

4. Planning for the delivery of integrated health care

4.1 *Care in your community* planning principles

It is vital to take a planned approach to the delivery of health care in order to move towards the health care system we want in the future. The complexity of managing chronic disease, planning ahead to prevent the onset of disease, or just providing needed care to healthy people through the course of their lives, means that we need to think strategically over the long term, and to plan systemically.

To meet the identified needs of the future health care system, planning for the development of future health care service delivery capacity will be based on the following principles:

Care in your community planning principles

- We will build up and consolidate health care services in community-based settings, improving the range, level and quality of services delivered.
- Services delivered in hospital settings will complement community-based services. Planning will identify which services in the specific local context can be delivered safely, effectively and efficiently in community-based settings, and which services should be delivered in hospital settings.
- Planning for delivery of health care services will start from the preferred options of providing services at people's homes or close to where people live, work, shop, meet or relax (for services currently in or proposed for hospital settings, the first question will be 'can it be delivered at home or in the community?').
- Planning will maximise equitable distribution of services, based on the characteristics and needs of local populations, with a focus on addressing disadvantage (including the needs of socioeconomically disadvantaged communities, Kooris, people with a disability and people with a mental illness).
- Planning will maximise ease of access to services, co-locating services where possible and undertaking service development/redevelopment in locations that people can easily get to.
- Planning will deliver collaborative outcomes, based on partnerships focused on a population health approach.

4.2 Integrated area-based planning

4.2.1 Introduction

This section sets out an approach to area-based planning that recognises that a range of planning already occurs, that there are different reasons for planning, and that particular types of planning are more appropriately done at different levels (not a one size fits all approach). There is also a need to take a system-wide approach and undertake detailed planning around specific requirements.

4.2.2 Scope of planning

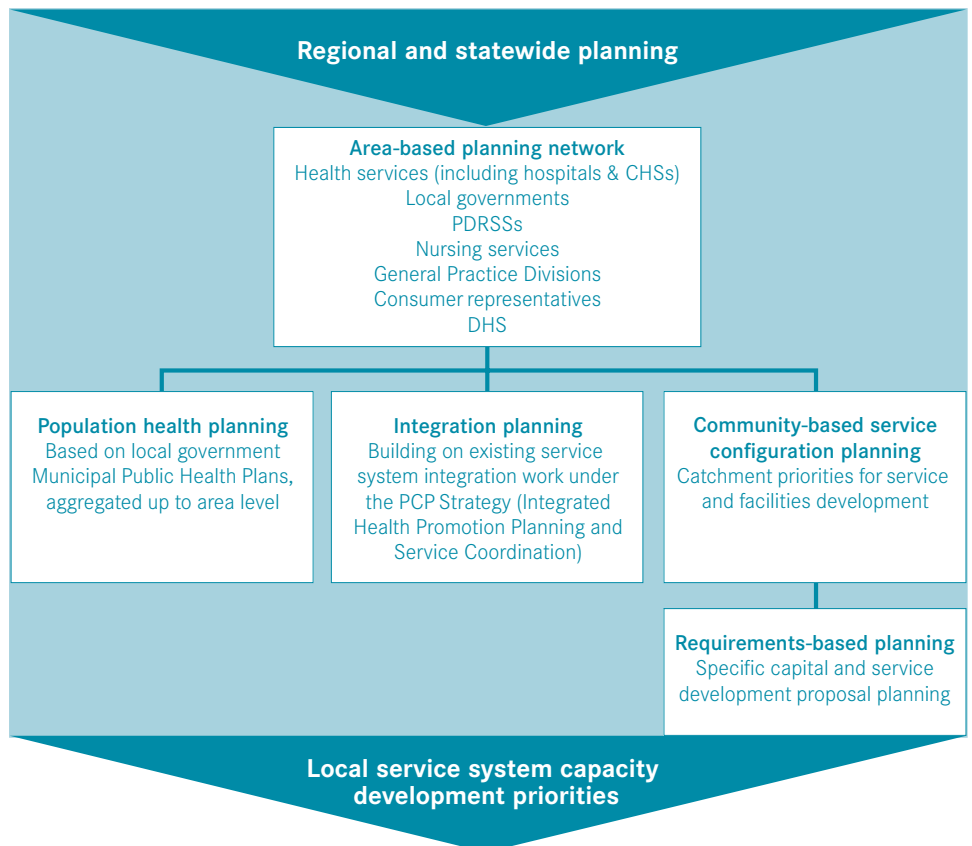
To enable area-based planning to make a substantial contribution to achieving the vision and principles underpinning this framework, a strategic planning approach is required. That is, one which provides the scope for comprehensive service system planning across the full spectrum of community-based health care, including:

- population health profiling (incorporating psycho-social and environmental determinants of health) based on national and state health priorities
- service system integration, workforce development, service coordination, change management and development of quality systems
- service system configuration (the type and location of facilities and the levels of care they provide)
- development of system capacity, including rollout of system-wide ICT capability (connectivity and networking), facilitation of planning, review and evaluation and identification of trends and strategic directions.

4.2.3 Integrated area-based planning approach

Planning will be conducted within each area by an area-based planning network, made up of local stakeholders and involving, at a minimum, health services (including hospitals and community health services); local government; nursing services; General Practice Divisions, consumer representatives and the Department of Human Services. It is expected that area-based planning networks will build on existing partnership arrangements, including Primary Care Partnerships (PCPs), Integrated Cancer Services, and ICT Alliances. In metropolitan areas, networks will link closely with Population Health and Primary Care Advisory Committees of health services.

Figure 1: Integrated area based planning



Detailed governance arrangements for planning networks will be developed in consultation with stakeholders. It is expected that planning networks will be responsible for particular integrated area-based planning catchments (see below). In some cases, it may be appropriate for planning networks to have responsibility for more than one area-based catchment. Network membership will also need to take account of overlapping responsibilities, where boundaries or service coverage may fall within or across multiple area-based catchments.

To cover the scope specified above, the approach to integrated area-based planning incorporates four elements:

- **Population health planning.** Population health profiling (including demography, burden of disease, psycho-social, economic and environmental factor analysis) should be incorporated into area-based planning on the basis of the work done by local governments through their existing Municipal Public Health Planning process. LGA profiles should be built up into profiles of area-based planning catchments. It will be important for local government involvement in integrated area-based planning to build on existing local government planning activities and trends, including community planning.
- **Integration planning.** Planning networks, working with other partners as required, should work collaboratively to plan for service system integration, service coordination, implementation of local area workforce development strategies and projects, change management, and the development and implementation of service system quality processes. This should build on the existing activity undertaken by PCPs in the areas of service coordination and integrated health promotion catchment planning.
- **Community-based service configuration planning.** This approach should build on current strategic planning processes where they exist (for example, Strategic Plans for Metropolitan Health Services) and should take an explicitly collaborative partnership approach that combines individual agency perspectives into a joint agreed plan. This plan should set out, at a catchment level, what services will be delivered where and by whom, including looking at opportunities for co-location and integration and for delivering services in new modes or settings (see Section 4.6 below). Service configuration should be described according to the levels of care that will be provided in particular locations to meet the needs of local communities (see Section 4.6.3 below). The priorities identified through this planning process will inform capital and service growth investment decision making and be one of the triggering requirements to initiate detailed requirements-based capital and service planning. Once integrated area-based planning is fully implemented, decision making on capital and service development projects will be informed by priorities identified within area-based plans.
- **Regional and statewide planning.** The Department of Human Services central and regional offices have a key role in planning and decision making to support equitable resource distribution. Within this role, the department will move to resource allocation that responds at a sub-regional level to the outcomes of area-based planning. The department also has a responsibility to develop regional and statewide plans for the development of service system capacity. In undertaking this kind of planning, the department will adopt a consistent approach that specifies how

capacities will be rolled out on a per area basis (including ICT connectivity and networking capacity). Department planning around access to statewide services (such as renal and ophthalmology services) will consider how each catchment population is serviced under these arrangements. The department will have a role in facilitating planning at each level and supporting an integrated approach, including providing data and analysis to support community-based service configuration planning and population health planning. The department will develop its capacity to more effectively identify trends in community-based health care at a statewide level, and to evaluate outcomes.

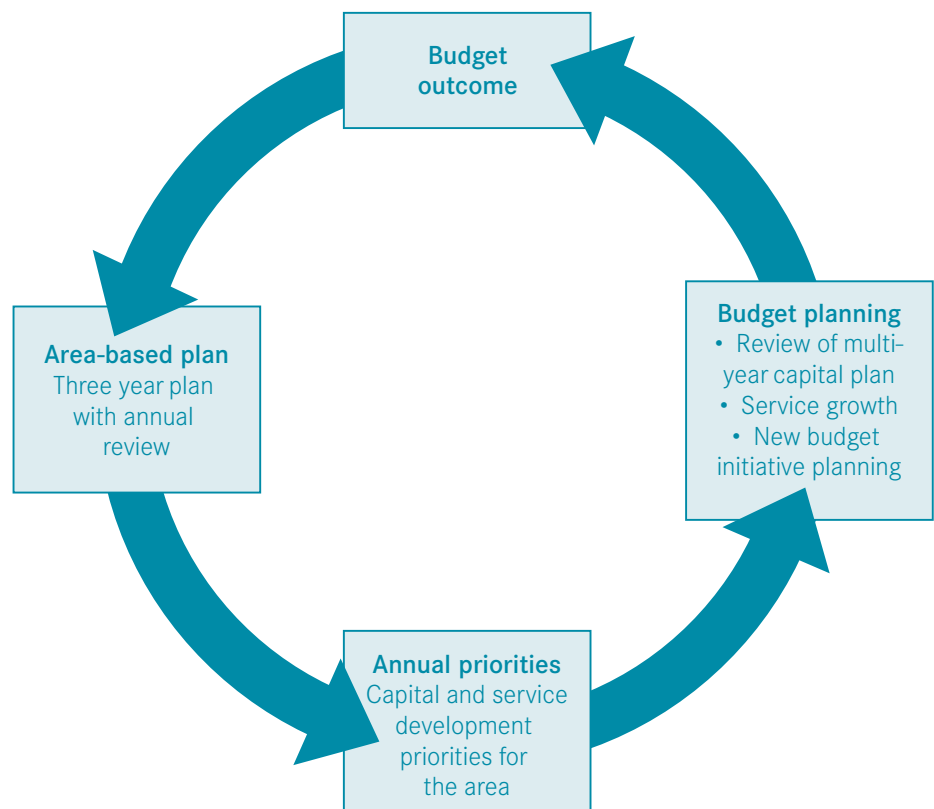
Consumer and carer involvement

An emphasis on community-based care provision places increased responsibility on individual care recipients, their family and carers. Unless the people using health care services are effectively involved in service planning decisions about their local health care system, planning will not reflect the true cost of health care delivery.

Planning cycle

Planning should be conducted on a rolling three-year cycle, with annual review for budgetary purposes. Planning will lead to the development of a comprehensive picture, on a per catchment basis, of the needs, priorities, capacities and strategic direction for the development of an integrated community-based health care service system. This information will be used to support decision making on the allocation of Department of Human Services service growth funding, new initiative funding and capital development funding (see Figure 2 below).

Figure 2: Planning cycle



Catchments for area-based planning

To support a consistent approach to area-based planning that can apply across the range of programs and services providing health care in the community, we need to adopt a single set of planning catchments. These catchments have been defined at a sub-regional level, are built up from LGAs, and fit within whole-of-government regional boundaries (based on Department of Human Services regions). These catchments align with PCP catchments and are, therefore, already in use by a number of Department of Human Services programs and a range of agencies. Because they are built up from LGAs, a substantial amount of planning data is readily available. A map of the integrated area-based planning catchments is provided at Appendix 2. There are 12 metropolitan Melbourne catchments, varying in size from 2-4 LGAs. The average population of metropolitan Melbourne catchments is 300,000. Although catchment sizes vary, most catchments (with three exceptions) have populations of between 200,000 and 400,000. There are 19 rural Victorian catchments, ranging in size from 1-4 LGAs. The average population of rural Victorian catchments is around 70,000. With the exception of Barwon and Central Highlands catchments, all rural catchments have populations of between 30,000 and 110,000.

It is important to note that a single set of sub-regional catchments will not be appropriate for the full range of programs and service types within the scope of this framework. The scope includes services that range in size of appropriate planning catchment from regional or larger (for example, some types of day surgical procedures) through to services that, in metropolitan locations, are appropriately planned on an LGA or sub-LGA basis (such as community nursing and some other community health funded services).

The overall objective in this planning approach is to increase self-sufficiency in community-based health care within each catchment. Each catchment will provide a comprehensive range of community-based health services, except where this is not possible for reasons of critical mass, economies of scale, or safety and quality.

Adopting a single set of area-based planning catchments means that there will be one agreed reference point for planning that is common across all relevant programs. This will support the development of an integrated planning cycle within the department, informed by the external area-based planning process and linked to the annual budget cycle.

4.3 Implementation of integrated area-based planning

The changes associated with the introduction of integrated area-based planning will have a significant impact on business practice for the Department of Human Services and for the health care providers it funds. For this reason, the approach will be introduced in a staged way. In the first stage (in the first half of 2006) the approach will be further refined and developed through trial planning activity, complemented by internal departmental work on program planning parameters. Further details of this initial trial activity are set out in Section 6.2 below. As part of the outcomes of these trials, plans will be used to inform decision making on capital development priorities for community-based health care and service growth and new funding across a selected group of department programs. Impact of plans on service growth and new initiative funding will initially be limited to renal dialysis, dental services, HARP CDM, chronic disease early intervention in CHSs, and community health counselling

services. This will apply to the 2006-07 and 2007-08 financial years. Commencing from 2007, coverage will be gradually extended to the full range of community-based health care services as set out at 1.3 above. This staged process will build upon work on program planning parameters (see Section 6.2 below) and related work such as the review of outpatient funding arrangements (see Section 5.2 below).

As noted, the Department of Human Services continues to have a role in the equitable allocation of funding for health care services across the state. In some cases there are well-established mechanisms for equity-based resource allocation at a regional level, such as the regional resource equity formula used by the Home and Community Care (HACC) program. Area-based planning priorities will provide another source of information for the department to make decisions about funding allocation at a sub-regional level. The intention is that, once fully implemented, integrated area-based planning will become the main mechanism for the department (in partnership with funded agencies) to negotiate resource allocation for new initiative and growth funding on a sub-regional basis.

4.4 Planning for the needs of the local population

Planning the future shape of the health care system has to focus on what is needed to improve the health outcomes of people in community settings and home-based settings. To maximise people's capacity for health and wellbeing in the local community, planning must focus on the following needs:

- management of chronic disease and complex care
- streamlined, effective and appropriate delivery of episodic and urgent care
- integrated health promotion and illness prevention.

4.4.1 Chronic and complex care

A consistent, planned approach to the management of chronic disease and complex care draws in Department of Human Services funded activities focused on substitution and diversion, intensive case management, community-based care coordination, and early intervention. It involves a range of programs and services including day procedures, such as renal dialysis and oncology services; a significant proportion of the specialist services provided by outpatient clinics; EDs; HARP CDM; chronic disease early intervention in CHSs; mental health services; alcohol and drug services; allied health and nursing services (including many of those provided through HACC); community health and sub-acute ambulatory care services (SACS) programs, patient transport services, and elements of post acute care (PAC) and palliative care services.

A consistent, planned approach to chronic and complex care will bring together various elements to support an integrated, systemic approach, including:

- developing consistent mechanisms to establish an enrolled population approach to management of chronic disease and complex care within area-based planning catchments
- integrating the Health Assist Line (HAL), the statewide information advice and referral service, with other services involved in chronic disease management and complex care, building the capacity of the HAL over time to be a first port of call for enrolled populations

We applaud the incorporation of a population-based approach that recognises the social determinants of health, promoting prevention and early intervention.

Women's Health Victoria

- developing consistent assessment processes across programs, supported by information sharing, to reduce duplication and fragmentation between various services that may be involved in a person's care
- adopting a consistent approach to case management, care coordination and key worker arrangements, addressing workforce issues, funding arrangements and service coordination
- integrating across Department of Human Services programs targeted at people with chronic conditions and complex care needs, including HARP CDM, chronic disease early intervention in CHSs, and elements of SACS and PAC, and gradually extending to the other programs and services identified above
- developing a focus in the HACC program on secondary prevention and short term but intensive goal-oriented interventions for people with existing disabilities, living in the community
- developing practical links and protocols with general practitioners (GPs) to better integrate their front-line role for the management of chronic disease and complex care with the range of services provided through State Government funding (starting with development of consistent protocols for engagement with GPs across HARP CDM, chronic disease early intervention in CHSs and the Emergency Management Strategy)
- building on the current role of PCPs (including their role in chronic disease early intervention in CHSs) to extend their involvement in the integration of community-based initiatives and programs to prevent and better manage chronic disease
- building the health care system's information management and information and communications capabilities in areas relevant to the effective management of chronic disease and complex care, including electronic referral, event summary architecture, and unique identifiers
- establishing improved support for self-care arrangements.

4.4.2 Episodic and urgent care

The health care system also needs to effectively meet the needs of those people who, while generally healthy, may occasionally need access to a number of health care services due to short-term illness or injury. There is evidence to suggest that current arrangements are not always appropriate to the needs of people in this category. For example, many public hospitals are experiencing large numbers of primary care type (PCT) presentations at their EDs. These people generally present to the ED disproportionately in the evenings and at weekends and require urgent primary care.

Continuing to improve the way the needs of these people are met will bring together programs and services, including day admissions and day procedures (including those provided to people with chronic disease and complex care needs); specialist and diagnostic services provided through outpatients and in other locations in the community; EDs and alternative urgent care arrangements (such as after hours or extended hours urgent primary care clinics); ambulance services; maternity services; and mental health crisis response services.

The approach to reconfiguring the systems that support the delivery of care to people needing episodic or urgent care will include:

- developing policy on the role of outpatients in community-based health care (including what services should remain on hospital sites versus what can be delivered in other facilities) and reviewing outpatient funding arrangements (see Section 5.2 below)
- the HAL taking all health information and advice calls currently being received by EDs, freeing up capacity and supporting a consistent approach to the provision of health information, advice and referral. The HAL will also have an educative role, over time contributing to changed behaviour, including better knowledge and understanding of health care issues and the health care system, leading to more informed choices and better capacity for self-care.
- developing ICT capacity, particularly broadband connectivity, that can support faster and more convenient health care service delivery, including use of videoconferencing for consultations and to provide specialist back-up, electronic referral, and the ability to request and obtain diagnostic results more quickly and easily
- developing service models that provide alternatives to presentation at EDs for urgent care, including general practice clinics co-located with EDs and community-based health facilities providing a ‘minor injury unit’ model, with capacity for basic diagnostics, suturing and fracture work, and observation facilities. (Western Region Health Centre is an example of such a facility, currently operating in Footscray.)
- establishing more effective protocols between GPs, EDs, CHSs, the HAL and other services involved in the delivery of episodic and urgent primary care.

4.4.3 Integrated health promotion and illness prevention

Population health approaches are increasingly being recognised as a key element in the planning of quality, efficient and equitable health systems internationally¹²³⁴⁵ and in Australia.⁶ These approaches increase understanding about what makes and keeps people healthy and describe strategies that aim to reduce inequities and improve the health and wellbeing of whole populations. In particular, consideration is given to interventions and strategies that address the broad biological, social and environmental determinants of health.⁷

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1. World Health Organisation Regional Office for Europe (1999). *The Verona Benchmark: System characteristics for implementation of investment for health approaches*. Copenhagen
 2. Health Canada (2001) *The Population Health Template: Key elements and actions that define a population health approach*. Health Canada, Population and Public Health Branch, Strategic Policy Directorate. Available at: <http://www.hc-sc.gc.ca/hppb/phdd/approach/index.html>
 3. World Health Organisation (2002) *Summary measures of population health concepts, ethics, measurement and applications*. Eds Murray C.J.L et al. Available at <http://www.who.int/pub/smph/en/index.html>
 4. Department of Health, United Kingdom (2000) *The NHS Plan*. Available at: <http://www.publications.doh.gov.uk/nhsplan/index.htm>
 5. Bennett J. (2003) *Investment in population health in five OECD countries*. OECD Health Working Papers No.2, OECD, Paris. Available at: <http://www.oecd.org/dataoecd/30/39/2510907.pdf>
 6. Australian Government Department of Health and Ageing Population Health Division <http://www.health.gov.au/pubhlth/index.htm>
 7. Department of Health & Human Services (DHHS) and the Department of Health & Ageing (DoHA), Consultation draft of the national chronic disease strategy (May-June 2005). Available at <http://www.dhhs.tas.gov.au/agency/pro/nsif/documents/DraftNCDSforcomment.pdf>

The Ottawa Charter for Health Promotion underpins these population health approaches, stressing the importance of advocacy for health; enabling people to achieve their full potential; and mediation between different interests in society. In Victoria, the term ‘integrated health promotion’ refers to agencies and organisations in a catchment working in a collaborative manner using a mix of health promotion interventions and capacity building strategies to address priority health and wellbeing issues. To achieve effective integrated health promotion program delivery in the current Victorian context the following points should be considered:

1. The role of partnerships - integration intensifies from networking through to formalised collaborative partnerships. The aim is to move towards the highest level of integration - collaboration.
2. Quality integrated health promotion practice and delivery should focus on implementing an appropriate mix of health promotion interventions (that encompass a balance of individual and population-wide health promotion interventions) supported by capacity building strategies to address the priority issues identified.
3. Clear identification of the key stakeholders or partners is required to make a difference on the identified priority issue. Integration across a broad range of sectors, including non-government organisations and community groups, is essential to address the determinants of health. Other organisations outside the ‘traditional’ primary health sector - such as local government, schools, housing, recreation clubs, and commercial businesses - are, therefore, seen as key partners in the development of effective approaches to improving health outcomes.

Figure 3: Health promotion interventions and capacity building strategies

Health promotion interventions and capacity building strategies				
<i>Individual focus</i>	←————→			<i>Population focus</i>
Screening, individual risk assessment immunisation	Health education and skill development	Social marketing Health information	Community action	Settings and supportive environments
Ensuring the capacity to deliver quality programs through capacity building strategies including:				
Organisational Development		Workforce Development	Resources	

This framework provides a consistent approach across primary, secondary and tertiary prevention activities, building on our existing prevention activities through a national approach and continuing to build upon the success of integrated health promotion catchment planning through the PCP Strategy. It will be characterised by:

- area-based planning for the health care needs of local communities stemming from a population health approach to health care planning
- considering the needs of all the population within a given area, not just those accessing health services
- a social model of health ensuring health and wellbeing is improved by addressing social and environmental determinants of health, in tandem with biological and medical factors

- the health care system working collaboratively with other sectors to address the social and environmental factors that inhibit wellbeing.

Health care providers will ensure that access to appropriate health promotion and/or prevention services is available to all people, regardless of the part of the health care system with which they interact. This will involve determining where and what activities are best delivered and that appropriate referral mechanisms support people as they move within the system.

4.5 Planning process

At the highest level, integrated area-based planning will use the following steps:

1. Determine the needs of the local catchment population in terms of the three areas of need (chronic and complex, episodic and urgent care, integrated health promotion and illness prevention).
2. Profile the existing service system on the basis of the schema for configuration of community-based health care services set out below (section 4.6).
3. Determine how the planning principles (4.1 above) and program planning parameters (to be developed) apply to the local service system.
4. Conduct an assessment of the local service system based on the identified local needs and the application of the planning principles and program planning parameters to the local service system.
5. Develop recommended priority actions to achieve service system integration goals and to move towards the future service system configuration in line with the schema set out below (section 4.6).

4.6 Service system configuration planning schema

The following section describes the schema for service system configuration planning that will underpin planning for community-based health care services.

In conducting integrated area-based planning, the following schema will be used to analyse the existing service system (step 2 above) and specify the future configuration of community-based health care services (step 5 above).

4.6.1 Modes of care

The mode of care is about the way care is provided. One of the most important aspects of the mode of care is the kind of capacity that is required to support the safe and effective delivery of the service. The modes of care are:

- **Inpatient admission:** care that requires a person to be bed-based overnight or longer and requires continuous or high level medical monitoring or supervision, with a capacity to respond immediately to a change in circumstances.
- **Same day admission:** care involving a procedure or treatment that does not require an overnight stay but requires access to a range of clinician, infrastructure and technology supports, including, for example, anaesthetists, specialist surgeons, theatres, recovery rooms, or high cost specialised equipment.
- **Specialist care:** care that requires specialised clinician, infrastructure or other support and is usually delivered according to specific disease or care requirements.

- **Primary care:** first level care provided by integrated referral systems in a way that gives priority to those most in need, maximises community and individual self-reliance and participation and involves collaboration with other sectors. While prevention and promotion activity needs to occur in all modes, primary care is the spearhead for integrated health promotion and illness prevention, and the health care mode that most people will encounter most frequently throughout their lives.
- **Group program:** care that is organised for groups of people with like needs and includes rehabilitation, education and peer support.
- **Self-care:** care that individuals undertake themselves or with the aid of a carer or family member, and which requires no specialised skills or professional training, but may require some information or education (including in use of equipment) provided by a practitioner or other resource (including online).

4.6.2 Settings of care

‘Settings of care’ refers to the physical setting for the delivery of care and is classified into:

- hospitals
- community-based health care facilities (refer to section 4.6.3 below)
- outreach (care delivered where a person lives, through a mobile facility or in some other public or private location, such as the workplace).

Health care services will be delivered in the most appropriate locations, balancing people’s preferences and issues of access with the need to ensure safety, quality, cost effectiveness, and efficiency.

Taking a person and family centred approach to determining appropriate settings for care will help the health care system to:

- strengthen and reorientate itself towards primary and secondary prevention
- integrate to support innovation and respond to emerging needs
- support and develop through co-location
- reduce fragmentation
- individually tailor care and address the needs of the whole individual and their family.

Health services will continue to deliver a broad range of integrated services, with inpatient back-up providing critical support at the technical and highly specialised end. The concept of integrated, community-based health care facilities (see 4.6.3 below) will underpin thinking about the design/redesign of new/existing facilities.

To achieve this, substantial changes are required including in:

- planning and developing appropriate settings of care
- the outlook and practice of health care providers
- the relationships between agencies and between practitioners.

4.6.3 Levels of care

Integrated, community-based health care services can be divided into four distinct levels. While this classification describes the level of facility at which care can be provided, planning for service delivery will be based on criteria around safety, quality, cost effectiveness and efficiency.

The four levels are:

Level 4 is health care provided on a same day basis that must be delivered in a hospital setting, requiring inpatient back-up in order to be safely and effectively delivered.

This level of care is delivered to a large population catchment, involves high degrees of specialisation and clinical risk, and requires significant critical mass to support safe, high quality and efficient service delivery. Sites delivering Level 4 care would generally be planned to service populations in excess of 200,000-250,000. Services at this level include EDs, radiotherapy, and day surgery or procedures involving a high degree of clinical risk (for example, stents, angiograms or some laparoscopic surgical procedures). Most outpatient services that are required immediately pre- and post-admission would also be provided at Level 4.

All existing metropolitan public hospitals and all regional health services should be considering the design implications of delivering Level 4 community-based health care, including where facilities are located and how they are set up on hospital sites, recognising the essential distinction between inpatient and 'walk-in, walk-out' care. Planning also needs to consider how Level 4 care integrates with other levels of community-based health care that may be delivered from the hospital site, taking into account the identified priorities within the three areas of need set out under 4.4 above (including the concept of health promoting hospitals).

Level 3 community-based health care centre example:

Cranbourne Integrated Care Centre

The Cranbourne Integrated Care Centre provides a range of same day services, including surgery, renal dialysis, specialist consulting services, a variety of community health services, South East Alcohol and Drug Service, community rehabilitation centre, mental health services and a domestic violence support service. The Royal District Nursing Service (RDNS) also operates from the Centre.

Level 3 requires specialist resources and has a high critical mass for services to be effectively and efficiently delivered. These services do not require inpatient back-up. Level 3 care requires sterile surgical theatres and associated staffing and infrastructure. Sites delivering Level 3 care would generally service populations of between 100,000-200,000. Care provided at Level 3 would include a range of day procedures (renal dialysis, day surgical procedures and dental day surgery), specialist services (including specialist mental health services such as Child and Adolescent Mental Health Services (CAMHS), and outpatient specialist clinics) and diagnostic services. Outreach services such as ambulance and Aged Care Assessment Services (ACAS) could be co-located at Level 3 sites. Level 3 service sites have a key role to play in health promotion and secondary and tertiary prevention for people with chronic disease and complex care needs. Planning should include critical mass considerations that could allow the facility to provide 24-hour access to some services.

New Level 3 sites would not be planned as isolated service delivery sites. Even where they are not explicitly part of a designated health precinct development, they should be part of a larger service precinct, including related health care and human services. They would also need to be planned for accessibility by both public and private transport. In metropolitan Melbourne, new Level 3 sites would generally only be developed within designated activity centres under *Melbourne 2030*. In rural locations, Level 3 care would usually be provided from existing facilities.

Level 2 community-based health care centre example:

Western Region Health Centre (WRHC)

WRHC is a large, integrated primary health agency providing a range of treatment, support and health promotion services from its six sites. WRHC medical services include observation facilities, general practice services and nursing. Separate diagnostic services are available across the road from its main site. WRHC also provides alcohol and other drug services (including pharmacotherapy), dental, psychiatric disability support (including residential rehabilitation), aged services (including case management and homeless outreach programs), counselling and casework, occupational therapy, speech therapy, dietetics, physiotherapy, health education and health promotion groups and programs.

Level 2 requires specialist resources, but a reduced level of back-up resources and/or a lower level of critical mass for efficient and effective service delivery. Level 2 sites do not require sterile theatres, but do require non-sterile procedure rooms and associated infrastructure. Some large stand-alone community health services already operate on this basis (for example, Western Region Health Centre – see box). Also included within Level 2 would be facilities such as minor injury units and walk in centres. Sites providing Level 2 care would generally be planned to service catchment populations of between 50,000-100,000. Care provided would include GP care, nursing, some specialist care, access to diagnostic services, some procedural services (including fractures and suturing) and observation facilities.

Level 2 sites could also provide a range of rehabilitation services and would be sites for integration of community health services and specialist community rehabilitation services. Links back to hospital-based sub-acute services and/or those provided on Level 4 sites would be required. As with Level 3 sites, Level 2 care also includes an important role in health promotion and secondary and tertiary prevention for people with chronic disease and complex care needs. Some cancer services and antenatal and postnatal maternity services (including specialist care for women experiencing moderate complications) would be delivered from a Level 2 site. Palliative care physician services and onsite palliative care specialist services could operate from a Level 2 site. Planning should include critical mass considerations that could allow extended hours/after hours delivery of some services (including GP clinic services).

As with Level 3 sites, Level 2 service sites would need to be planned for accessibility and proximity to locations where people shop, work, meet, relax and live. In metropolitan Melbourne, new Level 2 sites would generally only be developed within designated activity centres under *Melbourne 2030*. In rural locations, Level 2 care would usually be provided from existing facilities.

Level 1 sites would be focused on delivering primary care in a minor centre. Generally these services will be able to operate effectively at low levels of critical mass, with limited specialisation and low levels of clinical risk. They are services that would be frequently used by small local populations. Sites providing this level of care would generally be planned to service populations smaller than 50,000, down to only a few thousand. This level of care is currently provided in many small stand-alone community health service sites, or through the non-inpatient components of local health services. It includes services such as drug and alcohol services, counselling services, community nursing, allied health services, and integrated health promotion and primary prevention. Level 1 care can also include primary antenatal and postnatal care (for women experiencing normal pregnancy, without complications), and operate as a base for outreach services such as some HACC services (for example, home care and planned activity groups).

The location and number of Level 1 service sites will be driven by the needs of the immediate local population, generally at the level of a small town or suburb. A strong focus for the development of sites providing Level 1 care should be accessibility of an appropriate range of services at one location. In metropolitan Melbourne in particular, there is considerable potential to move over time to consolidate existing primary care service sites into integrated Level 1 sites that offer potential for improved quality of care, accessibility, sustainability (including improved prospects for workforce recruitment and retention) and efficiency of service delivery.

4.6.4 Implications of levels of care

These levels of care refer to modes of service delivery, but do not necessarily refer to a stand-alone facility. Rather, they may represent a design approach to elements of existing facilities which may deliver a range of care, including inpatient care. A key planning question, as per the planning principles at 4.1 above, is whether care needs to be delivered in an inpatient setting. This is particularly relevant in rural areas where regional, district and local health services may all have inpatient facilities, but would not all be seeking to provide community-based health care at Level 4. In the case of regional health services, their approach to the design and development of integrated, community-based health care services will focus on providing care up to and including Level 4. District health services would generally focus service development and design thinking on delivering community-based health care services up to and including Level 3. Local health services would be expected to have a focus on providing Level 1 and Level 2 care. For further details on service delivery expectations for regional, district and local health services, see *Rural directions for a better state of health* (Department of Human Services 2005).

Equally, a facility that provides care at a particular level would be expected to be providing lower levels of care as well. As such, a facility providing Level 4 care would also be providing care at Levels 1 to 3, underpinned by integrated, person-centred continuity of care across all levels.

New facilities

One of the most important implications for new facilities is that planning for service delivery will continue to move beyond a focus on the service capacity of individual agencies or programs. Designing facilities around the needs of people and of local populations will mean that a key development driver will be integrated delivery of an appropriate mix of services and improving the efficiency of service delivery.

Regardless of the mix of agencies or program funding streams delivering the services, facilities will be a site of integration for both physical and human resources. This includes design and operational elements like:

- shared reception and waiting areas
- shared reception staff
- shared consumables and rooms
- integrated business systems
- multidisciplinary teaming and flexible use of staffing resources
- maximising critical mass to support the efficient delivery of services, to improve recruitment and retention opportunities, and to provide a consolidated base that can support the delivery of a broader range of services.

One of the implications for new facility development is that in some cases it will make sense for existing service sites, which may be operated by separate agencies, to be consolidated within a new development. This will enable better access to a broader range of services, reduced administrative overheads, economies of scale in the use of physical fabric, equipment and consumables, streamlined delivery of care, improved quality processes and better use of scarce workforce capacity.

As noted above, location of service sites is an important part of planning to meet the needs of local communities. For new site developments, this means that:

- sites delivering Level 4 care will be located on existing or new hospital sites
- sites delivering care at levels 3, 2 or 1 will be located to maximise accessibility for people who live, work, shop, meet and relax in the local area (in metropolitan Melbourne, level 3 and 2 sites will be located within designated activity centres according to *Melbourne 2030*).

Existing facilities

All existing facilities will be classified based on this schema and service planning work or any future development/redevelopment proposals must incorporate similar design and operational elements as for a new facility development. Any redevelopment of existing facilities must consider the most appropriate mix of services for delivery from that location, rather than focusing on the existing organisational structure or the current or planned internal agency capacity. As a general rule, capital and service development for existing facilities needs to consider the scope for consolidating an appropriate mix of services in any redeveloped facility.

Within a planning catchment, where consolidation of existing services cannot be achieved through co-location, service delivery sites will need to examine the scope for 'virtual integration'. This approach needs to be considered both where it will improve efficiency (for example, through shared administrative arrangements, shared purchasing of consumables, shared use of facilities and equipment) or lead to improved care delivery for people using the services (for example, through business systems integration providing improved information management and waiting list management, and increased choice about where to receive a service). This will also entail shared processes and protocols for safety and quality (including clinical risk management, infection control and the like).

Information and communications technology

All agencies and services operating from community-based health care facilities will be expected to migrate to the HealthSMART environment. This shared application environment will be a basic prerequisite for effective integration within and between service delivery sites (see Section 5.5 below).

Key actions

- As part of the Metropolitan Health Strategy Refresh in 2006, DHS will consult with metropolitan health services and metropolitan regional offices to identify the appropriate current level of care designation for existing community-based health services (including services currently provided on hospital sites). This will inform the analysis of high priority areas for capital development and service growth in community-based health care services. Outcomes from this exercise will provide a high level set of recommendations for capital development and growth funding.
- Commencing in early 2006, local planning networks will be established in metropolitan and rural locations to develop and test an area-based planning methodology and to inform investment priorities for 2007-08. Experience in these test areas will be used to develop a final area-based planning methodology for broader application in 2007.
- For each Department of Human Services program within scope, work will be undertaken in parallel with the pilot area-based planning activity to develop individual program planning parameters based on the schema set out in Section 4.6 above.

