benefit 3	**Improved equity in health and wellbeing outcomes**	
Community	• Access to services, care and support that respond to the needs of the community. • Specific programs focussed on high incidence conditions, or parts of the community where access and outcomes need to be improved.	a. Improved health outcomes for high priority cohorts. b. Improved staff satisfaction.
Staff	• Able to provide the type of care that patients need.	
Health service	• Able to meet their core purpose to support health and wellbeing in their community.	
System	• Improvements in the health and wellbeing of the community.	
Benefit 4	**More sustainable and strengthened workforce**	
Community	• Care provided by capable and supported workforce.	a. Increased graduate rotation opportunities. b. Increased participation in workforce development activities. c. Increased use of adjacent HR and development supports.
Staff	• Access to increased training opportunities (type and number), clinical and non-clinical, leadership, research. • Access to a greater range of HR supports.	
Health service	• Increased training opportunities for new and established staff. • Improved staff attraction and retention.	

Benefit	Description	Measurable impact (5 years)
System	• Improved attraction and retention and reduced transaction costs. • Health careers are seen as rewarding and the health workforce are engaged and supported.	d. Improved workforce availability. e. Improved staff satisfaction. f. Improved workforce retention.
Benefit 5	**Improved clinical quality and safety (systems and outcomes)**	
Community	• Access to reliable, safe high-quality care, as close to home as is safe.	a. Reduced patient harm. b. Improved clinical governance maturity. c. Improved staff satisfaction. d. Reduced duplication of clinical governance activities.
Staff	• Access to increased supports and learning in relation to safe, high-quality care and supporting systems. • Support for career development in safety and quality leadership and practice.	
Health service	• Improvement in quality and safety systems (monitoring, managing, and improving). • Improved quality and safety performance. • Reduced duplication of clinical governance activities.	
System	• Improved quality and safety performance.	
Benefit 6	**Improved use of system resources**	
Community	• Access to reliable, safe high-quality care, as close to home as is safe. • A greater range of services available.	a. Reduced duplication of a range of corporate and clinical support processes and systems. b. Improved productivity (cost per bed day).
Staff	• Ability to focus on value adding work.	
Health service	• Improved distribution of service demand. • More sustainable services (efficiency, reduced duplication, better scale) across the shared catchment.	
System	• Greater value from the existing investments.	
Benefit 7	**Improved access to research related activity**	
Community	• Access to clinical trials at ADH.	a. Increased clinical trial participation.
Staff	• Opportunity to participate in research activities.	

Benefit	Description	Measurable impact (5 years)
	• Opportunity to build skills and career development in research. • Satisfaction from seeing patients access the most up to date care/leading care.	b. Number of research activities with a rural focus. c. Staff satisfaction. d. Value of research grants with a rural and/or rural metro focus.
Health service	• Wider range of grant opportunities (e.g. different community profiles, metro/rural). • Improved reputation as a research centre. • Greater health systems research.	
System	• Able to share learnings across the Victorian health care system. • Contribute to the knowledge based about effective health care delivery and community health and wellbeing.	

7 Options

7.1   Description of Potential Options

The development of this business case was initiated following an agreement by the Boards of ADH and EH to explore a voluntary amalgamation. Consistent with this, the business case assesses two options:

- Option 1: Base case, which represents no change from the current arrangements, and
- Option 2: Voluntary amalgamation of ADH and EH.

The business case assumes, that outside of specific efforts described for each of the options, that there is no other material change in the operations of ADH or EH. That means, for the purposes of Option 1, ADH and EH will continued to operate as they are operating in December 2025.

The business case also recognises that the Victorian health care system is in a period of transition with the recent commencement of the LHSN. ADH and EH are part of EMM LHSN along with YDMH and St Vincents Hospital Melbourne. Option 1 and Option 2 assume that the LHSN will deliver its intended benefits through the delivery of its Network Implementation Plan and related plans, and through this, will deliver some of the desired benefits.

A 'strengthened partnership' option (partnership between ADH and EH beyond LHSN) was considered. It was determined to not include it in the potential options as it could not be adequately differentiated from Option 1, which incorporates the LHSN partnership.

7.1.1 Base Case – No Change to Current Arrangements

The Base Case description is informed by the LHSN Implementation Plan and related plans, and assumes the activities described in these plans will be delivered. It is important to note that some of the deliverables within the Network Implementation Plan are contingent upon funding for the 2026/27 financial year. For the purposes of this business case, it is assumed that these will proceed with the necessary funding support provided by the Department of Health.

Table 12: Description of Option 1 – Base Case – No Change

Feature	Option 1 Description
Summary	ADH and EH remain operating as they are currently, responding to the needs of their local communities and delivering the government priorities as expressed in the Statement of Priorities for each organisation and the Statement of Expectations of the EMM LHSN.
Governance	Each health service has its own Board.
Leadership	Each health service has its own Chief Executive Officer, accountable to the respective Board.
Strategy	Each health service has its own Strategy (Strategic Plan).
Clinical services plan	Each health service has its own clinical services plan, which guides service delivery and development. These clinical services plans will be further

Feature	Option 1 Description
	augmented through the development of the EMM LHSN Clinical Service Plan in nominated clinical streams.
Service development and delivery	Each health service is responsible for its own service development and delivery and for working in partnership with the LHSN to develop services as agreed through the LHSN. The EMM LHSN Implementation Plan identifies the following service development to be operational within the 2025-2026 LHSN Implementation Plan: • Step closer care (pathways in agreed areas); • Sustaining Residential in Reach; • Hospital in the Home access for ADH and YDMH; • ADH will have access to EH Picture Archiving and Communication System (March – April 2026); and • Installation of new X-ray systems at ADH (July to August 2026). ADH and EH have recently worked to progress the development of an oncology service in the ADH catchment, and this would continue under the base case assumption. ADH are currently working on service development for renal dialysis (three chairs) with support for recurrent funding already confirmed. The relevant Hub service is yet to be confirmed. Current work is focussed on scoping infrastructure and equipment requirements.
Employment arrangements	Staff are employed by their respective health services, or where services are outsourced, under the contract arrangements overseen by the respective Boards and Chief Executive.
Workforce development	Each health service carries responsibility for the employment, safety, and development of its own workforce. ADH and EH already use the same Learning Management System to support their workforce development (hosted by EH) and this would continue. The workforce development being advanced by EH and ADH independently will be supplemented by the workforce development activities being progressed through the EMM LHSN, including the following for 2025-2026: • Development of a workforce plan on a page highlighting workforce development priorities for the LHSN; • Implementation of graduate allied health positions at ADH; • Implementation of a model for sharing nurse education and training; and • Collaboration between people and culture leaders/teams.
Safety and quality	The safety and quality of the care, services and workplaces is the responsibility of the respective Boards. Each health service is accredited under the National Safety and Quality Health Service (NSQHS) Standards, and other regulatory standards dictated by the scope of the clinical services they deliver.

Feature	Option 1 Description
	The EMM LHSN Annual Implementation Plan includes activities with a safety and quality focus including: • Participation in the Safer Care Victorian (SCV), Safer Together Program (STP) as members of the EMM LHSN and implementation of at least one STP initiative; • Each health service administers SCVs clinical governance maturity self-assessment and collects clinical governance maturity data; and • Establishment of/participation in a Quality Manager Network.
Legislative and regulatory compliance	Each health service has an obligation for its own legislative and regulatory compliance. The EMM LSHN Implementation Plan identifies work to coordinate legislative compliance system across EH, ADH and YDMH with implementation to commence in June 2026. This coordination will not remove the need for ADH and EH to each meet their legislative compliance and risk management obligations.
Non-clinical /corporate services	Each health service is responsible for the effective operation of their non-clinical/corporate support services. The EMM LHSN Implementation Plan identifies activities to streamline financial and procurement service, with the following timelines being worked towards: • EH supporting financial accounting and accounts payable at ADH/YDMH by June 2026; • Streamlined accounts receivable, cash management and receipting across EH/ADH/YDMH by June 2027; and • Endorsed model for shared procurement by June 2026.
Emergency preparedness, response and recovery	Each health service is responsible for the development and activation of their own emergency preparedness, response and recovery plans in line with their legislative obligations, and in line with the Health Services Emergency Management Policy. In the event of an emergency impacting ADH or EH, the relevant health service plan would be activated. Support between health services would require bi-lateral coordination.

7.1.2 Option 2 - Voluntary Amalgamation of Alexandra District Health and Eastern Health

Option 2 is the voluntary amalgamation of ADH and EH. Option 2 assumes that the implementation of the EMM LHSN successfully occurs, with the amalgamated health service maintaining membership in the EMM LHSN, meaning that the activities of Option 1 are also a feature of Option 2.

Table 13: Description of Option 2 – Voluntary Amalgamation

Feature	Option 2 Description
Summary	ADH and EH come together in a formalises structural arrangement to create a new legal entity (voluntarily amalgamated). The new entity (amalgamated health service) is responsible for responding to the needs of the newly defined catchment and communities, delivering the government priorities as expressed in the Statement of Priorities for the new organisation and the Statement of Expectations of the EMM LHSN of which the amalgamated health service will be a member.
Governance	The amalgamated health service has one Board, appointed in line with the Health Services Act 1998. The current Boards of EH and ADH no longer exist.
Leadership	The amalgamated health service has one Chief Executive.
Strategy	The amalgamated health service has a Strategy (Strategic Plan) recommended by the Board for approval by the Minister for Health.
Clinical services plan	The amalgamated health service has (will develop) a clinical services plan in line with government expectations. The amalgamated health service will participate in the clinical services planning activities of the EMM LHSN in the nominated clinical streams.
Service development and delivery	The amalgamated health service is responsible for service development and delivery to meet the needs of its newly defined community and for working in partnership with the EMM LHSN to develop services. In addition to those activities described in the EMM LHSN Implementation Plan, the voluntary amalgamation of ADH and EH will enable the development of additional services to meet the needs of the community, including: • Oncology – specialist clinics and infusion (service growth from the current initiative), • Dialysis as part of EH's Renal 'Hub'; • X-ray and ultrasound available at ADH; • More bed-based care at ADH; • More surgical procedures delivered from ADH theatre suite; • Expanded learning and training opportunities for staff; • Clearer pathways for escalating and de-escalating care to ensure patients are getting the right care in the right place with smooth transitions at the interface between sites and clinical information from a unified system; • New models of health care and support that respond to the growth in the ageing of the population and the right pathway for individual health care needs; and • Focus on the priority needs of the local communities (chronic illness, including mental health).

Feature	Option 2 Description
Employment arrangements	Staff are employed by the amalgamated health service, or where services are outsourced, under the contract arrangements overseen by the Board and Chief Executive of the amalgamated health service.
Workforce development	The amalgamated health service carries responsibility for the employment, safety, and development of its own workforce. In addition to those workforce development activities occurring through the EMM LHSN, the amalgamated health service will support: • Nursing, medical, and allied health rotations across full scope of clinical services and locations of the amalgamated health service; • Alignment of the current ADH and EH workforce development program; and • Increased training and development opportunities for nursing, medical and allied health staff enabled by the metropolitan and rural location of the amalgamated health service.
Safety and quality	The safety and quality of the care, services and workplaces is the responsibility of the Board. The amalgamated health service will be accredited under the National Safety and Quality Health Service (NSQHS) Standards, Aged Care Quality Standards, and other regulatory standards dictated by the scope of the clinical services it delivers. In addition to those safety and quality focussed development activities occurring through the EMM LHSN, the amalgamated health service will support: • Integration of clinical safety and quality systems so that there will be a unified system for the amalgamated health service (clinical governance, credentialing, scope of practice, policies, and procedures etc); • Integration of clinical incident and clinical risk management practice, processes, and systems, including Victorian Health Incident Management System (VHIMS) to create a unified system for the amalgamated health service; and • Accreditation process for a single organisation (rather than for the two legacy organisation as is the case currently).
Legislative and regulatory compliance	The amalgamated health service has an obligation for its legislative compliance and risk management practice. The EMM LSHN Implementation Plan identifies work to coordinate legislative compliance system across EH, ADH and YDMH with implementation to commence in June 2026. The support of this work will continue. The amalgamated health service will have a unified approach to meeting its legislative and regulatory compliance requirements.
Non-clinical /corporate services	The amalgamated health service is responsible for the effective operation of its non-clinical/corporate support services.

Feature	Option 2 Description
	The EMM LHSN Implementation plan identifies several activities over 2026 to align finance practices across EH, ADH and YDMH. This work will proceed as planned.
	In addition, the amalgamated health service will have unified systems for:
	• Budgeting, reporting; • Financial management (payroll, accounts, procurement); and • HR management (including whole employee lifecycle and LMS).
Emergency preparedness, response and recovery	The amalgamated health service is responsible for the development and activation of their own emergency preparedness, response and recovery plans in line with their legislative obligations, and in line with the Health Services Emergency Management Policy.

8 Stakeholder engagement

8.1   Approach

A stakeholder engagement program was designed and implemented to obtain feedback from staff, community and stakeholders as one of the inputs into the business case process. .

8.1.1 Stakeholder Engagement Goal

The goal of the engagement program was to ensure transparent, inclusive, and meaningful engagement with staff, stakeholders, and the community about the proposed voluntary amalgamation between ADH and EH. Information collected during the engagement period was one of the inputs considered in the development of a business case for a possible voluntary amalgamation.

8.1.2 Stakeholder Engagement Objectives

A series of objectives for stakeholder engagement were developed and informed the design and delivery of the stakeholder engagement process.

1. Provide timely, accurate, and accessible information to staff, stakeholders, and the broader community about the intent, process, and potential benefits of the proposed voluntary amalgamation through coordinated communications and engagement activities.

2. Create multiple accessible opportunities for staff, stakeholders, and community members to share their views, ask questions, and contribute feedback during the engagement phase.

3. Foster confidence in the leadership of both health services by demonstrating openness, responsiveness, and commitment to community wellbeing throughout the engagement process.

8.2   Engagement Activities

Engagement commenced on Thursday 6 November and concluded on Friday 21 November 2025. It involved a series of pre-planned and responsive activities focussed on staff engagement at ADH and EH and community engagement in the catchments of ADH and EH.

8.2.1 Staff Engagement

ADH and EH took a staff first approach to engagement supported by a series of announcement activities, a survey and increased presence in existing huddles and meetings to respond to staff questions and feedback.

8.2.1.1 Announcement

On the announcement day, senior staff, followed by all staff from both services were informed of the exploration of a voluntary amalgamation before any other stakeholders. Announcements were made by the CEOs and Chairs of each health service. More than 20 staff attended the in-person ADH all staff meeting and more than 900 staff from EH attended two online all staff briefings. Follow-up emails were sent to more than 12,000 staff across both organisations with

resources including talking points for senior leaders and Staff FAQs, with two subsequent updates to the Staff FAQs shared throughout the engagement period. EH's intranet page which included resources on the exploration of a voluntary amalgamation has had 1,144 views.

Both health services CEOs and executive leadership teams took part in department and team meetings during the engagement period, with staff encouraged to raise questions through daily handover and or huddle processes so that managers could address and resolve questions immediately.

Staff feedback from both health services was mostly positive of the Boards' decision to explore voluntary amalgamation. ADH staff understood the potential benefits, and many were advocates for change during community discussions and local Tea Talk sessions. EH staff were largely apathetic with the main question being 'What are the benefits to EH?', which was addressed proactively by leadership.

8.2.1.2 Survey

The public survey was completed by 92 staff across ADH and EH (32 ADH staff, and 62 EH staff), and two who identified as working across both services. Respondents recognised clear potential benefits in a possible voluntary amalgamation, including opportunities for strengthened service delivery, with more than 55 per cent of staff from both organisations rating service expansion and improved access to specialist care as extremely important. Other shared priorities included ensuring the local Alexandra district community's health needs shape decision-making (62 per cent) and continuously improving the quality of care (67 per cent). Urgent care, medical imaging and outpatient clinics consistently ranked as the most vital services, with more than 60 per cent identifying them as essential for themselves or their families. Open-ended feedback reflected optimism about opportunities for service growth, education and workforce capability, balanced with a desire for more communication about how services and roles may change.

ADH staff expressed particularly strong support for expanding local services, with 87 per cent rating service expansion and attracting skilled professionals as extremely important. They also highlighted the importance of community-led decision-making, with 90 per cent prioritising support for local jobs and ensuring community health needs drive planning. Medical imaging (86 per cent) and urgent care (79 per cent) were the most critical services for their own needs, while more specialist services and pathways to care were seen as major benefits. Concerns focused on job security, clarity on why this can only be achieved in a voluntary amalgamation and maintaining ADH's local identity. EH staff also saw value in the partnership, identifying improved quality of care (59 per cent), access to specialist clinical training (52 per cent) and strengthened workforce capability as important outcomes. Their priorities were more system-focused, highlighting population health, patient information systems and support for CALD, LGBTQI+ and First Nations communities. More than 60 per cent highlighted urgent care as the most vital community service, with mental health and psychosocial support (62 per cent) emerging as a higher community priority for this cohort than for ADH staff. Key concerns included the capacity of ADH to support increased demand, significant travel distances for EH staff and general uncertainty about the what the actual benefits to EH would be.

8.2.2 Community Engagement

Community engagement activities included 16 Tea Talk sessions held across the ADH and EH catchments, an online anonymous and confidential survey, social media activity and engagement with local media. The program included a presence at the Alexandra Spring Show, and a community meeting with the Alexandra and District Traders and Tourism Association (ADTTA). Community members were also invited to provide written feedback through a dedicated email address and the online survey. A comprehensive Connecting Care website was launched

to support the engagement period, hosting FAQs, background material, key documents, video case studies, and details of all engagement opportunities.

8.2.2.1   Survey

A survey that was made available online and in hard copy in community locations was in place for the two-week engagement period.

The survey results highlighted the importance of attracting and retaining skilled health professionals. For, those who had been an ADH patient in the past year, support for service expansion and improved access to specialist care was strong, with more than 80 per cent rating these as extremely important. This group also placed high value on local decision-making (85 per cent) and the protection of local identity (75 per cent). Urgent care, medical imaging and outpatient services were considered the most essential services both personally and for the broader community, with open-ended feedback revealing strong interest in more local services and treatments, visiting specialists, a larger workforce and long-term sustainability for ADH. Concerns focused on losing local autonomy, the two-week community engagement period, which was described as "rushed", and the need for guarantees that services at ADH would not be reduced.

Respondents who had used EH services in the past 12 months shared similar priorities, though their emphasis was angled at broader system improvements such as continuously improving quality of patient care (67 per cent) and strengthened patient information systems and transfer of care (57 per cent). Like ADH users, they prioritised urgent care (81 per cent) and medical imaging (71 per cent) as the most essential services and expressed optimism about opportunities to grow the workforce and broaden overall service availability. However, concerns were raised about how ADH would be governed, whether funding commitments would be sustained over time, and the risk of resources being diverted away from Alexandra and its surrounding areas to metropolitan locations.

Community members who had not used either service in the past 12 months also recognised the importance of strengthening local service access. They emphasised the need to support local jobs and the local economy (81 per cent), while identifying medical imaging (86 per cent), urgent care (71 per cent) and general practice as their most critical services. More emphasis on cancer care and home-based services (71 per cent) was also considered as key community health needs. This group sought clarity about how a possible voluntary amalgamation would be funded, how specialist expertise currently available at ADH would be maintained and improved, and whether the long-standing contributions of visiting medical officers would be protected.

Of the 24 paper surveys that community members completed, there was consistent support for improved access to services, particularly a desire to reduce the need to travel long distances for treatment. A key priority that emerged was the importance of locally delivered services in Alexandra. Some members of the community express dissatisfaction about the survey questions.

Together, all community members across both health organisation articulated a consistent expectation that any voluntary amalgamation must protect essential services, build local capability and deliver clear, tangible benefits to the community.

Table 14: Themes from Survey

Survey Themes	Key Points	Frequency
Service loss at ADH	Fear of losing imaging, surgery, primary health, urgent care, maternity. Becoming a "satellite" site of EH.	Raised by many
Local governance and autonomy	Loss of ADH board representation. Decisions made in Melbourne that don't reflect the health needs of the local community. Loss of rural voice. Desire to retain ADH name and local identity.	Raised by many
Financial concerns	EH's financial position. Unclear about how funding will flow into ADH. Concerns ADH will receive less funding if it is part of EH. Fear that resources will be redirected to metropolitan hospitals.	Raised by several
Consultation concerns	Short timelines. Survey design criticised. Perception of predetermined outcome. Lack of transparency.	Raised by several
Workforce and clinical safety	Visiting Medical Officers (VMOs) may leave. Staffing shortages. Concern that staff may be required to move sites or travel excessively. Metropolitan staff willingness/unwillingness to travel. Need for greater supervision of junior staff. The need for 24/7 medical coverage requirements to be met.	Raised by several
Alternative approach	Strengthen existing partnerships instead of amalgamating. Consider an Alexandra–Yea merger or Murrindindi Health.	Raised by some
Local access and partnerships	If local patients need to travel to Melbourne for specialist care. EH leadership team will not properly understand the local needs. Impact on home-based services. Fundraising culture, community involvement and volunteer base.	Raised by some

8.2.2.2   Tea Talks

Sixteen 'Tea Talk' (community engagement sessions) were held across the ADH and EH catchments providing community members with over 20 hours of direct contact with CEOs and Board members from both health services. More than 200 people attended the sessions, with feedback highlighting the accessibility of Board members and CEOs and the openness of the discussions. The Alexandra Tea Talk on 18 November was also broadcast live by local radio station UGFM, extending reach to the broader community.

Across the Tea Talk sessions, attendees expressed a mix of optimism about enhanced access to local healthcare services and concern about preserving ADH's local identity, governance, and leadership. Participants emphasised that if there were to be any structural change, including a voluntary amalgamation, local autonomy must be retained. There was a strong desire to maintain the ADH name, local leadership positions, and ensure local presence in oversight roles. Concerns about ADH becoming a "small fish in a big pond" were particularly evident in the Alexandra sessions, alongside broader anxieties about fair representation and decision-making authority.

Community members consistently raised questions and sought assurances regarding service continuity, funding allocation, and the equitable distribution of resources across both organisations. Metropolitan-centric decision-making and the potential prioritisation of EH facilities over AH's were frequent concerns. Financial stability, workforce planning, and transparency in reporting were also emphasised, reflecting community interest in sustainable service delivery.

Service expansion emerged as a clear priority across all sessions. The most urgent and consistently cited need was the reinstatement of X-ray and ultrasound services locally. Participants also highlighted mental health services, dialysis, aged care, rehabilitation, GP access, and improved patient pathways and information systems as key priorities. Transport barriers, workforce shortages, and the need for preventative and community-based programs were recurring concerns. Community members expressed frustration at the current travel burden to access essential services in Seymour, Mansfield, Lilydale, and Healesville, highlighting the personal and emotional impact of lack of local service access.

While some participants questioned whether a full amalgamation was necessary, suggesting that strengthened partnerships through the proposed Murrindindi Local Health Service Network could achieve similar outcomes, the community's overall sentiment indicated that support for structural change is contingent on clear commitments, including maintaining ADH local leadership and governance, ensuring service continuity, retaining the ADH identity, and providing transparent communication regarding funding, workforce, and service planning.

8.2.2.3   Email

The community email (feedback@connectingcare.net) was established to provide another avenue for the community to provide feedback. The email was referred to on the Connecting Care website and included as a call-to-action on social media posts published across the engagement period.

Thirteen emails were received with eight being RSVPs to one of the 16 Tea Talk sessions. In addition, a question was received from an ADH staff member. EH received one email from a consumer, which was responded to promptly. All emails were responded to within 24 hours.

The Alexandra and District Traders and Tourism Association (ADTTA) emailed questions it had received from the community and shared a report it developed titled "Mergers are not Magic" outlining questions and themes raised by community members and analysis of local and

international research. The ADTTA requested that the report be considered by the Boards of ADH and EH.

8.2.2.4   Website

A dedicated website was established (www.connectingcare.net) to house all public facing information relating to the exploration of a voluntary amalgamation between ADH and EH. The website included:

- A list of frequently asked questions (which was updated throughout the two-week community engagement period);
- Media release;
- Factsheet;
- Information on how the community could provide feedback;
- Links to the community engagement survey;
- The feedback@connectingcare.net email;
- Information about the 16 Tea Talk / community engagement sessions; and
- Two video case studies that highlighted the benefits to local healthcare through ADH and EH's current partnership.

In total, the website received 1,100 visitors, with 68 per cent visiting the website directly, 19 per cent accessing it from a social media channel and 13 per cent having it sent to them. This suggests high intentional interest, good awareness and strong word-of-mouth. Social posts played a meaningful but secondary role in driving traffic.

8.2.2.5   Other Community Engagement Activities

ADH had a stand at the Alexandra Spring Show on Saturday 8 November and the CEO and Executive Leaders were on-site to answer questions from the community.

ADH and EH CEOs attended a meeting with the ADTTA on Tuesday 11 November, which drew more than 20 attendees. The ADTTA organised an independent community meeting on Tuesday 18 November, which drew around 80 people and was broadcast on UGFM. This was planned to occur immediately before the second Alexandra Tea Talk with the intention for community members to attend both events. ADH representatives did not attend this meeting.

8.2.3 Other Stakeholder Engagement

Following the staff announcement of 6 November 2025, the Chairs and CEOs of both health services engaged via phone, email or in-person meetings with more than 150 stakeholders, including local Members of Parliament, council representatives, neighbouring and related health services, community groups, donors, volunteers, and clients to discuss the exploration of a voluntary amalgamation and community engagement process.

ADH's CEO, Chair and a Board member met with the ADH Community Engagement Committee on 7 and 19 November.

ADH and EH CEOs attended a virtual meeting with the CEO and Mayor of Murrindindi Shire Council on 12 November and met with the Chair of Yea and District Memorial Hospital on Monday 17 November.

Murrindindi Shire Council launched its own survey on 12 November to provide Murrindindi residents a chance to answer further questions. The survey remained open till 28 November and

Council distributed hard copies of its survey to local libraries and pharmacies across the Alexandra district.

On Friday 21 November 2025, the CEO of Murrindindi Shire Council provided a submission to the Chair of ADH for consideration. Murrindindi Shire Council's submission urged ADH to defer any decision on a voluntary amalgamation with EH until the Murrindindi Health and Aged Care Workforce Strategy Network Plan is completed and its options fully assessed.

On Friday 21 November 2025, the Chair of Yea and District Memorial Hospital provided two submissions to the Chairs of ADH and EH Boards for consideration. The two submissions were offered from two perspectives: firstly, as an advocate for the Murrindindi community, and secondly in relation to the potential effects the amalgamation may have on the Yea and District Memorial Hospital.

The submission from the perspective of the Murrindindi community called for deferral of any amalgamation decision, continued engagement with local partners, and full exploration of existing network models before structural change is considered. This submission was published on the YDMH website.

The second submission from the YDMH Board outlined the specific risks YDMH anticipates if the ADH and EH amalgamation proceeds. The submissions were marked as confidential and as such information about its contents have not been included in this public facing business case document.

8.2.4 Additional Media and Communications

8.2.4.1 Social Media

Five posts were shared across ADH's Facebook and Instagram pages, with the comments switched off. These posts were also shared across key community Facebook pages including Alexandra Newspapers, Murrindindi Notice Board and Alexandra 3714 Community News.

Table 15: Social Media Post Activity

Post	Views	Reactions	Shares
An announcement post	3,341	18	12
A list of all the Tea Talk / community engagement sessions	884	10	5
A post indicating that more FAQs had been uploaded to the website	1,514	10	7
A letter to the community from ADH Board member and Taggerty resident Alan Tudley	9,064	58	19
A carousel with the top ten most frequently asked questions received from the community during the engagement period.	1,164	7	6
Jane Poxon's interview on ABC Shepparton	693	2	0

There was considerable community discussion across Facebook community pages and local groups in the Alexandra district. The main pages and groups that hosted discussions include Alexandra Newspapers, Murrindindi Noticeboard, Alexandra 3714 Community News, Save Yea

Hospital and Alexandra Tourism (Alexandra & District Traders and Tourism Association (ADTTA)). Discourse online was balanced, with commenters genuine in their discussion on the topic, without being combative or dismissing the views of others.

The discussion on Facebook showed themes of strong local loyalty and desire to maintain current quality and local leadership. There was a mixed community sentiment toward a possible voluntary amalgamation with the Alexandra community commentary being mostly open to exploration, while Yea community responses were concerned about how any future decision might affect YDMH, with some questions arising as to why a whole-of-Murrindindi solution was not being explored.

There was interest in service expansion, especially cancer, dialysis and greater access to specialist services. Concerns were also raised about governance, loss of local independence and an overbearing metropolitan influence. This included scepticism that EH staff based in Melbourne would want to travel to work in Alexandra.

Negative perceptions were expressed by some on the community engagement program including criticism that it was rushed, that the survey was leading, and that there was not enough transparency. .

8.2.4.2 Media Engagement and Coverage

ADH and EH issued a media release to local media announcing the exploration of a voluntary amalgamation on 6 November. ADH also ran a print advertisement in the Alexandra Eildon Marysville Standard / Yea Chronicle on Wednesday 12 November promoting the Tea Talks / community engagement sessions.

During the engagement period, local media, particularly the Alexandra Eildon Marysville Standard / Yea Chronicle, contacted ADH, EH and the Department of Health with several media inquiries, which were responded to in a timely manner.

Media coverage was localised with the reporting focused on criticisms of the two-week timeframe for the community engagement program and references to past opposition to voluntary amalgamation during the Health Services Plan period. Feedback from other forums reflects a more nuanced view from the community, with a focus on specific issues rather than broader arguments for or against.

Key themes included:

- Mixed framing with some outlets reproducing materials accurately, while others used headlines or angles that implied a "merger" or "back-door process."
- Multiple outlets emphasised criticism of the two-week engagement period and referenced past community opposition, positioning this as an ongoing issue.
- Several stories highlighted commentary reinforcing themes of loss of autonomy, reduced services, and inadequate engagement.
- Repeated references to YDMH, local leadership concerns, and the "Murrindindi Health" idea, highlighting that place-based governance remains a core public issue.

8.3   Insights from Stakeholder Engagement

8.3.1.1 Insights from Staff Engagement

Staff engagement revealed a broadly aligned view that a possible voluntary amalgamation presents meaningful opportunities to strengthen services, improve access to care and secure a more sustainable workforce. Across both organisations, staff placed significant importance on

expanding existing services, attracting and retaining skilled staff and ensuring community health needs guide decision-making.

Feedback balanced support with practical concerns, with ADH staff particularly focused on preserving community identity and local services while EH staff highlighted workforce capability and clearer communication of mutual benefits as areas requiring further detail. Concerns around job security, travel expectations and viability were raised by staff from both organisations. Overall, staff were open to the potential of a voluntary amalgamation, provided it strengthens essential services, is done transparently and clearly demonstrates value for both health services and the communities they serve.

Overall:

- ADH and EH staff agree there are benefits from a possible voluntary amalgamation, with community access to specialist care, and service continuity and quality at the centre of their priorities.
- A successful partnership will require clear, consistent communication around service models, workforce impacts and how local identity and community voice will be preserved.
- Confidence in a possible voluntary amalgamation relies on maintaining essential services, minimising unnecessary travel and ensuring the benefits are mutual for both organisations.

8.3.1.2 Insights from Community Engagement

Community engagement activities indicated that local residents hold a deep commitment to the long-term sustainability of healthcare in Alexandra and the broader Murrindindi community and a strong desire to see services expanded, modernised and better supported. Feedback consistently emphasised the importance of retaining skilled health professionals, reinstating key services such as medical imaging, and improving access to specialists and coordinated pathways of care.

While many participants acknowledged the potential benefits of strengthened collaboration, particularly improved access to visiting specialists, better information systems and long-term workforce growth this was balanced by clear concerns about local identity, governance and the future of ADH's autonomy. Survey responses and in-person discussions highlighted fears of service loss, financial disadvantage, and metropolitan-centric decision-making if a voluntary amalgamation were to proceed. The two-week engagement period and a perception of limited transparency were also recurring themes.

Overall, community sentiment reflected cautious interest supported by strong conditions: any voluntary amalgamation must protect and enhance existing services, maintain local leadership and representation, strengthen rather than dilute the rural voice, and deliver tangible improvements that are felt locally, not just system wide. Community members demonstrated willingness to consider structural change, but only where commitments are explicit, future funding is safeguarded, and ADH's identity, history and community governance are respected.

Overall, the community feedback emphasised the following:

- Protecting local identity, governance and services is non-negotiable. Community members are open to amalgamation but require clear guarantees that ADH's name, leadership presence, board representation and essential services will not be diluted under a larger metropolitan organisation.
- Service continuity and expansion are central to community expectations. The community strongly support improved local access, particularly in urgent care, medical

imaging, mental health, dialysis, and specialist outreach, viewing these as the most important drivers of any structural change.

- Trust and confidence depend on transparent communication and sustained investment. Community members want clarity on funding flows, the future of local jobs and visiting medical officers, and how decisions will be made. Engagement needs to be thorough, ongoing and demonstrably responsive to local concerns to build long-term confidence in the process.

8.3.1.3   Insights from Other Stakeholder Feedback

Across the engagement period, stakeholders generally responded positively to the opportunity for enhanced collaboration and service improvement with many expressing supports for exploring structural change that could strengthen local healthcare access and long-term sustainability.

While overall sentiment was constructive, several stakeholders raised important concerns and sought further assurances. These included Murrindindi Shire Council, the ADTTA, local MP Cindy McLeish, and current and former ADH Community Engagement Committee members. Their feedback centred on governance, community representation, the integrity of the engagement process, financial impacts and the risk of diminished rural voice under a potential amalgamation.

8.3.1.4   Summary of Stakeholder Engagement

Across the engagement activities, the feedback overall was diverse but broadly consistent: community members strongly valued local services, skilled health professionals, and improved access to specialist care. This is consistent with the benefits identified in this business case.

Many participants recognised the potential benefits of a possible voluntary amalgamation between ADH and EH, particularly around service expansion, workforce growth and strengthened clinical pathways.

At the same time, a considerable proportion of feedback expressed caution about the implications of a voluntary amalgamation. Concerns centred on protecting local identity and governance, maintaining service continuity, ensuring transparent decision-making and safeguarding funding for rural communities. These issues will need to be consider in the design of an amalgamated health service.

Criticism of the short engagement timeframe and survey design was raised by some stakeholders. Written submissions from Murrindindi Council, the ADTTA, and YDMH called for guarantees, clearer evidence, and further assessment before any structural change is considered.

Overall, community sentiment indicated cautious interest with clear conditions: any voluntary amalgamation must strengthen and enhance, rather than reduce, local services, retain ADH's voice and identity, and deliver tangible improvements for the Murrindindi community.

A summary of staff, community and stakeholder feedback was made publicly available in mid-December 2025. It highlighted the key themes emerging from the engagement.

9 Options Analysis

The options analysis compares the base case with voluntary amalgamation to determine the approach that delivers the greatest overall value. This targeted assessment examines the relative costs, benefits, risks, and implications of maintaining the status quo versus pursuing a voluntary amalgamation. The sentiment of stakeholders directly affected by future implementation of voluntary amalgamation is included in the consideration set.

By focusing on these two clearly defined options, the analysis provides a transparent and evidence basis for identifying the preferred way forward.

In the following sections, the relative benefits, costs, and risks of each of the options are compared, and these together with the outputs of the stakeholder engagement are considered to arrive at a preferred option.

9.1 Benefits Analysis

The following table describes the performance of Option 1 and Option 2 against each of the seven benefits defined in the business case.

9.1.1 Performance of Option 1 and Option 2 Against the Benefits

Table 16: Performance of Option 1 and Option 2 against the benefits

Benefits	Option 1: Base case –no change from the current arrangements	Option 2: Voluntary amalgamation of ADH and EH
1. **Increased access to service and care closer to home**	No planned increase in bed based/inpatient activity. No increase in activity in theatre suite (procedures).	Increase in inpatient activity at ADH (low complexity procedures and general medicine activity), supported by workforce development and specific models of care. <table><tr><td></td><td>**FY26**</td><td>**FY27**</td><td>**FY28**</td></tr><tr><td>**Separations**</td><td>829</td><td>2105</td><td>2462</td></tr></table>
	No new increases (beyond current cancer services development) in specialist clinics.	Increase in specialist clinical activity at ADH: • Two new specialist clinic sessions per fortnight, accessed from ADH 2026/27, targeting general medicine and geriatrics. • Two new specialist clinic sessions per fortnight accessed from ADH in 2027/2028 – targeting low complexity surgery and paediatrics.

Benefits	Option 1: Base case –no change from the current arrangements	Option 2: Voluntary amalgamation of ADH and EH		
			FY26	**FY27**	**FY28**
		Appoint-ments	0	480	960
	Dialysis (3 chairs).	Dialysis (3 chairs). Dialysis to operate as part of EH Renal Hub with Hub support to ADH satellite site provided as part of integrated service. Reduction in overall costs associated with reduced Hub/Satellite Fees.		
2. **Improved integration and connectivity of care and service**	Step closer care (pathways in agreed areas) progressed through LHSN activity.	• Streamlined care for direct admission for interhospital transfers. • Streamlined approaches for intra-service referrals secondary/specialist consultation, supported by a unified EMR (to be implemented over time as part of EH overall EMR uplift). • Benefits from EH investment in patient driven pathways as part of Care @ Home program by 2027/28. • Single information source and access point for community to make it easier for patients, and referrers to find information about patient pathways and connect to services seamlessly by 2027/28.		
3. **Improved equity in health and wellbeing outcomes**	No specific focus on 'equity groups' is identified at this stage. Potential for the EMM LHSN Clinical Services Plan to identify priority cohorts, however service development to respond to these has not been committed to.	In addition to the Step Closer Care, • Focussed work on care pathways for specific groups in shared catchments that respond to health and wellbeing and equity priorities – informed by the clinical services plan. To be in place for three cohorts from the beginning of the 2027/28 financial year. • A specific program that seeks to better connect care for people with co-occurring mental health		

Benefits	Option 1: Base case –no change from the current arrangements	Option 2: Voluntary amalgamation of ADH and EH
		and substance use conditions through EH's Hamilton Centre.
4. **More sustainable workforce**	Workforce development occurring through LHSN focussed on: • Development of a workforce plan on a page highlighting workforce development priorities for the LHSN. • Implementation of graduate allied health positions at ADH. • Implementation of a model for sharing nurse education and training. • Collaboration between people and culture leaders/teams. ADH access to EH's learning management system will remain in place.	• Nursing medical and allied health rotation across full scope of clinical services and locations of the amalgamated health service. • Support for developing increased scope of practice roles in nursing and allied health to support service development and the UCC at ADH. • Increased training opportunity for current EH medical staff with the 'rural' categorisation of the ADH location. • Direct access to post graduate opportunities for current ADH staff. • Workforce development in research for current ADH staff leveraging from EH existing university partnerships. • All staff will have access to more job opportunities thorough internal application process. • Increased scale in amalgamated health service will provide more flexibility to respond to workforce challenges experienced at ADH.
5. **Improved clinical quality and safety (systems and outcomes)**	Work through the LHSN would continue as planned and deliver related benefits, including: • Participation in the Safer Together Program (SCV) as members of the EMM LHSN and implementation of at least one STP initiative. • Each health service administers SCVs clinical governance maturity self-assessment and collects clinical governance maturity data.	All the benefits of Option 1 related to LHSN work would be available for Option 2. Access to support and learning in relation to safe, high-quality care and supporting systems for all staff of the amalgamated health service. Opportunities for specialist medical, nursing, and allied health clinical supervision. Single system for credentialling and management of scope of practice

Benefits	Option 1: Base case –no change from the current arrangements	Option 2: Voluntary amalgamation of ADH and EH
	• Establishment of/participation in a Quality Manager Network. Some potential for greater sharing of expertise across the LHSN catchment, however regulatory and compliance obligations will remain with each health service.	Reduced duplication of clinical governance activities to release time to focus on clinical improvements. Improved clinical governance maturity leading to safer care and better outcomes for the community.
6. **Improved use of system resources**	Efficiencies in: • Legislative compliance system; and • Financial and procurement service as part of EMM LHSN work program. Some potential for greater sharing of expertise across the LHSN catchment, however regulatory and compliance obligations will remain with each health service.	A unified system of corporate support services resulting in reduced duplication and reduced costs associated with maintaining two separate systems. Single, accountable health service with clearer lines of responsibility, more efficient decision-making, and the ability to plan and invest with confidence for the long term. Increased reach of ICT investments to support a future digital health focus leveraging off EH existing infrastructure and expertise. Strategic opportunity to examine services planning to account for changing population needs, where the inequalities exist and impact both ADH and EH. This my result in improved distribution of service demand between hospitals, or to non-hospital locations of care. Stronger system resilience, with one at scale health service better able to respond to challenges such as workforce shortages, cost pressures, and increasing service demand. Over time, increasing the volume of activity at ADH through capability and capacity development of workforce could support an easier to transition to activity-based funding when the necessary service volumes have been achieved. This would not be possible with Option 1.

Benefits	Option 1: Base case –no change from the current arrangements	Option 2: Voluntary amalgamation of ADH and EH
		In relation to emergency preparedness, response and recovery: • Integrated and greater scale of emergency preparedness, (single emergency management framework and plan, single Board and CEO accountability, more systematic mitigation planning, and common policies, protocols and training) • More coordinated and resilient emergency response, (unified command across the catchment, greater scale to flex staff, equipment and manage patient and community impacts, single interface with system partners, and integrated ICT and clinical information systems for real-time visibility of capacity, demand and clinical risk across sites • More comprehensive and sustainable recovery, (psychosocial and mental health support able to be delivered at scale for staff and community, consistent community engagement and communication, greater capacity to support learning, improvement and resilience building).
7. **Improved access to research related activity**	No delivery of this benefit.	Patients of the amalgamated health service will have access to clinical trials in which EH is currently a participant. This will be of particular relevance to those patients with cancer where there is significant clinical trial activity occurring at EH.

Benefits	Option 1: Base case –no change from the current arrangements	Option 2: Voluntary amalgamation of ADH and EH
		Staff will be able to participate in research related activities as part of their daily work. Career development opportunities in research Rural nature of ADH catchment and population presents different research opportunities for EH and its research partners.

9.1.2 Overall Benefits Assessment

Across the seven benefits, Option 1 (Base case) delivers only modest, incremental gains largely through the EMM LHSN program, whereas Option 2 (Voluntary amalgamation) underpins a step-change in the scale and reliability of benefit realisation. Under Option 1, increased access, integration and equity depend on network-wide initiatives such as Step Closer Care pathways and shared planning, but with no additional committed bed-based activity or specialist clinics at ADH beyond the current cancer service and planned dialysis. In contrast, Option 2 explicitly funds and sequences additional inpatient activity, theatre lists and four new specialist clinic streams (general medicine, geriatrics, low complexity surgery, and paediatrics). This enables a more predictable expansion of service capacity in Alexandra and across the shared catchment, rather than relying on opportunistic or piecemeal development.

For Benefit 1 (increased access and care closer to home) and Benefit 2 (improved integration and connectivity), Option 1 maintains the current service profile at ADH, with no planned uplift in inpatient, procedural or specialist clinic volumes other than the three-chair dialysis service. Whilst EMM LHSN initiatives will support some pathway improvements and ICT access, residents of Murrindindi and surrounding communities would continue to travel frequently to metropolitan sites for low-complexity procedures and specialist review. Option 2, by comparison, provides a clear and funded pathway to grow multiday separations, low-complexity procedures and specialist appointments at ADH, alongside an integrated hub-and-satellite dialysis model. Over time this will be enhanced through a unified electronic medical record and streamlined inter-hospital transfer and referral processes. Together, these changes materially improve access to specialist care closer to home and simplify navigation for patients, referrers and staff in a way that is not achievable under Option 1.

Against Benefit 3 (equity of health and wellbeing outcomes) and Benefit 4 (sustainable and strengthened workforce), Option 1 offers limited mechanisms to address the higher burden of chronic disease, mental ill-health and co-occurring conditions in Murrindindi and the outer east, or to materially improve workforce sustainability in a small rural service. There is currently no defined program of services targeting high-priority cohorts under the base case, and workforce development continues to rely on small-scale local initiatives and time-limited partnership opportunities. Under Option 2, an amalgamated health service can design and deliver targeted programs for high-incidence conditions and priority cohorts, supported by expanded local service capability and access to clinical expertise easily accessible in an amalgamated health service. The amalgamated health service also offers broader career pathways across rural and metropolitan sites, more registrar and graduate rotations, enhanced supervision and education,

and access to a wider range of HR and wellbeing supports, strengthening attraction, retention and capability in a way that Option 1 cannot match.

For Benefit 5 (clinical quality and safety), Benefit 6 (use of system resources) and Benefit 7 (research-related activity), Option 1 is constrained by duplicated governance and corporate systems, and does not provide a pathway for ADH patients or staff to participate meaningfully in EH's research program. Under the base case, some quality gains and efficiency improvements may be achieved through EMM LHSN collaboration, but each health service retains separate clinical governance, credentialling and support functions, and there is no delivery of the research benefit. Option 2 more easily consolidates clinical governance into single systems for credentialling, incident management and policy, reduces duplication in corporate services, and over time improves productivity and has the potential for more efficient distribution of demand across sites of the amalgamated health service. Integration into EH's research infrastructure also provides ADH patients with access to clinical trials and staff with research and academic career pathways, delivering a benefit that is entirely absent under Option 1. In relation to Benefit 6 (use of system resources) emergency preparedness, response and recovery under Option 2 reduces fragmentation and duplication in emergency planning and governance, enhances the region's capacity to prepare for, absorb and adapt to emergencies, is able to support more equitable, timely and locally accessible care for rural and outer-metropolitan communities during and after emergencies, and improves the sustainability of recovery efforts for both communities and staff.

Collectively, these differences mean that Option 2 significantly outperforms Option 1 across all seven benefits, delivering deeper, broader and more sustainable value for the community, workforce, health services and the wider system.

9.2 Financial Analysis

The two options represent different scales of change. The creation of a new health service through voluntary amalgamation requires an investment in the administrative, strategic, and service development activity that will deliver the benefits, whereas the base case requires no additional investment above and beyond expected future investments in the EMM LHSN. It is important to note that there has been no commitment to this future investment in the EMM LHSN beyond FY 26 and no indication of specific funding to support ICT uplift incorporated in current and anticipated future implementation plans.

A financial analysis, forecasting the financial outcomes over the next five financial years, (assuming that voluntary amalgamation for Option 2 occurs in 2026), was completed for each option.

9.2.1 Overall Financial Assessment

Financial modelling was completed for both Option 1 (base case) and Option 2 (voluntary amalgamation) over the five financial years from 2026-27 to 2030-31. The modelling applies consistent indexation assumptions for revenue and expenditure, incorporates activity-based funding (ABF) projections where relevant, and includes indicative implementation costs associated with the EMM LHSN and, for Option 2, the additional one-off costs of amalgamation.

Under Option 1, ADH's operating position remains in deficit across the modelling horizon, with the annual deficit worsening to approximately $0.7 million by 2030-31. This deterioration reflects cost inflation (particularly salary and wage growth) outpacing revenue growth over time, even with the continuation of the $1.2 million "top-up" funding that supports ADH's current small rural status.

Under Option 2, the expanded service profile at ADH, including increased surgical and medical separations, new specialist clinics and dialysis activity drives substantial growth in NWAU. This activity growth, together with approximately $0.52 million per annum in risk-adjusted savings from reduced duplication of corporate functions and lower contractor and casual labour costs, results in a markedly stronger operating position for Option 2.

The projected operating result (before implementation costs) for the amalgamation scenario improves from a small deficit of approximately $0.1 million to annual surpluses of around $1.2 - $1.7 million from 2027-28 onwards. By comparison, the base case remains in deficit in every year. Across 2027-28 to 2030-31, the amalgamation component generates cumulative operating benefits of approximately $6.3 million relative to the base case, assuming the modelled growth in activity is achieved.

The modelling indicates that, while Option 2 requires higher upfront investment, the incremental operating benefits generated by increased activity and efficiency under amalgamation are sufficient to offset the combined implementation costs within the modelling horizon. Consolidated indicative implementation costs total $3.2 million and are expected to be paid back without any additional support from the Department of Health in the fourth year following amalgamation.

The proposal is therefore not primarily a savings initiative, but it does demonstrate that, for a similar level of public investment, Option 2 delivers a more sustainable operating trajectory, and better use of system resources than Option 1.

9.3   Risks Analysis

Risks for each of the potential options were explored during the Exploratory, Intent and Consideration Phases of the work program through:

- Analysis of the impacts of any potential change;
- Issues identified during the due diligence process; and
- Understanding the views and preferences of affected stakeholders.

The risks are organised into three discrete groups:

1. The design of the options - risks in how the option is configured and is intended to operate;
2. Implementation of the option - these are the risks associated with the process of change; and
3. Operation of the options - these are longer term risks that could emerge over time.

Reasonable/achievable mitigations are described for each of the identified risks and residual risk ratings nominated.

9.3.1 Risks of Option 1 – Base Case

Table 17:Risks of Option 1- Based Case

	Reasonable mitigations	Residual risk
Design risks		

	Reasonable mitigations	Residual risk
LHSN is unable to make an impact on sustainability of local services for ADH catchment.	ADH and EH continue to support LHSN partnership and delivery of LHSN implementation planned activities.	Medium
LHSN selects a priority service development focus other than ADH catchment.	Ensure an evidence-based approach to selection of service development priorities, noting the poorer health outcomes of the Murrindindi catchment.	Low
Transactional costs to support the partnership consume limited system resources.	Clarify resource requirements for LHSN participation early, including expected time commitments and in-kind contributions. Use existing governance structures, project management systems, and shared resources to minimise duplication.	Medium
No clear mandate to solve the challenge of local service access, service quality and workforce development for the ADH community within the partnership model.	Leverage the care close to home priority to focus LHSN efforts to the extent possible.	Medium
Implementation risks	**Reasonable mitigations**	
The work program of the LHSN is not able to be delivered as intended due to resource (funds, time) constraints and/or competing priorities.	Monitor progress regularly through structured reporting, performance indicators, and exception reporting and conduct risk-based adaptive planning.	Medium
Operation risks	**Reasonable mitigations**	**Residual risk**
The partnership is fractured during operation, stalling the progress of work.	Maintain transparent communication and shared reporting so all partners have consistent understanding of why the voluntary amalgamation was explored and why the decision to not amalgamate was made.	Low
Community expectations outpace partnership progress.	Develop a realistic, transparent communication plan that sets clear expectations about what will change, when, and what is still under development. Provide regular public updates (website, newsletters, community forums, local media) that highlight incremental progress and explain any delays.	Low
Existing strategic and enterprise risks within EH and ADH persist.	Each health service applies its local risk management framework to address operations risk related to safety, quality,	Medium

	Reasonable mitigations	Residual risk
	access, sustainability, continuity, and compliance.	

9.3.2 Risks of Option 2 – Voluntary Amalgamation

	Reasonable mitigations	Residual risk
Design risks		
Communities of Alexandra and surrounds perceive a loss of local connection/identity.	Maintain ADH identity on all local services, facilities and digital channels. Maintain ADH Community Engagement Committee. Ensure amalgamated health service Board includes a current Board member of ADH with the requisite skills. Keep local management in place at ADH. Continue to regularly engage with staff and community following amalgamation.	Medium
Use of EH name incorrectly signals to community and staff an EH takeover of ADH (distrust in messaging).	Provide consistent messages from both CEOs and Board Chairs, during the transition phase and continue with regular staff and community engagement following amalgamation. Hold staff and community information sessions and Q&A opportunities to address concerns directly. Ensure there is a central point for community queries to ensure rapid and accurate response.	Medium
Community unrest and loss of reputation for ADH and EH.	Continue with community engagement during transition period and after amalgamation. Promote case studies of improved service access, experience and staff experience arising from the voluntary amalgamation. Respond to staff or community issues promptly. Continue to monitor community sentiment through surveys, feedback channels and social listening, enabling quick response.	Low
Relationships within the LHSN are fractured as a result of the	Clear communication with LHSN partners at time of announcement. Statements from	Low

	Reasonable mitigations	Residual risk
amalgamation and make the work of the LHSN difficult.	CEOs and Board Chairs regarding commitment to support LHSN and work in partnership to deliver Statement of Expectations. Maintain transparent communication and shared reporting so all partners have consistent understanding of why the voluntary amalgamation was explored and why the decision to amalgamate was made.	
Implementation risks	**Reasonable mitigations**	**Residual risk**
Government does not provide decision in time to achieve 2026 implementation potentially delaying the realisation of the benefits.	Submit business case to DH for consideration in a timely manner. Commence early implementation work prior to Government's decision to reduce time to impact/benefits if amalgamation is approved.	Medium
Government does not provide requested financial support for effective implementation/ transition.	Stage implementation so early phases can proceed with minimal or reallocated resources and demonstrate progress to strengthen case for further investment. Engage early and regularly with Department of Health to build shared understanding of priorities, timelines, and risks. Prioritise high-value, activities to maintain momentum and demonstrate return on early investments. Develop a contingency plan identifying which activities can proceed and which would be deferred without risking go-live date, patient and staff safety.	Medium
Unable to attract the human resources to lead the Implementation.	Develop a clear role description and value proposition for implementation roles (e.g. flexible work, regional purpose-driven work). Consider secondments from ADH, EH or other LHSN partners. Allocate temporary project support to maintain momentum while roles are filled. Use external consultancy or interim leadership support if internal capacity is unavailable.	Low
Implementation plan is incorrectly scoped, and resources (time and money)	Undertake a detailed scoping and validation exercise before implementation, including subject-matter experts, clinical leaders,	Low

	Reasonable mitigations	Residual risk
are inadequate to deliver anticipated benefits.	finance, workforce, and project management input. Develop a phased implementation plan with realistic timelines, clear deliverables, and defined critical path tasks. Use scenario planning and sensitivity analysis to test cost and time assumptions and refine the plan accordingly.	
Leaders of ADH and EH are unable to prioritise amalgamation transition due to operational matters.	Embed the amalgamation transition as a defined strategic priority in CEO and executive KPIs and governance forums, with clear timelines, milestones and resourcing. Protect time for key leaders, to prevent day-to-day issues from derailing critical transition decisions. Joint ADH and EH Steering Committee to monitor this risk and make adjustments as required.	Medium
Staff confusion, anxiety or disengagement during transition.	Provide regular staff communication updates addressing "what this means for me." Hold frequent drop-in briefings, listening sessions and FAQ updates. Support managers with talking points and tools to guide team discussions. Highlight short-term wins and long-term benefits to maintain confidence. Address concerns quickly.	Medium
Administrative activities to support amalgamation take the focus away from service development and delivery.	Limit administrative burden through streamlined project governance and lean processes. Maintain a clear separation between "administrative transition" and "service improvement" workstreams with dedicated leads.	Low
Unable to implement planned ICT changes in timely way resulting in poor experience for amalgamated health service staff working at Alexandra.	Establish a detailed ICT transition plan with clear milestones, vendor and internal accountabilities, and dedicated project resourcing to ensure critical systems at Alexandra are implemented or stabilised before key amalgamation dates. Develop a contingency plan to maintain a positive staff experience if some ICT changes are delayed.	Low

	Reasonable mitigations	Residual risk
Unable to secure ongoing service delivery from current ADH VMOs.	Implement an early, structured engagement process with current ADH VMOs, including clear information on the amalgamation model, service expectations, remuneration and support, with formal agreements in place by defined deadlines.	Medium
Operation risks	**Reasonable mitigations**	**Residual risk**
Staff confusion, anxiety, or disengagement after amalgamation.	Provide regular staff communication updates addressing "what this means for me." Hold frequent drop-in briefings and listening sessions. Support managers with talking points and tools to guide team discussions. Highlight short-term wins and long-term benefits to maintain confidence. Address operational issues quickly.	Low
Disruption to day-to-day operations during ongoing change/harmonisation activities.	Maintain a detailed operational continuity plan. Stagger major changes to avoid peak service periods. Monitor key operational indicators (waiting times, workforce availability, incidents) with escalation triggers.	Low
Misalignment of processes, technology or policies between ADH and EH affects service quality.	As part of transition planning, conduct a gap analysis of key operational processes (clinical governance, workforce, ICT, finance). Prioritise harmonisation of high-risk processes first (clinical policies, credentialing, incident management). Implement standard operating procedures and shared training for affected staff.	Medium
Unable to recruit the staff for additional service provision at Alexandra outlined in the business case	Implement a proactive workforce strategy including early multi-channel recruitment, flexible role design (e.g. part-time and job-share options), promote professional development and clear career pathways - targeting clinicians interested in regional practice. Establish contingency arrangements, including cross-site staffing models, and	Medium

	Reasonable mitigations	Residual risk
	telehealth/virtual models of care to enable safe and reliable service uplift if recruitment is delayed.	

9.3.3 Overall Risk Analysis

The risk profile of Option 1 is dominated by strategic and structural risks that the existing partnership mechanisms may not be sufficient to address; such as the underlying issues of access, quality and sustainability for the ADH catchment. There is a medium residual risk that the EMM LHSN is either unable to materially improve the sustainability of local services or selects other geographic priorities, leaving Murrindindi's poorer health outcomes and service gaps largely unchanged. In addition, transactional demands on a small organisation, and the absence of a clear mandate within the partnership to "solve" the local access and workforce challenges mean that existing strategic and enterprise risks at ADH and EH are likely to persist, rather than reduce over time.

Option 2 (Voluntary amalgamation) introduces a different risk profile, characterised by higher short to medium term change and transition risk but with more direct levers to address long-term service, workforce and sustainability challenges. Design risks centre on community perception and trust, notably the risk that communities in Alexandra and surrounds perceive a loss of local identity or an "EH takeover", and that relationships within the LHSN are strained. These sit alongside the reputational risk for ADH and EH if community unrest is not well managed. Implementation risks are more numerous and operationally complex: they include the potential for inadequate transition funding, difficulty attracting implementation leadership, mis-scoped implementation plans, leadership bandwidth constraints, ICT transition delays, and uncertainty about securing ongoing VMO service delivery. However, the mitigations proposed are specific and actionable (e.g. retaining local management, maintaining ADH branding and engagement structures, structured VMO engagement, robust implementation planning and staged resourcing), and most residual ratings are assessed as low or medium after mitigation.

Comparing the two options, Option 1 carries a lower level of organisational disruption but a higher risk that the status quo is essentially maintained: key drivers for change such as local access, workforce resilience and long-term viability remain only partially addressed through the LHSN, with several risks remaining at a medium residual level despite relatively modest implementation complexity. Option 2 concentrates risk in a defined implementation window and in stakeholder perception but creates a stronger platform to systematically reduce the longer-term strategic and enterprise risks that currently face ADH and EH. On balance, the analysis indicates a trade-off between the comfort of lower short-term change effort (Option 1) and the more complex but more controllable transformation and integration risks of Option 2, which, if governed and resourced appropriately, are assessed as manageable within a medium–low residual risk envelope, and are more likely to shift the overall risk profile in favour of improved access, quality and sustainability over time.

9.4   Analysis of Stakeholder Sentiment

Details of the stakeholder engagement process can be found in chapter 8.

Overall, the engagement suggests cautious, conditional support for Option 2 (voluntary amalgamation) rather than a strong pull toward Option 1 (base case), especially among staff and many service-focused stakeholders. Staff feedback from both health services was "mostly

positive" about the Boards' decision to explore voluntary amalgamation, with ADH staff in particular understanding and advocating for the potential benefits, and survey results highlighting service expansion, access to specialist care and quality improvement as shared priorities. Broader stakeholder feedback similarly recognised the opportunity for structural change to strengthen local healthcare access and long-term sustainability.

At the same time, community and external stakeholder sentiment is clearly not an unqualified endorsement of Option 2. Many participants recognised the potential benefits of voluntary amalgamation, but a "considerable proportion" of feedback expressed caution and sought further assurances, particularly around protecting local identity and governance, maintaining service continuity, ensuring transparent decision-making and safeguarding funding for rural communities.

In contrast, Option 1 (Base case) attracts limited positive sentiment but some support as a "safer" or more controllable fallback, particularly for stakeholders whose primary concern is local autonomy and identity. The engagement material does not show strong enthusiasm for simply continuing current arrangements; rather, it indicates that most stakeholders value improved access, workforce sustainability and service reliability, and see some form of enhanced collaboration or structural change as necessary to achieve these aims. There is a view amongst some community members that the EMM LHSN should be provided with more time to deliver these benefits.

On balance, the sentiment profile can be summarised as: net support leaning toward Option 2 because of its potential benefits, but with significant conditionality that must be addressed on governance, identity, rural voice and engagement integrity. Option 1 remains acceptable mainly as a low-change default, not as a preferred path to deliver the improvements stakeholders are seeking.

10   Due Diligence

Due diligence is critical to ensuring that any decision to proceed is well-informed, transparent and defensible, providing assurance to the Secretary DH, Minister for Health, and stakeholders that the proposed voluntary amalgamation has been robustly assessed and is both viable and responsible.

The Guidance Note includes the following in relation to due diligence:

> *The due diligence process is designed to uncover any barriers to proceeding with amalgamation. As risks or barriers are identified, discussions would occur between the entities to consider if any mitigating strategies can be put in place and what if any of the issues are considered a 'threshold barrier' to amalgamation, i.e., an issue which cannot be mitigated to the satisfaction of both entities.*

In response to requests for documentation to support the due diligence, more than 90 artefacts were provided by ADH and EH including:

- Risk Registers;
- Activity and service planning data;
- Strategic and Clinical Services Plan and similar;
- Audited Financial Statements and Annual Reports;
- Current year budget information;
- Performance and compliance reporting information;
- Audit and Accreditation Reports;
- Contracts registers and related service level agreements; and
- Information about current and pending litigation.

The due diligence process required review and analysis of sensitive, confidential and commercial information about ADH and EH. As such the detailed due diligence report considered by the Boards of ADH and EH is not being made available as part of the public facing business case.

10.1   Outcome of Due Diligence Process

The following has been drawn from the Due Diligence Report considered by the Boards of ADH and EH in their decision about voluntary amalgamation.

The proposed voluntary amalgamation between ADH and EH is strategically aligned with the objectives of both organisations and broader Victorian health system priorities, and is expected to strengthen access, quality and sustainability of services for the shared catchment. A strong existing partnership, shared membership of the EMM LHSN, and current shared service arrangements (including oncology, graduate nursing and use of EH learning systems) provide a solid platform for amalgamation and increase confidence that the anticipated benefits can be realised.

Across contracts, contract liabilities, borrowings and subcontracting arrangements, no issues of themselves constitute a barrier to amalgamation.

The due diligence identifies that both organisations have frameworks and systems in place for contract, risk and internal audit management that are appropriate to their scale. These will need to be rationalised and integrated over time but do not, on their own, present a threshold risk to amalgamation.

Legislative and regulatory review has not identified impediments to a voluntary amalgamation proceeding under the Health Services Act 1988, noting that timely notification and engagement with relevant regulators will be required if the proposal is approved.

The clinical services, activity and performance profiles of ADH and EH are highly differentiated in scale but broadly compatible in intent, with no evidence in the documentation reviewed of unmanageable accreditation or quality issues. However, both organisations carry material strategic and operational risks (e.g. workforce, infrastructure, emergency access and cyber), which will require sustained oversight in an amalgamated health service.

Governance and management changes, including the transition from an ADH CEO to a Divisional Director role within the amalgamated health service structure, appear manageable and conceptually sound, but will need careful implementation to preserve local leadership presence and maintain staff and community confidence.

Transition of ADH VMO arrangements will need to be carefully managed to support continuity of service delivery at Alexandra.

Overall, based on the document-based review and subject to the stated limitations regarding reliance on secondary information and the constrained timeframe, the due diligence does not identify any definitive "threshold barrier" to a voluntary amalgamation, but highlights a series of financial, workforce, infrastructure, clinical and performance risks that must be explicitly acknowledged and actively managed through the business case, implementation planning and ongoing oversight.

11 Business Case - Preferred Option

The business case has assessed the extent to which the two potential options:

- Option 1 - Base case (no-change)
- Option 2 - Voluntary amalgamation

will deliver the intended benefits, whilst balancing the costs and potential risks.

Based on the assessment undertaken in this business case, Option 2 - Voluntary amalgamation is the preferred option.

Option 2 is the preferred option for several reasons. Option 2 is the only option that fully responds to the case for change across the shared catchment of ADH and EH. The current and projected burden of chronic disease, mental ill-health and ageing in Murrindindi, Yarra Ranges and the eastern metropolitan LGAs requires more than incremental improvement in existing arrangements. Under voluntary amalgamation, a single organisation can deliberately plan and invest in expanded local services for Alexandra and surround communities, including a staged increase in bed occupancy, additional theatre lists, new specialist clinics and a supported dialysis service operating as part of an EH hub-and-satellite model. These changes materially increase the volume and range of care provided closer to home in a way that the base case, which largely preserves separate strategies, clinical service plans and governance, cannot reliably deliver.

Option 2 also creates a structurally stronger platform for integrated, high-quality care across the catchment of an amalgamated health service. At present, transfers between ADH and EH involve movement between two legal entities, separate clinical governance systems and fragmented information, with duplication of policies, credentialling, incident management and accreditation effort. Under amalgamation, patients move within a single health service with one Board and Chief Executive, unified clinical governance, aligned models of care and, over time, a shared electronic medical record and common pathways. This simplifies escalation and de-escalation of care, strengthens referral pathways, and allows more effective use of metropolitan and rural clinical expertise, while underpinning workforce sustainability through rotations, shared education and research opportunities that are difficult to coordinate across two employers under the base case.

Financial modelling confirms that Option 2 delivers this expanded service footprint at a manageable and broadly comparable cost to Option 1 over the modelling horizon. The amalgamation scenario includes higher implementation and ICT costs up-front; consolidated implementation costs across the EMM LHSN and amalgamation are estimated at approximately $4.6 million. However, once the new activity revenue is established at ADH, the operating result under Option 2 improves significantly. Compared with the base case, the amalgamation component generates incremental operating benefits of approximately $1.7 million per year by 2030-31 (before implementation costs), driven by increase in NWAU and recurrent savings. Over to the period to 2031 the amalgamation generates a cumulative operating benefit which is sufficient to offset the combined implementation costs within the modelling period, with payback expected around 2029-30.

In parallel, Option 2 improves productivity through better use of theatre and bed capacity and reduces duplication in corporate and clinical support functions. The proposal is therefore not primarily a savings initiative; rather, it uses similar or modestly higher levels of public investment

to support more activity, more integrated care, and improved outcomes and experience for patients and staff.

Staff and service-focused stakeholders in both organisations expressed support for voluntary amalgamation as a means to expand local services, strengthen pathways and secure a more sustainable workforce. Community feedback from Alexandra and the broader Murrindindi area demonstrates support for sustainable local healthcare and interest in expanded services, alongside clear expectations that any structural change must protect local identity, governance voice and the rural perspective.

When benefits, costs, risks, implementation requirements and stakeholder sentiment are considered together, the analysis concludes that voluntary amalgamation delivers greater overall value than maintaining the status quo. Option 1 remains a low-risk default that preserves existing constraints. Option 2, while more complex to implement and requiring careful management of identity, governance and engagement risks, offers a more robust path to improved access, equity, quality, workforce sustainability and system efficiency, supported by financial modelling that demonstrates its affordability and long-term viability.

12   Description of Amalgamated Health Service

12.1   Vision, Objectives, and Values

The due diligence process revealed a reasonably tight alignment between the key elements of the enterprise strategy of both ADH and EH.

To support a smooth transition and alignment across the two organisations coming together through the amalgamation, ADH and EH agree that the amalgamated health service be *dedicated to providing high quality integrated acute care, mental health care, aged care, primary care and community care services, which are accessible, responsible and accountable to individual communities in the shared catchment, including the geographical area comprising eastern metropolitan Melbourne and Alexandra and district in the Murrindindi Shire, being the areas serviced by each of the amalgamating entities prior to the voluntary amalgamation, and to all Victorians for the statewide services that the amalgamated health service operates.*

12.2   Name and Branding

ADH and EH agree that the amalgamated health service be named 'Eastern Health'.

ADH and EH agreed, that at a time to be determined by the Board of the amalgamated health service, the current ADH site in Alexandra would be referred to as a campus of EH, retaining its local name: *Eastern Health – Alexandra District Health*.

12.3   Governance

12.3.1   Context and Background

In considering the options for governance for the amalgamated health service, the Steering Committee considered the current Board composition of both EH and ADH, and refenced guiding documents:

- Victorian Department of Health (2020) Director Capability Framework; and
- Victorian Department of Health (2020) The Director's Toolkit. A resource for Victorian health service boards.

The due diligence process highlighted a degree of consistency between the governance structures at ADH and EH, which for the most part is driven by the requirements of the *Health Services Act 1988*.

Whilst the composition of Victorian public health boards is based on capabilities, boards are more effective when these capabilities are augmented by the richness of the diverse experiences of Victorian communities.

With this in mind, the proposed Board composition will build from the existing skills-based Board of EH to ensure there is no loss of capability and skills required for continuity of governance and operations given the scale and complexity of a large (amalgamated) health service. Adding to this, the Board for the amalgamated health service should include one current ADH Board Director who has skills and experience to complement the existing EH Director skill mix. This approach is also sensitive to the opportunity for the governance structures of the amalgamated health service to reflect the enduring partnership of both organisations and as such brings

forward into the new governance arrangements the history and knowledge of the shared efforts of ADH and EH to improve outcomes for the local communities and workforces.

The amalgamating health services agree to propose that the current EH Board Chair be appointed as the Board Chair of the amalgamated health service for a period of two years after the commencement of the amalgamated health service. Board Committee Structure

ADH and EH agree that the Board committee structure currently in place at EH be retained for the amalgamated health service.

Community Advisory Committee

ADH and EH agree that the ADH Community Engagement Committee be retained and report to the Community Advisory Committee of the amalgamated health service to ensure local community voices of the ADH catchment are connected to the governance arrangements of the amalgamated health service. The current site leadership of ADH is a member of the Community Engagement Committee, and this arrangement should be retained.

ADH and EH agree that a member of the current ADH Community Engagement Committee be invited to join the current EH Community Advisory Committee.

The agreement to retain the ADH Community Engagement Committee is different to current arrangements between the EH Board and the various EH campuses/sites, where there is not a similar arrangement for a committee of site based local voices to formally feed into EH governance arrangements. ADH and EH agree that these different arrangements for the ADH community be maintained for a period of two years to support the transition to the amalgamated health service arrangements and be formally reviewed as part of the routine Board self-review.

Primary Care and Population Health Advisory Committee

The EH Primary Care and Population Health Advisory Committee has recently reviewed its Terms of Reference and broadened is membership and focus to include all members of the EMM LHSN. ADH and EH agree that this arrangement should be carried over to the amalgamated health service.

12.3.2 Chief Executive Officer

There will be one Chief Executive Officer of the amalgamated health service, appointed by the Board of the amalgamated health service in accordance with section 65S of the *Health Services Act 1988.*

12.3.3 Statement of Priorities

It is anticipated, that if voluntary amalgamation were approved, there would be a single Statement of Priorities developed annually between the Department of Health and the Board of the amalgamated health service.

12.3.4 Strategic and Clinical Services Planning

As described earlier, the due diligence process revealed a reasonably tight alignment between the key elements of the enterprise strategy of both ADH and EH.

If voluntary amalgamation is supported by the Minster for Health, representatives from EH and ADH will commence work on the development of a Strategic Plan for the amalgamated health service. In the first instance, EH's current Strategic Plan with any necessary amendments will be considered for adoption by the amalgamated health service. Approval of the strategic plan will

occur when the Board of the amalgamated health service has been established. Ensuring that the Strategic Plan is guiding the work of the amalgamated health service soon after its establishment will support the ongoing alignment of the legacy organisations.

Following completion of the Strategic Plan, a high-level Clinical Services Plan for the amalgamated health service will be completed. It is important to note that the EMM LHSN is undertaking clinical services planning within nominated clinical streams to support service development across the LHSN catchment. This will continue with the amalgamated health service a member of the EMM LHSN. Clinical services planning for the amalgamated entity will work to ensure alignment between the LHSN clinical service planning and that of the amalgamated health service.

12.3.5 Employment Arrangements

All existing ADH and EH staff will be employed by the amalgamated health service, known as EH. At the point of amalgamation, all ADH staff and EH staff will transfer across to the amalgamated health service with their current employment conditions (and awards) retained.

The amalgamated health service will use a differentiated approach to the provision of 'clinical support services/back of house services (environmental and food services and patient supports services). ISS currently supplies back of house services under contract for EH at several, but not all of its campuses. Environmental services, Food Services and Patient Support Services staff who provide these services for ADH are directly employed by ADH. To enable a sensible transition to an amalgamated health service, the amalgamated health service will directly employ those back of house service staff currently employed by ADH.

12.3.6 Organisational Structure

To support a smooth transition and uninterrupted operating of one of the largest Victorian health services, the amalgamated health service's organisational structure will reflect the current organisational structure at EH with no changes to the executive leadership positions at EH. Staff at EH and ADH will transition into arrangements in the amalgamated entity. For EH staff they will experience little to no change.

EH has a predominantly programmatic, rather than site-based structure and this will be retained in the amalgamated health, with the exception of the current ADH campus, where a new position of Divisional Director, ADH will be established.

At the point of amalgamation, all current ADH staff will report operationally to the Divisional Director, ADH. This is a senior nursing position with operational responsibility for the ADH site, reporting to the Executive Director Clinical Operations, EH. Clinical professional leadership for the amalgamated health service will be aligned with the current EH structures of the Chief Allied Health Officer, Chief Medical Officer and Chief Nursing and Midwifery Officer.

12.3.7 Eastern Health Foundation and Donations Management

Eastern Health Foundation, which is the charitable arm of EH will manage the philanthropic activities of the amalgamated health service. Current philanthropic practice supported by the Foundation sees donations tagged to specific purposes or campuses protected for these purposes and campuses. This approach will continue once ADH and EH are amalgamated ensuring that local philanthropic activities within the ADH community can continue to support their local community and their local hospital if that is the intention of the community. This approach would extend the to the management of existing and new bequests and other specified donations, which would be managed in line with their original intended purpose.

13 Legislative and Regulatory Requirements

13.1 By-Laws

The By-Laws for the amalgamated entity were modelled on EH's existing By-Laws and drafted by EH's Chief Counsel. The By-Laws were considered by the Steering Committee alongside the Business Case and were ratified by the Boards of ADH and EH as part of the business case process.

13.2 Terms of Agreement to Amalgamate

The sample voluntary amalgamation agreement provided in the resource section of the Guidance Note was used as the basis for drafting the voluntary amalgamation agreement. The agreement was drafted by EH's Chief Counsel.

The recommended Terms of Agreement to Amalgamate were considered by the Steering Committee alongside the Business Case and By-Laws and were ratified by the ADH and EH Boards.

14 Evaluation and Benefits Realisation

Following approval of the voluntary amalgamation, a Benefits Realisation Plan aligned with the seven benefits outlined in the business case will be more fully developed.

A key responsibility of an evaluation working group will be to prepare regular reports for senior leaders and the Board of the amalgamated health service leadership outlining the progress and impact of amalgamation and the delivery of expected benefits.

As the evaluation and benefits work progresses, information about progress and benefits will be developed and shared with staff and the community, including through to the ADH Community Engagement Committee and EH's Community Advisory Committee.

14.1   Purpose

The purpose of this Benefits Realisation Plan is to ensure that the seven identified benefits of voluntary amalgamation are delivered, measured and reported in a structured and transparent way over the first five years of the amalgamated health service.   The benefits span four stakeholder groups: community; staff; the health services; and the Victorian health system with proposed measures, as outlined in Table 11.   This plan describes how those benefits will be translated into baselines, targets, monitoring and reporting arrangements, and how emerging information will be used to refine models of care and service delivery.

14.2   Approach

The Benefits Realisation Plan is anchored to the seven benefits framework: (1) increased access to services and care closer to home; (2) improved integration and connectivity of care and services; (3) improved equity in health and wellbeing outcomes; (4) a more sustainable and strengthened workforce; (5) improved clinical quality and safety; (6) improved use of system resources; and (7) improved access to research-related activity.   For each benefit, the amalgamated health service will confirm and document: (a) a clear benefit statement, (b) primary and secondary indicators, (c) baseline values, (d) annual milestones and five-year targets, and (e) key assumptions and dependencies. This will ensure that the impact of amalgamation is tracked not only at a system level, but also for staff and communities in Alexandra and across the broader catchment.

14.3   Measurement Approach

The plan adopts a phased approach to measurement over a five-year horizon, aligned with the measurable impacts already identified for each benefit.   Illustrative indicators (to be finalised during transition to amalgamated health service) include:

Benefit 1: Increased access to service and care closer to home

- *Activity and access measures:* number of multiday separations at ADH; number of low-complexity procedures undertaken at ADH; number of specialist clinic visits at ADH; dialysis chair utilisation.
- *Experience and equity measures:* estimated reduction in travel time/distance for ADH catchment residents; patient-reported access and experience; proportion of ADH catchment patients able to complete care locally.

Benefit 2: Improved integration and connectivity of care and service

- *Operational measures:* timeliness of inter-hospital transfers; number of patients transferred "in one move" without repeat assessments; proportion of relevant pathways with unified EMR coverage; utilisation of step-closer-care and Care @ Home pathways.
- *Experience measures:* patient-reported ease of navigating services; staff-reported ease of handover and transfers.

Benefit 3: Improved equity in health and wellbeing outcomes

- *Program measures:* number and reach of programs targeting high-incidence conditions and high-priority cohorts (e.g. chronic disease, mental health, co-occurring substance use).
- *Outcome measures:* trends in avoidable admissions, condition-specific outcomes and patient-reported outcomes in priority cohorts in the ADH/EH catchment compared with baseline and state averages.

Benefit 4: More sustainable and strengthened workforce

- *Workforce measures:* staff satisfaction and engagement; attraction and retention rates; number of graduate and registrar rotations including rural placements; participation in workforce development and leadership programs; use of HR and wellbeing supports.

Benefit 5: Improved clinical quality and safety (systems and outcomes)

- *System measures:* clinical governance maturity scores; participation in Safer Care Victoria programs; reduction in duplicated governance activities; completion of credentialling and scope-of-practice processes in single systems.
- *Outcome measures:* rates of hospital-acquired complications, incidents and near misses; serious adverse events; safety culture survey results.

Benefit 6: Improved use of system resources

- *Efficiency measures:* cost per bed day; theatre utilisation at ADH; distribution of demand across sites; and extent of duplication removed in corporate and clinical support systems. ;

Benefit 7: Improved access to research-related activity

- *Research measures:* number of clinical trials accessible at ADH; participation of ADH patients in trials; number of research projects with a rural focus; research income (particularly rural/metro grants); staff participating in research and research training.

For each indicator, the Working Group will confirm data sources (e.g. VHIMS, VAED/VCDC, HR systems, local registries, surveys), frequency of collection (monthly, quarterly, annually) and reporting lines.

14.4 Phasing, Baselines and Targets

Benefits will be tracked across three phases:

- *Phase 1: Establishment (Year 0-1):* confirm benefit owners and indicators; establish baselines for all measures using the 2024-25 or 2025-26 year as appropriate; embed data collection processes; commence quarterly reporting on early indicators (e.g. activity, workforce, governance integration).
- *Phase 2: Early benefit realisation (Years 2-3):* monitor early access, integration, workforce and efficiency gains as service developments at Alexandra come online (e.g. increased bed occupancy, additional theatre lists, new clinics and dialysis service); refine pathways and resource allocation based on early results.

- *Phase 3: Consolidation and optimisation (Years 4-5):* assess progress against five-year targets; focus on equity and outcome improvements, research activity and sustained workforce benefits; identify further improvement opportunities and system-wide learning.

Baseline and target setting will be completed within the first six months post-amalgamation, led by the Benefits Realisation and Evaluation Working Group, drawing on historical ADH and EH data and, where relevant, statewide benchmarks to set realistic goals.

14.5   Reporting, Learning and Adaptation

Benefits realisation reports will be prepared quarterly for the Executive and Board and at least annually for DH and key stakeholders, summarising progress against each benefit, explaining variances and proposing corrective actions where necessary. A concise public-facing update will be provided annually to the community and staff (e.g. via the annual report, community forums and the Community Engagement Committee), highlighting tangible service changes and outcomes in Alexandra communities and across the catchment.

The Benefits Realisation Plan is deliberately designed as a "learning system". If certain benefits are not materialising as expected, for example, if access to local care is not improving, or workforce retention does not strengthen as planned, structured review and improvement work (e.g. rapid cycle Plan Do Check Act (PDCA), pathway redesign, alternative workforce models) will be sponsored. In this way, the evaluation and benefits realisation process will not only demonstrate the impact of amalgamation, but will actively support continuous improvement in service delivery, workforce experience and outcomes for the community.