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| Policy and funding guidelines 2024–25 |
| Policy guideThis policy guide sets out the operational and service delivery policy changes, obligations and standards for government-funded healthcare organisations. It aims to support a world-class healthcare system that helps all Victorians stay healthy and safe. |
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| Policy and funding guidelines 2024–25Policy guide |
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# Overview of the Policy and funding guidelines 2024–25

The *Policy and funding guidelines 2024–25* (the guidelines) provide the system-wide terms and conditions for government-funded healthcare organisations (funded organisations). This includes health services and hospitals, community service organisations and other organisations, such as Ambulance Victoria.

The guidelines:

* reflect the role of the Department of Health (the department) as the system steward
* provide policy changes relating to operational and service delivery
* set out contractual, statutory and other duties and requirements
* detail the budgetary landscape, including funding and pricing arrangements, as well as funded activity and targets.

The guidelines comprise two separate but related publications:

* *Policy guide* (this document)
* *Funding rules*.

## Policy guide

The *Policy guide* provides detailed information regarding operational and service delivery policy. This includes the conditions within which funded organisations operate, as well as the obligations, standards and requirements funded organisations are expected to adhere to.

### Part 1: Operational and service delivery policy

Part 1 provides health services with the policy changes for the year. Note that it is not a complete, holistic guide to operational and service delivery policy in Victoria.

### Part 2: Obligations, standards and requirements

Part 2 outlines the relevant standards and obligations to which funded organisations must adhere, ensuring the delivery of safe, high-quality services and responsible financial management.

## Funding rules

The *Funding rules* go over the budgetary and funding parameters within which funded organisations are expected to work.

### Part 1: Budgetary landscape and pricing arrangements

Part 1 details the budget highlights and outputs, and funding and pricing arrangements.

### Part 2: Funding and activity levels

Part 2 provides funding and activity tables that detail the modelled budgets, as well as targets for a range of programs across the health system.

In addition to these guidelines, funded organisations are expected to comply with all other applicable policies.

Ensure you are reading the most recent version of this document on the [Policy and funding guidelines webpage](https://www.health.vic.gov.au/policy-and-funding-guidelines-for-health-services) <https://www.health.vic.gov.au/policy-and-funding-guidelines-for-health-services>, as it may be updated throughout the year.

References to particular statutes, regulations or contracts are descriptive only.

If there are inconsistencies or ambiguities between these guidelines and any legislation, regulations and contractual obligations with the State of Victoria (acting through the department or the Secretary of the department), the legislative, regulatory and contractual obligations take precedence.

Each funded organisation should refer to the relevant statute, regulation or contract to ascertain all details of its legal obligations. If any funded organisation has specific queries regarding its legal obligations, it should seek independent legal advice.

Service agreements are contractual arrangements between entities for the delivery of services in the community, funded by the department. For entities funded through a service agreement, visit the [service agreement website](https://fac.dhhs.vic.gov.au/service-agreement) <https://fac.dffh.vic.gov.au/service-agreement> for funding information and activity tables that underpin service agreements.

Those entities funded through a service agreement can search for activity descriptions by visiting the [Department of Families, Fairness and Housing and Department of Health activity search](https://providers.dffh.vic.gov.au/families-fairness-housing-health-activity-search) <https://providers.dffh.vic.gov.au/families-fairness-housing-health-activity-search>.

## Terminology

The term ‘funded organisations’ relates to all entities that receive departmental funding to deliver services, unless specified otherwise.

For the purposes of the *Policy guide*, the term ‘health services’ relates to public health services, denominational hospitals, public hospitals and multipurpose services, as defined by the *Health Services Act 1988*, regarding services provided within a hospital or a hospital-equivalent setting, unless otherwise specified.

The term ‘community service organisations’ refers to registered community health centres, local government authorities and non-government organisations that are not health services.

The *Policy guide* is also relevant for Ambulance Victoria, Health Purchasing Victoria trading as HealthShare Victoria (HealthShare) and the Victorian Institute of Forensic Mental Health (known as Forensicare). The *Policy guide* specifies where aspects are relevant for these organisations.

Where the term ‘department’ is used, it refers to the Department of Health, unless otherwise specified.

Part 1: Operational and service delivery policy

# National programs

## Nationally Funded Centres Program

The Nationally Funded Centres Program aims to ensure optimal access to certain high-cost, low-volume technologies and procedures. It is available for all Australians, with program funding provided by state and territory governments.

Health services providing Nationally Funded Centres Program services are funded based on estimated annual activity that is linked to an annually indexed unit price. Funding is endorsed by the Health Chief Executives Forum and adjusted after the financial year to reflect actual activity.

Formal reviews of Nationally Funded Centres Program services continue in 2024–25.

In Victoria, Alfred Health, The Royal Children’s Hospital, Monash Health and St Vincent’s Hospital host Nationally Funded Centres Program services.

## Highly specialised therapies

As set out by the 2020–25 National Health Reform Agreement, highly specialised therapies (which include cell and gene therapies) are jointly funded by the Commonwealth, and state and territory governments, following approval from the Commonwealth’s Medical Services Advisory Committee. Highly specialised therapies are provided at selected public hospitals.

The *National framework for the assessment, funding and implementation of high cost, highly specialised therapies and services* has been developed with the collaboration of the Australian Government and all states and territories to ensure a nationally consistent approach to implement, monitor and evaluate these therapies.

Approved highly specialised therapies and provider sites in Victoria are the:

* CAR-T cell therapy Kymriah® to treat relapsing/refractory acute lymphoblastic leukaemia in children and young adults up to the age of 25 years at The Royal Children’s Hospital, Peter MacCallum Cancer Centre and Alfred Health
* CAR-Tcell therapy Kymriah® to treat relapsing/refractory diffuse large B-cell lymphoma, primary mediastinal B-cell lymphoma and transformed follicular lymphoma in adults at the Peter MacCallum Cancer Centre and Alfred Health
* CAR -T cell therapy Yescarta® to treat relapsing/refractory diffuse large B-cell lymphoma, primary mediastinal B-cell lymphoma and transformed follicular lymphoma, and high-grade B-cell lymphoma in adults at the Peter MacCallum Cancer Centre and Alfred Health
* CAR-T cell therapy Tecartus® to treat relapsed/refractory mantle cell lymphoma at the Peter MacCallum Cancer Centre and Alfred Health
* gene therapy Luxturna® to treat inherited retinal dystrophies in children and adults at The Royal Victorian Eye and Ear Hospital
* immunotherapy Qarziba® to treat high-grade paediatric neuroblastoma at The Royal Children’s Hospital and Monash Children’s Hospital.

To ensure the safe and high-quality provision of approved highly specialised therapies for specified clinical indications that are implemented in Victoria, the department will appoint provider sites. An expression of interest process will be conducted when more than one provider site is required to meet anticipated patient demand. Provision of these therapies is limited to sites that meet specific accreditation and capability requirements.

The department has developed the *Highly specialised therapy supply agreements checklist* for Victorian public health services to support department-endorsed health services providing approved highly specialised therapies to develop and execute supply agreements with a therapy manufacturer/distributor. This aligns with the existing devolved governance approach to delivering health services in Victoria’s public hospital system. The department provides this checklist to endorsed health services as required.

Health services delivering highly specialised therapies will be required to report cost data annually, 11 weeks after the end of the financial year, via a supplied template. Highly specialised therapy costs submitted to the department will enable timely annual reconciliation (including for interstate patient activity) and prior-year assessment/recall estimations. This is in line with the requirements of the National Health Reform Agreement in order to meet Victoria’s submission obligations to the Administrator of the National Health Funding Pool.

# Ambulance Victoria

The Victorian Government funds clinically necessary transport for concession patients, primarily pensioners and Health Care Card holders. The government provides this funding to Ambulance Victoria, which is responsible for delivering these transports.

Ambulance Victoria’s Membership Subscription Scheme insures patients against Ambulance Victoria ambulance transport costs. Ambulance Victoria also receives fees from third parties that are responsible for transporting patients using Ambulance Victoria services, including:

* the Department of Veterans’ Affairs for eligible veterans
* the Transport Accident Commission for eligible Victorians involved in a transport accident
* WorkSafe Victoria for eligible Victorians involved in a workplace accident
* public healthcare services
* private healthcare facilities
* general patients who are not eligible under any of the other criteria and do not have a membership subscription.

## Fee structure

Ambulance Victoria’s fees for each of its service lines are based on the average cost of delivering each of these services. The average cost of service recognises all direct and indirect costs of actual service delivery, including paramedics, transport platform, contribution to depreciation (vehicle replacement costs) and associated corporate costs.

Fees for ambulance services can be found on [Ambulance Victoria’s Fees and Terms webpage](https://www.ambulance.vic.gov.au/membership/fees-terms/) <https://www.ambulance.vic.gov.au/membership/fees-terms>.

Several other services provided through Ambulance Victoria will be funded directly or included as a loading in the above costs (for example, adult retrieval services).

In addition to the funding provided directly to Ambulance Victoria, the government also provides funding to Victoria’s health services for the interhospital transfer of patients (for example, the transfer of patients between health services or between the different campuses of a health service). Health services have discretion as to which patient transport provider they choose to engage to transfer non-concessional patients – either from Ambulance Victoria or a range of private non-emergency patient transport (NEPT) providers that are licensed by the department.

Timely payment for ambulance transports provided through Ambulance Victoria is expected under normal commercial terms.

# Acute inpatient services

## Acute admitted services

In Victoria, health services are funded to provide 24-hour acute admitted care. Some health services provide specialist admitted care services (for example, intensive care) or designated statewide services (for example, trauma or transplantation).

Health services are responsible for:

* ensuring the health service has the capability and capacity to deliver services described in its Statement of Priorities (SOP), with the ability to transfer patients to another health service if a patient requires care outside of the health service’s scope of delivery
* the medical, nursing, allied health and personal care, hotel services (for example, nutrition, bed and clean facilities), the required clinical support services (for example, pharmacists and medicines, blood management and blood products, and pathology) and other support services (for example, infection prevention, language services, clinical trial support and culturally safe environments for Aboriginal people)
* providing prosthetics, devices, medicines and wound care consumables prescribed during admission and, if required, on discharge from the health service
* the availability of suitably credentialed and privileged staff, and for managing contracted or brokered staff or services
* ensuring equitable access to services and treating each patient based on their clinical need
* offering services in the person’s home when safe, appropriate and consistent with patient preference
* offering services via video-telehealth in line with admission policy, with the required cultural and linguistic support, and consistent with patient preference
* ensuring there is discharge planning and service coordination with other health service programs (for example, rehabilitation and other Health Independence Program services) and community-based services, in the form of a timely clinical handover that includes a complete and current medication list
* offering services, such as patient pathways and electronic or telephone advice lines, to support referring clinicians, which may reduce demand for admitted services
* ensuring there are robust clinical governance structures and processes in place
* ensuring that no charges are raised for any service during the admission, and that charges raised on discharge are only those included in the National Health Reform Agreement
* meeting all requirements for claiming monies through private health insurance, Medicare, the Department of Veterans’ Affairs, the Transport Accident Commission, WorkSafe Victoria and for patients who are ineligible for Medicare
* ensuring there are fit-for-purpose facilities to:
	+ support the treatment of inpatients by multidisciplinary teams
	+ reduce the risk of errors, accidents and hospital-acquired conditions
	+ ensure the safety of patients, staff, visitors, volunteers and students
	+ ensure the privacy and dignity of patients, their carers and family
	+ enable isolation or transfer of patients with infectious conditions or who are immunocompromised
	+ support the care of terminally ill and dying patients
	+ support home-delivered admitted care.

# Acute specialist services

## Victorian Perinatal Autopsy Service

The Victorian Perinatal Autopsy Service (VPAS) is a statewide service that provides perinatal autopsies and investigations and related support, care and resources.

The service is fully funded and available for Victorian families who have experienced pregnancy loss from 20+ weeks’ gestation and have been either public or private patients. Families are not charged for autopsies for registered perinatal deaths (this includes stillborn babies delivered from 20 weeks’ gestation, or for infants who die before 28 days of life).

The Royal Women’s Hospital provides:

* auspicing and governance of VPAS
* centralised coordination of autopsy referrals and transportation of deceased babies from external health services
* provision of consistent, family information regarding the process of arranging a perinatal autopsy and how to access bereavement support and advice
* training and education for clinical staff involved in supporting families for pathways to still born baby autopsies.

For comprehensive information on how to access VPAS visit the [VPAS website](https://www.thewomens.org.au/health-professionals/victorian-perinatal-autopsy-service) <https://www.thewomens.org.au/health-professionals/VPAS>.

Autopsies are provided by three of the Maternity Capability Level 6 health services and their respective pathology service providers, including:

* The Royal Women’s Hospital and their pathology provider, The Royal Children’s Hospital
* Monash Health
* Mercy Hospital for Women and their pathology provider, Austin Pathology.

These services are then reimbursed at an agreed rate.

All public health services:

* are expected to use VPAS
* are allocated a VPAS autopsy site which health services can find out more about at the [Referrals to VPAS webpage](https://www.thewomens.org.au/health-professionals/victorian-perinatal-autopsy-service/referrals-to-vpas/) <https://www.thewomens.org.au/health-professionals/victorian-perinatal-autopsy-service/referrals-to-vpas>
* should offer and explain the importance of a perinatal autopsy, and pathological examination of the placenta by a senior clinician in all cases of perinatal death.

Perinatal autopsy findings directly inform and support the Consultative Council on Obstetric and Paediatric Mortality and Morbidity (CCOPMM) to provide expert advice on maternal and perinatal outcomes. Autopsy investigations help improve maternity and newborn care and education, by improving the quality of data on perinatal cause of death, and undertaking appropriate audits, investigations and classification.

Private health services are also encouraged to use the service.

## Infant Hearing Screening Service

The Victorian Infant Hearing Screening Program (VIHSP) provides a statewide newborn hearing screening service to babies born at all Victorian maternity hospitals. Screening is provided within the first weeks of life, as early detection and intervention improves outcomes for babies with hearing loss.

The service is provided by The Royal Children’s Hospital in public, private, metropolitan and regional maternity services.

For more information, as well as guidelines for referral to the Victorian Infant Hearing Screening Program visit the [VIHSP website](https://www.rch.org.au/vihsp/) <https://www.rch.org.au/vihsp/>.

## Organ and tissue donation

The Australian Organ and Tissue Donation Authority, in partnership with the department, funds the operational costs of DonateLife Victoria (an organ donation organisation) and health services to employ clinical staff dedicated to organ and tissue donation. Medical and nursing organ and tissue donation specialists are based at several metropolitan and regional health services. The Australian Organ and Tissue Donation Authority also provides support funding for health services to cover the extra costs associated with organ donation.

For more information, visit [Organ and tissue donation](https://www.health.vic.gov.au/patient-care/organ-and-tissue-donation) <https://www.health.vic.gov.au/patient-care/organ-and-tissue-donation>.

## Blood products supply funding

Funding for the Victorian blood and blood products supply will continue as per the *National Blood Agreement* (2003), using the Commonwealth–state government funding model of 63% and 37%, respectively. In compliance with the supply and funding arrangements in the agreement, sufficient volumes of blood and blood products will be available to public and private Victorian health services in 2024–25. This supply plan has been negotiated between the government, the National Blood Authority and the Australian Red Cross Lifeblood (previously known as the Australian Red Cross Blood Service).

Access to blood and blood products will be guided by the *Australian health provider* *blood and blood products charter*, which continues to be implemented with health providers nationally in 2024–245 The National Stewardship Expectations for the Supply of Blood and Blood Products is available from the [National Blood Authority website](https://www.blood.gov.au/) <https://www.blood.gov.au>.

Intravenous immunoglobulin is made available through the supply plan to health services for uses that have been agreed, according to the *Criteria for the clinical use of immunoglobulin in Australia*. Intravenous immunoglobulin is also available for direct purchase by health services for uses that have not been included in the criteria, due to insufficient evidence of efficacy, as demonstrated by the literature or specialist clinical consensus.

For more information about intravenous immunoglobulin, visit the [Criteria for the clinical use of immunoglobulin in Australia webpage](https://www.criteria.blood.gov.au/) <https://www.criteria.blood.gov.au/>.

Subcutaneous immunoglobulin is available to health services through the supply plan for agreed uses. The department is funding hospitals for patients being treated at home with self-administered subcutaneous immunoglobulin. For more information about access, visit the [Subcutaneous immunoglobulin (SCIg) access program](https://www.health.vic.gov.au/patient-care/subcutaneous-immunoglobulin-scig-access-program) <https://www.health.vic.gov.au/patient-care/subcutaneous-immunoglobulin-scig-access-program>.

Normal immunoglobulin is subject to national governance arrangements. For more information about normal immunoglobulin, visit [Access to Normal Human Immunoglobulin (NHIg) in Australia](https://www.blood.gov.au/blood-products/immunoglobulin-products/normal-human-immunoglobulin-nhig) <https://www.blood.gov.au/blood-products/immunoglobulin-products/normal-human-immunoglobulin-nhig>.

There is an ongoing commitment to safe transfusion practice in health services through the Blood Matters Program. For more information, visit [Blood and blood products](https://www.health.vic.gov.au/patient-care/blood-and-blood-products) <https://www.health.vic.gov.au/patient-care/blood-and-blood-products>.

## Genetics outpatient program

Public genetic outpatient services in Victoria provide a range of clinical consultations, including appropriate counselling and clinically indicated testing. This program does not fund genetic or genomic tests for admitted patients, which are considered separately, in line with the National Funding Model for acute admitted services. Genetics and genomics are becoming more integrated with routine healthcare in both acute and outpatient settings.

Funding models have been reviewed for clinical genetic outpatient settings (tier 2 class 20.08), with the transition to activity-based funding, in line with the National Funding Model policy and requirements.

This program funds access to public clinical genetic services with referral from a general practitioner (GP) or medical specialist, but self-referral may occur.

Public clinical genetic services are provided through metropolitan hubs at:

* Victorian Clinical Genetics Services
* The Royal Melbourne Hospital
* The Royal Women’s Hospital
* Monash Medical Centre Clayton
* Austin Hospital Heidelberg
* Mercy Hospital for Women Heidelberg
* Alfred Health.

The hub sites provide periodic clinical outreach clinics to other metropolitan, rural and regional centres.

Accredited laboratories provide genetic and genomic testing. Publicly funded testing can only be requested by publicly funded clinical genetic services. If a genetic or genomic test is not available in Victorian-accredited laboratories, it can be requested from an interstate or overseas-accredited laboratory.

Funding to support the Victorian Government’s initiative for genomic sequencing for children and adults with rare diseases and undiagnosed conditions is ongoing. This budget commitment facilitates access to a potential clinical diagnosis and streamlines the diagnostic process for patients. The funding supports access to genomic sequencing that is not funded under Medicare. The clinical care is provided at all sites.

Activity data is to be reported to the department to inform funding and policy decisions. It is expected that publicly funded clinical genetic services, where appropriate, will redirect savings to address growing demand.

Participating services must upload aggregated genetic outpatient clinic activity on the Agency Information Management System (AIMS) S10 form and report costs to the Victorian Cost Data Collection (VCDC). Genetics clinics are also required to meet national patient-level, data-reporting requirements through the Victorian Integrated Non-Admitted Health (VINAH) minimum dataset reporting platform or Non-Admitted Data Collection (NADC).

For more information, visit [Public genetic services in Victoria](https://www.health.vic.gov.au/patient-care/public-genetic-services-in-victoria) <https://www.health.vic.gov.au/patient-care/public-genetic-services-in-victoria>.

## Pharmaceuticals

Health services must provide pharmaceuticals at no charge to their admitted public and private patients. Health services participating in the programs outlined below can access reimbursements for pharmaceuticals and charge patient co-payments, where applicable.

### Pharmaceutical reforms

Pharmaceutical reforms are designed to make it safer, easier and more convenient for patients to receive adequate medication, and to put public health services on a more equal footing with private hospitals.

Health services participating in the *Pharmaceutical reform agreement* have access to the Commonwealth-funded Pharmaceutical Benefits Scheme and the Repatriation Schedule of Pharmaceutical Benefits for non-admitted and admitted patients on discharge, as well as a Commonwealth-subsidised list of pharmaceuticals for same-day admitted patients requiring chemotherapy.

These health services must incorporate the Australian Pharmaceutical Advisory Council’s guidelines into their practice, to achieve the continuum of quality use of medicines between the health service and the community.

For more information about pharmaceutical reforms, visit the [Pharmaceutical Benefits Scheme in Victoria’s public hospitals](https://www.health.vic.gov.au/patient-care/pharmaceutical-benefits-scheme-in-victorias-public-hospitals) <https://www.health.vic.gov.au/patient-care/pharmaceutical-benefits-scheme-in-victorias-public-hospitals>.

### Highly Specialised Drugs Program

The Highly Specialised Drugs Program provides Commonwealth funding for certain specialised medications that are prescribed for chronic conditions and are supplied through health service pharmacies. The highly specialised drugs on the Community Access Program that are prescribed in public hospitals can also be supplied to patients through community pharmacies.

For health services to be eligible for funding, the patient must:

* attend a hospital
* be same-day admitted or non-admitted
* be under appropriate specialised medical care
* meet the specific clinical indications for each medication
* be an Australian resident (or other eligible person).

The prescribing doctor must be affiliated with the specialised hospital unit. Health services are reimbursed for the medicine supplied, less a patient co-payment, via claims submitted to Medicare.

For more information, visit the [Highly Specialised Drugs Program](https://www.health.vic.gov.au/patient-care/highly-specialised-drugs-program) <https://www.health.vic.gov.au/patient-care/highly-specialised-drugs-program>.

### Direct-acting antiviral hepatitis C treatments

The Commonwealth listed several direct-acting antivirals for treating hepatitis C on both the Pharmaceutical Benefits Scheme and the Highly Specialised Drugs Program on 1 March 2016. Health services have access to both programs. Unlike Highly Specialised Drugs Program prescriptions, prescriptions approved under the Pharmaceutical Benefits Scheme have the advantage of being able to be dispensed in both hospital and community pharmacies.

For more information, visit [Hepatitis C medicines: fact sheet for public and private hospital prescribers and dispensers](https://www.pbs.gov.au/info/publication/factsheets/hep-c/hepc-factsheet-hospital-prescribers-dispensers) <https://www.pbs.gov.au/info/publication/factsheets/hep-c/hepc-factsheet-hospital-prescribers-dispensers>.

## Public fertility care

Public fertility care provides eligible Victorians with access to a broad range of assisted reproductive treatments and support, including access to donor services through the public egg and sperm bank at The Royal Women’s Hospital.

The goal of the program is to improve access to fertility care for Victorians, who are underserved or have limited access to the existing private services. In particular, this includes people on a low income, rural and regional Victorians, single people, LGBTIQA+ Victorians, people who require testing for monogenic conditions and people requiring fertility preservation for medical reasons, such as cancer treatment.

Victorian public fertility care services are led by Monash Health and The Royal Women’s Hospital from hubs in Parkville and Clayton Satellite sites delivered in partnership with other health services across the state are operating at Epping, Sunshine, Bendigo, Mildura, Heidelberg, Warrnambool, Shepparton, Ballarat and Geelong, providing care closer to home.

Victorians who wish to access public fertility care services will require a Medicare card and a referral from their GP or relevant specialist, which is sent to one of the participating health services.

The clinical access criteria are that:

* eggs to be fertilised must be 42 years or younger at the time of treatment
* there is a maximum of two stimulated treatment cycles of in vitro fertilisation (IVF) or intracytoplasmic sperm injection (ICSI) per person per lifetime.

Providers are required to report on output performance measures through key performance indicators on a quarterly basis. The department will commence a comprehensive evaluation of the service in 2024–25 to understand the impact and outcomes of the initiative and support its continued improvement.

For more information, visit [Public fertility care services](https://www.health.vic.gov.au/public-health/public-fertility-care-services) <https://www.health.vic.gov.au/public-health/public-fertility-care-services>.

# Mental health and wellbeing services

## Transforming the mental health and wellbeing system

The mental health and wellbeing system is being transformed around a community-based model of care. In this model, people receive most services locally and in the community throughout Victoria, close to their families, carers, supporters and networks. The reformed system will also have a greater focus on preventing mental distress and promoting wellbeing for all people in Victoria, along with embedded diversity, equity and inclusion.

The Royal Commission into Victoria’s Mental Health System set out a 10-year reform agenda to achieve this transformation, which will be implemented in three successive phases of activity. In 2024–25, a new phase of implementation will focus on reform priorities that translate policy and planning into systemic, operational change.

The implementation approach strikes a balance between pace and scale, and the urgency of addressing substantial current challenges.

The following sections provide guidance for existing and new policies and programs to fulfil immediate service delivery requirements, build new capabilities required, and to lay the groundwork or building blocks to sustain broader reform efforts over multiple years.

### Foundations of a new integrated and responsive system

#### Mental Health and Wellbeing Act 2022

The *Mental Health and Wellbeing Act 2022* (the Act) came into effect on 1 September 2023, replacing the *Mental Health Act 2014.*

The Act resets the legislative foundations to support transformation of Victoria’s mental health system. The Act promotes good mental health and wellbeing for all Victorians and supports the delivery of services that are responsive to the needs and preferences of Victorians.

New rights-based objectives and principles put the views, preferences and values of people living with mental illness or psychological distress, families, carers and supporters at the forefront of service design and delivery. It also establishes a new opt-out model for access to non-legal mental health advocacy support.

The Act also supports the establishment of new entities reforming the system architecture, including a new Mental Health and Wellbeing Commission and a new Chief Officer for Mental Health and Wellbeing.

Implementing the Act and supporting the sector is a priority. The department is supporting implementation of the Act across the sector by:

* engaging Act Implementation Leads within area mental health services to lead local planning and support to transition to the new legislation
* providing an interactive e-learning training course that introduces the mental health and wellbeing workforce to key aspects of the new Act, the differences between it and *the Mental Health Act 2014*, and the ways the new Act will apply to their work. Further learning and development activities will be rolled out over time, to embed the new legislation and to respond to insights from Act Implementation Leads and the broader workforce
* providing guidance materials and establishing an online helpdesk to receive and respond to sector enquiries about the Act.

The department is also partnering with several organisations to develop materials and provide support for consumers, families, carers and supporters, and the wider mental health and wellbeing sector, to understand the new legislation.

#### Mental Health and Wellbeing Commission

The Mental Health and Wellbeing Commission commenced on 1 September 2023, taking over the functions of the Mental Health Complaints Commissioner.

The new Commission will hold government to account for the performance of the system, monitor the implementation of the Royal Commission’s recommendations, and use its complaints and oversight functions to monitor, inquire and report on system-wide quality and safety.

The Commission is an independent statutory body reporting directly to the Victorian Parliament. It is led by a Chair Commissioner and three Commissioners, with at least one Commissioner being a person with lived experience of mental illness or psychological distress, and one being a family member, carer or supporter.

The Commission has quality, oversight and complaints-handling functions that extend to all mental health and wellbeing service providers. The Act makes clear that the Commission may consider complaints about service provider failure to comply with obligations in respect of the Act’s principles.

The Commission will be able to consider, for the first time, complaints from families, carers and supporters in relation to their experiences.

The Commission also has the power to hold own-motion inquiries – regardless of whether a complaint has been made. These inquiries have the potential to identify systemic issues and opportunities for quality improvement.

#### Interim regional bodies

Eight interim regional bodies (IRBs) have been established to provide advice to the department, as it plans, develops, coordinates, funds and monitors a range of mental health and wellbeing services in each region. The IRBs are the first step in a phased transition towards regional planning and governance for mental health.

The IRBs provide a platform for strong community participation and greater engagement at a regional level, and collaboration and cooperation across mental health and wellbeing services, and the broader health sector, including services funded by the Victorian Government and the Australian Government, and Primary Health Networks (PHNs). They advise the Department of Health on the mental health and wellbeing needs for their region, with the key roles of:

* building trusted relationships with service providers and establishing strong community participation processes
* developing a clear understanding of the communities across the region and what they see as the key needs and opportunities for future mental health regional governance
* Providing advice to government on issues and opportunities in their region.

The interim regional bodies do not play a role in the commissioning or monitoring of services.

The Act sets out that Regional Mental Health and Wellbeing Boards may be established to take the place of IRBs. Next steps for mental health regional governance are being developed.

#### Outcomes and performance framework

The Royal Commission recommended developing a new mental health and wellbeing outcomes framework (recommendation 1) and a new approach to service and system performance and accountability (recommendation 49). The framework will be aligned to the whole-of-government outcomes architecture.

The *Mental health and wellbeing outcomes and performance framework* (the framework) articulates what a high-quality, contemporary mental health and wellbeing system looks like. It represents a public commitment to the transformed system, as articulated by the Royal Commission. It will provide a mechanism for measuring the performance and impact of individual services and the whole system.

The framework, along with other important enablers, will underpin a value-based commissioning approach for the mental health and wellbeing system. Once endorsed and published, the framework will commence with an initial suite of measures that draws from existing data assets, has demonstrated known performance trends, and supports the department with a range of existing reporting requirements (such as statutory and national agreements).

The first year of implementation will run in parallel to the current *Mental health performance and accountability framework*, enabling services to continue reporting and using data to inform practice improvements, while the initial implementation of the framework takes place.

Once published, please visit the [mental health and wellbeing outcomes performance framework](https://www.health.vic.gov.au/mental-health-wellbeing-reform/a-new-mental-health-and-wellbeing-outcomes-and-performance-framework) <https://www.health.vic.gov.au/mental-health-wellbeing-reform/a-new-mental-health-and-wellbeing-outcomes-and-performance-framework> for implementation updates and links to the framework.

#### Statewide mental health and wellbeing service and capital plan

The Royal Commission found structural issues across the Victorian mental health and wellbeing system, including inadequate system planning. It concluded that the system has not benefited from consistent, integrated and sophisticated planning, and that limited demand forecasting had contributed to fragmented services and inequitable distribution of investment.

Effective system planning is critical to understanding and anticipating the mental health needs of Victorians and to ensure investment is directed where it is most needed.

Due for release in 2024, the inaugural *Statewide mental health and wellbeing service and capital plan* (statewide plan) responds to recommendation 47 of the Royal Commission.

It will support the Victorian Government’s efforts to transform the mental health and wellbeing system and to deliver world-leading outcomes for Victorians by:

* guiding prioritisation of investment and innovation, realising the Royal Commission’s vision
* guiding how more treatment, care and support can be shifted to community-based mental health and wellbeing services and other more appropriate settings
* establishing evidence-informed approaches to understanding what services people need and where they need them
* guiding investment decisions to support building physical infrastructure that is fit for purpose and welcoming
* providing a framework to guide and support the regional and entity-level service and capital planning.

The inaugural statewide plan focuses planning for level 4 Local Mental Health and Wellbeing Services, and level 5 Area Mental Health and Wellbeing Services. Future updates to the statewide plan will consider a broader range of existing and emerging services, including:

* specialist alcohol and other drugs services
* forensic mental health services
* suicide prevention and response services
* mental health and wellbeing promotion and prevention
* mental health and wellbeing services in broader system settings, such as in education, correctional services and housing.

#### Age streaming

Services are being reorientated around two age-based systems: one for infants, children and young people (0–25 years), and the other for adults and older adults (26+ years) (Figure 1).

This is so that:

* treatment, care and support are developmentally appropriate.
* there is equity in access, regardless of age
* there are flexible age-based transitions between streams and across services.

Figure 1: Mental health and wellbeing services across two age-based streams

The figure shows the two age-based systems set out in two boxes: infant, child and youth mental health and wellbeing system (0-25) and the other box is labelled ‘adult and older adult mental health and wellbeing system (26+)’.

Within the infant, child and youth mental health and wellbeing system (0-25), there are 2 service streams: the infant, child and family mental health and wellbeing service stream (0-11) and the youth, mental health and wellbeing service stream (12-25).



Source: *Royal Commission into Victoria’s Mental Health System final report*, vol. 1, p. 297.

The following key reform initiatives cut across service levels and will continue to progress implementation of a responsive and integrated system in 2024–25.

#### Service catchments

Mental health service catchments that have traditionally determined access to mental health services are planned to be reviewed, in line with recommendation 3.4 of the Royal Commission. This aims to remove rigid catchments for service delivery based on a person's place of residence.

While service delivery catchments will no longer be a feature of the system, clear and effective planning for catchments or areas is essential to supporting service planning and delivery. A review of service planning areas is underway in 2024 and will include engagement with services in 2024.

#### Core functions

The Royal Commission recommended that all Local Mental Health and Wellbeing Services and Area Mental Health and Wellbeing Services deliver three core functions. At a high level, these are defined as:

* integrated treatment, care and support
* helping people find and access treatment, care and support, and responding to crises
* supports for primary and secondary service providers.

Local Mental Health and Wellbeing Services and Area Mental Health and Wellbeing Services should have commenced planning or delivery for some aspects of these core functions. The government will engage with mental health and wellbeing service providers in the next 12 months to progress design and plan for the delivery of the core functions.

This will be a multiyear implementation process. Note that some core functions are already embedded and well understood across the sector, while others present new ways of working and require further design and planning.

#### Access policy and triage guidelines

A new access policy and updated triage guidelines are being developed. The access policy provides consumers, carers, professionals and service providers with a consistent, responsive, integrated and person-led approach to accessing mental health and wellbeing services across Victoria.

The access policy describes expectations of services to apply an approach of ‘how can we help?’ and ‘no wrong door’. Services will use these approaches to deliver the three front-end components of access and navigation support, initial support discussions and comprehensive needs assessment and planning discussions. These are described further in the components of the Victorian mental health and wellbeing system.

The current triage guidelines have been in place since 2010. The Royal Commission found that these guidelines no longer reflect contemporary best practice. A revised mental health access and intake scale will support Victorians across the lifespan to receive timely treatment, care and support at the required level of intensity.

The access policy and updated triage guidelines will outline the principles, components of the service system, access, intake and triage functions, data collection and reporting for mental health and wellbeing services.

The initial draft of the access policy and updated triage guidelines was developed in 2023, with further testing and refining to be undertaken over the next two years with Local Mental Health and Wellbeing Services and Area Mental Health and Wellbeing Services. The access policy and triage guidelines will then be finalised, and sector-wide rollout is expected in 2026.

### Six levels of an integrated and responsive system

The future mental health and wellbeing service system will consist of six levels (see Figure 2). Each level will be connected with the next. This will provide a system of staged care, with service providers working together to create a responsive, inclusive and integrated mental health and wellbeing system. This includes primary and secondary care and related services, Local Mental Health and Wellbeing Services, Area Mental Health and Wellbeing Services, and statewide services.

Figure 2: Mental Health and Wellbeing six-level system



Source: *Royal Commission into Victoria’s Mental Health System final report*, vol. 1, p. 297.

The following sections set out the 2024–25 policy and further reform activities for levels 4, 5 and 6 service levels and alcohol and other drug services.

## Level 4: Local Mental Health and Wellbeing Services

Level 4 of the mental health and wellbeing system comprises three age-based systems to support people’s needs. Local mental health and wellbeing services are currently being established for adults, older adults, and infants and children. Local Mental Health and Wellbeing Services will be formally networked with Area Mental Health and Wellbeing Services, enabling a smooth transition between different levels of treatment and support.

### Mental Health and Wellbeing Locals – adults and older adults (26+)

Mental Health and Wellbeing Locals (also referred to as Local Services) provide integrated treatment, care and wellbeing support to adults and older adults (aged 26 years and above) experiencing mental health concerns or psychological distress, and to their family, carers and supporters. This includes people who experience mental health and substance use concerns at the same time.

In October 2022, the first six Mental Health and Wellbeing Locals began operating in the areas of Benalla–Wangaratta–Mansfield, Brimbank, Frankston, Greater Geelong–Queenscliffe, Latrobe and Whittlesea.

The first fist six Local Services are also delivering social prescribing trials. Local Connections is a social prescribing initiative that aims to reduce loneliness and social isolation and improve mental health and wellbeing.

In December 2023, additional Mental Health and Wellbeing Locals commenced in Dandenong, Shepparton, Melton, Mildura, Lilydale, Bendigo–Echuca and Orbost–Bairnsdale.

Mental Health and Wellbeing Locals providers are expected to adhere to the *Local Adult and Older Adult Mental Health and Wellbeing Service: service framework* (service framework)[[1]](#footnote-2) developed and published by the department in 2022.

The service framework outlines the objectives, service features and functions, service model components, and the workforce, data reporting and operational requirements for the full functionality of the Mental Health and Wellbeing Locals. It reflects the findings of the Royal Commission and promotes the overall service philosophy of ‘how can we help?’.

It was developed in consultation with people with lived and living experience, and with technical and clinical advice from the mental health and wellbeing sector. The service framework is a working document that will be adjusted and refined as the service model matures.

### Local Services – young people (12–25)

The Royal Commission envisaged headspace services would be the primary provider of Local Mental Health and Wellbeing Services for young people aged 12–25. The Commonwealth funds headspace services through PHNs. The department will strengthen partnerships between headspace centres and Infant, Child and Youth Area Mental Health and Wellbeing Services by engaging with key stakeholders including headspace providers, Infant, Child and Youth Area Mental Health and Wellbeing Services, PHNs, headspace National and the Commonwealth to design step-up and step-down referral pathways, shared staff and infrastructure, and in the future, co-location between headspace services and Infant, Child and Youth Area Mental Health and Wellbeing Services. The department has also committed to enhancing the provision of clinical support to young people accessing headspace services through Infant, Child and Youth Area Mental Health and Wellbeing Services in-reach.

This is being led by the department with the Australian Government Department of Health.

### Children’s Mental Health and Wellbeing Locals – infants and children (0–11)

Three new Children’s Health and Wellbeing Locals (formally known as Hubs) have been established in the Department of Families, Fairness and Housing regions of Brimbank–Melton, Southern Melbourne and Loddon. The Children’s Health and Wellbeing Locals provide access to multidisciplinary paediatric health, mental health and family services for children aged 0–11 years who are experiencing developmental, emotional, relational and behavioural challenges, and their families.

In addition to these services, Children’s Health and Wellbeing Locals provide in-person group-based parenting sessions, as part of the continuum of parenting programs recommended by the Royal Commission.

The Children’s Health and Wellbeing Locals commenced delivering services in 2023. Their service delivery is guided by the service framework prepared by the Department of Health and local models of care developed by each Children’s Health and Wellbeing Local. These services are delivered in partnership with the Commonwealth through the Bilateral Agreement on Mental Health and Suicide Prevention (2022), as part of the Commonwealth’s national investment in Head to Health Kids.

## Level 5: Area Mental Health and Wellbeing Services

Area Mental Health and Wellbeing Services are being transformed to provide more capacity and expanded services.

### Area Mental Health and Wellbeing Service transformation

This transformation has been focused on eight actions for Area Mental Health and Wellbeing Services. These actions are:

* embedding lived experience in leadership, design and delivery
* establishing Area Mental Health and Wellbeing Service Streams (the Infant, Child and Youth Stream, and the Adult and Older Adult Stream)
* expanding core clinical services
* delivering more clinical activity outside of standard business hours
* implementing primary and secondary consultation across the system, and developing models of shared care
* forming partnerships with non-government organisations that provide wellbeing supports
* integrating mental health and alcohol and other drug treatment, care and support
* supporting the new Adult and Older Adult Local Mental Health and Wellbeing Services.

While the following eight actions remain important, it is expected that Area Mental Health and Wellbeing Services may narrow their focus to a subset of these actions, aligned to the service’s priorities and circumstances in 2024–25.

#### Embedding lived experience in leadership, design and delivery

One of the Royal Commission’s guiding principles was for people with lived and living experience (LLE) of mental health challenges, substance use and addiction (consumers, families, carers, supporters and communities) to be central to planning and delivery of mental health services. The Royal Commission envisaged LLE to be central to the decision-making processes, including:

* service planning, design, delivery and evaluation
* employed in senior leadership roles, including governance and boards
* supported to thrive in these roles.

This will ensure that the mental health and wellbeing system is designed by the people who access it. It will also ensure that services continue to be improved based on people’s experiences and become safer and more effective.

To help achieve this, Area Mental Health and Wellbeing Services will:

* expand lived experience system and policy leadership roles, consumer and family/carer consultants, and peer support workforces. Ensuring diversity across LLE roles, which reflect the local community
* services will ensure people with lived experience who work from a LLE perspective are represented across senior management and executive teams, including discipline leads, management, and executive roles
* ensure the expanding lived experience workforce is provided access to discipline-specific supports and professional development, such as discipline-specific supervision, communities of practice and relevant training
* review organisational governance structures and membership to ensure meaningful number of LLE positions are embedded across the strategic and operational planning, design, delivery and evaluation of each service. This will ensure LLE perspectives are meaningfully included in decision making around models of care, capital works and allocation of funding
* centre LLE leadership in the evaluation of services and identification of continuous improvement priorities and actions. This includes the strengthening of feedback loops between the service, consumers, families, carers and supporters, and monitoring lived experience outcome measures within local outcomes frameworks
* increase service capability and use of co-design and co-production with consumers, families, carers, and supporters, to ensure service improvements are informed by lived experience perspectives. This includes provision of training for people with lived experience to participate in service improvement projects.

The department will work with services to support plans to embed lived experience leadership and workforce throughout 2024–25.

#### Establishing two Area Mental Health and Wellbeing Service Streams (the Infant, Child and Youth Stream, and the Adult and Older Adult Stream)

Area Mental Health and Wellbeing Services comprise 22 Adult and Older Adult Area Mental Health and Wellbeing Services, and a minimum of 13 Infant, Child and Youth Area Mental Health and Wellbeing Services.

A subset of Area Mental Health and Wellbeing Services will deliver the Infant, Child and Youth Mental Health and Wellbeing Services. Each Infant, Child and Youth Area Mental Health and Wellbeing Service is to establish two service systems and resource them adequately to provide timely, developmentally appropriate treatment, care and support to all Victorians.

The two systems consist of:

* the Infant, Child and Youth Area Mental Health and Wellbeing System for Victorians aged 0–25 and their families
* the Adult and Older Adult Area Mental Health and Wellbeing System for Victorians aged 26 years and older.

As per the Royal Commission’s expectations, Area Mental Health and Wellbeing Services should align their services with aged-based streams and naming conventions:

* Infant, Child and Youth Area Mental Health and Wellbeing Service (for people aged 0–25 years), with two dedicated aged-based service streams of:
	+ Infant, Child and Family Service Stream (for infants and children aged 0–11 years, and their families, carers and supporters)
	+ Youth Service Stream (for young people aged 12–25, and their families, carers and supporters)
* Adult and Older Adult Area Mental Health and Wellbeing Service (for people aged 26 years and over, and their families, carers and supporters).

Further advice on the timing of transition to these naming conventions and streams is being provided in 2024.

Services and programs for young people aged up to 26 years, which were originally delivered by Adult Area Mental Health and Wellbeing Services, are intended to be transferred to Infant, Child and Youth Area Mental Health and Wellbeing Services. The department will work with impacted health services on this transition in 2024.

#### Expanding core clinical services

The expansion of core clinical services requires transformation of service offerings across all settings, moving beyond expansion of existing practice and models of care.

The inaugural statewide plan, due for release in 2024, provides an estimate of future demand for mental health and wellbeing services. This model considers the expansion of services in the context of population needs and system transformation aligned with the intent of the Royal Commission. It will support allocation of future growth in system capacity.

With future expansion, it is expected that health services will actively review their current model of care in both the Infant, Child and Youth Area Mental Health and Wellbeing Services stream, and the Adult and Adult Older Area Mental Health and Wellbeing Services stream, to ensure it aligns with the Royal Commission’s recommendations, and best practice.

#### Delivering more clinical activity outside standard business hours

Area Mental Health and Wellbeing Services are required to deliver a greater proportion of activity outside business hours. After-hours services should include a broad range of service offerings beyond crisis responses. Specific allocations have been included in community mental health funding to enable this to happen.

#### Implementing primary and secondary consultation across the system, and developing models of shared care

Primary and secondary consultation covers a broad range of activities, including the expectation that Area Mental Health and Wellbeing Services will actively ‘reach-in’ to other systems, such as primary care, disability services, community health, early parenting centres, maternal and child health, child protection, alcohol and other drug services, schools, universities and TAFEs, and family violence services.

Strengthened integration, consultation and shared-care arrangements with Local Mental Health and Wellbeing Services (such as headspace) are central to the functioning of the future service system. Local Mental Health and Wellbeing Services and Area Mental Health and Wellbeing Services will work together to develop referral pathways and shared-care arrangements.

In some cases, this process will be facilitated through the Area Mental Health and Wellbeing Service being directly involved in the delivery of a Local Mental Health and Wellbeing Service. In others, it will require collaborative relationships. Areas with an existing or planned Local Mental Health and Wellbeing Service within their area should prioritise collaboration with that service.

#### Forming partnerships with non-government organisations that provide wellbeing supports

As a mechanism to achieve enhanced wellbeing supports, Area Mental Health and Wellbeing Services will deliver services in partnership with non-government organisations in the reformed mental health and wellbeing system.

This will provide for integrated wellbeing supports delivered to Victorians receiving treatment, care and support from all Area Mental Health and Wellbeing Services, as recommended by the Royal Commission.

Further guidance about partnership reform will be provided by the department in 2024.

#### Integrating mental health and alcohol and other drug treatment, care and support

Health services will be required to deliver integrated treatment, care and support (integrated care) for people living with co-occurring mental illness and substance use or addiction. Health services must not exclude consumers living with substance use or addiction from accessing treatment, care and support.

The department has released [Guidance to support the delivery of integrated treatment, care and support](https://www.health.vic.gov.au/mental-health-reform/guidance-to-support-delivery-of-integrated-treatment-care) <https://www.health.vic.gov.au/mental-health-reform/guidance-to-support-delivery-of-integrated-treatment-care>, developed in consultation with the mental health and wellbeing, and alcohol and other drug sectors.

This document sets out key policy settings, principles and expectations to support consistent implementation of integrated care across both the mental health and wellbeing system, and the standalone alcohol and other drug system. Integrated care provides an opportunity for mental health and alcohol and other drug services to learn from each other, and explore ways to work more closely together, to support people living with mental illness and substance use or addiction.

Specific performance obligations, reporting requirements and other expectations relating to integrated treatment, care and support will be developed in consultation with the mental health and wellbeing sector during 2024. Youth Area Mental Health and Wellbeing Services and Adult and Older Adult Mental Health and Wellbeing Services receive funding for providing integrated care, which commenced at the end of 2022.

#### Supporting the new Mental Health and Wellbeing Locals

As stated in section 5.2, locally based mental health and wellbeing services that form part of level 4 are currently being established for adults and older adults, and infants and children. Note that these already exist in the form of headspace centres for young people.

For consumers aged 26 years old and over, Mental Health and Wellbeing Locals support adults and older adults and will be formally networked with Area Mental Health and Wellbeing Services, enabling a smooth transition between different levels of treatment and support.

In line with the Royal Commission’s recommendations, Area Mental Health and Wellbeing Services can be accessed via a referral from a Mental Health and Wellbeing Local or medical practitioner. Mental Health and Wellbeing Locals and their networked Area Mental Health and Wellbeing Service are expected to work together to develop referral pathways and shared-care arrangements.

In some cases, this process will be facilitated through the Area Mental Health and Wellbeing Service being directly involved in the delivery of a Mental Health and Wellbeing Local, while for others, it will require the establishment of collaborative relationships. Initial guidance on this is included in the [*Local Adult and Older Adult Mental Health and Wellbeing Services service framework*](https://www.health.vic.gov.au/publications/local-adult-older-adult-mental-health-wellbeing-service-framework) <https://www.health.vic.gov.au/publications/local-adult-older-adult-mental-health-wellbeing-service-framework >.

For consumers aged 12–25, headspace provides this local level service. Headspace services are commissioned and overseen by the Australian Government, through Primary Health Networks. Infant Child and Youth Area Mental Health and Wellbeing Services form part of the stepped-care network for headspace consumers. Area Services are often part of the consortium for local headspace providers, and headspace providers can refer complex clients to the Area Service for more intensive treatment. For consumers aged 0–11 and their families, carers and supporters, three Children’s Health and Wellbeing Locals have been established in Brimbank–Melton, Southern Melbourne and Bendigo. In line with the Royal Commission’s recommendations, these services provide multidisciplinary paediatric health, mental health and family services for children aged 0–11 years who are experiencing developmental, emotional, relational and behavioural challenges, and their families.

The three services are delivered by a local community health service, in formal partnership with the local Infant Child and Youth Area Mental Health and Wellbeing Service, and a local family service provider, noting that the family service provider can be internal to the community health service.

Each Children’s Health and Wellbeing Local has a shared intake procedure that includes community health, mental health and family services. This ensures that consumers and their families and carers receive the most appropriate integrated care.

### Bed-based services

Admitted care is an important part of the continuum of care. It needs to be available when it is in the best interests of the person living with a mental illness.

#### Acute care

In 2024–25, funding for acute admitted (care provided by Area Mental Health and Wellbeing Services) will transition to the national activity-based funding model. Health services will be allocated a national weighted activity unit target consistent with their admitted budgets for 2023–24. Health services will be required to continue to maintain existing bed capacity and occupancy rates during the transition phase. Further information on this reform is provided in the *Funding rules*.

#### Prevention and recovery care

Prevention and recovery care (PARC) services are short-term (usually up to 28 days), recovery-focused treatment and support services in residential settings. PARCs provide early intervention for people who are becoming unwell, and for people in the early stages of recovery following an acute inpatient admission. PARCs help to prevent acute inpatient admissions, and to assist people who are already admitted in an inpatient unit to be discharged as early as possible.

Youth PARCs are designed for young people aged 16–25 years, who are either:

* experiencing mental health challenges and/or psychological distress with or without co-occurring substance use or addiction, and would benefit from a brief intensive recovery support intervention (‘step-up’)
* in the early stages of recovery from an acute phase of mental ill health and/or psychological distress, with or without co-occurring substance use or addiction, and who need a time-limited period of additional support in order to strengthen gains made from spending time in an inpatient setting (‘step-down’).

The new *YPARC statewide service framework* was circulated to relevant Infant, Child and Youth Area Mental Health and Wellbeing Services in June 2023. It creates statewide consistency in the way that YPARC services are delivered, and ensures treatment, care and support is developmentally appropriate for young people aged 16–25 years who would benefit from a community bed-based residential service. Health services operating a YPARC are expected to align their local model of care with the *YPARC statewide service framework*.

#### Community and extended care

Secure extended care units (SECUs) are inpatient services for people who need a high level of secure and intensive clinical treatment for severe and unremitting mental illness. SECUs provide long-term management and treatment services at three metropolitan and three regional hospitals. There is some non-secure, extended-care bed capacity at two other hospitals.

Community care units (CCUs) provide residential clinical care and rehabilitation services in home-like environments to support the recovery of people experiencing a severe mental illness.

The department accepted the Royal Commission’s recommendation to implement a whole-of-system rehabilitation pathway in the coming years. The new pathway will include two new bed-based rehabilitation models of care for people living with mental illness who need ongoing intensive treatment, care and support.

Similarly, the department accepts the Royal Commission’s recommendation to co-design new community and intensive rehabilitation models of care for delivery at CCU and SECU demonstration sites in coming years. As recommended by the Royal Commission, following an evaluation of these initiatives, the department will consider applying these models to existing CCUs and SECUs.

### Mental health community support services

Mental health community support services (MHCSS) provide psychosocial rehabilitation support to people aged 16–64 years old, who are living with an enduring psychiatric disability that is attributable to a psychiatric condition. State-funded MHCSS are delivered across 15 service catchments, largely by non-government organisations.

The MHCSS program includes youth residential rehabilitation, supported accommodation, statewide supports, carer support, planned respite, Aboriginal mental health support and catchment-based intake assessment for bed-based services.

Bed-based MHCSS are funded on a bed-day rate. Most other MHCSS activity is block-funded, excluding continuity of support and youth outreach recovery support. Funding is indexed, consistent with the government’s annual determination for community service organisations.

Continuity of support has been provided to MHCSS clients who are not eligible for the National Disability Insurance Scheme (NDIS) because they do not meet age and residency criteria, as many MHCSS programs transitioned to the NDIS from 2016–2020. Previous MHCSS clients of these services became NDIS participants, including individualised client support packages, adult residential rehabilitation and select supported accommodation services.

### Early Intervention Psychosocial Support Response

The Early Intervention Psychosocial Support Response (also known as EIPSR) service is a psychosocial support model targeted to people aged 16–25 years and 26–65 years who:

* are part of the Area Mental Health and Wellbeing Service system
* are living with a severe mental illness and associated psychiatric disability
* are either:
	+ not eligible for the NDIS because they do not have significant, permanent functional impairment associated with their mental health condition
	+ eligible for the NDIS and waiting for an access decision and their NDIS plan to begin.

The service model provides short- to medium-term, specialist psychosocial support to help people:

* build their capacity to better manage their mental illness
* develop practical life skills for independent living and social connectedness
* achieve healthy, functional lives
* transition to the NDIS, where eligible.

Select health services are funded to deliver EIPSR in a contractual partnership with non-government, community-managed mental health providers.

The EIPSR program is funded until 30 June 2025 to support continued work on the development of core functions, and the reform of partnerships between Area Mental Health and Wellbeing Services and non-government organisations (NGOs), referred to in section 5.1.2: Six levels of an integrated and responsive system.

## Level 6: Statewide services

The Royal Commission conceptualised statewide services as the sixth and final level of the new mental health and wellbeing system. These services respond to the smallest proportion of people with the highest levels of need (see Figure 2).[[2]](#footnote-3)

Statewide services have a role in broader system improvement, including through research and capability building. These services have:

* a workforce with a high level of expertise and knowledge
* dedicated research focus
* a focus on providing treatment, care and support to a proportionately small number of people, often with higher levels of needs.

Work on the role and design of statewide services is being undertaken in parallel with broader reforms of the system to realise the vision of a six-level mental health and wellbeing system in Victoria.

#### A new mental health statewide service for people with lived experience of trauma

The Royal Commission recommended establishing a new Mental Health Statewide Trauma Service. This will deliver the best possible mental health and wellbeing outcomes for all people of all ages with lived experience of trauma.

In December 2022, the department appointed a consortium of 13 organisations, including a lead agency, to establish the Mental Health Statewide Trauma Service. This has now been formally renamed Transforming Trauma Victoria (TTV). TTV is currently in a design and development phase until June 2025.

It is expected that in the future, TTV will work in partnership with the Victorian Collaborative Centre for Mental Health and Wellbeing to facilitate system-wide opportunities for trauma research, education and training.

You can find updates on the design and development of TTV by visiting the [Mental Health Statewide Trauma Service website](https://www.health.vic.gov.au/mental-health-wellbeing-reform/mental-health-statewide-trauma-service)  <https://www.health.vic.gov.au/mental-health-wellbeing-reform/mental-health-statewide-trauma-service>.

#### A new statewide service for people living with mental illness and substance use or addiction (the Hamilton Centre)

The Hamilton Centre is the Victorian statewide service for people living with co-occurring mental illness and substance use or addiction. Led by Turning Point as the central coordinating agency, the Hamilton Centre has partnered with a clinical network to deliver specialist addiction treatment services across the state of Victoria. Initial sites are located at St Vincent’s Hospital Melbourne, Eastern Health, Western Health, Austin Health and Goulburn Valley Health.

The Hamilton Centre works to improve outcomes for people with co-occurring conditions by undertaking dedicated research and developing education and training initiatives for mental health and alcohol and other drug practitioners and clinicians.

Clinicians working in mental health services can visit the [Hamilton Centre website](https://www.hamiltoncentre.org.au/#home) <https://www.hamiltoncentre.org.au/#home> or call its helpline (1800 517 383, operational Monday to Friday, 9.00 am to 5.00 pm) to receive expert advice regarding integrated care and management of a consumer’s substance use or addiction needs, or for service navigation assistance and guidance between mental health and alcohol and other drug services.

For more complex and ongoing support, clinicians supporting consumers in Area Mental Health and Wellbeing Services may seek a referral to the Hamilton Centre Clinical Network for:

* longer-term workforce support (secondary consultation services) regarding the management of a client’s substance use or addiction needs
* integrated addiction and mental health treatment, care and support (primary consultations) for people living with mental illness and substance use or addiction, who have the most complex support needs.

The Hamilton Centre follows a shared, stepped-care model, with consumers remaining under the direct care of the referring service. Consultation services are delivered through both in-person and telehealth appointments, accessible across metropolitan, rural and regional Victoria.

### Forensic mental health

Forensicare delivers inpatient and community forensic mental health services across Victoria. It also provides mental health services in Victorian prisons. Services include:

* clinical assessment, treatment and management of people with a severe mental illness and offending behaviours
* provision of psychiatric reports for court
* multidisciplinary treatment for people at high risk in the community.

Forensicare is a statutory authority and provider of specialist forensic mental health services under the *Mental Health and Wellbeing Act 2022*.

Forensic mental health services are outlined below.

#### Thomas Embling Hospital

Thomas Embling Hospital is a 136-bed secure forensic mental health hospital that provides care and treatment for people living with a serious mental illness. Thomas Embling Hospital provides intensive, acute, subacute and extended rehabilitation for consumers, with a specific women-only unit for acute and subacute care.

Extended and transitional rehabilitation is provided within mixed gender units. Patients are admitted to the hospital from the criminal justice system under the Mental Health Act, the *Crimes (Mental Impairment and Unfitness to be Tried) Act 1997* or the *Sentencing Act 1991*. Patients may also be admitted from the general mental health system under the Mental Health Act.

Work is currently under way to implement the Royal Commission’s recommendations, which include refurbishing existing beds and expanding the number of beds at Thomas Embling Hospital. This expansion will provide an additional 82 beds to meet the needs of people living with a serious mental illness, and who require care and treatment within a forensic hospital setting, contributing to implementation of the Royal Commission’s recommendation 38.

#### Community Forensic Mental Health Services

Community Forensic Mental Health Services provide assessment and multidisciplinary treatment to high-risk consumers referred from Area Mental Health and Wellbeing Services, correctional providers, courts, the Adult Parole Board, Thomas Embling Hospital, prison services, government agencies and private practitioners.

Services include:

* the Community Integration Program
* the Problem Behaviour Program
* the Mental Health Court Liaison Service
* the Non-Custodial Supervision Order Consultation and Liaison Program for people subject to the Crimes (Mental Impairment and Unfitness to be Tried) Act
* the Forensicare Serious Offender Consultation Service
* Forensicare’s Court Reports Service
* the Forensic Clinical Specialist Program
* coordination of the Youth Justice Mental Health Initiative.

These community forensic services are being expanded by further investment in the implementation of the Royal Commission’s recommendation 37.2. The aim of this intervention is to provide specialised services to mental health consumers at risk of contact with the justice system – through more mental health clinicians having specialist skills to help this group, and more options for community-based care – so they are much less likely to be aggressive or violent when unwell.

The funding is scaling up from the lead demonstration site (Barwon) to full statewide operation (by the end of financial year 2025–26) of the new Regional Forensic Mental Health Teams and expanding the forensic clinical specialist workforce in regional Area Mental Health and Wellbeing Services.

#### Prison mental health services

Forensicare provides specialist forensic mental health services across 12 of Victoria’s 14 prisons. Services include mental health reception assessments, and dedicated units for the care and treatment of prisoners with mental illness, as well as outpatient care and mobile forensic mental health services. Forensicare’s prison services also provide suicide and self-harm prevention assessment services and Mental Health Transition Support Service.

There is capacity within prison settings for 141 sentenced persons to received unit-based mental health treatment from Forensicare. All Forensicare’s prison-based specialist mental health services are voluntary.

Forensicare has a formal link with Swinburne University of Technology through its research arm, the Centre for Forensic Behavioural Science, and established links with other tertiary organisations to support an ongoing commitment to promote knowledge and training in forensic mental health.

## Alcohol and other drug services

The Victorian alcohol and other drug services sector currently operates under a mixed-funding model that includes:

* residential services and most adult community-based services, funded via drug treatment activity units
* Aboriginal and youth-specific services, and some out-of-scope, community-based services, funded based on episodes of care
* other drug treatment activities, such as research, drug prevention and control, local initiatives and pharmacotherapy programs, which continue to be block- or grant-funded.

Funding provided to service providers is indexed in line with the government’s annual determination for community service organisations.

People presenting at emergency departments with acute mental health and alcohol and other drug issues are supported through an enhanced mental health and alcohol and other drug assessment and treatment response across three pathways – non-admitted, short-stay bed-based care and 28-day assertive outreach – providing them with the right support sooner and easing pressure on emergency departments. The department accepted the Royal Commission’s recommendation that each of the eight mental health and wellbeing regions should have at least one highest-level emergency department able to provide mental health and alcohol and other drug treatment.

Residential withdrawal services support clients to safely withdraw from alcohol and other drug dependence in a supervised residential or hospital facility. These services are appropriate for people with complex needs, including medically complex withdrawal symptoms, and other life, family and accommodation circumstances.

Residential rehabilitation provides a structured and therapeutic environment for people to address issues related to their alcohol and other drug use.

Specialist dual-diagnosis residential rehabilitation supports clients who may be experiencing a higher severity of mental health symptoms, combined with alcohol and other drug dependence. These services deliver targeted interventions to address the multiple complexities faced by clients with co-occurring alcohol and other drug and mental health needs.

The Hamilton Centre will deliver workforce training and education to enhance the integrated care capability of the alcohol and other drug workforce, to support the response to people with co-occurring mental illness and substance use or addiction who access alcohol and other drug services.

## Mental health and wellbeing programs

#### Suicide prevention and response

In response to the Royal Commission’s final report, Victoria’s future suicide prevention and response efforts will be driven by a new suicide prevention and response strategy. This strategy will build an evidence-informed, systems-based, whole-of-government and community-wide approach to suicide prevention and response.

For more information, visit [Victorian suicide prevention and response strategy](https://www.health.vic.gov.au/mental-health-wellbeing-reform/victorian-suicide-prevention-and-response-strategy) <https://www.health.vic.gov.au/mental-health-wellbeing-reform/victorian-suicide-prevention-and-response-strategy>.

In addition to the strategy, there are several current and planned programs and initiatives underway that contribute to Victoria’s suicide prevention and response efforts, which are discussed below.

##### SuicideLine Victoria

SuicideLine Victoria is a helpline delivered by Lifeline. It provides 24/7 telephone, web chat and video counselling to people 15 years and older, who are at risk of suicide, bereaved by suicide or concerned for someone at risk of suicide. Helpline services include intake and assessment, single and multi-session counselling, and support and referrals for Victorians in need.

##### Hospital Outreach Post-suicidal Engagement program

The Hospital Outreach Post-suicidal Engagement (HOPE) program is a peer, psychosocial (wellbeing) and clinical support service that delivers responsive outreach to people after a suicide attempt, planning or intent, and/or repeated self-harm.

HOPE teams support people and their family, friends, carers and other supporters for up to three months, helping them to identify and build protective factors against suicide.

For more information, visit [HOPE program](https://www.health.vic.gov.au/mental-health-reform/interim-recommendation-3) <https://www.health.vic.gov.au/mental-health-reform/interim-recommendation-3>.

##### Aftercare service for LGBTIQA+ people

In recognition that LGBTIQA+ people are at higher risk of suicide, often due to stigma, discrimination and an inability to access inclusive and safe supports and services, a new aftercare service model tailored to meet the needs of LGBTIQA+ people is currently being co-designed.

For more information, visit [LGBTIQA+ aftercare service](https://www.health.vic.gov.au/mental-health-reform/recommendation-27) <https://www.health.vic.gov.au/mental-health-reform/recommendation-27>.

While the co-design process is under way, Mind Australia is delivering a peer-led LGBTIQA+ aftercare service for people living in metropolitan Melbourne. More information is available on the [Mind website](https://www.mindaustralia.org.au/services/aftercare) <https://www.mindaustralia.org.au/services/aftercare>.

##### Distress brief support program

The Royal Commission recommended that the Victorian Government develop and implement a 14-day support program for adults (aged 18 years and over) experiencing psychological distress (recommendation 27.3). In partnership with the Australian Government, a distress brief support program is being developed and trialled in the City of Darebin and the Greater Shepparton local government areas.

For more information, visit [Distress brief support](https://www.health.vic.gov.au/mental-health-reform/recommendation-27) <https://www.health.vic.gov.au/mental-health-reform/recommendation-27>.

##### Statewide peer call-back service

The Royal Commission recommended that the Victorian Government establish a statewide peer call-back service for families, carers and supporters caring for people experiencing suicidal behaviour (recommendation 31.2). Development of the new service is currently under way.

For more information, visit [Statewide peer call-back service](https://www.health.vic.gov.au/mental-health-reform/recommendation-31) <https://www.health.vic.gov.au/mental-health-reform/recommendation-31>.

While codesign for the new service takes place, Roses in the Ocean has been engaged to expand their Peer Care Companion Warmline Service in Victoria. More information is available on the [Roses in the Ocean’s website](https://rosesintheocean.com.au/sector-priorities-collaborations/peer-care-companion-warmline/) <https://rosesintheocean.com.au/sector-priorities-collaborations/peer-care-companion-warmline/>.

##### Aboriginal-led suicide prevention and response

In recognition of the disproportionate impact of suicide on Aboriginal people, the Balit Durn Durn Centre, within the Victorian Aboriginal Community Controlled Health Organisation (VACCHO), is leading the co-design of an Aboriginal-led approach to prevent and respond to Aboriginal suicide. An advisory group to oversee the co-design process and provide advice of self-harm and suicide in Aboriginal communities has also been established.

In line with the principles of self-determination, this process will ensure suicide prevention and response efforts in Victoria are designed and shaped by Aboriginal people, communities and community-controlled organisations and centre Aboriginal ways of knowing, being and doing.

### Supporting Aboriginal social and emotional wellbeing

The Royal Commission identified the urgent need to address mental illness and suicide in Aboriginal communities. The Royal Commission’s vision is for a mental health and wellbeing system where Aboriginal self-determination is respected and upheld in the design and delivery of treatment, care and support. This includes Aboriginal people being able to choose to receive care within Aboriginal community-controlled organisations, within mainstream services or in a mix of both. Irrespective of where treatment, care and support are delivered for Aboriginal people, communities and families, it is fundamental that it is safe, inclusive, respectful and responsive.

All mainstream health services have an obligation to provide culturally safe care to Aboriginal people and communities. This must be embedded across all programs in the mental health, and social and emotional wellbeing sector.

The department is working in partnership with VACCHO through the Balit Durn Durn Centre for Excellence in Aboriginal Social and Emotional Wellbeing, the Aboriginal community-controlled sector and mainstream health services to deliver the Royal Commission’s recommendations to improve Aboriginal social and emotional wellbeing recommendations.

This work supports and builds on key actions and priorities committed under the *Balit Murrup: Aboriginal social and emotional wellbeing framework 2017–2027* (Balit Murrup).

Balit Murrup domains for action include:

* Domain 1: Improving access to culturally responsive services
* Domain 2: Supporting resilience, healing and trauma recovery
* Domain 3: Building a strong, skilled and supported workforce
* Domain 4: Integrated and seamless service delivery.

Priorities for 2024–25 include:

* expanding Aboriginal social and emotional wellbeing teams in 25 Aboriginal community-controlled health organisations (ACCHOs) – with statewide coverage by 2025. This expansion incorporates four Aboriginal social and emotional wellbeing demonstration projects, and 10 clinical and therapeutic positions, formerly established through Balit Murrup
* continuing to work with ACCHOs to transition to outcomes-based funding and reporting. This will embed greater self-determination into how the department supports ACCHOs to deliver social and emotional wellbeing services
* providing resources for ACCHOs to commission culturally appropriate, family-oriented, social and emotional wellbeing services for children and young people
* delivering the Aboriginal social and emotional wellbeing scholarship program, which supports Aboriginal students to access high-quality education and training to complete a mental health-related qualification
* expanding the Koori Mental Health Liaison Officer (KMHLO) program across 10 Infant, Child and Youth Area Mental Health and Wellbeing Services. This includes employing 10 KMHLOs during this year. This will help improve access to acute mainstream mental health services for Aboriginal infants, children and young people, and their families
* continuing support for the Balit Durn Durn Centre, established by VACCHO in May 2022
* funding 13 Infant, Child and Youth Area Mental Health and Wellbeing Services to undertake cultural safety training to improve practice and support Aboriginal young people and their families
* continuing to deliver the Aboriginal Mental Health Traineeship Program. This three-year traineeship program is building a skilled and qualified Aboriginal clinical mental health workforce in Adult Area Mental Health and Wellbeing Services. It provides full-time ongoing employment to Aboriginal people living in Victoria who successfully undergo supervised workplace training and clinical placements over three years, while concurrently completing a three-year, full-time Bachelor of Health Science (Mental Health) degree at Charles Sturt University. The program in 2024–25 will have a cohort of 10 Aboriginal mental health trainees employed at Eastern Health, Bendigo Health, Alfred Health, Peninsula Health, Monash Health, Latrobe Regional Health, Mildura Base Hospital and Forensicare.

# Ageing, aged and home care services

## Aged Care Assessment Services

Aged Care Assessment Services (ACAS) conduct comprehensive assessments of the care needs of frail older people. They have delegated authority to determine eligibility for Commonwealth home care, residential respite care, permanent residential care and flexible care.

My Aged Care is the central point for referrals for community-based assessments. Referrals for inpatient assessments continue to be made directly to the relevant ACAS. The department continues to support ACAS and health services to deliver high-quality and timely comprehensive assessments for people needing access to health and aged care services.

The Australian Government is implementing a new single assessment model to assess eligibility for all aged care services. This will replace assessment services that are currently delivered by ACAS and Regional Assessment Services (RAS). ACAS and RAS will transition to the single assessment model during 2024–25. Updated policy guidance for the new model will be provided to support implementation.

## Regional Assessment Services

RAS conduct home support assessments for older people who need entry-level home support and assistance to support them to live independently in their community. Outcomes of assessments may include referrals to Commonwealth Home Support Program services. My Aged Care is the central point for referrals for a home support assessment.

The Australian Government is implementing a new single assessment model to assess eligibility for all aged care services. This will replace assessment services that are currently delivered by ACAS and RAS. ACAS and RAS will transition to the single assessment model during 2024–25. Updated policy guidance for the new model will be provided to support implementation.

## Home and Community Care Program for Younger People

The Home and Community Care Program for Younger People (HACC PYP) is for people aged from birth to 65 years (and Aboriginal people from birth to 50 years) and their carers who need assistance with daily activities due to chronic illness, mental health issues, disability or other conditions. It provides one-off, intermittent or ongoing support for these people to undertake the activities of daily living.

Eligible people are those at risk of losing their independence without support and who are not eligible to receive supports through other programs. HACC PYP is funded by the Victorian Government to provide services in the home and in the community. The program aims to allow clients to maintain their independence in their homes and communities and optimise their health and wellbeing.

Funding for most recurrent services is based on a published set of unit prices per hour. This is used to determine the output targets for each service provider. Outputs are reported and monitored via the Victorian Community Support Services (VCSS, formerly HACC) minimum dataset on a quarterly basis.

For more information, visit [Home and community care data reporting](https://www.health.vic.gov.au/home-and-community-care/reporting-and-data) <https://www.health.vic.gov.au/home-and-community-care/reporting-and-data>, or read the [HACC PYP fees policy and schedule of fees](https://www.health.vic.gov.au/home-and-community-care/hacc-pyp-fees-policy-and-schedule-of-fees) <https://www.health.vic.gov.au/home-and-community-care/HACC PYP-fees-policy-and-schedule-of-fees>.

## Victorian Aids and Equipment Program

The Victorian Aids and Equipment Program assists eligible people to improve their independence and participate in the community. It also supports families and carers to maintain care arrangements by providing a range of subsidies for aids and equipment, and health-related products. The program funds the repair of equipment owned by the service provider.

Assistive technology programs and schemes funded under the program include:

* an equipment loan service for people who have been diagnosed with motor neurone disease
* specialist low-cost aids and equipment for people who have vision impairment
* lymphoedema compression garments
* individualised solutions
* electronic communication devices
* smoke alarms for those with profound or severe hearing loss
* aids and equipment subsidies for home and vehicle modifications, and a range of mobility aids
* domiciliary oxygen
* laryngectomy consumables
* continence products.

The client group for this activity is people of all ages, with some eligibility restrictions. For more information, visit the [Victorian Aids and Equipment Program](https://www.health.vic.gov.au/supporting-independent-living/victorian-aids-and-equipment-program) <https://www.health.vic.gov.au/supporting-independent-living/victorian-aids-and-equipment-program>.

## Aged support services

Aged support services provide a range of support, mostly for people who are living in their own homes. While clients of the services are generally aged 65 years or older, people aged under 65 years can also access the services listed below.

### Personal Alert Victoria

Personal Alert Victoria (PAV) is a daily monitoring and emergency response service for frail older people and people with a disability, who have high ongoing health and support needs, and mostly live alone. It aims to support clients to live independently for as long as possible.

PAV relies on nominated contacts (such as family, friends and neighbours) to provide assistance in responding to calls, ensuring public emergency services are used effectively.

The Personal Alert Victoria Response Service (PAVRS) is used when people do not have any relatives or other contact people.

### Victorian Eyecare Service

The Victorian Eyecare Service provides subsidised eyecare and visual aids to people experiencing disadvantage. The service is delivered by the Australian College of Optometry in Melbourne metropolitan regions and private practice optometrists in rural regions. Clients who identify as Aboriginal people are eligible for the Victorian Aboriginal Spectacles Subsidy Scheme, which is an added subsidy to the Victorian Eyecare Service. It aims to improve access to visual aids and eyecare for Aboriginal people living in Victoria, by further reducing the client contribution to $10.

### Public sector residential aged care

The department provides funding to public sector residential aged care services (PSRACS) to assist with operational expenses. PSRACS are funded to provide a specified number of available bed days and to meet set targets for resident occupancy.

In 2024–25, the department will continue to provide top-up funding to designated PSRACS to support the viability of small rural services, services supporting residents with specialised care needs and additional costs of the public sector workforce. This includes continuation of the unit-priced funding approach for high-care and low-care beds in designated services, which was introduced in 2011–12.

In 2022–23, the Australian Government introduced the Australian National Aged Care Classification (AN-ACC), a new funding model that provides revenue to PSRACS. The department is monitoring and modelling the revenue effects of the AN-ACC on PSRACS throughout 2024–25. It may change the allocation of top-up funding to PSRACS in response to revenue changes caused by the AN-ACC and other aged care reform funding changes.

Changes to the top-up funding allocations will be made to best use the available funding across PSRACS providers to achieve sector objectives and intended support. The department will notify PSRACS providers of any changes to their top-up funding.

Health services or other PSRACS providers must provide the number of available bed days for which they are funded for residential aged care. The available beds must be efficiently managed to optimise the availability and benefit for Victorians requiring residential aged care. If providers fail to maintain the agreed number of available beds or bed days, or they elect to reduce the number of available (operational) places, funding to the service may be adjusted to reflect this change.

This funding policy and process applies to departmental funding for PSRACS when:

* a PSRACS provider decides to make a reduction (short term or ongoing) in the number of aged care places due to local changes in demand over a period of time
* a PSRACS provider seeks to convert residential aged care places to other care types or programs (such as transition care)
* there are requests by PSRACS providers to reinstate non-operational (offline) places or increase operational places
* a review indicates failure to optimise service provision for those requiring residential care.

Health services must notify the department if they wish to change their service model mix. This includes changes to the number of total allocated places, operational residential care places or flexible care places.

Health services should notify their local departmental performance lead (the representative will liaise with the program area) to set out their plans, before implementing any change. The department will contact organisations that consistently fail to meet occupancy targets to discuss appropriate action (for example, to increase occupancy or review operations to better manage costs).

Where funding may be affected by service changes, the service may be requested to submit a transition plan describing changes and proposed timelines, and to seek the department’s agreement to the effective date for any associated funding adjustments.

Services may elect to increase their operational or flexible care places in the absence of further funding from the department. They should demonstrate to their board that the added costs can be covered from other income.

If services obtain extra residential aged care places without the approval of the department, state funding will not be provided to the service.

The department will work closely with services where opportunities to optimise available bed management are identified.

### Low-cost accommodation support

Low-cost accommodation support programs are a group of outreach programs for older and vulnerable Victorians with unmet complex needs, who are homeless or living in insecure or low-cost accommodation.

The programs link clients to relevant health, community care and welfare services to improve their health and social wellbeing. They include three subprograms: the Community Connections Program, Housing Support for the Aged, and the Older Persons High Rise Program.

# Rural and regional health

Rural and regional health services deliver safe, high-quality care close to where people live. The system has a hierarchy of health services. This includes regional, subregional, local and small rural health services (SRHS), including multipurpose services and bush nursing centres.

## SRHS

There are 35 SRHS, including six multipurpose services in Victoria. The funding model for SRHS is intended to support eight key principles of:

* flexibility
* person- and family-centred care
* community value
* transparency
* sustainability
* simplicity
* accountability
* service integration.

SRHS can use funds provided through the ‘Small rural services – acute health’ and ‘Small rural services – primary care’ outputs flexibly to deliver admitted and non-admitted services that meet the needs of their community. This includes acute care, subacute care, primary health care, home and community care program for younger people, health promotion and prevention activities. Funding arrangements for PSRACS are outlined in section 6.5.3: Public sector residential aged care.

Multipurpose services can flexibly use funding as SRHS. However, under the tripartite agreement with the Australian Government Department of Health, they are also able to flexibly use aged care funding to deliver both residential and home-based aged care services.

## Bush nursing centres

Bush nursing centres are located in geographically isolated or very small rural communities. They are generally the only primary healthcare provider in their community. These entities are funded under the SRHS funding model to support the flexible use of funding to deliver primary, community and home-based care that meets the needs of their communities.

Bush nursing centres are required to have a signed memorandum of understanding with their partnering health services for clinical governance support, and with Ambulance Victoria, regarding their remote area nursing role.

Bush nursing centres are expected to report data on their funded services to the department quarterly, to align with departmental requirements, as outlined in the *Community health program data reporting guidelines.*

From the first of July 2023, bush nursing centres transitioned to the Australian Commission of Safety and Quality in Health Care’s *National Safety and Quality Primary and Community HealthCare Standards*. For more information, visit the [Australian Commission of Safety and Quality in Health Care website](https://www.safetyandquality.gov.au/standards/primary-and-community-healthcare) <https://www.safetyandquality.gov.au/standards/primary-and-community-healthcare>.

Refer to section 19.1: Australian Health Service Safety and Quality Accreditation Scheme for roles and responsibilities regarding the reporting and monitoring of performance against the relevant safety and quality accreditation standards.

During 2024–25, the department will continue to work with bush nursing centres to ensure service delivery continues to align with government policy, and that standardised performance monitoring oversight mechanisms are in place.

## Victorian Patient Transport Assistance Scheme

The Victorian Patient Transport Assistance Scheme (VPTAS) subsidises the travel and accommodation costs incurred by rural Victorians and an approved escort, who have no option but to travel more than 100 kilometres one way, or an average of 500 kilometres a week for one or more weeks, to receive approved medical specialist services or specialist dental treatment.

For more information, including a copy of the claim form, visit the [Victorian Patient Transport Assistance Scheme (VPTAS)](https://www.health.vic.gov.au/rural-health/victorian-patient-transport-assistance-scheme-vptas) <https://www.health.vic.gov.au/rural-health/victorian-patient-transport-assistance-scheme-vptas>.

The current key subsidiaries for eligible patients and up to one escort include:

* 21c per kilometre for travel via a private vehicle
* a maximum of $49.50 per person, per night, for commercial accommodation
* economy class fares for public transport or flights.

Patients under the age of 18 may be eligible for two escorts.

## COAG section 19(2) exemptions initiative: improving access to primary care in rural and remote areas

The Victorian Government signed a memorandum of understanding with the Commonwealth (in effect until 30 June 2025) in relation to the COAG section 19(2) exemptions initiative to improve access to primary healthcare for Victorians living in eligible rural and remote communities.

The initiative aims to support rural and remote health services in small communities by increasing access to Commonwealth funding through the Medicare Benefits Schedule (MBS) and ensuring that eligible approved health services increase support for primary healthcare in these areas.

Under this initiative, public hospitals and bush nursing centres located in Modified Monash Model categories 5–7 can apply to the Victorian Department of Health and the Australian Government Department of Health and be granted an exemption from section 19(2) of the Health Insurance Act 1973 (Cth) by the Commonwealth Minister for Health.

Eligible services are services set out in the MBS, which are specified in the directions under section 19(2) of the Health Insurance Act (Cth). This may include professional non-admitted patient services, non-referred services (including eligible nursing and midwifery services), eligible allied health and dental services, and specified diagnostic imaging and pathology services. Non-admitted patients include those attending urgent care centres and outpatient clinics, and patients treated by an eligible health service employee offsite, including community and outreach services.

For more information, including guidance and templates to support application and reporting requirements, visit the department's [Improving access to primary care in rural and remote areas](https://www.health.vic.gov.au/improving-access-to-primary-care-in-rural-and-remote-areas) website <https://www.health.vic.gov.au/improving-access-to-primary-care-in-rural-and-remote-areas>.

# Primary, community and dental health

## Primary health services

### Community health program

Community health program funding provides for general counselling, allied health and community nursing. These services intervene early to maximise health and wellbeing outcomes. They also seek to prevent or slow the progression of ill health.

The community health program prioritises access for populations, families and children at risk of stigma and discrimination. This includes people who are socially or economically disadvantaged, experience poorer health outcomes and have complex care needs, or have limited access to appropriate healthcare services.

The program’s priority population groups are:

* Aboriginal and Torres Strait Islander people
* refugees and people seeking asylum
* people who are homeless or at risk of homelessness
* children in care and clients of child protection, Orange Door and ChildFIRST.

Access to the program is based on eligibility criteria and the principles set out in the program’s access policy. Priority groups are reflected in the eligibility criteria.

People, including children and young people, who are eligible to receive services through the program include people:

* who hold a Health Care Card or Pensioner Concession Card, or who are a dependent of a concession card holder
* with a low or medium income (as defined in the *Community health fees policy*)
* who belong to one or more of the priority population groups.

A new Community Health Demand Management Toolkit (the toolkit) has been developed in consultation with community health services. The toolkit supports consistent demand management across the state. It gives community health services the flexibility to adapt practices according to individual service models and local population needs.

The toolkit replaces the previous *Demand management framework* and priority tools for community health services. It responds to the recommendation from the 2018 audit of the program by the Victorian Auditor-General’s Office. This recommendation was that the department, in conjunction with community health services, should regularly review and revise the *Demand management framework* and clinical priority tools to ensure they reflect optimal practice.

This audit made recommendations for a new funding model. The new pricing and funding arrangements commenced from 1 January 2024.

A single unit price has been introduced for the ‘Community health’, ‘Small rural primary health – flexible services’, and ‘Integrated chronic disease management activities’ delivered by registered and integrated community health services. Ongoing work will determine the expansion of a single unit price for other activities within the community health program.

Community health program funding is activity based and the activity measure is service hours.

Funding can be used flexibly to meet the needs of local populations. To ensure services are targeted appropriately, consider:

* population health needs across different age groups and across the care continuum
* gaps in services for specific population groups that experience inequity in access or health outcomes
* the development of service models that are appropriate and accessible to local populations
* complementary services offered by other service providers and mechanisms for service coordination.

Funded organisations that identify a need for a specific population response should prioritise their community health program funding appropriately and refer to the relevant initiative guidelines.

Community health services are also funded to deliver a range of other healthcare services and programs, including sexual and reproductive health, and place-based primary prevention (under the activity name ‘Community health – health promotion’). Primary prevention aims to prevent illness occurring by eliminating or reducing underlying causes.

Support for specific population groups is also provided through programs and initiatives, including:

* the Refugee Health Program, which aims to increase refugee and asylum seeker access to primary health services, and assist newly arrived communities to improve their health and wellbeing
* the Healthy Mothers, Healthy Babies Program, which provides pregnancy, resilience and antenatal material support. It aims to improve the health outcomes for pregnant vulnerable women and their babies
* the Early Intervention in Chronic Disease initiative, which aims to assist people with chronic disease to improve their capacity to manage their condition, prevent complications and improve their health and wellbeing
* the Community Health Nurses in Sexual Assault Multidisciplinary Centres program, which provides health needs identification, holistic direct care planning and support, and referral to appropriate services for children and adults who have experienced sexual assault and their non-offending family members. More recently, nurses also support clients of family violence referrals
* the Innovative Health Services for Homeless Youth program, which promotes healthcare for young people who are homeless or at risk of homelessness. It funded by the Victorian and Australian governments to provide health promotion and services that respond to the complex health needs of young people and improve their access to mainstream health services
* the Community Asthma Program, which provides community-based asthma education and support for children and young people with asthma and their families, supporting avoidable hospital admissions
* the Family and Reproductive Rights Education Program, which aims to prevent the practice of female genital mutilation/cutting and to support the health and wellbeing of girls and women who have experienced this practice.

Agencies receiving specific initiative funding must demonstrate that funds are targeted to meet the aims of the initiative. This is achieved through reporting requirements (see section 29.8: Primary, community and dental health data reporting requirements).

For more information and the community health schedule of fees and income ranges used when assessing clients, visit the [Community health fees policy](https://www.health.vic.gov.au/community-health/community-health-fees-policy) <https://www.health.vic.gov.au/community-health/community-health-fees-policy>.

### Priority Primary Care Centres

The Victorian Government is investing in Priority Primary Care Centres (PPCCs) to provide GP-led care for people who need urgent care, but not an emergency response. This includes low-acuity conditions, such as fractures, burns and mild infections.

PPCCs aim to:

* increase access to primary care for people requiring urgent care, but not an emergency response
* reduce pressure on hospital emergency departments.

PPCC services are:

* free for everyone, with or without a Medicare card
* open extended hours, including in the after-hours period
* located with diagnostics on site or nearby.

There are 29 centres currently operational, including two dedicated paediatric PPCCs located at The Royal Children’s Hospital and Monash Children’s Hospital.

Victorian PHNs commission the PPCCs and provide oversight functions and project support. This includes collaboration on clinical resources to support high-quality, safe and consistent services and communication resources to promote the services to the Victorian community.

#### Medicare Urgent Care Clinics

In May 2022, the Commonwealth announced a funding agreement with Victoria, as part of its national Medicare Urgent Care Clinic (UCC) program. Under the agreement, the Commonwealth is funding 10 of Victoria’s PPCCs to June 2026. These clinics are co-badged PPCCs/Medicare UCCs.

Funding and associated arrangements for the co-badged clinics are governed by a Federation Funding Agreement.

### NURSE-ON-CALL

NURSE-ON-CALL is a Victoria-wide telephone helpline that provides immediate expert health advice from a registered nurse, 24 hours a day, 7 days a week.

NURSE-ON-CALL aims to provide the community with readily accessible advice on non-emergency health matters to assist callers’ decisions including whether to manage their symptoms themselves or visit a GP or hospital service. It also aims to reduce demand on hospital services by diverting cases where acute care is not clinically warranted.

In 2023–24, NURSE-ON-CALL introduced four new referral pathways to the Victorian Virtual ED (adults and paediatrics), Victorian Virtual GP (as part of the Commonwealth Primary Care Pilot program) and Priority Primary Care Centres.

## Dental health services

The public dental program delivers public dental care to eligible Victorians through the Royal Dental Hospital Melbourne, and more than 50 integrated and registered community health services across Victoria.

The department commenced implementation of new pricing and funding arrangements for public dental services from 1 July 2021. Work is continuing on Stage 1 components, including the alignment of clinical placement grants with the broader department approach to clinical placements funding. The department extended transition grants associated with the implementation of a consistent dental weighted activity unit (DWAU) price for public dental services until 30 June 2025. The transition grant component of agency budgets for affected agencies will reduce to 50% in 2024–25.

### Dental Health Program fees policy

Fees for public dental services apply to:

* people aged 18 years or older, who are Health Care Card or Pensioner Concession Card holders, or dependants of Concession Card Holders
* children aged from birth to 12 years, who are not Health Care Card or Pensioner Concession Card holders, and who are not dependants of Concession Card Holders.

For more information about the policy, including a fees schedule and exemptions, visit [Dental health](https://www.health.vic.gov.au/primary-and-community-health/dental-health) <https://www.health.vic.gov.au/primary-and-community-health/dental-health>.

### Participation in Commonwealth initiatives

The Child Dental Benefits Schedule is a means-tested benefits scheme (Family Tax Benefit A) for children aged up to 17 years, covering preventive and basic dental treatment. Public sector access to the Child Dental Benefits Schedule is currently available until 31 December 2026. For more information about eligibility and benefit caps, visit [Services Australia](https://www.servicesaustralia.gov.au/child-dental-benefits-schedule) <https://www.servicesaustralia.gov.au/child-dental-benefits-schedule>.

### Smile Squad

The Victorian Government’s school dental program (Smile Squad) offers free annual oral health examinations and free follow-up dental care for all children attending government primary and secondary schools in Victoria.

The program covers oral health education and examinations, X-rays, teeth cleaning, application of fluoride and dental sealants, fillings, root canals and mouthguards.

Oral health examinations are delivered by mobile teams of dental clinicians, using dental screening vans, who provide dental examinations and oral health promotion within a school setting, and identify children requiring treatment. Follow-up treatment is provided in fully equipped mobile vans at the school site or through referral to a local public dental clinic.

The program commenced with a proof-of-concept phase in late 2019, before pausing most operations for much of 2020 and 2021 in response to the COVID-19 pandemic. In 2022–23, the government provided additional funding for the delivery of the Specialised Services Strategy, providing specialised dental services for those children referred through Smile Squad.

Smile Squad has been rolled out to all Victorian government schools in 2023. Policy development is under way to deliver on the Victorian Government’s commitment to expand access to low-fee, non-government schools, commencing in 2026.

For more information on the school dental program, visit [Smile Squad](https://www.health.vic.gov.au/smile-squad) <https://www.health.vic.gov.au/smile-squad>.

### Administration of fluoride varnish by Aboriginal health practitioners

The Drugs Poisons and Controlled Substances Amendment (Registered Aboriginal and Torres Strait Island Health Practitioners) Regulations 2022 were made in February 2022 to enable registered Aboriginal and Torres Strait Islander health practitioners to obtain, possess and administer fluoride varnish to Aboriginal people to prevent tooth decay.

As at March 2024, eight Aboriginal Health Workers have completed the training, with seven of the workers located in the Loddon Mallee area.

The changes support a program that provides twice-yearly fluoride varnish applications and oral health promotion to Aboriginal children in a culturally appropriate healthcare settings, such as ACCHOs, childcare centres, and kindergartens. This will help reduce the incidence of tooth decay in a population group that is at high risk of oral disease.

The department is working with Dental Health Services Victoria, Aboriginal health organisations and community dental agencies in implementing the fluoride varnish program, including the provision of workforce training and referral pathways.

The fluoride varnish program is part of a new Aboriginal model of care for oral health being developed to strengthen culturally safe dental care and prevention services to Aboriginal people living in Victoria.

## Early Parenting Centres

Early Parenting Centres (EPCs) are operated by Victorian public health services and provide specialist support for Victorian families with children aged up to 4 years. They deliver flexible, targeted services that aim to enhance the parent–child relationship, and support parents with strategies for achieving their parenting goals. These goals are often in areas such as sleep and settling, child behaviour, and parent and child health and wellbeing. Families do not require a Medicare Card to access services at an EPC.

EPCs recognise the importance of the health and wellbeing of parents and the whole family for the health, wellbeing and development of the child.

Eight EPCs are currently operational. A significant EPC service expansion is under way across the state, with a further four EPCs to be established from mid 2024 to 2027.

EPCs are typically funded to deliver service offerings including day-stay programs, residential-stay programs, group-based programs and telehealth or outreach support. Funding is currently allocated using a blended funding model comprising block funding and activity-based funding, with annual targets (clients) specified.

In addition, a dedicated EPC for Aboriginal children and families will be established in Frankston. It will be funded to deliver day stay programs, group-based programs, and telehealth or outreach support.

For more information, visit [Early Parenting Centres](https://www.health.vic.gov.au/maternal-child-health/early-parenting-centres) <https://www.health.vic.gov.au/maternal-child-health/early-parenting-centres>.

# Public health

## Public health and prevention

The department leads reform in disease prevention and early detection. It has invested in a range of prevention initiatives targeting specific areas, including:

* tobacco and e-cigarette reform
* obesity
* physical activity
* healthy eating
* sexual health
* heart disease
* cancer screening
* skin cancer prevention.

The focus is on environmental, social and behavioural approaches at the population level that contribute to reducing or eliminating the causes of poor health and wellbeing.

Primary prevention aims to intervene before poor health outcomes occur. For example, by providing immunisations and promoting factors that protect health, wellbeing, safety and social outcomes. Examples include immunisation, tobacco control legislation, policies for nutritious food provision in early childhood services and other settings, and universal maternal and child health services.

Secondary prevention aims to identify diseases in the earliest stages, before the onset of signs and symptoms. Examples include screening, school-based mental health programs and stable housing.

The *Victorian public health and wellbeing plan 2023–2027* is a Victorian Government plan that guides the collective efforts of the department, other state government departments, health services, local government, NGOs, the private sector and communities.

The plan establishes an ambitious vision for the state: a Victoria free from the avoidable burden of disease and injury, so that all Victorians can enjoy the highest attainable standards of health, wellbeing and participation at every age.

The overall aim is to improve the health and wellbeing of all Victorians, and to reduce inequalities in health and wellbeing. The plan affirms the need for a life-course approach to maximising the health and wellbeing of all Victorians to achieve this vision.

The ten health and wellbeing priorities for Victoria are:

* improving sexual and reproductive health
* reducing harm from tobacco and e-cigarette use
* improving wellbeing
* increasing healthy eating
* increasing active living
* reducing harm from alcohol and drug use
* tackling climate change and its impact on health
* preventing all forms of violence
* decreasing antimicrobial resistance across human and animal health
* reducing injury.

The plan specifically advocates a collective effort by multiple stakeholders to address these complex issues.

The *Victorian public health and wellbeing outcomes framework* provides a comprehensive set of outcomes, indicators, targets and measures for the major population health and wellbeing priorities, and their determinants. It supports monitoring and reporting of collective efforts to improve Victorians’ health and wellbeing over the long term. The framework also identifies where data is available to assess health and wellbeing inequalities.

In October 2021, the Victorian Government released *Healthy kids, healthy futures*, a five-year action plan to support children and young people to be healthy, active and well. The whole-of-government plan offers a positive, strengths-based framework focused on supporting Victorian children and families to be as healthy as they can be, with a focus on healthy eating, active living and mental wellbeing.

It includes existing commitments, along with 13 priority actions to be delivered under four strategic objectives where:

* child, youth and family-focused places provide and promote healthier food and drink
* communities focus on the health and wellbeing of children and young people
* children, young people and families are supported to be healthy and raise healthy children
* active living opportunities are increased for children, young people and families.

Community health services and some SRHS are funded to deliver place-based primary prevention (under the activity names ‘Community health – health promotion’ and ‘Small rural – primary health flexible services’). These organisations align their work with the priority areas of the *Victorian public health and wellbeing plan 2023–27,* including increasing healthy eating, increasing active living and reducing harm from tobacco and e-cigarettes.

Local prevention efforts should be coordinated with councils and other local partners. This will establish a common approach to preparing local health and wellbeing plans. It will also confirm roles in leading and/or contributing to implementation of local priorities. Prevention activities should also align with the *Victorian public health and wellbeing plan* and other Victorian Government strategic directions.

For more information, visit [Victorian health and wellbeing plan](https://www.health.vic.gov.au/victorian-health-and-wellbeing-plan) <https://www.health.vic.gov.au/victorian-health-and-wellbeing-plan>.

### Chronic disease prevention

The Victorian Government funds strategies to reduce risk factors for chronic disease through a place-based approach to prevention, including increasing access to healthy food and drinks in places where people spend their time.

The Achievement Program, delivered by Cancer Council Victoria, is a comprehensive health and wellbeing quality framework for schools, early childhood services and workplaces (including health services) to support the creation of healthier environments. This framework provides best-practice benchmarks to guide settings in determining the policy, cultural and environmental changes needed to improve the health of workers, students, children and the wider community.

The standards cover health priority areas, such as healthy eating, physical activity, and mental health and wellbeing. Once the settings and benchmarks for the health priority areas have been met, the organisations can apply for Victorian Government recognition. For more information, visit [The Achievement Program](https://www.achievementprogram.health.vic.gov.au/) <https://www.achievementprogram.health.vic.gov.au>.

The Healthy Choices policy guidelines provide a framework for improving the provision and promotion of healthier foods and drinks that are available in the community through retail outlets, vending machines and workplace catering.

These policy guidelines support the implementation of Healthy Choices in hospitals, health services, sport and recreation centres, workplaces and parks. There are similar guidelines for schools and early years services.

From mid-2021, health services (hospitals, residential aged care services, integrated community health services) are required to implement the *Healthy Choices: policy directive for Victorian public health services* (Healthy Choices policy directive), which applies to in-house managed retail food outlets, all vending machines, and all staff and event catering. This includes a new requirement for high-sugar (red category) drinks not to be sold or promoted.

There has been a phased approach to implementation, with health services required to meet all requirements by 30 September 2023. With the support of the Healthy Eating Advisory Service (see further below), as at the end of 2023, 99% of health services met the food and drinks targets of the Healthy choices policy directive.

Annual monitoring (including retail and vending assessments using FoodChecker – an online food and drink assessment tool) and reporting on the Healthy Choices policy directive continues to be required.

For more information, visit [Healthy Choices](https://www.health.vic.gov.au/preventive-health/healthy-choices) <https://www.health.vic.gov.au/preventive-health/healthy-choices>.

The *Healthy Choices policy guidelines* have also been integrated into Sport and Recreation Victoria’s (SRV) funding requirements for local government sport and recreation grants, such as in new and upgraded community sports infrastructure across indoor stadiums and aquatic facilities.

When implementing Healthy Choices, funded organisations and key settings are encouraged to also integrate environmentally sustainable food procurement practices to ensure that food and drinks purchased with government funds not only promote health and wellbeing but also drive social and environmental outcomes. For more information visit [Healthy and more sustainable food procurement](https://www.health.vic.gov.au/public-health/healthy-and-more-sustainable-food-procurement) <https://www.health.vic.gov.au/public-health/healthy-and-more-sustainable-food-procurement>.

The Healthy Eating Advisory Service offers free support for implementing the *Healthy Choices policy guidelines* and the *Healthy Choices policy directive*, as well as implementing aligned food and drink policies in schools and early childhood services. Funded by the Victorian Government and delivered by Nutrition Australia – Victoria Division, it supports organisations to develop the skills and knowledge needed to remove sugary drinks and increase healthy food options in their retail food outlets, vending machines and catering. The service is available to health services, as well as early childhood services, schools, workplaces, sport and recreation facilities, parks and universities.

The service provides:

* email and phone implementation advice from qualified dietitians and nutritionists
* comprehensive online resources, recipes, tips, factsheets and case studies
* the FoodChecker tool for assessing products, menus, recipes and vending machines
* online training
* implementation forums and communities of practice.

For more information, visit the [Healthy Eating Advisory Service](https://heas.health.vic.gov.au) <https://heas.health.vic.gov.au>.

The Vic Kids Eat Well initiative is jointly delivered by Cancer Council Victoria’s Achievement Program and Nutrition Australia’s Healthy Eating Advisory Service. It aims to boost uptake of healthy eating across settings where children and families spend their time. It focuses on achievable actions that settings can take to create healthier places for children.

The actions of the Vic Kids Eat Well campaign align with or provide a significant step towards healthy eating policies, including the Healthy Schools Achievement Program benchmarks for healthy eating, Healthy Choices guidelines, and the *Canteens, healthy eating and other food services policy*. The Victorian Health Promotion Foundation (VicHealth) is a key partner in promoting the health and wellbeing of Victorians, and an important factor in the statewide public health system. VicHealth’s strategic directions are outlined in the *VicHealth strategy 2023–2033* reflecting the vision for a healthier, fairer Victoria where all Victorians benefit from good health and have the opportunity to thrive.

### Life! program

The *Life!* program provides healthy lifestyle education and skills, through group courses (online and face to face) and telephone health coaching, to adults who are at risk of developing type 2 diabetes or cardiovascular disease.

The program was launched in 2007, based on research findings from local and international trials demonstrating that lifestyle modification can reduce the incidence of type 2 diabetes. In 2012, it transitioned into a prevention program for type 2 diabetes and cardiovascular disease.

Funding is provided to Diabetes Victoria to deliver the *Life!* program and associated activities, including evaluation and continuous quality improvement of the program, as part of the prevention system in Victoria. This funding is output-based and results for participation are collected quarterly. Program targets are set out in the *Victorian* *State Budget Paper No. 3*.

### Cancer Screening Program pathways

#### Colonoscopy arising from a positive National Bowel Cancer Screening Program test

The National Bowel Cancer Screening Program (NBCSP) is an Australian Government population health initiative to improve the early detection and prevention of bowel cancer. People who meet the eligibility requirements to participate in the program receive an invitation through the mail to complete a faecal occult blood test at home, which is returned by mail to a laboratory for analysis. Participants with a positive screening test are encouraged to see their GP and are usually referred for a colonoscopy.

In providing colonoscopy services for NBCSP participants, all health services are expected to:

* provide services in accordance with the [Victorian colonoscopy categorisation guidelines](https://www.health.vic.gov.au/publications/colonoscopy-categorisation-guidelines) <https://www.health.vic.gov.au/publications/colonoscopy-categorisation-guidelines> which indicate a timeframe of 30 days for colonoscopy following a positive screening test. The [Victorian endoscopy categorisation decision support tool](https://endocatvic.net.au/endoscopy-categorisation) <https://endocatvic.net.au/endoscopy-categorisation> supports health services to apply the guidelines by providing automated clinical prioritisation, assisting clinicians to complete endoscopy referrals, and supporting consistent application of the guidelines
* report all NBCSP colonoscopies to the Victorian Admitted Episodes Dataset (VAED) using the NBCSP flag to ensure access to NBCSP funding under Funding arrangement Code 8
* report all NBCSP colonoscopy and histopathology data to the [National Cancer Screening Register](http://www.ncsr.gov.au/content/ncsr/en/healthcare-providers/RegisterAccess.html#hcpportal) <http://www.ncsr.gov.au/content/ncsr/en/healthcare-providers/RegisterAccess.html#hcpportal>, which operates as a safety net to ensure all participants with a positive screening test are followed up. It is also key to the effective monitoring and evaluation of the NBCSP.

For more information, visit [NBCSP](https://www.health.gov.au/initiatives-and-programs/national-bowel-cancer-screening-program) <https://www.health.gov.au/initiatives-and-programs/national-bowel-cancer-screening-program>.

#### Colposcopy arising from a positive National Cervical Screening Program test

In December 2017, the National Cervical Screening Program changed from providing a pap test every two years for women aged 18–69, to a human papillomavirus test every five years for women aged 25–74. Since 1 September 2022, invitations for the current five-year cervical screening cycle have been sent to eligible participants.

Several health services deliver public colposcopy services for women and people with a cervix who have had a positive test through the National Cervical Screening Program. Based on the colposcopy findings, if required, women will then be referred to gynaecology medical specialist clinics for treatment.

The National Cervical Screening Program referral pathways are documented on Cancer Council Australia’s [National Cervical Screening Program: guidelines for the management of screen-detected abnormalities, screening in specific populations and investigation of abnormal vaginal bleeding](https://wiki.cancer.org.au/australia/Guidelines%3ACervical_cancer/Screening)<https://wiki.cancer.org.au/australia/Guidelines:Cervical\_cancer/Screening>.

These guidelines and the rollout of universal cervical screening self-collection have been incorporated into gynaecology statewide referral criteria for gynaecology medical specialist clinics, which can be found on the [Statewide referral criteria website](https://src.health.vic.gov.au) <https://src.health.vic.gov.au>.

For more information, visit [National Cervical Screening Program](https://www.health.gov.au/our-work/national-cervical-screening-program) <https://www.health.gov.au/our-work/national-cervical-screening-program>.

#### Victorian Breast Screening Program

The BreastScreen Australia Program is jointly funded by the Commonwealth and state and territory governments. BreastScreen Victoria is contracted to deliver the program in Victoria. The program invites eligible people aged 50–74 years to have a free mammogram at a breast screening clinic every two years. People over the age of 40 with risk factors are also able to access the program, but do not receive direct invitation.

BreastScreen Victoria provides services through screening clinics, mobile vans and reading and assessment services. More information is available via the [BreastScreen Victoria website](http://www.breastscreen.org.au) <www.breastscreen.org.au>.

### Sexual and reproductive health and viral hepatitis

The department commissions sexual reproductive health and viral hepatitis services and programs to reduce the burden of disease, to improve the wellbeing of communities at risk or affected by high prevalence rates of blood-borne viruses (BBV), such as human immunodeficiency virus (HIV) and viral hepatitis’, and sexually transmissible infections (STI).

A wide range of agencies are funded to provide peer-based care and support, clinical care, health promotion, research, surveillance and workforce training.

The BBV/STI funding and reporting guidelines are updated annually and issued to funded agencies. All agencies funded for BBV/STI activities are required to acquit funding using the guidelines and templates provided. Standard contract management processes apply, including performance output monitoring, annual planning reporting and face-to-face meetings as required.

In 2022, the department released the *Victorian sexual and reproductive health and viral hepatitis strategy 2022–30*, which sets the overarching direction for achieving optimal sexual and reproductive health, and viral hepatitis outcomes for Victorians.

The strategy has seven plans. Six or for specific diseases and population groups, and one focuses on the system enablers contributing to better outcomes for Victorians’ sexual and reproductive health. The strategy and subplans support Victoria’s contribution to the National BBV and STI plans.

The *Victorian sexual and reproductive health and viral hepatitis strategy 2022–30:*

* *Strategy overview and system enabler plan 2022–30*
* *Victorian Aboriginal sexual and reproductive health plan 2022–30*
* *Victorian hepatitis B plan 2022–30*
* *Victorian hepatitis C plan 2022–30*
* *Victorian HIV plan 2022–30*
* *Victorian sexually transmissible infections (STI) plan 2022–30*
* *Victorian women’s sexual and reproductive health plan 2022–30.*

The plans outline target priority populations, goals and objectives specific to each disease, population or issue to deliver throughout the period of the strategy.

### Tobacco and e-cigarettes

To reduce the burden of smoking and vaping on the community, the Victorian Government, in partnership with VicHealth and Cancer Council Victoria, funds Quit Victoria to provide tobacco and vaping cessation services, social marketing campaigns and contributes to research. Together these programs provide:

* support services, including the Quitline, to deliver expert advice and personalised counselling to smokers and vapers wanting to quit
* programs targeted at priority groups with the highest rates of smoking and vaping
* Victorian anti-smoking and anti-vaping social marketing campaigns (integrated across television, radio, print and social media) to reduce smoking and vaping uptake and increase cessation
* research to inform tobacco and e-cigarette policy and regulatory reform, including annual surveys of smoking and vaping prevalence and behaviours.

The department also funds the Municipal Association of Victoria to manage the distribution of funds to councils, to educate businesses and the community regarding their responsibilities under the *Tobacco Act 1987*, to undertake test purchasing and to take enforcement action where necessary.

## Public health and health protection

The Victorian Chief Health Officer is the lead public health advisor to the Minister for Health and the Victorian Government, and they are the state’s spokesperson on public health issues. The Chief Health Officer works closely with areas of the department with public health and health protection responsibilities, including the Public Health Protection, Practice and Response branch and the Health Regulator, as well as with Local Public Health Units (LPHUs).

The Chief Health Officer has statutory powers under the *Public Health and Wellbeing Act 2008* to protect the health and wellbeing of Victorians, and is involved in overseeing policy, strategy and operations in health protection, coordinating investigations and management of public health risks, and undertaking risk communication with stakeholders, including the Victorian public.

The Chief Health Officer regularly informs Victorians about issues that have the potential to affect their health. Information is provided via health alerts and a range of other documents that are available on the department’s [Chief Health Officer website](https://www.health.vic.gov.au/public-health/chief-health-officer) <https://www.health.vic.gov.au/public-health/chief-health-officer>.

The department’s responsibility for health protection is to reduce the incidence of preventable disease by protecting the community against hazards resulting from, or associated with, communicable disease, food, water, or the environment.

This includes the delivery of programs that protect the health and wellbeing of Victorians, and the administration of statutory and legislative functions under the:

* *Public Health and Wellbeing Act*
* *Food Act 1984*
* *Safe Drinking Water Act 2003*
* *Radiation Act 2005*
* *Health (Fluoridation) Act 1973*.

Key areas of health protection activity include communicable disease and environmental health. The work of communicable disease aims to reduce the risk of current and emerging infectious diseases in Victoria, through implementing patient- and population-focused control strategies (including immunisation), based on surveillance and risk assessment.

Environmental health works to prevent ill health arising from environmental hazards, not related to waste or pollution. It responds to major threats to public health and regulates hazards, such as radiation, pesticides, cooling towers, safe drinking water and food safety.

### Victorian Tuberculosis Program

The department funds Melbourne Health to provide the Victorian Tuberculosis Program, a statewide service based at the Peter Doherty Institute for Infection and Immunity. Program staff provide case management to people with active tuberculosis for the duration of their treatment and conduct appropriate contact tracing and screening to minimise the public health risk of the spread of infection.

The department has developed performance measures for Melbourne Health, which are outlined in the Victorian Tuberculosis Program service objectives and scope document.

### Immunisation

The Royal Children’s Hospital, Western Health and Monash Health deliver specialist immunisation services to the Victorian community that cannot be delivered in primary care settings.

This includes specialist assessment and immunisation of high-risk populations, including immunisation under sedation, drop-in outpatient clinics for opportunistic immunisations, and Bacillus Calmette–Guérin (BCG) vaccine clinics for children under the age of five years.

Supporting the specialist immunisation services aligns with the department’s commitment to meet National Immunisation Program performance benchmarks outlined in the Essential Vaccines Schedule agreement with the Commonwealth.

## Local Public Health Units

LPHUs are the local frontline of Victoria’s statewide public health network. Each LPHU has responsibilities for public health activities and outcomes in a catchment, defined as a set of local government areas. LPHUs support the strategy and activity of the broader public health network.

LPHUs manage, facilitate and deliver high-value public health preparedness, prevention and local responsiveness to public health risks. They provide advice about escalating risk, issue or concern and mitigation to relevant department stakeholders. They also collect and use local data for surveillance of diseases in their catchment to inform and complement statewide surveillance functions.

Where appropriate, LPHUs respond to notifications of notifiable conditions in their catchment. They provide support and expertise for other emerging or known public health risks, including in relation to emergencies, at the request of the Secretary or Chief Health Officer.

LPHUs continue to strengthen their roles as a leading public health voice for their communities, engaging and guiding stakeholders. They work strategically to identify and address public health challenges in their catchment. In partnership with their communities, and as agents for the *Victorian public health and wellbeing plan 2023–2027* (VPHWP), LPHUs are important partners in the prevention system. They have a lead role in population health regional catchment planning and implementation in collaboration with partners including community health, primary care, women’s health, local government and Aboriginal communities.

LPHUs embed Aboriginal health and cultural safety capability within LPHU operations, connecting with ACCOs to enable self-determining approaches that meet the public health needs of Aboriginal communities in the catchment.

The department enables reporting, and monitors progress and outcomes across the statewide public health network. LPHUs work to achieve the VPHWP’s vision of a Victoria free from the avoidable burden of disease and injury, so that all Victorians can enjoy the highest attainable standards of health, wellbeing and participation at every age. They provide the department with local intelligence and metrics that inform understandings of effectiveness and value of locally implemented public health activities and the statewide public health strategy. The nine lead health services that maintain an LPHU will participate in regular reporting activities as per the LPHU Outcomes Framework.

# Health workforce training and development

## Training and development funding

The department provides training and development funding to Victorian public health services to contribute to the costs associated with developing a high-quality future health workforce for Victoria. This funding is in addition to training and development support provided through activity payments.

Multiple streams of funding are allocated to support the continuum of teaching and training activities including:

* professional-entry student placements
* transition-to-practice – early graduate positions (medical year one and two, nursing and midwifery, and allied health)
* postgraduate medical, nursing and midwifery positions
* other targeted workforce training and development programs.

In 2024–25, the department will confirm training and development funding for ongoing recurrent programs early in the financial year, to provide health services with greater certainty of annual budgets, with the aim of making minimal adjustments during the year, if reported activity is within the expected range.

### Professional-entry student placements

Subsidies to health services are allocated to support the delivery of professional-entry student placements. Subsidies are based exclusively on health services’ proportion of total (weighted) clinical placement activity for students enrolled in a professional-entry course of study in medicine, nursing (registered and enrolled), midwifery, paramedicine or allied health (including allied health assistants). For further information, Victorian public health services should refer to the relevant year’s [Fee schedule for clinical placement in public health services](https://www.health.vic.gov.au/education-and-training/fee-schedule-for-clinical-placement-in-public-health-services) <https://www.health.vic.gov.au/education-and-training/fee-schedule-for-clinical-placement-in-public-health-services>.

Some clinical placements, allied health internships and industry-based learning positions are not eligible for the professional-entry student placement subsidy. This is because they are funded through the transition-to-practice and postgraduate study streams of the grant.

### Transition-to-practice (graduate) positions

Transition-to-practice programs seek to ensure new graduates make a positive transition into the public sector health workforce and encourage them keep working in the sector. They are workplace-based programs designed to consolidate knowledge, skills and competence, and to assist the transition from student to competent, confident and accountable professional.

The department will provide funding for transition-to-practice programs in a number of areas, including:

* graduate allied health professionals
* hospital pharmacy interns
* nursing and midwifery graduates
* medical graduates (postgraduate year 1 and 2).

Subsidies to Victorian public health services contribute to the cost of supervision and on-the-job training in the first year for approved nursing, midwifery and specified allied health graduate positions, and in the first two years for approved medical graduate positions. For more information and details on funding eligibility and criteria, visit [Training and development funding](https://www.health.vic.gov.au/education-and-training/training-and-development-funding) <https://www.health.vic.gov.au/education-and-training/training-and-development-funding>.

Note: Victorian public mental health services do not use transition-to-practice subsidies outlined for nursing and allied health graduates. These services access subsidies through dedicated mental health training and development funding.

#### Allied health graduates

The allied health graduate disciplines that are eligible for transition-to-practice training and development funding include:

* art therapy
* audiology
* biomedicine
* dietetics and nutrition
* exercise physiology
* medical laboratory science
* medical physics
* music therapy
* nuclear medicine
* occupational therapy
* optometry
* orthoptics
* orthotics and prosthetics
* physiotherapy
* podiatry
* psychology
* radiography (diagnostic imaging)
* radiation therapy
* social work
* speech pathology.

#### Allied health pharmacy intern program

Training and development subsidies are available to health services employing pharmacy interns who are completing industry-based learning, for a total of 100 positions.

#### Medical prevocational training

This funding is available to health services providing positions for postgraduate year 1 (PGY1) medical officers and postgraduate year 2 (PGY2) medical officers accredited by the Postgraduate Medical Council of Victoria.

In 2024–25, rural and regional health services that receive these grants are expected to offer two-year prevocational training contracts to PGY1 doctors who undertake a 12-month internship.

### Postgraduate positions – medical, nursing and midwifery

Subsidies to Victorian public health services contribute to postgraduate study or employment arrangements, including the cost of supervision, for approved positions.

All health services must reconcile actual activity each year to receive postgraduate funding. Subsidies are approved and allocated based on each health service’s activity and priority workforce considerations.

#### Medical specialist training

The following programs are available for postgraduate medical specialist training:

##### Victorian Medical Specialist Training program

The Victorian Medical Specialist Training (VMST) program provides funding to health services to expand high-quality medical specialist training opportunities in priority locations and disciplines.

The VMST funding criteria focus on allocating funding for specialist training that aligns with community need. Funding aims to provide opportunities for system-level reforms to address workforce shortages by developing training pathways and rural employment opportunities. All positions must be newly created and increase accredited training capacity and/or capability.

Funding is available for two calendar years. Health services can apply for funding under one of three funding streams:

* funding stream A (metropolitan stream) – for expansion of training capacity and capability in specialities in limited supply in metropolitan Melbourne. Ten specialties were identified under this stream (as detailed in the current Training and Development Funding Program guidelines). Applications for other specialties may also be considered if there is evidence of a workforce shortage or need within a particular discipline
* funding stream B (regional and rural stream) – for expansion of training capacity and capability in any specialty in regional and rural health services. Eligibility for this funding stream involves training positions where at least 50% of training occurs in a regional or rural setting, including positions that are part of a training network
* funding stream C (innovation) – for flexible and innovative approaches that assist in the growth of specialist training capability and/or capacity in regional and rural Victoria, and support end-to-end training pathways.

##### Victorian Basic Paediatric Training Consortium

The Victorian Basic Paediatric Training Consortium aims to support equitable access to specialist training opportunities across Victoria. It also aims to deliver high-quality paediatric care aligned with community need. This includes improving the supply of rural and outer metropolitan paediatricians through developing end-to-end training pathways.

All hospitals that are accredited for basic paediatric training in Victoria are members of the consortium. The Victorian Basic Paediatric Training Consortium replaces the former Victorian Paediatric Training Program.

The consortium established the Extended Rural Stream, which provides a pathway for trainees to complete at least half of their basic paediatric training in rural and regional sites. The pilot commenced in 2022 and enables trainees to undertake most of their training in rural and regional locations. This promotes better recruitment and retention of paediatricians in rural and regional areas.

The consortium is supported by formal governance arrangements to provide oversight and management of the statewide basic paediatrics training program.

##### Basic Physician Training Consortia

The Basic Physician Training Consortia program provides annual funding to five consortia, which include all Victorian hospitals with accredited physician training positions. This supports distribution and management of basic physician trainees, addresses workforce shortages, and improves the quality of education and training in rural Victoria.

Positions are made available through this program via the ‘match’ undertaken annually by the PMCV.

##### Postgraduate nursing and midwifery education

The postgraduate nursing and midwifery education program provides funding for health services to provide clinical support for registered nurses and midwives undertaking postgraduate studies. The program is for areas of clinical practice where there is an identified workforce need, and that lead to an award classification of graduate certificate, graduate diploma or master-level studies.

Hospital operators should ensure all program areas comply with the *Safe Patient Care (Nurse to Patient and Midwife to Patient Ratios) Act 2015*, for example, Emergency, Coronary Care and Maternity.

##### Nursing and midwifery postgraduate scholarships

Nursing and midwifery postgraduate scholarships are provided to public health services to support registered nurses and midwives to undertake postgraduate study. The scholarships are for areas of clinical practice where there is an identified workforce need. Hospital operators should ensure that postgraduate nursing and midwifery scholarship requests prioritise the areas specified in the *Safe Patient Care (Nurse to Patient and Midwife to Patient Ratios) Act 2015*, for example Emergency, Coronary Care and Maternity. Identified priority clinical areas are detailed in the current [Training and development funding program guidelines](https://www.health.vic.gov.au/education-and-training/training-and-development-funding) <https://www.health.vic.gov.au/education-and-training/training-and-development-funding>.

In addition, targeted funding is available to support registered nurses to undertake postgraduate midwifery studies in rural public health services or regional consortia, which provide maternity services.

Health services are responsible for dissemination of information regarding scholarships, managing the application process, disbursing funds and monitoring outcomes of the scholarship program. Funding will be distributed to each health service (rather than consortia in regional and rural areas), with the exception of rural midwifery postgraduate scholarships.

As per previous scholarship arrangements, the nurse or midwife must agree to complete the course and work in the target area of practice in the Victorian public health service for two years.

For more information and eligibility criteria, visit [Training and Development Funding](https://www.health.vic.gov.au/education-and-training/training-and-development-funding) <https://www.health.vic.gov.au/education-and-training/training-and-development-funding>.

### Other targeted workforce training and development programs

#### Allied Health Leadership Program

The Allied health workforce enhancement plan provides funding for initiatives that collectively build the capacity and capability of the allied health sector to deliver high-quality and safe care and enhance client outcomes.

The Allied Health Leadership Program, an initiative under the *Allied health workforce enhancement plan*, is underpinned by the Allied health leadership development framework, which identifies stages of scaffolded leadership development across the career continuum. This framework informs the delivery of targeted allied health leadership capacity building initiatives.

#### Allied health research translation and clinical educator roles

To further enhance allied health workforce development, 10 senior allied health research and knowledge translation roles, and 10 clinical educator positions have been implemented across Victorian health services.

#### Continuing Nursing and Midwifery Education program

The Continuing Nursing and Midwifery Education program provides funding to health services to support planned and targeted nursing and midwifery education, which maintains and improves the skills and knowledge of nurses and midwives employed in their organisation.

Funding has previously been allocated on the basis of total nursing and midwifery full-time-equivalent (FTE) staff. Note that CNME funding distribution is being reviewed for 2024–25 and an addendum will be issued once allocation methodology is determined.

#### Making it Free to study Nursing and Midwifery initiative

To help build a stronger workforce, the department is offering scholarships and support to train and upskill the next generation of nurses and midwives. The Making It Free to Study Nursing and Midwifery (Making It Free) initiative will increase support across the workforce to build and retain a supply of nurses and midwives. Unique application processes are in place for most of these programs.

The following programs are supported through Making It Free initiative:

* undergraduate (entry to practice) nursing and midwifery scholarships for eligible individuals who commenced entry-to-practice nursing and/or midwifery studies in 2023 or 2024
* enrolled nurse to registered nurse transition scholarships for eligible individuals who commenced an eligible two-year enrolled nurse to registered nurse program of study in 2023 or 2024
* re-entry pathway scholarships for those who previously held registration as a nurse or midwife who participate in an eligible tertiary re-entry to nursing or midwifery program of study
* refresher pathway scholarships for nurses and midwives to refresh their clinical skills or to upskill through a public health service hosted refresher program
* support for new nurse practitioner candidates in both acute and community settings, including funding for health services to provide clinical supervision, salary support and scholarships for candidates for eligible individuals who commenced an eligible Master of Nursing (Nurse Practitioner) program of study in 2023 or 2024
* the Postgraduate Midwifery Employment Model in 2023, or 2026.

#### Maternity Connect Program

The Maternity Connect Program provides funding to support the ongoing education of rural and regional midwives, through facilitating clinical placements in larger, higher-acuity services. The funding covers travel and accommodation of participants, backfill of staff for the rural service, and a subsidy for the placement service to ensure clinical support.

#### Nursing and midwifery graduate sign-on bonus

A sign-on bonus, valued at $5,000, is available to existing nursing and midwifery students who graduate between 2022 and 2024, commence their careers with a Victorian public health service in the same calendar year or the calendar year immediately following course completion, and commit to working for two years. The sign-on bonus is paid in two instalments. The first payment of $2,500 is paid after the graduate commences work as a registered nurse or midwife, for example as a graduate in a transition-to-practice program, and the second payment of $2,500 is paid after two years of continuous work in the Victorian public health system (including the transition-to-practice year).

The sign-on bonus will encourage those who complete their study to take up careers in Victoria’s public health system. This funding will assist Victorian public health services to attract and retain graduate nurses and midwives. It will also contribute to building the strength, capability and resilience of Victoria’s nursing and midwifery workforces.

Eligible graduates are nominated by their health service and then invited to claim their sign-on bonus via a centralised sign-on bonus portal.

#### Rural Clinical Academic Program

The Rural Clinical Academic Program supports rural and regional health services that, in conjunction with Rural Clinical Schools, provide academic teaching and regional coordination for medical students who are hosted at the health service for an extended period. The funding recognises the increased costs of providing academic teaching, support, coordination and infrastructure for medical students based at a rural and regional health service for a period longer than six weeks.

The program is intended to ensure the types of learning experiences that medical students receive in rural and regional health services are of a high quality and demonstrate the varied and rewarding work occurring in these services. This funding is provided in addition to other training and development funding for professional-entry clinical placements that help students acquire clinical skills through applying theoretical knowledge to practice.

#### Victorian Rural Generalist Program

The Victorian Rural Generalist Program (VRGP) supports the development of end-to-end training pathways for rural generalists leading to employment in rural and regional Victoria.

The program supports rural and regional medical practitioners to gain advanced skills as part of supported pathways of general practice training. This includes either Fellowship of the Australian College of Rural and Remote Medicine or the Fellowship of the Royal Australian College of General Practitioners, and the Fellowship of Advanced Rural General Practice.

It includes training positions in areas such as obstetrics, anaesthetics, emergency medicine, paediatrics, Aboriginal health and mental health.

This helps ensure Victorian rural generalists are well equipped to work across rural and general practice and hospital settings.

The program supports specific rural generalist positions across the training pathway, including:

* Rural Generalist Year 1 (intern year)
* Rural Generalist Year 2 (PGY2+ year)
* Rural Generalist Advanced (PGY3+ year)
* Rural Generalist Consolidation (post-procedural advanced skills year).

Recruitment to training positions under the VRGP is undertaken via the statewide match process managed by PMCV.

The VRGP is supported by a statewide Clinical Lead and four Advanced Skills Clinical Leads to mentor and support trainees. Regional coordinators based in health services across each of the five rural regions also support development of the VRGP. The VRGP is governed by the VRGP *m*anagement *f*ramework, which includes regional networks and a Statewide Reference Committee.

#### Rural health workforce support

The department works collaboratively with Rural Workforce Agency Victoria to support a range of identified rural workforce development requirements across Victoria. It works directly with rural and regional health services, and community GPs to support recruitment of locums, including GPs providing services in public health services. Funding is allocated to provide locum support, and to support professional development for the rural medical and allied health workforces.

#### Mental health – training and development grants

Since 2000, the department has provided recurrent funding to Victorian Area Mental Health and Wellbeing Services to employ clinical educators and other core staff needed to deliver the services’ training and development program. Roles coordinate and provide expert clinical supervision and education to students on clinical placement, graduates and transition to mental health practice staff and other staff needing to acquire and develop mental health and alcohol and other drug capabilities and skills.

Commencing in 2018–19 and expanded to deliver on recommendations from the Royal Commission into Victoria’s Mental Health System, Area and Statewide Mental Health and Wellbeing Services were additionally funded to deliver graduate and transition to mental health practice programs. The latter programs are for already qualified clinical staff without mental health qualifications wanting to transition to work in mental health settings. Funding for 2024–25 includes for mental health nurses, allied health and psychiatry registrars as well as for junior medical officers to undertake mental health rotations.

#### Mental Health Workforce Scholarship Program

Scholarships are offered annually to mental health nurses, allied health, alcohol and other drug and lived and living experience workers working in mental health and/or alcohol and other drug services. These scholarships are offered to help support retention and support continued learning and development to help build skills, knowledge, capabilities and career satisfaction and improved outcome for consumers and their family, carers and supporters accessing mental health services. Partial (for example, up to $3,000 for a mental health nursing scholarship and up to $13,000 for a lived and living, allied health and alcohol and other drug scholarship) and full-fee (mental health nurse scholarship) scholarships are offered.

#### Mental health – clinical and non-clinical academic positions

Multiple Area Mental Health and Wellbeing Services and university academic partners receive recurrent funding to deliver mental health Academic Chair positions. Funding includes appointment of a senior mental health academic and additional funding for program support. Funded academics include psychiatry, mental health nursing, carer and consumer academics and their broader research program staff. Funded academic positions work in partnership with other health service and university staff to conduct applied research that builds understanding and improved treatments, therapies and other interventions to improve outcomes for mental health consumers and family, carers and supporters and the workforces that support them.

#### Registered undergraduate students of nursing and midwifery

In 2024–25, there is dedicated supplemental funding for health services to continue to engage registered undergraduate students of nursing (RUSON) and midwifery (RUSOM) positions.

### Funding conditions and allocation

Health services that receive training and development grant funding should ensure they meet eligibility and reporting requirements, as detailed in the current [Training and Development Funding Program guidelines](https://www.health.vic.gov.au/education-and-training/training-and-development-funding) <https://www.health.vic.gov.au/education-and-training/training-and-development-funding>.

Nursing and midwifery program areas must comply with the Safe Patient Care (Nurse to Patient and Midwife to Patient Ratios) Act. Where the department is made aware of noncompliance with this Act, training and development grant funding may be withheld or recovered.

All programs supported through training and development funding must conform to the most recent versions of guidelines (where available). This includes the guidelines and standards set by the Australian Health Practitioner Regulation Agency (AHPRA) and the national health practitioner boards.

The total grant pool limits the amount of funding allocated to individual health services. Reporting of eligible activity by health services to the department is essential to ensure timely and appropriate allocations of funding.

If programs or training positions include a period of rotating placements, lead organisations are required to ensure the other host organisations receive a pro rata portion of the grant that is equal to the length of the rotation.

For more information, visit [Health workforce](https://www.health.vic.gov.au/health-workforce) <https://www.health.vic.gov.au/health-workforce> or download the [Training and Development Funding Program guidelines](https://www.health.vic.gov.au/education-and-training/training-and-development-funding) <https://www.health.vic.gov.au/education-and-training/training-and-development-funding>.

# Capital funding programs

The department administers several capital grant programs to assist health services with the costs of hospital equipment and infrastructure replacement needs. These include the:

* Infrastructure Renewal Contribution Grant (IRCG)
* Regional Health Infrastructure Fund (RHIF)
* Medical Equipment Replacement Program (MERP)
* Engineering Infrastructure Replacement Program (EIRP).

These programs support health services to manage asset risk and maintain patient safety, occupational health and safety, and service availability and continuity. They improve the asset base and allow services to maintain and replace assets in a planned way.

The department has adopted a structured approach to allocating and managing funds. Where projects are unable to be completed and acquitted within a two-year period, allocations may be recalled and reappropriated to other priority projects.

## Infrastructure Renewal Contribution Grant

In 2024–25, $46 million will be distributed to public hospitals, including rural and SRHS, to assist health services with the costs of replacing hospital infrastructure and addressing critical risks. The infrastructure renewal contribution grant (IRCG) should be used to address urgent and critical infrastructure risk and asset replacement needs outlined in the annual asset management plan. The $46 million will be appropriated at 50% in July 2024. The remaining funds will be distributed in February 2025 to health services that submit their updated asset management plan by 31 December 2024 by emailing the Asset Planning in System Planning Division <assetmanagement@health.vic.gov.au>.

Prior to 2020, this grant was appropriated monthly from July.

## Regional Health Infrastructure Fund

The $790 million Regional Health Infrastructure Fund provides funding for rural and regional health services in a bid-based process and is administered by the Victorian Health Building Authority to address high-risk asset and capacity issues.

The key objectives of this fund are to assist rural and regional health services to:

* mitigate infrastructure risk and to maintain patient safety, healthcare worker safety, service availability and business continuity
* enhance service capacity, support contemporary models of care, and improve patient and staff amenity
* sustain and improve infrastructure assets that provide essential capacity for delivering responsive and appropriate clinical services across rural and regional public health facilities
* provide a stronger role for outer regional services that will allow care to be safely provided closer to where people live
* further incentivise health services and agencies to implement effective asset management that aligns with existing government frameworks and policies.

The capital funding will result in delivery of renewal, reconfiguration and refurbishments across a range of projects and service delivery streams and deliver the key Victorian Government policy objective of ensuring all Victorians can access high-quality healthcare, no matter where they live.

Funds are available for:

* construction – minor infrastructure, including replacement, reconfiguration, remodelling and refurbishment projects to address aged building fabric, compliance and demand issues
* medical equipment
* engineering infrastructure and plant
* information and communications technology (ICT)
* new technologies, including systems to reduce usage and increase efficiencies of power and water
* compliance-related capital and/or upgrade works (for example, AS4187, including pandemic improvement and readiness, fire and life-safety works)
* motor vehicles – eligibility is restricted to bush nursing centres only.

Submissions will be assessed by an evaluation panel using a defined set of assessment criteria. Submissions should reflect agreed policy objectives and how the proposed works will meet the objectives of better health for people in regional and rural Victoria.

Submissions will be assessed within the project categories (‘Regulatory and compliance’, ‘Quality and safety’ and ‘Respond to growing demand/capability’).

## Medical Equipment Replacement Program

As part of applying the Asset Management Accountability Framework (AMAF) requirements in strategic asset planning, the Medical Equipment Replacement Program will be transitioning from submission based to direct allocation over three years in accordance with health services asset replacement needs identified in their asset management plans.

In 2024–25, four health services will pilot the direct allocation program. Health services participating in the direct allocation pilot will be contacted via letter to the CEO by 1 June 2024. Direct allocation will be provided for prioritised assets identified by health services in their asset management plans, asset registers and the department. All remaining eligible health services will continue to participate in the high-value submission bid process and the Specific Purpose Capital Grants (SPCG).

## Engineering Infrastructure Replacement Program

As part of applying the AMAF requirements in strategic asset planning, the Engineering Infrastructure Replacement Program will be transitioning from submission based to direct allocation over three years in accordance with health services asset replacement needs identified in their asset management plans.

In 2024–25, three health services will pilot the full direct allocation program. Health services participating in the direct allocation pilot will be contacted via letter to the CEO by 1 June 2024. Direct allocation will be provided for prioritised assets identified by health services in their asset management plans, asset registers and the department Asset Information Management System. All remaining eligible health services will continue to participate in the high-value submission bid process and the SPCG.

# Health service compensable and ineligible patients

## Interstate patients

The National Health Reform Agreement requires jurisdictions with significant cross-border patient flows to enter into agreements to reconcile costs incurred for patient services provided to Medicare-eligible residents of other Australian states or territories.

In Victoria, health services provide admitted acute, mental health, emergency, subacute and non-admitted services to residents of other states and territories, consistent with the National Health Reform Agreement and the Medicare principles, which are:

* choice of services – Medicare-eligible persons must be given the choice to receive public hospital services free of charge as public patients, and can elect to be treated as a private patient to be admitted and treated, subject to the normal private patient admission requirements
* universality of services – access to public hospital services is to be on the basis of clinical need
* equity in service provision – to the maximum practicable extent, Victoria will provide public hospital services equitably to all eligible persons, regardless of their geographical location.

The services provided by Victorian health services to residents of other states and territories are part of a health service’s normal throughput targets. They are not counted as additional activity or funded separately.

## Medicare-ineligible patients and international patients

Health services should charge Medicare-ineligible patients for the full cost of their treatment including any treatment related to COVID-19. While individual health services may determine the level of fees chargeable, they should, at a minimum, be set to achieve full cost recovery. All health services should ensure that appropriate verification, billing and debt collection processes are in place to minimise bad debts.

Exemptions from charging fees include the following:

* Health services are required to provide Medicare-ineligible asylum seekers with full medical care, under the same arrangements that apply to all Victorian residents. Patients in this category are not to be billed. Funding for these patients is provided by the department as part of normal public patient throughout. For more information, visit [Hospital access for people seeking asylum](https://www.health.vic.gov.au/publications/hospital-access-for-people-seeking-asylum) <https://www.health.vic.gov.au/publications/hospital-access-for-people-seeking-asylum>.
* Tuberculosis (TB) patients are eligible to receive publicly funded services for TB-related treatment. For more information, visit [Hospital provision of tuberculosis and leprosy services](https://www.health.vic.gov.au/public-health/hospital-provision-of-tuberculosis-and-leprosy-services) <https://www.health.vic.gov.au/public-health/hospital-provision-of-tuberculosis-and-leprosy-services>.
* Visitors from a country that has a Reciprocal Health Care Agreement with Australia are eligible for medically necessary treatment. Refer to Hospital Circular 23/2009[[3]](#footnote-4) for more information.

### Medicare-ineligible patients

There are principles that provide a guide to making decisions regarding the treatment of Medicare-ineligible patients and apply to all Medicare-ineligible patients treated in Victorian public hospitals.

They include:

* Health services have a duty of care to treat emergency patients. All patients are able to access care in an emergency department, regardless of their eligibility status. Medicare-ineligible patients are expected to pay for these services.
* Fees charged to Medicare-ineligible patients are at the discretion of individual health services. Fees should be set at a minimum to achieve full cost recovery.
* Health services obtain an assurance of payment from all Medicare-ineligible patients before treatment.
* Medicare-ineligible patients should be provided with an indicative cost of treatment, including advice that they may incur out-of-pocket expenses for their treatment, if costs are not fully met by their private health insurance fund.
* Health services are encouraged to have collaborative arrangements in place to enable an appropriate referral to either another public or private health service, if treatment is not available at the patient’s first choice of health service.
* Health services may provide advice to Medicare-ineligible patients about alternative options for treatment, if a patient has been triaged within an emergency department as requiring non-urgent emergency care.
* Medicare-ineligible patients may access planned services within a public health service, subject to:
	+ the health service’s capacity to provide treatment within the context of overall demand for services
	+ an assessment of the patient’s clinical need for treatment during their stay in Australia
	+ the patient’s ability to provide an assurance of payment for services provided.
* When the patient is unable to pay for the treatment provided, some form of regular financial contribution should be encouraged. When the patient demonstrates an inability to give the required assurances for treatment already provided, a schedule of periodic payments should be negotiated.

### International patients seeking health services

Principles have been developed to guide health services that wish to treat people visiting Victoria, where health treatment is their primary focus.

Health services that wish to bring international patients to Victoria for the specific purpose of medical treatment must seek their board’s endorsement of this activity. They should also develop appropriate policies and guidelines to ensure any international patient activity protects the primacy of Victorian patients.

Board endorsement is not required for treatment provided to an international patient on a pro bono basis or for charitable purposes, or treatment provided to interstate or international patients under a government agreement.

Where a health service delivers care in collaboration with a private provider, board endorsement is only required where the public health service is the primary care provider.

In endorsing policies and guidelines, board members must assure themselves that certain principles will be met, including the following:

* Preferential treatment should not be given to full-fee-paying international patients over Victorian patients. Delivery of services and treatment within a public health service should only be provided to international patients, where capacity to provide treatment exists without disadvantaging Victorian patients.
* Health services need to assess the risks of the patient undergoing treatment in Victoria, to ensure the risk of complications is low, and they can respond to any potential complications that may arise, including access to emergency treatment and care.
* Prior to accepting a patient for treatment, health services should ensure any required aftercare management and follow up is available within the patient’s home country. This should include appropriate processes to transfer care back to a health service or clinician in the patient’s home country.
* Health services need to ensure the patient can pay the full cost of treatment or service, and that details are recorded in a contract outlining the services provided, costs and related timelines, before treatment begins.
* Patients should be provided with an indicative cost of treatment, including advice on additional treatment that may be required in the future.
* Contracts and fees for treatment should consider any unexpected complications that may arise and how any additional costs will be managed.
* Fees charged to international patients are at the discretion of individual health services.

These principles apply to all types of treatment or care provided to international patients. Health services must not provide treatment to international patients outside the scope of what is currently provided at the relevant public hospital site.

Health services should note the unclear international legal frameworks and regulatory environment for international patients seeking legal redress, following unsatisfactory outcomes from medical treatment in Victoria. Before accepting international patients, health services should assess these legal risks and the potential impact on medical indemnity insurance. Complaints from international patients should be handled as part of a health service’s normal complaints process.

Health services should advise the department if they are delivering services to full-fee-paying international patients.

Part 2: Obligations, standards and requirements

# Notification obligations

## Issues of public concern

The Health Services Act, *Ambulance Services Act 1986* and Mental Health Act specify the functions of health service boards and chief executive officers.

Included in these functions is the requirement for boards to ensure the relevant portfolio minister (Health, Ambulance Services or Mental Health) and secretary are advised about significant board decisions, and promptly informed about any issues of public concern or risks that affect or may affect the health service (Health Services Actss. 65S(2)(i), 33(2)(i) and 115E(2)(l); Ambulance Services Act s. 18 (1)(j); Mental Health Act s. 345).

Chief executive officers must also inform the board, secretary or delegate, and relevant minister, without delay, of any significant issues of public concern or significant risks affecting the health service (Health Services Actss. 40I(1)(h), 65XB(1)(h) and 115JC(1)(h); Ambulance Services Act s. 21(3)(h); Mental Health Act s. 340(3)(cg)).

## Changes to range or scope of activities

Before health services undertake a significant change in the range or scope of services, the planning implications of such a move must be discussed with the department. All health services should contact their departmental performance lead. The department must provide explicit approval before a health service can significantly alter its services.

## Exceptional events

There may be circumstances (including industrial action and natural disasters) beyond the reasonable control of health service management that may prevent the health service reaching its targeted throughput. At its discretion, and on a case-by-case basis, the department will consider submissions to adjust funding to health services, irrespective of throughput, for as long as such events continue.

Health services are expected to actively mitigate their financial exposure and any decline in throughput, during and following such events.

## Public health escalations

If any health service that maintains an LPHU recognises a public health risk that meets escalation criteria as per statewide policies and protocols, that is – or has the potential to go – beyond the LPHU’s scope of operations, the health service must notify the Chief Health Officer or delegate as soon as practicable or no longer than 24 hours from becoming aware of the risk or issue.

Other public health risks and issues that must be escalated include circumstances wherein a person has died from a notifiable condition, and/or the case or outbreak is likely to attract media attention.

# Standards

## Public sector values and employment principles

The [*Public Administration Act 2004*](https://www.legislation.vic.gov.au/in-force/acts/public-administration-act-2004/079) <https://www.legislation.vic.gov.au/in-force/acts/public-administration-act-2004/079> establishes values to guide conduct and performance in the Victorian public sector.

There are seven core public sector values:

* responsiveness
* integrity
* impartiality
* accountability
* respect
* leadership
* human rights.

These values, and how they can be demonstrated, are outlined in s. 7 of the Public Administration Act.More information about public sector values is available on the [Public sector values](http://vpsc.vic.gov.au/ethics-behaviours-culture/public-sector-values) website <http://vpsc.vic.gov.au/ethics-behaviours-culture/public-sector-values>.

Section 8 of the Public Administration Act outlines the principles of public sector employment and articulates what employers must do to comply. This includes establishing employment processes to ensure:

* employment decisions are based on merit
* employees are treated fairly and reasonably
* equal employment opportunity is provided
* human rights, as set out in the Charter of Human Rights and Responsibilities, are upheld
* public sector employees have a reasonable avenue of redress against unfair or unreasonable treatment
* a career in the public service is fostered (in the case of public service bodies).

The Victorian Public Sector Commission issues codes of conduct to reinforce the public sector values and standards on how to apply the employment principles. The codes and standards are binding, but not detailed, enabling employers to introduce policies and practices that suit their organisation, while also complying with the codes and standards. Employees should consider the codes, standards and any organisational policies when deciding what action to take.

# Safety

## Pre-employment safety screening

All health practitioners registered with AHPRA must meet pre-employment safety screening requirements. Clinicians, both those registered with AHPRA and self-regulated, need to adhere to credentialling and scope of practice processes according to local clinical governance frameworks. Pre-employment safety screening of medical practitioners with independent responsibility for patient care is subject to the requirements of the [Credentialing and scope of clinical practice for senior medical practitioners policy](https://www.bettersafercare.vic.gov.au/publications/credentialing-and-scope-of-clinical-practice-for-senior-medical-practitioners-policy) <https://www.safercare.vic.gov.au/best-practice-improvement/publications/credentialing-and-scope-of-clinical-practice-for-senior-medical-practitioners-policy>.

Pre-employment safety screening checks are a mandatory requirement of the department’s selection process. While pre-employment safety screening does not eliminate the risk of employing unsuitable people, it does minimise that risk.

Pre-employment safety screening checks may also include a Working with Children Check, which assesses people who work with or care for children in Victoria. Referee checks should also be undertaken by direct contact with nominated referees.

Health services must have a vaccination policy for all workers. Each worker and their role should be individually assessed for specific vaccine requirements, before or at the start of employment. This is determined by the likelihood of contact with patients and/or blood or body substances, taking possible contraindications into account.

Healthcare workers must provide a vaccination record and/or documented evidence of natural immunity to vaccine-preventable diseases recommended for healthcare workers to their health service employer. The employer is required to keep the information on file, in the event the healthcare worker is in contact with a vaccine-preventable disease.

For more information, visit [Vaccination for healthcare workers](https://www.health.vic.gov.au/immunisation/vaccination-for-healthcare-workers) <https://www.health.vic.gov.au/immunisation/vaccination-for-healthcare-workers>.

## Staff safety and wellbeing in Victorian health services

All funded organisations are responsible for the safety of their staff, patients and visitors. Funded organisations must have systems and processes in place to enable them to identify, assess and control occupational health and safety risks. This is in accordance with their obligations pursuant to the Occupational Health and Safety Act 2004.

The department and Safer Care Victoria are committed to working collaboratively with health and community services to enhance the health, safety and wellbeing of staff. Fundamental to this work will be an emphasis on building a positive and respectful workplace culture, including actions to address systemic issues that affect safety and wellbeing.

## Child safety

Responsibility for child safety is shared with the Department of Families, Fairness and Housing, and the [Commission for Children and Young People’s Child Safe Standards](https://ccyp.vic.gov.au/child-safe-standards/) <https://ccyp.vic.gov.au/child-safe-standards>.

The Commission for Children and Young People is an independent statutory authority that began operation in March 2013, replacing the former Office of the Child Safety Commissioner. The Commission for Children and Young People Act 2012 and *Child Wellbeing and Safety Act 2005* provides for the role of the Commission.

The Commission is responsible for administering the Reportable Conduct Scheme, which is set out under Part 5A of the Child Wellbeing and Safety Act and is also a sector regulator for the Child Safe Standards.

[The Department of Families, Fairness and Housing’s Child protection](https://services.dffh.vic.gov.au/child-protection) <https://services.dffh.vic.gov.au/child-protection> administers the *Children, Youth and Families Act 2005*, which creates a shared responsibility for family services, the child protection program, out-of-home care services and the Children’s Court, to act in the best interests of the child.

The [Child Information Sharing Scheme](https://www.vic.gov.au/child-information-sharing-scheme) <https://www.vic.gov.au/child-information-sharing-scheme> and aligned [Family Violence Information Sharing Scheme](https://www.vic.gov.au/family-violence-information-sharing-scheme) <https://www.vic.gov.au/family-violence-information-sharing-scheme> commenced in 2018. [Child Link](https://www.vic.gov.au/child-link) <https://www.vic.gov.au/child-link> became operational by December 2021, with authorised users progressively onboarded from 2022 onward.

### Child Safe Standards

Under the Child Wellbeing and Safety Act, organisations that provide services or facilities for children are required to comply with the Child Safe Standards to protect children from harm and abuse. The standards aim to promote the safety of children, prevent child abuse, and ensure organisations and businesses have effective processes in place to respond to and report all allegations of abuse.

The standards drive changes in organisational culture to embed child safety in everyday thinking and practice. This includes providing a minimum standard of child safety across all organisations.

The Child Safe Standards were updated on 1 July 2022 to better align with the [National Principles for Child Safe Organisations](https://childsafe.humanrights.gov.au/national-principles). The new standards also explicitly require organisations to establish a culturally safe environment for Aboriginal children and young people.

Changes to the Child Wellbeing and Safety Act came into effect on 1 January 2023, providing a broad suite of compliance and enforcement powers for regulators, resulting in new regulatory arrangements for some organisations, as summarised in Table 1.

Table 1: New regulatory arrangements – sector regulators and regulated entities

| Responsible regulator  | Regulated sectors |
| --- | --- |
| Department of Health | Hospitals, community health services, mental health services, alcohol and other drug treatment services, and maternal and child health services |
| Department of Families, Fairness and Housing | Providers of disability services, housing services, family violence and sexual assault services, support services for parents and families, and out-of-home care services |
| Victorian Registration and Qualifications Authority | Registered schools, school boarding premises, school sector organisations providing courses to overseas students, student exchange organisations, non-school secondary providers and some registered training organisations |
| Department of Education, via the Quality Assessment and Regulation Division | Early childhood services, including long and family day care, outside hours and vacation care services, and occasional care services |
| Wage Inspectorate Victoria | Organisations that employ children, and hold a permit under the Child Employment Act 2003 (Vic) |
| Commission for Children and Young People | All other organisations |

For more information about the Child Safe Standards, visit the [Child Safe Standards website](https://www.health.vic.gov.au/childsafestandards) <https://www.health.vic.gov.au/childsafestandards>.

## Patient and client safety

All funded organisations are responsible for the safety of their patients and clients. Funded organisations should have systems and processes in place to enable them to identify, manage and respond to adverse events, reducing the risk of such events recurring in future.

Victorian public health services and all services under their governance structures, who report patient, resident or client safety incidents through the Victorian Health Incident Management System (VHIMS), are subject to the overarching [Safer Care Victoria policy: Adverse patient safety events](https://www.bettersafercare.vic.gov.au/publications/policy-adverse-patient-safety-events) <https://www.bettersafercare.vic.gov.au/publications/policy-adverse-patient-safety-events>.

Community service organisations that provide services on behalf of the department, and do not report incidents through VHIMS, are subject to the department’s *Incident reporting instruction 2013*. For the reporting instruction and accompanying incident report form, visit the [Department of Health Incident Reporting Instruction, 2013](https://www.health.vic.gov.au/publications/department-of-health-incident-reporting-instruction-2013) <https://www.health.vic.gov.au/publications/department-of-health-incident-reporting-instruction-2013> or [Department of Health Incident Reporting form](https://fac.dffh.vic.gov.au/incident-report-form-complete-hand) <https://fac.dffh.vic.gov.au/incident-report-form-complete-hand>.

The *Incident reporting instruction 2013* provides guidance for reporting incidents or alleged incidents that involved or impacted patients or clients during service delivery. It does not replace an organisation’s own incident management systems and processes, which may be reviewed as part of the department’s routine contract and performance management arrangements. The department has implemented a critical incident reporting pathway for registered community health services to enable timely notification to the department when serious incidents occur. The critical incident reporting pathway reduces the reporting burden for registered community health services and replaces the need for manual reporting. Reporting requirements for registered community health services are outlined at [Incident reporting for Community health service](https://www.health.vic.gov.au/incident-reporting-community-health-services)s <https://www.health.vic.gov.au/incident-reporting-community-health-services>.

# Meeting the needs of all Victorians

The department aims to improve the lives of all Victorians, especially people and communities at risk of health disparities or with increased health and wellbeing needs.

This means health services must understand and respond to diverse and intersectional needs, experiences and identities. This includes those related to cultures, languages, faiths, abilities, ages, genders, sexualities, attributes, experiences and ways in which people identify.

An intersectional approach also recognises that communities are not homogenous, and that structural barriers and discrimination negatively impact access and inclusion.

Health services are required to ensure that whole-of-government and department strategy and policy documents guide local policy, service development and practice. These include:

* [Safe and strong: a Victorian gender equality strategy](https://www.vic.gov.au/safe-and-strong-victorian-gender-equality) <https://www.vic.gov.au/safe-and-strong-victorian-gender-equality>
* [Victorian and proud of it: Victoria’s multicultural policy statement](https://www.vic.gov.au/multicultural-policy-statement) <https://www.vic.gov.au/multicultural-policy-statement>
* [Inclusive Victoria: state disability plan (2022–2026)](https://www.vic.gov.au/state-disability-plan) <https://www.vic.gov.au/state-disability-plan>
* [Victorian autism plan](https://www.statedisabilityplan.vic.gov.au/victoria-autism-plan) <https://www.statedisabilityplan.vic.gov.au/victoria-autism-plan>
* [Pride in our future: Victoria’s LGBTIQA+ strategy 2022–32](https://www.vic.gov.au/victorian-lgbtiq-strategy) <https://www.vic.gov.au/victorian-lgbtiq-strategy>
* [Our promise, your future: Victoria’s youth strategy 2022–2027](https://www.vic.gov.au/victorias-youth-strategy-2022-2027) <<https://www.vic.gov.au/victorias-youth-strategy-2022-2027>>
* [Ageing well action plan](https://www.vic.gov.au/ageing-well-action-plan) <https://www.vic.gov.au/ageing-well-action-plan>
* [Victorian Aboriginal health and wellbeing partnership agreement 2023–2033](https://www.vaccho.org.au/ahwpf/) <https://www.vaccho.org.au/ahwpf/>
* [Victorian Aboriginal health and wellbeing partnership action plan 2023–25](https://www.vaccho.org.au/ahwpf/) <https://www.vaccho.org.au/ahwpf/>
* [Aboriginal and Torres Strait Islander cultural safety framework](https://www.health.vic.gov.au/health-strategies/aboriginal-and-torres-strait-islander-cultural-safety) <<https://www.health.vic.gov.au/health-strategies/aboriginal-and-torres-strait-islander-cultural-safety>>
* [Healthcare that counts: a framework for improving care for vulnerable children in Victorian health services](https://www.health.vic.gov.au/publications/healthcare-that-counts) <https://www.health.vic.gov.au/publications/healthcare-that-counts>
* [Diversity on Victorian government board guidelines](https://www.vic.gov.au/diversity-victorian-government-board-guidelines) <https://www.vic.gov.au/diversity-victorian-government-board-guidelines>.

Guidance on the needs of diverse communities is outlined in more detail in the following sections.

Other documents that provide guidance for working using an intersectional, person-centred approach include:

* [Designing for diversity](https://www.health.vic.gov.au/populations/designing-for-diversity) <https://www.health.vic.gov.au/populations/designing-for-diversity>
* [Safer Care Victoria’s Partnering in healthcare framework](https://www.bettersafercare.vic.gov.au/support-and-training/partnering-with-consumers/pih) <https://www.bettersafercare.vic.gov.au/support-and-training/partnering-with-consumers/pih>.

Services should consider the effectiveness of the ways in which they respond to the diversity of the Victorian community. They should seek to engage broadly with the communities they serve in service planning, and constantly monitor how well they are delivering for all, ensuring no group is underserved, excluded or subject to discrimination.

## Improving health and wellbeing outcomes of Aboriginal people living in Victoria

In 2021 the historic Yoorrook Justice Commission (the Commission) was legally established by the Victorian Government as the nation’s first formal truth-telling process into injustices experienced by First Peoples in Victoria. In June 2024 the Commission, which has the legal powers of a Royal Commission, held its first inquiry on injustice against First Peoples in health in Victoria.

The Minister for Health, Health Infrastructure and Ambulance Services, and the Minister for Mental Health and Ageing, both testified at the Commission. In their witness statements Ministers acknowledged that the Victorian healthcare system has historically failed and continues to fail to support First Peoples to receive timely, safe and respectful care. They took responsibility for this and committed to extensive change. These commitments are reflected in the 2024-25 Policy and Funding Guidelines, with core expectations of health services outlined in the sections below.

*Governance and priority setting*

Ministerial commitments to the Commission are aimed at amplifying and accelerating delivery of existing commitments to the Aboriginal Health and Wellbeing Partnership Forum (AHWPF), which is the lead decision-making body for Aboriginal health and wellbeing in Victoria. The AHWPF is co-chaired by the Victorian Minister for Health and VACCHO. AHWPF members represent the Victorian Aboriginal community-controlled health sector, the mainstream health sector and the department.

Koori Caucus (Aboriginal members of the AHWPF) identified a set of self-determined priorities for reforming the health system to improve the health and wellbeing outcomes of Aboriginal people living in Victoria. These were accepted as shared priorities of the AHWPF. The government has committed to progressing these priorities, and has acknowledged that many of them have already been repeated to Government for many years by First Peoples.

One of the priorities was developing a 10-year Victorian Aboriginal Health and Wellbeing Partnership Agreement (the Agreement). This was endorsed in 2023 and strongly aligned to Victoria’s commitments under the National Agreement on Closing the Gap. The statewide Agreement is a commitment from AHWPF members to work together to implement key reforms. This includes prioritising prevention and early intervention funding for Aboriginal community-controlled organisations, delivering self-determined, culturally safe healthcare, and funding sustainability of the Aboriginal community-controlled health sector.[[4]](#footnote-5)

Developing and implementing two-year Aboriginal health and wellbeing partnership action plans (action plans) is a key driver for delivering these reforms. The signed [Agreement and Action Plan](https://www.vaccho.org.au/ahwpf/) can be downloaded from VACCHO’s website: <https://www.vaccho.org.au/ahwpf/>. Health services have particular responsibility for the priority to “Strengthen cultural safety in the mainstream health service system”, which entails mandatory cultural safety training that is delivered by a relevant Aboriginal organisation, culturally safe service standards, and improved identification, discharge plans and referral pathways. These core expectations are reflected below.

The government is committed to ensuring the action plans are fully implemented within the two-year cycles. These actions are important steps along the journey towards a shared vision of Aboriginal people having access to a health system that is holistic, culturally safe, accessible and empowering.

Implementing the actions in these plans, along with the broader commitments made to the Yoorrook Justice Commission, is everyone’s responsibility. The entire health sector must work together in a way that is guided by self-determination, cultural safety, accountability and transparency. All parts of Victoria’s health system are accountable to the AHWPF for improving Aboriginal health and wellbeing outcomes.

## Culturally safe services for Aboriginal people living in Victoria

All Victorian public health services are required to deliver culturally safe care to Aboriginal patients and families, and to provide culturally safe workplaces for Aboriginal employees, as articulated in the SOP and [Aboriginal cultural safety fixed grant guidelines](https://www.health.vic.gov.au/publications/aboriginal-cultural-safety-fixed-grant-guidelines-cultural-safety-planning-and) <https://www.health.vic.gov.au/publications/aboriginal-cultural-safety-fixed-grant-guidelines-cultural-safety-planning-and>.

Cultural safety, as a protective factor in Aboriginal health, is the key to improving access to health services and deliver better health outcomes for Aboriginal Victorians. It is also an important enabler for strengthening the quality of prevention, early intervention and tertiary care and Closing the Gap in health and wellbeing outcomes.

Aboriginal cultural safety occurs when Aboriginal people and communities feel respected and safe – and the cultural richness, diversity, histories, strength and knowledge held by Victoria’s Aboriginal communities is recognised, understood and valued. Cultural safety is underpinned by Aboriginal self-determination, where Aboriginal voices contribute to the design and delivery of services, as articulated in the Victorian Government's [Self-determination reform framework](https://www.firstpeoplesrelations.vic.gov.au/self-determination-reform-framework) <https://www.firstpeoplesrelations.vic.gov.au/self-determination-reform-framework>.

At the Yoorrook Justice Commission, the Minister for Health acknowledged serious failures in cultural safety in mainstream health services. The Minister acknowledged that delivery of the AHWPF plan is not enough to address this, and that Government has a broader responsibility to lead, act and to improve the healthcare experience and healthcare outcomes for First Peoples. Reflecting this, expectations and accountabilities for health services have been strengthened below.

*Implementation of the Aboriginal and Torres Strait Islander cultural safety framework is mandatory*

The [Aboriginal and Torres Strait Islander cultural safety framework](https://www.health.vic.gov.au/publications/aboriginal-and-torres-strait-islander-cultural-safety-framework-part-1) <https://www.health.vic.gov.au/publications/aboriginal-and-torres-strait-islander-cultural-safety-framework-part-1> supports mainstream Victorian health, human and community services, along with the department, to create culturally safe environments, services and workplaces.

The framework provides a continuous quality improvement model to strengthen the cultural safety of individuals and organisations. It aims to help the department and mainstream health, human and community services to strengthen their cultural safety by participating in an ongoing learning journey. ￼ This training must address racism. It must be underpinned by a cultural safety plan that encourages patients and staff to speak up when racism occurs, and must identify a range of actions health services will undertake to stand against racism.

Training must be of high quality, with a strong preference towards in-person over online learning. It must align with the Aboriginal and Torres Strait Islander cultural safety framework. The training should be delivered by independent, expert, community-controlled organisations (or a Kinaway or Supply Nation certified Aboriginal business) able to safely challenge established organisational thinking and practices.[[5]](#footnote-6)

*Expectations of First Peoples Employment Plans*

The [Victorian Health Workforce Strategy](https://www.health.vic.gov.au/victorian-health-workforce-strategy) <https://www.health.vic.gov.au/victorian-health-workforce-strategy> commits to significantly expanding First Nations representation within mainstream professions and leadership roles, to an overall level equal to the Victorian population by 2034.[[6]](#footnote-7)

To achieve this, First Peoples employment plans are mandatory for all health services receiving Aboriginal Cultural Safety Fixed Grants, and for smaller health services that serve a significant local Aboriginal population.[[7]](#footnote-8) Plans must be aligned to the 5-year Aboriginal employment strategy for the Victorian public sector, Barring Djinang,[[8]](#footnote-9) and include an employment target that is reflective of local First Peoples populations, noting these vary across the state.

*Culturally safe and equitable care*

Aboriginal people living in Victoria are overrepresented in the healthcare system and face significant disparities in health outcomes. Health services are expected to take active steps to monitor, address, and eliminate these disparities. This includes:

* effective Aboriginal client and patient identification, including quality improvement processes to continually improve in this area, and
* senior executive and Board leadership and oversight of activities to identify, monitor, and close gaps in:
	+ rates of Aboriginal and non-Aboriginal patients for patients who leave, do not wait or are discharged against medical advice
	+ wait times for care experienced by Aboriginal and non-Aboriginal patients of equivalent clinical need
	+ clinical outcomes of Aboriginal and non-Aboriginal patients, including through improved discharge planning and pathways, and outpatient care.

To support this work, health services are expected to demonstrate:

* CEO and executive leadership that drives cultural safety and Aboriginal self-determination
* partnerships with ACCHOs, respected Aboriginal leaders and Elders, and Aboriginal communities to deliver healthcare improvements, including through:
	+ partnering to develop and deliver plans to identify and prioritise the health, wellbeing and service needs of the Aboriginal catchment population and service users.
	+ reporting and discussing the progress and outcomes of these plans.
	+ These requirements align with the National Safety and Quality Health Service (NSQHS) Standards, which health services are encouraged to review.[[9]](#footnote-10) For more information, guidance, tools and resources for health services, visit:
* [Aboriginal cultural safety in health services: guidance notes and resources](https://www.health.vic.gov.au/site-4/publications/aboriginal-cultural-safety-in-health-services-guidance-notes-and-resources) <https://www.health.vic.gov.au/health-strategies/aboriginal-and-torres-strait-islander-cultural-safety>
* [VACCHO accreditation programs](https://www.vaccho.org.au/cultural-safety-services/accreditation-programs/) <https://www.vaccho.org.au/cultural-safety-services/accreditation-programs>.

## Inclusive and accessible healthcare for LGBTIQA+ communities

Discrimination, stigma and exclusion continue to drive poorer health outcomes for LGBTIQA+ communities in Victoria.[[10]](#footnote-11)

[*Pride in our future: Victoria’s LGBTIQA+ strategy 2022–32*](https://www.vic.gov.au/victorian-lgbtiq-strategy) <https://www.vic.gov.au/victorian-lgbtiq-strategy> provides a vision and plan for LGBTIQA+ equality and inclusion. It states that Victorian health and community services should be approachable, welcoming, safe and inclusive for LGBTIQA+ Victorians. It also states that LGBTIQA+ people must be able to access services that meet their needs. Their health and care service experience should result in improved life outcomes.

The department expects all funded services to develop and implement local policies, procedures and training, so that LGBTIQA+ Victorians experience inclusive and accessible healthcare.

The Victorian Government has developed a number of documents to provide guidance to health services, including:

* [Community health pride: LGBTIQA+ inclusive practice resources](https://www.health.vic.gov.au/community-health/community-health-pride-lgbtiq-inclusive-practice-resources) <https://www.health.vic.gov.au/community-health/community-health-pride-lgbtiq-inclusive-practice-resources>
* [Inclusive collection and reporting of sex and gender data](https://www.health.vic.gov.au/publications/inclusive-collection-and-reporting-of-sex-and-gender-data) <https://www.health.vic.gov.au/publications/inclusive-collection-and-reporting-of-sex-and-gender-data>
* [LGBTIQA+ inclusive language guide](https://www.vic.gov.au/inclusive-language-guide) <https://www.vic.gov.au/inclusive-language-guide>
* [Understanding LGBTIQA+ health](https://www.health.vic.gov.au/populations/understanding-lesbian-gay-bisexual-transgender-and-intersex-health) <https://www.health.vic.gov.au/populations/understanding-lgbtiq-health>.

Funded organisations are encouraged to consider working towards Rainbow Tick accreditation. This quality framework assists health and human services organisations to demonstrate they are safe, inclusive and affirming services for LGBTIQA+ Victorians.

The Rainbow Tick guides organisations through a cycle of self-assessment and review by external assessors. This process determines the extent to which the organisation (or a service within the organisation) meets the needs of LGBTIQA+ consumers. The *2023–24 State Budget* provided $22.5 million over four years to help deliver Pride in our Future, including funding to expand Rainbow Tick in Victorian health services. For more information, visit [Rainbow Health Australia](https://rainbowhealthaustralia.org.au/) <https://rainbowhealthaustralia.org.au/>.

A whole-of-government LGBTIQA+ Taskforce, supported by a departmental Health and Wellbeing Working Group and Expert Advisory Groups, and the Commissioner for LGBTIQA+ Communities, provides advice to the department on the delivery of inclusive and accessible healthcare. Funded organisations can engage these groups by emailing the LGBTIQ Secretariat <LGBTIQSecretariat@health.vic.gov.au>.

### Trans and gender diverse people

Gender diverse is an umbrella term for a range of different genders. There are many terms gender diverse people use to describe themselves. A transgender person is someone whose gender does not exclusively align with their sex recorded at birth. A non-binary person is someone whose gender sits outside the spectrum of man or woman or male or female. There are many other terms that gender diverse people may use to describe themselves, including genderfluid, genderqueer, gender non-conforming, trans masculine or trans feminine. Trans and gender diverse people are part of the broader LGBTIQA+ community. They have distinct healthcare and social support needs, particularly during the process of questioning, defining and affirming their gender identity.

Health services should provide an inclusive environment for trans and gender diverse people, ensuring services meet their unique care needs and choices. This includes using pronouns and names preferred by the individual, providing non-gendered facilities where possible, minimising potentially harmful encounters with other patients, and avoiding assumptions about gender and sex-specific health issues.

Data-reporting changes commencing on 1 July 2024 mean Victorian hospitals will be required to report sex at birth and *gender* across key health service data collections. This data will help health services and the department monitor service uptake and outcomes for trans and gender diverse Victorians. It will also support the development of targeted programs and funding. For more information on specifications for revisions to data collections, visit the department’s [Annual changes process](https://www.health.vic.gov.au/data-reporting/annual-changes) <https://www.health.vic.gov.au/data-reporting/annual-changes>. For guidance on implementing this change see [Inclusive collection and reporting of sex and gender data](https://www.health.vic.gov.au/publications/inclusive-collection-and-reporting-of-sex-and-gender-data) <https://www.health.vic.gov.au/publications/inclusive-collection-and-reporting-of-sex-and-gender-data> linked above.

Funded organisations are encouraged to seek advice and resources from peak bodies and associations to drive service improvement and build workforce capability. For more information, visit [Trans and gender diverse health and wellbeing](https://www.health.vic.gov.au/populations/trans-and-gender-diverse-health-and-wellbeing) <https://www.health.vic.gov.au/populations/trans-and-gender-diverse-health-and-wellbeing>.

The department funds specialist gender services that can be engaged by health services for information and support.

In 2021–22, the Victorian Government provided $21.4 million over four years to deliver additional supports for trans and gender diverse young people. This includes an expansion of specialist gender clinics at Monash Health and The Royal Children’s Hospital, mental health and primary care at Orygen, and peer and family support at Transgender Victoria, Transcend and Monash Health.

The *2022–23 State Budget* committed $1.5 million over two years towards the Trans and Gender Diverse in Community Health Program, which delivers peer navigator support, two multidisciplinary clinics in Preston and Ballarat, and statewide trans and gender diverse health training. For more information, visit [Your Community Health](https://www.yourch.org.au/service-access/trans-and-gender-diverse-health) <https://www.yourch.org.au/service-access/trans-and-gender-diverse-health>.

### People with variations in sex characteristics

Some people are born with a variation to physical or biological sex characteristics including chromosomes, hormones or anatomy. These are often called intersex variations. There are many different intersex variations that can be identified prenatally, at birth, puberty or adulthood.

People with intersex variations use different terminology to name their bodies and experiences. Some use the term ‘intersex’, which is signified by the ‘I’ in LGBTIQA+ communities. Others do not connect to the term ‘intersex’ or with the acronym LGBTIQA+.

People with variations of sex characteristics are usually assigned male or female at birth or infancy, just like everyone else. Intersex people can have any gender identity or sexuality. Intersex variations are not abnormal and should not be seen as ‘birth defects’. They are natural biological variations that occur in up to 1.7% of all births.

Health services should understand what intersex variations are, including the difference between intersex variations and sexual orientation, transgender people and gender diversity. Health service staff should avoid asking questions related to a person’s intersex status, unless clinically necessary.

[(i) am equal: future directions for Victoria’s intersex community](https://www.health.vic.gov.au/publications/i-am-equal) <https://www.health.vic.gov.au/publications/i-am-equal> sets out the Victorian Government’s commitment to improve health and wellbeing outcomes, and experiences of people with intersex variations. The department is currently progressing work to establish the intersex protection system. This includes a mechanism to prohibit deferrable medical interventions modifying a person’s sex characteristics without personal consent, an oversight panel, and provisions to ensure the collection of data and transparency over what treatments are being performed.

Health services should also understand the potentially lifelong health impacts of conducting surgeries on intersex children, and/or giving them hormones to ‘normalise’ their genitals and remove gonads.

Funded organisations are encouraged to seek advice and resources from peak bodies and associations to drive service improvement and build workforce capability. For more information, guidelines and resources on the health needs and on supporting people with an intersex variation, visit [Health of people with intersex variations](https://www.health.vic.gov.au/populations/health-of-people-with-intersex-variations) <https://www.health.vic.gov.au/populations/health-of-people-with-intersex-variations>.

## Supporting health access and outcomes for people with disability

Victorian people with disability are diverse in their culture, language, sexuality, gender identity, age, ability, socioeconomic status and life experiences. Approximately 17% of Victorians are people with disability and many of these people have a hidden disability. People with disability have poorer health outcomes and face a range of systemic barriers, including in relation to communication and mobility, as well as physical and psychosocial support needs.

[Inclusive Victoria: state disability plan 2022–2026](https://www.vic.gov.au/state-disability-plan) <https://www.vic.gov.au/state-disability-plan> sets out whole-of-government commitments to improve the lives of Victorians with disability, including priority actions related to inpatient care, sexual and reproductive health, mental health and health service capability.

Inclusive Victoria outlines that health and community services should consider how to deliver a range of priority commitments and reforms, including enhancing referral pathways to respond to the needs of people with disability, co-design, developing disability confident and inclusive workforces, and effective data and outcomes reporting.

The [Victorian autism plan](https://www.statedisabilityplan.vic.gov.au/victoria-autism-plan) <https://www.statedisabilityplan.vic.gov.au/victoria-autism-plan> sets out additional actions to support people with autism.

The *2023–24 State Budget* has provided $2.1 million in 2023–24, and $6.5 million over three years to continue the Disability Liaison Officer (DLO) program, as part of *Inclusive Victoria: state disability plan 2022–26 commitment*.

DLOs provide direct support so that people with disability can access the healthcare they need, such as arranging reasonable adjustments, communication assistance and psychosocial support. They are based in health services across metropolitan and regional Victoria.

DLOs are also driving longer-term health service and system improvement projects, such as codesigning a disability identifier that could be integrated into electronic medical records, and trialling implementation of a health passport that people with disability could use to communicate their needs with a health service. DLOs also support delivery of *Inclusive Victoria: state disability plan 2022*–*26* and foster disability competency within health services.

For more information, contact the DLO at your health service or email the DLO Coordinator <DLOcoordinator@dhhs.vic.gov.au>.

## Inclusive and culturally responsive healthcare for multicultural communities, including refugees and people seeking asylum

### Multicultural communities

Victoria is home to one of the most culturally diverse societies in the world. We are among the fastest growing and most diverse states in Australia. Almost half of Victorians were born overseas or have at least one parent born overseas. Across Victoria, people have come from more than 300 countries, speak over 290 languages and follow over 200 different faiths.

The department’s [Multicultural health action plan 2023–27](https://www.health.vic.gov.au/multicultural-health-action-plan-2023-27) <https://www.health.vic.gov.au/multicultural-health-action-plan-2023-27> outlines commitments and actions to improve the health and wellbeing of multicultural communities in Victoria, particularly through embedding cultural competency into all services, programs and policies.

Multicultural communities experience significant health and wellbeing disparities when compared with the Australian-born population. This is largely the result of social determinants of health, such as language and communication barriers, experiences of racism and discrimination, financial stress and vulnerability, and low health literacy, as well as challenges navigating unfamiliar health and social service systems, and diverse cultural understandings of health, mental health and disability.

Government commitment to multiculturalism is outlined in [Victorian, and proud of it: Victoria’s multicultural policy statement](https://www.vic.gov.au/multicultural-policy-statement) <https://www.vic.gov.au/multicultural-policy-statement>.

Legislation that protects and promotes the rights of culturally diverse Victorians includes:

* [Multicultural Victoria Act 2011](https://www.legislation.vic.gov.au/in-force/acts/multicultural-victoria-act-2011/002) <<https://www.legislation.vic.gov.au/in-force/acts/multicultural-victoria-act-2011/002>>
* [Charter of Human Rights and Responsibilities Act 2006](https://www.legislation.vic.gov.au/in-force/acts/charter-human-rights-and-responsibilities-act-2006/014) <<https://www.legislation.vic.gov.au/in-force/acts/charter-human-rights-and-responsibilities-act-2006/014>>
* [Racial and Religious Tolerance Act 2001](https://www.legislation.vic.gov.au/in-force/acts/racial-and-religious-tolerance-act-2001/011) <<https://www.legislation.vic.gov.au/in-force/acts/racial-and-religious-tolerance-act-2001/011>>.

Services should familiarise themselves with multicultural health policies and programs funded by the department, including:

* [Centre for Culture, Ethnicity and Health](https://www.ceh.org.au) <https://www.ceh.org.au>
* [Victorian Transcultural Mental Health](https://vtmh.org.au) <<https://vtmh.org.au>>
* [Multicultural Centre for Women’s Health](https://www.mcwh.com.au/) <https://www.mcwh.com.au/>
* [The Royal Children’s Hospital’s Immigrant Health Service](https://www.rch.org.au/immigranthealth) <https://www.rch.org.au/immigranthealth>.

For more information on multicultural health and wellbeing, and funded initiatives, visit [Improving health for Victorian from culturally and linguistically diverse backgrounds](https://www.health.vic.gov.au/populations/improving-health-for-victorians-from-culturally-and-linguistically-diverse-backgrounds) <https://www.health.vic.gov.au/populations/improving-health-for-victorians-from-culturally-and-linguistically-diverse-backgrounds>.

### Refugees and people seeking asylum

Refugees and people seeking asylum can experience significant health and wellbeing disparities related to their refugee journey. This includes prolonged periods in refugee camps, experiences of war, torture and trauma, loss of or separation from family members, dangerous journeys to Australia, deprivation and limited or interrupted healthcare access.

Services should familiarise themselves with policies and programs funded by the department to support at-risk refugees and people seeking asylum, including the:

* [Refugee Health Program](https://www.health.vic.gov.au/community-health/refugee-health-program) <https://www.health.vic.gov.au/community-health/refugee-health-program>
* [Victorian Refugee Health Network](https://refugeehealthnetwork.org.au) <https://refugeehealthnetwork.org.au>
* [Victorian Foundation for Survivors of Torture (Foundation House)](https://foundationhouse.org.au) <<https://foundationhouse.org.au>>
* [Refugee Health Fellows program](https://refugeehealthnetwork.org.au/engage/refugee-health-fellows/) <https://refugeehealthnetwork.org.au/engage/refugee-health-fellows>.

Centre for Culture, Ethnicity and HealthThere are policies that set out how people seeking asylum can access health and community services. These policies allow access, despite ineligibility for Medicare or a Health Care Card, including to public hospital and ambulance services, dental services, community health, home and community care program services, and catch-up immunisation.

For more information, visit:

* [Hospital access for people seeking asylum](https://www.health.vic.gov.au/publications/hospital-access-for-people-seeking-asylum) <https://www.health.vic.gov.au/publications/hospital-access-for-people-seeking-asylum>
* [Guide to asylum seeker access to health and community services in Victoria](https://www.health.vic.gov.au/publications/guide-to-asylum-seeker-access-to-health-and-community-services-in-victoria) <https://www.health.vic.gov.au/publications/guide-to-asylum-seeker-access-to-health-and-community-services-in-victoria>.

The *2023–24 State Budget* committed $41.9 million in 2023–24 to support prevention and early intervention of chronic and preventable health conditions. This funding extends health services to support refugees and people seeking asylum in Victoria. For more information about that initiative and contact details for funded providers, visit [Refugee and asylum seeker health and wellbeing](https://www.health.vic.gov.au/populations/refugee-and-asylum-seeker-health-and-wellbeing) <https://www.health.vic.gov.au/populations/refugee-and-asylum-seeker-health-and-wellbeing>.

### Language services

Language services, including the use of qualified interpreters and high-quality translated health and service information, is an important aspect of the department’s efforts to deliver accessible, person-centred services that respond to the needs of culturally diverse and hearing-impaired communities.

Health services are expected to comply with the [Language services policy and guidelines](https://www.health.vic.gov.au/publications/language-services-policy) <https://www.health.vic.gov.au/publications/language-services-policy>. This will ensure quality language services are an integral part of their planning, policy and service response.

Health services should also ensure that frontline staff understand the policy and guidelines. Staff should receive training in assessing the need for an interpreter, and how to obtain and work effectively with interpreters and multicultural clients. Staff may breach their duty of care to a client if they unreasonably fail to provide or inform a client of their right to an interpreter.

Allowing family members or bilingual staff to interpret for a patient is not an acceptable replacement for obtaining the services of accredited interpreters. Unaccredited bilingual staff can communicate simple information in community languages, but they are not qualified interpreters. For this reason, their use should be limited to low-risk content, such as making appointments or obtaining basic personal details, such as name and address. Unaccredited bilingual staff cannot be used to communicate information that is legally binding or puts at risk either the client or organisation.

The department does not currently support the use of automated interpreting and translating technologies in place of qualified and credentialed interpreters and translators. There is a duty to ensure translations are accurate and culturally appropriate, communicate concepts effectively and are not likely to cause harm.

Health services are funded through different mechanisms to provide language services. Failing to provide an appropriately qualified and credentialed interpreter, or have important health-related information translated accurately into community languages, can have significant negative impacts, including reduced or adverse health and wellbeing outcomes.

All funded services must ensure interpreters engaged through an external language services provider are remunerated in accordance with Victorian Government minimum remuneration rates and conditions. Records of interpreters engaged and languages interpreted should be retained for reporting and future planning purposes.

The [Health Translations website](https://www.healthtranslations.vic.gov.au) <<https://www.healthtranslations.vic.gov.au>>, managed by the [Centre for Culture, Ethnicity and Health](https://ceh.org.au) <https://ceh.org.au>, provides access to more than 24,000 free and reliably translated resources. The centre also offers a range of training programs on cultural competence, health literacy and language services.

## Accessible and equitable health services for women

The Victorian Government is delivering a suite of election commitments relating to women’s health, totalling almost $154 million over the next four years (2023–24 to 2026–27), including $36.7 million in 2024–25. The women’s health package expands on the Victorian Government’s current investment in women’s health promotion services, sexual and reproductive health services, and specialist clinics.

Specifically, in 2024–25 the following initiatives will be delivered:

* 1,200 additional laparoscopies to help diagnosis and treat endometriosis, which can be debilitating and affects up to one in every nine women, many of whom are undiagnosed
* establishment of five new women’s health clinics, part of a total of 20 new clinics being developed over the four-year program. Extensive consultation will also take place in 2023–24 that will support the establishment of an Aboriginal-led clinic
* research initiatives to expand the evidence base for women’s health, including data support and research funding, an inquiry into women’s pain management, and work to establish a Women’s Health Research Institute. A women’s health equity dashboard will also be developed
* establishment of six new sexual and reproductive health hubs, expanding on the 11 existing hubs (and a further three will be established the following year to total 20 hubs)
* establishment of a mobile women’s health clinic to improve access for women in rural and regional Victoria
* women’s health scholarships, which will be provided for clinic staff, including allied health professionals; worth $20,000 each.

A Victorian Women’s Health Advisory Council was established in 2023–24 to guide development, design and implementation of initiatives. Membership includes multidisciplinary experts, such as policy makers, researchers, practitioners, representatives of peak bodies, professional associations and consumer groups.

There are complementary Victorian Government women’s health election commitments, including:

* making free pads and tampons available in select public settings (for example, schools, public hospitals and courts)
* establishing public fertility care services ($50 million)
* piloting an expanded role of community pharmacists that includes women’s healthcare – treatment of urinary tract infections, and reissuing prescriptions for contraceptives ($19 million)
* strengthening maternal and child health services ($39.27 million).

Further information on processes for determining and monitoring capability levels can be found at [Service Capability Frameworks for Victoria](https://www.health.vic.gov.au/health-system-design-planning/service-capability-frameworks-for-victoria) <https://www.health.vic.gov.au/health-system-design-planning/service-capability-frameworks-for-victoria>.

# Service capability frameworks

## Service capability frameworks and levels

Service capability frameworks are comprehensive guidelines developed for Victoria's health system to support the delivery of optimal care. The frameworks outline the essential elements required for clinical services to function safely and effectively and categorise these services into different levels of capability. Capability frameworks delineate care across six levels of complexity. Levels range from 1 (being the lowest complexity of care, broadly available) to level 6 (being the highest complexity of care, only available at major hospitals).

The following service capability frameworks apply to health service campuses within Victoria’s health system, encompassing a wide range of healthcare providers and facilities:

* [Capability frameworks for maternity and newborn services <](https://www.health.vic.gov.au/patient-care/capability-frameworks-for-maternity-and-newborn-care-in-victoria)https://www.health.vic.gov.au/patient-care/capability-frameworks-for-maternity-and-newborn-care-in-victoria>
* [Perioperative service capability framework](https://www.health.vic.gov.au/health-system-design-planning/perioperative-service-capability-framework-for-victoria) <https://www.health.vic.gov.au/health-system-design-planning/perioperative-service-capability-framework-for-victoria>
* [Palliative care capability framework](https://www.health.vic.gov.au/publications/palliative-care-service-capability-framework) <https://www.health.vic.gov.au/publications/palliative-care-service-capability-framework>.

Health services must operate within their agreed and published service capability level.

Visit [Service capability frameworks for Victoria](https://www.health.vic.gov.au/health-system-design-planning/service-capability-frameworks-for-victoria) <https://www.health.vic.gov.au/health-system-design-planning/service-capability-frameworks-for-victoria> for published capability levels and frameworks.

### Determining and monitoring capability levels

Service capability levels for all Victorian public health services are reviewed every two years and agreed to by the department, in partnership with services.

Annually, capability discussions relevant to each clinical stream delivered by the health service will occur as part of health service performance monitoring meetings.

Further information on processes for determining and monitoring capability levels can be found at [Service Capability Frameworks for Victoria](https://www.health.vic.gov.au/health-system-design-planning/service-capability-frameworks-for-victoria) <https://www.health.vic.gov.au/health-system-design-planning/service-capability-frameworks-for-victoria>.

The department will work with health services to facilitate planned or unplanned changes to levels of care as required.

For further information regarding planned or unplanned changes, including diversions related to maternity and newborn care, please refer to [Capability frameworks for maternity and newborn services <](https://www.health.vic.gov.au/patient-care/capability-frameworks-for-maternity-and-newborn-care-in-victoria)https://www.health.vic.gov.au/patient-care/capability-frameworks-for-maternity-and-newborn-care-in-victoria>.

## Future service capability frameworks

The department is continuing to develop and implement capability frameworks, in line with the recommendations of the 2016 *Report of the review of hospital safety and quality assurance in Victoria* (Targeting zero) and the *Statewide design, service and infrastructure plan for Victoria’s health system 2017–2037*.

The next tranche of capability frameworks to be developed and implemented will include:

* critical care
* urgent, emergency and trauma care.

The *Cancer services capability framework* has been developed and is currently under review.

The current *Palliative care service capability framework* is under review.

# Expectations, policies and performance

As a condition of funding, funded agencies must comply with the following expectations, guidelines, policies and performance-reporting requirements.

## Acute and specialist care

### Surgical and procedural services

All Victorian health services are expected to implement the new [Planned surgery and access policy 2024](https://www.health.vic.gov.au/patient-care/surgical-services-policies-and-guides) <https://www.health.vic.gov.au/patient-care/surgical-services-policies-and-guides> for release mid-2024. Health services are expected to fully implement the policy by June 2026. This policy supersedes the *Elective surgery access policy 2015*. This policy provides guidance to the clinical, administrative support staff, managers and executives of all public health services that provide planned (elective) surgery.

For more information about surgical policies and reporting requirements, visit [Surgical services](https://www.health.vic.gov.au/patient-care/surgical-services) <https://www.health.vic.gov.au/patient-care/surgical-services> and the [Elective Surgery Information System (ESIS)](https://www.health.vic.gov.au/data-reporting/elective-surgery-information-system-esis) <https://www.health.vic.gov.au/data-reporting/elective-surgery-information-system-esis>.

### Non-admitted specialist services

All Victorian public health services are expected meet the requirements of the [Managing referrals to non-admitted specialist services in Victorian public health services policy](https://www.health.vic.gov.au/publications/managing-referrals-to-non-admitted-specialist-services-in-victorian-public-health) <https://www.health.vic.gov.au/publications/managing-referrals-to-non-admitted-specialist-services-in-victorian-public-health> by January 2025.

Requirements related to incomplete referrals, internal and associated care referrals, treating in turn, and regular administrative and clinical audits to validate the list of waiting patients should be implemented by this time.

### Victorian endoscopy categorisation guidelines

Victorian health services that provide endoscopy services should ensure clinicians use the *Upper gastrointestinal endoscopy categorisation guidelines for adults 2018*. A decision support tool is available for these guidelines, to provide automated clinical prioritisation (including whether a procedure is recommended) when assessing a patient referred for an endoscopy procedure.

Victoria’s *Colonoscopy categorisation guidelines 2017* and *Upper gastrointestinal endoscopy categorisation guidelines for adults 2018*, and the decision support tool can be accessed at [Specialist clinics – resources](https://www.health.vic.gov.au/patient-care/specialist-clinics-resources) <https://www.health.vic.gov.au/patient-care/specialist-clinics-resources>.

### Cardiac care

The department will continue to implement the priority actions from the [Design, service and infrastructure plan for Victoria’s cardiac system](https://www.health.vic.gov.au/health-system-design-planning/design-service-and-infrastructure-plan-for-victorias-cardiac-system) <https://www.health.vic.gov.au/health-system-design-planning/design-service-and-infrastructure-plan-for-victorias-cardiac-system>. Health services are required to support the activities of this work.

### Admitted palliative care

Admitted palliative care services provide specialised care for people with a life-limiting illness (including respite care), who require an interdisciplinary and comprehensive approach to challenging physical, emotional, social and spiritual issues.

Palliative care is provided:

* in designated inpatient palliative care beds (or units) or standalone facilities
* in subacute wards
* by specialist consultancy services.

Admitted palliative care at home models can also be established. These models must include oversight of all patients by a palliative medicine specialist, with input from a specialist palliative care interdisciplinary team, access to after-hours care and health-service-endorsed escalation pathways to support safe return to hospital where required. The model must be endorsed by the department prior to commencement. There must be clear reporting structures in place to inform attribution of activity and outcomes by care setting (hospital/home). Admitted care in the home models must not duplicate existing state-funded community palliative care programs.

All designated palliative care inpatient units must provide care in line with the [Conditions of funding for admitted palliative care](https://www.health.vic.gov.au/patient-care/conditions-of-funding-for-palliative-care) <https://www.health.vic.gov.au/patient-care/conditions-of-funding-for-palliative-care>.

All health services providing admitted palliative care must report data elements linked to the Australian national subacute and non-acute patient phase of care, including specific elements for the final phase. They are also required to report patient-level costs for palliative care at the phase, through the VCDC, to enable a more accurate link of cost data to the phase of care.

Designated services can submit quarterly Clinical Indictors for Pain via the HealthCollect data portal and participate in the annual palliative care experience module of the Victorian Healthcare Experience Survey (VHES).

#### Day hospice

Some health services are funded to provide day hospice.

Day hospice provides people living with a life-limiting illness, and their families and carers, with a supportive environment to help improve their quality of life. This may include therapeutic activities, social interaction or assistance with treatments. This service applies to people of all ages living with a life-limiting illness and does not include overnight stays.

Health services funded for day hospice must submit activity data to the VINAH minimum dataset and cost data to the VCDC.

### Maternity and newborn services

#### Maternal and perinatal mortality and morbidity review

All health services providing maternity and newborn services must review all maternal and perinatal morbidity and mortalitieslocally. The hospital’s processes for this should align with the Perinatal Society of Australia and New Zealand’s Clinical Practice Guideline for Care Around Stillbirth and Neonatal Death.

For more information, visit [PSANZ Guidelines](https://www.psanz.com.au/guidelines) <http://www.psanz.com.au/guidelines>.

#### Regional maternal and perinatal mortality and morbidity committees

Six regional level 5 maternity services (Barwon Health, Latrobe Regional Health, Ballarat Health Services, Goulburn Valley Health, Albury Wodonga Health and Bendigo Health) provide leadership, management, reporting and coordination of the regional Maternal and Perinatal Mortality and Morbidity Committees. All rural and regional maternity and newborn services must participate in committee meetings.

Regional level 5 maternity and newborn services are also required to:

* maintain accurate records of regional maternal and perinatal mortality, and morbidity committee meetings
* submit summary reports outlining the key findings and recommendations of the committee, as requested by the department.

#### Generation Victoria (GenV)

[GenV](https://www.genv.org.au/) <https://www.genv.org.au> is led by the Murdoch Children’s Research Institute and The Royal Children’s Hospital. It is partially funded by the Victorian Government.

All health services providing maternity services are encouraged to support women to participate in GenV, which aims to improve community health by tracking and analysing the health outcomes of a cohort of Victorian children and their parents over time. GenV will provide new data to enable hospitals to better analyse long-term patient outcomes. GenV aggregate data will be available to validated health services, hospitals and researchers for analysis and study, reducing the time and burden of additional data collection.

With GenV providing staff across the state to recruit families into the cohort, it is not anticipated to affect routine health care. GenV staff will facilitate a transparent ‘opt-in’ consent process delivered in alignment with the VIHSP. This will ensure there is minimal impact on hospital staff and resources.

#### Incentivising better patient safety

The Victorian Managed Insurance Authority (VMIA) launched the Incentivising better patient safety program in July 2018. The program supports Victorian maternity services that provide planned maternity care to continue their commitment towards improvements in quality and safety, through the increased throughput of maternity staff in certain evidence-based, maternity skills education and training programs.

A refund on the maternity component of the health service’s medical indemnity premium will be provided when education and training is delivered according to the program’s eligibility criteria.

All health services providing planned birthing services (levels 2–6 maternity capability) are expected to have met the eligibility criteria established by the [Incentivising better patient safety program](https://www.vmia.vic.gov.au/risk-advisory/harm-prevention/incentivising-better-patient-safety) <https://www.vmia.vic.gov.au/risk-advisory/harm-prevention/incentivising-better-patient-safety>.

#### Adult, paediatric and neonatal intensive care registry data reporting

Health services that operate an adult or paediatric critical care unit must submit data to the Adult Patient Database and the Australian and New Zealand Paediatric Intensive Care Registry, administered by the [Australian and New Zealand Intensive Care Society’s Centre for Outcome and Resource Evaluation (ANZICS CORE)](https://www.safetyandquality.gov.au/acsqhc-arcr-294) <https://www.safetyandquality.gov.au/acsqhc-arcr-294>

Health services operating a level 5 or level 6 newborn service must submit data on babies who meet the collection’s eligibility criteria to the [Australian and New Zealand Neonatal Network <](https://anznn.net/)https://anznn.net/>https://anznn.net/>.

#### Retrieval and Critical Health Information System capacity

To facilitate statewide access to critical care beds, all health services providing adult, newborn and paediatric critical care services are required to update bed occupancy data on the [Retrieval and Critical Health Information System (REACH)](https://reach.vic.gov.au/#/portal/home) <https://reach.vic.gov.au/#/portal/home> four times a day, as per the [REACH manual](https://reach.vic.gov.au/#/guidelines/home) <https://reach.vic.gov.au/#/guidelines/home>.

#### Koori maternity services and culturally safe maternity care

Victoria’s 14 Koori maternity services provide culturally safe, flexible and holistic sexual and reproductive health care, pregnancy and postnatal care. Aboriginal women and women having Aboriginal babies are eligible to access care through a Koori maternity service.

Koori maternity services are a partnered service delivery model provided by ACCOs and public health services. Strong and effective partnerships between these services underpin good perinatal outcomes for Aboriginal women, babies and their families.

Services providing Koori maternity services (see Table 1) deliver these in line with the [Koori Maternity Services Program Guidelines](https://www.health.vic.gov.au/patient-care/aboriginal-maternity-services) <https://www.health.vic.gov.au/patient-care/aboriginal-maternity-services>. These guidelines also outline data collection requirements for these services.

In accordance with the [Capability frameworks for Maternity and Newborn services <](https://www.health.vic.gov.au/patient-care/capability-frameworks-for-maternity-and-newborn-care-in-victoria)https://www.health.vic.gov.au/patient-care/capability-frameworks-for-maternity-and-newborn-care-in-victoria>, all maternity services must provide culturally safe maternity and newborn care for Aboriginal women and families in line with the Koori maternity services program guidelines.

The key Koori maternity services partnerships for public health services are outlined in Table 2.

Table 2: Koori maternity services birthing and referral partners

| Region | Koori maternity service | Birthing and referral partners |
| --- | --- | --- |
| North and West Metropolitan | Victorian Aboriginal Health ServiceWestern Health (Sunshine Hospital)Northern Health (The Northern Hospital) | The Royal Women’s HospitalNorthern Hospital (Northern Health)Mercy Hospital for Women (Heidelberg) |
| Southern Metropolitan | Dandenong and District Aboriginal CooperativePeninsula Health (Frankston Hospital) | Monash Health (Dandenong Hospital, Monash Medical Centre, Casey Hospital)Frankston Hospital (Peninsula Health) |
| Barwon South West | Wathaurong Aboriginal Health ServiceGunditjmara Aboriginal Cooperative | University Hospital GeelongWarrnambool (South West Healthcare)Sunshine Hospital (Western Health)Royal Women’s Hospital  |
| Hume | Rumbalara Aboriginal CooperativeMungabareena Aboriginal Cooperative | Goulburn Valley HealthAlbury Wodonga HealthNortheast Health WangarattaRoyal Women’s HospitalMercy Hospital for Women (Heidelberg) |
| Gippsland | Gippsland and East Gippsland Aboriginal Co-operativeCentral Gippsland Aboriginal Health Service | Bairnsdale Regional Health ServiceCentral Gippsland Health Service (Sale)Latrobe Regional Hospital (Traralgon)West Gippsland Healthcare Group (Warragul)Monash Medical Centre (Monash Health) |
| Loddon Mallee | Mallee District Aboriginal Service (Mildura and Swan Hill)Swan Hill Aboriginal Health ServiceNjernda Aboriginal Corporation | Mildura Base HospitalSwan Hill District HealthEchuca Regional HealthBendigo HealthSunshine Hospital (Western Health) |

For further information about please visit [Koori maternity services](https://www.health.vic.gov.au/patient-care/aboriginal-maternity-services) <https://www.health.vic.gov.au/patient-care/aboriginal-maternity-services>.

### Victorian Paediatric Rehabilitation Service

The Victorian Paediatric Rehabilitation Service specifically caters for children and adolescents who, as a result of injury, medical and surgical intervention, or functional impairment, will benefit from a program of developmentally appropriate, time-limited, goal-focused multidisciplinary rehabilitation.

The Victorian Paediatric Rehabilitation Service consists of:

* a statewide director and program manager
* two inpatient services at The Royal Children’s Hospital and Monash Children’s Hospital (Monash Health) and medical directors
* eight ambulatory services, as part of the Health Independence Program at Ballarat Health Services, Barwon Health, Bendigo Health Care Group, Eastern Health, Goulburn Valley Health, Latrobe Regional Hospital, Monash Health and The Royal Children’s Hospital.

The service’s statewide appointments provide support, leadership and clinical services, where appropriate, across the Victorian Paediatric Rehabilitation Service sites. Participating health services facilitate visiting rights for service staff conducting clinical work. Visiting clinical staff will observe local policies and procedures, enabling the safe and effective provision of specialist paediatric rehabilitation care.

Activity is reported through the VAED and the VINAH minimum dataset. All Victorian Paediatric Rehabilitation Service providers are also expected to submit data to the Australasian Rehabilitation Outcomes Centre to support quality and outcome improvements. Cost data is reported at the patient level (or aggregate where patient level cannot be obtained) through the VCDC.

### Hospital in the home (HITH)

Acute admitted care provided to patients at home as HITH is funded at an equivalent rate to in-hospital acute care. While this section concerns HITH delivered for acute admitted patients, subacute admitted patients can also receive care in the home (see section 18.2: Subacute and non-acute care).

Due to the superior outcomes and experience that can be achieved through care at home, this should be the default setting of care, whenever it is safe, appropriate and consistent with patient preference. Health services are encouraged to continually investigate opportunities to utilise HITH as a substitute for in-hospital care, as acute admitted care practices and treatments evolve.

HITH patients must fulfil the criteria for admission as per the department’s policy at the [VAED criteria for reporting](https://www.health.vic.gov.au/data-reporting/victorian-admitted-episodes-dataset) <https://www.health.vic.gov.au/data-reporting/victorian-admitted-episodes-dataset>.

Client consent must be obtained before providing admitted services in the home. Documentation to support that the home-delivered services are a direct substitution for in-hospital national-weighted-activity-unit-funded acute admitted care must be in the health record.

HITH separations and bed days are reported in the Program Report for Integrated Service Monitoring (PRISM), which is sent to chief executive officers. This enables benchmarking against other health services, particularly the percentage of multi-day separations provided through HITH. Cost data is reported at the patient level (or at aggregate where patient level cannot be obtained) through the VCDC.

For more information, see the [Hospital in the Home guidelines](https://www.health.vic.gov.au/patient-care/hospital-in-the-home) <https://www.health.vic.gov.au/patient-care/hospital-in-the-home>. These guidelines will be refreshed in 2024.

### Specialist clinics

Health services are expected to comply with the [Access to non-admitted services in Victoria policy](https://www.health.vic.gov.au/patient-care/access-to-specialist-clinics-in-victoria)<https://www.health.vic.gov.au/patient-care/access-to-specialist-clinics-in-victoria>.

All health services providing specialist clinic services must ensure their procedures and policies align with the objectives and principles of current policies.

In line with health services’ responsibility to pay for ambulance transport to specialist clinics, health services are responsible for booking and authorising any Ambulance Victoria ambulance transport needed to transport patients to specialist clinics or health independence programs, where clinically necessary.

Home-delivered and telehealth (video or telephone) delivered care should be provided whenever it is safe, appropriate and consistent with patient preference.

Hospitals must provide patient-level specialist clinics data to the department. Activity-based health services must report patient-level specialist clinic data through the VINAH minimum dataset or the NADC.

SRHS and multipurpose services that are currently reporting specialist clinics activity only through AIMS S10, will progress their capability to report patient-level specialist clinics data through the VINAH minimum dataset or the NADC.

Hospitals are expected to report patient-level cost data (or aggregate where patient-level cannot be obtained) for all specialist clinic activity through the VCDC. All health services are expected to continue to improve their AIMS and cost data.

### Virtual care

Virtual care is the use of technology to enable care when a professional and patient are in a different location. Virtual care can be used by healthcare providers for medical, nursing, allied health, patient education, pharmacy services and support workers. It is an overarching term encompassing telehealth (telephone and video-enabled), telemedicine, tele-education, teletherapy, telemonitoring and remote monitoring.

The [Victorian virtual care strategy](https://www.health.vic.gov.au/victorian-virtual-care-strategy/overview) <https://www.health.vic.gov.au/victorian-virtual-care-strategy/overview> outlines that virtual care:

* is used wherever appropriate and preferred by the patient, to provide care closer to home
* is embedded in mainstream care provision
* enhances access and equity of care across the care continuum and improves Victorians’ experience and health outcomes

The Victorian [*Virtual care operational framework*](https://www.health.vic.gov.au/virtual-care-operational-framework) <https://www.health.vic.gov.au/virtual-care-operational-framework>:

* acts as a reference and enables health services that have already implemented virtual care services to aid in continuous improvement and standardisation of care
* provides guidance to support the implementation, operation and extension of virtual care in Victorian public health agencies.

Telehealth, as part of virtual care, offers the opportunity to provide care by substituting face-to-face care, where it is safe and acceptable for the consumer and clinician.

Health services are strongly encouraged to make use of the state-funded video consultation platform Healthdirect, where it is safe, appropriate and consistent with patient preference. Translation services should be made available when required for telehealth consultations.

Telehealth can be a direct method of service delivery (for example, for specialist consultations) or an adjunct to in-person care (for example, remote medical consultations complementing home visits for patients receiving HITH). Telehealth activity in specialist clinics and emergency departments, or as part of acute and subacute admissions, is funded through existing funding models for these services. While both phone and video consulting can be used, video consulting is preferred and is the only mode of telehealth that meets Criteria for Admission for reporting to the VAED.

Services provided via video telehealth consultations in emergency departments to patients located in other Victorian public emergency departments, urgent care centres, Victorian government or non-government residential aged care services, or correctional facilities, must be reported through the Victorian Emergency Minimum Dataset (VEMD) as described in the VEMD manual for 2023–24. They must align with [Reporting Telehealth Video Consultations in Victorian Emergency Departments](https://www.health.vic.gov.au/rural-health/telehealth) <https://www.health.vic.gov.au/rural-health/telehealth>.

MBS telehealth arrangements remain in place and provide for a wide range of telephone and video services by qualified health practitioners and support safe and equitable telehealth services which are informed by the MBS Review Taskforce Principles.

For information on these items, visit [MBS Telehealth Services – from 1 January 2024 <](https://www.mbsonline.gov.au/internet/mbsonline/publishing.nsf/Content/Factsheet-Telehealth-Updates-April%202023)https://www.mbsonline.gov.au/internet/mbsonline/publishing.nsf/Content/Factsheet-Telehealth-Updates-April%202023>

### Integrated hepatitis C services

The department funds 10 public health services and two community health services to provide nurse-led integrated hepatitis C services.

In 2024–25, health services are to continue realigning their service to focus on the effective use of primary care and targeted use of hospital specialist services.

This includes:

* implementing localised hepatitis C pathways developed by PHNs with local PHNs
* building capacity in primary care and community settings to deliver hepatitis C testing, treatment and care for non-complex clients
* strengthening referral pathways between specialist clinics and primary care for managing complex clients
* working with pharmacy providers to have drug supply in the community.

#### Direct-acting antiviral hepatitis C treatments

The Australian Government lists several medicines to treat hepatitis C on the Pharmaceutical Benefits Scheme (PBS) and the Highly Specialised Drugs Program.

Nurse practitioners experienced in the care and management of people living with HIV and hepatitis B in the community, and hepatitis C in corrective services settings, are now eligible to prescribe s. 100 medicines. The relevant medicines listed for prescribing by nurse practitioners are identified by ‘NP’ in the PBS Schedule. For more information about these arrangements, visit the [National Health (Highly Specialised Drugs Program) Special Arrangement 2021](https://www.legislation.gov.au/Details/F2022C00177) <https://www.legislation.gov.au/Details/F2022C00177> that came into effect on 1 February 2022.

For more information, also visit [Hepatitis C Medicines](https://www.pbs.gov.au/info/publication/factsheets/hep-c/hepc-factsheet-hospital-prescribers-dispensers) <https://www.pbs.gov.au/info/publication/factsheets/hep-c/hepc-factsheet-hospital-prescribers-dispensers>.

Integrated hepatitis C services activity is reported as part of the VINAH minimum dataset. For community health centres with integrated hepatitis C services, work is continuing to report activity through the Service Agreement Management System to the Community Health minimum dataset.

In the interim, community health services can report using the NADC. For more information, email the Health Data Standards and Systems (HDSS) helpdesk <hdss.helpdesk@health.vic.gov.au>.

Health services that are funded to provide integrated hepatitis C services must provide aggregate data on the numbers of patients attending clinics, waiting times and the numbers of patients being transitioned to community providers, to the department on request.

For more information, visit:

* [Community health data reporting](https://www.health.vic.gov.au/community-health/community-health-data-reporting) <https://www.health.vic.gov.au/community-health/community-health-data-reporting>
* [Victorian health services performance](https://vahi.vic.gov.au/reports/victorian-health-services-performance) <https://vahi.vic.gov.au/reports/victorian-health-services-performance>
* [Hepatitis C – Better Health Channel](https://www.betterhealth.vic.gov.au/health/conditionsandtreatments/hepatitis-c) <https://www.betterhealth.vic.gov.au/health/conditionsandtreatments/hepatitis-c>.

### Disability and the NDIS

Health services should deliver high-quality care that is accessible, welcoming, safe and effective to all Victorians, including people with disability, wherever they are treated. People with disability should receive treatment and care, and the application of patient rights and responsibilities, that are afforded to any person in the community receiving health care with the same or similar clinical needs.

Consistent with person-centred care, aids (such as Auslan) should be used where necessary to overcome communication difficulties, and to promote active participation of people with disability in decisions about their treatment and care. *Inclusive Victoria: state disability plan 2022–2026* sets out six systemic reforms for making things fairer for people with disability, including:

* co-design with people with disability
* Aboriginal self-determination
* intersectional approaches
* accessible communications and universal design
* disability-confident and inclusive workforces
* effective data and outcomes reporting.

Health services are required to develop disability action plans to improve the quality of care for people with disability, share these with their community and report on outcomes annually.

For more information, visit [*Inclusive Victoria: state disability plan 2022–2026*](https://www.vic.gov.au/state-disability-plan) <https://www.vic.gov.au/state-disability-plan>.

#### Working with the NDIS

Health and community services are responsible for effective interaction with the NDIS, to enable timely access to support and services for people with disability, who have new or changed needs following a hospital admission.

Health and community services are required to operate effectively in the market-based environment that is presented by the NDIS for delivering disability services:

* Health services should have processes in place to identify NDIS participants, or those eligible to become participants.
* When providing care to NDIS participants, health services should ensure NDIS-eligible activity and equipment is billed to the NDIS.
* NDIS participants may access health and community services to seek care that is funded in their NDIS support plan. It may be that health services are their provider of choice for specialist services, or the provider of last resort in areas where markets are developing.

Health services should consider registering as an NDIS service provider. This will enable health services to access additional revenue by billing the NDIS for funded activities for eligible clients. In regional areas, this will ensure access to certain NDIS-eligible allied health and nursing interventions for NDIS participants, where these services may otherwise not be available locally.

For more information, visit: [NDIS Quality and Safeguards Commission](https://www.ndiscommission.gov.au/providers/becoming-registered-provider) <https://www.ndiscommission.gov.au/providers/becoming-registered-provider>.

#### Admitted patients

The NDIS employs health liaison officers (HLOs) to assist NDIS participants to move through the NDIS pathway while in hospital. They are essential contacts for health services for engaging with the NDIS, specifically relating to discharge planning and escalation of protracted discharge delays.

Their role includes:

* promoting understanding of the NDIS within health services to support hospital discharge, such as understanding the hospital discharge participant pathway from access to pre-planning, plan development and implementation
* promoting awareness of the scope of supports and services provided by the NDIS
* linking directly with health clinicians and allied health professionals to provide support and coordination for discharge planning, case conferences and information exchange
* engaging directly with NDIS participants (patients) to problem solve barriers to discharge
* escalation of protracted and complex discharges to the NDIS Hospital Interface Branch for prioritisation.

NDIS-funded HLO positions support all health services throughout Victoria. NDIS offers a targeted hospital discharge pathway that differs from the NDIS pathway available to existing and prospective NDIS participants in the community. Hospitals that do not have an allocated HLO can refer and seek support by emailing the National Disability Insurance Agency’s (NDIA) central HLO inbox <health.liaison.officer@ndis.gov.au>. Referrals will be triaged and allocated to a HLO that supports the local health network.

#### Hospital admission and discharge

When an existing or prospective NDIS participant is admitted to hospital:

* with patient consent, the health service must notify the NDIS at the earliest convenience, if changes to the patient's NDIS plan may be required to support their discharge. This will trigger the NDIS to commence planning for delivery of an interim discharge plan within 15–30 days of the health service’s notification of admission
* the NDIS participant referral form and the NDIS consent form should be completed and submitted to the NDIA’s central HLO inbox, to share information to support planning for the participant’s discharge as soon as practicable
* inpatient allied health assessments to support discharge are to be completed by the health service
* the health service must provide the NDIS with the relevant evidence to support NDIS access requests and participant plan variations and reassessments. This can be done by submitting the NDIS discharge assessment form or the health service’s equivalent template.

#### Health service responsibility for aids, equipment and domiciliary oxygen

This information is provided to clarify responsibilities of public health services in providing aids, equipment and domiciliary oxygen for patients being discharged.

Health services have a responsibility to provide aids and equipment for up to 30 days, at no cost to the patient (excluding a refundable deposit, if applicable). This includes domiciliary oxygen and continence aids required by patients for recuperation and safe and effective discharge, to prevent unnecessary continued hospitalisation or readmission. This responsibility applies, except for pre-existing VA&EP and NDIS clients receiving domiciliary oxygen or continence aids.

Health services may charge the patient fees for these aids and equipment, after the expiry of the 30-day post-discharge period. Alternatively, patients may choose to make their own arrangements.

Health services will need to work closely with the NDIS to ensure a smooth discharge for admitted patients who are eligible for the NDIS. For admitted patients being discharged, who are not eligible for the NDIS, health services should provide any aids or equipment necessary to enable discharge, for as long as these are required.

For more information about fees and charges for providing aids, equipment and domiciliary oxygen, visit [Patient fees and charges for public health services](https://www.health.vic.gov.au/hospitals-and-health-services/patient-fees-and-charges-for-public-health-services) <https://www.health.vic.gov.au/hospitals-and-health-services/patient-fees-and-charges-for-public-health-services>.

## Subacute and non-acute care

The primary treatment goal of subacute and non-acute care is to optimise a consumer’s functioning and quality of life.

Subacute services can be delivered as either admitted or ambulatory care, and should be delivered in the home, whenever it is safe, appropriate, consistent with the patient’s preference and compliant with Victorian funding policy. Admitted subacute services should be delivered in the home, with reference to the same guidance for HITH (see section 18.1.8 Hospital in the Home).

Health services are delineated to provide rehabilitation and geriatric evaluation, and management services (GEM), through the [Planning the future of Victoria’s subacute service system: a capability and access planning framework](https://www.health.vic.gov.au/patient-care/subacute-planning-framework)<https://www.health.vic.gov.au/patient-care/subacute-planning-framework>. Health services should align their services with the department’s published capability level at all times.

Health services providing rehabilitation, GEM, and Health Independence Program services should ensure they align their services based on their service capability level. Local health services delineated as level 2 will provide and report maintenance care.

### Rehabilitation, geriatric evaluation and management, and maintenance care

#### Rehabilitation

Rehabilitation care is when the primary clinical purpose or treatment goal is improvement in the functioning of a consumer with impairment, activity limitation or participation restriction, due to a health condition. The consumer will be capable of actively participating in rehabilitation.

Rehabilitation care is always:

* managed by a clinician with special expertise in rehabilitation
* evidenced by an individual, multidisciplinary management plan that is documented in the consumer’s medical record, including negotiated goals within specified timeframes and documented assessment of functional ability.

#### Geriatric evaluation and management (GEM)

GEM is care in which the primary clinical purpose or treatment goal is improving the functioning of a consumer with multidimensional needs that are associated with medical conditions related to ageing. This includes falls, incontinence, reduced mobility, delirium or depression. The consumer may have complex psychosocial problems and is usually (but not always) an older person.

GEM is always:

* managed by a clinician with special expertise in GEM
* evidenced by an individual, multidisciplinary management plan that is documented in the consumer’s medical record, which includes negotiated goals within indicative timeframes and documented assessment of functional ability.

An evaluation of the GEM program in Victoria has been undertaken. For information about this program and to read the report, visit [Evaluation of the Geriatric Evaluation and Management program in Victoria](https://www.health.vic.gov.au/patient-care/evaluation-of-the-geriatric-evaluation-and-management-program-in-victoria) <https://www.health.vic.gov.au/patient-care/evaluation-of-the-geriatric-evaluation-and-management-program-in-victoria>.

The evaluation sought to:

* understand the extent to which GEM is delivering an efficient and effective service
* understand how GEM supports the broader health service system, including interfaces within health services, and with external community and aged care services
* identify the current and future challenges and enablers for GEM, and how it needs to evolve to meet the needs of older Victorians now and into the future.

#### Maintenance care

Maintenance care is care in which the primary clinical purpose or treatment goal is supporting a consumer with impairment, activity limitation or participation restriction, due to a health condition. Following assessment or treatment, the consumer does not require further complex assessment or stabilisation.

It is not intended that maintenance care substitutes for other forms of non-acute care. It should emphasise a restorative approach to care after treatment.

#### Admitted geriatric evaluation and management and rehabilitation – reporting requirements

All health services providing inpatient rehabilitation and GEM services must report a functional independence measure score on admission and separation (excluding paediatric rehabilitation), and GEM. This is a mandatory VAED reporting requirement. Relevant records submitted to the department without a functional independence measure score will be rejected.

A ‘Program identifier for specialist acquired brain injury rehabilitation service’ (code 09) is to be reported for patients in the two designated specialist acquired brain injury rehabilitation services located at Caulfield Hospital, Alfred Health and the Royal Talbot Rehabilitation Centre, Austin Health.

A ‘Program identifier for specialist spinal rehabilitation service’ (code 10) is to be reported for patients in the two designated specialist spinal rehabilitation services located at Caulfield Hospital, Alfred Health and the Royal Talbot Rehabilitation Centre, Austin Health.

For program details and service model information, visit [Rehabilitation and complex care](https://www.health.vic.gov.au/patient-care/rehabilitation-and-complex-care) <https://www.health.vic.gov.au/patient-care/rehabilitation-and-complex-care>.

### Transition Care Program

The Transition Care Program is funded by the Commonwealth and state and territory governments through joint per diem contributions. The flexible care places used in the program are legislated by the *Aged Care Act 1997* (Cth) and the Aged Care Principles pursuant to that Act. The [Transition Care Programme guidelines](https://www.health.gov.au/resources/publications/transition-care-programme-guidelines) <https://www.health.gov.au/resources/publications/transition-care-programme-guidelines> updated in 2022, govern the program.

For more information, visit the [Transition Care Program](https://www.health.vic.gov.au/patient-care/transition-care-program) <https://www.health.vic.gov.au/patient-care/transition-care-program>.

### Health Independence Program

Health Independence Program services aim to provide hospital substitution and diversion services by supporting people in the community, in ambulatory settings and in their homes, which may include residential facilities. Health Independence Program services focus on improving and optimising people’s function and participation in activities of daily living, to allow them to maximise their independence and return to, or remain in, their usual place of residence.

Home-delivered and telehealth (video or telephone) delivered care should be provided whenever it is safe, appropriate and consistent with consumer preference.

For more information, visit [Health Independence Program guidelines](https://www.health.vic.gov.au/patient-care/health-independence-program-guidelines) <https://www.health.vic.gov.au/patient-care/health-independence-program-guidelines>.

#### Health Independence Program service delivery components

The components of the program that a consumer receives will be based on their assessed needs and will assist them to meet their identified goals.

This may consist of one or more of:

* non-admitted rehabilitation (such as rehabilitation at home or in a community rehabilitation centre)
* care coordination – short-term or complex
* consumer self-management, education and support
* access to specialist services, including specialist assessment (such as linking to residential in-reach services, a specialist medical clinic or specialist subacute clinic, such as chronic pain management, falls and balance, or continence clinics)
* short-term supports (such as post-acute care)
* complex psychosocial issues management.

#### Reporting requirements

Organisations must transmit data to the VINAH minimum dataset if they receive funding under:

* the Health Independence Program:
	+ subacute ambulatory care services (including paediatric rehabilitation)
	+ Hospital Admission Risk Program
	+ post-acute care
	+ residential in-reach service
* community palliative care.

The definition of a Health Independence Program contact is provided in the VINAH manual business rules. The program’s counting unit will be ‘direct non-admitted contacts’, which are defined as contacts where all of the following VINAH minimum dataset characteristics are met, including:

* contact account class Public Eligible (MP) or Reciprocal Health Care Agreement (MA)
* contact client present status where either the patient, their carer, or both, are present (10, 11, 12, 13 or 20)
* contact delivery mode that is direct (1, 2, 3, 4,5 or 8)
* contact delivery setting that is not the ED (13)
* contact inpatient flag does not equal I (Inpatient/Admitted).

The AIMS S11 form will continue to be required to report service events for Commonwealth reporting processes.

Non-admitted subacute care programs and services that reliably submit data to the VINAH minimum dataset for all subacute program streams will be able to cease providing AIMS S11 data, once agreement has been reached with the department.

Hospitals are expected to report patient-level cost data (or aggregate where patient-level cannot be obtained) for all subacute and non-acute activity through the VCDC, as detailed in section 29.1.8 Victorian Cost Data Collection.

For more information, visit:

* [*Planning the future of Victoria’s subacute service system: a capability and access planning framework – 2013*](https://www.health.vic.gov.au/publications/planning-the-future-of-victorias-subacute-service-system-a-capability-and-access) <https://www.health.vic.gov.au/publications/planning-the-future-of-victorias-subacute-service-system-a-capability-and-access>
* [Health Independence Program guidelines](https://www.health.vic.gov.au/patient-care/health-independence-program-guidelines) <https://www.health.vic.gov.au/patient-care/health-independence-program-guidelines> – these will continue to guide health service and departmental directions for these services in 2024–25.

### Community palliative care

Designated community palliative care services provide end-of-life and palliative care to clients and carers that is responsive, multidisciplinary and evidence-based. Care is tailored to the preferences, values and goals of the individual, and to their stage of illness, and can be early or late in the illness trajectory. Care includes complex pain and symptom management, and assistance with physical, spiritual, social and cultural concerns related to life-limiting illness and bereavement.

Practical help includes respite and financial assistance for equipment that supports the safety of clients, carers and staff in the home.

These services must provide care in line with the [Conditions of funding for palliative care](https://www.health.vic.gov.au/patient-care/conditions-of-funding-for-palliative-care) <https://www.health.vic.gov.au/patient-care/conditions-of-funding-for-palliative-care>.

The department will monitor community palliative care services progress against episode targets (see *Funding rules*, part 2: Funding and activity levels).

#### After hours

Outside business hours (usually between 7.00 am and 5.00 pm Monday to Friday, excluding public holidays), all designated community palliative care services must provide or arrange a minimum level of service to their clients that includes:

* specialist palliative care telephone advice to clients, carers and families primarily (but not only) about symptom management if required – this may include secondary consultation with a specialist palliative care provider where relevant
* a health professional visit if required, based on the client’s, carer’s or family’s needs (if it is safe for staff to undertake the visit)
* any other after-hours care negotiated between clients, their carers and the community palliative care service on an individual basis.

#### Reporting requirements

All designated community palliative care services must report activity using the program and stream element, as described in the VINAH minimum dataset, which includes that:

* contacts will be reported through the VINAH minimum dataset as per the standard VINAH reporting requirements
* the AIMS S11 form will continue to be required to report service events for Commonwealth reporting processes, until the AIMS S11 and the VINAH minimum dataset reliably match, and agreement to cease has been reached with the department
* funded services must submit quarterly Clinical Indictors for Pain data, via the HealthCollect data portal
* funded services must participate in the annual palliative care experience module of the VHES
* patient-level cost data (or aggregate where patient-level cannot be obtained) for community palliative care activity are to be reported through the VCDC.

### Palliative care consultancy teams

Funding allocations for hospital-based and regional specialist palliative care consultancy form part of the health service modelled budgets in their acute and subacute allocation.

#### Hospital-based palliative care consultancy teams

Hospital-based palliative care consultancy teams provide specialist advice and support to other clinicians in their hospital and, in certain instances, direct care. They are to report patient-level data using the VINAH minimum dataset.

#### Regional palliative care consultancy teams

Regional palliative care consultancy teams provide a combination of direct care and secondary consultations to other clinicians within their designated rural region or subregion.

#### Reporting requirements

All hospital-based and regional palliative care consultancy services must report activity using the program and stream element, as described in the VINAH minimum dataset, which includes that:

* contacts will be reported through the VINAH minimum dataset as per the standard VINAH reporting requirements
* the AIMS S11 form will continue to be required to report service events for Commonwealth reporting processes, until the AIMS S11 and the VINAH minimum dataset reliably match, and agreement to cease has been reached with the department
* the AIMS Palliative Care Consultancy Program (PCCP) form will continue to be required to report for accountability and service planning (number of contacts, number of referrals, active episodes, number of episodes opened and closed, and number of patients)
* services reporting aggregate activity via AIMS S11, and not able to transition to patient-level VINAH minimum dataset reporting for 2024–25, are to continue reporting via AIMS S11 and PCCP, and make the necessary changes to report patient-level activity to the VINAH minimum dataset from 1 July 2024
* palliative care consultancy teams are to work closely with costing personnel in their service so that their activity is correctly recorded and apportioned within the service, and appropriately captured and attributed in the VCDC.

### Statewide consultancy services

A range of statewide services are funded to provide specialist advice in relation to particular diagnoses or population groups, including:

* the Victorian Paediatric PCCP
* Very Special Kids
* the Statewide Specialist Bereavement Service provided through Grief Australia
* Motor Neurone Disease Association Victoria.

#### Reporting requirements

Statewide palliative care services are to report patient-level data using the VINAH minimum dataset or the NADC (see section 29.1.5 Victorian Integrated Non-Admitted Health minimum dataset).

The AIMS PCCP form will continue to be reported for accountability and service planning (number of contacts, number of referrals, active episodes, number of episodes opened and closed, and number of patients). The AIMS S11 reporting can cease once the AIMS S11 and the VINAH minimum dataset/NADC data reliably match, and/or agreement to cease has been reached with the department.

For more information about palliative care consultancy services, including the Victorian Paediatric PCCP business rules, visit the [Palliative Care Program](https://www.health.vic.gov.au/patient-care/palliative-care-program) <https://www.health.vic.gov.au/patient-care/palliative-care-program>.

### Palliative care consortia

Palliative care consortia support the department to implement *Victoria’s end of life and palliative care framework* across the state. Consortia play an important role in regional education and training activities, and linking palliative care into the regional health and community care system.

Each consortium receives funding to support the manager role and contribute to consortium activities. One member organisation of each consortium acts as the fund holder, noting that:

* all funding grants for consortia are allocated to the nominated fund holder organisations
* each Consortium Executive Committee is responsible for allocating funds to consortium activities in its region.

Each consortium is required to submit an annual report to the department before 30 September 2024. The report should outline their key achievements and activities for 2023–24 and include a financial statement that accounts for expenditure throughout the financial year.

For more information about palliative care consortia, visit the [Palliative Care Program](https://www.health.vic.gov.au/patient-care/palliative-care-program) <https://www.health.vic.gov.au/patient-care/palliative-care-program>.

### Victorian Artificial Limb Program

Victorian Artificial Limb Program services must report service events as a non-admitted subacute service through the AIMS S11 form and report the cost data to the VCDC. Health services are required to report patient-level activity via the VINAH minimum dataset.

Services expected to provide artificial limbs under the Victorian Artificial Limb Program in 2024–25 include:

* The Royal Children’s Hospital
* Peninsula Health
* Melbourne Health
* Alfred Health
* Barwon Health
* Grampians Health Ballarat
* Austin Health
* St Vincent’s Health
* Latrobe Regional Hospital
* Bendigo Health
* South West Healthcare.

People accessing the Victorian Artificial Limb Program service and equipment may be eligible for the NDIS. Health services are expected to identify NDIS participants, or those eligible to become participants, who are accessing their Victorian Artificial Limb Program services, and ensure NDIS-eligible activity and equipment is billed to the NDIS.

### Victorian Respiratory Support Service

The Victorian Respiratory Support Service is required to report activity through the AIMS S11 and S12 forms, and report contacts through the VINAH minimum data set. It is also required to report patient-level cost data through the VCDC.

### Total parenteral nutrition

Five health services provide total parenteral nutrition services for non-admitted consumers who self-administer total parenteral nutrition at home. The services are Austin Health, Melbourne Health, Monash Health, St Vincent’s Health and The Royal Children’s Hospital.

Activity is to be reported via the AIMS S12 form by the twelfth day following the end of the month, and be reported to the VINAH minimum dataset.

Cost data reported must be reported via the VCDC and should consider the cost of consumables, equipment, maintenance and overheads. It should not include the cost of consultations with a health professional.

Health services should count and report consultations with health professionals separately.

### Home enteral nutrition

Activity is to be reported via the AIMS S12 form by the 12th day following the end of the month, and be reported to the VINAH minimum dataset.

Cost data reported must be reported via the VCDC and should consider the cost of consumables, equipment, maintenance and overheads. It should not include the cost of consultations with a health professional.

Health services should count and report consultations with health professionals separately.

## System improvements

### Strengthening Hospital Responses to Family Violence (SHRFV)

Health services are expected to embed a whole-of-hospital model for responding to family violence, to meet the requirements of the Child Information Sharing Scheme (CISS) and the Family Violence Information Sharing Scheme (FVISS), and to align to the [Family Violence Multi-Agency Risk Assessment and Management Framework](https://www.vic.gov.au/family-violence-multi-agency-risk-assessment-and-management) (MARAM) <https://www.vic.gov.au/family-violence-multi-agency-risk-assessment-and-management> and align to protect and promote health and life and reduce inequalities under Victoria’s Public Health and Wellbeing Act. Health services are required to develop sustainable practices to address and reduce family violence.

SHRFV led health services are required to provide access to appropriate training and resources for the health services they support, actively participate in the SHRFV community of practice, and provide quarterly data as part of the program reporting requirements.

SHRFV lead health services are required to actively mentor health services they support to roll out and embed FVISS, CISS and MARAM, inclusive of the family violence workplace support. They are also required to report funding expenditure on a biannual basis and to acquit SHRFV funds at the end of the financial year.

Health services are expected to develop sustainable family violence practices, and a system with a focus on building a knowledge base with policies and processes, to support implementation of the family violence information sharing schemes and MARAM into the future.

The Royal Women’s Hospital and Bendigo Health are the statewide leads for SHRFV in 2024–2025. SHRFV leads will work to embed the SHRFV initiative at their health service and build partnerships to support health services in the region to implement the SHRFV whole-of-hospital service model to meet MARAM, FVISS and CISS and align to MARAM.

SHRFV supports health services to implement family violence, child safety and wellbeing reform. It provides policies, procedures, and guidelines for the reforms to work in hospitals and integrated health services, a community of practice and forums as needed to inform and advance the reforms. It enables workforce engagement on key issues, developments, and next generation reform. It supports system and clinical champions and specialists to address issues and change culture. It also supports health professionals who experience family violence and are information sharing contacts within the service.

The SHRFV Tool Kit is available on [The Royal Women’s Hospital website](https://www.thewomens.org.au/health-professionals/clinical-resources/strengthening-hospitals-response-to-family-violence) <https://www.thewomens.org.au/health-professionals/clinical-resources/strengthening-hospitals-response-to-family-violence>.

For more information, visit [Information sharing and MARAM reforms](https://www.vic.gov.au/information-sharing-schemes-and-the-maram-framework) <<https://www.vic.gov.au/information-sharing-schemes-and-the-maram-framework>>.

### Prevent and respond to risks of occupational violence and aggression, and bullying and harassment

All funded organisations are responsible for the safety of their staff, patients and visitors. Funded organisations must have the systems and processes in place to enable them to identify, assess and control occupational health and safety risks, in accordance with their obligations under the Occupational Health and Safety Act.

The department and Safer Care Victoria will continue to work with health services in 2024–25 to implement initiatives to better prevent and respond to risks of occupational violence and aggression and bullying and harassment.

For more information about these initiatives, visit [Worker health and wellbeing in Victorian health services](https://www.health.vic.gov.au/health-workforce/worker-health-and-wellbeing-in-victorian-health-services) <https://www.health.vic.gov.au/health-workforce/worker-health-and-wellbeing-in-victorian-health-services>. Health services are expected to regularly refer to the information provided on this webpage, and to implement the guidance and resources, including minimum standards.

The department requires that all Victorian public health services undertake the Victorian Public Sector Commission’s People Matter Survey in 2024, including the ‘Negative behaviour’ section.

Health services must publicly report all incidents of occupational violence in their annual report. The department will continue to work with health services and boards in 2024–25 to improve reporting and support risk management.

### Medical treatment planning and decisions, and advance care planning

The *Medical Treatment Planning and Decisions Act 2016* ensures people are provided with medical treatment that is consistent with their preferences and values. It clarifies the legal effect of an advance care directive, and provides a single process for identifying who should make decisions on behalf of a person and a process for making these decisions.

If a registered health practitioner fails to act in accordance with relevant provisions of this Act, it will constitute unprofessional conduct.

Health services are required to have processes in place that:

* include systematic implementation of advance care planning and identification of medical treatment decision-makers,
* include advance care planning as a parameter in assessment of outcomes, such as mortality and morbidity review reports, patient experience and other routine data collection
* enable and promote the use of My Health Record to support communication of advance care plans.

Advance care planning should be embedded into the usual care that health services provide, resulting in an increase in the number of both admitted and non-admitted consumers with an advance care directive or plan alert, and an identified medical treatment decision maker. This will be measured through mandatory VAED, VEMD and VINAH minimum dataset items.

For more information, visit [Advance care planning](https://www.health.vic.gov.au/patient-care/advance-care-planning-1) <https://www.health.vic.gov.au/patient-care/advance -care-planning-1>.

## Integrated cancer services

All health services that treat cancer patients are expected to be active members of the Integrated Cancer Service (ICS) for their area, and to support the implementation of the network’s purpose to promote the development of a cohesive, integrated and multidisciplinary approach to the provision of cancer care.

ICSs will help achieve the goals stated in the Victorian cancer plan 2020 – 2024 and future cancer plans, being:

* achieving equitable outcomes for all Victorians
* halving the proportion of Victorians diagnosed with potentially preventable cancers
* ensuring Victorians have the best possible experience of the cancer treatment and care system
* increasing one- and five-year survival of Victorians with cancer.

 A continuing focus for ICSs in 2024–25 is to work in collaboration with relevant cancer services to streamline service improvement priorities within and across the ICS regions. This is in addition to participating in statewide initiatives to support improvement in cancer outcomes. It will include positive contribution to delivery of the Victorian ICS Implementation Plan, in support of the Victorian cancer plan.

It will also include a greater focus on improving access and timeliness of cancer care, in accordance with the nationally endorsed [Optimal Care Pathways](https://www.cancervic.org.au/get-support/for-health-professionals/optimal-care-pathways) <https://www.cancervic.org.au/get-support/for-health-professionals/optimal-care-pathways>.

Host organisations are required to hold funds on behalf of the ICS and act as employers for ICS program staff. Host organisations need to ensure appropriate human resource management (including annual performance appraisals), fiscal management processes and accounting procedures are in place. A senior executive should be nominated as the key management contact regarding these matters.

The ICS governance committees, with clinician and consumer input, are responsible for:

* decision-making about using funds in accordance with both local and statewide priorities for cancer reform
* accountability for ICS funding
* ensuring value for money
* ensuring sound project management and evaluation processes are employed.

Host organisations and the ICS governance committees must agree to any charges levied by the host for infrastructure support. These charges must be reflective of actual costs incurred and should be reported in the ICS budget.

The accountability requirements of the ICS governance committees are to:

* report progress against the current Victorian ICS Implementation Plan and their local workplan
* provide half-yearly financial statements (for periods ending 31 December and 30 June)
* participate in the department’s cancer reform meetings and workshops
* provide an annual report for public dissemination
* submit a log of clinical indicator outliers quarterly identified via the Statewide Cancer Indicator Platform (SCIP) application
* participate in processes to evaluate the impact of cancer reform activities, including reporting outcomes against targets and milestones.

The department reserves the right to conduct an ICS program office performance and financial audit.

For more information, visit [Integrated Cancer Services](https://www.health.vic.gov.au/health-strategies/integrated-cancer-services) <https://www.health.vic.gov.au/health-strategies/integrated-cancer-services>.

## Perinatal services performance indicators

Safer Care Victoria publishes an annual report of Victorian perinatal services performance indicators. The report contains individual hospital (or campus) level data, allowing comparison with the statewide average. The report aims to improve outcomes for Victorian women and babies, by reporting on benchmarking data. Safer Care Victoria works directly with health services to understand their results to improve outcomes.

Health services use this report to:

* track their own performance and trends, using raw local health service data, as required
* compare results with services of a similar profile (size and capability)
* undertake ongoing local audits, including adverse event reviews, through their perinatal mortality and morbidity committees
* perform local analysis of specific groups or cohorts of cases, such as age profiles
* identify priority areas for focus and plan for performance improvement within a continuous framework
* evaluate improvement programs and provide feedback to relevant stakeholders
* disseminate results internally to build engagement with the maternity team
* provide education and support to staff and local communities
* collaborate with neighbouring health services and community-based healthcare providers to improve local practice, referral systems and performance.

Selected indicators have recommended strategies for improvement, which should be undertaken by health services that are looking to improve or have suboptimal outcomes.

These indicators include:

* an assessment of their capability and the processes to support regular clinical audits, and the provision of performance data feedback to clinicians
* a multidisciplinary review of local clinical practice guidelines and protocols, to ensure they are based on current evidence and research
* a review of organisational barriers that constrain continual practice improvement
* benchmarking with peer group services
* engaging with other health services to achieve better outcomes that support local and regional improvement (this may include referral of results to their regional perinatal morbidity and mortality committee for expert multidisciplinary consideration)
* identifying improvement goals, including timelines, and working with Safer Care Victoria to monitor performance and improvement initiatives over time.

Safer Care Victoria will work with health services to identify future improvement priorities for 2024–25. For more information, visit [Victorian perinatal services performance indicators 2020–21](https://www.safercare.vic.gov.au/publications/victorian-perinatal-services-performance-indicators-2020-21) <https://www.safercare.vic.gov.au/publications/victorian-perinatal-services-performance-indicators-2020-21>.

## Blood Matters Program

The Blood Matters Program assists health services to monitor patient blood management and transfusion practices, in line with guidelines and standards to provide recommendations and support for best practice.

Health service performance reporting is required through participation in audits and surveys on practice and governance.

Participation in the Blood Matters Program’s Serious Transfusion Incident Reporting program is expected, as it supports national healthcare standards. Reporting of serious adverse events related to blood or blood components is required, including clinical reactions and procedural events.

These include:

* near-miss incidents
* events related to Rh D immunoglobulin
* cell salvage.

Health services are expected to align blood management and transfusion practices with national guidelines, standards and strategies, including the:

* [National stewardship expectations for the supply of blood and blood products](https://www.blood.gov.au/supply-system/managing-blood-supply/national-stewardship-program#:~:text=all%20blood%20products%20are%20used,the%20wastage%20of%20blood%20products) <https://www.blood.gov.au/supply-system/managing-blood-supply/national-stewardship-program#:~:text=all%20blood%20products%20are%20used,the%20wastage%20of%20blood%20products>
* [Patient blood management guidelines](https://www.blood.gov.au/clinical-guidance/patient-blood-management) <https://www.blood.gov.au/clinical-guidance/patient-blood-management>
* [NSQHS Standards](https://www.safetyandquality.gov.au/standards/nsqhs-standards)<https://www.safetyandquality.gov.au/standards/nsqhs-standards>
* [National wastage and haemovigilance strategies](https://www.blood.gov.au/national-blood-management-improvement-strategy-2018-2024) <https://www.blood.gov.au/national-blood-management-improvement-strategy-2018-2024>.

The department established the transfusion nurse/trainer/safety officer and patient blood management role across Victoria. It continues to financially support these positions. Health services are expected to have roles in place to ensure compliance with national guidelines and the NSQHS Standards. Services are funded to achieve this through acute admitted funding.

Health services are expected to support compliance with the national guidelines and the NSQHS Standards through activities that include:

* employing an appropriately trained nurse or scientist who, where able, holds a Specialist Certificate in Blood Management Foundations and/or Graduate Certificate of Transfusion Practice
* ensuring the role operates within an effective health service blood management and quality governance structure
* incorporating patient blood management practices – that is, a patient-centred approach to safe and appropriate transfusion practice, in line with national clinical guidelines, standards and strategies (NSQHS blood management standard 7)
* participating in Blood Matters Program audits, educational forums and other activities.

For more information, visit [About the Blood Matters Program](https://www.health.vic.gov.au/patient-care/about-the-blood-matters-program) <https://www.health.vic.gov.au/patient-care/about-the-blood-matters-program>.

## Pathology reform

In October 2020, the Victorian Government endorsed a reform program to consolidate existing public hospital pathology services into three independent public pathology entities that will ensure Victoria’s public pathology system can continue to deliver high quality pathology services and meet increasing demand for pathology services. The goals of this reform include establishing more effective and scaled public pathology services, improving career pathways for the pathology workforce, and facilitating the sharing of pathology results.

Time-limited funding is being made available to the newly forming entities to cover establishment costs up until the entities become operational.

As the structure arrangements are being finalised, networks are working with health service staff to consider optimal operating arrangements and identify opportunities for closer collaboration across the laboratories that are coming together. Work is continuing on the implementation of the new integrated laboratory information systems (LIS), one for each network, that will facilitate the sharing of pathology information between laboratories and offer advanced decision-making support to clinicians.

Timelines for the creation of the entities and the implementation of LIS systems is being agreed between each of the entities and the department, recognising that the significant work that is required to disaggregate existing pathology services from within individual hospitals and collaborate on implementing a shared pathology service.

## Planned (elective) surgery reform

Significant steps to drive planned surgery recovery and reform have been realised through the delivery of the *COVID Catch-Up Plan* (announced in April 2022). This program of work laid out a foundation for system recovery and pathway for sustainable reform. To this end, the [Planned surgery reform blueprint](https://www.health.vic.gov.au/planned-surgery-reform-blueprint) (the blueprint) <https://www.health.vic.gov.au/planned-surgery-reform-blueprint> was released in October 2023.

Informed by 18 months of extensive research and engagement, the blueprint sets out a systematic approach to system-wide reform. It is forward looking and provides streamlined direction setting and advice to ensure improvements and innovations to planned surgery are consistently delivered across the public surgery system with the aim to ensure:

* All Victorians can access timely planned surgery or non‑surgical treatment, when they need it, and experience safe and equitable outcomes, now and into the future.

To achieve this aim, the blueprint mobilises four key pillars of change and 10 reforms:

* Pilar 1: Positive patient experiences and outcomes
	+ Reform 1: Expand same-day models of care
	+ Reform 2: Increase the availability of non-surgical treatment pathways
	+ Reform 3: Enhance integration of primary care in the perioperative journey
* Pillar 2: Sustainable healthcare workforce
	+ Reform 4: Expand advanced scope of practice roles and create novel roles
	+ Reform 5: Strengthen the workforce for the future
* Pillar 3: Optimal health service efficiency
	+ Reform 6: Scale high-throughput approaches (such as High-Intensity Theatre lists)
	+ Reform 7: Digitise referral pathways and establish data-sharing platforms
	+ Reform 8: Expand virtual care delivery
	+ Reform 9: Regionalise planned surgery preparation list management
* Pillar 4: Strong system stewardship
	+ Reform 10: Build robust data and intelligence infrastructure.

The Blueprint signals an ongoing commitment to transforming the planned surgery system. The department will continue to support and collaborate with health services to implement the 10 reforms, now and into the future.

## Safer Care for Kids

In 2021-22, Safer Care Victoria (SCV) saw an increase in sentinel events related to patient deterioration, particularly in children and young people. In response, SCV proactively brought together more than 100 healthcare leaders, clinicians, patients, and families to explore challenges encountered and improvements to accessing paediatric emergency healthcare in Victoria. The [*See Me, Hear Me Improving the Safety of Care for Victorian children: White paper series No 1 white paper*](https://www.safercare.vic.gov.au/sites/default/files/2023-11/SCV%20White%20Paper%20Number%201%20-%20See%20Me%20Hear%20Me%20-%20Improving%20the%20Safety%20of%20Care%20for%20Victorian%20Children.docx)was the key output of this consultation, published in November 2023. The white paper included three priority recommendations to improve safety for children in Victorian healthcare services:

* Deliver a state-wide family and carer escalation of patient deterioration process.
* Implement a 24/7 system of virtual paediatric emergency consultation.
* Mandate the use of the Victorian Children’s Tool for Observation and Response (ViCTOR) chart wherever children and young people have vital signs recorded.

The recommendations were endorsed by Minister for Health, and the Safer Care for Kids project was launched to co-design and implement the recommendations in close partnership with affected families, the health sector, and the department.

### Mandated use of the ViCTOR chart wherever children and young people have vital signs recorded

Victorian health services are required to use the updated ViCTOR chart that now includes a family and carer concern question, wherever children and young people have their vital signs recorded, in alignment with the mandate in the Statement of Priorities 2023-24, by June 30, 2026.

### Implement a 24/7 system of virtual paediatric emergency consultation

SCV and the department will progress plans in tandem with ongoing system reforms to ensure this recommendation is met. This includes progressing opportunities to:

* Enhancing awareness of the paediatric consultation services currently available (Victorian Virtual Emergency Department (VVED) and Paediatric Infant Perinatal Emergency Retrieval (PIPER)).
* Promote escalation pathways including:
	+ Urgent Care Centres continuing to access VVED for virtual consultation for less unwell to moderately unwell child, with clear escalation pathways to PIPER.
	+ Care of critically unwell children is escalated via PIPER.

### Deliver a state-wide family and carer escalation of patient deterioration process

VVED will lead a pilot escalation line in 2024 called the ‘Urgent Concern Helpline’. This will provide an escalation process for consumers, their families and/or carers of paediatric patients in health services to escalate any concerns about a deterioration in health, of themselves or a loved one, when they feel their concerns are not being heard. Insights from this pilot will inform further expansion.

For more information, please visit Safer Care for Kids <https://www.safercare.vic.gov.au/safer-care-for-kids>, or email <culture.capability@safercare.vic.gov.au>.

## Victorian Virtual Emergency Department

The Victorian Virtual Emergency Department (VVED) is delivered by Northern Health in collaboration with other health services. It allows select, non-urgent patients (adults and children) to receive virtual video assessments, 24 hours a day, 7 days a week, from emergency doctors and nurses.

Building on funding provided in 2023–24 state budget, the service has received $235 million in funding over four years to continue to expand the service.

The service has supported more than 250,000 patients to access time-critical care since it began in October 2020. About 80% cent of these patients do not require transport to, or care at, an emergency department.

The service also supports Ambulance Victoria paramedics statewide to treat patients, rather than transport them to emergency departments, freeing up paramedics to return to the road to assist critical patients. The VVED also takes direct referrals from residential aged care facilities statewide. The service continues to expand to ensure equitable access to virtual emergency care. The VVED service is available to all Victorians to seek virtual care through the self-referral pathway.

For more information, visit the [VVED](https://www.vved.org.au) <https://www.vved.org.au>.

## Health Service Partnerships

Health Service Partnerships (HSPs) continue to demonstrate their value in working at a geographical level to bring health services together to work collaboratively across a region to address problems and priorities.

Since their establishment, HSPs have coordinated the delivery of key departmental priorities including Better at Home and the planned surgery recovery program.

The success of the model has resulted in additional requests to HSPs to support implementation of flagship projects, including the residential in-reach program that aims to maximise opportunities for aged care residents to receive care at home and more recently, the Safer Care Victoria (SCV) Safer Together Program.

In addition to these departmental priority projects, HSPs have also identified local priority projects which they have been progressing to respond to local challenges.

In 2024–25, each HSP will continue to receive establishment grant funding to enable HSPs to continue to coordinate the HSP and undertake local collaborative activities. Supplementary to the establishment grant funding, HSPs will receive dedicated project funding in 2024–25 to deliver the following strategic priority projects:

* supporting health services to improve Aboriginal health outcomes and cultural safety for Aboriginal consumers
* maintaining an uplift to the Residential In-Reach program
* Safer Care Victoria’s (SCV) statewide Safer Together Program.

The *Health Service Partnership policy and guidelines 2024–25* set the framework and expectations for how HSPs operate and their relationship with other partnerships, including local and area health partnerships.

There will be no change to the expectation that all members of HSPs participate meaningfully and effectively in their partnership, to collectively achieve decision-making by consensus.

For more information, visit [Health Service Partnership policy and guidelines](https://www.health.vic.gov.au/publications/health-service-partnership-policy-and-guidelines) <https://www.health.vic.gov.au/publications/health-service-partnership-policy-and-guidelines>.

## Better at Home

The *2022–23 State Budget* provided $698 million over four years to deliver more health care within consumers’ homes, through the use of home-delivered and virtual care. This was in addition to the $120.9 million over three years that was announced in the *2020–21 State Budget*.

Better at Home is increasing the delivery of health care within consumers’ homes, where appropriate and preferred by the consumer, through home-based and virtual care.

The program funding supports the delivery of more acute admitted, subacute admitted and non-admitted home-based care.

The funding will be allocated to health services based on applications submitted via HSPs, in recognition of the benefits of health services working together to achieve transformation.

For more information, visit the [Better at Home initiative](https://www.health.vic.gov.au/patient-care/better-at-home-initiative) <https://www.health.vic.gov.au/patient-care/better-at-home-initiative>.

##  Mental health and wellbeing services

### Key policies and guidelines

The Chief Psychiatrist guidelines provide specialist advice on operational and clinical practice in relation to the Mental Health and Wellbeing Act. For more information, visit [Chief Psychiatrist guidelines](https://www.health.vic.gov.au/key-staff/chief-psychiatrist-guidelines) <https://www.health.vic.gov.au/key-staff/chief-psychiatrist-guidelines>.

On 1 September 2023, new compliance requirements took effect in specific areas of clinical practice overseen by the Chief Psychiatrist. These changes respond to the expanded jurisdiction of the Chief Psychiatrist under the *Mental Health and Wellbeing Act 2022.* They relate to the oversight of chemical restraint and mental health and wellbeing services in custodial settings. On 1 April 2024, new compliance requirements also took effect in the emergency departments and urgent care centres of designated mental health services. These requirements relate to the oversight of restrictive interventions in those settings. Information about these changes can be found on the [Office of the Chief Psychiatrist website](https://www.health.vic.gov.au/chief-psychiatrist/office-of-the-chief-psychiatrist-reform-activities-and-news) <https://www.health.vic.gov.au/chief-psychiatrist/office-of-the-chief-psychiatrist-reform-activities-and-news>.

Program management circulars articulate or clarify departmental policy on key aspects of service provision. These are available from the [Office of Chief Psychiatrist](https://www.health.vic.gov.au/practice-and-service-quality/chief-psychiatrist) <https://www.health.vic.gov.au/practice-and-service-quality/chief-psychiatrist>.

All funded clinical mental health services must be accredited against the NSQHS Standards (2nd edition) in 2024–25.

As a condition of funding, organisations must adhere to all relevant regulations, safety and quality standards, and Chief Psychiatrist guidelines relating to the funded activity. All funded clinical mental health services must comply with the department’s program guidelines, which are available from the Mental Health and Wellbeing Division.

Organisations can obtain copies of the relevant standards and guidelines from their department program and service advisor or, in some instances, through the department’s [Funded Agency Channel[[11]](#footnote-12)](https://fac.dffh.vic.gov.au) <https://fac.dffh.vic.gov.au>.

For more information on mental health service, programs and program guidelines, visit [Mental health](https://www.health.vic.gov.au/mental-health) <https://www.health.vic.gov.au/mental-health>.

### The Mental Health Performance and Accountability Framework (MHPAF)

The MHPAF specifies the department’s current performance and accountability requirements for funded clinical mental health services. It outlines how the department will measure, monitor and assess performance at the agency, service and program levels. This framework provides a key mechanism for monitoring whether a mental health service is delivering services that are consistent with the department’s requirements.

The Royal Commission into Victoria's Mental Health System recognised that achieving good outcomes for individuals, including people with lived experience of mental illness or psychological distress, families, carers and supporters, for the workforce and the wider community, is fundamentally important and foundational to the system’s reform agenda.

The Royal Commission recommended a new *Mental health and wellbeing outcomes framework* be developed that adopts a broad view of mental health and wellbeing outcomes, which is used to drive system reform and improvement. The Royal Commission also called for a new *Performance monitoring and accountability framework*. The department has integrated these two recommendations into the *Mental health and wellbeing outcomes and performance framework*.

Within an outcomes approach, outcomes and performance are inextricably linked. Outcomes measure the achievement of intended goals, or the actual change or difference resulting from an intervention. Performance metrics tell us what actions have been taken to achieve outcomes.

This new framework is a key instrument to help embed an outcomes approach in system reform, improvement and accountability. It will support evolution of the mental health and wellbeing system using a whole-of-system approach, enabling service providers, regions, communities and all levels of government to collaborate and drive positive change.

Once published, the first year of implementation (expected to be 2024–25) will run in parallel to the current *Mental health performance and accountability framework*, enabling services to continue reporting and using data to inform practice improvements, while the initial implementation of the framework takes place. After this initial year, the new Framework and related measures will be in force and will replace the MHPAF.

Please visit the [Mental Health and Wellbeing Outcomes and Performance Framework website](https://www.health.vic.gov.au/mental-health-wellbeing-reform/a-new-mental-health-and-wellbeing-outcomes-and-performance-framework) <<https://www.health.vic.gov.au/mental-health-wellbeing-reform/a-new-mental-health-and-wellbeing-outcomes-and-performance-framework>> for implementation updates and links.

### Alcohol and other drug services standards and guidelines

Service standards and guidelines that apply to funded alcohol and other drug services are listed in section 31: Service standards and guidelines. Where organisations receive funding for an activity or service, it is a condition of funding that they adhere to the service standards and guidelines listed under the relevant activity.

Organisations can obtain copies of the relevant standards and guidelines from their departmental program and service advisor or, in some instances, through the department’s [Funded Agency Channel website](https://fac.dffh.vic.gov.au) <https://fac.dffh.vic.gov.au>.

Organisations must deliver services in line with the Victorian [Alcohol and other drug program guidelines](https://www.health.vic.gov.au/aod-service-standards-guidelines/alcohol-and-other-drug-program-guidelines)<https://www.health.vic.gov.au/aod-service-standards-guidelines/alcohol-and-other-drug-program-guidelines>, the *Victorian alcohol and other drug client charter*, and the *Victorian alcohol and drug treatment principles*.

For more information and copies of the guidelines, charter and principles, visit [Alcohol and other drug](https://www.health.vic.gov.au/alcohol-other-drugs)s <https://www.health.vic.gov.au/alcohol-other-drugs>.

##  Ageing, aged and home care services

Service standards and guidelines that apply to funded aged and community care services are listed in section 31: Service standards and guidelines. If organisations receive funding for an activity or service, it is a condition of funding that they adhere to the service standards and guidelines listed under the relevant activity. The performance targets and monitoring requirements for the relevant ageing, aged and home care services are outlined at section 30: Performance targets and monitoring.

### Public sector residential aged care – infection prevention and control

The department provides funding to PSRACS to assist with operational expenses. PSRACS are funded to provide a specified number of available bed days and to meet set targets for resident occupancy.

Health services must report on the aged care infection control module to the Victorian Healthcare Associated Infection Surveillance System (VICNISS) Coordinating Centre to monitor infection prevention and control practices, and antimicrobial use in PSRACS.

PSRACS must have appointed infection prevention and control lead nurses, as required by the Australian Government.

### Rights and interests for aged care residents

Health services operating PSRACS must meet Commonwealth legislative requirements relating to protecting consumers’ rights and interests.

This includes meeting obligations for:

* minimising restrictive practices
* the Charter of Aged Care Rights
* consumers’ accommodation agreements
* prudential standards
* aged care quality and safety standards
* police checks for key personnel, staff and volunteers
* mandatory reporting of incidents, as per the Serious Incident Response Scheme
* proactive management of complaints, including those lodged through the Aged Care Quality and Safety Commissioner.

##  Primary, community and dental health

### Community health

The service standards and guidelines that apply to the community health program are listed in section 31: Service standards and guidelines. If organisations receive funding for an activity or service, it is a condition of funding that they adhere to the service standards and guidelines listed under the relevant activity. The performance targets and monitoring requirements for community health are outlined in section 30: Performance targets and monitoring.

### Identifying and managing vulnerable children

*Healthcare that counts: a framework for improving care for vulnerable children in Victorian health services* articulates the role of all Victorian health services in the early identification and effective response to vulnerable children.

This framework is a quality improvement and best-practice guide that should be implemented in all hospitals, health services and community service organisations delivering health programs in Victoria. It includes five action areas to guide system improvement, as well as indicators of best practice. This will enable health services to annually benchmark and self-assess their implementation progress, using the accompanying self-assessment tool.

The framework is being updated in 2024–25 and will align with the Victorian Child Safe Standards.The framework is supported by free online training at the [Children at Risk Learning Portal](https://vulnerablechildren.kineoportal.com.au) <https://vulnerablechildren.kineoportal.com.au> and the [Vulnerable Children website](https://www.health.vic.gov.au/populations/vulnerable-children) <https://www.health.vic.gov.au/populations/vulnerable-children>, where copies of the framework and other resources are available.

### Victorian Forensic Paediatric Medical Service

The Royal Children’s Hospital is the statewide governing body for the Victorian Forensic Paediatric Medical Service. Paediatric forensic services are provided by The Royal Children’s Hospital, Monash Medical Centre and all regional health services. A key function of the service is to provide a forensic assessment of injury and neglect to children from birth to 18 years, where there is suspected child abuse and neglect.

The Royal Children’s Hospital is responsible for providing leadership and clinical guidance for the statewide service, and all regional health services are expected to provide appropriate 24-hour clinical forensic services for these children.

## Local public health units

### Key policies and guidelines

In relation to case and outbreak investigation and management of notifiable conditions, the nine lead health services that host an LPHU must abide by condition-specific protocols, outbreak-specific guidelines, system-specific agreements and quick-entry guide documents.

Communicable disease protocols and associated operational documents guide Victoria’s public health response to notifiable disease incidents, outbreaks and events. The protocols outline the correct and consistent application of public health actions. They set out minimum standards for infectious disease notification surveillance, follow-up and case/contact management.

The Victorian *h*ealth and *w*ellbeing *p*lan 2023*–*2027 (VPHWP), outlines 10 priorities designed to drive coordinated action where we can make the greatest gains to Public Health. The associated *VPHWP outcomes framework* sets key indicators and defines how to monitor and measure achievement. In collaboration with key partners, the nine lead health services that maintain LPHUs prepare and implement regional population health catchment plans in line with the priorities of the VPHWP and local municipal public health and wellbeing plans, as well as the LPHU *population health catchment planning framework*.

Within LPHUs, public health activities to support Aboriginal communities and ACCOs should be guided by the principles of the AHWPF, and the five domains and self-determined priorities detailed in the *Victorian Aboriginal health and wellbeing partnership agreement action plan (2023–25)*. Alignment to the Aboriginal Health and Wellbeing Partnership Forum, agreement and action plan will enable LPHUs to enable Aboriginal self-determination in public health operations.

### LPHU outcomes framework

The LPHU outcomes framework sets out the department’s expectations related to public health activities performed by each LPHU. The framework supplements the content in this guide and the Statement of Priorities. Reporting against this framework provides a transparent approach to monitoring and assessing the effectiveness of public health interventions. This is part of program funding requirements and the collective efforts to improve public health outcomes for Victorians.

Health protection indicators in the LPHU outcomes framework set out authorised functions and the preparedness, prevention and delivery of local public health responses for notifiable conditions and outbreaks, including COVID-19. This includes providing advice about escalating risk, issues or concerns, and mitigation to relevant department stakeholders.

Prevention and population health indicators within the *LPHU outcomes framework* focus on LPHU’s role in partnering with community-based organisations and councils to implement the Victorian *public health and wellbeing plan* (VPHWP). Through development and implementation of LPHU *p*opulation *h*ealth *c*atchment *p*lans, LPHUs establish local priorities in collaboration with the department and local stakeholders. LPHUs work collaboratively to implement local disease prevention and population health initiatives, drawing on evidence-informed initiatives, and implementing statewide programs. The objective is to demonstrably reduce the risk factors that contribute to the burden of preventable chronic disease, in line with key indicators of the *Victorian public health and wellbeing plan outcomes framework*.

The department continues to revise and strengthen the LPHU *o*utcomes *f*ramework as the roles of LPHUs and the statewide public health network evolve. Ongoing consultation with LPHUs iteratively identifies the most relevant indicators and measures for the current funding period and reflects the network’s outcomes-based approach to public health prevention, promotion and response activities. This framework will support further evolution of the statewide public health network and will be reviewed with other public health frameworks and plans to ensure a coherent, whole-of-system approach.

High-level performance and monitoring targets related to the *LPHU outcomes framework* are summarised in Table 20 of Section 30.1.2 of this document.

### Authorised Officers

To undertake certain functions, each LPHU must ensure it has Authorised Officers to exercise powers under the Act, if required.

Health service staff appointed as Authorised Officers under s. 30 of the Public Health and Wellbeing Act 2008(Vic) must comply with the provisions of the Authorised *officer governance and accountability framewor*k (2023). They must meet individual mandatory training, qualification, and competency requirements, as detailed in section 5.2 of the framework. They must also be qualified in line with the requirements listed in section 6.1. All Authorised Officers must maintain an understanding of legal and regulatory provisions that relate to their statutory role.

The Secretary may give a direction to an Authorised Officer appointed by the Secretary in relation to the performance of the Authorised Officer's functions or duties or the exercise of the Authorised Officer's powers.

Authorised officers are also obliged to meet certain obligations set out under the *Public Health and Wellbeing Act 2008* (Vic) when exercising powers.

### Aboriginal health and cultural safety

Aboriginal health and cultural safety capability should be embedded within LPHU operations, in line with local Aboriginal self-determined needs and priorities. The department supports capacity building of LPHUs to enable Aboriginal self-determination.

The AHWPF is the lead decision-making body for Aboriginal health and wellbeing in Victoria. LPHU operations related to Aboriginal health should be guided by the principles and domains of the AHWPF’s Aboriginal Health and Wellbeing Partnership Agreement 2023–2033 (Agreement), and the self-determined priorities and actions detailed in the AHWPF’s *Victorian Aboriginal Health and Wellbeing Partnership Agreement action plan 2023–25* (action plan).

LPHUs should adopt mechanisms available through the AHWPF and the action plan reporting to effectively monitor and evaluate their progress towards outcomes, enabling approaches that meet the public health needs of Aboriginal communities in their catchment. This includes partnering with Aboriginal communities and ACCOs to deliver Aboriginal public health services.

View the [Agreement and action plan](https://www.vaccho.org.au/ahwpf/) <https://www.vaccho.org.au/ahwpf/>.

Health services that host an LPHU must consider the cultural safety of their operations, both internally and externally. Internal operations include culturally safe recruitment, employment and retention practices of Aboriginal staff members such as providing clear role scope, opportunities for leadership and professional development. LPHUs are expected to maintain culturally safe partnerships with Aboriginal communities and ACCOs in line with the *Aboriginal and Torres Strait Islander Cultural Safety Framewor*k and associated *Guidelines.*

# Accreditation

Funded organisations have obligations related to clinical service provision. These requirements ensure the quality of services and the safety of consumers.

## Australian Health Service Safety and Quality Accreditation Scheme

The Australian Commission on Safety and Quality in Health Care (ACSQHC) is responsible for formulating and administering national accreditation schemes for healthcare services that relate to healthcare safety and quality matters.

The department is responsible for monitoring and responding to the accreditation status of health service organisations.

All Victorian public health services must maintain their accreditation through the ACSQHC where they are accredited against the National Safety and Quality Health Service Standards (NSQHS) Standards. This includes:

* public health services, including denominational services
* public hospitals
* multipurpose services
* clinical mental health services provided by public health services (including Forensicare)
* public dental housed within health or community health services
* bush nursing centres (are accredited against National Safety and Quality Primary and Community Healthcare Standards (NSQPCHS).

The department and Safer Care Victoria must be notified of noncompliance against either accreditation scheme within 24 hours of becoming aware, in line with the *Performance monitoring framework*. Notification must occur via the health service’s relevant Director Performance, Hospitals and Health Services. Performance against accreditation will be reviewed as part of the department’s performance monitoring processes.

The regulatory response will be based on the outcome of the accreditation assessment and allow for escalation of monitoring and intervention, including possible action under the Health Services Act or the Mental Health Act.

For further details and information regarding the standards, visit [Australian Commission on Safety and Quality in Health Care](https://www.safetyandquality.gov.au/standards) <https://www.safetyandquality.gov.au/standards>.

## Pathology services

The National Association of Testing Authorities (NATA) is the national accreditation body recognised by government for accrediting pathology laboratories.

Victoria has made an undertaking to NATA that any:

* laboratory operated by a health service whose principal function is to conduct pathology services, must obtain and maintain accreditation from NATA or the Royal College of Pathologists of Australasia for the pathology services it provides
* pathology service required for a public, private or compensable admitted patient of a health service, must only be requested from a laboratory that holds accreditation from NATA or the Royal College of Pathologists of Australasia for the type of service required
* pathology service required for a patient attending an outpatient clinic of a health service, must only be requested from a laboratory that holds accreditation from NATA or the Royal College of Pathologists of Australasia for the type of service required.

The conduct of any pathology service provided for a health service that is not under the direct management of a pathology laboratory accredited by NATA or the Royal College of Pathologists of Australasia (for example, services provided by research laboratories, specialist clinical laboratories or at the point of care), must be overseen by a pathology laboratory that is accredited by NATA or the Royal College of Pathologists of Australasia for the relevant scope of services.

All public health services are required to adhere to these undertakings as a condition of funding.

## Ambulance

Ambulance services in Australia are not currently part of an accreditation or external assessment process.

## Mental health and alcohol and other drug clinical and community support services

All funded clinical mental health services must be accredited against the NSQHS Standards.

Organisations that receive funding for Mental Health and Wellbeing Locals must be accredited against relevant standards, as per the service agreement, this could include the National Standards for Mental Health Services 2010.

Organisations that receive funding for MHCSS programs must be accredited against relevant standards, as per the service agreement. This includes the National Standards for Mental Health Services 2010.

Implementation of the new NSQHS Standards for community managed organisations will commence in 2024. Health services providing alcohol and other drug treatment services must be accredited against the NSQHS Standards (see section 19.1: Australian Health Service Safety and Quality Accreditation Scheme).

Organisations that receive funding for alcohol and other drug services must establish and implement plans to deliver services that are consistent with the *Victorian alcohol and other drug charter*. The ongoing implementation of plans to deliver services consistent with the charter, and in alignment with the *National quality framework for drug and alcohol treatment services*, is also expected of organisations that will receive funding for alcohol and other drug services in 2024–25.

These services must continue to be accredited within existing generic accreditation frameworks by an entity certified by either the International Society for Quality in Health Care, or the Joint Accreditation System of Australia and New Zealand.

## Aged care

### Public sector residential aged care service accreditation and quality approach

The Australian Government has the primary responsibility for funding and regulating residential aged care services under the Aged Care Act. In accordance with this legislation, all Victorian PSRACS are expected to comply with minimum aged care quality and safety standards at all times, in order to receive recurrent Commonwealth subsidies. The monitoring, assessment and accreditation of residential aged care services against the aged care quality and safety standards, is undertaken by the Aged Care Quality and Safety Commission.

The department actively supports PSRACS to provide high-quality care to residents. The department encourages and supports PSRACS to excel in the delivery of evidence-based, best-practice, person-centred, safe, effective, appropriate, integrated and coordinated services, so that a good quality of life is experienced by every resident, every day.

### Home and Community Care Program for Younger People

In 2024–25, the department will be undertaking service improvement of HACC PYP to ensure the program continues to meet the needs of clients within the service sector and to support service quality.

### Other programs funded under the Ageing, Aged Care and Home Support Program outputs

Providers that receive less than $100,000 in funds to deliver Ageing, Aged Care and Home Support Program supports will not be independently assessed. Those organisations that receive the bulk of their funding from the health or primary health outputs, and that undergo accreditation in line with the requirements associated with the output, are not required to undergo further accreditation.

For governance and management standards, other providers can choose an accreditation body, which offers standards that are consistent with the governance and management requirements of the Human Services Standards accreditation. For more information, visit [Human Services Standards](https://providers.dffh.vic.gov.au/human-services-standards) <https://providers.dffh.vic.gov.au/human-services-standards>.

Relevant quality standards could include the National Standards for Disability Services, Evaluation and Quality Improvement Program (EQuIP), ISO 9001:2015, the NSQHS Standards and the Quality Improvement Council Standards.

# Clinical governance

## Health service clinical governance

All health services and funded organisations must ensure their clinical governance policies and frameworks comply with the current [*Delivering high-quality healthcare: Victorian clinical governance framework*](https://www.safercare.vic.gov.au/support-and-training/clinical-governance) <https://www.safercare.vic.gov.au/support-training/clinical-governance>.

### Adverse patient safety events, including sentinel events

During 2024–25, health service entities, as described in the *Health Legislation Amendment (Quality and Safety) Act 2022* and bush nursing centres are in scope of the Safer Care Victoria [Policy: Adverse patient safety events](https://www.safercare.vic.gov.au/publications/policy-adverse-patient-safety-events#goto-download) <https://www.safercare.vic.gov.au/publications/policy-adverse-patient-safety-events#goto-download>. As such, they will be expected to identify and review adverse patient safety events (including sentinel events) according to the policy, the Victorian Sentinel event guide and associated resources.

Sentinel event notifications and review outcomes must be submitted through the secure [sentinel event portal](http://www.vhimscentral.vic.gov.au) <www.vhimscentral.vic.gov.au>. Health service staff must be onboarded to the portal prior to sentinel event notification and report submission. Resources to support the notification and review of sentinel events is available at: [Notify and review a sentinel event](https://www.safercare.vic.gov.au/notify-us/sentinel-events/notify-and-review-a-sentinel-event) <www.safercare.vic.gov.au/notify-us/sentinel-events/notify-and-review-a-sentinel-event>.

Sentinel event review reports that do not meet the above expectations will be referred back to the health service. Safer Care Victoria will provide advice and support to assist the health service to meet these expectations, before resubmission of the final sentinel event review report.

Access guidance on review processes and other resources from the [Sentinel events webpage](https://www.safercare.vic.gov.au/notify-us/sentinel-events) <https://www.safercare.vic.gov.au/notify-us/sentinel-events>. Email Safer Care Victoria’s Sentinel Events team <sentinel.events@safercare.vic.gov.au> or telephone 1300 543 916 during business hours.

### Statutory duty of candour

Relevant health services to undertake statutory duty of candour (SDC) processes when a serious adverse patient safety event (SAPSE) occurs. Health service entities must refer to the Health Services (Quality and Safety) Regulations 2020 to view the SAPSE definition, which is also equivalent to ISR 1 and 2 events in the VHIMS minimum dataset.

The scope of the SDC includes ‘health service entities' under the *Health Services Act 1988*, as well as any services under their governance.

These include:

* public hospitals
* public health services
* multipurpose services
* denominational hospitals
* private hospitals
* day procedure centres
* ambulance services within the meaning of the *Ambulance Services Act 1986*
* NEPT services within the meaning of the *Non-Emergency Patient Transport and First Aid Services Act 2003*
* Forensicare, established by s. 328 of the *Mental Health Act 2014*.

When a patient suffers a SAPSE, these health service entities are required to comply with the SDC by providing an apology, a written account of the facts, a description of the health service entity’s response and the steps taken to prevent reoccurrence of the event. They also need to comply with the [Victorian duty of candour guidelines](https://www.safercare.vic.gov.au/support-training/adverse-event-review-and-response/duty-of-candour) <https://www.safercare.vic.gov.au/support-training/adverse-event-review-and-response/duty-of-candour>.

The SDC AIMS form is available via the [HealthCollect portal](https://www.healthcollect.vic.gov.au) <https://www.healthcollect.vic.gov.au> (health service staff members reporting this data will need a login to the HealthCollect portal).

For more information about the AIMS data collections, including the AIMS manual, visit the [AIMS webpage](https://www.health.vic.gov.au/data-reporting/agency-information-management-system-aims) <https://www.health.vic.gov.au/data-reporting/agency-information-management-system-aims>.

For the SDC reporting guidelines, training modules and additional resources, visit [Safer Care Victoria](https://www.safercare.vic.gov.au/support-training/adverse-event-review-and-response/duty-of-candour) <https://www.safercare.vic.gov.au/support-training/adverse-event-review-and-response/duty-of-candour>. Email the SDC team <dutyofcandour@health.vic.gov.au>.

### Health services performance and quality and safety reporting

The eHealth division of the department collects, analyses and reports performance and quality and safety measures to health services, the department, Safer Care Victoria and other government agencies. From February 2024, the entity formerly known as the Victorian Agency for Health Information (VAHI) has been incorporated into the eHealth division. However, reporting products distributed outside the department continue to use the VAHI brand for continuity.

Information is provided to health services as part of a suite of routine performance reports, such as the *Victorian health services performance monitor* (Monitor), the *Program report for integrated service monitoring* (PRISM), mental health performance reports, and a series of specialist quality and safety reports to support performance and safety and quality monitoring, and promote service improvement.

VAHI’s reporting suite is being progressively replaced by digital interactive reports and dashboards which are generally made available to authorised users in the sector via the [VAHI portal](https://www.safercare.vic.gov.au/vahi-portal) <https://www.safercare.vic.gov.au/vahi-portal>. The dashboards provide enhanced capacity for health services to interrogate, explore and export the data, as well as being useful visualisations of indicators over time.

Key interactive dashboards include:

* Health Services Performance Monitoring Dashboard (digital version of the Monitor report)
* a suite of Surgery Recovery and Reform dashboards
* a new Mental Health and Wellbeing Regional Dashboard
* a suite of quality and safety dashboards including, Hospital Acquired Complications, Cardiovascular Quality and Safety, Maternity and Newborn Safety and Public Sector Residential Aged Care Quality Indicators
* a range of program-specific performance dashboards including Emergency Care, Palliative Care, and Health Independence Program.

Continued digital transformation of VAHI’s reporting suite will be a key focus in 2024–25, with a strong focus on priority areas for government including Planned Care Recovery and Reform, Women’s Health, and enhanced quality and safety insights. eHealth will work closely with Safer Care Victoria and relevant areas within the department, and consult with the sector, as it transforms its existing reports and develops new reports and analytics. To prioritise work across these areas, the *Board safety and quality report* andthe *Quality and safety in Victorian private hospitals report,* will be retired until further notice.

eHealth is also responsible for providing the Victorian community with information about health services quality, safety and performance, through the publication of a range of performance measures provided every quarter at [Victorian Health Services Performance](https://vahi.vic.gov.au/reports/victorian-health-services-performance) <https://vahi.vic.gov.au/reports/victorian-health-services-performance>. In 2024–25, eHealth will work to expand the time series of publicly available data (currently limited to five quarters) and will move to monthly reporting where data permit.

Through this website, the public can search and view results on a range of performance measures related to:

* number of patients treated
* emergency care
* planned (elective) surgery
* mental health
* specialist clinics
* dental care
* ambulance services
* quality, safety and patient experience.

As well as developing and reporting quality and safety measures, eHealth plays a key role in the developing, testing and validating measures used in the [Performance monitoring framework](https://www.health.vic.gov.au/funding-performance-accountability/performance-monitoring-framework) <https://www.health.vic.gov.au/funding-performance-accountability/performance-monitoring-framework> and the *Mental health performance and accountability framework* (available at the same link). In 2024–25, eHealth will work with stakeholders on measure and report development as part of the new *Mental health outcomes and performance framework*.

Where measures form part of the health service’s Statement of Priorities (SOP), Monitor reflects the targets set for performance. Monitor is currently produced monthly, with some measures presented less frequently, depending on the performance policy requirements, nature of the underlying data and the measure calculation methodology. In 2024–25, monthly PDF versions of Monitor and PRISM will be discontinued, reverting to quarterly publications only. Monthly data in SOP performance indicators will be available in the interactive Health Services Performance Monitoring Dashboardon the VAHI portal.

New performance measures are typically ‘shadowed’ for a year in PRISM, to provide the sector with an opportunity to investigate their results, validate their coding and incorporate the measures into their local performance and clinical governance systems. Business rules and technical specifications for the measures are available on request.

PRISM reports on health services’ performance at a more granular level and across a range of access, quality, safety, operational and financial performance measures that are not reported in Monitor. It is not provided for SRHS, which instead receive a customised version of Monitor.

VAHI reports all rely on data submitted by health services, and its capacity to provide timely and accurate information relies greatly on the quality of the coding, and the timeliness and completeness of the data submitted by health services.

For further information about performance, safety and quality metrics, reports and dashboards managed by eHealth, including requests for access to the VAHI portal, please email VAHI <vahi@vahi.vic.gov.au>.

### Clinical quality registries

Clinical quality registries collect information to drive improvements in the quality and safety of health care – through the analysis of clinical data to identify benchmarks for clinical performance and related variation in clinical outcomes. Victorian public health services and clinicians currently contribute data to approximately 50 health-related national and state-based clinical registries.

The Victorian Government provided funding for nine clinical quality registries in 2024–25. It is committed to ensuring data from clinical quality registries are used effectively by government agencies and the health sector to drive quality improvements.

The department works in partnership with registry custodians and key stakeholders to help registries meet contractual arrangements and associated funding obligations. The contracts stipulate that quarterly or biannual reports of summarised data are submitted to Safer Care Victoria and/or the department.

Data in these reports identify individual Victorian public health services and are used to inform statewide quality improvement activity and service planning. Data from clinical registries are also used by Safer Care Victoria for the purpose of recognising system vulnerabilities and key risks, to identify improvement opportunities and to monitor delivery of improvements.

Registry data have also been linked with other datasets to better inform the development of various statewide quality and safety indicators.

For the State Trauma Registry, the Cardiac Surgery Registry, the Australian and New Zealand Intensive Care Society Adult Patient Database and the Victorian Cardiac Outcomes Registry, it is mandatory for public health services covering procedures captured by these registries to provide data to these collections.

### VICNISS surveys and health service reporting requirements

The effective prevention and control of infection are an integral part of the quality, safety and clinical risk management operations at all health services.

Health services’ monitoring of the occurrence and rate of infections, and comparing these with peer services, provides useful information on how the service is performing and can guide improvement. More information can be found on the [VICNISS website](http://www.vicniss.org.au) <www.vicniss.org.au>.

#### Healthcare-associated infections

VICNISS collects and analyses data from individual hospitals, including data on risk-adjusted, procedure-specific infection rates (surgical site infections), *Staphylococcus aureus* bacteraemia-associated infections and central line-associated bloodstream infections in ICUs.

#### Healthcare worker influenza immunisation

Health services must take all reasonable steps to ensure staff are protected against vaccine-preventable diseases. High coverage rates for immunisation in healthcare workers are essential to reduce the risk of transmission in healthcare settings.

Health services must report healthcare workers’ influenza vaccination rates to the department annually. For information on the healthcare worker influenza immunisation program, visit [Vaccination for healthcare workers](https://www.health.vic.gov.au/immunisation/vaccination-for-healthcare-workers) <https://www.health.vic.gov.au/immunisation/vaccination-for-healthcare-workers>.

#### Health service and hospital reporting requirements

Depending on the size and type of services provided, all public health services must provide data to VICNISS for the above measures. The results are shared with health services through the VICNISS online member portal, and reports are produced and distributed by the Department of Health.

#### Streamlining clinical trial research

The government encourages health services to pursue clinical trial activity. The Coordinating Office for Clinical Trial Research in Safer Care Victoria manages the *Streamlining clinical trials and research framework* for the ethical and scientific review of multisite clinical trials.

The framework includes all human research conducted as a single-site or multisite project. All health services participating in the framework should assist the consolidation of research activity information concerning Victoria’s public hospital sector.

This is done using an electronic information platform to enter data for all ethics applications (both single and multisite), and research governance and site-specific assessments for single-site and multisite studies involving human subjects.

Additional data collection may be required at health services. This will be determined by Safer Care Victoria via the Coordinating Office for Clinical Trial Research.

Health services that participate in the review, and those accepting single scientific and ethical review of research on human subjects involving multisite research at more than one public health service site, are required to:

* sign the standard memorandum of understanding between the department and the health service, for the purpose of facilitating a single ethical review in Victoria – this has extended to the initiative involving national mutual acceptance of multisite ethical review for clinical trials, and health and medical research in other jurisdictions that have joined national mutual acceptance
* have their ethics committees provide either single ethics review or intra- and interjurisdictional ethical review, certified with the National Health and Medical Research Council and accredited by the department in Victoria, and comply with any additional accreditation requirements.

It is expected that health services participating in the streamlining of ethical and scientific review of multisite research will comply with all matters agreed in the memorandum of understanding. This includes acceptance of a single ethics review decision by an accredited and certified human research ethics committee, reporting requirements and research governance obligations associated with the conduct of a research project. They must also ensure that electronic data is captured for national reporting of clinical trial activity, under the directive of the Australian Government Department of Health and Aged Care.

Health services hosting a Victorian-accredited and National Health and Medical Research Council-certified human research ethics committee that reviews multisite clinical trials, and health and medical research, must demonstrate sufficient ethical reviews to maintain expertise.

For more information, visit [Clinical Trials and Research](https://www.clinicaltrialsandresearch.vic.gov.au/) <https://www.clinicaltrialsandresearch.vic.gov.au>.

For information about conducting research in relation to Aboriginal health and wellbeing, see marra ngarrgoo, marra goori: The Victorian Aboriginal health, medical and wellbeing research accord,available on the VACCHO website <https://www.vaccho.org.au/accord/>.

## Community health clinical governance

Funded organisations receiving community health program funding are expected to have strong clinical governance systems and practices in place, to ensure the quality and safety of services. Organisations must review their clinical governance structures and have adequate internal documentation, to ensure consistency and compliance with the department’s clinical and quality governance policy frameworks.

Accreditation is a key measure of the performance of organisational clinical governance and the management systems that underpin good governance.

Organisations that receive funding through primary health output group activities must be accredited by a body or entity that is accredited by the International Society for Quality in Health Care or the Joint Accreditation System of Australia and New Zealand.

For registered community health services, applicable standards include:

* National Safety and Quality Primary and Community Healthcare Standards
* NSQHS Standards
* Quality Improvement Council Health and Community Services Standards
* EQuiP
* ISO 9001:2015.

Integrated community health services are subject to the accreditation requirements of their parent health service and are required to comply with NSQHS Standards.

Registered community health services are also guided by the *Community services quality governance framework* and with Safer Care Victoria’s *Clinical governance framework.*

All public dental services must be assessed against either the NSQHS Standards or the National Safety and Quality Primary and Community Healthcare Standards.

In accordance with the Health Services Act, registered community health services are required to comply with performance standards (also known as gazetted standards) in the five areas of:

* governance
* management
* financial management
* risk management
* quality accreditation and service delivery.

Compliance against the performance standards will be monitored through an attestation from registered community health services. Registered community health services that have organisation-wide accreditation against either the National Safety and Quality Primary and Community Healthcare Standards or the NSQHS Standards, and have met all service agreement financial accountability requirements, are able to provide evidence of their accreditation status in lieu of completing the attestation.

# Consumer rights and community participation

The Australian Commission for Safety and Quality in Health Care maintains the second edition of the Australian Charter of Healthcare Rights reflecting an increased focus on person-centred care and empowers consumers to take an active role in their health care. The charter describes the rights that all consumers can expect when receiving health care. These rights apply to all people in all places where health care is provided in Australia.

The commission has developed a range of resources to support the implementation and use of the charter, including a poster and an infographic for consumers. Other resources include an Easy English version, an Auslan video, large print and Braille versions, and translations in 19 community languages. Healthcare organisations can also adapt the resources to their specific context.

Safer Care Victoria and the department recommend using the new charter and resources. Victoria-specific resources are no longer available. To download all charter resources, visit the [Australian Commission for Safety and Quality in Healthcare](https://www.safetyandquality.gov.au/consumers/working-your-healthcare-provider/australian-charter-healthcare-rights/supportive-resources-second-edition-australian-charter-healthcare-rights) <https://www.safetyandquality.gov.au/consumers/working-your-healthcare-provider/australian-charter-healthcare-rights/supportive-resources-second-edition-australian-charter-healthcare-rights>.

Organisations can now also adapt resources to specific contexts via the commission’s Partnering with Consumers team.

## Consumer, carer and community participation

Safer Care Victoria developed the *Partnering in healthcare framework* (2019) to support health services with practical strategies for consumer participation, and partnerships between consumers and health professionals, to deliver higher-quality care that is safe, equitable and clinically effective.

The framework comprises five interdependent domains that work together to produce better outcomes.

The five domains are:

* personalised and holistic
* working together
* shared decision-making
* equity and inclusion
* effective communication.

In 2024–25, each health service must identify at least two domains and priorities on which to focus, complete a Statement of Intent and submit these to Safer Care Victoria by 31 October 2024.

For more information, visit the [*Partnering in healthcare framework*](https://www.bettersafercare.vic.gov.au/support-and-training/partnering-with-consumers/pih) <https://www.bettersafercare.vic.gov.au/support-and-training/partnering-with-consumers/pih>.

All funded organisations must actively support and promote consumer, carer and community participation at all levels of health care, including support for community advisory committees. In achieving the baseline requirements of the policy, health services will be required to meet the second edition of the [NSQHS Standards](https://www.safetyandquality.gov.au/standards/nsqhs-standards) <https://www.safetyandquality.gov.au/standards/nsqhs-standards>.

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The *Victorian Carers Recognition Act 2012* outlines the requirements to support people in care relationships. The Act encourages organisations and services to better respect the important role carers have in our community. Councils and relevant funded organisations must report on how they have met their obligations under the Act in their annual report. This may be as simple as including a paragraph detailing the actions taken during the year to comply with the Act.

For more information, including legal responsibilities and obligations of local government and organisations, visit [Supporting people in care relationships](https://www.health.vic.gov.au/supporting-independent-living/supporting-people-in-care-relationships) <https://www.health.vic.gov.au/supporting-independent-living/supporting-people-in-care-relationships>.

## Victoria’s health experience

The VHES program surveys recent users of Victorian public health services to collect feedback about their experience of care. The program includes inpatient, emergency department, maternity, specialist clinic, palliative care, ambulance, mental health, HACC PYP and community health services.

The surveys are designed around the five domains of Safer Care Victoria’s *Partnering in healthcare framework*. Results from the VHES program are shared with Victorian public health services, Safer Care Victoria and the department. They provide actionable insights that support improvement in patient-centred care and service delivery.

The VHES program has transitioned to a predominantly electronic data collection approach, providing the opportunity to invite more Victorians to share their experiences of care and delivering more timely insights to health services, the department, and Safer Care Victoria.

The department will consult the sector and stakeholders on future directions for the program during 2024–25.

### Core VHES program surveys

The core VHES program includes maternity, adult and paediatric inpatient, and adult and paediatric emergency surveys. These surveys run continuously throughout the year, with data finalised on a quarterly basis.

All Victorian publicly funded health services, where relevant and funded to deliver a particular service, are expected to participate in these surveys. Three patient experience indicators in the *Performance management framework* are sourced from the inpatient survey. These indicators are reported on a quarterly basis in *Monitor*. Overall inpatient and emergency department patient experience measures are also reported in the Victorian Government’s *Budget Paper No.3: Service delivery*.

### Your Experience of Service survey and the Carer Experience Survey

The Your Experience of Service (YES) survey and the Carer Experience Survey (CES) are national tools designed to collect information on the experiences of consumers and their families, carers and supporters accessing adult mental health and wellbeing services, and selected MHCSS. The surveys are delivered annually as part of the VHES program and are at present the only standardised self-reported consumer and carer experience measures available.

YES and CES results provide services with contemporary lived experience insights. Health services should use them to develop service improvement responses in partnership with lived experience leadership. Services should embed key YES and CES indicators in local outcomes frameworks to ensure performance is measured against the perspectives and experiences of consumers and families, carers and supporters.

The YES and CES will be essential components of public monitoring and reporting service system improvement against the new *Mental health and wellbeing outcomes and performance framework*. Services are encouraged to invest in the ongoing implementation of the YES and CES surveys to ensure experience data is meaningful and actionable to drive continuous improvement.

## Health service community advisory committees

Victoria has a statutory requirement that each public health service board (listed under Schedule 5 of the Health Services Act) establishes a community advisory committee. Boards have a responsibility to ensure that community advisory committees are integrated with the health service and are representative of their communities. Community advisory committees are at the heart of consumer, patient and carer participation in the design and delivery of health services.

Health services should undertake relevant planning with the community advisory committee to ensure that consumers, carers and community members are actively involved and supported to participate in service development, planning and quality improvement.

Community advisory committees are one part of a strategy to help health services involve consumers under the Partnering in healthcare framework. The aim is to offer care that is safe, effective, person-and-family-centred, equitable and clinically effective.

For more information and to download the guidelines, visit Building your healthy community: [A guide for health service community advisory committees](https://www.bettersafercare.vic.gov.au/publications/a-guide-for-health-service-community-advisory-committees) <https://www.bettersafercare.vic.gov.au/publications/a-guide-for-health-service-community-advisory-committees>.

### Primary care and population health advisory committees

Under the Health Services Act, public health services must have a primary care and population health advisory committee. Health services should continue to work through these committees to consider the broader needs of the community.

## Partnerships

All funded organisations are encouraged to participate in locally relevant partnerships, local collaboratives, and alliances with other health and human services organisations, where appropriate.

Commonwealth-funded PHNs are charged with improving access to primary care services and ensuring better coordination of care with local healthcare providers. They do not deliver services, but they do commission and integrate local services to increase the efficiency and effectiveness of medical services for consumers, particularly those at risk of poor health outcomes.

## Complaint management

All funded organisations must have effective and responsive complaint management systems in place that are timely, appropriate and lead to improvements in quality and safety. All hospitals must have an appropriately resourced role that is responsible for addressing patient concerns and is visible and accessible to consumers. The contact details for the identified role should be readily accessible (including on the hospital’s website). There should be a variety of inclusive mechanisms for consumers to provide feedback to health services.

Health services should have systems for aggregating complaints data and addressing issues, as part of their continuous improvement. This includes, but is not limited to, mechanisms for identifying potential serious adverse patient safety event (SAPSE), clinical incidents and near misses to provide more robust systems for using complaint and incident data as a safety signal, in accordance with SDC legislative requirements.

Health services are expected to demonstrate compliance with the *Health Complaints Act 2016 Complaint Handling Standards* and regularly review their complaints management procedures, as part of their ongoing quality and safety governance process.

In addition to health service complaint management processes, the Health Complaints Commission (HCC) is an independent and impartial statutory body that derives their powers and functions from the *Health Complaints Act 2016*.

The HCC resolve complaints about healthcare and the handling of health information in Victoria. They can also investigate matters and review complaints data to help health service providers improve the quality of their service. The HCC act independently and impartially.

The HCC also actively engages in the health sector through training in complaints handling, and the relevant laws governing health service and health records complaints.

For more information on the HCC and their role, training and resources and their role in investigations please visit the website of the [Health Complaints Commissioner](https://hcc.vic.gov.au/) <https://hcc.vic.gov.au>.

## Historical forced adoption

The 2021 Inquiry into Responses to Historical Forced Adoption in Victoria requires all public hospitals directly involved in historical forced adoptions to develop a specific application form for mothers and people who are adopted to request their hospital records.

If a hospital record cannot be located or is unavailable, public hospitals must make every effort to explain to information applicants why a hospital record cannot be located, including details of when and how records were destroyed, if possible. A template application form has been shared with public hospitals directly involved in historical forced adoptions.

# Financial requirements

## Health service procurement and purchasing requirements

Health Purchasing Victoria, a body corporate established under the Health Services Act, is undertaking its statutory functions as HealthShare Victoria, and is responsible for supply chain operations and purchasing policy compliance.

Supply chain operations:

* improve the collective purchasing power for Victorian public health services and hospitals, by establishing statewide supply agreements for health-related goods and services
* manage the bulk purchasing, and efficient supply and distribution of medical consumables for Victoria’s public health services, with HealthShare Victoria’s distribution centre operations being a central part of the end-to-end supply chain
* support better patient outcomes by enabling consistent access to goods and evidenced-based product selection.

To achieve these outcomes, health services participating in the HealthShare Victoria supply chain and logistics services are required to ensure all purchasing for goods on the HealthShare Victoria catalogue is undertaken via this service.

The compliance function:

* develops, implements and reviews policies and audits to promote best value and probity, in relation to the supply of goods and services to health services. HealthShare Victoria’s purchasing policies establish a procurement policy framework for health services and incorporate the strategic approach and guidance of the Victorian Government Purchasing Board policies. These policies are mandated for all Schedule 1 and 5 (of the Health Services Act) health services, and may be viewed at [HealthShare Victoria Purchasing Policies and Transition](https://healthsharevic.org.au/purchasing-policies-and-compliance/hsv-health-purchasing-policies/)<https://healthsharevic.org.au/purchasing-policies-and-compliance/hsv-health-purchasing-policies/> ensures probity is maintained in purchasing, tendering and contracting activities in health services
* provides advice, employee training and consultancy services, in relation to the supply of goods and services to the health sector
* monitors health service compliance with purchasing policies and HealthShare Victoria directions, and reports irregularities to the Minister for Health.

### Compliance framework

To meet its responsibilities in monitoring health service compliance with purchasing policies, and to promote probity among health service management and employees with procurement responsibilities, HealthShare Victoria has developed a compliance framework that includes support and prevention activities, such as education, training, advice and guidance, and monitoring.

Mandated health services must complete an annual compliance self-assessment requiring:

* compliance with the Health Purchasing Policies and the HealthShare Victoria Collective Agreements
* approval and submission to HealthShare Victoria by the health service’s chief executive officer, for inclusion in the HealthShare Victoria annual report.

Mandated health services must complete compliance audits to the Health Purchasing Policies requiring:

* the chief executive officer of a mandated health service to audit compliance as per the Health Services Act
* an audit once every three years (health services must provide the final audit report to HealthShare Victoria by 30 June in the year the audit is scheduled)
* findings to be reported to the HealthShare Victoria Board and monitored until the health service has addressed and closed the issues. HealthShare Victoria must report high-risk areas of noncompliance to the Minister for Health.

Mandated health services must provide information and data on contracting and procurement activities, as requested by HealthShare Victoria. HealthShare Victoria can require the chief executive officer of a mandated health service to provide information, and transparency and probity in purchasing, tendering and contract activities.

The overlapping probity directives that health services should ensure they meet include that:

* mandated health services must comply with the Health Purchasing Policies to support best-value procurement
* health services must ensure their probity controls take into consideration recommendations contained in the Victorian Ombudsman’s report [Probity controls in public hospitals for the procurement of non-clinical goods and services](https://www8.austlii.edu.au/au/other/VicOmbPRp/2008/4.pdf) <https://www8.austlii.edu.au/au/other/VicOmbPRp/2008/4.pdf > and the Victorian Auditor-General’s Office report.

Health services are also encouraged to consult with HealthShare Victoria on any high-value or high-risk procurement activities.

## Compliance with financial requirements

### Borrowing approval

Section 30(2) of the Health Services Act requires registered funded agencies to obtain approval from both the Minister for Health and the Treasurer before seeking financial accommodation. An approved borrower may obtain financial accommodation, whether within or outside Victoria, secured or arranged in a manner and for a period approved by the Treasurer. These borrowings are guaranteed by the state.

Section 44 of the Ambulance Services Act requires an ambulance service to obtain approval from the Treasurer before seeking financial accommodation. An approved borrower may obtain financial accommodation, within Australia, secured or arranged in a manner and for a period approved by the Treasurer.

All registered funded agencies and ambulance services must obtain the appropriate approvals before seeking to borrow funds from third parties, and before entering into third-party finance arrangements for any overdrafts, borrowings or finance leases. These funds may be for purposes such as capital works and equipment expenditure.

The *Standard motor vehicle policy*, issued under the authority of the Minister for Finance, now mandates the acquisition of new vehicles through VicFleet, which is funded through the government’s finance lease facility. Under these requirements, all registered funded agencies and ambulance services are approved borrowers for the purpose of motor vehicle finance leases obtained through VicFleet.

### Capital expenditure

Registered funded agencies and ambulance services must not enter into any expenditure related to equipment purchases, capital works, or purchase or disposal of real property, where the estimated total costs, real property value or total end costs of the works exceed 10% of the annual revenue of the agency or health service, or $5 million (whichever is the lesser amount), unless the:

* agency or health service has provided a detailed business plan relating to the proposed expenditure to the Secretary to the department
* expenditure has been approved by the Secretary to the department.

The Secretary’s approval in relation to any expenditure referred to in the above clauses does not imply or in any way obligate the Secretary or the department to provide any financial support for the works.

### Leases

Compliance with Australian Accounting Standard *AASB16 Leases* requires most operating leases (the exceptions being low-value asset leases, with an individual leased asset less than $10,000, and leases of less than 12 months duration) to be reported on the balance sheet.

All balance sheet leases must be recorded in the BDO Lead software provided by the department and reported in trial balances submitted via the Health Agencies Reporting Tool (HeART). Exceptions are motor vehicle leases with VicFleet, and leases attributable to public-private partnership arrangements, which are not required to be recorded in the BDO Lead software.

The 30 June lease liabilities that funded agencies submit through their estimates trial balance submissions[[12]](#footnote-13) via HeART will contribute to an overall lease-borrowing cap that is provided to the Department of Treasury and Finance for approval, and will constitute the agency’s borrowing cap for the year. Each entity must manage its lease liability within this lease-borrowing cap, and actual balances as at 30 June will be compared with the entity’s approved cap to assess compliance.

An entity should seek approval from the Treasurer, through the department, for any lease contracts that will cause the overall lease liabilities to exceed the lease-borrowing cap approved through the estimates trial balance submission process, to avoid a breach of the Standing Directions 2018 under the Financial Management Act(Standing Directions).

All leases must be assessed to determine whether they include a financial accommodation, as defined by the *Borrowing and Investment Powers Act 1987* (which is referenced in the Health Services Act), and health services must follow the existing processes for approving a lease that includes a financial accommodation (borrowing).

Even though the accounting distinction between operating and finance leases no longer exists, there is still a legal distinction between operating and finance leases, based on the transfer of rights between the lessor and lessee. This means that the definition of financial accommodation under the Borrowing and Investment Powers Act does not include operating leases. As such, there is no change to the processes for approving operating leases and borrowings for health agencies.

Lease commitments should continue to be undertaken in accordance with the *Victorian Government risk management framework*.

For more information, visit the [*Victorian Government risk management framework*](https://www.dtf.vic.gov.au/planning-budgeting-and-financial-reporting-frameworks/victorian-risk-management-framework-and-insurance-management-policy) <https://www.dtf.vic.gov.au/planning-budgeting-and-financial-reporting-frameworks/victorian-risk-management-framework-and-insurance-management-policy>.

### Investments

Standing Direction 3.7.2 Treasury management, including the Central Banking System, requires all public sector entities, including public hospitals, to ensure that all financial assets, subject to the exceptions identified in the Standing Direction, be deposited within the Central Banking System, unless an exemption has been provided by the Assistant Treasurer under Standing Direction 1.5(b).

The Standing Direction 3.7.2 provides details of the requirements for financial assets and should be referred to, including definitions and specific exceptions.

## Goods and services tax

Funded organisations must register for an Australian Business Number and register for goods and services tax (GST), where required under the *Goods and Services Tax Act 1999*. Each funded organisation is responsible for its own tax compliance and liabilities.

Public hospitals and Ambulance Victoria are government-related entities under ss.8 and 41 of the *Australian Business Number Act 1999.* Funding between one government-related entity and another government-related entity that is sourced from appropriations and for non-commercial activity, is outside the scope of GST, pursuant to ss.9–17(3) of the Goods and Services Tax Act.

# Asset and environmental management

Asset management refers to the coordinated activities, carried out over the asset’s whole life cycle, to realise the full value from assets in delivering their service delivery objectives. Realisation of value will normally involve a balance of costs, risks, opportunities and performance benefits.

Health services must manage, maintain and replace assets, in accordance with the Standing Directions and the Victorian Government’s *Asset management accountability framework* (AMAF).

The Standing Directions require the chief executive officer of funded organisations (health services) to attest compliance with the requirements of the AMAF in their annual reports, and that their organisation complies with the requirements of the AMAF. In meeting its compliance with the AMAF, the department requires health services to submit annual asset management plans and maintain accurate asset registers for all assets under their control.

This requirement is for all the physical asset classes held. It extends across all stages of the life cycle, including planning, acquisition, operation and maintenance, and disposal.

The chief executive officer of funded organisations (health services) must assign responsibility, accountability and reporting requirements. They must also establish and maintain management processes to plan, report, monitor and assess controlled assets. Health services can build asset management capability through attending and actively participating in the Victorian Health Asset Management Communities of Practice and other asset management forums.

Consistent with the Victorian Government policy expressed in the AMAF, the department expects asset management governance, planning and practice in funded organisations to be consistent with the scale of their organisation.

The health service board should be regularly informed about the status of asset management system performance, asset key performance indicators, and any material risk posed in addition to any planned timing of specific investment or disinvestment.

For more information on the AMAF, visit the [*Asset management accountability framework*](https://www.dtf.vic.gov.au/infrastructure-investment/asset-management-accountability-framework) <https://www.dtf.vic.gov.au/infrastructure-investment/asset-management-accountability-framework>.

Environmental management refers to the actions taken by an organisation to meet the requirements of environmental legislation and improve sustainability performance.

## Asset management strategy and planning

Health services need to systematically identify their service delivery and asset needs over time, to establish a plan on how to manage their entire asset base, undertake renewal forecasting and manage individual assets throughout their life cycle.

A key requirement of the AMAF is an asset management strategy that considers strategic (strategic asset management plan) and tactical (asset management plan) asset management.

Effective asset management planning relies on strong governance, aligned corporate leadership, and the input of key affected and specialist groups across the health service. It also requires ongoing performance monitoring and strategic oversight to facilitate prudent risk assessment, asset allocation, and overall asset management planning quality and implementation.

Each health service is required to submit an annual asset management plan for 2024–25, detailing how they are managing their asset base.

### Asset management plans

As part of the assurance framework for appropriate management of assets, health services must submit annual asset management plans to the Asset Planning team in the System Planning Division, by no later than 31 December each year.

At a minimum, the plans should cover:

* summary asset data
* asset performance
* current condition
* prioritised asset risks
* demand analysis
* maintenance program
* renewal forecast (operation and capital)
* list of allocations to address prioritised risks (for all capital funding sources, including the infrastructure renewal contribution grant)
* disposal plans
* resourcing plans.

Asset management plans must be submitted by the end of December, in order to receive full appropriation of the Infrastructure Renewal Contribution Grant (IRCG).

To be eligible for the IRCG, Health Services must outline how the Infrastructure Renewal Contribution Grant will be utilised to address infrastructure risks and asset replacement needs.

### Reporting

As a condition of funding, all 2024–25 specific-purpose capital grant expenditure must be reported as part of the departments Agency Information Management System by the end of each September.

The report needs to correlate with the lodged health service asset management plans to demonstrate effective asset management planning and prioritised replacement of in-scope assets. This annual reporting helps to demonstrate financial and asset accountability (including potential audits), and that critical risk mitigation is achieved.

Health services must demonstrate that the assets are being appropriately maintained, asset performance is monitored and critical asset failures are reported to the department.

### Planning and implementation

Health services should use their asset management plans to prioritise asset replacement according to critical risk, and to guide investment of specific-purpose capital grants at the health-service level. The devolved funding model facilitates responsive and flexible time-critical replacements, enabling a health service to intervene to avert unacceptable clinical service interruptions or failures.

Health services may also submit for funds to replace high-value engineering infrastructure or medical equipment. Consistent with prioritisation and rationing requirements, health services must fund the installation and infrastructure associated with the replacement of high-cost medical equipment, or the scoping of the works/tender documentation for high-cost engineering infrastructure. Health services may choose to use their specific-purpose capital grant for this purpose, if it is considered by the health service to be the highest risk of all the outstanding in-scope assets.

### Accountability

Specific-purpose capital grants must be managed and invested in accordance with health service or hospital board fiduciary responsibilities, and as set out in the program guidelines.

Health services reporting on asset replacement under the initiative must demonstrate financial and asset accountability, including investment against asset management plans. Grant reporting will be used for both accountability and policy, and practice development purposes.

The level of grant is conditional on meeting funding requirements – risk-based prioritisation of investment aligned with health service asset management plans.

Where health services have not fully acquitted received capital funding, the department and/or VHBA may recall distributed funds for reallocation to other high-risk projects across the sector as per the system needs determined by the department.

### Procurement of assets

Health services must comply with government policies and guidelines in their procurement activities.

The department requires health services to engage early and work collaboratively with HealthShare Victoria to maximise value-for-money procurement of medical equipment and deliver the most efficient purchasing arrangements, including standardisation and bulk purchasing, and achievement of economies of scale. Health services are also required to comply with AMAF requirements around assets acquisition.

For more information about compliance and health purchasing policies, sign in to [HealthShare Victoria](https://healthsharevic.org.au) <https://healthsharevic.org.au>.

### Disposal of assets

Planning for disposal should start well before the economic life of the asset has ended or the need for service has finished. It should incorporate consideration of unplanned disposals or destruction of assets.

Health services must comply with relevant approval processes and, where possible, select a disposal method, including retirement, replacement, renewal or redeployment, which maximises the financial benefits associated with the disposal, as per AMAF asset disposal requirements.

The asset status should be updated in the asset management plan and asset register.

## Property portfolio management

Property portfolio management supports the delivery of services from real property assets. In this context, ‘real property’ means both the land and the buildings attached to that land.

Health services must actively manage their property portfolios to ensure real property assets under their control or ownership are fully utilised and realise full-service delivery potential.

Health services must:

* maintain an accurate dataset of all real property assets and annually review landholdings, in accordance with the Victorian Government landholding policy
* ensure formal tenure agreements are executed on all land that is department-owned or controlled (such as Crown land committees of management)
* ensure all real property transactions undertaken comply with the requirements of all relevant legislation, ministerial directions and Victorian Government policy (such as the Land transactions policy and guidelines)
* provide biannual reports to the department on property disposals, including advance notification of properties to be declared as surplus to requirements.

Real property assets under health service management should be zoned appropriately for current or proposed use. Health services should consolidate multiple freehold parcels held under separate titles, to simplify future property management activities.

As funded organisations seek to best match services to consumer needs, service agreements with third parties will require legal tenure agreements relating to the occupation of premises that adequately address legislative and service requirements, and related risks. Where tenure agreements are proposed for premises located on Crown land, funded organisations must ensure they have the right to enter into such agreements and must comply with legislative requirements and government policy regarding their implementation.

## Asset maintenance

Clause 3.4.3 of the AMAF requires the establishment of systems and processes for undertaking maintenance activities and monitoring asset performance.

Maintenance is defined as ‘a combination of all technical, administrative and managerial actions during the life cycle of an item intended to retain it in, or restore it to, a state in which it can perform the required function’.

Asset maintenance enables targeted action to be undertaken in a timely and cost-effective way. This helps the asset portfolio to remain safe and reliable for the lowest possible long-term cost.

Health services are responsible for monitoring asset performance and providing appropriate maintenance activity within the right frequency for assets under their direct or indirect control.

This ensures asset risks are being mitigated or eliminated during the life cycle in order to:

* keep them in an appropriate condition for the health services they support
* prevent service delivery interruptions or service quality risks
* minimise risks to consumer safety, and occupational health and safety
* ensure long-term service performance.

For a set of general and additional maintenance standards that should be applied to all critical areas in hospitals and health services, visit [Maintenance standards for critical areas in Victorian health facilities](https://www.health.vic.gov.au/publications/maintenance-standards-for-critical-areas-in-victorian-health-facilities) <https://www.health.vic.gov.au/publications/maintenance-standards-for-critical-areas-in-victorian-health-facilities>.

## Critical asset service failure

Clause 3.1.5 of the AMAF requires appropriate risk management strategies and processes to support the establishment of asset management, including processes to identify and maintain assets that are at risk of critical service failure.

Within business continuity plans, health services must define critical assets and recovery procedures for systems, as well as processes for the management of emergency events and issues, within its operational context, capability and associated risk.

In the event of a critical asset service failure, health services must provide a summary incident report detailing the critical asset service failure and the corrective action to the Asset Planning Team in the System Planning Division by emailing the team <assetmanagement@health.vic.gov.au>, within four weeks of the incident.

## Health service environmental management and sustainability

### Environmental Management Plan Requirements

Health services are required to prepare an environmental management plan that addresses legislative requirements and key sustainability risks and opportunities. Health services must provide finalised environmental management plans to the Climate Health Victoria team at the Department of Health <chv@health.vic.gov.au>.

Health services have environmental obligations under a range of legislation including:

* *Environmental Protection Act 2017* (Victoria)
* *Climate Change Act 2017* (Victoria)
* *National Greenhouse and Energy Reporting Act 2007* (Commonwealth).

In addition to legislative requirements, health services as public sector organisations have obligations to:

* reduce greenhouse gas emissions and improve climate resilience in accordance with the Victorian Government’s [Victoria’s climate change strategy](https://www.climatechange.vic.gov.au/victorias-climate-change-strategy) <https://www.climatechange.vic.gov.au/victorias-climate-change-strategy> and the associated:
	+ [Whole of Victorian Government pledge](https://www.climatechange.vic.gov.au/victorian-government-action-on-climate-change) <https://www.climatechange.vic.gov.au/victorian-government-action-on-climate-change>
	+ [Health and human services climate change adaptation action plan](https://www.health.vic.gov.au/environmental-health/climate-change-strategy) <https://www.health.vic.gov.au/environmental-health/climate-change-strategy>[[13]](#footnote-14)
* publicly report on environmental performance in accordance with [*FRD 24 Reporting of environmental data by government entities*](https://www.climatechange.vic.gov.au/victorian-government-action-on-climate-change/government-environmental-reporting) <https://www.climatechange.vic.gov.au/victorian-government-action-on-climate-change/government-environmental-reporting>
* incorporate sustainability principles into their procurement activities as outlined in the [Social Procurement Framework](https://www.buyingfor.vic.gov.au/social-procurement-framework) <https://www.buyingfor.vic.gov.au/social-procurement-framework>.

Environmental management plans are to include:

* an assessment of environmental and climate risks including current and potential controls (see section 25 for guidance on risk management)
* assigned responsibilities for environmental management and reporting
* a plan to improve environmental performance identifying key initiatives to be implemented.

The *Environment Protection Act 2017* has a general environmental duty that requires all organisations to reduce the risk of harm to human health and the environment so far as is reasonably practical. Recognising this requirement, the breadth and detail of the environmental management plan should be commensurate to each health service’s risk.

Health services can choose:

* to call their environmental management plan by another name (for example, sustainability strategy) so long as it includes the elements identified above
* the time period covered by their environmental management plan, so long as it is not greater than five years.

Further information on environmental reporting requirements can be found in section 29.12.

### Sustainability requirements in capital works

All capital works funded directly by health services, regardless of the funding source, are to meet the business-as-usual requirements in the department’s [Guidelines for sustainability in capital works](https://www.vhba.vic.gov.au/guidelines-sustainability-capital-works) <https://www.vhba.vic.gov.au/guidelines-sustainability-capital-works>.

The department expects the inclusion of a sustainability budget of 2.5% of total construction costs, which will assist in meeting expectations that health services are responding to climate change obligations.

### Guidance

In addition to the documents already referenced in previous sections, health services may also wish to have regard to:

* any guidance material on environmental management plans and health portfolio environmental priorities as published by the department on its website
* guidance material prepared by the [Department of Energy, Environment and Climate Action on directors’ duties with respect to climate risk](https://www.boards.vic.gov.au/directors-duties-respect-climate-risk) <https://www.boards.vic.gov.au/directors-duties-respect-climate-risk>
* guidance from the [Victorian Managed Insurance Agency (VMIA](https://www.vmia.vic.gov.au/tools-and-insights/climate-change/understanding-victorian-risk-management-expectations)) <https://www.vmia.vic.gov.au/tools-and-insights/climate-change/understanding-victorian-risk-management-expectations> on how Victorian public sector agencies should approach climate change risk management
* guidance contained within the [Clinical and related waste guidance – supplement for healthcare staff](https://www.health.vic.gov.au/publications/clinical-and-related-waste-guidance-supplement-for-healthcare-staff) <https://www.health.vic.gov.au/publications/clinical-and-related-waste-guidance-supplement-for-healthcare-staff>. This document outlines waste management strategies that may assist health services to satisfy waste-related requirements under the Environmental Protection Act 2017 and associated regulations. This includes establishing separate waste streams for pharmaceutical and clinical wastes
* the [National Australian Built Environment Rating System (NABERS) sustainable portfolio index](https://www.nabers.gov.au/news/nabers-sustainable-portfolios-index-2024-confirms-top-performers) <https://www.nabers.gov.au/news/nabers-sustainable-portfolios-index-2024-confirms-top-performers> which (from April 2024) includes energy and water ratings for Victoria’s public hospital. NABERS’ public hospitals ratings set benchmarks for the energy and water performance of buildings and provide an incentive for public hospitals to improve performance over time.

# Digital health

Health services are required to operate safe, secure and cost-effective information communication technology (ICT) and digital health programs in alignment with *Security of Critical Infrastructure Act 2018* when applicable, and both Victorian and national digital health strategies.

Health services are responsible for deploying secure ICT and digital health technology to support safe provision of care within their health service and protect patient information. Accountability rests with health service boards.

The Australian Government Department of Health and Aged Care released its [National digital health blueprint 2023–2033](https://www.health.gov.au/resources/publications/the-digital-health-blueprint-and-action-plan-2023-2033?language=en) (the blueprint) <https://www.health.gov.au/resources/publications/the-digital-health-blueprint-and-action-plan-2023-2033?language=en> in December 2023. The blueprint recognises that digital health technologies enable more efficient and collaborative health care for both patients and healthcare providers. Digital health technologies make health care more affordable, convenient, and accessible to more people.

Complementing the blueprint, the Australian Digital Health Agency has released:

* [*National digital health strategy 2023–2028*](https://www.digitalhealth.gov.au/national-digital-health-strategy) <https://www.digitalhealth.gov.au/national-digital-health-strategy>
* [*Connecting Australian healthcare: national healthcare interoperability plan 2023–2028*](https://www.digitalhealth.gov.au/about-us/strategies-and-plans/national-healthcare-interoperability-plan)<https://www.digitalhealth.gov.au/about-us/strategies-and-plans/national-healthcare-interoperability-plan>.

These three foundation documents provide a vision for a more connected healthcare system across Australia. They will inform the development of Victoria’s eHealth Strategy and future direction of [Victoria’s digital health roadmap](https://www.health.vic.gov.au/publications/victorias-digital-health-roadmap) (the roadmap) <https://www.health.vic.gov.au/publications/victorias-digital-health-roadmap>.

## Governance

The department supports Victorian public health services in their delivery of digital health solutions, including:

* lifting digital health maturity
* enhancing the safety, quality of patient care through the digitisation
* safe guard patient privacy through strengthening of data governance
* risk reduction in the health sector through investment in cyber security, ICT infrastructure, and resilience planning and best practice
* operating health sector applications and ICT services
* providing a 24 hours a day, 7 days a week ICT and cyber incident management service.

The department’s eHealth Division supports Victoria’s public health sector to:

* reduce paper-based care processes and associated patient safety risks
* embed patient-centred care by joining up healthcare records
* extend and enhance ‘better at home’ and virtual care programs
* improve consumer access to their own healthcare information.

Implementation of the roadmap and safe operation of digital health programs and projects are advised by two sector-based bodies, being:

* Victoria’s Health Chief Information Officer Forum
* the Victorian Clinical Informatics Council.

In addition, specific governance forums inform and steer major projects, such as health service consolidation, implementation of statewide health information sharing and, in collaboration with the Mental Health Division and sector, the statewide electronic mental health and wellbeing record.

The Victorian Health Chief Information Officer Forum meets monthly. It is the sector’s primary ICT information-sharing and decision-making forum, seeking to achieve a consistent and interoperable public health system for Victoria.

The forum is chaired by a health service chief information officer, with secretariat support provided by the chair. Health service, Rural Health ICT Alliance and regional health service chief information officers (or their equivalent) are expected to attend these monthly meetings and contribute to its working groups.

Working groups are established as initiatives of relevance to the sector. They are formed to assist in realising system and cost efficiencies, and in optimising security capabilities, consistency and interoperability in Victoria’s public health system. These include:

* Health Sector Cybersecurity Working Group and ICT Operations Assurance Working Group
* Community health cybersecurity and ICT operations assurance Working Group
* Medical Device Cybersecurity Working Group.

Health services are required to participate in all relevant working groups.

The Victorian Clinical Informatics Councilmeets six times a year. It is the sector’s peak clinical informatics advisory body. Its role is to identify and promote best practice in digital health adoption, and support realisation of the roadmap.

The council is chaired by a senior clinician with expertise in digital health. Membership is drawn from the health sector representing all relevant clinical and informatics bodies.

The council:

* represents the opinions of broader groups with particular expertise and experience in relevant areas of health
* recommends establishment of time-limited clinical advisory groups for specific initiatives
* advocates for investment and application of digital health systems and research, to achieve ongoing improvement in patient safety, quality of care and the patient experience
* keeps abreast of, shares and disseminates emerging evidence-based digital health best practices
* advises on safety and quality risk mitigation and remediation pertaining to identified issues with clinical information systems (CIS) identifies priorities based on clinical safety and quality needs.

## Statewide programs

The eHealth Division is responsible for developing, establishing and maintaining the overarching programs that:

* underpin digital health investment
* realise health reform
* optimise continuity of care
* operate core applications to connect records and optimise the security and resilience of health sector ICT applications and services.

Health services and their respective boards are accountable for local digital health strategies, plans and activities. These strategies, plans and activities align with the roadmapand statewide programs.

This model of two-tiered accountability facilitates information sharing, protects patient and clinical data, mitigates risk and leverages aggregated purchasing power.

### Secure and resilient systems

The roadmapsets out a program of work to improve the reliability and resilience of healthcare information systems.

Health services are required to participate in a number of statewide programs, including the:

* Victorian Health Service Cyber Security Program
* Victorian ICT Operations Assurance Program
* Victoria’s Digital Health Maturity Model biennial assessments
* rollout of the department’s health information-sharing program of work, including My Health Record, national digital health initiatives (for example, national healthcare identifiers), unique patient identification, health information exchange and recommendation 62 of Royal Commission into the Victorian Mental Health System.

Rural and regional health services must participate in ICT alliances via joint venture agreements, as specified in the *Rural public health care agencies ICT alliance policy*.

Non-participation in any of these programs puts at risk the integrity of healthcare delivery and requires approval from the health service board and negotiation with the Digital Health branch.

#### Cybersecurity

Health services are required to use department-sponsored cybersecurity tools and must ensure they are maintained. If a health service wishes to use an alternative, they are required to work with the department, demonstrate that it meets or exceeds the protection of the department funded tool, and seek a formal exemption. Health services will not receive funding for non-department sponsored tools.

Health services are required to implement the *Health sector cybersecurity maturity framework* and the *Medical device cybersecurity framework*, which includes mandated cybersecurity controls for systems and devices. These frameworks require health services to attest the cybersecurity controls through an online self-assessment (facilitated through the Victorian Managed Assurance Agency) and to participate in cybersecurity audits when they are directed by the department.

Health services are responsible for the cybersecurity risk management of third-party suppliers. This includes the responsibility to work with third parties to identify, assess, prioritise and implement proportionate cybersecurity controls to protect against cyberattacks.

#### ICT recovery planning

Health services must develop and maintain their business impact analysis (BIA) and conduct their disaster recovery tests regularly. Recovery testing results are to be reported to the department’s eHealth Division every two years, commencing in 2023–24.

In its 2016–17 audit of public hospitals, the Victorian Auditor-General stated that ‘by not resolving long-standing IT systems control issues, public hospitals are at continual significant risk of their systems and data becoming unreliable. Common unresolved IT systems issues include incomplete policies for managing IT systems, such as disaster recovery and business continuity plans.

Requirements for ICT recovery planning (the process for recovering ICT systems) can be derived from the BIA. The BIA lays the cornerstone of a standards-based approach to all business continuity management practices, including establishing requirements for developing ICT disaster recovery solutions.

Resilience initiatives need to consider how the context of the health service operating environment is subject to constant change.

Some examples include:

* susceptibility to a wide range of hazards from physical and natural (including extreme weather events and climate change), supply chain and personnel, to cyber and information security
* technological advances and increased connectivity, which fosters efficiencies, but also increases the likelihood and impact of disruptions
* an increasingly volatile geopolitical environment, and susceptibility of critical infrastructure to attack by nation states, state-sponsored actors, issue-motivated groups or extremist groups seeking to advance their own interests.

#### Service recovery and ICT dependencies

Capturing the relationship between healthcare delivery and ICT systems is central to designing and specifying the recovery requirements of new ICT solutions and services. A key attribute of all activities assessed during the BIA is the recovery time objective (RTO).

Activities that have highly effective manual workarounds and a low reliance on ICT systems being available can be sustained for longer periods and will likely have a longer ICT RTO. Activities that have no (or relatively ineffective) manual workarounds, quickly generate large backlogs, and a high reliance on ICT systems being available cannot be sustained for long periods will have a shorter ICT RTO.

#### Connecting care

‘Connecting care’ is one of the five programs of work identified in the roadmap. The objective of ‘Connecting care’ is to securely enable continuity of care to support Victorians in their journey across health settings and providers.

Joining up consumer and client care requires commitment from the department and health services to participate in and jointly deliver the following pieces of work.

#### My Health Record

Connection to My Health Record across Victorian public health services is designed to enhance patient safety. During 2024–25, health services are expected to work towards uploading by default:

* 90% of eligible pathology reports to My Health Record by July 2025
* 75% of eligible discharge summaries to My Health Record by July 2025
* 50% of eligible diagnostic imaging reports to My Health Record by July 2025.

#### Unique patient identification

Unique patient identification provides a unified view of patient details and identifiers across Victorian health services, as recommended in *Targeting zero*. The system provides a foundation for clinical information sharing across health services and provides a valuable tool to health services for the management of patient identification.

All health services and registered community health organisations are required to connect to Victoria's unique patient identification service, to enable health information sharing at the point of care.

#### Contemporary information architecture for mental health and wellbeing

The Royal Commission into Victoria’s Mental Health System recommended that the Victorian Government develop, fund and implement modern infrastructure for ICT systems. This includes:

* a statewide mental health and wellbeing record
* a mental health information and data exchange and repository
* replacement of the department’s legacy Client Management Interface/Operational Data Store (CMI/ODS) system
* development of a consumer portal.

The department is working with providers of mental health and wellbeing services to develop and implement these systems.

#### Health information sharing

During 2024–25 and beyond, public health services are required to participate in the design, implementation, training and adoption of the department’s health information exchange program of work.

The department’s centralised health information sharing system, CareSync Exchange, will enable public hospitals and other specified health services to share specified patient health information for the purpose of providing medical treatment to patients.

#### Safer Transfer of Care

The Safer Transfer of Care Program[[14]](#footnote-15) aims to expand the use of electronic referrals (eReferrals) to reduce or eliminate the use of printed letters and faxed documents between the primary and acute health sectors. During 2024–25, public health services will be expected to adopt the use of eReferrals, particularly as it relates to streamlining of service delivery of planned (elective) surgery workflows through HSPs.

### Health information exchange privacy management framework

The *Health Legislation Amendment (Information Sharing) Act 2023*, which commenced on 7 February 2024 and amended the *Health Services Act 1988* (the Act), enables the establishment of a secure Electronic Patient Health Information Sharing System (the system), also referred to as CareSync Exchange.

The legislation required the Minister to establish a Privacy Management Framework for the system. The Privacy Management Framework outlines the roles, obligations and governance involved in protecting Victorian health consumers’ privacy in the system. It was developed following extensive consultation with clinicians, consumers, health services and other relevant stakeholders including privacy regulators, industry, and representative bodies.

The Act requires authorised users of the system to comply with the Privacy Management Framework.  This includes clinicians, health services and the department.

The [Privacy Management Framework](https://www.health.vic.gov.au/quality-safety-service/health-information-sharing-legislation-reform) <https://www.health.vic.gov.au/quality-safety-service/health-information-sharing-legislation-reform> is available from mid-2024.

For further information about the Privacy Management Framework contact the Health Information Sharing team by email <HIEprogram@health.vic.gov.au>.

#### Safer Transfer of Care

The Safer Transfer of Care Program[[15]](#footnote-16) aims to expand the use of electronic referrals (eReferrals) to reduce or eliminate the use of printed letters and faxed documents between the primary and acute health sectors. From 2024–25 onwards, public health services are expected to use eReferrals, particularly as it relates to streamlining of service delivery of planned (elective) surgery workflows through HSPs.

### Strategic ICT investments

Prior to approaching the market for strategic ICT investments, health services must seek approval from the Secretary of the department. Strategic projects should align with the roadmap*.* Where there is ambiguity, health services must consult with the eHealth Division.

Health services must report their ICT strategies, plans and projects to the eHealth Division. The branches have planning and assurance roles for the sector to ensure:

* prescribed levels of ICT and cybersecurity capability are in place to support safe clinical care, mitigate risk of unplanned outages and cyber threats, and provide a standard approach to incident management and resolution of issues
* appropriate project governance and planning is in place to support the delivery of successful ICT-enabled health service projects
* engagement with the Strategy, Cybersecurity and Assurance Branch for project assurance on the full lifecycle of the project.

All health service projects with an ICT component greater than $1 million are to be subjected to departmental project assurance. These must be reported via the Strategy, Cybersecurity and Assurance Branch to the Department of Government Services for inclusion in the public quarterly ICT project dashboard.

Projects managed by a Rural Health ICT Alliance are to be reported by the alliance. Alliance member projects are also to be reported via the designated project reporting coordinator for submission. All projects on this dashboard with an ICT budget exceeding $10 million are to be subject to independent project quality assurance, commissioned by the Strategy, Cybersecurity and Assurance Branch.

Health services must ensure that all strategic ICT procurements are conducted in a manner consistent with the relevant Victorian Government Purchasing Board best-practice procurement guidelines and HealthShare Victoria health-purchasing policies. Exemption from these guidelines and policies requires approval from the Secretary of the department.

#### Assessment using Victoria’s Digital Health Maturity Model

The Victorian Auditor-General 2017 report, *ICT strategic planning in the health sector*, recommended that the department comprehensively assess the health sector’s ICT maturity to ensure digital health investment decisions have been informed by clinical ICT maturity. In 2019, Victoria’s Digital Health Maturity Model was developed and maturity assessments across health services were conducted.

During 2022–23, public health services participated in the second cycle of maturity assessment. Health services are required to self-assess against the model at least every two years. The next cycle is due in 2024–25.

## ICT and Cybersecurity incidents

In its role as system manager, the eHealth Incident Management Team must be informed of major ICT incidents within the hour, when they occur in health services or their third-party providers. All cybersecurity incidents, regardless of severity, must be reported to the Incident Management Team as soon as the intrusion is detected or suspected. Notification of cybersecurity and ICT incidents must be done by calling 1300 598 686, then providing a report of the incident by emailing the Incident Management Team <Digital.Health.Incident.Notification@health.vic.gov.au>.

Health services are responsible for reporting cybersecurity incidents and data breaches from third party suppliers to the eHealth Incident Management Team.

Depending on the type of incident, health services may need to consider national reporting obligations, such as to the Office of the Australian Information Commissioner, and the Department of Home Affairs under the *Security of Critical Infrastructure Act*.

Health services are required to work with the eHealth Incident Management Team throughout the life of ICT and cybersecurity incidents. This means department staff must attend incident management meetings and be provided with incident documentation, reporting and planning.

The department manages the reporting and engagement with the Department of Government Services Cyber Incident Response Service and aligns with the [Victorian Government’s Cyber Security Incident Management Plan](https://www.vic.gov.au/cyber-incident-management-plan) <https://www.vic.gov.au/cyber-incident-management-plan>.

## Health ICT asset management

Health services must manage, maintain and replace assets, in accordance with the Standing Directions and the Victorian Government’s *Asset management accountability framework* (AMAF). Compliance with the AMAF applies to ICT assets.

Asset management refers to an organisation’s coordinated activities to realise the full value of assets in delivering service delivery objectives such as improving patient care, enhancing data security, or increasing operational efficiency. This process is carried out over the whole asset life cycle.

The four key stages of the asset life cycle are:

* planning – determination of asset requirements, based on an assessment of both service delivery needs and the capability of the existing asset base to meet these needs. This could involve evaluating current ICT infrastructure, identifying gaps, and forecasting future needs
* acquisition – procurement of assets to meet an identified service need, including the assessment of procurement options such as leasing, purchasing, or developing in-house
* operation and maintenance – management and use of an asset to deliver services, including routine maintenance tasks, software updates, and monitoring system performance
* disposal – treatment of an asset that has either reached the end of its useful life, is considered surplus or is underperforming. This could involve selling, recycling, or decommissioning the asset.

Health services must submit ICT asset management data on a quarterly basis. This data should include detailed information about the asset type, asset category and usage. The supply of data is essential in assisting with cybersecurity incidents and provides evidence on the need for investment, which can then support the full appropriation of technology refresh grants.

Effective ICT asset management is crucial for health services to deliver their service objectives. Regular assessment and updating of ICT asset records, along with timely data submission, can help in managing cyber incidents.

The ICT assets that are in scope include:

**Hardware**

* servers (virtual and physical)
* network appliances (wi-fi access points, firewalls, switches, routers, bridges, gateways, modems, repeaters, and hubs)
* PCs (laptops and desktops)
* mobile devices, smartphones, tablets, and SIM cards issued by the department or agency
* business-critical IP phones and phone lines, and cloud phone systems
* networked multifunction devices, printers, scanners, and faxes

**Software**

* applications (client-side, on-premise data centre, and cloud-hosted)
* databases and middleware
* security certificates
* cloud applications (SaaS)
* cloud platforms (PaaS)
* cloud infrastructure (IaaS)

**Services**

* outsourced, third-party hosted and managed services
* internet of things (IoT), embedded systems and electronic medical devices.

## Digital health foundations

Victorian public health services must apply statewide and national digital health ICT standards and guidelines in their programs of care.

Statewide standards include the:

* *Virtual care standard and guide* – articulates the minimum requirements to successfully implement and maintain virtual care services in Victorian public health services
* *eReferral standard* – articulates the principles and design considerations required to successfully implement and manage effective transition of care
* *Governance and use of the National Health Service Directory (NHSD)* – describes how to upload data into the NHSD system, and how to upload its data to health applications. NHSD is the primary source for services directory and location information. Health services use this directory as the primary source for practitioner information, for the purposes of distributing discharge summaries to GPs and specialists, and for identifying eReferral recipients
* Clinical Information System and Electronic Medical Record Application and Interoperability Standard – articulates the minimum set of functional requirements for implementation of CIS and EMR by VPHS
* Patient Administration System and Interoperability Standard – defines the minimum set of functional requirements for implementation of the patient administration system (PAS)
* *Queue management and outpatient system integration principles* – provides the recommended approach for interoperability between an outpatient appointment booking system and an outpatient queue management application
* *Medications management interface standard* – describes the approach for interfacing of an electronic prescribing system to a pharmacy application.
* *Digital health unified implementation guide* – assists health services with definitive usage of the HL7 2.4 Standard for applications that send HL7 messages to, and receive HL7 messages from, digital health applications.

For more information, visit [Digital health standards and guidelines](https://www.health.vic.gov.au/quality-safety-service/digital-health-standards-and-guidelines) <https://www.health.vic.gov.au/quality-safety-service/digital-health-standards-and-guidelines>.

National standards include:

* standard national clinical documents, including eReferral, discharge summary, shared health summary and event summary, accessed at the [Australian Digital Health Agency’s Clinical documents](https://developer.digitalhealth.gov.au/topic/clinical-documents) <https://developer.digitalhealth.gov.au/topic/clinical-documents>
* national terminology for enterprise-wide electronic medical record implementations at [Australian standard terminology and the Australian medicines terminology](https://www.digitalhealth.gov.au/newsroom/product-releases) <https://www.digitalhealth.gov.au/newsroom/product-releases>
* interactions with My Health Record are cited in Actions 1.17 and 1.18 of the [NSQHS Clinical Governance Standard](https://www.safetyandquality.gov.au/our-work/clinical-governance/clinical-governance-standard) <https://www.safetyandquality.gov.au/our-work/clinical-governance/clinical-governance-standard>
* provision of clinical documents to My Health Record and provision of viewing access to clinical staff, to enhance the safety and continuity of patient care, and meet the requirements of the *My Health Record Act 2012* (Cth) – this includes the ability to apply national individual healthcare identifiers for patients, healthcare provider identifiers for individual clinicians and healthcare provider identifiers for organisations, as well as other requirements under the *Healthcare Identifiers Act 2010* (Cth)
* the *National product catalogue* and associated standards and specifications, which are specified by GS1 at the [National product catalogue](https://www.gs1au.org/our-services/national-product-catalogue) <https://www.gs1au.org/our-services/national-product-catalogue>
* the [*National eHealth security and access framework*](https://developer.digitalhealth.gov.au/resources/national-ehealth-security-and-access-framework-v4-0)<https://developer.digitalhealth.gov.au/resources/national-ehealth-security-and-access-framework-v4-0>, which is maintained by the Australian Digital Health Agency through its national Cybersecurity Centre
* the *Health Records Act 2001 Health Privacy Principles*, for security of health information, and for storing personal and sensitive information outside of Victoria
* compliance and alignment with the Baseline Cybersecurity Controls based on ASD Essentials 8, Centre for Internet Security, and the *National Institute of Standard and Technology (NIST) cybersecurity framework*. These controls outline the minimum security controls that public health services and community health centres must implement, to protect their systems and their patient/client data against a range of adversaries
* the *National guidelines for on-screen display of medicines information* and *National guidelines for on-screen presentation of discharge summaries*, which are maintained by the ACSQHC. For reference documents, visit the [ACSQHC](https://www.safetyandquality.gov.au/our-work/e-health-safety) <https://www.safetyandquality.gov.au/our-work/e-health-safety>
* the Royal College of Pathologists of Australasia’s Standardised Pathology Informatics in Australia – for guidelines and associated information models and terminology reference sets, visit [Pathology terminology and information standardisation](https://www.rcpa.edu.au/Library/Practising-Pathology/PTIS) <https://www.rcpa.edu.au/Library/Practising-Pathology/PTIS>
* the AMAF, which applies to non-current assets (physical and intangible), but not financial assets, controlled by government departments, agencies, corporations, authorities and other bodies that are captured by the [Financial Management Act Standing Directions of the Minister for Finance](https://www.vic.gov.au/tafe-toolkit-financial-management-act-standing-directions) <https://www.vic.gov.au/tafe-toolkit-financial-management-act-standing-directions>.

The Australian Digital Health Agency website is a useful source of reference material for digital health planning. Technical specifications can be found on the agency’s [Digital Health Developer Portal](https://developer.digitalhealth.gov.au/?from=corporate) <https://developer.digitalhealth.gov.au/?from=corporate>. The information contained on this site is subject to change.

# Risk management

## Risk management and assurance

Risk management and assurance activities are essential components of good corporate governance for all funded organisations. These activities will facilitate better service outcomes and quality care, and minimise claims and losses.

### Risk management

The Health Services Act, Public Administration Act and the Financial Management Act require funded organisations to have effective and accountable risk management systems and strategies in place.

Health service management and boards are responsible for their organisation’s governance, risk management and control processes. Internal auditors assist both management and the audit committee by examining, evaluating, reporting and recommending improvements to the adequacy, efficiencies and effectiveness of these processes.

To ensure risks are being managed consistently, some funded organisations are required under the department’s service agreement, Standing Direction 3.7.1of the *Standing Directions of the Minister for Finance* and the Victorian Government risk management framework to attest annually that the responsible body is satisfied that:

* the organisation has a risk management framework in place, consistent with AS ISO 31000:2018 Risk Management – Guidelines
* the risk management framework is reviewed annually, to ensure it remains current and is enhanced as required, and that the organisation demonstrates a positive risk culture
* the organisation defines its risk appetite
* it is clear who is responsible for managing each risk
* shared risks are identified and managed through communication, collaboration and/or coordination, by the affected agencies
* the organisation contributes to the identification and management of state-significant risks, as appropriate
* strategic and business planning and decision-making processes embed risk management and demonstrate consideration of the organisation’s material risks
* adequate resources are assigned to risk management
* the organisation’s risk profile and risk appetite is reviewed at least annually.

An organisation’s risk management framework can consist of:

* a risk management policy and plan that integrates with corporate and business planning
* risk appetite statements
* risk registers and profiles
* an incident management system (refer to section 15.4: Patient and client safety)
* risk management tools, templates and training
* business continuity, cyber security and emergency management plans
* compliance and quality systems
* a fraud and corruption control plan.

These components assist funded organisations to develop an effective positive risk and organisational culture, which includes clinical and all other operational activities.

Health services should articulate how they manage asset-related risk in their asset management strategy, as developed as part of their compliance with the AMAF.

For more information on [risk management](https://infostore.saiglobal.com/en-au/Standards/AS-ISO-31000-2018-1134720_SAIG_AS_AS_2680492), visit <https://infostore.saiglobal.com/en-au/Standards/AS-ISO-31000-2018-1134720\_SAIG\_AS\_AS\_2680492> and [Risk management – principles and guidelines](https://infostore.saiglobal.com/en-au/Standards/HB-158-2010-129591_SAIG_AS_AS_274229) <https://infostore.saiglobal.com/en-au/Standards/HB-158-2010-129591\_SAIG\_AS\_AS\_274229>.

### Assurance activities

Assurance activities provide a degree of confidence regarding the outcome of the evaluation or measurement of the subject matter against predetermined criteria.

The subject matter can take many forms, such as:

* corporate governance practices
* management of risk
* effectiveness and efficiency of operations
* systems, processes, people and performance
* data reliability, completeness, integrity and availability
* accreditation and certifications
* patient or client outcomes and satisfaction
* compliance with laws, regulations and contracts.

Internal and external audits (which are independent), second-line reviews, attestations, accreditations and surveys are some categories of assurance activities, which funded organisations may use to provide reasonable assurance to their board, audit committee and management that they are on track to achieve their objectives.

An organisation’s assurance framework can consist of:

* an assurance strategy aligned to the internationally accepted three-lines model
* an internal audit function aligned to internal audit standards
* an assurance map detailing the sources of all assurance activities
* registers and reports to track implementation progress of management actions to address issues and recommendations
* key performance indicators of assurance activities.

### Integrity governance

Publicly funded health services are expected to use resources in a responsible and ethical manner that delivers value for money. All health services must have the appropriate assessment and mitigation strategies in place, to ensure robust integrity practice across their organisation. The *Integrity governance framework* and assessment tool has been developed as a good practice assessment and reporting tool, to guide and support robust integrity practice.

The framework is aimed at health service leaders of all levels, including team leaders, managers, executive management and the board. It emphasises the important role that leadership plays in managing integrity risks, and that risks can occur at any level of an organisation.

The tool focuses on four domains of integrity risks within a health service: employment principles and personnel procurement; contract and project management; finance; and governance. For more information and to access the tool, visit the [*Integrity governance framework* and assessment tool](https://www.health.vic.gov.au/funding-performance-accountability/integrity-governance-framework-and-assessment-tool) <https://www.health.vic.gov.au/funding-performance-accountability/integrity-governance-framework-and-assessment-tool>.

Health services are required to attest in their annual report that appropriate internal controls exist to review and address integrity, fraud and corruption risks.

## Emergency management

### Health services emergency management policy

The *Health services emergency management policy* directs health services to have arrangements in place to minimise health effects and service disruption to communities from health emergencies and emergencies with health impacts.

Health services should be well prepared for emergencies and able to implement an appropriate response that meets the needs of their communities.

The policy supports:

* emergency preparedness obligations for health services
* access to resources and information to help prepare for emergencies.

For the policy and other emergency management information, visit the [Health services emergency management policy](https://www.health.vic.gov.au/health-services-emergency-management-policy) <https://www.health.vic.gov.au/health-services-emergency-management-policy>.

The *Health services emergency management policy* came into effect on 1 November 2021, replacing the former *Health and human services emergency management policy*.

### State Health Emergency Arrangements

The State Health Emergency Arrangements (SHEA) comprise the State Emergency Management Plan (SEMP) Health Emergencies Sub-Plan, alongside a suite of supporting doctrine, such as emergency-specific operational response plans, protocols and guides.

The SEMP Health Emergencies Sub-Plan provides the arrangements and roles and responsibilities to ensure an integrated and coordinated approach for the management of health emergencies. It includes guidance regarding mitigation, preparedness, response, relief and recovery activities, in line with the SEMP.

The SHEA doctrine (previously known as State Health Response Arrangements or SHERA) consists of internal and external documents. For the external documents, visit the [State Health Emergency Arrangements](https://www.health.vic.gov.au/emergencies/state-health-emergency-response-arrangements) <https://www.health.vic.gov.au/emergencies/state-health-emergency-response-arrangements>.

Review of the SHEA doctrine is currently being undertaken, which is anticipated to be completed within 12 months.

LPHUs will have a role to play in providing locally based support to health emergencies and emergencies with health impacts and consequences. LPHUs should be aware of local public health risks and hazards and prepare for them appropriately. Further, LPHUs help provide a seamless and coordinated public information and community engagement response. In 2023, a draftLPHU Emergency Management Operating Model was developed for implementation and review during the 2023–24 high risk season. During 2024–25, the department and LPHUs will collaborate on lessons management and continuous improvement actions. This work will be undertaken within the next 12 months, in collaboration with LPHUs to ensure the final operating model is developed and implemented prior to the next high-risk season.

## Fire risk management

Funded organisations are responsible for ensuring they comply with the Department of Families, Fairness and Housing’s[*Fire risk management procedures and guidelines*](https://providers.dffh.vic.gov.au/fire-risk-management-procedures-and-guidelines)<https://providers.dffh.vic.gov.au/fire-risk-management-procedures-and-guidelines> relevant to the premises they operate.

Any building surveyor, fire safety engineer or auditor appointed for any works must be accredited by the Department of Families, Fairness and Housing. Refer to the list of [accredited practitioners](https://providers.dffh.vic.gov.au/fire-risk-management-accreditation) <https://providers.dffh.vic.gov.au/fire-risk-management-accreditation>.

Funded organisations are responsible for ensuring they comply with all laws, regulations and mandatory standards relating to fire and life safety in buildings (which also includes protection from external threats such as bushfire), and general safety requirements that apply to any premises from which the funded organisation operates. This is irrespective of whether the relevant regulatory requirements place the obligation on the owner or occupier of those premises.

Key fire risk management requirements include that funded organisations must:

* ensure appropriate operational readiness measures are developed, implemented and reviewed. In doing this, funded organisations should prepare for, respond to and recover from emergencies, in accordance with the ‘all hazards’ approach. This includes bushfire, flood, relocation and evacuation, and prolonged service interruption
* ensure essential services are maintained
* comply with the Department of Families, Fairness and Housing’s capital development guidelines on fire risk management
* ensure that (at the time of client placement in any premises) the premises comply with all laws relating to fire protection, fire safety, health and general safety that apply to any premises from which the organisation operates
* ensure the premises are suitable for efficient client evacuation, taking into account the fire systems installed, and the relocation and evacuation capacities of the client. If any relevant change occurs that may affect a client’s ongoing ability to evacuate safely, the organisation’s Emergency Planning Committee must be informed and appropriate action taken.

Health services funded by the department must comply with the Department of Families, Fairness and Housing’s guidelines on fire risk management, and must complete and return an Annual Fire Safety Certificate to the Fire Services Team by <FRMUCertificates@homes.vic.gov.au>, or through their respective fire services coordinator by 1 September each year.

For more information on fire risk management and annual fire safety certificates, visit the [fire risk management and procedures website](https://providers.dffh.vic.gov.au/fire-risk-management-procedures-and-guidelines) <https://providers.dffh.vic.gov.au/fire-risk-management-procedures-and-guidelines> or email Fire Service Stream <fireservicesteam@homes.vic.gov.au>.

# Legal obligations

## Privacy

Funding is provided on the condition that the funded organisation:

* complies with the provisions of the *Privacy and Data Protection Act 2014* (Vic), the *Health Records Act 2001* (Vic), and other applicable information-sharing and privacy obligations imposed by law, codes of practice or guidelines made under those laws (collectively the Privacy Legislation) in performing funded services
* ensures its employees, officers, agents and subcontractors comply with the terms of any funding agreement(s) between the department and the funded organisation, including any Privacy Legislation, where applicable.

## Public interest disclosures and mandatory notifications

Where applicable, the funded organisation agrees to comply with and be bound by the provisions of the Public Interest Disclosures Act 2012 (Vic) (formerly known as the Protected Disclosure Act 2012 (Vic) and the mandatory notification obligation under s. 57 of the *Independent Broad-based Anti-corruption Commission Act 2011* (Vic).

## Intellectual property

The rights and obligations of funded organisations and the State of Victoria, regarding ownership and management of intellectual property, reflect the *Whole of Victorian Government intellectual property policy* and are set out briefly below.

Funding is provided with the following conditions:

* All intellectual property developed by a funded organisation with funding provided by the department (Project IP) vests in the funded organisation, unless the department advises the funded organisation in writing, prior to the delivery of all or part of the funded services, that the State of Victoria will own the Project IP.
* The funded organisation grants to the State of Victoria a non-exclusive, worldwide, perpetual, irrevocable royalty-free licence to exercise all rights in relation to the Project IP (including background and third-party intellectual property incorporated into Project IP). The licence includes the right to sublicense the Project IP. For the avoidance of doubt, the rights conferred on the State of Victoria under the licence include, without limitation, the right to use, reproduce, adapt, broadcast, publish, communicate to the public and otherwise disseminate the Project IP for the benefit of the Victorian public.
* The funded organisation will ensure it obtains all necessary consents (including moral rights consents and consents from owners of third-party intellectual property) to enable the State of Victoria to exercise all the rights conferred on the State of Victoria referred to above.
* Immediately following a written request, the funded organisation will provide all material containing Project IP to the department, to enable the department to exercise its rights under the licence.
* The funded organisation will properly manage the Project IP in a manner that allows the State of Victoria to enjoy the full benefit of the funded services.
* The funded organisation must not accept co-funding, or involve any person in the delivery of the services, on terms that would jeopardise or limit any licence to be granted to the State of Victoria, without obtaining the department’s prior consent in writing.

Where a funded organisation has a service agreement with the department, the department’s service agreement more fully records the parties’ rights with respect to Project IP and takes precedence over these guidelines.

# Payments and cash flow

## Payments to funded organisations

In 2024–25, the department will make monthly payments over 13 periods (two payment periods in July) to all health services through the Modelling and Payments System. Details of grants and payments can be accessed via [Tableau[[16]](#footnote-17)](https://www.tableau.com) <https://www.tableau.com>. The department will monitor hospital cash flows, as reported monthly in the financial data (HeART) cashflow statement.

The department will make monthly payments to community service organisations through the Service Agreement Management System. For cashflow percentages of individual payment schedules of service agreements and details of the funded activities, login to My Agency via the [Funded Agency Channel](https://fac.dffh.vic.gov.au) <https://fac.dffh.vic.gov.au>. The department will monitor community service organisation performance and financial sustainability.

Payments may be adjusted for recall, loans, enterprise bargaining agreements, indexation, awards and prepayments.

## Enterprise bargaining

### Expiring agreements and enterprise bargaining

Negotiations for new enterprise agreements were finalised in 2023–24 for:

* public health sector biomedical engineers
* public health sector dentists
* public health sector specialist dentists
* HealthShare Victoria public health sector maintenance workers
* Remembrance parks (cemetery).

Negotiations for new enterprise agreements are occurring during the 2024–25 financial year for:

* ambulance administration and management
* Ambulance Victoria paramedics
* Breast Screen Victoria
* public health sector mental health professionals
* Geelong Cemeteries Trust
* Greater Metropolitan Cemeteries Trust
* public health sector managers and administrative workers
* HealthShare Victoria
* public health sector medical scientists, pharmacists and psychologists
* public health sector nurses and midwives.

### Wages policy

The Victorian Government’s current *Wages policy* and the *Enterprise bargaining framework* have applied since 4 April 2023. The three pillars of the *Wages policy* are:

* wages – increases in wages and conditions capped at a rate of growth of 3.0% per annum and cash payment(s) distributed across the workforce to a value not exceeding 0.5% of the value of wages and allowances
* best-practice employment commitment – public sector agencies are to outline measures to operationalise elements of the government’s public sector priorities that reflect good practice, and can be implemented operationally or without significant cost
* additional strategic changes – changes to allowances and other conditions will only be allowed if the government agrees that the changes will address key operational or strategic priorities.

Health services are expected to comply with other aspects of government policy, including wages and industrial relations policy, as made from time to time.

For more information, visit [*Wages policy* and the *Enterprise bargaining framework*](https://www.vic.gov.au/wages-policy-and-enterprise-bargaining-framework) <https://www.vic.gov.au/wages-policy-and-enterprise-bargaining-framework>.

### Budgeting for new agreements

Enterprise bargaining settlements are rarely timed to coincide with the beginning of a financial year. Therefore, there may be part-year cost effects in any given financial year, relating to both expiring and new enterprise bargaining outcomes. In contrast, budget indexation applies on a full financial year basis.

Health services must identify and account for indexation as it relates to supporting increased wage and salary costs. The baseline wage increases contained in the applicable wages policy must be funded by health services before any additional supplementation is sought from the Department of Treasury and Finance.

When new enterprise agreements take effect, or are likely to take effect in a financial year, health services must keep funding equal to these amounts available for such increases. This remains true, even when enterprise bargaining processes become protracted or complex, and remain unresolved at the end of the financial year in which settlement was expected to occur and have cost effect.

Health services must also ensure enterprise agreement costs are properly attributed to other relevant revenue sources, where existing employment costs are met from those other sources.

## Long service leave

The department assumes the liability arising from the net increase in the long service leave provision for public hospitals, denominational hospitals and some statutory authorities (‘eligible agencies’), except for changes to the long service leave provision due to any subsequent recognition of gains or losses on revaluation, which is in accordance with the Department of Treasury and Finance’s *Resource management framework*. All agencies must, however, reflect the movements in the long service leave provision associated with the revaluations in their long service leave provision, in accordance with accounting standards.

The department funds the annual increase in the long service leave provision[[17]](#footnote-18) of its eligible agencies as follows:

* an amount equal to 2.8% of defined salaries and wages is included in the price and paid as grants to the department’s eligible agencies (with a few exceptions)
* a grant payable to the department’s eligible agencies is recognised for the balance not paid as the grant described above (a debtor in respect of this non-cash grant will be recognised by each eligible agency).

Eligible agencies will continue to manage their long service leave and cash requirements. Long service leave funding paid by the department in excess of actual long service leave payouts during the current and prior financial years should be maintained and managed by eligible agencies. It should also be used as the first call for any future settlements over and above the (current) 2.8% of long service leave included in the price.

## Medical indemnity insurance

The department has developed the medical indemnity risk-rated premium model, in consultation with, and on the advice of, the Victorian Managed Insurance Authority and its actuaries. The medical indemnity risk-rated premium model allocates a share of the statewide medical indemnity insurance premium to individual hospitals and health services.

# Data collection changes

The following subsections describe data collection changes. For more information, visit [Annual changes process](https://www.health.vic.gov.au/data-reporting/annual-changes) <https://www.health.vic.gov.au/data-reporting/annual-changes>.

## VAED

From 1 July 2024, the following changes have been made to the VAED:

* a new data element has been added to the VAED to collect ‘Reason for discharge delay’
* ‘Sex at birth’ is required to be reported
* the number of diagnosis codes that can be reported has increased from 40 to 100
* three new ‘Impairment’ codes have been added for reporting of COVID-19
* the ‘Medically ready for discharge date’ data element has been renamed to ‘Clinically ready for discharge date’. The definition has been updated and mental health care type had been included for reporting
* changes have been made to the reporting guides for ‘Duration of non-invasive ventilation in ICU’
* reporting of ‘Gender’ has become mandatory.

Victorian health services must ensure their software can create a submission file in accordance with the *Updated specifications for revisions to the Victorian Admitted Episodes Dataset (VAED) for 2024–25* on the [annual changes process webpage](https://www.health.vic.gov.au/data-reporting/annual-changes) <https://www.health.vic.gov.au/data-reporting/annual-changes> and ensure reporting capability is achieved to maintain compliance with reporting timeframes.

## ESIS

From 1 July 2024, ‘Sex at birth’ is required to be reported and reporting ‘Gender’ is mandatory.

Victorian health services must ensure their software can create a submission file in accordance with the *Specifications for revisions to the Elective Surgery Information System (ESIS) for 2024–25* on the [annual changes process webpage](https://www.health.vic.gov.au/data-reporting/annual-changes) <https://www.health.vic.gov.au/data-reporting/annual-changes> and ensure reporting capability is achieved to maintain compliance with reporting timeframes.

## AIMS

From 1 July 2024:

* reporting of Victorian Respiratory Support Service (VRSS) – aggregate data for VRSS service events will no longer be reported on the AIMS S12 but will instead be reported on the AIMS S11 ‘Sub acute non-admitted activity’ form.
* reporting of urgent care activity on the AIMS S10 ‘Acute non-admitted clinic activity’ form will cease. From July 2024, all urgent care activity will be reported using the AIMS ‘Urgent care centre’ form.

## VEMD

From 1 July 2024, ‘Sex at birth’ is required to be reported and reporting ‘Gender’ is mandatory.

Victorian health services must ensure their software can create a submission file in accordance with the *Specifications for revisions to the Victorian Emergency Minimum Dataset (VEMD) for 2024–25* on the [annual changes process webpage](https://www.health.vic.gov.au/data-reporting/annual-changes) <https://www.health.vic.gov.au/data-reporting/annual-changes> and ensure reporting capability is achieved to maintain compliance with reporting timeframes.

## VINAH minimum dataset

From 1 July 2024, the following changes have been made to the VINAH minimum data set:

* introduction of a new program/stream for reporting of Early Parenting Centres patient level non-admitted data
* introduction of a new data element for reporting of indigenous status for programs that only report at episode level
* reporting of contact account class has been expanded to include the Palliative Care Consultancy program/stream(s)
* new and amended streams for the Victorian Respiratory Support Service program
* new concept for contracted care incorporating brokerage
* updated reporting guide for contact client present status
* updated reporting guide for contact Medicare benefits schedule item number
* brokerage concept has been removed
* ‘Patient/client sex at birth’ is required to be reported
* reporting of the existing VINAH data element ‘Patient/client gender’has become mandatory.

Victorian health services must ensure their software can create a submission file in accordance with the file named “Specifications for revisions to the Victorian Integrated Non-Admitted Health Minimum Data Set (VINAH MDS) for 2024–25 on the [annual changes process webpage](https://www.health.vic.gov.au/data-reporting/annual-changes) <https://www.health.vic.gov.au/data-reporting/annual-changes> and ensure reporting capability is achieved to maintain compliance with reporting timeframes.

## Non-Admitted Data Collection (NADC)

From 1 July 2024, changes have been made to the NADC that include:

* introduction of a new program/stream for reporting of Early Parenting Centres
* new and amended streams for the Victorian Respiratory Support Service program
* new concept for contracted care reporting within the business rules for service provider
* ‘Patient/client sex at birth’ is required to be reported.
* reporting of the existing data element ‘Patient/client gender’ has become mandatory.

## Victorian Perinatal Data Collection

In 2024–25, there will be a continuing focus for the Victorian Perinatal Data Collection (VPDC) on reporting compliance. This will ensure data is received in a timely manner and data quality issues are identified as early as possible.

As of 1 July 2024, a number of new data items will be added to the VPDC and some existing data items will be removed. These changes are set out in the *Specifications for revisions to the VPDC for 1 July 2024*, accessible at the [VPDC website](https://www.health.vic.gov.au/quality-safety-service/victorian-perinatal-data-collection) <https://www.health.vic.gov.au/quality-safety-service/victorian-perinatal-data-collection>.

## Public sector residential aged care

Performance and quality improvement changes are as follows:

* PSRACS are expected to consider recommendations from the Royal Commission into Aged Care Quality and Safety, and how they can apply these to improve quality and safety for consumers.
* Over 2022–23, the department will work with PSRACS to implement recommendations from the Royal Commission into Aged Care Quality and Safety. It is expected that PSRACS will participate in projects and activities to progress implementation of the recommendations.
* PSRACS must continue to implement continuous improvements that demonstrate a systematic ongoing effort to improve the quality of care and services, and meet the Aged Care Quality and Safety Standards.

## ACAS

Since August 2016, all ACAS data is recorded in the Australian Government's My Aged Care system. The Australian Government provides monthly performance reports to the department, to support performance review activities. The department and aged care assessment service providers are able to run data reports, using the My Aged Care Business Intelligence report platform and the Australian Government’s Qlik platform.

The Australian Government is implementing a new single assessment model to assess eligibility for all aged care services. This will replace assessment services that are currently delivered by ACAS and RAS. ACAS and RAS will transition to the single assessment model during 2024–25. Updated data guidance for the new model will be provided to support implementation.

## Mental health and wellbeing services – CMI/ODS

Victoria’s *Mental Health and Wellbeing Act 2022* commenced on 1 September 2023. The Act applies to state-funded mental health and wellbeing service providers. Changes have been implemented to the CMI/ODS to support compliance with the Act.

# Data collection requirements

Data reporting and analysis are core elements of the department’s health monitoring and funding system. In general, health services and other funded organisations must comply with standard definitions for reporting financial and statistical data, as set out in the relevant 2024–25 versions of data collection manuals, and any other amending documents prepared by the department.

## Key systems

The department operates several data collections on different aspects of health service activity. Key systems include:

* HeART/Common Chart of Accounts
* VAED for admitted patient activity
* VEMD for designated ED activity
* ESIS for monitoring planned (elective) surgery waiting lists
* VINAH minimum data set for non-admitted patient activity
* NADC for non-admitted patient activity
* AIMS used primarily to collect summary-level statistical information
* VCDC for patient-level costs
* VPDC for births
* CMI/ODS for mental health client data.

### Financial data

Financial data must be submitted at the consolidated entity level, via HeART,[[18]](#footnote-19) for all health services and other portfolio entities (excluding cemeteries and VicHealth). Submit financial data by close of business on the 12th calendar day after the end of the month to which the financial data relates (for example, the submission for October is required by close of business on 12 November).

Financial data must be submitted in a timely manner, as the month will be closed for further updates once ‘rolled over’ to the next month. Data relating to approved budgets (‘SOP budget’, ‘FTE budget’ and ‘Activity targets’) and estimates trial balances are required reporting are outlined in more detail below.

The data elements required on a monthly basis are:

* trial balance
* cash flow statement (including tied and committed funds)
* monthly cash flow forecast to 30 June (including tied and committed funds)
* actual FTE
* estimated activity for the month as aligns to financial reporting.

Data submitted through HeART will be used each month as a basis for performance monitoring and for whole-of-government reporting. This collective data is reported to the Department of Treasury and Finance, and must be complete and accurate. If the data submitted to the department is inaccurate or incomplete, entities may be required to amend and resubmit this data through the HeART system. This resubmission must occur in a timely manner.

Entities are also required to report both an approved budget (‘SOP Budget’), and estimate trial balances (end-of-year forecast) to the department through the HeART system, noting that:

* the submitted approved budget (‘SOP Budget’) should match the agreed SOP and only be amended when agreed with the department. The FTE and activity budgets/targets are also required to be submitted once the SOP is signed
* estimates are to be in the form of a full end-of-year trial balance and reflect the most up-to-date forecast across the trial balance. At certain dates, as advised separately by the department, the estimate trial balance submissions must be accompanied by a chief financial officer sign-off (a template will be provided by the department)
* the trial balance estimates for sign-off are outlined below
* October – updated EOFY estimate including September actuals, due to be submitted on 23 October 2024
* December – updated EOFY estimate including November actuals, due to be submitted on 20 December 2024
* February – updated EOFY estimate including January actuals, due to be submitted on 26 February 2025
* March – updated EOFY estimate where revenue and or expenditure has moved by 2%, due to be submitted on 21 March 2025
* April – updated EOFY estimate including March actuals, due to be submitted on 24 April 2025
* May – updated EOFY estimate including April actuals, due to be submitted on 23 May 2025
* June – updated EOFY estimate where revenue and or expenditure has moved by 2%, due to be submitted on 20 June 2025.

Entities will provide this information in accordance with the department's timelines. Late data submissions of trial balances will be monitored and reported through performance monitoring staff in the department along with the Data Quality Assurance Program.

### VAED

The VAED contains the core set of clinical, demographic, administrative and financial data for admitted patient episodes occurring in Victorian health services. Maintaining the accuracy of the VAED is essential to ensuring accurate and equitable funding outcomes, supporting health services’ planning, policy formulation, quality and safety monitoring, program evaluation and epidemiological research. Analyses and consolidated activity data are provided from the VAED to meet the department’s reporting obligations to the Commonwealth and to various research institutes.

For more information on the VAED and to download the VAED manual, visit the [VAED website](https://www.health.vic.gov.au/data-reporting/victorian-admitted-episodes-dataset) <https://www.health.vic.gov.au/data-reporting/victorian-admitted-episodes-dataset>.

The department publishes the VAED manual on the HDSS website to provide clarity on reporting requirements for health services and information for data users.

Health services are expected to audit and reconcile their VAED data regularly throughout the year.

#### Submission guidelines

All organisations that receive funding for admitted patient services must submit data to the VAED minimum dataset.

Health services (including SRHS) will assign clinical codes to patient episodes reported to the VAED using the current ICD-10-AM/ACHI classification, in accordance with Australian Coding Standards, along with Victorian additions to the Australian Coding Standards, national coding advice and coding advice issued by the department through the Victorian ICD Coding Committee (Victoria’s jurisdictional coding advisory committee).

Public health services must submit admitted patient data to the VAED, according to the timelines in Table 3. Health services may submit data more frequently than the minimum standards specified in the table.

Table 3: VAED timelines

| VAED  | Timeline |
| --- | --- |
| Admission and separation details for the month (E5, J5 and V5 records) | Must be submitted by 5.00 pm on the 10th day of the following month  |
| Diagnosis and procedure, subacute and palliative care details (X5, Y5, S5 and P5 records) | Must be submitted by 5.00 pm on the 10th day of the 2nd month following separation |
| Data for the 2024–25 financial year | Must be submitted by 5.00 pm on 10 August 2025 |
| Final corrections to data for 2024–25 | Must be submitted by 5.00 pm on 24 August 2025 |

It is the health service’s responsibility to ensure that data files are submitted on or before the 10th of each month, regardless of the actual day of the week.

#### Penalties for noncompliance

Where health services are noncompliant with the timelines specified above, the department may apply penalties that include:

* up to $20,000 per month, if more than 1% of admission and separation details (E5, J5) for a given month are submitted after the timeline specified
* up to $20,000 per month, if more than 1% of episodes for a given month are submitted without diagnosis, procedure, subacute or palliative care details (X5, Y5, S5, P5) by the deadline specified
* up to $2,000 per episode, if there is a significant number of episodes that are ‘dummy coded’ or do not meet the VAED business rules.

The above requirements apply to all account classes, including the Department of Veterans’ Affairs.

Data that is flagged as unfit for reporting and analysis will be regarded as noncompliant, and penalties as above may apply.

#### Exemptions from penalties

If difficulties are anticipated in meeting the relevant data submission timeframes, the health service must contact the department, indicating the nature of the difficulties, remedial action being taken and the expected submission schedule.

For a pro forma to assist this process, visit [VAED](https://www.health.vic.gov.au/data-reporting/victorian-admitted-episodes-dataset) <https://www.health.vic.gov.au/data-reporting/victorian-admitted-episodes-dataset>. This form must be submitted if a health service cannot meet the reporting deadline.

Requests for an exemption from late penalties will only be considered if received prior to the relevant deadlines, and if the manual aggregate data (S1A form) has been completed by the due date. Extensions or exemptions are not issued in advance. Late submissions penalties are assessed after the end-of-year consolidation deadline, taking into account the health service’s compliance performance for the financial year.

For any full-month period that the health service is unable to supply unit record data, the health service is required to submit aggregate data using the AIMS S1A form submitted via HealthCollect. The health service must complete the AIMS S1A form by the 10th of the month. For assistance with the S1A, email the HDSS helpdesk <hdss.helpdesk@health.vic.gov.au>. Failure to complete the S1A form by the due date may result in late submission penalties.

#### Software upgrades and migrations

Health services are requested to email the HDSS helpdesk <hdss.helpdeks@health.vic.gov.au> as soon as a decision is made to implement new software applications that will affect VAED reporting.

Multiple health services often implement new software at the same time, and the department is frequently asked for advice on data migration, to support testing and so forth. To ensure the department can provide sufficient support, early notification is appreciated. Please advise the software being changed and whether it is a PAS or an EMR, the data collections involved, migration plans, go-live dates and the main health service contacts.

Health services implementing software migrations must undertake VAED data submission testing before resuming VAED data submissions to the production (live) environment. Health services will be exempt from late data submission penalties for an agreed period of no more than two months, provided the S1A form is completed on time.

Health services undertaking software upgrades may also choose to undertake the VAED data submission testing process before resuming VAED data submissions to the production (live) environment. Health services will be exempt from late data submission penalties for one month, provided the S1A form is completed on time.

### VEMD

The VEMD contains de-identified demographic, administrative and clinical data detailing emergency department presentations at Victorian public hospitals.

For more information on the VEMD and to download the VEMD manual, visit the [VEMD website](https://www.health.vic.gov.au/data-reporting/victorian-emergency-minimum-dataset-vemd) <https://www.health.vic.gov.au/data-reporting/victorian-emergency-minimum-dataset-vemd>.

The department publishes the VEMD manual on the HDSS website to provide clarity on reporting requirements for health services and information for data users.

Health services are expected to reconcile their VEMD data regularly throughout the year.

#### Submission guidelines

Public health services reporting to the VEMD must adhere to the timelines in Table 4.

Table 4: VEMD timelines

| VEMD | Timeline |
| --- | --- |
| All presentations to be submitted every weekday  | All presentations must be supplied by 5.00 pm the following business day |
| All presentations for the full month without errors | Must be complete and correct – that is, zero rejections and notifiable edits by 5.00 pm on the 10th day of the following month, or the prior business day |

Any corrections to 2024–25 data must be submitted before final consolidation of the VEMD on 27 July 2025.

#### Penalties for noncompliance

Where health services are noncompliant with the timelines specified above, the department may apply penalties that include:

* up to $5,000 per month, if presentations for the first 14 days of the month are not submitted by the timelines specified in Table 4
* up to $10,000 per month, if presentations for the full month are not submitted by the timelines specified in Table 4
* up to $10,000 per month, if a file with all presentations for the full month contains errors by the timelines specified in Table 4.

Data flagged as unfit for reporting and analysis will be regarded as noncompliant and penalties as above may apply.

#### Exemptions from penalties

If difficulties are anticipated in meeting the relevant data submission timeframes, the health service must contact the department, indicating the nature of the difficulties, remedial action being taken and the expected submission schedule.

For a pro forma to assist this process, visit the [VEMD](https://www.health.vic.gov.au/data-reporting/victorian-emergency-minimum-dataset-vemd) < https://www.health.vic.gov.au/data-reporting/victorian-emergency-minimum-dataset-vemd>. This form must be submitted if a health service cannot meet the reporting deadline.

Requests for an exemption from late penalties will only be considered if received prior to the relevant deadlines, and if the manual aggregate data spreadsheet has been completed by the due date. Extensions or exemptions are not issued in advance. Late submissions penalties are assessed after the end-of-year consolidation deadline, taking into account the health service’s compliance performance for the financial year.

For any full-month period that the health service is unable to supply unit record data, the health service is required to submit aggregate data using the manual aggregate data spreadsheet that is available from the [VEMD](https://www.health.vic.gov.au/data-reporting/victorian-emergency-minimum-dataset-vemd) <https://www.health.vic.gov.au/data-reporting/victorian-emergency-minimum-dataset-vemd>. The health service must submit the completed spreadsheet by the 10th of the month.

Failure to complete the manual aggregate data spreadsheet by the due date may result in late submission penalties.

#### Software upgrades and migrations

Health services are requested to email the HDSS helpdesk <hdss.helpdeks@health.vic.gov.au> as soon as a decision is made to implement new software applications that will affect VEMD reporting.

Multiple health services often implement new software at the same time, and the department is frequently asked for advice on data migration, to support testing and so forth. To ensure the department can provide sufficient support, early notification is appreciated. Please advise the software being changed, whether it is a PAS or an EMR, the data collections involved, migration plans, go-live dates and the main health service contacts.

Health services undertaking software migrations must undertake VEMD data submission testing before resuming live VEMD data submission. Health services will be exempt from late data submission penalties for an agreed period of up to two months, provided the manual aggregate data spreadsheet is completed on time.

Health services undertaking software upgrades will be exempt from late data submission penalties for one month, provided the manual aggregate data spreadsheet is completed on time.

### ESIS

The ESIS is a patient-level collection of planned (elective) surgery waiting list data from approved Victorian public healthcare services.

For more information on the ESIS and to download the ESIS manual, visit [ESIS](https://www.health.vic.gov.au/data-reporting/elective-surgery-information-system-esis) <https://www.health.vic.gov.au/data-reporting/elective-surgery-information-system-esis>.

The department publishes the ESIS manual on the HDSS website to provide clarity on reporting requirements for health services and information for data users.

Health services are expected to audit and reconcile their ESIS data regularly throughout the year.

#### Submission guidelines

Public health services reporting to the ESIS must adhere to the minimum submission timelines in Table 5.

Table 5: ESIS timelines

| ESIS | Timeline |
| --- | --- |
| All activity (registrations, removals, readiness, urgency, and scheduling events) for the first 15 days of the month | Must be submitted by 5.00 pm on the 3rd business day after the fifteenth of the reporting month |
| All activity (registrations, removals, readiness, urgency, and scheduling events) for the remaining days of the month (sixteenth and subsequent) | Must be submitted by 5.00 pm on the 3rd business day of the following month |
| All activity for the full month without errors | Must be complete and correct – that is, zero rejections, notifiable or correction edits – by the 14th day of the following month, or the prior business day |

Any corrections to 2024–25 data must be submitted before final consolidation of the ESIS database on 24 August 2024.

#### Penalties for noncompliance

Where health services are noncompliant with the timelines specified above, the department may apply a penalty of:

* up to $5,000 per month, if episodes for the first 15 days are not submitted by the timelines specified in Table 5
* up to $10,000, if episodes for the full month are not submitted by the timelines specified in Table 5
* up to $10,000, if a file with all episodes for the full month contains errors by the timelines specified in Table 5.

Data that is flagged as unfit for reporting and analysis will be regarded as noncompliant, and penalties as above may apply.

#### Exemptions from penalties

If difficulties are anticipated in meeting the relevant data submission timeframes, the health service must contact the department, indicating the nature of the difficulties, remedial action being taken and the expected submission schedule.

For the pro forma to assist this process, visit [ESIS](https://www.health.vic.gov.au/data-reporting/elective-surgery-information-system-esis) <https://www.health.vic.gov.au/data-reporting/elective-surgery-information-system-esis>. This form must be submitted if a health service cannot meet the reporting deadline.

Requests for an exemption from late penalties will only be considered if received prior to the relevant deadlines, and if the manual aggregate data spreadsheet is completed by the due date. Extensions or exemptions are not issued in advance. Late submission penalties are assessed after the end-of-year consolidation deadline, taking into account the health service’s compliance performance for the financial year.

For any full-month period that the health service is unable to supply unit record data, the health service is required to submit aggregate data using the manual aggregate data spreadsheet. The health service must submit the completed spreadsheet by the 14th of the month.

To access the spreadsheet, visit [ESIS](https://dhhsvicgovau.sharepoint.com/sites/Accountability/Shared%20Documents/PFG%2024-25/ESIS) <https://www.health.vic.gov.au/data-reporting/elective-surgery-information-system-esis>.

Failure to complete the manual aggregate data spreadsheet by the due date may result in late submission penalties.

#### Software upgrades and migrations

Health services are requested to inform the HDSS helpdesk <hdss.helpdeks@health.vic.gov.au> as soon as a decision is made to implement new software applications that will affect ESIS reporting.

Multiple health services often implement new software at the same time, and the department is frequently asked for advice on data migration, to support testing and so forth. To ensure the department can provide sufficient support, early notification is appreciated. Please advise the software being changed, whether it is a PAS or an EMR, the data collections involved, migration plans, go-live dates and the main health service contacts.

Health services undertaking software migrations must undertake ESIS data submission testing before resuming live ESIS data submission. Health services undertaking software migrations will be exempt from late data submission penalties for an agreed period of up to two months, provided the manual aggregate data spreadsheet is completed on time.

Health services undertaking software upgrades will be exempt from late data submission penalties for one month, provided the manual aggregate data spreadsheet is completed on time.

### VINAH minimum dataset

The VINAH minimum data set is a patient-level reporting system that is built around a generic framework suitable for reporting a wide range of non-admitted patient-level data.

Organisations that receive funding under any of the following programs must transmit valid and complete data to the VINAH minimum data set, including:

* complex care (FCP)
* early parenting centres
* health independence program
* subacute ambulatory care services
* hospital admission risk program
* post-acute care
* residential in reach
* home based dialysis
* home enteral nutrition
* medi-hotel (optional)
* palliative care
* palliative care consultancy
* specialist clinics (outpatients)
* total parenteral nutrition
* transition care program
* Victorian artificial limb program
* Victorian HIV and sexual health services
* Victorian respiratory support service.

For clarity on reporting requirements for health services, and information for data users more information is provided in the [VINAH manual](https://www.health.vic.gov.au/data-reporting/victorian-integrated-non-admitted-health-vinah-dataset) <https://www.health.vic.gov.au/data-reporting/victorian-integrated-non-admitted-health-vinah-dataset>.

Health services are expected to reconcile their VINAH data regularly throughout the year.

#### Submission guidelines

Health services reporting to the VINAH minimum data set will be required to adhere to the minimum submission timelines in Table 6. Health services are encouraged to submit more frequently than the minimum standards in the table. It is the funded organisation’s responsibility to ensure data files are submitted in time to meet the processing schedule detailed below, regardless of the actual day of the week.

Table 6: VINAH minimum dataset timelines

| VINAH minimum dataset | Timeline |
| --- | --- |
| Submission data for client, referral, episode and contact details for the month | Must be submitted before 5.00 pm on the 10th day of the following month |
| Clean data for client, referral, episode and contact details for the month | Must be submitted before the file consolidation at 5.00 pm on the 14th day of the following month, or the preceding business day if the 14th falls on a weekend or public holiday when data must be complete – that is, zero rejections |

Funded organisations are encouraged to transmit data frequently and may transmit as often as desired, ensuring the following minimum requirements are met:

* VINAH minimum dataset compliance is reckoned on a monthly basis. Data for each calendar month (reference month), as specified in the ‘reported when’ component of each data element in the VINAH minimum dataset manual, must be transmitted as specified below.
* Funded organisations must ensure all client, referral, episode and contact details for the month are submitted to the HealthCollect portal for the reference month, by no later than 5.00 pm on the 10th day of the month following the reference month.
* All errors are to be corrected in time for the VINAH minimum dataset file consolidation at 5.00 pm on the 14th day of the month following the reference month. Complete data for the month is expected to be transmitted by the 14th day.

Data for the financial year must be completed in time for the VINAH minimum dataset file consolidation on 24 August. Any final corrections must be received at the HealthCollect portal before the VINAH minimum dataset database is finalised on 24 August 2025.

#### Penalties for noncompliance

If funded organisations do not comply with these timelines, the department may apply a penalty of:

* up to $10,000, if an initial transmission of a reference month’s activity for a program is not submitted within the timelines specified in Table 6
* up to $10,000, if a reference month’s complete activity for a program is not submitted in accordance with the timelines specified in Table 6.

Funded organisations that have VINAH minimum dataset reporting obligations for multiple programs (for example, subacute ambulatory care services, the Hospital Admission Risk Program and post-acute care), should note that the above penalties apply per program.

Data that is flagged as unfit for reporting and analysis will be regarded as noncompliant, and penalties as above may apply.

#### Exemptions from penalties

Organisations seeking exemption from penalties for late data must complete a ‘Late data request form’ (available on the HealthCollect portal) advising of the issues experienced, the organisation’s plan for overcoming the issues and the expected submission date. Exemptions will be granted at the department’s discretion.

Organisations must report aggregate data for acute non-admitted activity via the AIMS S10 form, subacute non-admitted activity via the AIMS S11 form, subacute non-admitted multidisciplinary case conferences activity via the AIMS S11A form, and episodic non-admitted activity via the AIMS S12 form.

#### Software upgrades and migrations

Health services are requested to inform the HDSS helpdesk <hdss.helpdeks@health.vic.gov.au> as soon as a decision is made to migrate to new software applications that will affect VINAH minimum data set reporting.

Multiple health services often implement new software at the same time, and the department is often asked for advice on data migration, to support testing and so forth. To ensure the department can provide sufficient support, early notification is appreciated. Please advise the software being changed, whether it is a PAS or an EMR, the data collections involved, migration plans, go-live dates and the main health service contacts.

Health services undertaking software migrations must undertake VINAH minimum data set submission testing before resuming live VINAH minimum data set submissions. Health services undertaking software migrations will be exempt from late data submission penalties for three months.

Health services undertaking software upgrades will be exempt from late data submission penalties for one month.

Health services must ensure their 2024–25 VINAH minimum data set is transmitted completely by 24 August 2025, and should ensure software updates and migrations do not prevent complete VINAH minimum data set transmissions by this date, as no extensions will be possible.

### NADC

The NADC is a flat file extract for non-admitted patient-level reporting. Health services unable to report to the VINAH minimum dataset may request to report this collection, which includes a limited number of data items based on the IHACPA ABF Non-Admitted Patient Care Patient Level Specifications and meets the department’s national reporting obligations.

Health services are mandated to report non-admitted activity data through the VINAH minimum dataset. The NADC has been developed for use in exceptional circumstances only. Service providers will require department approval to submit non-admitted activity through NADC, rather than through the VINAH minimum dataset.

Information about reporting this collection, including specifications and obtaining approval to report this collection, can be obtained by emailing the HDSS helpdesk <hdss.helpdeks@health.vic.gov.au>.

Table 7: NADC timelines

| NADC | Timeline |
| --- | --- |
| Submission date for all service events in the month | Must be submitted before 5.00 pm on the 10th day of the following month |
| Clean date for all service events for the month | Must be submitted before the NADC file consolidation at 5.00 pm on the 14th day of the following month, or the preceding working day if the 14th falls on a weekend or public holiday when data must be complete – that is, zero rejections |

Funded organisations must meet the following minimum requirements:

* Funded organisations must make at least one submission for the reference month, by no later than 5.00 pm on the 10th day of the month following the reference month.
* All errors are to be corrected in time for the NADC file consolidation at 5.00 pm on the 14th day of the month following the reference month. Complete data for the month is expected to be transmitted by the 14th day.

Data for the financial year must be completed in time for the NADC file consolidation on 24 August. Any final corrections must be received before the NADC database is finalised on 24 August 2025.

It is the funded organisation’s responsibility to ensure the department receives the data in time to meet the processing schedule detailed above, regardless of the actual day of the week.

Penalties and exemptions for penalties are in line with the VINAH minimum dataset.

### AIMS

Health services will provide AIMS data to the department electronically via the HealthCollect web portal, and in accordance with the timelines specified in the AIMS manual.

The data collections within AIMS have different due dates and reporting intervals, as documented in the AIMS manual. AIMS data submissions are made through the [HealthCollect portal](https://www.healthcollect.vic.gov.au/desktopdefault.aspx?ReturnUrl=%2f)[[19]](#footnote-20) <https://www.healthcollect.vic.gov.au>.

#### Penalties for noncompliance

If health services are noncompliant with these timelines, the department may apply a penalty of up to $5,000 for each return that is not submitted by the due date specified in the AIMS manual.

Organisations seeking exemption from penalties for late data must email the HDSS help desk <hdss.helpdesk@health.vic.gov.au>, advising of the issues experienced, the organisation’s plan for overcoming the issues and the expected submission date.

For more information, visit [AIMS](https://www.health.vic.gov.au/data-reporting/agency-information-management-system-aims) <https://www.health.vic.gov.au/data-reporting/agency-information-management-system-aims>.

### VCDC

Victorian public hospitals are required to report costs for all hospital activity, regardless of funding source, and are expected to maintain patient-level costing systems that monitor service provision to patients and determine accurate patient-level costs.

Victorian health services are required to adhere, where possible, to the Australian Hospital Patient Costing Standards (v 4.2) (or the most recent version, in the instance that a successor becomes available), in conjunction with VCDC documentation, guidelines, specifications and business rules, and any other guidance provided by the department in the coming year.

#### Format and scope

The cost data submission to the department must comply with the VCDC file specifications and reporting requirements. For more information, visit [VCDC Reporting requirements, data specifications, business rules and guidelines](https://www.health.vic.gov.au/publications/vcdc-reporting-requirements-data-specifications-business-rules-and-guidelines) <https://www.health.vic.gov.au/publications/vcdc-reporting-requirements-data-specifications-business-rules-and-guidelines>.

The cost data submitted should be quality assured and cover all areas of hospital activity undertaken by the health service, including (but not limited to) four broad categories of:

* admitted – a patient who undergoes a hospital's admission process to receive treatment and/or care. This treatment and/or care is provided over a period of time, and can occur in hospital and/or in the person's home (for HITH patients), and include acute, subacute and mental health
* emergency – a dedicated area in a hospital that is organised and administered to provide emergency care (including reception, triage, initial assessment and management) to people who perceive the need for, or are in need of, acute or urgent care
* non-admitted – a patient who does not undergo a hospital’s formal admission process. There are several categories of non-admitted patient: emergency department, outpatient, subacute and other non-admitted patient (treated by hospital employees off the hospital site, which includes community/outreach services)
* specialist clinical mental health – a dedicated area in a hospital that delivers a range of hospital and community-based clinical mental health services. This includes both admitted and non-admitted (community) patients.

The National Health Reform Agreement specifies that these areas are activity-base funded and cost data is required from all these services to support development of national weights.

#### Reconciliation and data integrity

Health services are expected to:

* audit and reconcile their data before, during and after the allocation of their patients’ costs
* examine and review their current cost data for completeness across all services
* conduct data quality assurance of their data that provides a level of understanding of the usefulness of the patient-level data for development of funding models, and interpretation for analysis and reporting.

#### Submission and timeframes

The VCDC submission involves a five-phase process to ensure the data submitted meets the requirements specified in the documentation.

The five phases include:

* phase 1 – receipt of a submission
* phase 2 – file validations
* phase 3 – linking/matching VCDC to activity
* phase 4 – data quality assurance checks
* phase 5 – receipt of a reconciliation report and data quality statement.

Health services reporting VCDC data will be required to adhere to the minimum submission timelines in Table 8.

Health services may submit more frequently than the minimum standards in the table.

Table 8: VCDC actions and reporting timelines

| Actions | Date |
| --- | --- |
| VCDC Secure Data Exchange portal open | 23 September |
| First submission of files to VCDC – phase 1 | 23 October |
| Following provision of report(s) – complete phase 2 and phase 3 | Within five weeks |
| Following provision of report(s) – complete phase 4 | Within four weeks |
| Following final file – submission of reconciliation report and data quality statement | Within one week |
| Department of Health to consolidate Victorian cost database | 15 January |

#### Penalties for noncompliance

Health services will be assessed to have complied with the department’s data requirements if they have:

* provided the data required as specified in the data request
* provided the data in the timeframes requested.

If a health service does not meet both these requirements, they will be regarded as being noncompliant. However, where health services are experiencing issues complying with the above timeframes, they are to inform the department via an email to VCDC assist before the submission is required. In this instance, the department’s VCDC Team will work with the health service to improve the data submission process over time.

Where health services are noncompliant with the format or timelines specified above, the department may apply penalties that include:

* up to $20,000 per month, if cost data is not submitted by the timeline specified
* up to $2,000 per episode, if there are a significant number of episodes that do not meet the VCDC business rules.

#### Exemptions from penalties

If difficulties are anticipated in meeting the relevant data transmission timeframes, the health service must contact the department, indicating the nature of the difficulties, remedial action being taken and the expected transmission schedule.

#### Software upgrades and migrations

Health services undertaking software migrations must undertake VCDC data submission testing prior to resuming live VCDC data transmissions. Health services must ensure their VCDC is transmitted by the due date. They should ensure software updates and migrations do not prevent complete VCDC transmissions by this date.

### VPDC

Health services where births occur (or the midwife or medical practitioner who attends a birth that does not occur in a health service) are required to report information about the birth, in the form approved by the CCOPMM, being the data custodians), for inclusion in the VPDC. Refer to section 29.1.15: Consultative councils reporting requirements.

Under the Public Health and Wellbeing Regulations 2019, VPDC data is to be submitted within 30 days of the birth, unless otherwise specified by the CCOPMM.

The VPDC is a population-based surveillance system for collecting and analysing comprehensive information on, and in relation to, the health of mothers and babies, to contribute to improvements in their health outcomes. It contains information on obstetric conditions, procedures and complications, birth outcomes, neonatal morbidity, congenital anomalies and a range of other details, and must be reported for every birth in Victoria. The definition of a birth for this purpose means a birth or stillbirth that is required to be registered under the *Births, Deaths and Marriages Registration Act 1996*.

For the VPDC manual, including data definitions, business rules and submission guidelines, visit the [VPDC](https://www.health.vic.gov.au/quality-safety-service/victorian-perinatal-data-collection) <https://www.health.vic.gov.au/quality-safety-service/victorian-perinatal-data-collection>

### Victorian Health Incident Management System minimum dataset

The department, in consultation with Safer Care Victoria, administers the Victorian Health Incident Management System minimum dataset (VHIMS MDS). The VHIMS MDS is a standardised dataset for the collection and classification of clinical, occupational health and safety incidents (also known as adverse events), near misses and hazards.

The VHIMS MDS is subject to the department’s annual review and change cycle. All Victorian public health services and registered community health services, and services under their governance structures, are required to report data to the VHIMS 2 MDS, in accordance with the current [VHIMS Data Manual](https://www.health.vic.gov.au/publications/victorian-health-incident-management-system-minimum-dataset) <https://www.health.vic.gov.au/publications/victorian-health-incident-management-system-minimum-dataset>.

Implementation of the 2024–25 MDS has been delayed. Health services are required to commence reporting the 2024–25 MDS by 1 April 2025, or earlier at their discretion. Prior to 1 April 2025, health service may continue to report in accordance with the *VHIMS data manual 2023–24*.

Health services are no longer able to submit the VHIMS interim dataset.

For more information about the VHIMS MDS visit the [Victorian Health Incident Management System](https://vahi.vic.gov.au/ourwork/analysis-and-insights/safety-and-surveillance-reporting). <https://vahi.vic.gov.au/ourwork/analysis-and-insights/safety-and-surveillance-reporting>.

#### Near-real-time reporting

The department and Safer Care Victoria require near-real-time incident data to support monitoring and surveillance activities, including timely identification of new and emerging patient and workforce safety risks.

In-scope health services are required to submit all new and updated incidents to the department daily, via the VHIMS Central Solution or the VHIMS Application Programming Interface. Reports identify where gaps in data submission exist, including noncompliant health services.

In 2024−25, registered community health services are exempt from near real-time reporting requirements. These services are required to submit all closed incidents to the department weekly, with the transition to near real-time reporting expected from 1 July 2025. Registered community health services may choose to implement near-real-time reporting prior to 1 July 2025 at their discretion.

#### Penalties for noncompliance

No penalties for late data submission of the VHIMS MDS will apply in 2024–25. However, health services are advised that the department may apply late data penalties from 1 July 2025. Further details about late data penalties will be available in the *Policy and funding guidelines* 2025–26.

### Better Patient Dataset

The Better Patient Dataset contains a core set of demographic information about every patient who has been treated in a Victorian health service. Regular updates of the Better Patient Dataset are essential for optimum health services’ planning, policy formulation, program evaluation and epidemiological research.

Health services will provide the Better Patient Dataset to the department electronically for each month, in accordance with departmental specifications, by the 10th day of the following month, or as otherwise requested by the department due to changed circumstances.

#### Penalties for noncompliance

If health services are noncompliant with these timelines, the department may apply a penalty of up to $3,800 for each return that is not submitted by the due date specified above.

Organisations seeking exemption from penalties for late data must write to the Specialist Manager, Centre for Victorian Data Linkage advising of the issues experienced, the organisation’s plan for overcoming the issues and the expected submission date.

### VICNISS

Safer Care Victoria receives infection surveillance reports from health services via the VICNISS coordinating centre. All public health services are required to participate in the VICNISS healthcare-associated infections surveillance program. The size of the health service and type of services provided will determine the mandatory reporting requirements.

The reporting requirements for individual health services indicators are listed in Part B of the SOP. They include:

* surgical site infections following hip and knee arthroplasty, coronary artery bypass graft surgery, colorectal surgery and caesarean section
* intensive care unit central line-associated blood stream infections
* hand hygiene compliance rates
* Staphylococcus aureus bacteraemia.

Further infection surveillance activities can be undertaken by health services on a voluntary, as needs basis. Health services with a statistically significant higher rate than the aggregate are notified, and requested to provide information on actions that are being taken to reduce this rate. Continued occurrence of higher-than-expected results may lead to a formal outlier review process by Safer Care Victoria.

A limited number of healthcare-associated infections performance indicators are reported publicly on the [Victorian Health Services Performance website](https://vahi.vic.gov.au/reports/victorian-health-services-performance) <https://vahi.vic.gov.au/reports/victorian-health-services-performance>.

Rates for Staphylococcus aureus bacteraemia and compliance with the National Hand Hygiene Initiative guidelines are publicly reported on the [MyHospitals website](https://www.aihw.gov.au/reports-data/myhospitals) <https://www.aihw.gov.au/reports-data/myhospitals>.

### Victorian State Trauma Registry

All public health services, including the three designated major trauma services, must participate in the Victorian State Trauma Registry (VSTR). The key requirement is the delivery of trauma data, in the form requested by the registry, to the registry on time. The department contracts the VSTR to collect data on major trauma patients from health services.

The performance and effectiveness of the Victorian State Trauma System is monitored via the registry. The failure to deliver data on time affects the governance of the Victorian State Trauma System and the ability of the registry to deliver reports to health services. State aggregate data is reported every year in the VSTR summary report.

To access these reports, visit the [VSTR](https://www.health.vic.gov.au/patient-care/victorian-state-trauma-registry) <https://www.health.vic.gov.au/patient-care/victorian-state-trauma-registry>.

### Victorian Audit of Surgical Mortality

The Victorian Audit of Surgical Mortality is a peer-review audit of deaths associated with surgical care, which is undertaken through the Royal Australasian College of Surgeons Victorian Office. Surgeon participation in the audit is a requirement of the college’s continuing professional development program. It is funded by the department and Safer Care Victoria is the contact manager.

The audit strengthens relationships with the department as a recommendation of [Targeting zero: the review of hospital safety and quality assurance in Victoria](https://www.health.vic.gov.au/publications/targeting-zero-the-review-of-hospital-safety-and-quality-assurance-in-victoria) <https://www.health.vic.gov.au/publications/targeting-zero-the-review-of-hospital-safety-and-quality-assurance-in-victoria>. The formation of the Perioperative Mortality Committee has further strengthened information-sharing arrangements with the Victorian Perioperative Consultative Council (VPCC) being included in Commonwealth Qualified Privilege legislation.

Two ministerial advisory councils, VPCC and CCOPMM, were established to monitor, analyse, review, investigate and report on matters on specialised areas within health care, to identify preventable harm, and reduce mortality and morbidity. Please refer to section 18.5 for perinatal services performance indicators.

The councils make recommendations to help health services and clinicians improve clinical practice and systems of care, using their annual reports to detail the councils’ research and activities. The councils also directly advise the Minister for Health, the department and Safer Care Victoria on strategies to improve clinical performance and avoid preventable harm.

### Consultative councils reporting requirements

#### Victorian Perioperative Consultative Council (VPCC)

The VPCC oversees, reviews and monitors perioperative care in Victoria. Health services and clinicians report adverse events (including death) that may occur prior to, during or following surgery, to the VPCC. For further details please refer to the [VPCC website](https://www.safercare.vic.gov.au/about/vpcc) <https://www.safercare.vic.gov.au/about/vpcc>.

#### Consultative Council on Obstetric and Paediatric Mortality and Morbidity

The CCOPMM considers, investigates and reports on obstetric and paediatric mortality and morbidity in Victoria. The CCOPMM is also responsible for the:

* Victorian Perinatal Data Collection (VPDC), a population-based surveillance system that collects and analyses information on the health of mothers and babies during the birth episode. Refer to section 28.7 for data collection changes
* Victorian Congenital Anomalies Register, which is a surveillance system for congenital anomalies in Victoria.

CCOPMM reviews and identifies preventable harm for these mortality and morbidity cases. It must report any preventable harm identified in its review process to the Secretary of the department and the chief executive officer of Safer Care Victoria. For further details please refer to the [CCOPMM website](https://www.safercare.vic.gov.au/councils/CCOPMM) <https://www.safercare.vic.gov.au/councils/CCOPMM>.

### Cardiac Surgery Registry

The Cardiac Surgery Database Project is coordinated by Monash University’s School of Public Health and Preventive Medicine. Safer Care Victoria expects all Victorian public health services that perform cardiac surgery to participate. This project is an initiative of the Australian and New Zealand Society of Cardiac and Thoracic Surgeons (ANZSCTS) and is overseen by the ANZSCTS Cardiac Surgery Database Steering Committee.

The Cardiac Surgery Database Project includes maintaining a comprehensive clinical registry, statistical analysis and report generation. These components enable a structured peer-review process that can identify variation in performance at the practitioner and health service levels. The funding arrangements for this registry, outlined in a contract managed by eHealth, stipulate that quarterly reports of summarised data are submitted to Safer Care Victoria and/or the department.

The Cardiac Surgery Database Project is a part of this extensive effort to leverage clinical registries for benchmarking and quality improvement in healthcare at both national and jurisdictional levels. Data in these reports are received with Victorian public health services identified by name, to better support and strategically guide statewide quality improvement activity and service planning. Registry data are also received for linkage to inform the development of statewide quality and safety indicators.

For more detailed information, including annual reports and specific contact details for inquiries, please refer to the resources provided by Monash University's School of Public Health and Preventive Medicine, accessible at the [Monash Clinical Registries website](https://www.monash.edu/medicine/sphpm/registries) <https://www.monash.edu/medicine/sphpm/registries>. Additionally, detailed data and insights are available through [the Australian and New Zealand Society of Cardiac and Thoracic Surgeons (ANZSCTS) official website](https://anzscts.org/database/about/) <https://anzscts.org/database/about/>.

### Victorian Cardiac Outcomes Registry

The department has supported the development and implementation of a cardiac outcomes registry that aims to help improve the safety and quality of health care provided to cardiovascular patients in Victoria. All Victorian public health services that perform percutaneous coronary interventions must provide this data to the Victorian Cardiac Outcomes Registry (VCOR).

This registry is coordinated by Monash University’s School of Public Health and Preventive Medicine. It has the support of the Cardiac Society of Australia and New Zealand. The funding arrangements for this registry, outlined in a contract managed between the department and VCOR, stipulate that quarterly reports of summarised data are submitted to Safer Care Victoria and/or the department.

Data in these reports are received with Victorian public health services identified by name to better support and strategically guide statewide quality improvement activity and service planning. Registry data are also received for linkage to inform the development of statewide quality and safety indicators.

### Australian Stroke Clinical Registry

The Australian Stroke Clinical Registry (AuSCR) is a collaborative national effort to monitor, promote and improve the quality of acute stroke care. It is a prospective, multicentre, observational outcomes database that is designed to collect data on the demographics, presentation, diagnosis, treatment and outcomes of hospitalised patients with stroke. Safer Care Victoria promotes the implementation of the registry at all metropolitan and regional stroke units.

The registry funding arrangements, outlined in a contract managed between the department and AuSCR by VAHI, stipulate that biannual reports of summarised data are submitted to Safer Care Victoria and/or the department.

Data in these reports are received, with Victorian public health services identified by name, to better support and strategically guide statewide quality improvement activity and service planning. Registry data are also received for linkage to inform the development of statewide quality and safety indicators.

### Radiotherapy services reporting

Radiotherapy providers must report monthly to:

* the Victorian Radiotherapy Minimum Dataset
* AIMS form S8 for consultations only
* AIMS form S10
* the VINAH minimum dataset or the NADC for patient-level reporting.

The department contributes data from the Victorian Radiotherapy Minimum Dataset to other agencies, as required. The data is included in the Victorian Cancer Registry’s annual cancer incidence report and the quarterly PRISM report. The PRISM report presents waiting times at providers of public radiotherapy and forms part of reporting to the relevant health service.

### Renal dialysis reporting

All health services that provide facility dialysis must report public and private admitted activity at the unit record level to the VAED. This includes activity in all facilities.

Health services are required to report episode-level activity to the VINAH minimum data set for all patients enrolled in the home-based dialysis program.

### VHES

The existing agreement with Ipsos Public Affairs to deliver the VHES program has been continued for 2024−25. The department will continue to oversee the implementation of the contract requirements, and work with Safer Care Victoria analyse and report healthcare experience data to inform actionable, quality and safety improvements.

Health service upload procedures are outlined below.

#### Upload procedures

For continuous surveys, health services must upload contact details of eligible consumers to the contractor by the fifteenth of the month following discharge. This upload includes the service received, which determines the type of questionnaire sent.

For the annual ambulance services surveys (planned and emergency), the nominated health service must upload contact details of eligible patients for the two months nominated for survey collection.

For the annual palliative care and specialist clinic survey, health services must provide consumer contact details, in line with the VHES data upload manual.

In 2024−25, the mental health annual Your Experience of Service Survey is anticipated to continue as a hybrid model comprising an in-situ paper-based survey with open digital links available for patients to complete the survey online. The Carer Experience of Service Survey will require nominated health services to upload contact details of eligible patients for the survey collection period.

Data transfers occur in a secure online environment through the [Project Control Portal](https://www.vhes.com.au/Account/Login?ReturnUrl=%2f) <https://www.vhes.com.au/Account/Login?ReturnUrl=%2f>. The portal provides access to the *Data upload manual* and the template required for submission.

Quarterly reports are available online at [VHES results](https://results.vhes.com.au) <https://results.vhes.com.au>. These results are currently only available to registered health services and departmental staff.

## Data integrity

Accurate data is important for funding purposes, performance monitoring, reporting, policy development and planning, and for maintaining public confidence in the health system.

Health service boards of management are accountable for the accuracy of reported data. Boards are expected to make data integrity the responsibility of their audit committee and ensure that data accuracy is subject to appropriate controls, including regular internal audits.

Health services are required to:

* maintain board and board audit committee scrutiny of data integrity practices
* continue with implementation of security improvements for all health service systems where data is collected and stored, including implementation of unique user identity and password controls, and routinely reviewing ICT system transaction logs
* implement recommendations from audits conducted at their health services
* provide a data quality attestation in the health service’s annual report.

Health services should refer to the [*Data integrity guidelines for health services 2018*](https://vahi.vic.gov.au/ourwork/health-data-integrity-program/data-integrity-guidelines-health-services) <https://vahi.vic.gov.au/ourwork/health-data-integrity-program/data-integrity-guidelines-health-services>. These provide guidance for health services to ensure the integrity of data reported. Importantly, they also assist health services to meet the requirements for integrity in the data provided by them when reporting their activity and performance.

The Health Data Integrity Program will continue in 2024–25, incorporating the same core health data collections previously subject to regular review, including the:

* VAED
* ESIS
* VEMD
* VCDC
* VINAH minimum data set
* Admitted Subacute Care data reported to VAED.

The program is led by the Health Data Integrity Unit in eHealth and comprises a mixture of formal audits of core datasets based on established audit protocols.

The program ensures that health data collections accurately reflect health service policy intent, service provision and the care that was provided to consumers.

The program seeks to increase confidence in the accuracy of health services’ data by:

* reviewing data recording and reporting practices, and health service compliance with department policies and business rules
* monitoring, reporting on and strengthening internal controls used in health services
* monitoring, detecting, reporting on and mitigating the risks and consequences of inaccurate health data
* providing stakeholders with an accurate picture of the strengths, weaknesses and threats related to health data integrity, and recommending opportunities to improve it.

The Health Data Integrity Program may be expanded to additional health service data collections, based on stakeholder priorities and analytics.

The Health Data Integrity unit has also developed a monitoring and analytical system, comprising several reports across these datasets to monitor changes in data through a targeted approach, based on data analytics and risk assessment. It is anticipated that where potential data integrity issues are flagged, the unit will continue to consult with the relevant health services on these issues.

Health services are expected to actively participate in the program, including reviewing reports on findings and recommendations. Unresolved issues that warrant escalation may be referred for further consideration, as part of the health service performance monitoring process.

### System updates

The VAED, VEMD, ESIS, VINAH, NADC, VCDC, AIMS and VPDC data collections are reviewed annually to ensure they are relevant for performance monitoring against current operational priorities, as well as to provide up-to-date indicators of ongoing clinical activity trends.

The department remains committed to balancing the resources required to collect and report data against the need for quality data for monitoring, planning and fulfilment of the department’s own reporting obligations. These aims are achieved through various consultative committees and reference groups, for specific data collections and feedback received through specific departmental program areas and Safer Care Victoria.

Proposed changes to data collections are released for comment, and specifications for change are distributed by 31 December and published by 15 January, prior to the financial year to which they apply, to give health services sufficient time to plan and implement the specified changes.

The HDSS bulletin provides advice on data quality issues to health services that contribute to the VAED, VEMD, ESIS, VINAH minimum data set, NADC and AIMS. The bulletin is the primary method by which amendments to standards and reporting timelines for these data collections are published during the year. Updates to VPDC reporting are directed to health service stakeholders by email and relevant documents published on the [VPDC website](https://www.health.vic.gov.au/quality-safety-service/victorian-perinatal-data-collection) <https://www.health.vic.gov.au/quality-safety-service/victorian-perinatal-data-collection>.

Health services should ensure that appropriate staff subscribe to the HDSS bulletin to remain up to date with any changes. The HDSS bulletin is issued electronically via both web and email. It is provided at no charge. Subscriptions may be arranged by visiting [HDSS Subscribe](https://www.health.vic.gov.au/data-reporting/subscribe) <https://www.health.vic.gov.au/data-reporting/subscribe> or emailing the HDSS helpdesk <HDSS.Helpdesk@health.vic.gov.au>. Changes of contacts for the VPDC should be emailed to the HDSS Helpdesk.

### Penalties for noncompliance

If health services are noncompliant with the timelines specified in these guidelines, penalties may apply. Refer to the relevant dataset for more information.

## Subacute data reporting requirements

For all subacute program data reporting requirements, refer to section 18.2: Subacute and non-acute care.

## Ambulance Victoria data reporting requirements

Ambulance Victoria will continue to submit the Victorian Ambulance Dataset (VADS) data monthly, according to the timelines specified in Table 9.

Until both the department and Ambulance Victoria confirm the accuracy of VADS data for the purposes of public reporting and performance monitoring, Ambulance Victoria will be required to continue aggregate Ambulance Minimum Dataset reporting, as specified in Table 9.

Table 9: Ambulance Victoria data reporting and timelines

| Data reported | Description and submission timeline |
| --- | --- |
| VADS – Request for service and response data | Year-to-date submission to VADS to be received by the 10th day of the month following the case date |
| VADS – Transport and patient data | Year-to-date submission to VADS to be received by the 10th day of the 2nd month following the case date |
| Aggregate Ambulance Minimum Dataset | Indicators identified in Table 16 will be supplied to the department in spreadsheet format by the 10th day of the month following the monthly reporting period |
| All data submissions for the 2023–24 financial year | Year-to-date submission must be received before final consolidation of the VADS on 10 August 2024 |

## Mental health services data reporting requirements

Information about clinical mental health services that is relevant to funding, activity and performance monitoring is collected by the department through a range of channels, including:

* the CMI/ODS, which captures service activity data and aspects of mental health care required under the *Mental Health and Wellbeing Act 2022*
* the mental health Triage Minimum Dataset
* reportable deaths and other notifications to the Chief Psychiatrist
* the annual Mental Health Establishments collection
* quarterly data collection (MHCSS reporting)
* a quarterly MHCSS aggregate spreadsheet report
* a monthly Mental Health and Wellbeing Locals aggregate collection
* the VAED (see section 28.1: VAED)
* the VEMD (see section 28.4: VEMD).

The collections underpin public accountability for service provision, quality and safety, with the outputs contributing to a range of national datasets, and performance measurement and monitoring for Commonwealth, state and departmental purposes.

For mental health data and performance reporting, visit [VAHI’s Mental health](https://vahi.vic.gov.au/reports/victorian-health-services-performance/mental-health) page <https://vahi.vic.gov.au/reports/victorian-health-services-performance/mental-health> and the [Mental health performance reports](https://www.health.vic.gov.au/research-and-reporting/mental-health-performance-reports) <https://www.health.vic.gov.au/research-and-reporting/mental-health-performance-reports>.

### CMI/ODS

The statewide ODS is simultaneously updated from local CMI systems as data is captured, providing a live, 24-hour, 7-day statewide view of the transactional history of mental health services.

Health services are expected to use the CMI/ODS to record clinical mental health activity, to ensure statewide visibility of consumer care across all designated mental health services. Data entry timeframes differ, according to the type of data being recorded (see Table 10 for details).

Table 10: CMI/ODS reporting timelines

| Data entry | Rationale | Due date |
| --- | --- | --- |
| Compulsory order/legal status | Timely information regarding compulsory/forensic/security client status | Twice daily, 7 days per week |
| Admissions, transfers and separations  | Statutory reportingMaintenance of statewide bed register | Twice daily, 7 days per week  |
| Client registration and episode creation | Informational continuity of care | Daily, within 24 hours following mental state assessment |
| Contacts | Statutory reporting | On 10th of the month following the contact |
| Outcome measures | Statutory reporting | On 10th of the month following the measure collection  |
| Electroconvulsive therapy procedures | Statutory reporting | As soon as practicably possible |
| Seclusion and restraint | Statutory reporting | On 10th of the month following the period of seclusion/restraint |
| Diagnosis | Statutory reporting | Inpatients: On t10th of the month following the diagnosis event |

Departmental circulars and bulletins detail the business rules for key data requirements and guidelines for data recording practices.

Business rules for data recording can be found under CMI/ODS under the heading of Data Quality at [Reporting requirements and business rules for clinical mental health services](https://www.health.vic.gov.au/research-and-reporting/reporting-requirements-and-business-rules-for-clinical-mental-health) <https://www.health.vic.gov.au/research-and-reporting/reporting-requirements-and-business-rules-for-clinical-mental-health>, as well as mental health bulletins and program management circulars.

Regular meetings are held with hospital mental health system administrators to discuss system and data issues. Regular system upgrades are performed to improve the functionality and utility of the system and data.

#### Data integrity

Services must review and reconcile data quality issues identified by the department and provide return advice on a quarterly basis. Validation reports are updated monthly.

Quarterly returns are to be submitted by:

* July–September: last business day of November
* October–December: last business day of February
* January–March: last business day of May
* April–June: last business day of August.

Outstanding validation issues for the 2023–24 financial year must be reconciled by 30 November 2024. Selected health services may be subject to audits of their mental health service hours reported via the CMI/ODS.

#### Electroconvulsive therapy

The Chief Psychiatrist requires that all occasions of electroconvulsive therapy (ECT) be reported to the Office of the Chief Psychiatrist. All ECT course details and procedures are to be recorded on the CMI/ODS, as soon as practicably possible after each procedure.

### National Mental Health Establishments Database

The National Mental Health Establishments Database collection captures all mental health workforce data and expenditure. It is compiled to meet the Mental health services annual report and national mental health reporting requirements.

The data collection for the previous financial year begins in October each year, with health services, residential service providers and departmental divisions required to submit a return.

As has been the practice in previous years, the Mental Health Establishments collection for 2022–23 will be pre-populated with health service activity data from the CMI/ODS when available. This information is subject to health service review and amendment as required.

For more information, visit [HealthCollect](https://www.healthcollect.vic.gov.au)[[20]](#footnote-21) <https://www.healthcollect.vic.gov.au>.

Reporting timelines for the Mental Health Establishments collection are outlined in Table 11.

Table 11: Mental Health Establishments collection reporting timelines

| Collection period | Reporting requirements | Due date |
| --- | --- | --- |
| 2022–23 | Stage 2: Resolution of any final issues and any additional clarification required for the Australian Institute of Health and Welfare for 2022–23. Validations and questions sent to health services must be finalised by end of July 2024 | 26 July 2024 |
| 2023–24 | New financial year data submission opens through the HealthCollect portal and remains open for one month. Data entry by health services is to be finalised by end of October 2024, when the portal will close | 25 October 2024 |
| 2023–24 | Stage 1 Validations: Resolution of services’ initial validation issues arising from the HealthCollect portal data submission | 28 February 2025 |
| 2023–24 | Stage 2: Resolution of any final issues and any additional clarification required for the Australian Institute of Health and Welfare. Validations and questions sent to health services must be finalised by end of July 2025 | 25 July 2025 |

### Mental health triage minimum dataset

Triage minimum dataset submissions are to be provided in the prescribed format on a monthly basis by the fifteenth of each month. The data file must be sent to triage minimum dataset <triagemds@health.vic.gov.au> submitted via the Managed File Transfer (MFT) portal. Documentation detailing the format and reporting requirements can be found at [Mental health triage service](https://www.health.vic.gov.au/practice-and-service-quality/mental-health-triage-service) <https://www.health.vic.gov.au/practice-and-service-quality/mental-health-triage-service>.

### MHCSS

Agencies funded to deliver MHCSS activity are expected to provide data quarterly. Compliance with these reporting requirements is a key accountability requirement to be used as part of the ongoing review and monitoring processes.

Quarterly Data Collection data must be submitted by the 7th of the month following the end of the quarter by emailing MHCSS <mhcss@health.vic.gov.au>.

The supplementary MHCSS Excel spreadsheet is an aggregate data collection. It must be submitted by the 15th of the month following the end of the quarter. The file must be submitted via the MHCSS data email <mhcssdata@health.vic.gov.au>.

#### Mental Health and Wellbeing Locals

Currently, providers of Mental Health and Wellbeing Locals are required to collect and report aggregate data, submitted to the department using the HealthCollect online platform. The submission of aggregate data is a requirement of funding. Monthly data is to be submitted by the fifteenth day of the following month.

Recommendation 62 of the Royal Commission into Victoria’s Mental Health System recommended that the Victorian Government develop, find and implement modern infrastructure for ICT systems including a statewide mental health and wellbeing record (see section 24.2.1: Contemporary information architecture for mental health and wellbeing). The department is working with providers of mental health and wellbeing services to develop and implement these systems and Mental Health and Wellbeing Locals will be required to work with the department in support of this work.

#### Reportable deaths

All clinical mental health service providers, including specialist mental health services in custodial settings, must report deaths to the Chief Psychiatrist.

#### Deaths on mental health inpatient units

Any inpatient death at a designated mental health service or a bed-based mental health unit in a custodial setting is to be reported, regardless of legal status, cause or location of death. Notifications can be made by telephone 1300 767 299, or by emailing the Office of the Chief Psychiatrist <ocp@health.vic.gov.au>.

For the purposes of this policy, an inpatient is defined by the Chief Psychiatrist as any person, regardless of legal status, who:

* has been admitted to a mental health inpatient unit
* is on approved leave from an inpatient unit
* has absconded from an inpatient unit
* has been transferred to a non-psychiatric ward during a mental health admission
* has been discharged from a mental health inpatient unit within the previous 24 hours.

#### Non-inpatient and non-compulsory consumer deaths

The Chief Psychiatrist requires all unexpected, unnatural or violent deaths (including suspected suicides) to be reported if:

* a person was assessed by a clinical mental health service provider and was not provided with treatment, or
* a person sought clinical mental health services from a mental health provider and was not provided with mental health services.

People are considered to be mental health consumers until their case is closed and they have been notified of this closure, or the service has made all reasonable efforts to do so.

Designated mental health services and MHCSS must notify the Chief Psychiatrist of a consumer’s death using the MHWA 125 ‘Notice of death’ form.

Victorian public health and community service organisations that provide services on behalf of the department (such as MHCSS), and report patient, resident or client safety incidents through VHIMS, are subject to the overarching [Policy: Adverse patient safety events](https://www.safercare.vic.gov.au/publications/policy-adverse-patient-safety-events) <https://www.bettersafercare.vic.gov.au/publications/policy-adverse-patient-safety-events> and supporting framework.

Community organisations that provide services on behalf of the department and do not report incidents through VHIMS are still subject to the department’s incident reporting instruction. The reporting instruction can be found at [Incident reporting](https://fac.dffh.vic.gov.au/incident-reporting) <https://fac.dffh.vic.gov.au/incident-reporting>. The accompanying incident report form can be found at [Incident report form](https://fac.dffh.vic.gov.au/incident-report-form-complete-hand) <https://fac.dffh.vic.gov.au/incident-report-form-complete-hand>.

For more information on what is meant by ‘reportable deaths’ and the procedures for reporting them, see the [Chief Psychiatrist’s reporting directive on reportable deaths](https://www.health.vic.gov.au/chief-psychiatrist/reportable-deaths-mental-health-and-wellbeing-act-2022) <https://www.health.vic.gov.au/chief-psychiatrist/reportable-deaths-mental-health-and-wellbeing-act-2022>.

#### Sentinel event reporting of suicides

Suspected suicide or serious self-harm within a healthcare setting is categorised as a sentinel event (that is, unexpected healthcare incidents that result in death or serious disability) and should be notified to Safer Care Victoria’s Sentinel event program. This includes suicides on mental health inpatient units, as well as those in other health settings, such as acute, subacute or rehabilitation services, or compulsory clients while on approved or non-approved leave.

For more information, visit [Sentinel events](https://www.safercare.vic.gov.au/notify-us/sentinel-events) <https://www.bettersafercare.vic.gov.au/notify-us/sentinel-events>.[[21]](#footnote-22)

#### Restrictive interventions reporting (seclusion, bodily restraint or chemical restraint)

The *Mental Health and Wellbeing Act 2022* regulates the use of restrictive interventions. Part 3.7 of the Act outlines when restrictive interventions can be used, who can authorise them and the monitoring of restrictive interventions when used. Section 3 of the Act defines a ‘restrictive intervention’ as ‘seclusion, bodily restraint or chemical restraint’. Chemical restraint is newly defined in the Act; its regulation commenced on 1 September 2023.

All restrictive interventions must be reported to the Chief Psychiatrist.

In accordance with the *Mental Health and Wellbeing Act 2022* and the [Chief Psychiatrist’s guideline for restrictive interventions](https://www.health.vic.gov.au/key-staff/reducing-restrictive-interventions) <https://www.health.vic.gov.au/key-staff/reducing-restrictive-interventions>, an authorised psychiatrist must give a written report to the Chief Psychiatrist on the use of any restrictive intervention (s. 118 of the Act). This report must contain the details required by the Chief Psychiatrist and be given to the Chief Psychiatrist within the time stipulated (s. 118 of the Act).

In practice, restrictive interventions are recorded contemporaneously into the CMI database, with each designated mental health service submitting collated data on restrictive interventions from the previous month via the Office of the Chief Psychiatrist [SharePoint portal](https://dhhsvicgovau.sharepoint.com/sites/OCP) <https://dhhsvicgovau.sharepoint.com/sites/OCP>. The submission of this data must be completed by the 10th of each month.

Restrictive interventions must also be reported to the Chief Psychiatrist when they are used on people receiving a mental health and wellbeing service in the emergency departments and urgent care centres of designated mental health services and when they are used on people who are receiving compulsory treatment under the Mental Health and Wellbeing Act. All restrictive interventions must be recorded and reported, regardless of the person’s/patient’s status under the Mental Health and Wellbeing Act.

Services are obligated to provide appropriate information to persons subjected to restrictive interventions about their rights, including post-intervention support.

#### Episodes of extended seclusion

In addition to the routine monthly Seclusion Register reporting procedures,[[22]](#footnote-23) designated mental health services must provide a clinical report to the Chief Psychiatrist of any episode of seclusion that exceeds 12 hours for adults, and four hours for aged and young people under 18 years of age.

Should the episode of seclusion exceed 48 hours, it is expected that escalation processes, including case conferencing and second opinions, occur within their designated mental health service. Where an extended period of seclusion in excess of 48 hours is anticipated, it must be discussed with the authorised psychiatrist or delegate to outline strategies aimed at reducing the behaviours and avoiding the need for a restrictive intervention.

When seclusion is used for extended periods of time or on a recurrent basis, it is good clinical practice for mental health services to undertake case conferencing and a second opinion, external to the treating team, to develop a care plan that outlines strategies for behavioural change and avoiding the need for seclusion. If the seclusion episode exceeds seven consecutive days, the authorised psychiatrist or delegate must contact the Chief Psychiatrist and provide a clinical report and care plan.

#### Extended admission to a high-dependency area

Mental health services will be required to present evidence of an active case-conferencing process to assist in bringing the admission to conclusion for any admission to a high-dependency area exceeding 30 consecutive days and at any time on request thereafter.

#### Sexual safety reporting

All sexual safety incidents occurring in bed-based designated mental health services and bed-based mental health and wellbeing services in custodial settings must be reported via the [Victorian Health Incident Management System (VHIMS)](https://vahi.vic.gov.au/ourwork/analysis-and-insights/safety-and-surveillance-reporting) <https://vahi.vic.gov.au/ourwork/analysis-and-insights/safety-and-surveillance-reporting>.

The relevant services must send data collated from this reporting process to the Office of the Chief Psychiatrist on a monthly basis.

Sexual safety incidents are alleged, witnessed or suspected occurrences of sexual activity, sexual harassment and sexual assault.

Serious sexual safety incidents that are assigned an incident severity rating (ISR) of 1 or 2 through VHIMS must also be reported directly to the Office of the Chief Psychiatrist within 24 or 72 hours respectively. The Office of the Chief Psychiatrist reviews all ISR 1 and 2 incidents and works closely with services to ensure that incidents are responded to thoroughly and that risks are addressed.

While the reporting of sexual safety incidents to the Office of the Chief Psychiatrist is an important part of governance, services must also have strong local governance processes to ensure that sexual safety is addressed, prevention strategies are embedded, and risks can be eliminated.

Detailed information about reporting requirements for sexual safety is available in the [Chief Psychiatrist’s directive for sexual safety reporting](https://www.health.vic.gov.au/chief-psychiatrist/improving-sexual-safety) <https://www.health.vic.gov.au/chief-psychiatrist/improving-sexual-safety>.

Further information is available in the [Chief Psychiatrist’s guideline on improving sexual safety in mental health and wellbeing services](https://www.health.vic.gov.au/chief-psychiatrist/improving-sexual-safety) <https://www.health.vic.gov.au/chief-psychiatrist/improving-sexual-safety>.

#### ECT

##### Treatment reports

Designated mental health services must report the use of ECT to the Chief Psychiatrist. The information to be submitted includes:

* the date, name, UR number, sex and age of each person
* the names of the doctors giving the anaesthetic and ECT
* treatment laterality, pulse width and stimulus level
* a clinical outcome measure
* the nature of the consent given for treatment.

The authorised psychiatrist is responsible for ensuring reports are submitted. However, the authorised psychiatrist may designate a staff member, preferably the ECT coordinator, to undertake this function.

Reports can now be submitted online. Data must be returned within a month of treatment.

##### Adverse events

The Chief Psychiatrist must be notified about adverse events directly related to ECT that either:

* result in death (including near-misses), serious injury or serious illness
* require transfer to an ED or similar setting.

These notifications must be made using an ‘ECT serious adverse event report’ form.

Other incidents and near misses should be reported to the service’s own ECT committee and safety-monitoring bodies.

##### People under the age of 18 years

The Mental Health and Wellbeing Act regulates the use of ECT for all young people under the age of 18 years in Victoria, whether voluntary or compulsory. This includes young people in public mental health services, and private hospitals and clinics, even when the young person has given informed consent to treatment.

A psychiatrist must apply to the Mental Health Tribunal to perform a course of ECT, even if the young person provides informed consent.

The Chief Psychiatrist does not make decisions concerning treatment. However, the Chief Psychiatrist must be informed **in advance** of plans to administer ECT to a young person.

The [Electroconvulsive treatment – Chief Psychiatrist’s guideline](https://www.health.vic.gov.au/publications/chief-psychiatrists-guideline-on-electroconvulsive-treatment) <https://www.health.vic.gov.au/publications/chief-psychiatrists-guideline-on-electroconvulsive-treatment> provides guidance about the prescription and performance of ECT in Victorian public mental health services.

#### Neurosurgery for mental illness

Neurosurgery for mental illness can only be performed with the informed consent of the person and the approval of the Mental Health Tribunal.

Following treatment, the authorised psychiatrist treating the person must provide a written report to the Chief Psychiatrist, which includes a description of the treatment’s outcome within three months after the surgery is performed, and again within 12 months after the surgery is performed.

#### Reporting of incidents where there is failure to comply with the Mental Health and Wellbeing Act

The Chief Psychiatrist has statutory roles and functions under the *Mental Health and Wellbeing Act 2022* (Part 6.3). This includes providing clinical leadership to clinical mental health service providers in relation to their obligations under the Act, the regulations and any Codes of Practice (s. 267(1)(d).

Where there is a failure to comply with the Act, designated mental health services should report it to the Chief Psychiatrist. This includes incidents anywhere within designated mental health services, including emergency departments, urgent care centres and general hospital wards.

The report should be completed in writing by the authorised psychiatrist, or their delegate, within three business days. The report can be emailed to the Office of Chief Psychiatrist <ocp@health.vic.gov.au>. Where required, contact the Office of Chief Psychiatrist on 1300 767 299 for further guidance.

The report should include:

* demographic details of the consumer/s affected by the failure to comply
* circumstances of the incident, including the consumer’s legal status under the Act
* whether an open disclosure has been completed with the person and/or carers and family members, including supports provided to the person
* any remedial action to prevent a future occurrence of such incidents.

If the service becomes aware of an incident involving a failure to comply with the Act through a complaint investigation by the Mental Health and Wellbeing Commission or other authorities, it must be reported to the Chief Psychiatrist immediately.

Designated mental health services must include this reporting requirement in their local policies and procedures. They should ensure that it is communicated to all clinical staff to enable them to comply with the Act.

For more information, visit [Reporting a failure to comply with the Mental Health and Wellbeing Act 2022](https://www.health.vic.gov.au/publications/victorian-chief-psychiatrist-practice-direction-reporting-of-incidents-where-there-is) <https://www.health.vic.gov.au/publications/victorian-chief-psychiatrist-practice-direction-reporting-of-incidents-where-there-is>.

### Victorian Alcohol and Drug Collection

The Victorian Alcohol and Drug Collection (VADC) supports public accountability for service provision. Outputs contribute to the alcohol and other drug Treatment Services National Minimum Dataset, as well as performance measurement and monitoring for Commonwealth, state and departmental purposes. All alcohol and other drug treatment service providers must submit activity data via the VADC.

Alcohol and other drug treatment service providers must ensure client management systems can meet VADC reporting requirements. For details on data specifications, bulletins and the submission process, visit [VADC](https://www.health.vic.gov.au/funding-and-reporting-aod-services/victorian-alcohol-and-drug-collection-vadc) <https://www.health.vic.gov.au/funding-and-reporting-aod-services/victorian-alcohol-and-drug-collection-vadc>.

VADC data must be submitted monthly, with data due by the 15th day of the subsequent month. Data for the prior financial year must be finalised before the consolidation date of first of January.

### Needle and Syringe Program portal

The Commonwealth and the Victorian Government fund services to reduce the harms associated with alcohol and other drug use. The harm reduction services data collection records the level of activity in these services, in terms of contacts, service provision (for example, needles provided and returned, education and referrals) and responses to harm reduction questions, as well as information about the free provision of a range of injecting and safe-sex equipment, and the disposal of returned waste.

Harm reduction services data is provided by:

* needle and syringe programs
* mobile overdose response services
* mobile drug safety workers.

All primary needle and syringe program providers and recipients of *Ice Action Plan* funding must report via the Needle and Syringe Program portal. Contact alcohol and other drug enquries <AOD.enquiries@health.vic.gov.au> for further information about the portal.

### Drugs and Poisons Information System

The department operates an electronic information system known as the Drugs and Poisons Information System (DAPIS), to support its administration of the Drugs, Poisons and Controlled Substances Act 1981.

DAPIS is a standalone system. It provides the department with the ability to receive, process and record treatment permits issued to doctors prescribing Schedule 8 drugs to consumers. This includes Schedule 8 permits for opioid replacement therapy (pharmacotherapy). It also allows processing and recording of notifications of drug dependence made by prescribers, and warrants to prescribe certain Schedule 4 medicines.

The system is also used to record information collected during prescription-monitoring activities and during investigative processes. Interventions are initiated if unlawful or possibly unsafe prescribing is identified. Noncompliant health practitioners may be subject to further action, ranging from educational counselling to prosecution. Where applicable, offending is referred to AHPRA, the Veterinary Practitioners Registration Board of Victoria or Victoria Police.

DAPIS also records licences and permits issued to organisations or individuals who have a legitimate need to use, possess, manufacture or supply medicines and poisons, as part of their practice or business (such as pharmaceutical wholesalers, research, educational or industrial organisations, or health services). The information system also records the payment of fees relating to these licences and permits.

### SafeScript – Victoria’s real-time prescription monitoring system

SafeScript is computer software that allows prescription records for certain high-risk medicines to be transmitted in real time to a centralised database, which can then be accessed by medical practitioners, nurse practitioners and pharmacists, during a consultation with a consumer.

SafeScript provides practitioners and pharmacists with a clinical tool to make safer decisions about whether to prescribe or dispense a high-risk medicine. It facilitates early identification, treatment and support for consumers who are developing signs of substance-use disorder.

The data for SafeScript is collected automatically from prescription exchange services, which currently support ePrescribing, the electronic transfer of prescriptions from medical clinics to pharmacies.

When a prescription is issued at a medical clinic or dispensed at a pharmacy, the prescription exchange service sends a record of the prescription in real time to SafeScript. No additional data entry is necessary to record a prescription in SafeScript.

Authorised departmental officers may also access SafeScript as part of their regulatory role in ensuring the safe supply of medicines in the community.

It is mandatory for medical practitioners, nurse practitioners and pharmacists to take all reasonable steps to check SafeScript before prescribing or dispensing a medicine monitored in SafeScript, unless exempted under the Drugs, Poisons and Controlled Substances Regulations 2017.

SafeScript has joined the National Data Exchange, as part of a Commonwealth system established to enable data sharing between the jurisdictions. The department remains responsible for the care and control of SafeScript in Victoria.

### Opioid replacement therapy dispenser census

#### Opioid replacement therapy dispenser census

The department conducts an opioid replacement therapy dispenser census collection. It surveys all community, correctional, health service and specialist pharmacotherapy service dispensaries dosing opioid replacement therapy consumers in Victoria.

All dispensers are emailed a link to an electronic survey for completion and return. The survey collects demographical information, including details of opioid replacement therapy drug type and formulation, via a series of questions emailed and returned directly to the Pharmacotherapy Program by the dispensing agencies. Aggregated data is used for policy and planning purposes, such as identifying gaps in treatment areas for focused access improvements. Finally, it collects data of consumers who identify as Aboriginal, as at 30 June for the reporting period.

The data provides a count of consumers being dosed at a given time. This allows patterns of opioid replacement therapy access to be monitored across the state, which in turn, informs departmental sector support activities. This data is then aggregated at a national level to determine opioid replacement therapy access trends nationally.

## Public health data reporting requirements

Complete and accurate financial data on public health activity is required to be submitted via HeART (see section 29.1.1). For funding related to LPHUs, data submitted through HeART using codes relevant to funded activities will be used quarterly as a basis for performance monitoring and for whole-of-government reporting.

The department provides health services hosting an LPHU with access to systems and data. This allows a coordinated approach to data management and sharing across the networked public health system to perform public health functions, in respect of communicable diseases. Collection, analysis and reporting from these systems is used to track notifiable conditions under the Public Health and Wellbeing Act and Regulations (2019).

### Public Health Event Surveillance System

The department has licensed the Maven Enabled Disease Surveillance System, known locally as the Public Health Event Surveillance System (PHESS) for the purpose of infectious disease notification, management and analysis in Victoria.

LPHUs will accurately complete the minimum required fields on PHESS related to the case and outbreak investigation and management of notifiable conditions, as per condition-specific protocols, outbreak-specific guidelines, system-specific agreements and quick-entry guide documents.

As well as being used to monitor and manage notifiable conditions across Victoria, these data are required for statewide reporting to the National Interoperable Notifiable Diseases Surveillance System under a national agreement.

These national and jurisdictional data and reporting requirements are mandated under the *National Health Security Act 2007* (Cth) and its National Notifiable Disease List instrument, the *National Health Security Agreement* (2008) and the World Health Organization’s *International Health Regulations* (2005).

### Transmission and Response Epidemiology Victoria

The department provides LPHUs access to the Transmission and Response Epidemiology Victoria (TREVI) database system and associated systems and data to allow a coordinated approach to data management to perform public health functions, with respect to COVID-19.

LPHUs are required to accurately complete the minimum required fields on TREVI related to the case and outbreak investigation and management of COVID-19, as per pandemic-specific protocols, system-specific agreements and quick-entry guide documents.

### Public Health Operational Response Management System

The department provides access to the Public Health Operational Response Management System (PHORMS) (Noggin platform) to allow a coordinated approach to data management to perform public health functions in respect to legionellosis.

LPHUs will complete the minimum required fields on PHORMS related to the case, outbreak and cluster investigation and management of legionellosis as per the legionellosis protocol.

## Aged care data reporting requirements

Data collection requirements and timelines for ageing, aged and carer support, and aids and equipment services are provided in Table 12.

Information on performance is collected through a range of channels, including the:

* VCSS minimum dataset for the HACC–PYP and low-cost accommodation program
* Victorian aids and equipment reporting template
* HACC PYP fees data collection
* HACC PYP annual service activity reports
* residential aged care services data collection.

The Carers Recognition Act sets out obligations for councils and organisations covered by that Act, including the obligation to raise awareness and understanding of the care relationship principles, as set out in the Act. Relevant organisations must report on their compliance against these obligations in their annual report. Specific requirements can be found in ss. 5, 11 and 12 of the Act.

Table 12: Ageing, aged and home care – data collection and reporting requirements

| Activity no. | Activity name | Data collection description |
| --- | --- | --- |
| 13005 | ACAS  | Quarterly report on audit of assessments and client satisfaction |
| 13015 | HACC PYP Linkages Packages  | VCSS (formerly HACC) minimum dataset |
| 13015 | HACC PYP Linkages Packages  | Annual HACC PYP fee report |
| 13023 | HACC PYP Service Development Grant | Electronic project report |
| 13024 | HACC PYP Assessment | VCSS (formerly HACC) minimum dataset  |
| 13026 | HACC PYP Community Care | VCSS (formerly HACC) minimum dataset  |
| 13026 | HACC PYP Community Care | Annual HACC PYP fee report |
| 13031 | Public sector residential aged care supplements (including Small rural – residential aged care supplements previously reported under 35011) | Residential aged care services data collection and residential aged persons mental health data collectionForms: AIMS S5-129 AN-ACC Residential aged care services data collection; AIMS Public sector residential aged care services quality indicators; and AIMS S5-115 AN-ACC Aged persons’ mental health residential aged care services data collection; PSRACS financial data submitted to the department to HeART must be submitted using the Campus codes allocated to each health service (for assistance, email Planning and Operations <planning.operations@health.vic.gov.au >. PSRACS VICNISS infection control module; participation in the annual Aged Care National Antimicrobial Prescribing Survey; monitoring and reporting on significant organisms, such as MRSA, VRE and CDI;[[23]](#footnote-24) resident vaccination rates for influenza, herpes zoster and pneumococcal; staff vaccination rates for influenza (for assistance, contact the VICNISS Coordinating Centre on (03) 9342 9333 or by emailing VICNISS <vicniss@mh.org.au>)PSRACS are to continue to enter their quality indicator data via AIMS, and data will be submitted to the Commonwealth on behalf of the PSRACS |
| 13038 | HACC PYP Service System Resourcing | VCSS (formerly HACC) minimum dataset as relevant |
| 13038 | HACC PYP Service System Resourcing | HACC PYP Annual Service Activity Report as relevant |
| 13043 | HACC PYP Flexible Service Response | HACC PYP Annual Service Activity Report as relevant |
| 13043 | HACC PYP Flexible Service Response | VCSS (formerly HACC) minimum dataset as relevant |
| 13043 | HACC PYP Flexible Service Response | Annual HACC PYP fee report, where relevant |
| 13056 | HACC PYP Planned Activity Group | Annual HACC PYP fee report |
| 13056 | HACC PYP Planned Activity Group | VCSS (formerly HACC) minimum dataset |
| 13063 | HACC PYP Volunteer Co-ordination | VCSS (formerly HACC) minimum dataset  |
| 13096 | HACC PYP Allied Health | VCSS (formerly HACC) minimum dataset |
| 13096 | HACC PYP Allied Health | Annual HACC PYP fee report |
| 13097 | HACC PYP Delivered Meals | VCSS (formerly HACC) minimum dataset |
| 13099 | HACC PYP Property Maintenance | VCSS (formerly HACC) minimum dataset |
| 13099 | HACC PYP Property Maintenance | Annual HACC PYP fee report |
| 13130 | HACC PYP Volunteer Coordination Other |  |
| 13131 | RDNS[[24]](#footnote-25) HACC PYP Allied Health | VCSS (formerly HACC) minimum dataset |
| 13131 | RDNS HACC PYP Allied Health | Annual HACC PYP fee report |
| 13210 | ACAS Training and Development | Commonwealth My Aged Care Screening and Assessment Workforce Training Strategy |
| 13223 | HACC PYP Nursing | VCSS (formerly HACC) minimum dataset |
| 13223 | HACC PYP Nursing | Annual HACC PYP fee report |
| 13223 | HACC PYP Nursing | HACC PYP Annual Service Activity Report, where relevant |
| 13227 | ACCO[[25]](#footnote-26) Services – HACC PYP | VCSS (formerly HACC) minimum dataset |
| 13227 | ACCO Services – HACC PYP | HACC PYP fees data collection |
| 13227 | ACCO Services – HACC PYP | HACC PYP Annual Service Activity Report, where relevant |
| 13229 | HACC PYP Access and Support | VCSS (formerly HACC) minimum dataset |
| 13229 | HACC PYP Access and Support | A&S activity annual report |
| 13230 | Commonwealth Regional Assessment Service | Quarterly report on audit of home support assessment and client satisfaction |
| 35030 | Small rural – HACC PYP Health Care and Support  | VCSS (formerly HACC) minimum dataset |
| 35030 | Small rural – HACC PYP Health Care and Support  | Annual HACC PYP fee report, where relevant |
| 35030 | Small rural – HACC PYP Health Care and Support  | HACC PYP Annual Service Activity Report, where relevant |

## Primary, community and dental health data reporting requirements

A summary of reporting requirements is shown in Table 13.

### Community health services

All funded organisations receiving community health program funding must submit data that outlines service delivery performance against targets. Agencies are responsible for accurate and timely submission of data, as per the documented reporting requirements.

The Community health program data submission guidelines are available from [Community health data reporting](https://www.health.vic.gov.au/community-health/community-health-data-reporting) <https://www.health.vic.gov.au/community-health/community-health-data-reporting>.

Community health data must be submitted quarterly, with data due by the fifteenth of the month following the end of each quarter.

All health services receiving community health program funding must ensure that:

* information systems comply with the department’s reporting requirements
* service information remains up to date on the National Human Services Directory.

Additional evidence may be required from time to time, to demonstrate that funding has been used appropriately.

### Dental health services

The department requires a monthly extract of dental health program dataset items. This extract includes all episodes created during the reporting period, and any episodes modified during the reporting period. Agencies with multiple databases should provide one extract per database.

The department is responsible for validating monthly extracts and providing error reports to agencies.

Table 13: Primary, community and dental health – data collection and reporting requirements

| Activity no. | Activity name | Data collection description |
| --- | --- | --- |
| 27017  | Oral health – health promotion | Report against agreed deliverables linked to the Victorian action plan to prevent oral disease 2020–30 |
| 27019 | Royal Dental Hospital Melbourne dental care | Dental health program dataset |
| 27023 | Community dental care | Dental health program dataset |
| 28000 | Health Self-Help (Band 1)  | Annual activity report |
| 28015 | Family and Reproductive Rights Education Program | Community health minimum dataset |
| 28016 | Family and Reproductive Rights Education Program – health promotion | Report against health promotion plan |
| 28018 | Family planning – health promotion | Report against health promotion plan |
| 28021 | Innovative Health Services for Homeless Youth – health promotion | Report against health promotion plan |
| 28048 | Language services | Community health minimum dataset |
| 28050 | Women’s health – health promotion | Report against health promotion plan |
| 28055 | Health support for children in care | Community health minimum dataset |
| 28063 | Family planning – education and training | Quarterly report  |
| 28064 | Family planning – clinical services and training | Community health minimum dataset |
| 28066 | Innovative Health Services for Homeless Youth | Community health minimum dataset |
| 28068 | Family planning  | Community health minimum dataset |
| 28071 | Aboriginal services and support | Local reporting |
| 28072 | Integrated chronic disease management | Community health minimum dataset |
| 28074 | Diabetes Connect  | Community health minimum datasetManual Data Collection |
| 28076 | Refugee and asylum seeker health services | Community health minimum dataset |
| 28080 | Healthy Mothers Healthy Babies | Community health minimum dataset |
| 28081 | National Diabetes Services Scheme  | Monthly report |
| 28085 | Community health – health promotion | Report against health promotion plan |
| 28086 | Community health | Community health minimum dataset |
| 28088 | ACCO services – primary health | Roundtable reporting |
| 28090 | Multi-disciplinary Centre – Community Health Nurse | Community health minimum dataset |
| 28091 | Community Asthma Program | Community health minimum dataset |
| 28092 | Infant Child and Family health and Wellbeing Hubs | Community health minimum dataset |
| 35048 | Small rural – Primary Health Flexible Services | Community health minimum dataset or other relevant data collection, if funding is used for another allowable purpose |

## Workforce data reporting requirements

Reporting is required against workforce programs and datasets to inform statewide policy, planning and funding, and to ensure effective investment in the development of Victoria’s future workforce.

### Health services payroll and workforce minimum employee dataset

Health services must transmit information detailed in the *Health Services Payroll And Workforce Minimum Employee Dataset – Data Dictionary* to the department. Data must be transmitted to the department by the 10th day of the following month, or the prior working day, if the 10th day of the following month falls on a weekend or public holiday. Payroll data is required monthly, while workforce information is required biannually, covering the periods ending 31 December and 30 June each year.

Where health services undertake their own payroll processing, they must transmit the information directly to the department. In cases where health services engage a payroll bureau to process their payroll, health services may authorise the bureau to transmit the data to the department on their behalf. However, health services remain responsible for the accuracy of the data transmitted.

Where a health service decides to change payroll providers, it will be necessary to complete an accreditation process, prior to the change, to ensure continuity of data transmission to the department will not be compromised.

## Training and Development Funding reporting and eligibility requirements

### Eligibility requirements

All Victorian public health services are eligible to receive training and development funding.

To receive funding, organisations must:

* ensure all funded programs conform to the most recent versions of the *Training and Development Funding: program guidelines*, including the guidelines and standards set by AHPRA and the national health practitioner boards
* comply with specific eligibility and reporting requirements for each stream (described below)
* report against the mandatory externally reportable Best Practice Clinical Learning Environment (BPCLE) framework through a revised and simplified tool (note that the BPCLE Tool is no longer in use).

For more information regarding the BPCLE framework, and detailed guidelines for the *Training and Development Funding: program guidelines*, visit:

* [BPCLE framework](https://www.health.vic.gov.au/education-and-training/best-practice-clinical-learning-environment-bpcle-framework) <https://www.health.vic.gov.au/education-and-training/best-practice-clinical-learning-environment-bpcle-framework>
* [Training and Development Funding: program guidelines](https://www.health.vic.gov.au/education-and-training/training-and-development-funding) <https://www.health.vic.gov.au/education-and-training/training-and-development-funding>

### Professional-entry student placements

Professional-entry student placement funding is provided for eligible clinical placement days reported for eligible disciplines and courses at Victorian public health services. Eligible activity, disciplines and courses are detailed in the current [Training and Development Funding: program guidelines](https://www.health.vic.gov.au/education-and-training/training-and-development-funding) <https://www.health.vic.gov.au/education-and-training/training-and-development-funding>.

To access the professional-entry student placement subsidy, health services must:

* plan and report clinical placement activity through Placeright biannually (or via the HealthCollect portal for agreed medical placement activity not yet managed via Placeright)
* adhere to the Standardised Schedule of Fees for clinical placement of students in Victorian public health services for 2024.

Health services are also encouraged to:

* establish a Student Placement Agreement with all education provider partners, including uploading it to Placeright, where the system is used to manage eligible funded activity; and
* adhere to the Standard Student Induction Protocol (SSIP) to ensure conformity of practices across the sector.

Note, templates provided by the department have been updated by a sector-led working group and now reflect industry expectations for clinical placements in health services.

For more information on these resources, visit:

* [Fee schedule for clinical placement in public health services](https://www.health.vic.gov.au/education-and-training/fee-schedule-for-clinical-placement-in-public-health-services) <https://www.health.vic.gov.au/education-and-training/fee-schedule-for-clinical-placement-in-public-health-services>
* [Placeright](https://www.health.vic.gov.au/education-and-training/placeright) <https://www.health.vic.gov.au/education-and-training/placeright>
* [Student Placement Agreement](https://www.health.vic.gov.au/education-and-training/student-placement-agreement) <https://www.health.vic.gov.au/education-and-training/student-placement-agreement>
* [Standardised student induction protocol](https://www.health.vic.gov.au/education-and-training/standardised-student-induction-protocol) <https://www.health.vic.gov.au/education-and-training/standardised-student-induction-protocol>.

### Transition to Practice (graduate) positions

To access Transition to Practice funding for allied health, medical (year one and two), and nursing or midwifery graduates, the following criteria must be met:

* Transition to Practice (graduate) positions for medical, nursing and midwifery **are attempted to be filled** through the PMCV statewide match process, or another process as determined by the department.
* Health services must report on the headcount and FTE of new graduates for the previous calendar year, and a projection for the forthcoming year.
* Health services must allocate adequate training and supervision to each position, and meet the accreditation requirements where relevant, and must advise the department if a graduate does not commence in, or complete, an allocated position.
* No fees may be charged to graduates applying for, undertaking or exiting from Transition to Practice programs.

Health services participating in the department’s pilot of two-year (PGY1 and PGY2) medical prevocational training contracts will be required to:

* provide written offers of PGY2 employment to all their medical interns
* have in place duly signed two-year prevocational contracts (in the case of acceptances)
* report all medical intern responses to offers of PGY2 employment (acceptances, declines and non-responses)
* report any request to prematurely terminate the two-year prevocational training contract.

For eligibility criteria, visit the [Training and Development Funding: program guidelines](https://www.health.vic.gov.au/education-and-training/training-and-development-funding) <https://www.health.vic.gov.au/education-and-training/training-and-development-funding>.

### Postgraduate positions – medical, nursing and midwifery

All health services must reconcile actual activity at the completion of the calendar year.

All health services receiving funding for the Victorian Medical Specialist Program, Victorian Basic Paediatric Training Program and Basic Physician Training Consortia Program must complete the relevant program reports. This includes providing confirmation at each stage of training, including at recruitment, resignation, completion or any other change in the training pathway.

Funded postgraduate nursing and midwifery programs must lead to an award classification at graduate certificate, graduate diploma or master level. Where students are enrolled in a master-level program with exit points at graduate certificate or graduate diploma level, only the graduate certificate or graduate diploma components are eligible.

Master-level studies that lead to endorsement as a nurse practitioner may be eligible. However, individuals receiving Nurse Practitioner Candidate Support Packages, as part of the Making It Free to Study Nursing and Midwifery initiative (outlined in Section 10.1.4: Other targeted workforce training and development programs) or the Women’s Health stream, are excluded. Postgraduate activity, including FTE and headcount are excluded. Postgraduate activity, including FTE and headcount of staff who undertook postgraduate study during the calendar year, must be reported via HealthCollect.

Eligible postgraduate education programs must include a requirement for supervised clinical support.

Postgraduate (entry-to-practice) clinical placement model midwifery studies are not eligible for this stream of the training and development grant but are eligible for a professional-entry student placement subsidy.

For eligibility criteria, visit the [Training and Development Funding: program guidelines](https://www.health.vic.gov.au/education-and-training/training-and-development-funding) <https://www.health.vic.gov.au/education-and-training/training-and-development-funding>.

### Other targeted workforce training and development programs

#### Making it Free to Study Nursing and Midwifery initiative

Refer to section 10.1.4.

#### Continuing nursing and midwifery education (CNME)

The department requires the reconciliation of continuing nursing and midwifery education activity that occurred in each financial year. A link to an online reporting form will be provided to funding recipients. Note, CNME funding distribution is being reviewed for 2024–25 and an addendum will be issued once allocation methodology is determined.

#### Prevocational medical education and training

The department requires annual reconciliation of the expenditure of funds allocated for prevocational medical education and training. Health services receiving this stream of funding will be provided with a reporting template.

#### Rural Clinical Academic program

Rural Clinical Academic program accountability requires that health services and their partner universities jointly sign off on an annual acquittal of prior-year funding and provide a current-year funding submission. A template will be provided for participating health services to complete.

#### Mental health – clinical and non-clinical academic positions

The mental health clinical and non-clinical academic program requires auspice services and agencies to provide details of academic position holder activity and contribution to mental health workforce development. Services will be required to contribute to planning activities for the Victorian Collaborative Centre.

#### Mental health – training and development grants

Victorian Area Mental Health and Wellbeing Services receive a recurrent mental health training and development grant that pays for educators and other core staff needed to deliver the services’ training and development program.

Templates will be provided to mental health services in 2024–25 for completion, requesting details of learning and development resources that are supported by the funding.

#### Mental Health Workforce Scholarship Program

The Mental Health and Wellbeing Workforce Scholarship program offers scholarships on an annual basis for mental health nurses, allied health, alcohol and other drug and lived and living experience workers. For mental health nursing scholarships, applicants must be working in a Victorian public mental health and wellbeing service. For allied health, alcohol and other drug and lived and living experience scholarships, applicants can be working in a state-funded mental health or alcohol and other drug services including those delivered by non-government organisations. For more information, visit [the program’s website](https://www.health.vic.gov.au/mental-health-workforce/mental-health-and-wellbeing-workforce-scholarship-program) <https://www.health.vic.gov.au/mental-health-workforce/mental-health-and-wellbeing-workforce-scholarship-program>.

The scholarship program administrator provides regular reporting on the number of scholarship recipients who commence and complete their course of study.

#### Mental health – clinical and non-clinical academic positions

The mental health clinical and non-clinical academic program requires auspice services and agencies to provide details of academic position holder activity and contribution to mental health workforce development. Services will be required to contribute to planning activities for the Victorian Collaborative Centre.

#### Registered undergraduate students of nursing and midwifery

Health services will be advised on the arrangements for the allocation of funding.

Where services are unable to recruit graduate nurses and/or midwives, in 2024–25 transition-to-practice (graduate) nursing and midwifery funding may be reprioritised to fund RUSON/M positions in public health services, above funding allocation ratios. Transition-to-practice (graduate) nursing and midwifery funding will not exceed the allocation specific to nursing and midwifery graduate numbers.

##  Commonwealth–state reporting requirements

#### National Health Reform Agreement

Funded organisations may receive payments arising from Commonwealth–state agreements outside of the National Health Reform Agreement, including Commonwealth own-purpose expenditure and intergovernmental agreements.

Funding received under such arrangements is subject to each program’s specific conditions of funding. Organisations funded under Commonwealth–state programs must submit regular reports, as required for the Commonwealth. In most cases, the department will submit these reports to the Commonwealth.

The information required, format and timelines for individual programs are detailed in the applicable agreements with the Commonwealth and the guidelines applicable to the appropriate Commonwealth–state programs.

#### National Health Information Agreement

Under the National Health Information Agreement, states and territories provide Public Hospital Establishment and Local Health Network data to the Australian Institute of Health and Welfare for inclusion in National Minimum Datasets.

##  Environmental data and reporting requirements

Financial Reporting Direction 24 (FRD 24) introduced new whole-of-government reporting requirements for the 2022-23 reporting year including new reporting obligations for Victorian public hospitals, health services and cemeteries. Data reported through the FRD 24 process is used to inform environmental indicators and associated commentary in health service annual reports.

The department’s Environmental Data Management System (EDMS) has been configured to meet the FRD 24 quantitative reporting requirements with routine updates made to the platform to ensure reporting fields correspond to reporting requisites. FRD24 provides flexibility for the reporting period with the Department of Health encouraging health services to move to an annual reporting period of 1 April to 31 March from 2023–24 reporting year onwards.

Reporting guidance for hospitals and health services is provided in the department's [Health service environmental requirements and environmental management planning](https://www.health.vic.gov.au/planning-infrastructure/health-service-environmental-requirements-and-environmental-management) <https://www.health.vic.gov.au/planning-infrastructure/health-service-environmental-requirements-and-environmental-management>. Additional information on reporting requirements can also be found at [Government environmental reporting](https://www.climatechange.vic.gov.au/victorian-government-action-on-climate-change/government-environmental-reporting) <https://www.climatechange.vic.gov.au/victorian-government-action-on-climate-change/government-environmental-reporting>.

Public hospitals and health services are required to upload data on procured services for electricity, natural gas, water, waste, transport services (including air travel) in the EDMS to meet environmental reporting requirements on a quarterly basis ([section 23.5: Health service environmental management, planning and reporting](#_Health_service_environmental)). This can include liquefied petroleum gas (LPG), small sites on retail energy contracts, non-potable water (where metered), and specialist recycling streams. For all operational vehicles, health services will need to provide details for non VicFleet vehicles. Please note the department has access to information on VicFleet vehicles and this does not need to be provided by health services. Public hospitals and health services are to configure any behind-the-meter solar arrays to automatically feed net generation data into the EDMS. For advice on how to configure this, visit [Reporting solar photovoltaic data](https://www.vhba.vic.gov.au/reporting-solar-photovoltaic-data) <https://www.vhba.vic.gov.au/reporting-solar-photovoltaic-data>.

For access to the EDMS, visit [Eden Suite](https://dse.edensuite.com.au/cas/login?service=https%3A%2F%2Fdse.edensuite.com.au%2FCarbonInsight%2Fj_spring_cas_security_check) <https://dse.edensuite.com.au>. Eden Suite is the software used to host the department’s environmental data management system. Further information concerning manual uploading requirements for health services can be found in the *Public environmental reporting guidelines*.

The department will upload electricity, gas and waste data centrally where public hospitals and health services utilise statewide HealthShare Victoria contracts (or State Purchase Contracts) water data sourced direct from water retailers, and cogeneration data (under the Energy Services Agreement) centrally.

# Performance targets and monitoring

## Health services covered under the health services act

The *Performance monitoring framework* describes the contextual, strategic and operational aspects of monitoring and improvement for health services’ performance in core areas, such as clinical quality and safety, timely access to care and patient experience.

For information on coverage and more, visit [Performance monitoring framework](https://www.health.vic.gov.au/funding-performance-accountability/performance-monitoring-framework) <https://www.health.vic.gov.au/funding-performance-accountability/performance-monitoring-framework>.

### Services provided under a service agreement

Service agreements are contractual arrangements between organisations funded to deliver services in the community and the department, which provides funding for this. Should your organisation be funded through a service agreement, for funding information and activity tables that underpin service agreements, visit [Service agreement](https://fac.dffh.vic.gov.au/service-agreement) <https://fac.dffh.vic.gov.au/service-agreement>.

For those organisations funded through service agreements, you can search for activity descriptions by referring to the [Department of Health activity description index](https://fac.dffh.vic.gov.au/department-health-activity-description-index) <https://fac.dffh.vic.gov.au/department-health-activity-description-index>.

### Performance tables

Table 14: HACC PYP – performance targets and monitoring

| Activity no. | Activity name | Measure description  | Unit of measure | Frequency | Status | Output type |
| --- | --- | --- | --- | --- | --- | --- |
| 13015 | HACC PYP Linkages – case management | Number of hours of service | Hours of case management | Quarterly | Mandatory | Key output measure |
| 13015 | HACC PYP linkages | Number of hours of service | Hours | Quarterly | Mandatory | Non-KPOM |
| 13023 | HACC PYP Service Development Grant | One electronic project report submitted | Report | Yearly | Mandatory | Key output measure |
| 13024 | HACC PYP Assessment | Number of hours of service | Hours | Quarterly | Mandatory | Key output measure |
| 13026 | HACC PYP Community Care  | Number of hours of service | Hours | Quarterly | Mandatory | Key output measure |
| 13038 | HACC PYP Service System Resourcing | Number of events, services, hours as relevant | Number of relevant items | Quarterly | Mandatory | Non-KPOM |
| 13038 | HACC PYP Service System Resourcing | HACC PYP Annual Service Activity Report as relevant | Report | Yearly | Mandatory | Key output measure |
| 13043 | HACC PYP Flexible Service Response | HACC PYP Annual Service Activity Report as relevant | Report | Yearly | Mandatory | Key output measure |
| 13043 | HACC PYP Flexible Service Response | Number of hours of service, meals as relevant, reported in FSR MDS Outlet | Hours | Quarterly | Non-mandatory | Non-KPOM |
| 13056 | HACC PYP Planned Activity Group | Number of hours of service (provided to clients) | Hours | Quarterly | Mandatory | Key output measure |
| 13063 | HACC PYP Volunteer Co-ordination | Number of hours of coordinator time | Hours | Yearly | Mandatory | Key output measure |
| 13063 | HACC PYP Volunteer Co-ordination | Number of hours of service to clients | Hours | Quarterly | Non-mandatory | Non-KPOM |
| 13096 | HACC PYP Allied Health | Number of hours of service | Hours | Quarterly | Mandatory | Key output measure |
| 13097 | HACC PYP Delivered Meals | Number of meals (funding is a subsidy for meal delivery only) | Meals | Quarterly | Mandatory | Key output measure |
| 13099 | HACC PYP Property Maintenance | Number of hours of service | Hours | Quarterly | Mandatory | Key output measure |
| 13103 | Language services | Number of occasions of service | Occasions of service | Monthly | Mandatory | Key output measure |
| 13130 | HACC PYP Volunteer Co-ordination Other | Investment activity | n/a | n/a | n/a | n/a |
| 13131 | RDNS HACC PYP Allied Health | Number of hours of service | Hours | Quarterly | Mandatory | Key output measure |
| 13156 | Seniors health promotion | Report against agreed objectives | Reports | Yearly | Mandatory | Key output measure |
| 13223 | HACC PYP Nursing | Number of hours of service | Hours | Quarterly | Mandatory | Key output measure |
| 13223 | HACC PYP Nursing | HACC PYP Annual Service Activity Report as relevant | Report | Yearly | Mandatory | Non-KPOM |
| 13223 | HACC PYP Nursing | Number of hours of worker time, as relevant |  |  |  |  |
| 13227 | ACCO Services – HACC PYP | Number of hours of service, meals as relevant | Hours | Quarterly | Mandatory | Non-KPOM |
| 13227 | ACCO Services – HACC PYP | HACC PYP Annual Service Activity Report as relevant | Report | Yearly | Mandatory | Key output measure |
| 13229 | HACC PYP Access and Support | Number of hours of service | Hours | Quarterly | Mandatory | Key output measure |
| 13229 | HACC PYP Access and Support | HACC PYP Access and Support annual narrative | Report | Yearly | Mandatory | Non-KPOM |
| 35030 | Small Rural HACC PYP Health Care and Support | Number of hours of service | Hours  | Quarterly | Mandatory | Non-KPOM |
| 35030 | Small Rural HACC PYP Health Care and Support | HACC PYP Annual Service Activity Report as relevant | Report | Yearly | Mandatory | Key output measure |

Table 15: Ageing, aged and home care – performance targets and monitoring

| Activity no. | Activity name | Measure description | Unit of measure | Frequency | Status | Output type |
| --- | --- | --- | --- | --- | --- | --- |
| 13005 | ACAS | Number of completed assessments | Number | Quarterly | Mandatory | Key output measure |
| 13005 | ACAS | Percentage of priority 1, 2 and 3 assessments completed on time  | Percentage | Quarterly | Mandatory | Other standard measure |
| 13005 | ACAS | Percentage of referrals actioned within three calendar days | Percentage | Quarterly | Mandatory | Other standard measure |
| 13005 | ACAS assessment | Percentage of assessments and support plans that are of appropriate quality | Percentage  | Quarterly | Mandatory | Other standard measure |
| 13005 | ACAS assessment | Percentage of clients satisfied with their assessments | Percentage  | Quarterly | Mandatory | Other standard measure |
| 13019 | Personal Alert Victoria | Number of units allocated | Number of units | Quarterly  | Mandatory | Key output measure |
| 13053 | Victorian Eyecare Service | Number of occasions of service (metropolitan) | Occasions of service | Quarterly | Mandatory | Key output measure |
| 13053 | Victorian Eyecare Service | Number of occasions of service (outreach) | Occasions of service | Yearly | Mandatory | Other standard measure |
| 13053 | Victorian Eyecare Service | Number of occasions of service (rural) | Occasions of service | Yearly | Mandatory | Other standard measure |
| 13067 | Victorian Aids and Equipment Program | Number of clients assisted | Clients | Quarterly | Mandatory | Key output measure |
| 13067 | Victorian Aids and Equipment Program | Applications acknowledged in writing within 10 working days of applications | Per cent | Quarterly | Mandatory | Key output measure |
| 13067 | Victorian Aids and Equipment Program | Clients satisfied with the aids and equipment system | Per cent | Annual | Mandatory | Key output measure |
| 13082 | Low-cost accommodation support | Number of clients assisted | Clients | Quarterly | Mandatory | Key output measure |
| 13083 | Aged training and development | Number of filled positions (academic) | Positions | Quarterly | Mandatory | Key output measure |
| 13083 | Aged training and development | Number of filled positions (training) | Positions | Quarterly | Non-mandatory | Other standard measure |
| 13100 | Aged research and evaluation | Report against agreed objectives | Reports | Yearly | Mandatory | Key output measure |
| 13103 | Language services | Number of occasions of service | Occasions of service | Monthly | Mandatory | Key output measure |
| 13210 | ACAS training and development | Funds expended on training needs of staff | Dollars | Yearly | Mandatory | Key output measure |
| 13230 | Commonwealth Regional Assessment Service  | Number of completed assessments  | Number | Quarterly  | Mandatory  | Key output measure  |
| 13230 | Commonwealth Regional Assessment Service | Percentage of referrals and assessments completed on time | Percentage  | Quarterly | Mandatory | Other standard measure |
| 13230 | Commonwealth Regional Assessment Service | Percentage of assessments and support plans of appropriate quality | Percentage  | Quarterly | Mandatory | Other standard measure |
| 13230 | Commonwealth Regional Assessment Service | Percentage of clients satisfied with their assessments | Percentage  | Quarterly | Mandatory | Other standard measure |
| 13230 | Commonwealth Regional Assessment Service | Percentage of clients receiving reablement | Percentage  | Quarterly | Mandatory | Other standard measure |
| 13301 | Aged quality improvement | Current authorisations for information exchange between the department and the Commonwealth Department of Health and Aged Care Quality and Safety Commission | Signed documents | Yearly | Mandatory | Other standard measure |

Table 16: Ambulance Victoria – performance targets and monitoring

| Service plan | Activity | Measure description  | Unit of measure | Reporting frequency | Status  |
| --- | --- | --- | --- | --- | --- |
| Quantity – transports | Emergency road: allEmergency road: metroEmergency road: rural and regionalNon-emergency stretcher: allNon-emergency stretcher: metroNon-emergency stretcher: rural and regionalNon-emergency clinic carFixed-wing emergencyFixed wing non-emergencyRotary wing | Number of transports provided | Number | Monthly | Mandatory |
| Quantity – incidents | Emergency road: allEmergency road: metroEmergency road: rural and regionalTreatment without transportNon-emergency stretcher: allNon-emergency stretcher: metroNon-emergency stretcher: rural and regionalNon-emergency clinic carFixed-wing emergency | Number of Triple Zero (000) calls or planned events to which one or more ambulance resources are dispatched | Number | Monthly | Mandatory |
| Patient experience | Patient experience | Percentage of respondents who rated care, treatment, advice and/or transport received from the ambulance service as ‘good’ or ‘very good’ Percentage of respondents who rated care and treatment received from paramedics as ‘good’ or ‘very good’ | Percentage | Annual | Mandatory |
| Governance, leadership and culture | Safety culture | Composite of safety culture score, based on 8 safety culture items in the People Matter Survey | Percentage | Annual | Mandatory |
| Safety and quality | Healthcare worker immunisation – influenza | Healthcare worker immunisation – influenza | Percentage | Annual | Mandatory |
| Safety and quality | Pain reduction | Adult patients who achieved a meaningful reduction in pain | Percentage | Quarterly | Mandatory |
| Safety and quality | Stroke patients transported | Adult patients suspected of having a stroke, who were transported within 60 minutes to a health service with the capability to deliver intravenous thrombolysis | Percentage | Quarterly | Mandatory |
| Safety and quality | Trauma patients transported | Trauma patients transported to the highest-level trauma service within 45 minutes, or transported by air directly to a major trauma service | Percentage | Quarterly | Mandatory |
| Safety and quality | Cardiac arrest survived event rate | Adult VF/VT patients with vital signs at hospital | Percentage | Quarterly | Mandatory |
| Safety and quality | Cardiac arrest survived event rate | Adult VF/VT patients surviving to hospital discharge | Percentage | Quarterly | Mandatory |
| Access | Response time state wide | Emergency Code 1 incidents responded to within 15 minutes | Percentage | Monthly | Mandatory |
| Access | Response time state wide | Emergency Priority 0 incidents responded to within 13 minutes | Percentage | Monthly | Mandatory |
| Access | Response time urban | Emergency Code 1 incidents responded to within 15 minutes, in centres with a population >7,500 | Percentage | Monthly | Mandatory |
| Access | Average response time | Average time to respond to Emergency Code 1 incidents | Minutes | Monthly | Mandatory |
| Access | Clearing time at hospital | Average ambulance hospital clearing time | Minutes | Monthly | Mandatory |
| Access | Call referral | Events where a Triple Zero (000) caller receives advice or service from another health service provider, as an alternative to emergency ambulance response | Percentage | Monthly | Mandatory |
| Access | 40-minute transfer | Proportion of patients transferred from paramedic care to hospital emergency care, within 40 minutes of ambulance arrival | Percentage | Weekly | Mandatory |

**Note**: Additional measures will be developed and included in the data submissions.

Table 17: Mental health service – performance targets and monitoring

**Note**: Some targets are provided in the MHPAF and related processes. These targets are referenced in the below table via the initialism ‘tbc’.

| Domain | Measure or indicator | Unit | Adult report | CAMHS report | Older person report  | Government target | Frequency | Status |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Safety | Rate of ended seclusion episodes per 1,000 occupied bed days within an acute inpatient unit – all ages | Episodes per 1,000 occupied bed days | Yes | Yes | Yes | < 8/1,000 occupied bed days (adult)< 5/1,000 occupied bed days (older persons and CAMHS) | Quarterly | Mandatory |
| Safety | Seclusion duration – all ages | Hours | Yes | Yes | Yes | - | Quarterly | Mandatory |
| Safety | Bodily restraint rate – all ages | Episodes per 1,000 occupied bed days | Yes | Yes | Yes | - | Quarterly | Mandatory |
| Appropriateness | Percentage of mental health consumers reporting a positive experience of care in the last three months or less | Per cent | Yes | Yes | No | 80% | Annual  | Mandatory |
| Appropriateness | Rate of YES survey completion | Per cent | Yes | Yes | No | 20% | Annual | Mandatory |
| Appropriateness | Percentage valid HoNOS[[26]](#footnote-27) compliant – all inpatient, all ages | Per cent | Yes | Yes | Yes | > 85% | Quarterly | Mandatory |
| Appropriateness | Percentage valid HoNOS compliant – ambulatory, all ages | Per cent | Yes | Yes | Yes | > 85% | Quarterly | Mandatory |
| Appropriateness | Percentage of self-rating measures completed BASIS for adults and aged, SDQ for children and young people 4–17 years[[27]](#footnote-28) | Per cent | Yes | Yes | Yes | > 85% | Quarterly | Mandatory |
| Effectiveness | Percentage of readmissions within 28 days of separation – inpatient (adult, aged, CAMHS)  | Per cent | Yes | Yes | Yes | 14% adult and CAMHS7% aged | Quarterly | Mandatory |
| Effectiveness | Percentage of closed community cases re-referred within six months (lagged) | Per cent | Yes | Yes | Yes | < 25% | Quarterly | Mandatory |
| Effectiveness | LSP-16 compliance | Per cent | Yes | No | Yes | > 85% | Quarterly | Mandatory |
| Continuity of care | Percentage of consumers followed up within 7 days of separation – inpatient (CAMHS, adult, older persons) | Per cent | Yes | Yes | Yes | 88% for all age cohorts | Quarterly | Mandatory |
| Accessibility | Percentage of admissions with a preadmission contact – inpatient  | Per cent | Yes | Yes[[28]](#footnote-29) | Yes | > 61%All age ranges | Quarterly | Mandatory |
| Accessibility | Percentage of mental health-related emergency department presentations with a length of stay of less than four hours  | Per cent | Yes | Yes | Yes | < 81% | Quarterly | Mandatory |
| Efficiency and sustainability  | Trimmed average length of acute mental health inpatient stay ≤ 35 days | Days | Yes | Yes | No | < 16 days | Quarterly  | Mandatory |
| Efficiency and sustainability | Trimmed average length of acute mental health inpatient stay ≤ 50 days | Days | No | No | Yes | < 30 days | Quarterly  | Mandatory |

Table 18: Primary, community and dental health – performance targets and monitoring

| Activity no. | Activity name | Measure description | Unit of measure | Frequency | Status | Output type |
| --- | --- | --- | --- | --- | --- | --- |
| 27019 | RDHM Dental Care | Number of clients | Clients | Yearly | Mandatory | Key output measure |
| 27023 | Community Dental Care | Number of clients | Clients | Yearly | Mandatory | Key output measure |
| 28015 | Family and Reproductive Rights Education Program | Number of hours of service | Hours | Quarterly | Mandatory | Key output measure |
| 28016 | Family and Reproductive Rights Education Program – Health Promotion | Report against health promotion plan | Reports | Yearly | Non-mandatory | Other standard measure |
| 28018 | Family Planning – Health Promotion | Report against health promotion plan | Reports | Yearly | Non-mandatory | Other standard measure |
| 28021 | Innovative Health Services for Homeless Youth – Health Promotion | Report against health promotion plan | Reports | Yearly | Non-mandatory | Other standard measure |
| 28048 | Language Services | Number of occasions of service | Occasions of service | Quarterly | Mandatory | Key output measure |
| 28050 | Women’s Health – Health Promotion | Report against health promotion plan | Reports | Yearly | Non-mandatory | Other standard measure |
| 28055 | Health support for children in care | Number of hours of service | Hours | Quarterly | Mandatory | Key Output measure |
| 28063 | Family Planning – Education and Training | Number of hours of service | Hours | Quarterly | Mandatory | Key output measure |
| 28064 | Family Planning – Clinical Services and Training | Number of hours of service | Hours | Quarterly | Mandatory | Key output measure |
| 28066 | Innovative Health Services for Homeless Youth | Number of hours of service | Hours | Quarterly | Mandatory | Key output measure |
| 28067 | Women’s Health | Number of hours of service | Hours | Quarterly | Mandatory | Key output measure |
| 28068 | Family Planning | Number of hours of service | Hours | Quarterly | Mandatory | Key output measure |
| 28071 | Aboriginal Services and Support | Number of hours of service | Hours | Quarterly | Mandatory | Other standard measure |
| 28071 | Aboriginal Services and Support | Report against agreed objectives | Reports | Yearly | Mandatory | Key output measure |
| 28072 | Integrated Chronic Disease Management | Number of hours of service | Hours | Quarterly | Mandatory | Key output measure |
| 28074 | Diabetes Connect | Number of hours of services  | Hours | Quarterly  | Mandatory | Key output measure |
| 28076 | Refugee and Asylum Seeker Health Services | Number of hours of service | Hours | Quarterly | Mandatory | Key output measure |
| 28080 | Healthy Mothers Healthy Babies | Numbers of hours of service | Hours | Quarterly | Mandatory | Key output measure |
| 28081 | National Diabetes Services Scheme | Number of packs of needles and syringes  | Needles and syringes | Monthly  | Mandatory | Key output measure |
| 28085 | Community Health – Health Promotion | Report against health promotion plan | Reports | Yearly | Mandatory | Other standard measure |
| 28086 | Community Health | Number of hours of service | Hours | Quarterly | Mandatory | Key output measure |
| 28088 | ACCO services – Primary Health | Development of service profile | Completed service  | Yearly | Mandatory | Key output measure |
| 28090 | Multidisciplinary Centre – Community Health Nurse | Number of hours of service | Hours | Quarterly | Mandatory | Key output measure |
| 28091 | Community Asthma Program | Number of hours of service | Hours | Quarterly | Mandatory | Key Output measure |
| 28092 | Infant Child and Family health and Wellbeing Hubs | Number of hours of service | Hours | Quarterly | Mandatory | Key Output measure |

Table 19: Public health – performance targets and monitoring

| Activity no. | Activity name | Measure description | Unit of measure | Frequency | Status | Output type |
| --- | --- | --- | --- | --- | --- | --- |
| 16119 | School and adult immunisation services | Number of people immunised | People | Yearly | Mandatory | Key output measure |
| 16163 | Food safety education | Report against agreed objectives | Reports | Yearly | Mandatory | Key output measure |
| 16203 | Regulation of ART[[29]](#footnote-30) and associated legislation | Report against agreed objectives | Reports | Yearly | Mandatory | Key output measure |
| 16206 | Laboratory testing | Provision of a public health reference/testing service | Services | Yearly | Mandatory | Key output measure |
| 16206 | Laboratory testing | Percentage of notifications within specified timelines | Notifications | Yearly | Mandatory | Other standard measure |
| 16206 | Laboratory testing | Provision of required testing, in accordance with accredited standards | Testing | Yearly | Mandatory | Other standard measure |
| 16206 | Laboratory testing | Provision of required testing, in accordance with accredited standards | Testing | Yearly | Mandatory | Other standard measure |
| 16234 | Public Health Legislative Review | Report against agreed objectives | Reports | Yearly | Mandatory | Key output measure |
| 16308 | Injury prevention | Report against agreed objectives | Reports | Yearly | Mandatory | Key output measure |
| 16348 | Children’s obesity | Report against agreed objectives | Reports | Half-yearly | Mandatory | Key output measure |
| 16349 | Obesity – community projects | Report against agreed objectives | Reports | Yearly | Mandatory | Key output measure |
| 16373 | BBV and STI – clinical services | Report against agreed objectives | Report | Yearly | Mandatory | Key output measure |
| 16449 | Smoking information – advice and interventions by Quit Victoria | Research reports | Reports | Yearly | Mandatory | Key output measure |
| 16450 | Diabetes prevention | Report against agreed objectives | Reports | Quarterly | Mandatory | Key output measure |
| 16452 | Aboriginal health advancement by VACCHO | Report against agreed objectives | Reports |  Yearly | Mandatory | Key output measure |
| 16453 | Aboriginal health worker support ACCHOs | Report against agreed objectives | Reports |  Yearly | Mandatory | Key output measure |
| 16454 | Health promotion initiatives inclusive of PHU catchment planning, eye health, healthy kid advisers, Working together for health. | Report against agreed objectives | Reports | Yearly | Mandatory | Key output measure |
| 16460 | Targeted recruitment for screening programs | Report against agreed deliverables | Reports | Yearly | Mandatory | Key output measure |
| 16505 | BBV and STI – training and development | Report against agreed deliverables | Reports | Yearly | Mandatory | Key output measure |
| 16506 | BBV and STI – research | Report against agreed deliverables | Reports | Yearly | Mandatory | Key output measure |
| 16507 | BBV and STI – laboratory services | Report against agreed deliverables | Reports | Reports | Mandatory | Key output measure |
| 16508 | BBV and STI – health promotion and prevention | Report against health promotion plan | Reports | Yearly | Mandatory | Key output measure |
| 16509 | BBV and STI – community-based care and support | Report against agreed deliverables | Reports | Yearly | Mandatory | Key output measure |
| 16513 | Screening and preventative messages | Report against agreed deliverables | Reports | Yearly | Mandatory | Key output measure |
| 16514 | Screening service development | Report against agreed deliverables | Reports | Yearly | Mandatory | Key output measure |
| 16515 | Education and training in screening programs | Report against agreed deliverables | Reports | Yearly | Mandatory | Key output measure |
| 16516 | Screening counselling and support | Number of occasions of service | Occasions of service | Yearly | Mandatory | Key output measure |
| 16517 | Cancer and screening registers | Statistical report within an agreed timeline and publicly available | Reports | Yearly | Mandatory | Key output measure |
| 16518 | Cancer and screening intelligence | Report against agreed objectives | Reports | Yearly | Mandatory | Key output measure |
| 16519 | Screening tests and assessments | Percentage of target population screened over an agreed period | Percentage | Yearly | Mandatory | Other standard measure |
| 16519 | Screening tests and assessments | Number of clients screened | Clients | Yearly | Mandatory | Key output measure |

Table 20: Local public health units – performance targets and monitoring

| Domain | Function | Measure description  | Unit of measure | Reporting frequency | Status  |
| --- | --- | --- | --- | --- | --- |
| Health Protection | Receive and document notifications of notifiable conditions | Percentage of notifications received and entered onto the statewide surveillance system | Percent (target 100%) | Annual | Mandatory |
| Health Protection | Document notifications of notifiable conditions in a timely manner | Percentage of notifications documented in a timely manner  | Percent (target 100%) | Annual | Mandatory |
| Health Protection | Manage cases of notifiable conditions in accordance with statewide protocols | Percentage of case investigations undertaken for allocated cases in accordance with statewide protocols | Percent (target 100%) | Quarterly | Mandatory |
| Health Protection | Respond to cases of notifiable conditions in a timely manner | Percentage of case investigations undertaken for allocated cases within timeframes specified in statewide protocols  | Percent (target 100%) | Quarterly | Mandatory |
| Health Protection | Respond to local outbreaks in a timely manner | Percentage of investigations into local outbreaks of urgent conditions initiated within the timeframes specified in statewide protocols | Percent (target 100%) | Quarterly | Mandatory |
| Health Protection  | Accurately complete cases of notifiable conditions on statewide databases in accordance with guidelines  | Percentage of investigations are completed on statewide databases in accordance with quick entry guides and statewide protocols | Percent (target 100%) | Quarterly | Mandatory |
| Population Health | Align to the priorities of the Victorian Public Health and Wellbeing Plan 2023 –2027 | LPHU Population Health Catchment Plan developed that reflects priorities of the Victorian Public Health and Wellbeing Plan and local Municipal Public Health and Wellbeing Plans.  | Catchment Plan (target 100%) | 6-year plan from 20232-year review 2025  | Mandatory |
| Population Health | Align to the priorities of the Victorian Public Health and Wellbeing Plan 2023 –2027 | Report against LPHU Population Health Catchment Plan, describing achievements in accordance with the LPHU Population Health Catchment Planning Framework | Report against Population health catchment plan | Annual | Mandatory |
| Emergency Management | Provide support and public health expertise for public health risks | Report against activities undertaken for emergencies in accordance with the [SEMP health emergencies sub-plan](https://www.emv.vic.gov.au/responsibilities/state-emergency-management-plan-sub-plans/semp-health-emergencies-sub-plan) <https://www.emv.vic.gov.au/responsibilities/state-emergency-management-plan-sub-plans/semp-health-emergencies-sub-plan> and the [SEMP viral (respiratory) pandemic sub-plan](https://www.emv.vic.gov.au/responsibilities/semp-sub-plans/semp-viral-respiratory-pandemic-sub-plan) <https://www.emv.vic.gov.au/responsibilities/semp-sub-plans/semp-viral-respiratory-pandemic-sub-plan> | Complete After-Action Reporting, after the event of a relevant emergency in the LPHU catchment | Quarterly, where an emergency response exists  | Mandatory |

Note: The performance targets and monitoring described in this table are exclusively applicable to lead health services that maintain a Local Public Health Unit. For more detail on the functions and measures, refer to the LPHU Outcomes Framework.

# Service standards and guidelines

Table 21: SRHS – service standards and guidelines

| Activity no. | Service standards and guidelines description | Service standards and guidelines description |
| --- | --- | --- |
| 13031 | Aged Care Act (Cth) as amended (residential only) | Aged Care Act (Cth) as amendedCommonwealth Department of Health resources:[My Aged Care](https://www.myagedcare.gov.au) <https://www.myagedcare.gov.au>[Aged care resources](https://www.health.gov.au/health-topics/aged-care/aged-care-resources) <https://www.health.gov.au/health-topics/aged-care/aged-care-resources>Small rural health services guide 2003–04 and updates |
| 35010 | Aged Care Act (Cth) as amended support services | Aged Care Act (Cth) as amendedCommonwealth Department of Health resources:[MyAged Care website](https://www.myagedcare.gov.au) <https://www.myagedcare.gov.au>[Aged care resources](https://www.health.gov.au/health-topics/aged-care/aged-care-resources) <https://www.health.gov.au/health-topics/aged-care/aged-care-resources>Small rural health services guide 2003–04 and updates |
| 35024 | Small rural health services guide 2003–04 and updates rural – flexible health service delivery | Small rural health services guide 2003–04 and updates |
| 35025 | Small rural health services guide 2003–04 and updates rural – TAC– acute health | Small rural health services guide 2003–04 and updates |
| 35026 | Small rural health services guide 2003–04 and updates rural – Department of Veterans’ Affairs – acute health | Small rural health services guide 2003–04 and updates |
| 35028 | Small rural health services guide 2003–04 and updates rural – acute health service system development and resourcing | Small rural health services guide 2003–04 and updates |
| 35030 | Victorian HACC program manual 2013 | [HACC PYP interim guidelines](https://www.health.vic.gov.au/home-and-community-care/hacc-program-for-younger-people) <https://www.health.vic.gov.au/home-and-community-care/hacc-program-for-younger-people>[HACC PYP fees policy](https://www.health.vic.gov.au/home-and-community-care/hacc-pyp-fees-policy-and-schedule-of-fees) <https://www.health.vic.gov.au/home-and-community-care/hacc-pyp-fees-policy-and-schedule-of-fees> |
| 35042 | Alcohol and other drug program guidelines – drugs services | Alcohol and other drug program guidelinesAlcohol and other drug performance management frameworkAdult alcohol and other drug screening and assessment toolIncident reporting instruction (May 2013)Victorian alcohol and other drug Treatment PrinciplesVictorian alcohol and other drug client charterSevere Substance Dependence Treatment Act 2010 |
| 35048 | Small rural – primary health flexible services | Small rural health services guide 2003–04 and updates[Victorian health and wellbeing plan](https://www.health.vic.gov.au/victorian-health-and-wellbeing-plan) <https://www.health.vic.gov.au/victorian-health-and-wellbeing-plan>[Community Health Integrated Program guidelines](https://www.health.vic.gov.au/community-health/community-health-integrated-program-chip-guidelines) <https://www.health.vic.gov.au/community-health/community-health-integrated-program-chip-guidelines> |
| 35052 | Small rural health services guide 2003–04 and updates specified services | Small rural health services guide 2003–04 and updates |

Table 22: Drug services – service standards and guidelines

|  |  |
| --- | --- |
| Service standards and guidelines description | Activity no. |
| Alcohol and other drug program guidelines | 34041, 34045, 34046, 34048, 34049, 34051, 34053, 34056, 34060, 34064, 34074, 34078, 34080, 34084, 34202, 34204, 34205, 34206, 34208, 34006, 34009, 34021, 34040, 34041, 34042, 34044, 34045, 34046, 34047, 34048, 34049, 34050, 34053, 34057, 34060, 34061, 34062, 34066, 34069, 34070, 34078, 34079, 34082, 34084, 34200, 34202, 34203, 34205, 34209, 34211, 34212, 34213, 34214, 34300, 34301, 34303, 34304, 34305, 34306, 34307, 34308, 34309, 34310 |
| Alcohol and other drug Withdrawal Guidelines | 34050, 34056, 34064, 34203, 24204, 34214, 34303, 34310 |
| Guide for developing a workplace alcohol and other drug policy | 34009 |
| Youth alcohol and other drug treatment services – Assessment and Intervention Tool | 34041, 34045, 34046, 34048, 34049, 34051, 34053, 34056, 34060, 34064, 34075, 34078, 34080, 34084, 34202, 34204, 34205, 34206, 34208, 34309, 34310 |
| Adult alcohol and other drug intake and assessment tools | 34006, 34009, 34021, 34040, 34041, 34042, 34044, 34045, 34046, 34047, 34048, 34049, 34050, 34053, 34057, 34060, 34061, 34062, 34066, 34069, 34070, 34078, 34079, 34082, 34084, 34200, 34202, 34203, 34205, 34209, 34211, 34212, 34213, 34214, 34300, 34301, 34303, 34304, 34305, 34306, 34307, 34308, 34309, 34310 |
| Child Wellbeing and Safety Act | 34003, 34004, 34006, 34009, 34021, 34040, 34041, 34042, 34044, 34045, 34046, 34047, 34048, 34049, 34050, 34053, 34056, 34057, 34060, 34061, 34062, 34064, 34066, 34069, 34070, 34071, 34078, 34079, 34080, 34082, 34084, 34200, 34202, 34203, 34204, 34205, 34206, 34207, 34209, 34211, 34212, 34213, 34214, 34300, 34301, 34303, 34304, 34305, 34306, 34307, 34308, 34309, 34310 |
| Children, Youth and Families ActCommission for Children and Young People ActWorking with Children Act 2005Protocol between drug treatment services and child protection for working with parents with alcohol and other drug issues | 34003, 34004, 34006, 34009, 34021, 34040, 34041, 34042, 34044, 34045, 34046, 34047, 34048, 34049, 34050, 34053, 34056, 34057, 34060, 34061, 34062, 34064, 34066, 34069, 34070, 34071, 34078, 34079, 34080, 34082, 34084, 34200, 34202, 34203, 34204, 34205, 34206, 34207, 34209, 34211, 34212, 34213, 34214, 34300, 34301, 34303, 34304, 34305, 34306, 34307, 34308, 34309, 34310 |
| Clinical treatment guidelines for alcohol and drug clinicians – Co-occurring acquired brain injury/cognitive impairment and alcohol and other drug use disorders – 2006National comorbidity guidelines | 34003, 34004, 34006, 34009, 34021, 34040, 34041, 34042, 34044, 34045, 34046, 34047, 34048, 34049, 34050, 34053, 34056, 34057, 34060, 34061, 34062, 34064, 34066, 34069, 34070, 34071, 34078, 34079, 34080, 34082, 34084, 34200, 34202, 34203, 34204, 34205, 34206, 34207, 34209, 34211, 34212, 34213, 34214, 34300, 34301, 34303, 34304, 34305, 34306, 34307, 34308, 34309, 34310 |
| Methamphetamine Treatment Guidelines 2019 | 34003, 34004, 34006, 34009, 34021, 34040, 34041, 34042, 34044, 34045, 34046, 34047, 34048, 34049, 34050, 34053, 34056, 34057, 34060, 34061, 34062, 34064, 34066, 34069, 34070, 34071, 34078, 34079, 34080, 34082, 34084, 34200, 34202, 34203, 34204, 34205, 34206, 34207, 34209, 34211, 34212, 34213, 34214, 34300, 34301, 34303, 34304, 34305, 34306, 34307, 34308, 34309, 34310 |
| Code of practice for running safer music festivals and events | 34004 |
| Cultural diversity guide | 34003, 34004, 34006, 34009, 34021, 34040, 34041, 34042, 34044, 34045, 34046, 34047, 34048, 34049, 34050, 34053, 34056, 34057, 34060, 34061, 34062, 34064, 34066, 34069, 34070, 34071, 34078, 34079, 34080, 34082, 34084, 34200, 34202, 34203, 34204, 34205, 34206, 34207, 34209, 34211, 34212, 34213, 34214, 34300, 34301, 34303, 34304, 34305, 34306, 34307, 34308, 34309, 34310 |
| Community Offenders Advice and Treatment Service (COATS): Community Correctional Services and Drug Treatment Services Protocol | 34003, 34004, 34006, 34009, 34021, 34040, 34041, 34042, 34044, 34045, 34046, 34047, 34048, 34049, 34050, 34053, 34056, 34057, 34060, 34061, 34062, 34064, 34066, 34069, 34070, 34071, 34078, 34079, 34080, 34082, 34084, 34200, 34202, 34203, 34204, 34205, 34206, 34207, 34209, 34211, 34212, 34213, 34214, 34300, 34301, 34303, 34304, 34305, 34306, 34307, 34309, 34310 |
| Drugs, Poisons and Controlled Substances Act | 34061, 34308, 34070 |
| Health Complaints Act | 34041, 34045, 34046, 34048, 34049, 34051, 34053, 34056, 34060, 34064, 34074, 34078, 34080, 34084, 34202, 34204, 34205, 34206, 34208, 34006, 34009, 34021, 34040, 34041, 34042, 34044, 34045, 34046, 34047, 34048, 34049, 34050, 34053, 34057,34060, 34061, 34062, 34066, 34069, 34070, 34078, 34079, 34082, 34084, 34200, 34202, 34203, 34205, 34209, 34211, 34212, 34213, 34214, 34300, 34301, 34302, 34303, 34304, 34305, 34306, 34307, 34308, 34309, 34310 |
| Incident Reporting Instruction 2013 | 34003, 34004, 34006, 34009, 34021, 34040, 34041, 34042, 34044, 34045, 34046, 34047, 34048, 34049, 34050, 34053, 34056, 34057, 34060, 34061, 34062, 34064, 34066, 34069, 34070, 34071, 34078, 34079, 34080, 34082, 34084, 34200, 34202, 34203, 34204, 34205, 34206, 34207, 34209, 34211, 34212, 34213, 34214, 34300, 34301, 34303, 34304, 34305, 34306, 34307, 34308, 34309, 34310 |
| Client incident management guide | 34003, 34004, 34006, 34009, 34021, 34040, 34041, 34042, 34044, 34045, 34046, 34047, 34048, 34049, 34050, 34053, 34056, 34057, 34060, 34061, 34062, 34064, 34066, 34069, 34070, 34071, 34078, 34079, 34080, 34082, 34084, 34200, 34202, 34203, 34204, 34205, 34206, 34207, 34209, 34211, 34212, 34213, 34214, 34300, 34301, 34303, 34304, 34305, 34306, 34307, 34308, 34309, 34310 |
| Interagency protocol between Victoria Police and nominated agencies | 34003, 34004, 34006, 34009, 34021, 34040, 34041, 34042, 34044, 34045, 34046, 34047, 34048, 34049, 34050, 34053, 34056, 34057, 34060, 34061, 34062, 34064, 34066, 34069, 34070, 34071, 34078, 34079, 34080, 34082, 34084, 34200, 34202, 34203, 34204, 34205, 34206, 34207, 34209, 34211, 34212, 34213, 34214, 34300, 34301, 34303, 34304, 34305, 34306, 34307, 34309, 34310 |
| Management response to inhalant use: Guidelines for the community care and drug and alcohol sector | 34003, 34004, 34006, 34009, 34021, 34040, 34041, 34042, 34044, 34045, 34046, 34047, 34048, 34049, 34050, 34053, 34056, 34057, 34060, 34061, 34062, 34064, 34066, 34069, 34070, 34071, 34078, 34079, 34080, 34082, 34084, 34200, 34202, 34203, 34204, 34205, 34206, 34207, 34209, 34211, 34212, 34213, 34214, 34300, 34301, 34303, 34304, 34305, 34306, 34307, 34309, 34310 |
| Victorian alcohol and other drug client charter | 34003, 34004, 34006, 34009, 34021, 34040, 34041, 34042, 34044, 34045, 34046, 34047, 34048, 34049, 34050, 34053, 34056, 34057, 34060, 34061, 34062, 34064, 34066, 34069, 34070, 34071, 34078, 34079, 34080, 34082, 34084, 34200, 34202, 34203, 34204, 34205, 34206, 34207, 34209, 34211, 34212, 34213, 34214, 34300, 34301, 34303, 34304, 34305, 34306, 34307, 34308, 34309, 34310 |
| Policy for maintenance pharmacotherapy for opioid dependence (2016)National guidelines for medication-assisted treatment of opioid dependence (2014) | 34047, 34057 |
| The Victorian sexual and reproductive health and viral hepatitis strategy 2022–30Victorian sexually transmissible infection plan 2022–30Victorian HIV plan 2022–30Victorian hepatitis B plan 2022–30Victorian hepatitis C plan 2022–30Victorian women’s sexual and reproductive health plan 2022–30Victorian Aboriginal sexual and reproductive health plan 2022–30Strategy overview and system enabler plan 2022–30Eighth National HIV Strategy 2018–2022Fourth National Sexually Transmissible Infections Strategy 2018–2022Fifth National Aboriginal and Torres Strait Islander Blood-Borne Viruses and Sexually Transmissible Infections Strategy 2018–2022Third National Hepatitis B Strategy 2018–2022Fifth National Hepatitis C Strategy 2018–2022 | 34070, 34308 |
| National needle and syringe programs strategic framework 2010–2014 | 34070, 34308 |
| Medically supervised injecting room performance monitoring framework | 34308 |
| National Ice Action Strategy 2015 | 34041, 34045, 34046, 34048, 34049, 34051, 34053, 34056, 34060, 34064, 34074, 34078, 34080, 34084, 34202, 34204, 34205, 34206, 34208, 34006, 34009, 34021, 34040, 34041, 34042, 34044, 34045, 34046, 34047, 34048, 34049, 34050, 34053, 34057, 34060, 34061, 34062, 34066, 34069, 34070, 34078, 34079, 34082, 34084, 34200, 34202, 34203, 34205, 34209, 34211, 34212, 34213, 34214, 34300, 34301, 34303, 34304, 34305, 34306, 34307, 34308, 34309, 34310 |
| National Drug Strategy 2017–2026 | 34041, 34045, 34046, 34048, 34049, 34051, 34053, 34056, 34060, 34064, 34074, 34078, 34080, 34084, 34202, 34204, 34205, 34206, 34208, 34006, 34009, 34021, 34040, 34041, 34042, 34044, 34045, 34046, 34047, 34048, 34049, 34050, 34053, 34057, 34060, 34061, 34062, 34066, 34069, 34070, 34078, 34079, 34082, 34084, 34200, 34202, 34203, 34205, 34209, 34211, 34212, 34213, 34214, 34300, 34301, 34303, 34304, 34305, 34306, 34307, 34308, 34309, 34310 |
| Service specification for the delivery of selected non- residential alcohol and drug treatment services in Victoria | 34300, 34301, 34302, 34303, 34304 |
| Rainbow eQuality guide | 34003, 34004, 34006, 34009, 34021, 34040, 34041, 34042, 34044, 34045, 34046, 34047, 34048, 34049, 34050, 34053, 34056, 34057, 34060, 34061, 34062, 34064, 34066, 34069, 34070, 34071, 34078, 34079, 34080, 34082, 34084, 34200, 34202, 34203, 34204, 34205, 34206, 34207, 34209, 34211, 34212, 34213, 34214, 34300, 34301, 34303, 34304, 34305, 34306, 34307, 34308, 34309, 34310 |
| Severe Substance Dependence Treatment Act  | 34003, 34004, 34006, 34009, 34021, 34040, 34041, 34042, 34044, 34045, 34046, 34047, 34048, 34049, 34050, 34053, 34056, 34057, 34060, 34061, 34062, 34064, 34066, 34069, 34070, 34071, 34078, 34079, 34080, 34082, 34084, 34200, 34202, 34203, 34204, 34205, 34206, 34207, 34209, 34211, 34212, 34213, 34214, 34300, 34301, 34303, 34304, 34305, 34306, 34307, 34308, 34309, 34310 |
| Practice Standards for Australian Poisons Information Centres 2014 | 34003 |
| Victorian Needle and Syringe Program Operating Policy and Guidelines | 34070, 34308 |

Table 23: Ageing, aged and home care – service standards and guidelines

| Activity no. | Activity name | Service standards and guidelines description  |
| --- | --- | --- |
| 13005 | Aged Care Assessment | Aged Care Act, as amendedMy Aged Care Assessment Manual – for RAS and Aged Care Assessment Teams (2021 and addendums)My Aged Care Screening and Assessment Workforce Training Strategy 2019My Aged Care Screening and Assessment Workforce Training Strategy 2023Aged Care Assessment Program style guide (2020) (Commonwealth Department of Health)Guidelines as provided by the CommonwealthStandards and guidelines for the Commonwealth’s new single assessment model will be provided once available. |
| 13015 | HACC PYP Linkages | Victorian HACC PYP program manualVictorian HACC PYP fees policy |
| 13019 | Personal Alert Victoria | Personal Alert Victoria program and service guidelinesPersonal Alert Victoria response service guidelines |
| 13023 | HACC PYP Service Development Grant | Victorian HACC PYP program manual |
| 13024 | HACC PYP Assessment | Victorian HACC PYP program manual*Framework for Assessment in the HACC PYP program in Victoria 2007* |
| 13026 | HACC PYP Community Care | Victorian HACC PYP program manualVictorian HACC PYP fees policy |
| 13031 | Public Sector Residential Aged Care Supplement | Aged Care Act, as amendedCommonwealth Department of Health resources:[My Aged Care](https://www.myagedcare.gov.au) <https://www.myagedcare.gov.au>[Aged care guides and policies](https://www.health.gov.au/health-topics/aged-care) <https://www.health.gov.au/health-topics/aged-care> |
| 13035 | Support for Carers | Carers Recognition ActVictorian charter supporting people in care relationships and information kitVictorian Support for Carers Program Guidelines 2019 |
| 13038 | HACC PYP Service System Resourcing | Victorian HACC PYP program manual |
| 13043 | HACC PYP Flexible Service Response | Victorian HACC PYP program manualVictorian HACC PYP fees policy |
| 13053 | Victorian Eyecare Service | Victorian Eyecare Service program guidelines (2015, interim) |
| 13056 | HACC PYP Planned Activity Group  | Victorian HACC PYP program manualVictorian HACC PYP fees policy |
| 13063 | HACC PYP Volunteer Co-ordination | Victorian HACC PYP program manual |
| 13067 | Victorian Aids and Equipment | VA&EP guidelines |
| 13082 | Low-cost Accommodation Support | Community Connection Program Quality Standards Framework and Data Collection Guidelines *2001*Flexible Care Fund guidelines for the Older persons high rise programOlder persons high rise program submission guidelinesHousing Support for the Aged program submission guidelinesSRS Oral Health Promotion initiative guidelines 2018 |
| 13096 | HACC PYP Allied Health | Victorian HACC PYP program manualVictorian HACC PYP fees policy |
| 13097 | HACC PYP Delivered Meals | Victorian HACC PYP program manual |
| 13099 | HACC PYP Property Maintenance | Victorian HACC PYP program manualVictorian HACC PYP fees policy |
| 13109 | Aged Care Assessment Service Evaluation Unit | Aged Care Act, as amendedMy Aged Care Assessment Manual – for RAS and Aged Care Assessment Teams (2021) and addendumsMy Aged Care Screening and Assessment Workforce Training Strategy 2019My Aged Care Screening and Assessment Workforce Training Strategy 2023Aged Care Assessment Program style guide (2020) (Commonwealth Department of Health)Guidelines as provided by CommonwealthStandards and guidelines for the Commonwealth’s new single assessment model will be provided once available. |
| 13130 | HACC PYP Volunteer Co-ordination Other | Victorian HACC PYP program manual |
| 13131 | RDNS HACC PYP Allied Health | Victorian HACC PYP program manualVictorian HACC PYP fees policy |
| 13156 | Seniors Health Promotion | Victorian HACC PYP program manualOlder persons high rise program guidelines |
| 13223 | HACC PYP Nursing | Victorian HACC PYP program manualVictorian HACC PYP fees policy |
| 13227 | ACCO Services – HACC PYP | Victorian HACC PYP program manualVictorian HACC PYP fees policy |
| 13229 | HACC PYP Access and Support | Victorian HACC PYP program manual  |
| 13230 | Commonwealth Regional Assessment Services | My Aged Care Assessment Manual – for RAS and Aged Care Assessment Teams (2021) and addendumsVictorian RAS operational guidelines (2023)*My Aged Care quality framework* (2021)My Aged Care Screening and Assessment Workforce Training StrategyGuidelines as provided by the CommonwealthStandards and guidelines for the Commonwealth’s new single assessment model will be provided once available. |
| 13301 | Aged Quality Improvement  | Aged Care Act, as amendedCommonwealth Department of Health resources:[My Aged Care](https://www.myagedcare.gov.au) <https://www.myagedcare.gov.au>[Aged care guides and policies](https://www.health.gov.au/health-topics/aged-care) <https://www.health.gov.au/health-topics/aged-care> |

Table 24: Primary, community and dental health – service standards and guidelines

| Activity no. | Activity name | Service standards and guidelines description |
| --- | --- | --- |
| 2701027011270172701927020270232702427025270262702827029 | Dental health  | [Dental health](https://www.health.vic.gov.au/primary-and-community-health/dental-health) <https://www.health.vic.gov.au/primary-and-community-health/dental-health> |
| 28015280162801828050280632806428068280672808528086 | Women’s health | [Improving women’s health](https://www.health.vic.gov.au/populations/improving-womens-health) <https://www.health.vic.gov.au/populations/improving-womens-health>[Health promotion](https://www.health.vic.gov.au/population-health-systems/health-promotion) <https://www.health.vic.gov.au/population-health-systems/health-promotion> |
| 28021280662808528086 | Young people | [Community Health Integrated Program guidelines](https://www.health.vic.gov.au/community-health/community-health-integrated-program-chip-guidelines) <https://www.health.vic.gov.au/community-health/community-health-integrated-program-chip-guidelines>[Children, youth and families](https://www.health.vic.gov.au/community-health/children-youth-and-families) <https://www.health.vic.gov.au/community-health/children-youth-and-families>[Young people who are homeless or at risk](https://www.health.vic.gov.au/community-health/young-people-who-are-homeless-or-at-risk) <https://www.health.vic.gov.au/community-health/young-people-who-are-homeless-or-at-risk> |
| 2803328043280692807428080280842808528086 | Community health | [Community Health Integrated Program guidelines](https://www.health.vic.gov.au/community-health/community-health-integrated-program-chip-guidelines) <https://www.health.vic.gov.au/community-health/community-health-integrated-program-chip-guidelines>[Victorian health and wellbeing plan](https://www.health.vic.gov.au/victorian-health-and-wellbeing-plan) <https://www.health.vic.gov.au/victorian-health-and-wellbeing-plan> [*Victorian Aboriginal Affairs Framework 2018–23*](https://www.firstpeoplesrelations.vic.gov.au/victorian-aboriginal-affairs-framework-2018-2023) <https://www.firstpeoplesrelations.vic.gov.au/victorian-aboriginal-affairs-framework-2018-2023>[Healthy choices: policy directive and guidelines for health services](https://www.health.vic.gov.au/publications/healthy-choices-policy-directive-and-guidelines-for-health-services) (applicable to integrated community health services) <https://www.health.vic.gov.au/publications/healthy-choices-policy-directive-and-guidelines-for-health-services>[Registration and governance of community health services](https://www.health.vic.gov.au/community-health/registration-and-governance-of-community-health-centres)<https://www.health.vic.gov.au/community-health/registration-and-governance-of-community-health-centres>[Community Health Demand Management Toolkit](https://www.health.vic.gov.au/community-health/managing-demand-for-community-health-services)<https://www.health.vic.gov.au/community-health/managing-demand-for-community-health-services>[Community Health Program access policy](https://www.health.vic.gov.au/community-health/community-health-program-access-policy)<https://www.health.vic.gov.au/community-health/community-health-program-access-policy> |
| 28048280762808528086 | Culturally diverse groups  | [Refugee Health Program](https://www.health.vic.gov.au/community-health/refugee-health-program) <https://www.health.vic.gov.au/community-health/refugee-health-program> includes the:Guide to asylum seeker access to health and community services in Victoria – these standards should be referenced until supersededGuide for the Refugee Health Nurse ProgramRefugee and asylum seeker health services: Guidelines for the community health program[Refugee and asylum seeker health and wellbeing](https://www.health.vic.gov.au/populations/refugee-and-asylum-seeker-health-and-wellbeing) <https://www.health.vic.gov.au/populations/refugee-and-asylum-seeker-health-and-wellbeing> includes the Refugee and Asylum Seekers Health Action Plan 2014–18[Cultural responsiveness framework – Guidelines for Victorian health services](https://www.health.vic.gov.au/publications/cultural-responsiveness-framework-guidelines-for-victorian-health-services) <https://www.health.vic.gov.au/publications/cultural-responsiveness-framework-guidelines-for-victorian-health-services> outlines the government’s approach to cultural responsiveness in health services[Language services policy](https://www.health.vic.gov.au/publications/language-services-policy) <https://www.health.vic.gov.au/publications/language-services-policy>[Health Translations Directory](http://www.healthtranslations.vic.gov.au) <https://www.healthtranslations.vic.gov.au> |
| 28054 | Partnerships and system support | [Working with general practice](https://www.health.vic.gov.au/primary-care/working-with-general-practice) <https://www.health.vic.gov.au/primary-care/working-with-general-practice> |
| 280712808528086 | Aboriginal health | [Community Health Integrated Program guidelines](https://www.health.vic.gov.au/community-health/community-health-integrated-program-chip-guidelines) <https://www.health.vic.gov.au/community-health/community-health-integrated-program-chip-guidelines>[Aboriginal health](https://www.health.vic.gov.au/health-strategies/aboriginal-health) <https://www.health.vic.gov.au/health-strategies/aboriginal-health>[*Victorian Aboriginal Affairs Framework 2018–23*](https://www.firstpeoplesrelations.vic.gov.au/victorian-aboriginal-affairs-framework-2018-2023) <https://www.firstpeoplesrelations.vic.gov.au/victorian-aboriginal-affairs-framework-2018-2023> |
| 2807228074280812808528086 | People with chronic disease | [Community Health Integrated Program guidelines](https://www.health.vic.gov.au/community-health/community-health-integrated-program-chip-guidelines) <https://www.health.vic.gov.au/community-health/community-health-integrated-program-chip-guidelines> |
| 2808028085280862821228213 | Maternal health | [Community Health Integrated Program guidelines](https://www.health.vic.gov.au/community-health/community-health-integrated-program-chip-guidelines) <https://www.health.vic.gov.au/community-health/community-health-integrated-program-chip-guidelines>[Healthy Mothers, Healthy Babies](https://www.health.vic.gov.au/community-health/healthy-mothers-healthy-babies) <https://www.health.vic.gov.au/community-health/healthy-mothers-healthy-babies>[Sleep and settling](https://www.health.vic.gov.au/maternal-child-health/sleep-and-settling) <https://www.health.vic.gov.au/maternal-child-health/sleep-and-settling> |
| 280822808528086 | Child health | [Child health services: Guidelines for the community health program](https://www.health.vic.gov.au/publications/child-health-services-guidelines-for-the-community-health-program) <https://www.health.vic.gov.au/publications/child-health-services-guidelines-for-the-community-health-program>[Child health teams](https://www.health.vic.gov.au/community-health/child-health-teams) <https://www.health.vic.gov.au/community-health/child-health-teams>.**Note**: Organisations receiving funds regarding 28085/28086 should note these funds can be applied flexibly across the range of initiatives to meet community needs |

Table 25: Public health – service standards and guidelines

| Activity no. | Service standards and guidelines description  |
| --- | --- |
| 1637316377650516506165071650816509 | BBV/STI program guidelines for funded agencies (current edition) |
| 16454 | [Victorian health and wellbeing plan](https://www.health.vic.gov.au/victorian-health-and-wellbeing-plan) <https://www.health.vic.gov.au/victorian-health-and-wellbeing-plan>[Municipal public health and wellbeing planning](https://www.health.vic.gov.au/population-health-systems/municipal-public-health-and-wellbeing-planning)<https://www.health.vic.gov.au/population-health-systems/municipal-public-health-and-wellbeing-planning>[Healthy choices policy guidelines](https://www.health.vic.gov.au/preventive-health/healthy-choices)<https://www.health.vic.gov.au/preventive-health/healthy-choices>[Healthy Choices: policy directive and guideliines for health](https://www.health.vic.gov.au/publications/healthy-choices-policy-directive-and-guidelines-for-health-services) services <https://www.health.vic.gov.au/publications/healthy-choices-policy-directive-and-guidelines-for-health-services> |
| 28085 | [Community Health – Health Promotion program 2021–25](https://www.health.vic.gov.au/publications/community-health-health-promotion-2021-25)<https://www.health.vic.gov.au/publications/community-health-health-promotion-2021–25> |

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# Glossary and acronyms

| Term | Definition |
| --- | --- |
| ACAS | aged care assessment services |
| ACCHO | Aboriginal Community Controlled Health Organisation |
| ACCO | Aboriginal community-controlled organisation |
| ACSQHC | Australian Commission on Safety and Quality in Health Care |
| AHPRA | Australian Health Practitioner Regulation Agency |
| AHWPF | Aboriginal Health and Wellbeing Partnership Forum |
| AIMS | Agency Information Management System |
| AMAF | Asset management accountability framework |
| AN-ACC | Australian National Aged Care Classification |
| ANZICS | Australian and New Zealand Intensive Care Society |
| ANZSCTS | Australian and New Zealand Society of Cardiac and Thoracic Surgeons |
| AOD | Alcohol and other drug |
| AuSCR | Australian Stroke Clinical Registry |
| BBV | blood-borne virus |
| BIA | Business Impact Analysis |
| BPCLE | Best practice clinical learning environment (framework) |
| CAMHS | Child and adolescent mental health services |
| CCOPMM | Consultative Council on Obstetric and Paediatric Mortality and Morbidity |
| CCUs | Community Care Units |
| CES | Carer Experience Survey |
| CIS | Clinical Information System |
| CISS | Child Information Sharing Scheme |
| CMI/ODS | Client Management Interface and Operational Data Store |
| Cth | Commonwealth |
| DAPIS | Drugs and poisons information system |
| the department | Department of Health |
| DFFH | Department of Families, Fairness and Housing |
| DLO | disability liaison officer |
| DWAU | dental weighted activity unit |
| ECT | electroconvulsive treatment |
| EDMS | Environmental data management system |
| EIPSR | Early Intervention Psychosocial Support Response  |
| EIRP | Engineering Infrastructure Replacement Program |
| EMR | Electronic Medical Record |
| EPC | Early Parenting Centre(s) |
| EQuIP | Evaluation and Quality Improvement Program |
| eReferrals | electronic referrals |
| ESIS | Elective Surgery Information System |
| Forensicare | Victorian Institute of Forensic Mental Health |
| FRD 24 | Financial Reporting Direction 24 |
| FTE | full-time equivalent |
| GEM | Geriatric Evaluation and Management |
| GenV | Generation Victoria |
| GP | general practitioner |
| GST | Goods and Services Tax |
| HACC PYP | Home and Community Care Program for Younger People |
| HDSS | Health Data Standards and Systems |
| HeART | Health Agencies Reporting Tool |
| HITH | Hospital in the Home |
| HLO | health liaison officer |
| HOPE | Hospital Outreach Post-suicidal Engagement Program |
| ICS | Integrated Cancer Service |
| ICT | Information and communication technology |
| IP | Intellectual Property  |
| KMHLO | Koori Mental Health Liaison Officer  |
| LPHU | Local Public Health Unit |
| Making It Free | Making It Free to Study Nursing and Midwifery |
| MARAM | Family violence multi-agency risk assessment and management framework |
| MBS | Medicare Benefits Schedule |
| MDS | Minimum Dataset |
| MERP | Medical Equipment Replacement Program |
| MFT | Managed File Transfer |
| MHCSS | Mental Health Community Support Services |
| MHPAF | Mental health performance and accountability framework |
| Monitor | Victorian Health Services Performance Monitor |
| NADC | Non-Admitted Data Collection |
| NATA | National Association of Testing Authorities |
| NBCSP | National Bowel Cancer Screening Program |
| NDIA | National Disability Insurance Agency |
| NDIS | National Disability Insurance Scheme |
| NEPT | Non-Emergency Patient Transport  |
| NGO | non-government organisation |
| NIST | National Institute of Standard and Technology |
| NSQHS | National Safety and Quality Health Service |
| OCP | Office of the Chief Psychiatrist |
| PARC | Prevention and recovery care |
| PAS | Patient Administration System |
| PAV | Personal Alert Victoria |
| PAVRS | Personal Alert Victoria Response Services |
| PBS | Pharmaceutical Benefits Scheme |
| PCCP | Palliative Care Consultancy Program |
| PGY | postgraduate year |
| PHESS | Public Health Event Surveillance System |
| PHN | Primary Health Network |
| PHORMS | Public Health Operational Response Management System |
| PMCV | Postgraduate Medical Council of Victoria |
| PPCC | Priority Primary Care Centre |
| PRISM | Program Report for Integrated Service Monitoring |
| PSRACS | public sector residential aged care services |
| RAS | Regional Assessment Services |
| RCVMHS | Royal Commission into Victoria’s Mental Health System |
| RTO | Recovery Time Objective |
| RUSOM | Registered Undergraduate Student of Midwifery |
| RUSON | Registered Undergraduate Student of Nursing |
| SAPSE | serious adverse patient safety events |
| SCIg | Subcutaneous immunoglobulin |
| SCIP | Statewide Cancer Indicator Platform |
| SCV | Safer Care Victoria |
| SDC | Statutory Duty of Candour |
| SECU | secure extended care unit |
| SEMP | State Emergency Management Plan  |
| SHEA | State Health Emergency Arrangements  |
| SHRFV | Strengthening Hospital Responses to Family Violence |
| SOP | Statement of Priorities |
| SPCG | Specific Purpose Capital Grants |
| SRHS | small rural health service |
| SRV | Sport and Recreation Victoria |
| STI | sexually transmissible infections |
| TAFE | Technical and Further Education |
| TB | tuberculosis |
| TREVI | Transmission and Response Epidemiology Victoria |
| UCC | Urgent Care Clinic |
| VA&EP | Victorian Aids and Equipment Program |
| VACCHO | Victorian Aboriginal Community Controlled Health Organisation |
| VADC | Victorian Alcohol and Drug Collection |
| VADS | Victorian Ambulance Dataset |
| VAED | Victorian Admitted Episodes Dataset |
| VAHI | Victorian Agency for Health Information |
| VCDC | Victorian Cost Data Collection |
| VCSS | Victorian Community Support Services (formerly HACC) minimum dataset |
| VEMD | Victorian Emergency Minimum Dataset |
| VES | Victorian Eyecare Service |
| VHBA | Victorian Health Building Authority |
| VHES | Victorian Healthcare Experience Survey |
| VHIMS | Victorian Health Incident Management System |
| VICNISS | Victorian Healthcare Associated Infection Surveillance System |
| VIHSP | Victorian Infant Hearing Screening Program |
| VINAH | Victorian Integrated Non-Admitted Health minimum dataset |
| VMIA | Victorian Managed Insurance Authority |
| VMST | Victorian Medical Specialist Training |
| VPAS | Victorian Perinatal Autopsy Service |
| VPCC | Victorian Perioperative Consultative Council |
| VPDC | Victorian Perinatal Data Collection |
| VPHWP | Victorian Public Health and Wellbeing Plan |
| VRGP | Victorian Rural Generalist Program |
| VRSS | Victorian Respiratory Support Service |
| VVED | Victorian Virtual Emergency Department |
| YES | Your Experience of Service |
| YPARC | youth prevention and recovery care |

1. [<](file:///Users/andrewmacrae/Desktop/%3C)https://www.health.vic.gov.au/sites/default/files/2022-08/service-framework-local-adult-and-older-adult-mhw-services-August-2022.pdf> [↑](#footnote-ref-2)
2. State of Victoria 2021, *Royal Commission into Victoria’s Mental Health System, final report*, vol. 1: A new approach to mental health and wellbeing in Victoria, Parl. Paper No. 202, Session 2018–21 (document 2 of 6), p. 249. [↑](#footnote-ref-3)
3. Health services are to contact finance departments to obtain the circular 23/2009. [↑](#footnote-ref-4)
4. To support sustainability of the Aboriginal community-controlled sector, the department has commenced transitioning ACCOs to outcomes-based funding (OBF), starting with the delivery of multi-year (four year) recurrent funding cycles from July 2023. [↑](#footnote-ref-5)
5. Note that health services should not rely solely on their Aboriginal Cultural Safety Fixed Grants for this training. Cultural safety is a critical quality and safety issue, and health services need to consider broad budgets, such as corporate Learning and Development (L&D) budgets. [↑](#footnote-ref-6)
6. https://content.health.vic.gov.au/sites/default/files/2024-02/victorian-health-workforce-strategy.pdf, p 22 [↑](#footnote-ref-7)
7. Those health services will be directly notified of this expectation by the department. [↑](#footnote-ref-8)
8. See <https://vpsc.vic.gov.au/workforce-programs/aboriginal-employment/barring-djinang-strategy/> [↑](#footnote-ref-9)
9. [NSQHS Standards User guide for Aboriginal and Torres Strait Islander health](https://www.safetyandquality.gov.au/publications-and-resources/resource-library/nsqhs-standards-user-guide-aboriginal-and-torres-strait-islander-health) <https://www.safetyandquality.gov.au/publications-and-resources/resource-library/nsqhs-standards-user-guide-aboriginal-and-torres-strait-islander-health>. [↑](#footnote-ref-10)
10. [The health and wellbeing of the LGBTIQ+ population in Victoria: findings from the Victorian Population Health Survey 2017](The%20health%20and%20wellbeing%20of%20the%20LGBTIQ%2B%20population%20in%20Victoria%3A%20findings%20from%20the%20Victorian%20Population%20Health%20Survey%202017) <https://vahi.vic.gov.au/report/population-health/health-and-wellbeing-lgbtiq-population-victoria>. [↑](#footnote-ref-11)
11. A registered account with login and password is required to access the portal. [↑](#footnote-ref-12)
12. Final cut-off dates for the estimates trial balance submission that will contribute to the 30 June year-end cap will be communicated separately. These submissions will contribute to the determination of the current financial year revised budget numbers, as part of the State of Victoria Budget Papers preparation process. [↑](#footnote-ref-13)
13. The *Whole of Victorian Government pledge* and *Health and human services climate change adaptation action plan* are updated every five years. An update of the pledge is expected in 2025. This may have additional requirements applicable to health services. [↑](#footnote-ref-14)
14. Initiative 3.4 in [Victoria’s digital health roadmap](https://www.health.vic.gov.au/publications/victorias-digital-health-roadmap). <https://www.health.vic.gov.au/publications/victorias-digital-health-roadmap> [↑](#footnote-ref-15)
15. Can be found as initiative 3.4 in [Victoria’s digital health roadmap](https://www.health.vic.gov.au/publications/victorias-digital-health-roadmap). <https://www.health.vic.gov.au/publications/victorias-digital-health-roadmap> [↑](#footnote-ref-16)
16. A registered account with login details is required to access the portal. [↑](#footnote-ref-17)
17. The increase excludes the impact of bond rate and probability factors (revaluations). [↑](#footnote-ref-18)
18. The HeART replaces the previously used ‘F1’ template from the July 2021 reporting period onwards. [↑](#footnote-ref-19)
19. A registered account with login details is required to access the portal. [↑](#footnote-ref-20)
20. A registered account with login details is required to access the portal. [↑](#footnote-ref-21)
21. A registered account with login details is required to access the portal. [↑](#footnote-ref-22)
22. Permission from the OCP is required to access the Register. [↑](#footnote-ref-23)
23. Methicillin-resistant *Staphylococcus aureus*, vancomycin-resistant enterococci and *Clostridium difficile* infection [↑](#footnote-ref-24)
24. Royal District Nursing Service [↑](#footnote-ref-25)
25. Aboriginal community-controlled organisation [↑](#footnote-ref-26)
26. HoNOS refers to the Health of the Nation Outcome Scale and is a key mental health consumer outcome measure that has been implemented nationally. A capable service is results oriented and has systems in place to regularly monitor client outcomes. Work on activity-based funding development also draws on HoNOS. [↑](#footnote-ref-27)
27. Behaviour and Symptoms Identification Scale (BASIS-32) and Strengths and Difficulties Questionnaire (SDQ) are used by consumers and/or carers (SDQ only), to present their views on how well they can cope with their usual activities, to inform discussions with the Area Mental Health and Wellbeing Service. There are collected as part of the outcome measures suite at predefined points of time. Consumers should be actively involved in treatment planning, decision-making and definition of treatment objectives. Consumer self-assessment outcome measures provide one mechanism for achieving this goal. [↑](#footnote-ref-28)
28. There is slight variation in definition, because results are attributed to the client’s home Area Mental Health and Wellbeing Service, not the separating Area Mental Health and Wellbeing Service, as for adults and older people. [↑](#footnote-ref-29)
29. Assisted reproductive treatment [↑](#footnote-ref-30)