

HEALTHCARE

More time for care: improve the administration around it

Alongside People / Advice and hands-on implementation

A practical AI paper for Melbourne healthcare organisations.

If staff are already trying AI but its useful place in your organisation remains unclear, we can help you make sense of the options. Together we establish what better would look like and where to begin. The administrative example below is one way to explore that question.

The useful starting point. Start with the coordination around care: finding the right procedure, preparing an internal brief and keeping administrative instructions current. A useful improvement gives staff capacity for more valuable work while preserving privacy, accuracy and accountability. The first test is whether the whole job becomes easier, including checking and correction.

Where the opportunity begins

A healthcare administrator may spend a morning reconciling contradictory instructions before answering a straightforward operational question. Which contact owns a facilities request? Which booking procedure is current? What needs to be included in an internal service update? Finding and checking the answer can take more effort than writing it.

These are useful situations to examine with staff. We should establish whether the friction comes from inaccessible information, unclear ownership, outdated documents or repetitive preparation. AI might help assemble a source-linked draft; a better document register or simpler form may resolve more of the problem.

Our recommendation is to start away from clinical decisions. This paper concerns internal administrative preparation. Diagnosis, triage, treatment recommendations, patient prioritisation and decisions that restrict access to care are outside its proposed pilot. We also exclude clinical notes and ambient recording. Those uses require their own specialist assessment and authority.

Administrative work still deserves careful boundaries. A roster, correspondence thread or appointment record can reveal personal or health information. Calling a task “back office” does not make its inputs suitable for an AI tool.

The Victorian context

The Victorian Department of Health now provides minimum standards, governance models and escalation material for AI in Victorian public health services. Its source page describes requirements that must be met before use, rather than treating an experiment as an exemption. The documents were updated on 3 June 2026; the page was updated on 7 July 2026. These public-health requirements should not be presented as a universal policy for every private practice. [Victorian public health AI resources](#).

The Department's explanation of the Health Records Act says its Health Privacy Principles apply to health information handled in Victoria across public and private sectors. Identifying information collected while providing health services may itself be health information. The practical implication is to ask the organisation's information and privacy owners about the actual data, not assume a spreadsheet is harmless because it lacks a diagnosis column. [Health Records Act explanation](#).

For organisations within its scope, OVIC's enterprise AI guidance expects preparation that includes privacy impact assessment, information-security assessment, training, incident response and continuing review. Buying an enterprise tool does not settle those questions. [OVIC enterprise AI guidance](#).

These sources support planning; this paper does not determine legal compliance or approve a tool.

A fictional workflow: prepare the weekly administration brief

A fictional Melbourne health service circulates a weekly brief about facilities contacts, approved administrative procedures and operational notices. A coordinator gathers the material; department managers check it before circulation. Several drafts repeat old instructions because a superseded notice remains easy to find.

The proposed change uses a small approved collection of non-personal administrative documents. AI prepares a draft identifying each statement's source, document version and unresolved conflict. It can report that two instructions differ. It cannot decide which is authoritative, invent a contact, access patient systems or send the brief.

The document owner resolves conflicts. The coordinator checks completeness and the manager approves circulation. A visible "not confirmed" item is preferable to a fluent answer that hides missing evidence. This is a constructed example, not an account of our healthcare work.

What would make this worth continuing?

The following is a decision aid for the fictional trial, not an observed result. Agree the limits with the people responsible before testing.

- **Accepted result:** A manager-approved administration brief with current sources and unresolved conflicts made visible.
- **Who judges it:** The coordinator, document owners and managers who use the brief.
- **Hold and return to the manual route when:** A patient source is accessed, personal information appears or an incorrect instruction could affect a consequential action.

- **Evidence for another step:** Compare accepted briefs of similar scope, including source verification, correction and manager effort.

A fictional permitted-source example is a non-personal facilities notice identifying an approved request procedure. An appointment list is different: it may reveal health information even without a diagnosis column. The organisation must decide which real sources are permitted.

Use the [one-workflow worksheet](#) to record the agreed question, evidence and next decision.

Five states, with evidence before expansion

Understand. Follow one brief from request to approved circulation. Ask the recipient which missing details cause follow-up. Identify source owners, permitted documents and approvals; record preparation and review effort separately. The potential benefit is less searching and fewer conflicting instructions. The gate is a named owner, a clear problem, authorised information and a baseline. If documents cannot be classified or approved, stop before connecting a tool.

Try. Compare a manual brief with a draft prepared from synthetic or approved non-personal examples. Include an expired notice, a missing date and two contradictory instructions. The potential benefit is faster assembly. The gate is traceable facts, visible uncertainty and checking effort within the agreed limit. No generated claim passes merely because its wording sounds professional.

Repeat. Have a second coordinator use the documented instructions on a different set of notices. Record corrections and reasons for manual handling. The potential benefit is dependable preparation across staff changes. The gate is comparable quality across representative repetitions, including an awkward example, and a fallback that someone other than the author can follow.

Operate. Only with explicit approval, establish routine drafting within the agreed collection. Name an owner and backup, limit access, retain source versions and test a pause. The potential benefit is less coordination effort around a recurring brief. The gate is exercised recovery, visible exceptions and acceptance of the ongoing workload. Routine use does not authorise access to patient records.

Improve. Review whether staff actually have more useful capacity and whether recipients trust and use the brief. Retire duplicated notices or improve source ownership if those changes matter more. The gate is a recorded retain, revise or stop decision supported by observations. More AI autonomy is not a required next step.

This original Alongside People framework is a discussion aid, not a health-service accreditation, validated maturity score or official standard.

A proposed 30-day pilot

Days 1-7: follow the current process, select the document collection, obtain relevant approvals and record a baseline. Days 8-14: prepare paired drafts offline with agreed examples; inspect every output. Days 15-23: repeat with another staff member and exercise missing-source and tool-failure scenarios. Days 24-30: review evidence, operating burden and the next decision with the sponsor.

If approvals or source preparation take longer, the timetable changes. Live circulation is not necessary to learn from the pilot. The proposal is a planning example, not a promise of a 30-day engagement or permission to use real health information.

Measure useful capacity

Choose accepted-brief preparation effort as the primary measure, including searching, prompting, review and correction. Record elapsed time separately. Preserve the original baseline and compare briefs of similar scope; show differences rather than attributing all change to AI.

Guardrails include unsupported statements, wrong or expired instructions, missing sources, review effort, inaccessible wording and any inappropriate information exposure. Include tool charges, configuration, training and ongoing document maintenance in cost. Agree tolerances before trialling; an information-handling incident or consequential incorrect instruction triggers a pause and the organisation's incident process.

Recovered minutes are potential capacity, not automatically cash savings or additional patient appointments. Ask staff what useful work became possible and whether the change shifted effort onto managers.

Permissions, recovery and our role

Grant access only to the approved collection. Retain original documents and drafts in authorised systems, use the organisation's retention rules and treat retrieved content as information rather than instructions to the automation. No sending, record amendment or source deletion belongs in the initial tool permissions.

On failure, hold the draft, identify affected material and return to the established manual brief. Reconcile any previously circulated error through the authorised correction process. A backup coordinator should complete this exercise before routine use.

Our team can help understand the work, design the experiment and implement the agreed drafting and review process. We can connect approved information, document responsibilities and prepare a usable handover. Your organisation retains clinical, information-governance and operational authority; specialist approval and ongoing support are separately agreed.

Bring us a recurring administrative job, the people doing it and a representative example that can be shared. We can help establish whether a practical change is worth making.

Source check: 3 October 2026. Official sources above support the narrow policy statements; the workflow, five states and pilot are our proposed method. Recheck applicable requirements before use.

If you are already trying AI and are unsure what deserves further investment, [tell us what you have tried and what you want to improve](#). We can help find the starting point together.

Read the structured HTML edition: alongsidepeople.com/resources/ai-for-healthcare