

Portland District Health

STRATEGIC PLAN | JULY 2026–JUNE 2029



Our commitment to inclusion and allyship

Portland District Health is committed to fostering an inclusive, equitable and culturally safe environment for our consumers, community and workforce. We recognise and respond to the diverse needs of Aboriginal and Torres Strait Islander peoples, people with disability, culturally and linguistically diverse communities, older people, and people of diverse sexual orientations, gender identities and expressions.

We will work in partnership with consumers, carers, community organisations and representative groups to ensure our services and workplaces are accessible, responsive and person-centred.

Portland District Health is committed to advancing Aboriginal self-determination and Closing the Gap priorities through strengthened partnerships with Aboriginal

Community Controlled Health Organisations, including Winda-Mara Aboriginal Corporation and Dhauwurd-Wurrung Elderly and Community Health Service, Traditional Owners and Aboriginal communities. These partnerships will ensure Aboriginal voices inform organisational planning, service improvement and evaluation.

This commitment is supported through implementation of the Aboriginal and Torres Strait Islander Workforce Strategy and a sustained focus on cultural safety across all levels of the organisation, to improve health, wellbeing and employment outcomes for Aboriginal and Torres Strait Islander peoples.



ACKNOWLEDGEMENT OF TRADITIONAL OWNERS OF COUNTRY

We acknowledge the Traditional Owners of the lands and waterways in which we live and work, the Gunditjmara people of South West Victoria. We honour and pay respects to their Elders, past, present and emerging.

A message from our Chair and Chief Executive Officer

The Portland District Health Strategic Plan for 2026-2029 (the Plan) is our commitment to our community. It sets out how we will continue strengthening local healthcare so people in our region can access high-quality care close to home.

Since our last Plan, Portland District Health (PDH) has strengthened our services, improved clinical structures and expanded partnerships with regional health services and local clinicians. This progress is thanks to our staff, whose work and dedication to patients and clinical excellence have built a stronger health service.

But more needs to be done. We need to continue evolving with our region. Our community is ageing, demand for services is growing and more people are living with complex health conditions. Meeting these needs means strengthening local services while working more closely with partners in town, across the South West and across the state.

This Plan sets an ambitious agenda for Portland District Health. Achieving our goals will not be possible in isolation. Our success is intrinsically linked to our ability to work collaboratively with our partners, our community, and our staff.

The principle of regional collaboration is not just a strategic enabler; it is the cornerstone of our approach. By joining forces with our health service partners across the South West, we can achieve far more than we could alone. This includes joint workforce recruitment to attract the best talent, sharing data and systems to improve efficiency, coordinating our marketing and advocacy efforts, and working together to ensure the sustainable delivery of health services across our entire region.

By connecting services across the region and expanding care in the community, we can help people stay well and out of hospital for longer.

The Plan focuses on four areas where we believe we can make the greatest difference: the services we provide, the care experience for patients and families, the strength of our workforce and the systems that support safe, coordinated healthcare.

We are committed to being a proactive and reliable partner. We will continue to build and nurture our relationships, based on trust, mutual respect, and a shared vision for a healthier community. Together, we will navigate the challenges and seize the opportunities that lie ahead, ensuring that Portland District Health remains a vibrant and essential part of our community for years to come.

This Plan aligns with Commonwealth and Victorian healthcare priorities, including: delivering the right care at the right time and place; strengthening our role within the health system; prevention, health promotion, and early intervention; quality, safety, and patient-centred care; virtual health; the recommendations of the Royal Commissions into Victoria's Mental Health System and Aged Care; and the effective management of chronic conditions.

With dedicated staff, strong community support and more partnerships across our region, PDH is well placed to deliver high-quality healthcare with clarity and optimism.



Emeritus Professor Peter Matthews
Chair



Karena Prevett
Chief Executive Officer

About Portland District Health

MEDICAL UNITS

Anaesthetics
Cardiology
Dermatology
Endocrinology
Endoscopy
Ear, Nose and Throat Surgery
General Surgery + Laparoscopy
General Medicine
Geriatric Medicine
Nephrology
Obstetrics and Gynaecology
Oncology
Orthopaedics
Paediatrics
Plastic Surgery
Respiratory Medicine
Urgent Care (Emergency Medicine)

DIAGNOSTIC

Echocardiography
Holter Monitoring
Pathology
Pharmacy
Medical Imaging:
- CT Scanning
- General X-rays
- Ultrasound
- Breast Screen
- Fluoroscopy
- Bone Density
- OPG/Cone beam CT
Sleep Studies
Stress Testing

NURSING & MIDWIFERY SPECIALTIES

Chemotherapy
Day Procedure
Discharge Planning
Hospital in the Home
Maternal and Child Health
Medical – Acute
Midwifery – Neonatal Care
Needle Exchange
Palliative Care
Perioperative
Renal Dialysis
Residential Aged Care
Short Stay UCC
Sub-Acute care
Surgical – Acute

PRIMARY, COMMUNITY & ALLIED HEALTH

Alcohol and Other Drug Services, including Counselling
Cancer Support
Community Palliative Care
Community Transport
Continence
Counselling:
- Psychology
- Social Worker
Community Nursing
Diabetes Education
Dietetics
District Nursing
Community Rehab

HARP
Post-Acute Care
Health Promotion
Aged Care:
- Home Care
- Personal Care
- Social Support (individual and group)
Lymphoedema
Occupational Therapy
Physiotherapy
Practice Nurses
Speech Therapy

SUPPORT SERVICES

Finance
Human Resources
Building Services
Administration
Health Informatics
IT
Food Services
Meals on Wheels
Environmental Services
Staff Education
Quality & Safety
Infection Control & Prevention
Supply
Telecare (Care Call)
Volunteer Services

CONSULTATION

The development of this Strategic Plan followed a comprehensive and structured process. During a strategic planning retreat held in late 2025, the Board, Executive, and community representatives participated in facilitated sessions over a two-day period, supported by an external consultant. This was complemented by extensive consultation with staff, community members, stakeholders, and partners.

WHAT WE HEARD

PERCEPTIONS

- Positive momentum
- Historical challenges
- Community expectations high
- Clear communication needed
- Partnership focus required

ENVIRONMENTAL FACTORS

- Demographics & geography impacting services and workforce
- Social health issues
- Systemic & structural issues including funding
- Technology & integration

PRIORITIES

- Workforce development
- Service clarity & expansion
- Partnerships & collaboration
- Digital transformation
- Communication

SUCCESS

- Clinical safety and operational effectiveness
- Strong workforce and culture
- Financial sustainability
- Strong reputations
- Strong relationship

IMPLEMENTATION AND MONITORING

Delivery of this Strategic Plan will be supported through established governance arrangements, with oversight provided by the Board and Executive through regular monitoring of strategic priorities, performance measures and implementation progress. Annual Operational Plans, aligned with the organisation's Statement of Priorities and relevant Victorian Government policy frameworks, will translate strategic objectives into measurable actions and accountabilities.

Regional partnerships and participation with Local Health Service Networks will play a key role in delivering the Plan by strengthening collaboration, service integration, workforce planning and shared responses to community health needs. These partnerships will support coordinated care, improve access and equity, and enable the health service to contribute to regional and statewide priorities while achieving local strategic outcomes.

Glenelg Shire healthcare snapshot and regional context

Australia’s healthcare system is complex and demand for care continues to rise. In rural communities, people rely on multiple providers and services, sometimes travelling significant distances to access care. Local data highlights the pressures shaping healthcare in our region. Glenelg Shire has an older population, higher rates of chronic disease and greater barriers to accessing primary care. These realities reinforce the importance of strong local services and a health system that works together for the needs of our community.



THE HEALTH OF OUR COMMUNITY

HEALTH CONDITIONS AND DISEASE PREVALENCE (DIRECT HOSPITAL IMPACT)

Residents of Glenelg Shire experience a higher burden of chronic health conditions than the Victorian average. Diabetes prevalence is 6.3 per cent, compared with 4.6 per cent statewide (+37 per cent). Overweight and obesity rates are very high compared with the rest of Victoria. Rates of chronic and cardiovascular diseases are also higher than the Victorian average. Youth mental health conditions are higher than elsewhere in Western Victoria, and more adults experience high or very high psychological distress than the Victorian average.

ACCESS TO PRIMARY AND ALLIED HEALTH

Access to primary and allied health services in Glenelg Shire is more limited than the Victorian average. A very high proportion of residents report being unable to access a GP within the past 12 months, while access across the rest of Victoria is generally better. Allied health access is lower than the state average, and fewer residents seek mental health support.

RISK FACTORS IMPACTING HOSPITAL DEMAND

Several behavioural risk factors linked to preventable illness are more prevalent in Glenelg Shire. Smoking and vaping rates are 22 per cent, compared with the statewide average of 18 per cent. Risky alcohol consumption is higher, with more adults at increased risk of harm than the Victorian average. Physical inactivity is also higher, with 21 per cent of adults reporting no moderate or vigorous activity. Smoking during pregnancy affects approximately 25 per cent of pregnancies, higher than the Victorian average, and food insecurity affects more than 7 per cent of adults, compared with 4.6 per cent statewide.

MATERNAL AND CHILD HEALTH

Maternal and child health indicators in Glenelg Shire are poorer than the Victorian average. Early antenatal care non-attendance is 47 per cent, compared with a statewide rate of 36 per cent. Children who are developmentally vulnerable account for 24 per cent, compared with 20 per cent statewide. The rate of smoking during pregnancy is approximately 25 per cent, which is also higher than the Victorian average.

SOCIAL DETERMINANTS (INDIRECT HOSPITAL IMPACT)

Several social and demographic factors further influence health outcomes in Glenelg Shire. Family violence rates are approximately 74 per cent higher than the Victorian average. Around 25 per cent of households are low income, which is higher than the state average. Homelessness levels are also higher.

FIRST NATIONS POPULATION

In 2021, the Australian Bureau of Statistics recorded 575 people identifying as Aboriginal and Torres Strait Islander in Glenelg Shire. This is more than three times the Victorian average.

The proportion of Aboriginal and Torres Strait Islander peoples in Glenelg Shire has increased from 1.2 per cent of the local population in 2003 to 2.9 per cent in 2021.



OUR STRATEGIC ENVIRONMENT

AGEING POPULATION:

Accelerating demand for holistic, community-based aged care services.

COMMUNITY EXPECTATIONS:

Expectations for locally delivered, person-centred care remain high, even where care is complex or costly.

NATURAL DISASTERS AND CLIMATE EVENTS:

Remain unpredictable but increasingly frequent.

POLICY AND FUNDING VOLATILITY:

Continues to increase regulatory load and uncertainty.

WORKFORCE STRATEGY:

Attract, maintain and develop a strong and sustainable workforce to support the capacity and capabilities of the health service.

EVOLVING TECHNOLOGY DEPENDENCE:

Is reshaping how care is delivered.

ENVIRONMENTAL, ECONOMIC AND HOUSING PRESSURES:

Are emerging as new demand drivers (climate change, cost of living, housing stress).

WHAT THIS MEANS FOR HEALTHCARE IN OUR REGION

1 HIGHER CHRONIC DISEASE BURDEN

More people are living with diabetes, cardiovascular disease and obesity.
Strategic implication: We will strengthen prevention, chronic disease management and coordinated community care.

2 BETTER ACCESS TO PRIMARY CARE

Limited access to GPs and allied health places greater pressure on hospitals.
Strategic implication: We will improve integration between primary care, community services and hospital care.

3 PREVENTION AND EARLY INTERVENTION

Smoking, risky alcohol use and physical inactivity increase preventable illness.
Strategic implication: We will invest in health promotion and community-based wellbeing programs.

4 INTEGRATED CARE

Health outcomes are influenced by social, economic and community factors.
Strategic implication: We will work alongside community partners to provide connected, person-centred care.

5 SUPPORTING AN AGEING POPULATION

An older population means greater demand for aged care, rehabilitation and palliative care.
Strategic implication: We will expand services that help people remain independent and well at home.

6 STRENGTHENING MENTAL HEALTH

Young people require earlier access to mental health and wellbeing support.
Strategic implication: We will strengthen partnerships and improve access to local mental health services.

7 WORKING BETTER TOGETHER

No single health service can meet every need alone.
Strategic implication: Through the South West Local Health Service Network we will share workforce, expertise and services to improve care across the region.

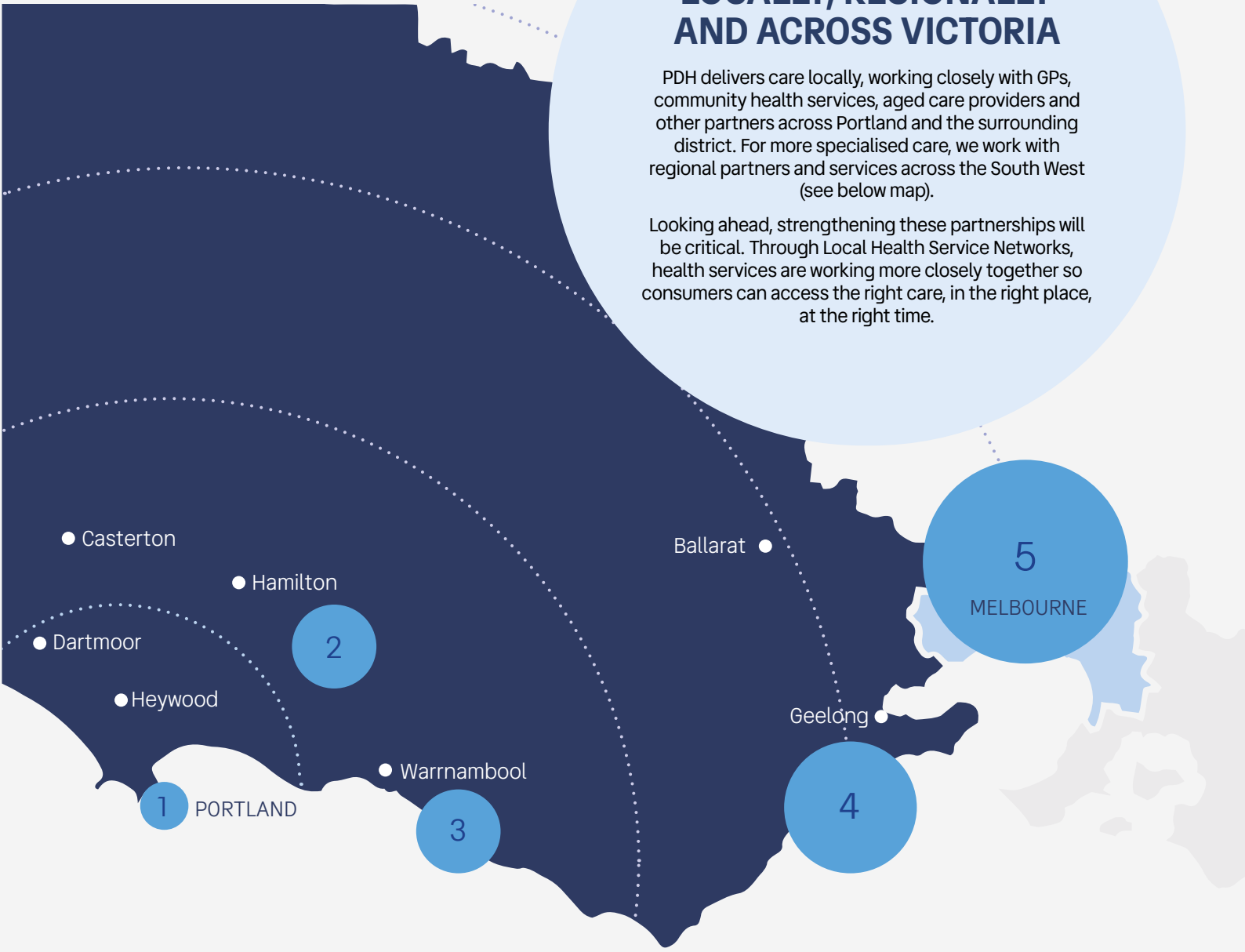
WHAT THIS MEANS FOR PORTLAND DISTRICT HEALTH

Portland District Health is more than a hospital. We are a critical regional health partner, delivering integrated care close to home while working collaboratively across the South West to improve access, strengthen our workforce and support healthier communities.

WORKING TOGETHER LOCALLY, REGIONALLY AND ACROSS VICTORIA

PDH delivers care locally, working closely with GPs, community health services, aged care providers and other partners across Portland and the surrounding district. For more specialised care, we work with regional partners and services across the South West (see below map).

Looking ahead, strengthening these partnerships will be critical. Through Local Health Service Networks, health services are working more closely together so consumers can access the right care, in the right place, at the right time.



- 1 Portland District Health 2 Western District Health Service 3 South West Healthcare 4 Barwon Health 5 Metropolitan tertiary hospitals

Services

Helping people stay well and live at home for longer, with the right care at the right time.

WHAT WILL CHANGE

- PDH will place greater focus on care delivered in the community and at home, supported by hospital and specialist services when needed.
- Stronger coordination between clinical services, allied health, aged care and community supports will help people receive the right care earlier, recover safely at home and reduce unnecessary hospital stays.
- Consolidated and enhanced women’s health services, including birthing and gynaecology.

OUTCOMES BY 2029

- More care delivered in the community, with more than 85 per cent of patients able to access key health and community services locally through PDH.
- Embedded recommendations from the regional Clinical Services Plan to improve self-sufficiency.
- Theatre utilisation at above 90 per cent.
- Uptake of food bank, social and emotional supports, and cancer screening services at 90 per cent of projected levels.
- Implementation of the Aboriginal and Torres Strait Islander Workforce Strategy 2025–2027.
- Key clinical partnerships maintained.

WHAT THIS MEANS KERRIE’S STORY

Kerrie lives locally and manages complex health conditions including asthma, a heart murmur and chronic pain. These issues previously led to frequent ambulance callouts and emergency department visits, with care often fragmented across services.

Through PDH’s Hospital Admission Risk Program, Kerrie now has a coordinated care plan shared across providers including PDH, Western District Health Service, Ambulance Victoria and community health

services. With respiratory monitoring, medication support and community rehabilitation in place, Kerrie is experiencing fewer hospital presentations and greater stability at home.

This coordinated, community-based care helps people remain well at home while reducing pressure on hospital services.



Photo credit: Maddi Jennings

Experience

Supportive, connected healthcare centred around consumers and their families.

WHAT WILL CHANGE

- More care delivered locally, with clearer pathways between GPs, community health, hospital and specialist services, and better support before, during and after treatment.
- Stronger coordination between PDH and Local Health Service Network partners, helping consumers move smoothly between local, community and specialist care.
- Strengthened patient information and communication systems.
- Strengthened relationships with Aboriginal and Torres Strait Islander peoples.
- Strengthened future healthcare infrastructure.

OUTCOMES BY 2029

- Master planning for facilities completed, including (subject to funding) Urgent Care Centre, Wards, Pharmacy and Harbourside Lodge.
- Strengthened patient information and communication systems that are more timely, consistent and accessible.
- Enabled digitised and online access for appointment booking, results and information portals.
- Carers and families included in planning, discharge and follow-up.
- Developed remote patient monitoring and remote consultation capabilities.
- Reinforced the “personal touch” of care through recognition, empathy and acknowledgement in every patient interaction.
- Embedded a continuous feedback loop by collecting, responding and acting on patient and carer feedback.

WHAT THIS MEANS ANNA'S* STORY

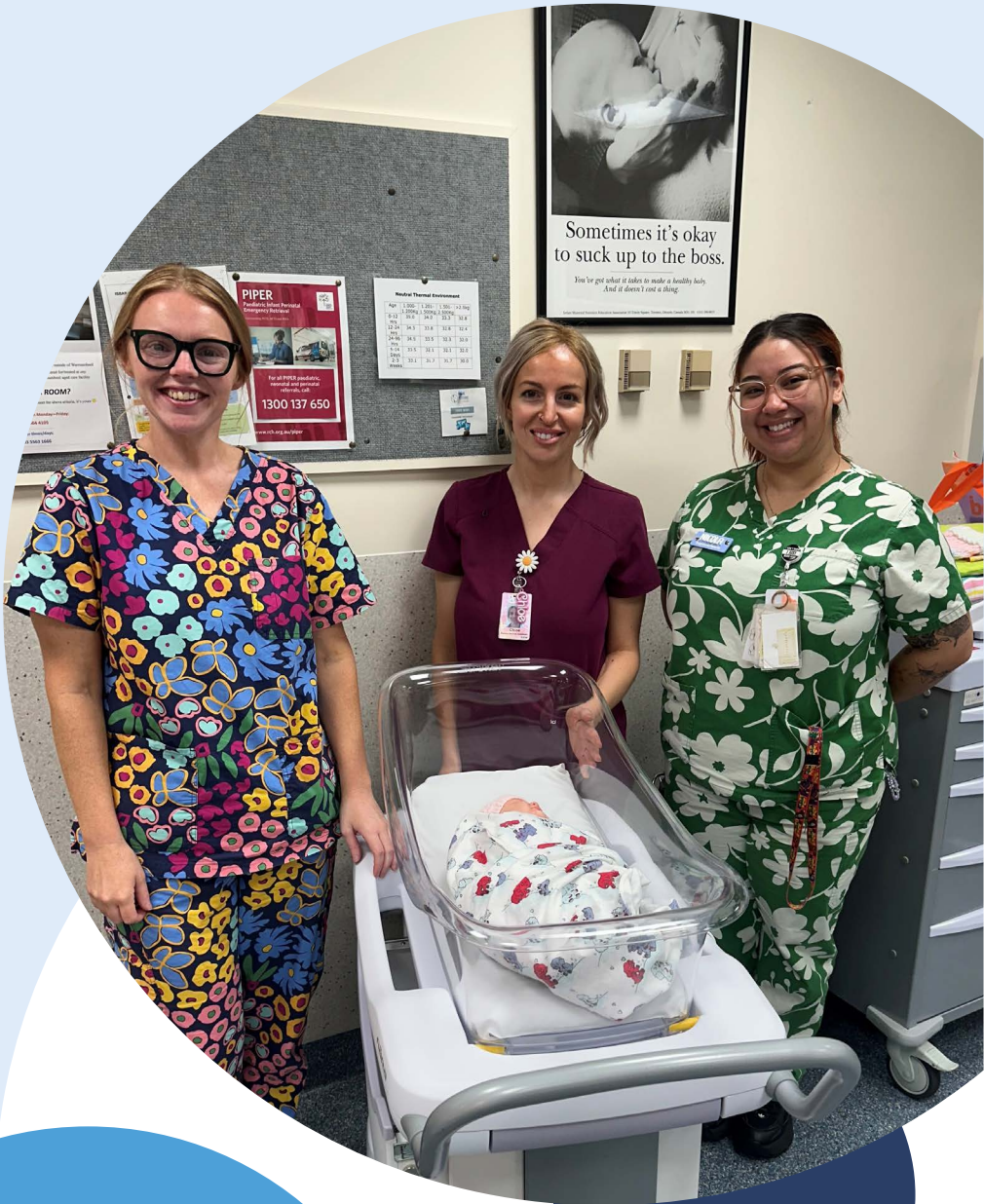
Anna received her maternity care locally through PDH, including antenatal care, scans and midwifery support. Having delivered two babies at Barwon Health before moving to Portland, Anna was excited to give birth locally.

Anna described PDH's midwives as professional, supportive and safe. She was at ease throughout her pregnancy, receiving consistent holistic care.

After the birth, serious complications required urgent specialist cardiac care and Anna was transferred to Barwon Health. Once stabilised, mother and baby returned to Portland for postnatal care and follow-up support.

PDH's maternity team worked with Barwon Health specialists to deliver connected care from start to finish, providing specialist treatment when needed and ongoing support close to home. It shows how strong local services, backed by regional partnerships, create safer and more connected care.

* Name has been changed to preserve patient confidentiality



Workforce

A skilled, stable workforce built on strong culture, career progression and high-quality care.

WHAT WILL CHANGE

- More training, development and career pathways, helping staff build skills, grow their careers and remain working in Portland.
- A stronger workplace culture and team environment, supported by collaboration across PDH and the Local Health Service Network.
- PDH will be an employer of choice, driven by our positive culture and value-added propositions.

OUTCOMES BY 2029

- More clinicians progressing into advanced practice roles within PDH.
- A stronger local workforce with more opportunities for career progression, with less than five per cent vacancy and less than 15 per cent staff turnover.
- More than 80 per cent of staff give our safety culture a positive response in the People Matter Survey
- Expanded telehealth provision where clinically appropriate.
- Established sustainable partnership and student pathways.
- Developed whole-of-workforce career pathways from graduates to senior medical staff, including allied health, nursing and administrative and support staff.
- Promoted PDH as a regional workforce hub, leveraging university partnerships and regional collaboration for recruitment, training and marketing.
- Explored flexible hours and shift sharing opportunities.
- Empowered staff and leaders through mentoring, clinical supervision, flexible working and clear accountability.
- Digitised workforce systems, including implementing electronic rostering, online recruitment and HRIS integration.
- Strengthened foundational HR systems including orientation, performance review, succession planning, recruitment and accreditation.
- Expanded entry-level training pathways including graduate nurse and EN programs, traineeships (including RUSON/RUOSM), and support-service skill pipelines.

WHAT THIS MEANS NATHALIE, GEORGE & JO'S STORIES

Three PDH nurses have developed advanced clinical skills as nurse practitioners, working across oncology (Nathalie), chronic disease (George) and palliative care (Jo).

Through training and experience gained across the region, they have built specialist expertise while continuing to care for consumers in their local community. These roles allow them to make advanced clinical decisions, coordinate complex care and work closely with doctors and specialist teams.

Back in Portland, their skills strengthen the local health service and allow more care to be delivered close to home. By bridging nursing and medical models of care, they provide holistic, patient-centred support for people managing complex and serious illness. Their work shows how investing in local staff builds capability at PDH while ensuring the community benefits from highly skilled clinicians.



Image: Portland's nurse practitioners

Systems

Connected, reliable systems that make care simpler, safer and more coordinated.

WHAT WILL CHANGE

- Shared digital health systems across services, ensuring clinicians work from the same records and information, making it simpler for consumers to move through the health system.
- More connected health services across the Local Health Service Network, supported by shared systems and coordinated care.

OUTCOMES BY 2029

- Connected digital systems supporting safer, more coordinated care, with a PDH-wide dashboard improving clinical and operational decision-making.
- Electronic rostering and workforce systems fully implemented across PDH.
- Strengthened budgeting and business intelligence to improve financial insight and planning.
- Improved performance monitoring with the use of dashboards and data to strengthen governance and accountability.
- Improved data collection and reporting for operational and clinical decision-making.
- Developed and implemented a modern rostering system linked to workforce and payroll.
- Advanced the PDH Digital Roadmap including electronic records, regional connectivity and SWARH collaboration.
- Pursued regional system partnerships for continuity, stability and shared efficiencies.
- Strengthened organisational sustainability through diversified philanthropic and community support.

WHAT THIS MEANS

ANGELA'S STORY

Angela has lived with Type 1 diabetes for more than 20 years and previously managed her condition through multiple daily injections and frequent appointments to keep her blood glucose levels stable.

Through new technology, including an insulin pump and continuous glucose monitoring, Angela's care is now supported by PDH's diabetes team. Credentialed Diabetes Educators monitor glucose data remotely and work closely with Angela's endocrinologist to adjust treatment when needed.

With connected systems supporting her care, Angela no longer has to repeat tests or manage multiple appointments across services. Her care team works from the same information, helping her manage her diabetes more confidently while reducing unnecessary hospital and specialist visits.



Image: Portland's Diabetes Educators

Being part of Portland District Health

Your best health and wellbeing, close to home

Your best health and wellbeing, close to home



OUR PURPOSE

Togetherness, courage, optimism

Togetherness, courage, optimism

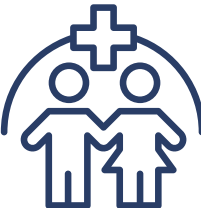


**ORGANISATION
VALUES**



Choice, connection, clarity, consistency

Choice, connection, clarity, consistency



OUR PROMISE



Compassion, accountability, respect, excellence

Compassion, accountability, respect, excellence



**OPERATIONAL
VALUES**

