

Use of Oversight Powers in Victorian Public Hospitals

Evidence review, verification of the "Public Healthcare Oversight in Victoria" document, and resourcing–safety evidence

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Purpose and summary

This memo answers three questions. Has the Secretary or the Minister used formal powers to direct hospitals, or has Hospitals Victoria directed budget measures, because of poor performance, including in quality and safety? How accurate is the "Public Healthcare Oversight in Victoria" document? What other evidence links resourcing to safety and quality of care?

Bottom line

- **Financial levers are used often and across the whole system.** In 2024 the Secretary and the Minister wrote to boards requiring services to operate within budget. The department then required budget action plans to break even and cut funded activity ([PAEC](#); [VHA](#)). Hospitals Victoria was set up in August 2024 to take a "more assertive role" on hospital finances ([DH Annual Report 2024–25](#)).
- **Safety levers are used rarely, case by case, and mostly in an advisory form.** Ministers have appointed board delegates and monitors. Only one board, Djerriwarrh in 2015, has been dismissed over a safety failure in the period reviewed ([VAGO 2016](#)). A review recommended dismissing the cohealth board in 2026, and the government did not do so ([Premier](#); [Herald Sun](#)).
- **No public example was found of a s 42 Secretary direction, or of funding withheld, because of a quality or safety failure.** The Secretary has used s 42, for example to require influenza vaccination of staff in 2022 ([Secretary directions](#)).
- **The attached document is broadly right on structure but overstates the levers.** The tier-linked funding consequences, "automatic" escalation and "punitive" sentinel-event responses are not in the published framework.

Examples of powers being used

Financial and budget directions

Date	Action	Who	Source
May 2024	Letter to boards: services "will be required to operate within their prescribed budgets for the remainder of 2023–24 and ongoing". A Minister's letter to boards on 8 May covered 2023–24 cash.	Secretary; Minister	PAEC hearing, Nov 2024
June 2024	Budget action plans requiring financial breakeven by 30 June 2025, needing department approval. Activity cuts left some services more than \$10m worse off. Small rural services were asked to contribute up to 70% of their cash reserves.	Department	VHA
June 2024	The department directed hospitals to find savings. The AMA reported recruitment freezes, fewer elective operations and frozen capital works. One service was asked to find more than \$300,000.	Department	The Age ; ABC
Aug 2024	Letters from the Minister and the Secretary requiring savings were raised in Parliament. A recorded executive meeting considered closing beds and wards and reducing elective surgery and breast	Minister; Secretary	Hansard, 14 Aug 2024

Date	Action	Who	Source
	screening.		
19 Aug 2024	Hospitals Victoria began operating, with "strategic oversight of hospital finances" and a "more assertive role in the financial sustainability of the system". The report says quality is led by "other parts of the department".	Department	DH Annual Report 2024-25
May 2026	The Minister told PAEC that financial performance is managed through budgets, performance oversight and "agreed corrective actions".	Minister	PAEC hearing, May 2026

Safety and governance interventions

Date	Service	Action and trigger	Source
Apr-Oct 2015	Djerriwarrh Health Services	A delegate was appointed in April 2015 after a perinatal death cluster (7 of 11 deaths likely avoidable). The board was dismissed in October 2015 and an administrator appointed. VAGO found that "appropriate and timely action could have averted some of the serious consequences".	VAGO 2016 ; ABC ; Premier
Mar 2021	Yarram and District Health Service	Board delegate appointed for 12 months under s 40C(1). The trigger is not stated in the Gazette.	Gazette
Dec 2022	Albury Wodonga Health	Delegate appointed for three months from 16 December 2022 under s 65ZAA. This followed an SCV clinical governance review completed in September 2022. The Gazette does not state the trigger.	Gazette ; AWH
Feb 2025	Mildura Base Public Hospital	Board delegate appointed under s 40C(1). Untriaged referrals were later linked to patient harm.	Gazette ; The Age
June 2025	Northern Health	Alleged altering of ambulance offload times. The Minister directed the department to investigate with the hospital and declined calls for an external investigation.	HelloCare
July 2026	cohealth	A joint review recommended dismissing the board (health.gov.au ; Herald Sun). Instead, the government appointed a board monitor for 12 months.	Premier

What the pattern shows

- **The powers exist.** Under s 40C the Minister can appoint up to two board delegates, considering finances, safety and quality, and the duty of candour ([HSA s 40C](#)). Section 42 lets the Secretary direct the purposes, staffing, patients and services of a hospital ([HSA s 42](#)). The 2024-25 framework lists triggers for performance support, including "an actual or forecast deficit" and "overall safety and quality ... requiring systemic improvement" ([PMF 2024-25](#)).
- **The two kinds of levers are used unevenly.** Budget requirements were issued to every service in writing, with deadlines and approval steps. Safety interventions were reactive, followed media or review findings, and stopped short of removing boards except at Djerriwarrh.
- **Escalation is not visible.** Gazette notices do not state why a delegate was appointed. Service tiers are not published. VAGO found the department did not monitor health services' compliance with the Victorian Clinical Governance Framework ([VAGO 2021](#)).

- **Limits of this search.** It covers public sources only. Secretary letters, performance improvement plans and tier decisions are not published, so other interventions may exist. A PAEC question on notice or an FOI request would settle the count.

Verification of the attached document

The attached document is an AI chat export with numbered references that do not link to sources. Claims were checked against the [2026–27 performance monitoring framework](#) and the primary sources above.

Claim	Verdict	Evidence
Hospitals Victoria leads performance oversight and funding	Supported, with nuance	PMF 2026–27, s 7.2.2. The 2024–25 annual report frames its role as financial, with quality led elsewhere.
Four tiers, from Enhanced Autonomy to Mandated Intensive Support	Supported	PMF s 2.3; PMF 2024–25 s 3.3.2
Escalation includes delegates, directions, board dismissal and administrator	Supported	PMF s 4.5, Appendix 8
Department can restrict services and redirect funding	Partly	Limits on spending and contracts, and suspending services for safety risk, are listed. Revoking maternity services and redirecting funding are not stated.
Statements of Priorities are agreements between the department and boards	Partly	They are legislated agreements with the Minister (health services) or the Secretary (hospitals), per PMF s 3.1.1 and Appendix 4.
Tier-linked funding effects (Tier 1 block grants; Tier 3 reserve deployment and spending freeze; Tier 4 "every dollar approved")	Not in framework	The framework describes oversight intensity, improvement plans and directed actions, not these funding rules.
Hospitals pay administrators' costs	Not in framework	Not addressed
Funding capped at about 104% of baseline activity	Not in framework	No such cap appears in the PMF. The figure appears to come from an older VAGO report.
Falling below quality indicators automatically moves a service into Tier 3 or 4	Not supported	Tiering uses judgement across domains and intelligence; nothing is automatic (PMF s 3.3, 4.2).
Sentinel events trigger "instant, public, punitive" interventions	Not supported	The PMF describes reporting, review and learning. Reports are de-identified (DH QON).
Department triggers short-notice accreditation assessments	Not in framework	The PMF says only that HSIC coordinates support with SCV (s 8.1).
Adverse events in about 10% of admissions, 50% avoidable	Misstated	The Quality in Australian Health Care Study found 16.6% and 51% (Wilson et al. 1995).
Hand hygiene rose from 63% to 86%; VHES "scattergun"; Virtual ED lowered infections; Minister can dismiss the CEO	Unverified	Not checked against primary sources. Do not cite without a source.

Recommendation: do not cite the attached document directly. Its structural claims can be cited to the PMF itself. Its descriptions of financial consequences and automatic, punitive escalation should be dropped.

Further resourcing–safety evidence to include

Link	Key finding	Source
Nurse staffing ratios	Queensland ratio legislation (27 hospitals): lower odds of death (OR 0.89). Each one fewer patient per nurse: OR 0.93 for death and readmission.	McHugh et al., Lancet 2021
Nurse workload	Each extra patient per nurse: about 7% higher 30-day mortality (US, 168 hospitals; Europe, 300 hospitals).	Aiken 2002 ; Aiken 2014
Nursing hours (Australia)	Mandated nursing hours per patient day in WA reduced mortality, sepsis, pneumonia and pressure injury.	Twigg et al. 2011
ED crowding and access block	WA: overcrowding raised the hazard of death at 7 days (HR 1.3). Occupancy of 100% or more: HR 1.3 against occupancy below 90%. ACT: 10-day mortality RR 1.34.	Sprivulis et al., MJA 2006 ; Richardson, MJA 2006
Delay to admission	England, 7.5 million admissions: 30-day mortality rises from 5 hours after arrival, in a dose–response pattern.	Jones et al., EMJ 2022
Bed occupancy and infection	Systematic review: high occupancy and understaffing are associated with spread of hospital-acquired infection.	Kaier et al. 2012
Doctor fatigue	AMA Victoria survey: 46% of Eastern Health junior doctors reported clinical errors due to workload or understaffing; 42% at the Royal Women's reported fatigue-related errors.	The West Australian
Unopened capacity	20 new emergency beds at the RCH left empty because of staffing shortages.	The Age
Cost of harm returns as premiums	Public hospital medical indemnity premium of \$380.9m in 2025–26, up 26.4%. Claims frequency rose 47% over four years. Premiums are partly rated on claims experience.	VMIA
Victoria's own policy logic	Parliament legislated minimum nurse and midwife ratios in 2025, on the premise that staffing affects safety.	Hansard, 6 Mar 2025

Caveat: most staffing and crowding studies are observational. The consistency, dose–response patterns and natural experiments (Queensland, WA) make a causal link plausible, but effect sizes should be quoted as associations.

Suggested use

- Add a short section to the public-release report contrasting frequent, system-wide financial directions with rare, case-by-case safety interventions. Use the two tables above.
- Add the resourcing–safety evidence to the false-economy argument. The VMIA premium rise is a direct, Victorian cost of harm.
- Ask a PAEC member to seek, through a question on notice, the number of services in each tier, delegates appointed since 2020 and their triggers, and any s 42 directions issued since 2020.