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| Policy and Funding Guidelines 2022–2023 |
| **Policy Guide** |

This Policy Guide sets out the operational and service  
delivery policy changes relevant to, and obligations and standards required of, government-funded healthcare organisations. The Guide is underpinned by the aim to help Victorians stay safe and healthy, and deliver a world-class healthcare system that leads to better health outcomes for all Victorians.

The *Policy and Funding Guidelines 2022–2023* (the Guidelines) represent the system-wide terms and conditions (for funding, administrative and clinical policy) of funding for government-funded healthcare organisations.

The Guidelines reflect the government and department’s role as system stewards, and underpin the department’s individual contracts with funded organisations (including but not limited to Statements of Priorities (SOPs) and service agreements). They set out the requirements that funded organisations must comply with as part of their contractual and statutory obligations, outline activity that is required to receive funding, and provide detailed expectations of administrative and clinical conduct.

The guidelines are relevant for all funded organisations, which include health services, community service organisations and other funded organisations, such as Ambulance Victoria.

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

Funded organisations should always refer to 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> for the most recent version of the publications that comprise the guidelines, as items may be updated throughout the year.

Where these guidelines refer to a statute, regulation or contract, the reference and information provided is descriptive only.

In the case of any inconsistencies or ambiguities between these guidelines, and any legislation, regulations and contractual obligations with the State of Victoria, acting through the Department of Health (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.

**Please note:** Service agreements are contractual arrangements between entities funded to deliver services in the community and the department, which provides funding for this. Should your entity be funded through a service agreement, for funding information and activity tables that underpin service agreements, please visit the [service agreement website](https://fac.dhhs.vic.gov.au/service-agreement) <https://fac.dffh.vic.gov.au/service-agreement>.

Those entities funded by 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>.

To receive this publication in an accessible format email [Commissioning and System Improvement; Accountability](mailto:accountability@health.vic.gov.au) on <Accountability@health.vic.gov.au>.

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In this document, ‘Aboriginal’ refers to both Aboriginal and Torres Strait Islander people. ‘Indigenous’ or ‘Koori/Koorie’ is retained when part of the title of a report, program or quotation.

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# Overview of the Policy and Funding Guidelines 2022–23

The *Policy and Funding Guidelines 2022–23* (the Guidelines) represent the system-wide terms and conditions for government-funded healthcare organisations (funded organisations), which include 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 operational and service delivery policy changes, and outline contractual, statutory, and other duties and requirements
* detail the budgetary landscape, including funding and pricing arrangements, as well as funded activity and targets
* consist of two separate, although interconnected, publications: the Policy Guide and the Funding Rules.

Policy Guide

The Policy Guide provides detailed information on various operational and service delivery policy items, including the conditions within which funded organisations operate, as well as the obligations, standards and requirements to which funded organisations are expected to adhere.

Part 1: Operational and Service Delivery Policy

Part 1 is not intended to be a complete, holistic guide to operational and service delivery policy in Victoria, but instead provides an annual publication to health services that identifies and highlights the novel policy changes for a range of delivered services.

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.

# 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 (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, but 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 2022–23.

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 by the Commonwealth’s Medical Services Advisory Committee. Highly specialised therapies are provided at selected public hospitals. The *National implementation framework* endorsed by the Health Chief Executives Forum has been developed to ensure there is a nationally consistent approach to implementing, monitoring and evaluating 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 and Peter MacCallum Cancer Centre
* CAR T-cell 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 The Alfred
* 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
* 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.

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 servicesto 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. This checklist will be provided by the department to endorsed health services as required.

## 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. The membership subscription scheme fees will be indexed at a rate of 1.75 per cent from 2021-22 prices. In 2022–23, a single 12-month membership will be $49.94 and $99.87 for a family 12-month membership.

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
* the Victorian WorkCover Authority 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 the [Ambulance Victoria fees 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 are 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 inter-hospital 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 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 and personal care, hotel services (for example, nutrition, bed and clean facilities), the required clinical support services (for example, allied health, 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 credentialled 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
* 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 is clinical governance
* 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, 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

### Perinatal Autopsy Service

The Victorian Perinatal Autopsy Service is a specialist perinatal pathology service available for Victorian families who have experienced pregnancy loss from 20+ weeks’ gestation. The service is fully funded, with service coordination and administration provided by The Royal Women’s Hospital. Services are provided at an agreed rate by three level-6 maternity services (The Royal Women’s Hospital, Monash Health and Mercy Hospital for Women), and their respective pathology service providers.

The value of a perinatal or infant autopsy and pathological examination of the placenta should be explained and offered to parents where there is uncertainty about the cause of death.

All public health services are expected to use the service. Private health services are also encouraged to use the service. 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.

For comprehensive information on access to the service (including pathology requests), parental consent forms, 24-hour advice and clinical practice guidelines, please visit the [Victorian Perinatal Autopsy Service website](https://www.thewomens.org.au/health-professionals/vpas) <https://www.thewomens.org.au/health-professionals/victorian-perinatal-autopsy-service>.

### 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.

Read more about [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 per cent and 37 per cent, 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 2022–23. This supply plan has been negotiated between the government, the National Blood Authority and the Australian Red Cross LifeBlood (previously known as the Blood Service). Victoria’s contribution in 2022–23 will be more than $130 million.

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 2022–23. 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.

More information about intravenous immunoglobulin is available from the [Criteria for the Clinical Use of Immunoglobulin in Australia webpage](https://www.blood.gov.au/ig-criteria) <https://www.blood.gov.au/ig-criteria>.

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. More information about access is available from 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. More information about normal immunoglobulin is available from [Access to Normal Human Immunoglobulin (NHIg) in Australia](https://www.blood.gov.au/NHIg) <https://www.blood.gov.au/NHIg>.

There is an ongoing commitment to safe transfusion practice in health services through the Blood Matters Program. Read more about [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 health care in both acute and outpatient settings.

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

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

Public clinical genetic services are provided through three metropolitan hubs at:

* Parkville – Victorian Clinical Genetics Services, The Royal Children’s Hospital, The Royal Melbourne Hospital, The Royal Women’s Hospital and Peter MacCallum Cancer Centre. An ocular genetics clinic based at the Royal Victorian Eye and Ear Hospital also operates through a partnership with Royal Melbourne Hospital
* Clayton – Monash Medical Centre
* Heidelberg – Austin Hospital and Mercy Hospital for Women.

These hubs also 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.

In 2022–23, funding to support the Victorian Government’s initiative for genomic sequencing for children and adults with rare diseases and undiagnosed conditions has been continued to 30 June 2023. This budget commitment facilitates access to a potential clinical diagnosis, avoiding the costly and lengthy diagnostic odyssey these patients currently undergo. This funding supports access to genomic sequencing that is not funded under Medicare. The clinical care is provided through the hubs, including in rural and regional Victoria, through outreach clinics.

Activity data is to be reported to the department to inform funding and policy decisions, and as new genetic and genomic tests are added to Medicare. 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 data set 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 [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.

Read more about [direct-acting antiviral hepatitis C treatments](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 Service

Public fertility care services are to be progressively offered by selected public health services from 2022. Access to a broad range of assisted reproductive treatment and the establishment of access to a public egg and sperm bank, for the first time in Victoria, will ensure that more eligible Victorians, who are currently unable to afford treatment and/or are underserved or excluded in Victoria’s well-established private market, can access services. This includes single people, LGBTIQ+ Victorians, and people with cancer or genetic conditions who need fertility care.

The model of care will operate under a number of principles aimed at delivering public fertility care services in Victoria, including:

* **high-quality, safe, value-based care** – services will provide safe, evidence-based and high-value public fertility care to Victorians, which maximises the total number of people able to benefit from this initiative, using evidence-based access criteria and treatments. Providers will foster continuous improvement in the safety and quality of the fertility care they provide
* **person-centred care** – providers will offer a broad range of fertility care services that are clinically appropriate to the needs of the patient and their individual circumstances. The health and wellbeing, including emotional and mental health, of persons undergoing treatment, donors and surrogates will be protected
* **equitable access** – services will improve access to people currently underserved or excluded in Victoria’s current market, such as low-income earners, people who need access to donor or surrogacy services, people who need fertility preservation due to medical treatment and people who need genetic testing for monogenic conditions
* **Inclusive and culturally safe** – services will be inclusive of, and accessible to, a broad range of service users and families, including single people, Aboriginal Victorians, LGBTIQ+ Victorians, people with a disability, people from culturally diverse communities, and people from rural and regional communities.

## Mental Health and Wellbeing Services

### Community Mental Health and Wellbeing Services

#### New Community Mental Health and Wellbeing System

The mental health and wellbeing system is being transformed around a community-based model of care, in which people receive most services locally and in the community throughout Victoria, close to their families, carers, supporters and networks.

The service system will consist of six levels (Figure 1). Each level will connect with the next, providing a system of staged care, with service providers working together to create a responsive and integrated mental health and wellbeing system.

Figure 1: Mental health and wellbeing six-level system

Regional Mental Health  
 and Wellbeing Boards

Families, carers and supporters, informal supports, virtual communities,  
and communities of place, identity and interest

Broad range of government and community services

Primary and secondary mental health and related services

Local Mental Health and Wellbeing Services

Area Mental Health and Wellbeing Services

Statewide services

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

The new service arrangement includes two parallel age-based systems: one for infants, children and young people (0–25 years), and the other for adults and older adults (26+ years).

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 2: Mental health and wellbeing age-based streams

Wellbeing system (0–25)

Adult and older adult mental health and wellbeing system (26+)

Infant, child and family mental health and wellbeing service stream (0–11)

Youth mental health and wellbeing service stream (12–25)

Older adult mental health and wellbeing service stream

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

#### New Integrated and Responsive System and Regional Bodies

Throughout 2022–23, health services will have an opportunity to support the development of new system-wide architecture and associated reforms, including a new Mental Health and Wellbeing Act, implementation of Victoria’s *Mental Health and Wellbeing Workforce Strategy 2021–2024,* and preparing for the introduction of activity-based funding for mental health and wellbeing services.

Eight interim regional bodies 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 interim regional bodies are the first step in a phased transition towards regional governance and will be in place until the establishment of Regional Mental Health and Wellbeing Boards. The Boards will be established by the end of 2023, subject to being legislated.

They will also provide a platform for strong community participation, and greater engagement, collaboration and integration across services, beyond the mental health and wellbeing system, including both Victorian Government and Commonwealth Government/Primary Health Network-funded services.

#### Local Mental Health and Wellbeing Services

Locally based mental health and wellbeing services are currently being established for adults, older adults, and infants and children. Local services will be formally networked with Area Mental Health and Wellbeing Services, enabling a smooth transition between different levels of treatment and support.

Local Adult and Older Adult Mental Health and Wellbeing Services will be required to provide integrated treatment, care and support to people living with mental illness and substance use or addiction.

In 2022–23, the first tranche of Local Adult and Older Adult Local Mental Health and Wellbeing Services will commence operating in the areas of Greater Geelong and Queenscliff, Brimbank, Whittlesea, Frankston, Latrobe and Benalla, Wangaratta and Mansfield.

Set to open from mid-2023 onwards, the next 21 Local Adult and Older Adult Mental Health and Wellbeing Services will be located in Dandenong, Shepparton, Melton, Mildura, Lilydale, Bendigo, Echuca, Orbost, Bairnsdale, Melbourne, Werribee, Truganina, Ballarat, Craigieburn, Sunbury, Ringwood, Horsham, Ararat, Warrnambool, Hamilton and Portland.

Three new infant, child and family local services based in community health services, and providing comprehensive care for children 0–11 years with developmental, emotional, behavioural challenges, will be established in 2022–23 in the Department of Families, Fairness and Housing regions of Brimbank-Melton, Southern Melbourne and Loddon.

#### Area Mental Health and Wellbeing Services

Area Mental Health and Wellbeing Services are being transformed to provide more capacity and expanded services. This includes 22 Adult and Older Adult Area Mental Health and Wellbeing Services, and 13 new Infant, Child and Youth Area Mental Health and Wellbeing Services.

The priorities for Area Mental Health and Wellbeing Services are outlined below, consistent with completed transformation plans. In 2022–23, the focus will be on implementation of these plans. Funding will continue to be provided to support transformation and deliver key priority reforms.

##### Embedding lived experience in the leadership, design and delivery of Area Mental Health and Wellbeing Services

Embedding lived experience in the leadership, decision-making, design and delivery of reform of mental health and wellbeing services will mean that implementation reflects what consumers and carers want and need, and will benefit from their valuable experiences and perspectives.

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

* support and expand their consumer and carer consultants, and their peer support workforces
* ensure people with lived experience who work from that perspective are represented on senior management teams
* use co-design and service feedback methods that are trustworthy to lived-experience communities.

##### Establishing two service streams for Area Mental Health and Wellbeing Services

Health services are to establish two service streams and resource them adequately to provide timely, developmentally appropriate treatment, care and support, with coordinated, seamless transitions between the two services of:

* the infant, child and youth area mental health and wellbeing stream for Victorians aged 0–25 and their families (inclusive of the young person’s twenty-fifth year), noting that this service stream has two distinct sub-streams of 0–11-year-olds (inclusive of the child’s eleventh year) and 12–25-year-olds
* the adult and older adult area mental health and wellbeing stream for Victorians aged 26 years and older.

##### Expanding and increasing core clinical capacity

Core clinical capacity continues to expand in 2022–23. A new allocation model has been deployed that estimates demand for tertiary-level services within each age group, using the *National mental health service planning framework*, to ensure that:

* funding reflects the level of therapeutic intervention each person needs to achieve a good therapeutic outcome
* growth is distributed to lift the activity levels of health services that have historically been funded less than their share, relative to demand
* every health service will be able to provide treatment, care and support to significantly more people.

The department will monitor health services’ performance against targets (including after-hours, and primary and secondary support). The department will have regular performance discussions with health services, including a mid-year review.

The performance management approach will evolve to ensure there is line of sight on areas that the Royal Commission into Victoria’s Mental Health System (RCVMHS) called out as essential reforms, such as the level of therapeutic intervention a person receives, the accessibility of services, and primary and secondary consultation.

With this significant 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 stream, and the adult and adult older area mental health and wellbeing stream, to ensure it aligns with the directions in the RCVMHS’s Interim Report and Final Report, and best practice.

Community mental health teams should be delivering the full scope of practice now expected of them since the RCVMHS, including (but not limited to):

* triage and navigation functions, and warm referrals to other parts of the mental health and wellbeing system, including Local Mental Health and Wellbeing Services where they are established
* case management at appropriate levels of intervention to achieve a positive therapeutic outcome, with a comprehensive range of best-practice pharmacological and psychology therapies available
* single-session therapy as standard practice for appropriate clients
* 24/7 crisis support
* proactive engagement of consumers who are hard to reach or prematurely disengaged from treatment, including mobile assertive outreach teams in Youth Area Mental Health and Wellbeing Services
* same or next-day follow up for mental health presentations to hospital emergency departments
* sufficient levels of consultation liaison into general medical wards
* active and respectful engagement and inclusion of families, carers and supporters, including the provision of support, therapy and/or referral to other parts of the mental health and wellbeing system
* clinical assessments for autism spectrum disorder.

Detailed business rules will be progressively developed and communicated to health services.

Recall policy has been tightened up to ensure increased community service mental health funding results in the delivery of extra services. Recall policy will be managed at the health service level and there will be no payment for overperformance. Refer to Table 1.5 in the Funding Rules for recall rates.

##### Increasing the accessibility of Area Mental Health and Wellbeing Services

Area Mental Health and Wellbeing Services are delivering an increasing proportion of activity outside of business hours. To achieve this, the proportion of activity that is delivered outside of normal business hours will increase to 20 per cent by 2024–25.

##### Primary and secondary consultation across services and the system

Area Mental Health and Wellbeing Services will receive funding to provide primary and secondary consultation.

As a core responsibility of community teams, clinicians and support staff from Area Mental Health and Wellbeing Services will actively ‘reach in’ to other systems, such as primary care, community health, early parenting centres, maternal and child health nurses, child protection, alcohol and other drugs (AOD) services, schools, universities and Victorian Technical and Further Education (TAFE), and family violence, to see Victorians engaged in these systems, provide joint clinical care with clinicians and workers in these systems, and build capability and relationships.

Primary and secondary consultation and shared models are important in establishing staged care between Area Mental Health and Wellbeing Services and Local Mental Health and Wellbeing Services. It will assist people to move between the two tiers as their needs change, and facilitate coordinated referral pathways and strong relationships at service and clinician levels, between these two tiers at local levels. Primary and secondary consultation will also help to build the capability of Local Mental Health and Wellbeing Services.

As such, Area Mental Health and Wellbeing Services will prioritise primary and secondary consultation into the three aged-based categories of Local Mental Health and Wellbeing Services, being:

* three infant and child health and wellbeing hubs (as established in three areas)
* headspace centres
* Local Adult and Older Adult Mental Health and Wellbeing Services (as established in six areas in 2022–23).

###### Partnerships with non-government organisation that provide wellbeing supports

As a mechanism to achieve a better balance of clinical treatment and wellbeing supports, Area Mental Health and Wellbeing Services must partner with clinical mental health services and non-government providers of wellbeing supports.

This will provide for integrated wellbeing supports delivered to Victorians receiving treatment, care and support from all Area Mental Health and Wellbeing Services from 2022–23, as recommended by the RCVMHS under Core Function 1: Integrated treatment, care and support.

Further guidance about the new partnership arrangements will be provided, so they can be established by the end of 2022.

###### Integrated mental health and alcohol and other drugs treatment, care and support

Health services will be required to deliver integrated mental health, and AOD treatment, care and support for people living with mental illness and substance use or addiction. Further, health services must not exclude consumers living with substance use or addiction from accessing treatment, care and support.

In early 2022–23, the department will release high-level guidance, developed in consultation with the mental health and wellbeing, and AOD sectors, which sets out key policy settings, principles and expectations to support consistent implementation of integrated treatment, care and support across both the mental health and wellbeing system, and the standalone AOD system.

Youth Area Mental Health and Wellbeing Services and Adult and Older Adult Mental Health and Wellbeing Services will receive capability uplift funding in 2022–23 to provide integrated mental health, and AOD treatment, care and support by the end of 2022.

##### Supporting the new Local Adult and Older Adult Mental Health and Wellbeing Services

There must be strong collaboration between Local Mental Health and Wellbeing Services and Area Adult and Older Adult Mental Health and Wellbeing Services, to ensure that for consumers who need to move between the different tiers of the system, health and wellbeing outcomes are optimised and efficient.

As Local Mental Health and Wellbeing Services are established, they will be networked to an Area Adult and Older Adult Mental Health and Wellbeing Service.

Access to Area Adult and Older Adult Mental Health and Wellbeing Services for new consumers will be on referral from a Local Adult and Older Adult Mental Health and Wellbeing Service, or through a medical referral, psychiatric triage service or crisis presentation.

#### Statewide Services

There is a range of health-service-operated specialist mental health services that are specifically targeted to Victorians with severe and complex illnesses. To deliver the RCVMHS statewide services recommendations, statewide services must be planned and delivered in a way that minimises the distance people need to travel to connect with these services.

Over time, links between statewide services and the Victorian Collaborative Centre for Mental Health and Wellbeing, recommended in the RCVMHS’s Interim Report, will be established to take advantage of the centre’s research and knowledge-sharing capabilities.

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

The RCVMHS recommended the establishment of a new Statewide Trauma Service by the end of 2022, to deliver the best possible mental health and wellbeing outcomes for all people of all ages with lived experience of trauma. It is expected that the Statewide Trauma Service will be hosted within the Victorian Collaborative Centre for Mental Health and Wellbeing to facilitate system-wide opportunities for trauma education and training.

The Statewide Trauma Service will also work with Area Mental Health and Wellbeing Services to employ up to three specialist trauma practitioners by the end of 2026, who will be based in Adult and Older Adult Area Mental Health and Wellbeing Services, as well as Infant, Child and Youth Area Mental Health and Wellbeing Services.

The department will seek to appoint a consortium of providers to establish the Statewide Trauma Service by the end of 2022.

##### A new statewide service for people living with mental illness and substance use or addiction

Comprised of a Lead Agency and an initial four Partner Providers situated across Victoria, the statewide service will undertake dedicated research into mental illness and substance use or addiction, and develop education and training initiatives for a broad range of mental health, and AOD practitioners and clinicians.

The statewide service will provide specialist addiction treatment and care (primary consultations) to consumers with high-intensity substance use or addiction needs, and co-occurring mental illness. It will also provide expert advice (secondary consultations) to support and build the capacity of the mental health and AOD workforce in providing integrated care.

The department will work with health services during 2022–23 to establish a model of care and consumer options and pathways for the statewide service, which will commence operations by the end of 2022.

#### Alcohol and Drug Services

The Victorian alcohol and 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 AOD issues will be supported with an enhanced mental health and AOD 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 accepts the RCVMHS’s recommendation that each of the eight mental health and wellbeing regions have at least one highest-level emergency department able to provide mental health and AOD treatment.

Residential withdrawal services support clients to safely withdraw from AOD 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 AOD use.

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

### Bed-Based Services

Best-practice mental health clinical care provides for accessible treatment that is delivered in the least restrictive way possible. Within a community treatment-based model, admitted care forms an important part of the overall continuum of care, and needs to be funded so it is available when it is in the best interests of the person with a mental illness.

In 2022–23, funding for admitted mental health activity will be distributed to health services, based on the bed capacity that is available at each health service, with the number of bed days available. Adult, child, aged and specialist bed types will receive the same price per bed day.

Health services will receive funding in proportion to the acute bed capacity that is available at the health service, with a supplementary transition grant.

#### Acute Care

In 2022–23, acute (child 0–11 and adolescent 12–25, and 26+ adult, older persons and specialist) care provided by Area Mental Health and Wellbeing Services that deliver admitted inpatient mental health care will be reimbursed, based on a single unit price, irrespective of the bed setting or patient characteristics.

The Area Mental Health and Wellbeing Service target will be based on the total number of acute bed days. Statewide targets associated with acute admitted care are set out in the *Victorian State Budget Paper No. 3,* as part of the clinical inpatient separations*.* This will continue to improve the contemporary and high-quality treatment and care across Victoria. Funding is provided for bed-based mental health services to increase access to acute care for Victorians living with mental illness.

As part of consolidation work on achieving a single price, a supplementary transition grant will continue to be provided, to ensure existing funding is maintained.

The unit price is not intended to reimburse health services for the total cost of providing admitted care, because there are several supplementary funding grants. The transition grant and other mental health specified grants contribute to meeting the costs of mental health admitted care.

#### 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 psychiatric inpatient admission. PARCs aim to assist in preventing acute inpatient admissions, and to assist those who are already admitted to be discharged as early as possible.

Youth PARCs are for young people aged 16 to 25 years, who are experiencing significant mental health problems and are either:

* becoming unwell, or who are unwell, but whose recovery progress has plateaued – these young people benefit from a brief intensive recovery support intervention (called step-up)
* in the early stages of recovery from an acute phase of mental ill health and who need a time-limited period of additional support, in order to strengthen gains made from spending time in an inpatient setting, which helps to consolidate their community transition and treatment plans (step down).

A new statewide service framework is in development to ensure that all Youth PARCs provide a consistent model of treatment, care and support to young people aged 16–25 years.

#### 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 compulsory 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 accepts the RCVMHS’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 require ongoing intensive treatment, care and support.

Similarly, the department accepts the RCVMHS’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 RCVMHS, following an evaluation of these initiatives, the department will consider applying these models to existing CCUs and SECUs, and to enhance and expand infrastructure accordingly.

### Mental Health and Wellbeing Programs

#### Suicide Prevention and Response

In response to the RCVMHS’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.

In addition to the strategy, there are a number of current and planned programs and initiatives underway that contribute to Victoria’s suicide prevention and response efforts.

##### SuicideLine Victoria

SuicideLine is a helpline delivered by On The Line that 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, support and referrals for Victorians in need.

##### Hospital Outreach Post-Suicidal Engagement Program

The Hospital Outreach Post-Suicidal EngagementProgram (HOPE) is a psychosocial and clinical support service that delivers responsive outreach to individuals following a suicide attempt, or to those who are at significant risk of suicide with serious planning or intent and/or repeated intentional self-harm. HOPE teams support individuals and their personal support networks (family, friends and other carers) for up to three months, helping them to identify and build protective factors against suicide.

HOPE now operates at 21 sites, and eight of nine subregional outreach sites have commenced operation. All 21 sites are progressively implementing broader (out of hospital) referrals into the program and extended service hours. An evaluation of the HOPE expansion recommendation has commenced and is due to be completed by 30 June 2023.

Four new HOPE sites specifically for children and young people, in partnership with four health services (Alfred Health, Monash Children’s Hospital, The Royal Children’s’ Hospital and Orygen), are now operational, and the evaluation that will inform further statewide expansion has commenced, with completion due by 30 March 2024.

##### Aftercare service for LGBTIQ+ people

Co-design of the new aftercare service model tailored to meet the needs of LGBTIQ+ people will commence in 2022–23. LGBTIQ+ people are at higher risk of suicide, often due to stigma, discrimination and inability to access culturally safe support and services.

##### Distress Brief Intervention

The RCVMHS recommended that the Victorian Government develop and implement a 14-day Distress Brief Intervention program for adults (aged 18 years and over) experiencing psychological distress by the end of 2022 (rec 27.3). Modelled on Scotland’s Distress Brief Intervention program, a proof of concept will be developed and delivered in one metropolitan and one regional area, targeting areas that have the highest rates of psychological distress.

##### Statewide Peer Call-Back Service

In 2022–23, a statewide peer call-back service for families, carers and supporters caring for people experiencing suicidal behaviour will be co-designed and piloted over 18 months.

##### Self-determined Aboriginal-led suicide prevention and postvention

Aboriginal communities and Aboriginal community-controlled organisations will determine suicide prevention and response approaches, based on their own needs. Funding will be provided to support the delivery of culturally safe and appropriate postvention and bereavement supports, as well as Aboriginal community-led co-production of suicide prevention and response initiatives.

#### Supporting Aboriginal Social and Emotional Wellbeing

The RCVMHS identified the urgent need to address mental illness and suicide in Aboriginal communities. It also highlighted the central role of self-determined Aboriginal organisations and communities, and the important role of Aboriginal culture and connection to Country for improved Aboriginal social and emotional wellbeing.

The department is working in partnership with the Victorian Aboriginal Community Controlled Health Organisation (VACCHO) to deliver Aboriginal social and emotional wellbeing recommendations from the RCVMHS.

Priorities for 2022–23 include:

* the Balit Durn Durn Centre – which has been established as a Centre of Excellence in Aboriginal Social and Emotional Wellbeing. The Centre supports best practice, research and evaluation in social and emotional wellbeing
* the Aboriginal Mental Health Traineeship Program – to provide 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 the three-year, full-time Bachelor of Health Science (Mental Health) degree at Charles Sturt University. The program is offered through Eastern Health (two positions), Bendigo Health (two positions), Alfred Health, Peninsula Health, Monash Health, Latrobe Regional Health, Mildura Base Hospital and Forensicare
* the Aboriginal Social and Emotional Wellbeing Scholarship program – which supports Aboriginal students to undertake social and emotional wellbeing qualifications to build the growing demand for Aboriginal staff in Social and Emotional Wellbeing Teams and the mainstream sector
* Aboriginal Social and Emotional Wellbeing Teams expansion – to achieve statewide coverage of multidisciplinary Social and Emotional Wellbeing Teams in 25 VACCHOs within five years. This incorporates four former demonstration projects funded through Balit Marup
* Balit Marup – a significant initiative to build the clinical and therapeutic Aboriginal workforce
* the Koori mental health liaison officer program – which is provided at all rural and regional designated mental health services and some metropolitan designated mental health services, to improve access for Aboriginal people to mental health services and support high-quality, holistic and culturally appropriate health care and referrals. Program funding is allocated to Mildura Hospital, Latrobe Regional Hospital, Barwon Health, Ballarat Health Services, Albury Wodonga Health, Goulburn Valley Health, Bendigo Health and South-West Healthcare. The metropolitan services are Northern Health and The Royal Children’s Hospital
* Aboriginal clinical and therapeutic mental health positions – which aim to increase the Aboriginal workforce available to deliver culturally responsive, trauma-informed services that can address the social and emotional wellbeing, and mental health needs of Aboriginal people in Victoria. There are 10 Aboriginal clinical and therapeutic mental health positions in Aboriginal community-controlled organisations across rural and metropolitan areas. The clinical and therapeutic mental health positions are selected from a broad range of disciplines (such as mental health nurses, occupational therapists, psychiatrists, psychologists and social workers), as determined by the selected service provider
* funding for five Koori mental health beds at St Vincent’s Hospital Melbourne – managed in conjunction with the Victorian Aboriginal Health Service.

In 2022–23, the department will also work with VACCHO, the Aboriginal community-controlled sector and mainstream health services to:

* support the Balit Durn Durn Centre to lead the co-design of two healing centres
* provide primary consultation, secondary consultation and shared care for Infant for Child and Youth Area Mental Health and Wellbeing Services to support Aboriginal community-controlled health organisations
* commission Aboriginal community-controlled health organisations to deliver culturally appropriate, family-oriented, social and emotional wellbeing services for children and young people
* design and establish a culturally appropriate, family-oriented service for infants and children who require intensive social and emotional wellbeing supports, in partnership with an Infant, Child and Youth Area Mental Health and Wellbeing Service.

This work with VACCHO, Aboriginal community-controlled organisations and mainstream health services will build a culturally safe and responsive service system, which will enable Aboriginal children and young people to access specialist mental health services, family-oriented therapeutic care and intensive multidisciplinary care, delivered through Aboriginal organisations, in partnership with mainstream mental health services.

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

#### 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, and 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 Act 2014*.

Services include:

* Thomas Embling Hospital – a 136-bed secure forensic mental health hospital providing 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’s 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 underway to implement the recommendations from the RCVMHS, which includes refurbishing existing beds and expanding the number of beds at Thomas Embling Hospital. This will provide an additional 127 beds to meet the needs of individuals living with a serious mental illness, and who require care and treatment within a forensic hospital setting
* Community Forensic Mental Health Services – providing 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, Non-Custodial Supervision Order Consultation and Liaison (for people subject to the Crimes (Mental Impairment and Unfitness to be Tried) Act, the Forensicare Serious Offender Consultation Service, Court Report Services, Forensic Clinical Specialist Coordination, Youth Justice Mental Health Coordination and a Mental Health Community Corrections Screening pilot.
* 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. There are 141 prison-based mental health beds across the Victorian prison system that are serviced by Forensicare. 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.

#### Mental Health Community Support Services

The Mental Health Community Support Services (MHCSS) program is an integral part of the Victorian Government’s specialist mental health service system. State-funded MHCSS are delivered across 15 service catchments. Delivered largely by non-government organisations, 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.

The MHCSS program includes activity types such as youth residential rehabilitation, supported accommodation, mutual support and self-help, 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 given to service providers will be indexed, consistent with the government’s annual determination for community service organisations.

A funding commitment was made to in-scope MHCSS programs to be fully transitioned to the National Disability Insurance Scheme (NDIS) by 30 June 2020. Clients of these services have become NDIS participants. In-scope MHCSS programs include individualised client support packages, adult residential rehabilitation and select supported accommodation services. Continuity of support has been provided to clients of in-scope MHCSS programs who are not eligible for the NDIS, because they do not meet age and residency criteria.

#### Early Intervention Psychosocial Support Response

The Early Intervention Psychosocial Support Response is a psychosocial support model targeted to adult clients of the clinical mental health service system, who are living with a severe mental illness and associated psychiatric disability, and are either:

* not eligible for the NDIS because they do not have significant, permanent, functional impairment(s) 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 eligible clients to:

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

Select health services are funded to deliver the Early Intervention Psychosocial Support Response in a contractual partnership with non-government, community-managed mental health providers.

## 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 Commonwealth Government intends to implement a new integrated assessment model to assess eligibility for all aged care services. This will replace assessment services that are currently delivered by ACAS. The government has confirmed this will commence in July 2023, and has extended agreements with the department for ACAS for an additional 12 months, until 30 June 2023.

### Regional Assessment Services

Regional Assessment Services conduct home support assessments for older people, who require entry-level home support and assistance to support them to live independently at home and 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 Commonwealth Government intends to implement a new integrated assessment model to assess eligibility for all aged care services. This will replace assessment services that are currently delivered by Regional Assessment Services. The government has confirmed this will commence in July 2023 and has extended agreements with the department for Regional Assessment Services for an additional 12 months, until 30 June 2023.

### Home and Community Care Program for Younger People

The Home and Community Care Program for Younger People (HACC-PYP) is targeted to people from birth to 65 years (and Aboriginal people from birth to 50 years), who need assistance with daily activities due to physical and/or psychosocial functional impairment, chronic illness and short-term health needs, and their carers. The HACC-PYP is funded by the Victorian Government to provide a range of services in the home and in the community. The goal of the program is 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, 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 [HACC in Victoria – Reporting and data](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 (VA&EP) assists eligible clients 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 also funds the repairs of equipment owned by the service provider.

Assistive technology programs and schemes funded under the VA&EP 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, where their need for the aids and equipment items available under the VA&EP relates to a health condition, and those aged over 65 years with age- or disability-related needs for aids and equipment. Applicants must be permanent residents of Victoria or hold a permanent protection visa.

### 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 also access the services listed.

#### Personal Alert Victoria

Personal Alert Victoria 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. Personal Alert Victoria aims to keep clients living independently for as long as possible.

Personal Alert Victoria 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 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 Victorians 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 2022–23, 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, as introduced in 2011–12.

The Commonwealth Government has indicated that during 2022–23, it will change the funding model that provides revenue to PSRACS. The new model is known as the Australian National Aged Care Classification or AN-ACC. The department will monitor and model the revenue effects of AN-ACC on PSRACS throughout 2022–23, and may change the allocation of top-up funding to PSRACS in response to revenue changes caused by AN-ACC.

Changes to the top-up funding allocations will be 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 ensure they provide the number of available bed days for which they are funded for residential aged care. There is also an expectation that the available beds will be efficiently managed to optimise the availability and benefit for Victorians requiring residential aged care. Where providers fail to maintain the agreed number of available beds or bed days, or 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 (time-limited or ongoing) in the number of available residential aged care places it operates, 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 (off-line) 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. Rural and regional services should notify their local departmental performance lead in the first instance (the representative will liaise with the program area), and metropolitan Melbourne services should notify the PSRACS Operations and Development Unit, detailing any 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’ outlining their intentions, with a description of the 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, but 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 Program

Low cost accommodation 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 sub-programs; the Community Connections Program, Housing Support for the Aged, and the Older Persons High Rise Program.

## Rural health

Rural and regional health services play a key role in delivering safe, high-quality care close to where people live. The system has a hierarchy of health services, with regional, subregional, local and small rural health services (SRSH), including multi-purpose services and bush nursing centres.

### Small Rural Health Services

There are 36 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 flexibly to deliver a range of admitted and non-admitted services that meet the needs of their community. This includes acute care, subacute care, primary health care, health promotion and prevention activities, and HACC-PYP.

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 Commonwealth 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, and are generally the only primary healthcare provider. These entities are funded under the SRHS funding model to support the flexible use of funding to deliver a range of primary, community and home-based care, to meet the needs of their communities.

With an increase in compliance obligations, bush nursing centres are now required to have formal agreements with their partnering health services for quality and safety 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.*

During 2022–23, the department will continue to work with bush nursing centres to implement longer-term arrangements that best align with bush nursing centre service delivery and government policy, including oversight mechanisms that enable safe and quality care.

### Victorian Patient Transport Assistance Scheme

The Victorian Patient Transport Assistance Scheme 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.

Details, including a copy of the claim form, can be found at the [Victorian Patient Transport Assistance Scheme](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.

### 7.4 Improving Access to Primary Care in Rural and Remote Areas – COAG 19(2) Exemption Initiative

The Victorian Government is commencing participation in this initiative through a 2022–2025 Memorandum of Understanding with the Commonwealth Government.

The Initiative aims to support rural and remote health services in small communities, by increasing access to Commonwealth funding through the Medicare Benefits Schedule, and ensuring that eligible approved health services increase support for primary health care 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 Commonwealth Department of Health and be granted an exemption from section 19(2) of the *Health Insurance Act 1973 (*Clth) by the Commonwealth Minister for Health.

Eligible services are services set out in the Medicare Benefits Schedule, which are specified in the directions under section 19(2) of the Health Insurance Act (Clth). Such services may include professional non-admitted patient services, non-referred services (including eligible nursing and midwifery services), eligible allied health and dental services, 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/outreach services.

Guidance and templates to support application and reporting requirements are located on the department’s [Rural health webpage](https://www.health.vic.gov.au/hospitals-and-health-services/rural-health) <https://www.health.vic.gov.au/hospitals-and-health-services/rural-health>.

## Primary, Community, Public and Dental Health

### Primary Health Services

#### Community Health Program

Community health program funding provides for general counselling, allied health and community nursing. These services aim to intervene early to maximise health and wellbeing outcomes, and 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, 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 people
* people with an intellectual disability
* refugees and people seeking asylum
* homeless people and people at risk of homelessness
* people with a serious mental illness
* children in out-of-home care.

The *Demand management framework* and priority tools for community health services are currently being updated. This update is likely to include an expansion of the priority populations.

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

Funding is to be used flexibly to meet the needs of local populations. To ensure services are targeted appropriately, factors that should be considered when planning include:

* 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. The current funding model is being reviewed, and it is anticipated that a more sophisticated funding model will be developed to allow flexibility for services to adapt to changing community and client needs.

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.

Additional support for specific population groups is also provided through a number of programs and initiatives, including:

* the Refugee Health Program – 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 – provides pregnancy, resilience and antenatal material support. It aims to improve the health outcomes for pregnant vulnerable women and their babies. The Victorian State Budget 2020–21 invested $1.2 million (over four years) to continue the program through community health services in rural and regional locations
* the Early Intervention in Chronic Disease initiative – 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 – 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 – promotes health care for young people who are homeless or at risk of homelessness. It is a Victorian and Commonwealth Government-funded program, which helps fund 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 – 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 – aims to prevent the practice of female genital mutilation/cutting, and support the health and wellbeing of girls and women who have undergone 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 (refer to section 29.7 ‘Primary, community and dental health data reporting requirements’).

The community health schedule of fees and income ranges used when assessing clients are available at [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>.

#### Supercare Pharmacies

The Victorian Supercare Pharmacies initiative supports up to 20 community pharmacies to operate 24 hours a day, seven days a week, with a nurse onsite from 6.00 pm to 10.00 pm for assessment and treatment of minor injuries and illnesses, and risk assessment of lifestyle conditions. Supercare Pharmacies provide round-the-clock access to pharmacists for advice, supply of medicines and dispensing prescriptions.

This initiative has been implemented in three stages:

* Stage 1 commenced in mid-2016 with five Supercare Pharmacies.
* Stage 2 commenced in mid-2017 with another seven Supercare Pharmacies.
* Stage 3 commenced in mid-2018 with the final eight Supercare Pharmacies.

The specific objectives of the initiative are:

* to reduce preventable emergency department admissions for minor injuries and illness after hours, through strengthening the local primary care system
* to provide an alternative option for Victorians requiring healthcare advice and medicine supply, which is high quality, easily accessible and close to home.

#### 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.

#### Health Condition Support Grants Program

Peer support helps decrease the overall burden of disease by encouraging better health outcomes for group members. This includes improved health literacy and self-management.

Every two years, the Health Condition Support Grants program assists small health-condition-specific peer support groups with administrative costs of up to $5,000 per year.

The program provides one-off grants for a two-year period to peer support groups for people with chronic health conditions and diseases to:

* increase the capacity of people with a chronic health condition to live independently in their community
* encourage a network of peer support and information exchange for people with chronic health conditions, and their families and carers
* increase opportunities for peer support groups to access education about their condition, and share their experiences and strategies for managing the condition.

The grants are open to health condition peer support groups that:

* meet of their own accord to provide mutual support to self-manage their health needs
* provide education programs and information to members.

For more information, refer to the [Health Condition Support Grants program](https://fac.dffh.vic.gov.au/news/health-condition-support-grants-program) <https://fac.dffh.vic.gov.au/news/health-condition-support-grants-program>.

### Dental Health Services

The public dental program delivers public dental care to eligible Victorians through the Royal Dental Hospital Melbourne, and over 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.

#### 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 preventative and basic dental treatment. Eligibility was extended to include children under the age of two years in the 2021–22 Commonwealth budget. Eligible children have access to a benefit cap of $1,026 over a two-calendar-year period. Public sector access to the Child Dental Benefits Schedule is available to 31 December 2022, as announced in the 2019–20 Commonwealth budget.

#### 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 are not dependants of concession card holders.

For more information about the policy, including a fees schedule and exemptions, refer to [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>.

#### School Dental Program (Smile Squad) Initiative

The Victorian Government’s School Dental Program 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. The program fully resumed rollout to schools in early 2022 and is planned to reach 100 per cent of schools by 2023.

Further information on the School Dental Program is available at [Smile Squad](https://www.smilesquad.vic.gov.au) <[https://www.smilesquad.vic.gov.au](https://www.smilesquad.vic.gov.au/)>

#### 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 children’s teeth to prevent tooth decay.

The changes will support a program that will provide twice-yearly fluoride varnish applications and oral health promotion to Aboriginal children in a culturally appropriate healthcare setting, such as Aboriginal community-controlled health organisations. This will help reduce the incidence of tooth decay in a population group that is at high risk of oral disease.

The department will work with Dental Health Services Victoria, Aboriginal health organisations and community dental agencies to implement the fluoride varnish program, including providing 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 Victorians.

### Early Parenting Centres

Early Parenting Centres are operated by Victorian public health services and provide specialist support for Victorian families with children aged 0–4 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.

EPC services are part of a broader service system for supporting families, which includes maternal and child health services, supported playgroups and community-based parenting programs. The role of EPCs recognises the importance of the health and wellbeing of parents and the whole family on the health, wellbeing and development of the child.

Three EPCs are currently operational. A further eight EPCs are being established across the state, to become operational across 2023–2025.

EPCs are funded to deliver a range of service offerings, including day-stay programs, residential-stay programs, group-based programs and telehealth/outreach support. Funding is currently activity-based, with annual targets (clients) specified.

In 2021, the department conducted a funding model review to identify a more effective funding approach. Recommendations were provided to the department in early 2022, and work is underway to progress the determination and implementation of an appropriate future funding model.

## Public Health

### Public Health and Prevention

The department invests in a range of activities that aim to reduce the likelihood of developing a chronic disease or disorder. The focus is on environmental, social and behavioural approaches at the population level, which contribute to reducing or eliminating the causes of poor health and wellbeing.

Primary prevention aims to prevent problems occurring in the first place by eliminating or reducing underlying causes. This is achieved by controlling the exposure to risk and promoting factors that protect health, wellbeing, safety and social outcomes. Examples include immunisation, tobacco control legislation, and universal maternal and child health services.

Secondary prevention aims to stop, interrupt, reduce or delay the progression of a problem through early detection and intervention. Examples include screening, school-based mental health programs and the stabilisation of housing.

The *Victorian public health and wellbeing plan 2019–2023* is a Victorian Government plan that guides the collective efforts of the department, other state government departments, health services, local government, non-government organisations, the private sector and communities.

The plan establishes an ambitious vision for the state: a Victoria free of 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:

* tackling climate change and its impact on health
* reducing injury
* preventing all forms of violence
* increasing healthy eating
* decreasing the risk of drug-resistant infections in the community
* improving mental wellbeing
* increasing active living
* improving sexual and reproductive health
* reducing harmful alcohol and drug use
* reducing tobacco-related harm.

The plan specifically advocates a collective effort by multiple stakeholders to address these complex issues. The next plan is due on 1 September 2023.

The Victorian public health and wellbeing outcomes framework provides a comprehensive set of outcomes, indicators, targets and measures for our major population health and wellbeing priorities and their determinants. It supports monitoring and reporting of our 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 framing 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’). From 2021–25, these programs are expected to strengthen their alignment to the focus areas of the *Victorian public health and wellbeing plan 2019–23,* including increasing healthy eating, increasing active living and reducing tobacco (including e-cigarette) related harm.

It is expected that local prevention efforts are coordinated with councils and other local partners to establish a common approach to preparing local health and wellbeing plans, and confirm roles in leading and/or contributing to implementation of local priorities. It is also expected that there is alignment to the Victorian public health and wellbeing plan and other key strategic directions of the Victorian Government.

More information can be found at [Advice for public health and wellbeing planning in Victoria: planning cycle 2017–2021](https://www.health.vic.gov.au/publications/advice-for-public-health-and-wellbeing-planning-in-victoria-planning-cycle-2017-2021) <https://www.health.vic.gov.au/publications/advice-for-public-health-and-wellbeing-planning-in-victoria-planning-cycle-2017–2021>.

#### Chronic Disease Prevention

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

The Achievement Program 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. More information is available on the [Achievement Program website](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. Many health services are already integrating the Healthy Choices policy guidelines into their retail food service and vending contracts, putting Victoria on the path to meeting its 2024 target of 80 per cent of health services meeting Healthy Choices in their retail food outlets and vending machines[[1]](#footnote-2).

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

There will be a phased approach to implementation, with health services required to meet all requirements by 30 September 2023. Annual monitoring (including assessments using FoodChecker – an online food and drink assessment tool) and reporting will be required.

More information is available at [Healthy Choices policy guidelines](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 the funding requirements for local government sport and recreation grants. This includes the 2017–18 Better Indoor Stadiums Fund and the 2018–19 Community Sports Infrastructure Fund, in the criteria of the Better Pools category.

The Healthy Eating Advisory Service offers free support for implementing the Healthy Choices policy guidelines. Funded by the Victorian Government and delivered by Nutrition Australia Vic 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
* comprehensive online resources, recipes, tips, factsheets and case studies
* the FoodChecker tool
* online training
* implementation forums and communities of practice.

More information is available from the [Healthy Eating Advisory Service website](https://heas.health.vic.gov.au/) <https://heas.health.vic.gov.au>.

The new Vic Kids Eat Well campaign is jointly delivered by the Cancer Council Victoria, through the Achievement Program, and Nutrition Australia, through the 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 School Canteens and Other School Food Services Policy. A new team of Healthy Kids Advisors will provide a boosted effort in 13 selected areas.

Both Vic Kids Eat Well and Healthy Kids Advisors are flagship initiatives of *Healthy Kids Healthy Futures.* The initiatives form part of a comprehensive effort with multiple partners within these communities to improve the health and wellbeing of Victorian children and young people. This includes close alignment with the VicHealth Local Government Partnership initiative.

#### Life! Helping You Prevent Diabetes, Heart Disease and Stroke Program

The *Life! Helping you prevent diabetes, heart disease and stroke* (Life!) program is run across Victoria. It provides healthy lifestyle education and skills, through group courses 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 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. Funding for the Life! program is recalled for each participant target that is not met.

#### National Cancer Screening Program Pathways

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

The National Bowel Cancer Screening Program (NBCSP) is a government population health initiative to improve the early detection and prevention of bowel cancer. People eligible to participate in the program receive an invitation through the mail to complete a faecal occult blood test at home, which is sent by mail to a laboratory for analysis. Participants with a positive screening test are required to see their general practitioner 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 [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
* report all NBCSP colonoscopies to the Victorian Admitted Episodes Dataset (VAED) under funding arrangement Code 8
* report NBCSP colonoscopy and histopathology data to the National Cancer Screening Register, 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.

More information is available from [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

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

In December 2017, the National Cervical Screening Program changed from providing a Pap test every two years to women aged 18–69, to a human papillomavirus test every five years to women aged 25–74. In addition, women who have never screened or under-screened are able to access a cervical screening self-collection test. Some health services experienced an anticipated spike in demand as a result of changes to the National Cervical Screening Program.

Invitations for the next five-year cervical screening cycle will be sent out to eligible women from 1 September 2022. This is anticipated to cause a spike in demand for colposcopy services from December 2022 for a period of approximately two years, as participants take up the invitation. The policy change to offer self-collection cervical screening tests to all women (not just under-screened or never-screened women) from 1 July 2022 is not expected to cause a spike in demand for colposcopy.

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:Cervical_cancer/Screening)<https://wiki.cancer.org.au/australia/Guidelines:Cervical\_cancer/Screening>.

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

More information is available at the [National Cervical Screening Program](https://www.health.gov.au/initiatives-and-programs/national-cervical-screening-program) <https://www.health.gov.au/initiatives-and-programs/national-cervical-screening-program>.

#### Sexual Health and Viral Hepatitis

The department’s Sexual Health and Viral Hepatitis team commissions prevention 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 (BBVs), such as HIV and viral hepatitis, and sexually transmissible infections (STIs).

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 will release 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 contains six documents, including the:

* Strategy overview and system enabler plan 2022–30
* Victorian Aboriginal sexual and reproductive health and viral hepatitis plan 2022–30
* Victorian hepatitis B plan 2022–30
* Victorian hepatitis C plan 2022–30
* Victorian HIV plan 2022–30
* Victorian Sexually Transmissible Infections plan 2022–30
* Victorian women’s sexual and reproductive health plan 2022–30.

The six tailored plans outline service and information access, prevention, testing, treatment and care priority actions, and activities specific to each disease, population or issue.  They also outline the time-bound and stepped targets the Victorian Government has set to drive progress and measure effectiveness.

When the strategy is released, the BBV/STI funding and reporting guidelines will be updated accordingly.

#### Tobacco Control

To reduce the burden of smoking on the community, the Victorian Government funds non-government organisations, such as Quit Victoria, the VACCHO and Alfred Health, to provide:

* clinical smoking cessation support services, including the Quitline and dedicated Aboriginal Quitline, which provide expert advice and personalised counselling to smokers wanting to quit
* programs targeted at sub-populations with the highest rates of smoking, low socioeconomic groups, Aboriginal Victorians, people experiencing mental illness, and those affected by alcohol and drugs
* continuous, sustained Victorian anti-smoking social marketing campaigns (integrated across television, radio, print and social media) to reduce smoking uptake and increase cessation
* research to inform tobacco control policy and regulatory reform, such as annual surveys of smoking prevalence and behaviours
* training for health professionals (including Aboriginal health workers) in providing brief smoking cessation interventions
* support for health services to implement best-practice smoking cessation support in routine care.

The department 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*, and to take enforcement action where necessary.

#### 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.

#### Eye Health Prevention in Primary Health Care

The department funds the Embedding eye health prevention into primary health care initiative, delivered by the Victorian Primary Health Networks. The aim is to increase rates of eye screening and early detection of eye disease for at-risk groups in Victoria, by embedding eye health prevention into primary healthcare clinical practice (including community health). The initiative is a being delivered in partnership with Vision 2020 Australia, which will provide eye health resources, education, training and support to the primary health sector to identify and refer at-risk patients for an eye test.

### Health Protection

The Victorian Chief Health Officer leads the Health Protection branch, is the lead public health advisor to the Minister for Health and the Victorian Government, and is the state’s spokesperson on public health issues.

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 strategy and policy in health protection, coordinating investigations and management of public health risks, and undertaking all manner of 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 accessible on the [Chief Health Officer webpage](file:///C:/Users/BridieW/AppData/Roaming/Microsoft/Word/Chief%20Health%20Officer%20webpage) <https://www.health.vic.gov.au/public-health/chief-health-officer>.

*The Public Health and Wellbeing Amendment (Pandemic Management) Act 2021* made major reforms to the Public Health and Wellbeing Act. It creates a targeted regulatory framework that supports transparent and accountable government action to keep Victorians safe during pandemics, both through the ongoing management of the COVID-19 pandemic in Victoria, and in the event of future pandemics affecting our state.

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.

Key areas of health protection activity include communicable disease prevention and control. This work 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.

The department’s Environmental Health unit works to prevent ill health arising from environmental factors. It responds to major threats to public health and regulates hazards, such as radiation, pesticides, cooling towers and plumbing systems, to promote the health and wellbeing of the Victorian community.

Food safety and regulatory activities are aimed at protecting the community from food-related illnesses and hazards. Activities support public health improvement through strategic regulatory policy and programs to achieve a healthier community.

Since 1 November 2018, Victorian public and private hospitals have been required to notify the department of anaphylaxis presentations under an amendment to the Public Health and Wellbeing Act.

Anaphylaxis presentations must be notified in accordance with the prescribed requirements of the Public Health and Wellbeing Regulations.

### Local Public Health Units

Lead health services are funded to maintain Local Public Health Units (LPHUs), which serve as the place-based frontline of Victoria’s statewide public health strategy. In doing this, each LPHU is an agent for the *Victorian Public Health and Wellbeing Plan 2019–2023*.

There are nine LPHUs across Victoria, each with responsibilities to a catchment defined as sets of local government areas. They manage, facilitate and deliver high-value public health prevention, regulation and response for their communities, and work strategically on public health challenges that are unique to their catchment.

While administered by lead health services, and receiving business support from those services, LPHUs take direction on public health priorities and statewide strategies from the Chief Health Officer and other representatives of the department.

LPHU workforces are administered by health services and therefore, are not part of the Victorian Public Service. They focus on understanding and handling socially dynamic and locationally unique challenges. They are best placed to understand their local communities and to provide tailored solutions to meet the needs of their communities. This requires LPHUs to ensure they have an optimised structure for their specific context. There are three mandated positions that every LPHU must fill, as linked to the commissioning arrangements: LPHU Director, Operations Manager, and an identified Aboriginal and Torres Strait Islander Health Lead.

An operational framework for the statewide network of public health units will be reviewed and updated annually. The framework will describe how the units and the department work together in a practical sense to achieve optimal outcomes, determined by Victoria’s public health strategy and executive leadership. LPHUs will be responsible for outcomes involving prevention and population health programs, and health protection activities in their catchment, including responses to certain communicable diseases and local handling of COVID-19.

LPHUs may work with their lead health service and other units in the statewide network to share innovations and determine how best to meet the outcomes for which responsibility has been delegated. Operational frameworks and functional models may require LPHUs to nominate various ‘lead’ persons for specific operational requirements. Such leads will serve as contacts and responsive operational decision-making, but it may be only one aspect of the position within the LPHU.

A *LPHU Outcomes and Performance Framework* will be developed, reviewed and updated annually, in consultation with LPHUs, describing the service standards and strategic priorities for LPHUs, and the metrics that assess achievement towards the state’s public health strategy. This tool is LPHU-specific, being directly relevant to the intersection between the public health responsibilities that are delegated to LPHUs, and the broader Victorian public health and wellbeing outcomes framework. This framework will monitor and enable reporting on progress, against collective efforts across the system, including the public health division within the department and LPHUs, to achieve health and wellbeing for Victorians.

## Health Workforce Training and Development

### Training and Development Funding

Training and development funding is provided to public health services to recognise the additional costs that are inherent in the teaching and training activities of public health services.

The funding aims to support the development of a high-quality future health workforce for Victoria through subsidising:

* professional-entry student placements
* transition-to-practice positions for medical, nursing and allied health
* postgraduate medical, nursing and midwifery study
* other targeted workforce training and development initiatives.

In 2022–23, 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 or allied health (including allied health assistants).

In 2022–23, medical biophysics, medical laboratory science and medical radiations (nuclear medicine, radiography and radiation therapy) disciplines are eligible for professional-entry student placement funding for activity recorded in Placeright, the department’s web-based student placement management system.

A limited number of professional clinical placements, professional development year or industry-based learning positions are not eligible for the professional-entry student placement subsidy, because they are funded through the transition-to-practice and postgraduate study streams of the grant. These include internships in hospital pharmacies and the employment model for midwifery.

In 2022–23, the department will provide additional funding on a time-limited basis to increase clinical placements. This is to support the Victorian Government’s commitment to expanding enrolled nurse training through the offer of free training with TAFE providers. Health services will be advised of the conditions of funding and application process to provide placements in 2023.

Additional funding is available in 2022–23 through the Boosting our Healthcare Workforce initiative[[2]](#footnote-3) to restore Victoria’s healthcare workforce pipeline, following significant disruption during the coronavirus (COVID-19) pandemic. This initiative supports the delivery of extra standard clinical student placement days in the public health system, to decrease the delayed and deferred placement backlog. Health services will be advised of the funding arrangements for 2022–23 as soon as these are confirmed.

#### 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 are encouraged to stay working within the sector.

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

* allied health graduates
* pharmacy interns
* nurse and midwifery graduates
* medical graduates (post-graduate year (PGY) one and two – PGY1 and PGY2).

Subsidies to 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 details on funding eligibility and criteria, download the Program Guidelines 2021–22 at [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>.

##### Allied health graduates

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

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

##### Allied health 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

In 2021, the department extended two-year (PGY1 and PGY2) medical prevocational training contracts to all rural and regional health services, with PGY1 positions commencing in 2021.

PGY2 training and development funding has been aligned to allow these health services to offer two-year prevocational training contracts to medical interns commencing from 2021.

Rural and regional health services that receive training and development funding for PGY2 positions must support end-to-end training pathway positions being developed under the Victorian Rural Generalist Program.

##### Mental health nursing and allied health graduates

Public mental health services across Victoria are excluded from receiving transition-to-practice subsidies for nursing and allied health graduates, because they are provided with subsidies through Mental Health Training and Development funding.

##### Enrolled Nurse Transition to Practice Program

In 2022–23, the Enrolled Nurse Transition to Practice Program will provide funding to health services to coordinate and deliver graduate programs for newly registered enrolled nurses in their first year of practice. Health services that are eligible for funding are expected to deliver workplace-based programs designed to consolidate knowledge and skills, and transition new enrolled nurses to practice as safe, confident and accountable professionals.

This initiative is part of the Nursing and Midwifery Workforce Development Fund. It will complement the government’s free TAFE initiative, by providing employment pathways for enrolled nurses completing a Diploma of Nursing. Additional funding for 2022–23 has been provided via the 2022–2023 State Budget[[3]](#footnote-4).

Funding will be through direct allocation to health services and will vary, depending on the number of program participants. Health services will be requested to submit an Enrolled Nurse Transition to Practice Program funding application.

##### Registered undergraduate students of nursing and midwifery

Dedicated funding for registered undergraduate students of nursing/midwifery positions has been provided via the 2022–2023 State Budget[[4]](#footnote-5). Health services will be advised on the arrangements for the allocation of funding, once these are confirmed.

In 2022–23, transition to practice (graduate) nursing and midwifery funding may be used to fund registered undergraduate students of nursing in health services, above ratios. Funding will **not exceed** the funding that is allocated specific to nursing and midwifery graduate numbers.

#### Postgraduate Positions – medical, nursing and midwifery

Subsidies to 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 program provides funding in targeted specialties to assist health services to increase the number of accredited medical specialist training positions.

Victorian Medical Specialist Training funding criteria was changed from 2020 to focus on improved alignment between Victorian Medical Specialist Training funding and workforce policy outcomes, government priorities and opportunities for system-level reforms. All positions must be newly created and increase accredited training capacity. Funding may be provided for proposals as short as six months, or for the full length of a training program (up to five years).

All proposals will be assessed against one of two funding streams:

* **Funding stream A** expands training capacity in specialities that are considered in limited supply. Proposals for other specialties may also be considered.
* **Funding stream B** improves training capacity and capability in regional and rural health services. The department supports training that enables trainees to complete their full training program, while undertaking the majority of their training in a rural or regional location.

###### Victorian Basic Paediatric Training Consortium

The Victorian Basic Paediatric Training Consortium aims to support equitable access to specialist training opportunities across Victoria, and 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 Postgraduate Medical Council of Victoria.

##### Nursing and midwifery

The postgraduate nursing and midwifery program provides funding for health services to provide clinical support for registered nurses and midwives undertaking postgraduate studies that lead to an award classification of graduate certificate, graduate diploma or master-level studies.

In 2022–23, the department will be prioritising postgraduate qualifications that assist health services to implement the amended *Safe Patient Care (Nurse to Patient and Midwife to Patient Ratios) Act 2015*.

#### 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 is allocated on the basis of total nursing and midwifery full-time-equivalent staff.

##### 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, in areas of clinical practice where there is an identified workforce need.

Scholarship funding is allocated annually to eligible public health services (or for rural health services to fundholders within the five rural health regions), and is calculated based on nursing and midwifery full-time-equivalent staff.

##### Maternity Connect Program

The Maternity Connect Program provides funding to support the ongoing education of rural midwives and neonatal nurses, 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. Participants are prioritised according to rural workforce need and the availability of placements.

Eligibility for funding through the program is determined in collaboration with health services.

##### Prevocational medical education and training

Prevocational medical education and training funding is provided to health services to support junior medical staff training, primarily through employing medical education officers. Funding is limited to the size of the funding pool, with the allocated model including a base payment per health service, plus a per capita allocation for each intern position. Rural and regional health services also receive a rural loading on the per capita allocation.

##### 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, while they are 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 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, to gain either the 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).

The Victorian Rural Generalist Program is supported by a statewide lead and four clinical leads to mentor and support trainees. Coordinators based in health services across each of the five rural regions also support development of the program. The program is governed by the *Victorian Rural Generalist Program management framework*, 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.

#### Funding Conditions and Allocation

Health services that receive training and development grant funding should ensure they meet eligibility and reporting requirements, as outlined in section 29.9 ‘Training and Development Funding Reporting and ’.

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 the 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), including the guidelines and standards set by the Australian Health Practitioner Regulation Agency 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 organisation(s) 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 Program Guidelines 2021–22 at [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>.

## Capital Funding Programs

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

* Infrastructure Renewal Contribution Grant
* Regional Health Infrastructure Fund
* Metropolitan Health Infrastructure Fund
* Medical Equipment Replacement Program
* Engineering Infrastructure Replacement Program.

These programs support health services to manage risk and maintain patient safety, occupational health and safety, and service availability and continuity, by enhancing the asset base, and maintaining and replacing 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.

Find more information at [Grant programs](file://internal.vic.gov.au/DHHS/HomeDirs7/vidfr3p/Desktop/Grant%20programs) <https://www.vhba.vic.gov.au/resources/grant-programs>.

### Infrastructure Renewal Contribution Grant

In 2022–23, $40 million will assist health services with the costs of replacing hospital infrastructure and will be distributed to public hospitals, including rural and small rural health services. The $40 million will be appropriated at 50 per cent in July 2022. The remaining funds will be distributed in January 2023 to those health services that submit their updated asset management plan by 31 December 2022 to the Victorian Health Building Authority by [emailing Asset Management Submissions](mailto:assetmanagement@health.vic.gov.au) <assetmanagement@health.vic.gov.au>.

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

Read more about asset management plans and the Victorian Health Asset Management Communities of Practice at [Asset Management](https://www.vhba.vic.gov.au/resources/asset-management) <https://www.vhba.vic.gov.au/resources/asset-management>.

### Regional Health Infrastructure Fund

The $790 million Regional Health Infrastructure Fund provides funding for rural and regional health services on a bid-based process and is managed centrally by the department.

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 health care, 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
* minor medical equipment
* engineering infrastructure and plant
* information and communications technology
* new technologies, including systems to reduce usage and increase efficiencies of power and/or 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.

Applications are assessed on readiness of the project, service efficiency, demand pressure, quality, safety and compliance risk, clinical risk and fitness of purpose for assets.

## 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 ensure the provision of 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, COVID-19 Costs and International Patients

Health services should charge Medicare-ineligible patients for the full cost of their treatment. 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:

* 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, refer to [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[[5]](#footnote-6) 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 are encouraged to 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.

#### COVID-19 Costs

COVID-19 is an infectious disease associated with significant morbidity and mortality. It is in the interest of the health of all Victorians that patients being investigated and managed for COVID-19 are able to access appropriate health care.

Patients have the right to elect to be treated privately and should be provided with the necessary information to make an informed decision. Where private insurance is available, health services should ensure there are no out-of-pocket costs incurred, so there is no impediment to maintenance of public health.

Patients from overseas who do not have private insurance and are not eligible to be treated for this condition under Medicare rules may present at public hospitals. Under the National Partnership on COVID-19 Response, the Commonwealth Government will provide a 50 per cent contribution for the treatment of non-Medicare eligible patients.

To protect public health and minimise the potential barriers for continuing care, both inpatient and outpatient services related to COVID-19 (including pathology, diagnostics and pharmaceuticals), should be provided free of charge to all people presenting to public hospitals and health services in Victoria, regardless of Medicare eligibility or residency status. This will include receiving a vaccine, once other eligibility criteria have been met. In the rare event of requiring hospital treatment following a COVID-19 vaccination, any associated out-of-pocket costs should also be waived.

#### 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, and 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:

* 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 after-care 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.

For advice or assistance in relation to treating international patients, health services can [email the department’s International Health team](mailto:email%20the%20department’s%20International%20Health%20team) <internationalhealth@health.vic.gov.au>.

Part 2: Obligations, Standards and Requirements

## Notification Obligations

### Issues of Public Concern

The *Health Services Act 1988*, *Ambulance Services Act 1986* and *Mental Health Act 2014* 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* *1986* s. 18 (1)(j); *Mental* *Health* *Act 2014* s. 345).

Chief executive officers must also inform the board, secretary 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 1986* s. 21(3)(h); *Mental* *Health* *Act 2014* 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 and improvement 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, which 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.

## 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 and 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 from [Public Sector Values](https://vpsc.vic.gov.au/ethics-behaviours-culture/public-sector-values) <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, which 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 the Australian Health Practitioners Regulation Authority must meet pre-employment safety screening requirements. 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.bettersafercare.vic.gov.au/publications/credentialing-and-scope-of-clinical-practice-for-senior-medical-practitioners-policy>.

The department and all funded organisations must undertake pre-employment safety screening checks on all applicants prior to employment. Pre-employment safety screening checks are a mandatory requirement of the department’s selection process, and are designed to safeguard the department’s integrity by helping to prevent the employment of unsuitable people. While pre-employment safety screening does not eliminate the risk of employing unsuitable people, it does minimise that risk on the basis of available and relevant information.

Pre-employment safety screening checks may also include a Working with Children Check (WWCC), 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.

Refer to information about [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 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, in accordance with their obligations pursuant to the *[Occupational Health and Safety Act 2004](https://www.legislation.vic.gov.au/in-force/acts/occupational-health-and-safety-act-2004/032)* <https://www.legislation.vic.gov.au/in-force/acts/occupational-health-and-safety-act-2004/032>.

The department is 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 focused on addressing systemic issues, in relation to bullying and harassment, and occupational violence and aggression.

### Child Safety

#### Commission for Children and Young People

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 promotes improvement in policies and practices affecting the safety and wellbeing of Victorian children and young people, with a particular focus on vulnerable children and young people.

This includes:

* promoting the rights, safety and wellbeing of children and young people
* providing independent scrutiny and oversight of services for children and young people, particularly those in the out-of-home care, child protection and youth justice systems, and driving safe, rights-based and child-centred services
* advocating for best-practice policy, program and service responses to meet the needs of children and young people
* promoting the views and experiences of children and young people to increase the awareness of government and the community
* supporting and regulating organisations that work with children and young people to prevent abuse, respond appropriately to allegations of child abuse, and to have child-safe practices.

The Commission’s functions include conducting inquiries into the deaths of children involved with child protection, inquiries about the services provided to an individual child or a group of vulnerable children or young people, and systemic inquiries. The Minister for Child Protection may also recommend the Commission conduct an inquiry. Commission inquiries can examine services to children and young people, including child protection services, youth justice services, a community service, health service, human services or a school.

The Commission administers the Reportable Conduct Scheme and is also a regulator for the Child Safe Standards.

#### Children, Youth and Families Act

The Children, Youth and Families Act 2005 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. This must always be the paramount consideration.

To determine whether an action or decision is in a child’s best interests, consideration must be given to:

* protecting the child from harm
* protecting the child’s rights
* promoting the child’s development.

The ‘best interests’ principles focus on children’s safety, development and wellbeing in the context of their age and stage of life, their culture and gender. These principles draw attention to important dimensions of a child’s experience, which may be affected by their family dynamics and circumstances. This includes the need for timely decision-making, given the possible harmful effects of delay, and continuity and permanency in the child’s care. Intervention into the parent-child relationship is limited to that necessary to secure the safety and wellbeing of the child, and removal from parental care is limited to only where there is unacceptable risk of harm.

Other principles must be considered, where they are relevant to the decision or action. Departmental and community services practitioners must consider decision-making principles when making a decision or taking action in relation to a child. The decision-making principles promote fair and transparent processes and enable the active participation of relevant parties. Additional decision-making principles are included for Aboriginal children, recognising Aboriginal self-determination and self-management.

To adhere to these principles, a child-centred and family-focused approach is required, as described and supported in the Best Interest Case Practice Model. This model provides the foundation for case practice in child protection, as well as for family services and placement services.

The Children, Youth and Families Act provides for intervention by statutory child protection services to protect children from abuse and neglect, where their parents have not protected, or are unlikely to protect, them from harm. These powers are balanced with comprehensive safeguards, including judicial oversight, and accountability procedures to protect the rights of children and parents. The [Child Protection Manual](https://www.cpmanual.vic.gov.au/) <http://www.cpmanual.vic.gov.au> includes policy, procedures and supporting advice regarding statutory child protection services. It also contains protocols, practice resources and tools that are relevant to child protection practice.

The Children, Youth and Families Act enables the Family Division of the Children’s Court to make various orders for the care or protection of children. These orders are administered by the Department of Family, Fairness and Housing’s (DFFH) child protection program.

The legislation also provides for the DFFH and community services to support families and, where necessary, care for children. It allows for the principal officer of an Aboriginal agency to be authorised to undertake specified functions and powers, in relation to a protection order for an Aboriginal child. The department is working with Aboriginal agencies to progressively implement these provisions, with the first authorisations having been made in 2018.

The Children, Youth and Families Act also sets out mandatory reporting requirements for certain professions. A mandatory reporter must make a report to child protection if, in the course of practising their profession or carrying out duties of their office, position or employment, they form a belief on reasonable grounds that a child is in need of protection from physical injury or sexual abuse.

The professions that are mandatory reporters include:

* registered medical practitioners
* nurses
* midwives
* registered psychologists.

More information is available on the DFFH’s [Children, youth and families – Mandatory reporting webpage](https://providers.dffh.vic.gov.au/mandatory-reporting) <https://providers.dffh.vic.gov.au/mandatory-reporting>.

#### Child Wellbeing and Safety Act

The Child Wellbeing and Safety Act established the Child Information Sharing Scheme to enable workers in prescribed organisations or services to share information to promote children’s wellbeing or safety. This Act also authorises the creation of Child Link, a web-based platform that displays information about a child to authorised key professionals who have responsibility for child wellbeing and safety.

Together, these child information-sharing reforms promote earlier risk identification and support to children, as well as enabling better collaboration between child and family services, and supporting children’s participation in services.

The Child Information Sharing Scheme and aligned Family Violence Information Sharing Scheme commenced in 2018. From April 2021, additional education and health workforces are able to use the schemes as part of Phase 2. Prescribed organisations and services are supported with training and ministerial guidelines. Child Link became operational by December 2021, with authorised users progressively onboarded from 2022 onward.

For more information, visit [Child Link](https://www.vic.gov.au/child-link) <https://www.vic.gov.au/child-link>.

#### Worker Screening Act

The *Worker Screening Act 2020* ensures that only people with a valid WWCC are engaged in paid or voluntary child-related work (where a child is under the age of 18 years). The purpose of the WWC check is to assist in protecting children from sexual or physical harm by ensuring that people who work with, or care for, children are subject to a screening process.

Under the Worker Screening Act, a person needs a WWCC if they meet all five conditions of ‘child-related work’, including that:

* they are an adult who ‘works’ with children aged under 18 years of age. The term ‘work’ includes engaging in voluntary work and providing practical training, as well as paid employment
* they are working with children at, or for one of, the services, places or bodies, or in one of the activities listed in the Act (visit [Do I need a check?](file:///C:/Users/BridieW/AppData/Roaming/Microsoft/Word/Do%20I%20need%20a%20check) <https://www.workingwithchildren.vic.gov.au/do-i-need-a-check>)
* their work usually involves direct contact with children
* the contact they have with children is not occasional direct contact that is incidental to their work
* they are not exempt from having a WWCC.

Under the Act, a person does not require a WWCC if their work involves only occasional direct contact with a child and that contact is incidental to their work. However, irrespective of whether a facility has a paediatric-specific ward, staff engaged in admissions, theatre, recovery, ward cleaning and food services in a ward with regular or planned admissions of patients under the age of 18 years are required to apply for a WWCC, as direct contact with children is not considered to be incidental to their work.

For more information, visit [Working with Children Check](https://www.workingwithchildren.vic.gov.au) <https://www.workingwithchildren.vic.gov.au>.

#### Child Safe Standards

Organisations that provide services or facilities for children are required to implement 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 work by driving changes in organisational culture by embedding child safety in everyday thinking and practice, and providing a minimum standard of child safety across all organisations.

The Commission for Children and Young People has primary oversight and regulatory responsibility for the standards. The department is defined as a relevant authority under the Child Wellbeing and Safety Act, and has responsibility for promoting and overseeing compliance with the standards for organisations that it funds or regulates, and that provide services or facilities to children.

New Child Safe Standards commenced on 1 July 2022 and more information can be found on the [New Child Safe Standards are coming](https://ccyp.vic.gov.au/child-safe-standards/new-child-safe-standards-start-in-victoria-on-1-july-2022-to-better-protect-children/) website <https://ccyp.vic.gov.au/child-safe-standards/new-child-safe-standards-start-in-victoria-on-1-july-2022-to-better-protect-children/>.

Read more about:

* the [new Child Safe Standards](https://ccyp.vic.gov.au/news/new-child-safe-standards-start-in-victoria-on-1-july-2022-to-better-protect-children/) <https://ccyp.vic.gov.au/news/new-child-safe-standards-start-in-victoria-on-1-july-2022-to-better-protect-children>.

Further information about the new standards can be obtained by subscribing to the [Commission for Children and Young People updates](https://ccyp.vic.gov.au/contact/sign-up-for-commission-updates/) <https://ccyp.vic.gov.au/contact/sign-up-for-commission-updates>.

New regulations under the Child Wellbeing and Safety Act for the Child Safe Standards will come into operation on 1 January 2023, following the *Child Wellbeing and Safety Amendment (Child Safe Standards Regulators and Infringements) Regulations 2022*. The regulations prescribe the department as a sector regulator, in relation to various health services and hospitals, and infringement offences and associated penalties.

Further information can be accessed on the [Child Safe Standards web](file:///C:/Users/BridieW/AppData/Roaming/Microsoft/Word/Child%20Safe%20Standards%20web)page <https://www.health.vic.gov.au/childsafestandards>.

#### Reportable Conduct Scheme

The Reportable Conduct Scheme is set out under Part 5A of the Child Wellbeing and Safety Act,and aims to improve oversight of how organisations respond to allegations of child abuse and child-related misconduct.

Heads of organisations subject to the Reportable Conduct Scheme are legally required to notify the Commission for Children and Young People of allegations of reportable conduct against a child or young person by a worker or volunteer in their organisation. Organisations must notify the Commission within three days of the head of the organisation becoming aware of the reportable allegation.

The scheme also requires heads of organisations to ensure there is appropriate investigation of the allegations, and provide updates to the Commission about who will conduct the investigation, the outcomes of the investigation, and the actions the organisation will take as a result of those outcomes.

Read more about the [Reportable Conduct Scheme](https://ccyp.vic.gov.au/reportable-conduct-scheme) <https://ccyp.vic.gov.au/reportable-conduct-scheme>.

### 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 and community service organisations that provide services on behalf of the department, and 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> and supporting framework.

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*. The reporting instruction and accompanying incident report form are available from the [Funded Agency Channel’s Health incidents webpage](https://fac.dffh.vic.gov.au/incident-reporting/health) <https://fac.dffh.vic.gov.au/incident-reporting/health>.

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.

All community health services are expected to be using VHIMS to report incidents, with the transition expected to be complete in 2022. For more information, visit [Incident reporting arrangements for community health services](https://www.health.vic.gov.au/community-health/incident-reporting-arrangements-for-community-health-services) <https://www.health.vic.gov.au/community-health/incident-reporting-arrangements-for-community-health-services>.

## Meeting the Needs of all Victorians

The department is focused on improving the lives of all Victorians, especially people and communities at risk or with increased need. This requires a focus on understanding our communities better, including the diverse range of Victorian cultures, languages and ways in which people identify.

An intersectional approach recognises that communities are not homogenous, and services must reflect the unique needs of community and individuals. Health services are required ensure the following whole-of-government and Department of Health strategy and policy documents guide local policy and service development:

* [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/inclusive-language-guide) <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>
* [The Victorian LGBTIQ+ Strategy 2022-32](https://www.vic.gov.au/victorian-lgbtiq-strategy) <https://www.vic.gov.au/victorian-lgbtiq-strategy>
* [Youth Policy: Building Stronger Youth Engagement in Victoria](https://www.youthcentral.vic.gov.au/get-involved/youth-programs-and-events/victorian-government-youth-policy) <https://www.youthcentral.vic.gov.au/get-involved/youth-programs-and-events/victorian-government-youth-policy>
* [*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>
* [Department of Health’s Operational Plan 2021–22](https://www.health.vic.gov.au/about/our-operational-plan) <<https://www.health.vic.gov.au/about/our-operational-plan>>
* [The Premier’s Circular No. 2015/02 Good Board Governance](https://www.vic.gov.au/good-board-governance) <<https://www.vic.gov.au/good-board-governance>> (outlining the government’s drive to obtain more equitable gender and cultural representation on boards)

Guidance on the needs of particular diverse communities is outlined in more detail in the following sections. In addition, the following documents provide guidance on working in an intersectional, person-centred approach:

* [Designing for Diversity – policy and service design resources](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>
* [Service Guideline for Gender Sensitivity and Safety](https://www.health.vic.gov.au/publications/service-guideline-for-gender-sensitivity-and-safety) <https://www.health.vic.gov.au/publications/service-guideline-for-gender-sensitivity-and-safety>

Services should consider the effectiveness of the ways in which they respond to diversity in 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 under-served.

### Culturally Safe Services for Aboriginal Victorians

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.

Aboriginal Victorians are overrepresented in the healthcare system and face significant disparities in health outcomes. Aboriginal cultural safety is a key determinant to improving access to health services and improving health outcomes for Aboriginal Victorians. It is also an important enabler for the quality of prevention, early intervention, 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. For more information, visit [Aboriginal and Torres Strait Islander cultural safety](https://www.health.vic.gov.au/health-strategies/aboriginal-and-torres-strait-islander-cultural-safety) <https://health.vic.gov.au/health-strategies/aboriginal-and-torres-strait-islander-cultural-safety>.

Cultural safety is underpinned by Aboriginal self-determination where Aboriginal voice contributes 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>.

To strengthen the cultural safety of health care across the organisation and improve Aboriginal health outcomes, health services are required to demonstrate:

* CEO and executive leadership to drive cultural safety and Aboriginal self-determination
* partnerships with Aboriginal community-controlled health organisations, respected Aboriginal leaders and Elders, and Aboriginal communities to deliver healthcare improvements
* Aboriginal employment plans in line with agreed public service workforce targets, and demonstration of increased Aboriginal employment, including leadership positions and across all clinical and non-clinical roles
* plans to identify and prioritise the health, wellbeing and service needs of the Aboriginal catchment population and service users – including improved patient identification, discharge planning and outpatient care
* delivery of best-practice Aboriginal cultural safety training to all health service employees
* a culturally safe welcoming environment with Aboriginal cultural symbols and spaces demonstrating, recognising, celebrating and respecting Aboriginal communities and culture
* effective Aboriginal and Torres Strait Islander patient identification, including quality improvement processes to continually improve in this area
* strategies to increase transparency and accountability of cultural safety across health services by monitoring of Aboriginal health data, and cultural safety indicators and targets. This includes oversight by the health service board, executive and Aboriginal governance groups, and data-sharing agreements with Aboriginal community-controlled health organisations.

These requirements align with the National Safety and Quality Health Service (NSQHS) Standards, and health services are encouraged to review the [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>.

For further 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/site-4/publications/aboriginal-cultural-safety-in-health-services-guidance-notes-and-resources>
* [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 LGBTIQ+ Communities

Discrimination, stigma and exclusion continues to drive poorer health outcomes for some lesbian, gay, bisexual, transgender, intersex and queer (LGBTIQ+) Victorians experiencing poorer health outcomes[[6]](#footnote-7).

The [Victorian LGBTIQ+ Strategy 2022–2032](file:///C:/Users/BridieW/AppData/Roaming/Microsoft/Word/Victorian%20LGBTIQ+%20Strategy%202022–2032) <https://www.vic.gov.au/victorian-lgbtiq-strategy> provides a vision and plan for LGBTIQ+ equality and inclusion. It outlines that Victorian health services should be approachable, welcoming, safe and inclusive for LGBTIQ+ Victorians. It also outlines that LGBTIQ+ people must be able to access services that meet their needs, and that their health 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 LGBTIQ+ Victorians experience inclusive and accessible health care.

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

* [Understanding lesbian, gay, bisexual, transgender and intersex health](https://www.health.vic.gov.au/populations/understanding-lesbian-gay-bisexual-transgender-and-intersex-health) <https://www.health.vic.gov.au/populations/understanding-lesbian-gay-bisexual-transgender-and-intersex-health>
* [Data collection standards – lesbian, gay, bisexual, transgender and intersex communities](https://www.vic.gov.au/victorian-family-violence-data-collection-framework/data-collection-standards-lesbian-gay-bisexual) <https://www.vic.gov.au/victorian-family-violence-data-collection-framework/data-collection-standards-lesbian-gay-bisexual>
* [Rainbow eQuality, a guide to LGBTI-inclusive practice for health and community service agencies](https://www.health.vic.gov.au/populations/rainbow-equality) <https://www.health.vic.gov.au/populations/rainbow-equality>
* [LGBTIQ+ Inclusive Language Guide](https://www.vic.gov.au/inclusive-language-guide) <https://www.vic.gov.au/inclusive-language-guide>.

Funded organisations are encouraged to consider working towards the Rainbow Tick accreditation. The Rainbow Tick guides organisations through a cycle of self-assessment and review by external assessors, to determine the extent to which the organisation (or a service within the organisation) meets the needs of LGBTIQ+ consumers.

Further information is available from [Rainbow Health Australia](https://rainbowhealthaustralia.org.au/) <https://rainbowhealthaustralia.org.au/>.

A whole-of-government LGBTIQ+ Taskforce, supported by a departmental Health and Wellbeing Working Group, an Intersex Expert Advisory Group and a Trans and Gender Diverse Expert Advisory group, and the Commissioner for LGBTIQ+ Communities provide advice to the department on the delivery of inclusive and accessible health care. Funded organisations can engage these groups by [emailing the LGBTQI Secretariat](mailto:LGBTIQSecretariat@health.vic.gov.au) <LGBTIQSecretariat@health.vic.gov.au>.

#### Trans and Gender Diverse People

A transgender person is someone whose gender is different to what was assigned to them at birth. Gender diverse generally refers to a range of genders expressed in different ways. Trans and gender diverse people are part of the broader LGBTIQ+ community and have distinct healthcare and social support needs, particularly during the difficult 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.

It also means providing respectful, supportive advice on access to health services associated with gender affirmation, such as support to explore gender identity, medical treatment to affirm gender, speech therapy and voice training, and mental health and wellbeing support.

Funded organisations are encouraged to seek advice and resources from peak bodies and associations to drive service improvement and build workforce capability.

More information and resources on trans and gender diverse health and wellbeing, and funded initiatives, is available:

* [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>
* [Service Guideline for Gender Sensitivity and Safety](https://www.health.vic.gov.au/publications/service-guideline-for-gender-sensitivity-and-safety) *<*https://www.health.vic.gov.au/publications/service-guideline-for-gender-sensitivity-and-safety>

The department funds a number of 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 mental health support, primary medical care and peer supports for trans and gender diverse young people. This includes an expansion of health and mental health services, and primary care at Monash Health, The Royal Children’s Hospital and Orygen, and peer and family supports at Transgender Victoria, Transcend, and Monash Health, as well as the development of improved pathways between specialist gender services.

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 a statewide trans and gender diverse health training and capacity building program.

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 an Intersex Variation

People with intersex variations are born with physical, hormonal or genetic features that do not fit the typical expectations for male or female bodies.

‘People with intersex variations’ is one of a number of terms used to refer to people who have variations in parts of the body associated with sex and/or reproductive development. Other terms include ‘differences of sex development’ or 'variations of sex characteristics'.

Health services should understand what intersex is, including the difference between intersex and sexual orientation, intersex and transgender, and intersex and gender diversity.

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.

Health service staff should avoid asking questions related to a person’s intersex status, unless clinically necessary.

Funded organisations are encouraged to seek advice and resources from peak bodies and associations to drive service improvement and build workforce capability. Further information, guidelines and resources on the health needs and on supporting people with an intersex variation can be found at [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>.

The [(i) Am Equal future directions paper](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, inclusive of 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.

### Supporting Health Access and Outcomes for People with a Disability

Victorian people with disability are diverse in their culture, language, sexuality, gender identity, age, ability, socioeconomic status and life experiences. Approximately 17 per cent 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 service accessibility and discrimination.

The [Inclusive Victoria: state disability plan 2022–2026](file:///C:/Users/BridieW/AppData/Roaming/Microsoft/Word/Inclusive%20Victoria:%20state%20disability%20plan%202022–2026) <https://www.vic.gov.au/state-disability-plan> sets out whole-of-government commitments aimed at improving the lives of Victorians with a disability, including priority actions related to inpatient care, sexual and reproductive health, mental health and health service capability. The [Victorian Autism Plan](https://www.statedisabilityplan.vic.gov.au/victoria-autism-plan) <https://www.statedisabilityplan.vic.gov.au/victoria-autism-plan> also sets out additional actions to support autistic people.

The 2022–23 State budget has committed $14.6 million to deliver the Victorian State Disability Plan. This included an allocation of funding to extend the Disability Liaison Officer (DLO) Program in 2022–23, to identify and address barriers for people with disability in accessing health services.

DLOs are based in health services across Victoria and help people with disability to access the health care they need, including vaccinations. DLOs also partner with health service teams to support delivery of the *Inclusive Victoria: state disability plan 2022–26* to reduce systemic health services access barriers.

For more information, contact the DLO at your health service. You can also [email the DLO Coordinator](mailto:email%20the%20DLO%20Coordinator) <DLOcoordinator@dhhs.vic.gov.au>.

### Responding to Cultural and Linguistic Diversity

Victoria is renowned for its cultural and linguistic diversity. Almost half of Victorians were born overseas or have at least one parent born overseas. Across Victoria, people have come from more than 200 countries, speak over 250 languages and follow over 130 different faiths.

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>.

A range of legislation also protects and promotes the rights of Victoria’s culturally and linguistically diverse communities, including the:

* [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>>.

The department recognises that Victoria’s multicultural communities experience worse health and wellbeing outcomes than the Victorian population as a whole. This is largely the result of social determinants of health, such as financial stress, food insecurity, discrimination and low English language proficiency.

Needs are particularly complex for refugees and people seeking asylum. Services should familiarise themselves with policies and programs funded by the department to support these at-risk groups, including:

* [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>
* [Refugee Minor Program (DFFH)](https://services.dffh.vic.gov.au/refugee-minor-program) <https://services.dffh.vic.gov.au/refugee-minor-program>
* [Victorian Transcultural Mental Health](https://vtmh.org.au) <https://vtmh.org.au>
* [Victorian Foundation for Survivors of Torture (Foundation House)](https://foundationhouse.org.au/) <https://foundationhouse.org.au>
* [Centre for Culture, Ethnicity and Health](https://www.ceh.org.au) <https://www.ceh.org.au>.

It is particularly important to be aware of health and community services access policies for people seeking asylum, which allow access despite ineligibility for Medicare or a healthcare 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>.

In the 2022–23 State Budget, $5.7 million was provided to continue and expand supports for people seeking asylum and refugees.

This includes the Support for Asylum Seekers initiative that delivers case coordination, basic needs assistance, homelessness assistance, mental health support and GP care to people seeking asylum who are ineligible for Commonwealth safety net supports.

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 service provision, 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>, and ensure quality language services are an integral part of their planning, policy and service response.

Health services should also ensure that frontline staff are familiar with the policy and guidelines, and receive training on how to assess the need for an interpreter, and how to obtain and work effectively with both 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 as they are not qualified interpreters, this 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 use of automated interpreting and translating technologies in place of qualified and credentialed interpreters and translators is not currently supported. There is a duty to ensure translations are accurate, culturally appropriate, not likely to cause harm and communicate concepts effectively.

Health services are funded through a range of mechanisms to provide language services. Failure 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](file:///C:/Users/BridieW/AppData/Roaming/Microsoft/Word/Health%20Translations%20website) <<https://www.healthtranslations.vic.gov.au>>, which is managed by the [Centre for culture, ethnicity and health](https://ceh.org.au) <https://ceh.org.au>, provides access to over 24,000 free and reliably translated resources. The centre also offers a range of training programs on cultural competence, health literacy and language services.

## Capability Frameworks

### Maternity and Newborn Capability Levels

The [*Capability frameworks for Victorian maternity and newborn services*](https://www.health.vic.gov.au/patient-care/maternity-and-newborn-care-in-victoria)<https://www.health.vic.gov.au/patient-care/maternity-and-newborn-care-in-victoria> describe the requirements for providing safe and high-quality maternity and newborn care across six levels.

Service capability levels for all public health services providing planned maternity and newborn care are reviewed and determined by the department, in conjunction with individual services. Health services must operate within their agreed and published maternity and newborn capability level.

The capability levels, including the frameworks, can be downloaded at [Maternity and newborn care in Victoria](https://www.health.vic.gov.au/patient-care/maternity-and-newborn-care-in-victoria) <https://www.health.vic.gov.au/patient-care/maternity-and-newborn-care-in-victoria>.

#### Continuity of Maternity Services

Planned or unplanned changes to a service’s maternity and newborn capability (such as planned infrastructure works or unplanned changes to essential workforce) must be escalated to the department and a management plan developed, agreed and communicated to staff, patients, key partners and the community.

The occasions that a health service cannot meet its capability requirements should be rare, and each health service must have plans to ensure service continuity.

Services that are unable to provide care at the determined level for any period of time must:

* ensure the details of the change in service capability and the plan to manage the temporary change in service delivery (such as transfer of labour care agreements) are formally agreed and documented with local health services and other providers that will be affected (including Ambulance Victoria and the Paediatric Infant Perinatal Emergency Retrieval service)
* develop and communicate a clear, personalised care plan for women who are booked in and likely to birth over the period, including key contacts at both the referring and the receiving hospital(s)
* ensure information about how the local community can access care during this period is communicated effectively.

In advance of any planned or unplanned changes to a health service’s maternity and newborn capability, health services must advise the department via the Manager, Health Performance for the appropriate region (South East, North East or Western Health) of the steps taken to action the above requirements.

When maternity diversion is required, health services must complete the standard maternity diversion template and email it to the Manager, Health Performance for the appropriate region (South East, North East or Western Health). The frequency and duration of service provision outside the determined capability levels will be monitored by the department. This, along with other factors, will inform decision-making about ongoing capability levels for the service.

### New 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*.

Capability frameworks delineate care for clinical streams and core hospital services 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).

In 2019–20, the department released capability frameworks for surgical and procedural services, and renal care, and undertook an initial process to assess health services’ current capability levels and service gaps for these areas.

This work was paused during 2020 and 2021, due to the impact of the COVID-19 pandemic.

In 2022–23, the department plans to work with health services and expert advisory groups to:

* progress finalisation and implementation of the surgery and anaesthetics frameworks
* develop a new mental health capability framework
* develop a cancer capability framework.

This will be followed by the development and implementation of capability frameworks in:

* urgent, emergency and trauma care
* critical care.

Further frameworks are proposed for:

* renal
* pathology
* diagnostic imaging and nuclear medicine
* pharmacy
* cardiac.

This will involve consulting with health services and other key stakeholders to confirm the service descriptors and service requirements for each level of complexity for each of these service streams.

Health services will be expected to complete self-assessments and other service information to facilitate the allocation of capability levels. When capability levels have been allocated, health services will be required to operate within their agreed and published capability level.

Health services should note the existing *Palliative care service capability framework* is currently being reviewed and a draft will be available for consultation in 2022–23.

## 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 to meet the requirements of [Victoria’s Elective surgery access policy 2015](https://www.health.vic.gov.au/publications/elective-surgery-access-policy-2015) <https://www.health.vic.gov.au/publications/elective-surgery-access-policy-2015>. The policy provides guidance to the clinical, administrative support staff, managers and executives of all public health services that provide elective surgery. A revision of the policy is planned for 2022–23, with changed requirements to cover elective surgery and other planned procedures.

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 health services are required to meet the requirements of the Specialist clinics in Victorian public hospitals access policyhttps://www.health.vic.gov.au/publications/specialist-clinics-in-victorian-public-hospitals-access-policy. It provides guidance to the clinical, administrative support staff, managers and executives of all public health services that provide non-admitted specialist services. A revision of the policy is planned for 2022–23.

Public health services must only accept referrals where they have the capability and capacity to provide safe and appropriate care.

They must not accept referrals:

* that are incomplete and unable to be assessed (for example, incomplete demographic or clinical information)
* that do not meet statewide referral or, in their absence, local clinical criteria
* when the patient requires services that are not provided by the health service that has received the referral
* when the referral information indicates that the patient can be more effectively managed in the primary care setting.

#### Victorian Endoscopy Categorisation Guidelines

Victorian health services that provide endoscopy services should ensure clinicians use the Upper gastrointestinal endoscopy categorisation guidelines for adults 2018.

To assist with this, the department has recently made the Decision Support Tool for Victoria’s Colonoscopy and Gastroscopy Categorisation Guidelines available 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>.

#### Bariatric Surgery

Bariatric surgery is limited to three designated centres at The Alfred, the Austin Hospital and Western District Health Service.

#### 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 stand-alone 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. The model must be endorsed by the department prior to commencement, and have 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 funded programs, such as community palliative care – this includes services provided by another state-funded community palliative service.

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 must 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 acute 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 data set and cost data to the VCDC.

#### Maternity and Newborn Services

##### Maternal and perinatal mortality and morbidity committees

All health services providing maternity and newborn services must review all maternal and perinatal morbidity and mortalities. The hospital’s processes should align with the *Perinatal Society of Australia and New Zealand: 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>.

From 2021, the six regional level 5 maternity services 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 quarterly 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 in June and December each year, and [submit by email](mailto:maternity@health.vic.gov.au) <maternity@health.vic.gov.au>.

A review of summary reports by Safer Care Victoria and the department will ensure that regional committee findings and recommendations can be consolidated and reviewed at a state-wide level.

##### Generation Victoria

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 impact on routine health care. GenV staff will facilitate a transparent ‘opt-in’ consent process delivered in alignment with the Victorian Infant Hearing Screening Program. This will ensure there is minimal impact on hospital staff and resources. GenV is led by the Murdoch Children’s Research Institute and The Royal Children’s Hospital, and is partially funded by the Victorian Government.

##### Incentivising Better Patient Safety

The Victorian Managed Insurance Authority 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 birth suite staff in certain evidence-based, maternity skills education and training programs. The program identifies three high-risk maternity focus areas. 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.

##### 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.

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.

##### 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.

##### Koori Maternity Services

Victoria’s Koori Maternity Services provide culturally safe and responsive care. All Aboriginal women and women having an Aboriginal baby are eligible to access pregnancy and postnatal care through a Koori Maternity Service.

Strong and effective partnerships between Koori Maternity Services and public health services underpin good perinatal outcomes for Aboriginal women, babies and their families. Koori Maternity Services and public hospitals operate with formal partnerships and agreed referral pathways for providing high-quality and safe antenatal, intrapartum and postnatal care for Aboriginal women and their babies.

The [Koori Maternity Services guidelines](https://www.health.vic.gov.au/publications/koori-maternity-services-guidelines) <https://www.health.vic.gov.au/publications/koori-maternity-services-guidelines> establish the program objectives and requirements for service delivery. All maternity services must ensure that delivery of maternity and newborn care for Aboriginal women, families and babies aligns with the Koori Maternity Services guidelines.

There are 14 Koori Maternity Services located across Victoria, with 11 services located in Aboriginal community-controlled organisations and three in public health services. The key partnerships between Koori Maternity Services and public health services are outlined in Table 1.

Table 1: Public health services partnering with Koori Maternity Services

| Region | Koori Maternity Service | Key birthing partners |
| --- | --- | --- |
| North and West Metropolitan | Victorian Aboriginal Health Service  Western Health (Sunshine Hospital)  Northern Health (The Northern Hospital) | The Royal Women’s Hospital  Sunshine Hospital (Western Health)  The Northern Hospital (Northern Health) |
| Southern Metropolitan | Dandenong and District Aboriginal Cooperative  Peninsula Health (Frankston Hospital) | Monash Health  Frankston Hospital (Peninsula Health) |
| Barwon South West | Wathaurong Aboriginal Health Service  Gunditjmara Aboriginal Cooperative | University Hospital Geelong  Warrnambool (South West Healthcare) |
| Hume | Rumbalara Aboriginal Cooperative  Mungabareena Aboriginal Cooperative | Goulburn Valley Health  Albury Wodonga Health |
| Gippsland | Gippsland and East Gippsland Aboriginal Co-operative  Central Gippsland Aboriginal Health Service | Bairnsdale Regional Health Service  Central Gippsland Health Service (Sale) |
| Loddon Mallee | Mallee District Aboriginal Service  Swan Hill Aboriginal Health Service  Njernda Aboriginal Corporation | Mildura Base Hospital  Swan Hill District Health  Echuca Regional Health |

Public health services and Aboriginal community-controlled organisation funded to provide a Koori Maternity Service (this includes Western Health, Northern Health and Peninsula Health) must submit data to the Koori Maternity Services minimum dataset via the online form at [Aboriginal 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 is composed 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

Acute admitted care provided to patients at home as Hospital in the Home (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 [Victorian Admitted Episodes Dataset: 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 2022.

#### Specialist Clinics

Health services currently in scope to report specialist clinics data through the VINAH minimum data set are expected to comply with the [Specialist clinics in Victorian public hospitals access 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 data set or the NADC. Small rural health services and multi-purpose 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 data set 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.

#### Telehealth

Telehealth offers the opportunity to minimise infection risk during the COVID-19 pandemic, and improve patient choice and experience beyond it. Health services are encouraged to make it the default delivery mode for services, where it is safe, appropriate and consistent with patient preference.

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.

Telehealth consultations should particularly target patient cohorts that are underserviced by the conventional face-to-face service model, irrespective of the clinic or specialty. Translation services should be made available when required for telehealth consultations.

Services provided via telehealth video consultations in specialist clinics must be reported through the VINAH minimum data set as described in the VINAH manual for 2022–23.

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 2022–23. 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>.

Medicare Benefits Scheme telehealth items have been introduced to support the response to the COVID-19 pandemic. Fact sheets with information on these items can be found at [MBS Telehealth Services from January 2022](http://www.mbsonline.gov.au/internet/mbsonline/publishing.nsf/Content/Factsheet-Telehealth-Arrangements-Jan22) <http://www.mbsonline.gov.au/internet/mbsonline/publishing.nsf/Content/Factsheet-Telehealth-Arrangements-Jan22>.

#### 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 2022–23, 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 Public Health Networks with local Public Health Networks
* 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 Commonwealth Government lists several medicines to treat hepatitis C on the Pharmaceutical Benefits Scheme 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 Pharmaceutical Benefits Scheme Schedule. 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 details these arrangements.

For more information, 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 data set. 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](mailto:hdss.helpdesk@health.vic.gov.au) <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 Minimum Dataset](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/NDIS–Health Interface

Health services should deliver high-quality care that is accessible, welcoming, safe and effective to all Victorians, including people with a disability, wherever they are treated. People with a 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 promote active participation of people with a 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:

* People accessing health-funded services and equipment may be eligible for the NDIS. 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 register as NDIS service providers. 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.

The NDIS supports 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 complex 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 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 for 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.

There are a number of NDIS-funded HLO positions throughout Victoria. Hospitals that do not have an HLO can refer and seek support by [emailing the HLO service](mailto:vic.health.liaison@ndis.gov.au) <vic.health.liaison@ndis.gov.au>. Referrals will be triaged to the next available HLO.

##### 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 patient’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 18.1.9 ‘Hospital in the Home’).

Health services are delineated to provide rehabilitation and geriatric evaluation, and management services, 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, geriatric evaluation and management, 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 care in which the primary clinical purpose or treatment goal is improvement in the functioning of a patient with impairment, activity limitation or participation restriction due to a health condition. The patient will be capable of actively participating in rehabilitation.

Rehabilitation care is always:

* managed by a clinician with special expertise in rehabilitation
* evidenced by an individualised, multidisciplinary management plan that is documented in the patient’s medical record, including negotiated goals within specified timeframes and documented assessment of functional ability.

##### Geriatric evaluation and management

Geriatric evaluation and management is care in which the primary clinical purpose or treatment goal is improving the functioning of a patient with multidimensional needs that are associated with medical conditions related to ageing, such as falls, incontinence, reduced mobility, delirium or depression. The patient may have complex psychosocial problems and is usually (but not always) an older patient.

Geriatric evaluation and management is always:

* managed by a clinician with special expertise in geriatric evaluation and management
* evidenced by an individualised, multidisciplinary management plan that is documented in the patient’s medical record, which includes negotiated goals within indicative timeframes and documented assessment of functional ability.

An evaluation of the geriatric evaluation and management program in Victoria has been undertaken, and the report is available at [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 geriatric evaluation and management is delivering an efficient and effective service
* understand how geriatric evaluation and management 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 geriatric evaluation and management, 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 patient with impairment, activity limitation or participation restriction due to a health condition. Following assessment or treatment, the patient 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 geriatric evaluation, and management services must report a Functional Independence Measure score on admission, and on separation, for patients with rehabilitation (excluding paediatric rehabilitation), and geriatric evaluation and management. 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 jointly funded by the Commonwealth, state and territory governments through joint per diem contributions. The flexible care places used in the program are legislated by the *Aged Care Act (Cth)1997* and the Aged Care Principles pursuant to the Act. The [Transition Care Programme guidelines](https://www.health.gov.au/resources/publications/transition-care-programme-guidelines) (updated July 2022) <https://www.health.gov.au/resources/publications/transition-care-programme-guidelines> govern the program.

For more information, see 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 patient preference.

##### Conditions of funding

It is expected that health services will continue to provide the Health Independence Program service components for which they are funded, based on their subacute service capability framework level. More information is available from the [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 client receives will be based on the client’s assessed needs and will assist the client 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
* client 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 that receive funding under any of the following programs must transmit data to the VINAH minimum dataset:

* 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 data set 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 or 5)
* contact delivery setting that is not the emergency department (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 data set 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 29.1.7 ‘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 2022–23.

#### 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>.

##### 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 data set, which includes that:

* contacts will be reported through the VINAH minimum data set 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 such time as the AIMS S11 and the VINAH minimum data set 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

##### Hospital-based consultancy teams

Hospital-based consultancy programs 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 data set. The AIMS S11 form is required for any activity meeting the national definition of service events for Commonwealth reporting processes.

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). AIMS S11 reporting can cease once the AIMS S11 and the VINAH minimum data set reliably match, and/or agreement to cease has been reached with the department.

Health services reporting aggregate activity via AIMS S11, and not able to transition to patient-level VINAH minimum data set reporting for 2022–23, are to continue reporting via AIMS S11 and PCCP, and make the necessary changes to report patient-level activity to the VINAH minimum data set from 1 July 2022.

Hospitals are to ensure that any specialist inpatient palliative care consultancy activity relevant to their hospital is appropriately allocated and included in patient-level cost data through the VCDC regional palliative care consultancy teams.

Funding allocations for regional palliative care consultancy form part of the health service modelled budgets in their acute and subacute allocation. Regional palliative care consultancy teams provide a combination of direct care and secondary consultations to other clinicians in their region.

###### Reporting requirements

The department will work with health services to plan for their transition to patient-level reporting via the VINAH minimum data set from 1 July 2023.

In the meantime, services are required to provide the AIMS S11 form for any activity meeting the national definition of service events for Commonwealth reporting processes. 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). AIMS S11 reporting can cease once the AIMS S11 and the VINAH minimum data set reliably match, and/or agreement to cease has been reached with the department.

Hospitals are to ensure that any relevant inpatient palliative care consultancy activity relevant to their hospital is appropriately allocated and included in patient-level cost data through 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:

* Victorian Paediatric Palliative Care Consultancy Program
* Very Special Kids
* Statewide Specialist Bereavement Service
* Motor Neurone Disease Association Victoria.

###### Reporting requirements

From 1 July 2022, statewide palliative care services are to report patient-level data using the VINAH minimum data set or the NADC (see section 29.1.4 ‘Victorian Integrated Non-Admitted Health minimum data set’).

For now, services are required to provide the AIMS S11 form for any activity meeting the national definition of service events for Commonwealth reporting processes. 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 data set/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 Palliative Care Consultancy Program 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:

* 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 2023. The report should outline their key achievements and activities for 2022–23, and include a financial statement that accounts for expenditure throughout the financial year.

For more information about palliative care consortia, see 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

Funding for the Victorian Artificial Limb Program will continue to be provided as a block grant to health services as a non-admitted subacute service.

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 data set from 1 July 2022.

Services expected to provide artificial limbs under the Victorian Artificial Limb Program in 2022–23 are:

* The Royal Children’s Hospital
* Peninsula Health
* Melbourne Health
* Alfred Health
* Barwon Health
* Ballarat Health Services
* 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

Funding for the Victorian Respiratory Support Service will continue to be provided as a block grant to Austin Health as a non-admitted subacute service.

The Victorian Respiratory Support Service is required to report activity through the AIMS S12 form, 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

In 2022–23, funding will again be provided to five health services to support total parenteral nutrition services for non-admitted patients, 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.

Health services funded to provide total parenteral nutrition will be required to report activity and cost data to the department in 2022–23. Activity is to be reported via the AIMS S12 form by the fourteenth day following the end of the month, and be reported to the VINAH minimum data set. Cost data reported via the VCDC 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.

For more information about home-delivered total parenteral nutrition funding arrangements, download [HEN and TPN – home delivered: Funding arrangements for Victorian Public Health Services](https://www.health.vic.gov.au/publications/hen-and-tpn-home-delivered-funding-arrangements-for-victorian-public-health-services) <https://www.health.vic.gov.au/publications/hen-and-tpn-home-delivered-funding-arrangements-for-victorian-public-health-services>.

#### Home Enteral Nutrition

Funding is provided to support home enteral nutrition services given to non-admitted patients who self-administer enteral nutrition at home.

Health services funded to provide home enteral nutrition must report activity and cost data to the department in 2022–23.

Activity is to be reported via the AIMS S12 form by the fourteenth day following the end of month and to be reported to the VINAH minimum data set. Cost data reported via the VCDC 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.

For more information about home-delivered enteral nutrition funding arrangements, download [HEN and TPN – home delivered: Funding arrangements for Victorian Public Health Services](https://www.health.vic.gov.au/publications/hen-and-tpn-home-delivered-funding-arrangements-for-victorian-public-health-services) <https://www.health.vic.gov.au/publications/hen-and-tpn-home-delivered-funding-arrangements-for-victorian-public-health-services>.

### System Improvements

#### Strengthening Hospital Responses to Family Violence (SHRFV)

Health services are expected to support the work of embedding a whole-of-hospital model for responding to family violence, to meet the requirements of the Child Information Sharing Scheme and the Family Violence Information Sharing Scheme, and to align to the *Family Violence Multi-Agency Risk Assessment and Management Framework* (MARAM).

Health services are required to facilitate access to appropriate training and resources for supported health services, actively participate in the community of practice, and provide quarterly data, as part of the program reporting requirements.

Lead health services are required to actively mentor supported health services to roll out and embed the information sharing schemes and MARAM, inclusive of the family violence workplace support. There is also a requirement to report funding expenditure on a biannual basis and acquit 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 metropolitan and regional health services.

The Strengthening Hospital Responses to Family Violence (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’s Worker Wellbeing Centre will continue to work with health services in 2022–23 to implement initiatives to better prevent and respond to risks of occupational violence and aggression, and bullying and harassment. These initiatives can be found at [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 the webpage, and implement the guidance and resources, including minimum standards.

The implementation of the minimum standards, guidance and supporting tools at each health service will be monitored by the department during 2022–23. The department requires that all Victorian public health services undertake the Victorian Public Sector Commission’s People Matter Survey in 2023, 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 2022–23 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 this Act, it will constitute unprofessional conduct.

Health services are required to have processes in place that:

* include advance care planning and identification of medical treatment decision-makers, in communication with other providers
* 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 patients with an advance care directive/plan alert and an identified medical treatment decision-maker. This will be measured through mandatory VAED, VEMD and VINAH minimum data set 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>.

#### Standardised Emergency Number and the Deteriorating Patient

Victorian health services that utilise an internal number to activate an internal emergency response are required to transition to the standard internal emergency number: 22 22. This does not apply to health services or sites using triple zero. Internal emergency response processes currently in place should not change, only the number dialled to activate an internal response.

Standardising the internal emergency number across Victoria will improve staff recall of the internal emergency number, particularly where staff transfer between health services, and will reduce the likelihood of a delay in responding to an emergency.

Health services should ensure that an appropriate clinical governance committee and clinical lead oversee this change. The chief executive officer at each health service is required to complete an Attestation Form prior to the transition date.

For more information, visit the [Standardised Emergency Number Project](https://www.health.vic.gov.au/quality-safety-service/standardised-emergency-number-project) <https://www.health.vic.gov.au/quality-safety-service/standardised-emergency-number-project>.

### 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 vision to improve patient experiences and outcomes, by coordinating cancer care and driving best practice.

ICSs will help achieve the goals stated in the Victorian cancer plan, being that Victorians:

* know their risk and have their cancer detected earlier
* with cancer have timely access to optimal treatment
* with cancer and their families live well.

A continuing focus for ICSs in 2022–23 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.

The Victorian Cancer Registry has reported a drop in notifications of newly diagnosed cancers since the COVID-19 pandemic. To respond to this situation, the ICS will work with health services to support post-COVID recovery, through the implementation of projects that specifically improve access and timeliness of care.

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. A detailed reporting schedule for ICS will be provided in September 2022. The report will identify requirements and timelines.

The accountability requirements of the ICS governance committees are to:

* provide an annual forum and report of 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 2022–23) for public dissemination
* 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 [Victoria’s 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.

Health services should use this report to:

* track their own performance and trends, using raw local data more frequently, if 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.

During 2022–23, Safer Care Victoria and the Victorian Agency for Health Information (VAHI) will also collaborate to develop a dashboard that presents key perinatal indicators for benchmarking and improvement on a monthly basis.

Safer Care Victoria will work with health services to identify future improvement priorities for 2022–23. For more information visit [Victorian perinatal services performance indicators](https://www.bettersafercare.vic.gov.au/publications/victorian-perinatal-services-performance-indicators-2019-20) <https://www.bettersafercare.vic.gov.au/publications/victorian-perinatal-services-performance-indicators-2019-20>.

### 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, which include:

* near-miss incidents
* events related to RhD 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.health.vic.gov.au/practice-and-service-quality/chief-psychiatrist) <https://www.blood.gov.au/document/national-stewardship-expectations-supply-blood-and-blood-products-pdf and the <https://www.blood.gov.au/pbm-guidelines> <https://www.blood.gov.au/pbm-guidelines>
* *National Safety and Quality Health Service (NSQHS) Standards (2nd edition),* available on the [Australian Commission on Safety and Quality in Health Care website](https://www.safetyandquality.gov.au/standards/nsqhs-standards/assessment-nsqhs-standards) <https://www.safetyandquality.gov.au/standards/national-safety-and-quality-health-service-nsqhs-standards/assessment-nsqhs-standards>
* national wastage and haemovigilance strategies, available at the [National Blood Authority](https://www.blood.gov.au/blood-product-management-improvement) <https://www.blood.gov.au/blood-product-management-improvement>.

The department established the transfusion nurse/trainer/safety officer, and patient blood management role across Victoria, and 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, and 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, such as one who holds a Specialist Certificate in Blood Management Foundations/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 shared pathology networks, to deliver integrated and patient-centred pathology services to the Victorian public hospital system.

Consultation on the most appropriate model for the shared pathology services with key stakeholder groups is continuing, to ensure that the new services remain highly responsive to health services and patient needs.

As these arrangements are being agreed, networks have commenced working collaboratively to consider service design principles and operating models. An immediate focus for networks is to implement new integrated Laboratory Information Systems, connected by a health information exchange, to facilitate the sharing of pathology information between laboratories and health services. These technologies are a key enabler to more integrated pathology services that will deliver more effective and efficient pathology services to Victorian communities.

Funding is being made available to participating health services to support the formation of the networks and implement the Laboratory Information Systems.

### Elective Surgery Reform

The COVID-19 pandemic and necessary pauses to non-urgent surgery have led to a considerable amount of deferred care, and record numbers of Victorians waiting for surgery.

The Victorian Government is focused on system recovery and supporting more Victorians to receive access to surgery, as soon as possible.

To this end, on 3 April 2022, the Victorian Government announced a record investment of $1.5 billion to deliver a COVID Catch Up Plan to boost surgical activity across Victoria.

When fully implemented, the plan will enable a record 240,000 Victorians to receive surgery every year by June 2024. This represents an extra 40,000 procedures each year, compared to pre-pandemic levels.

The plan is comprised of several elements, including:

* $524.6 million to maximise public activity and throughput, through new Rapid Access Hubs, increased twilight and after-hours work, and expanded same-day models of care
* $20.3 million for a Surgical Equipment Innovation Fund to upgrade, modernise and replace surgical equipment and image-capture systems
* $548.1 million to maximise all available private hospital capacity to support public patients
* $69.2 million for rapid patient prioritisation and assessment, through the establishment of Surgery Recovery Patient Support Units and using non-surgical treatment pathways.

The plan is supported by an $80 million workforce investment package, including upskilling more than 1,000 nurses, and theatre and sterilisation technicians, training an additional 400 perioperative nurses, and recruiting a further 2,000 highly skilled healthcare workers from overseas.

The plan’s implementation will be enabled through effective governance, including appointment of a Chief Surgical Adviser, a taskforce, and delivery and innovation teams, which will oversee and drive delivery of the plan.

### Health Service Partnerships

Established in July 2021, Health Service Partnerships replaced the health service ‘clusters’ that emerged during the COVID-19 pandemic, along with the Regional Area Health Partnerships that preceded them.

By bringing together all public health services in eight geographical areas across Victoria, Health Service Partnerships provide an important platform to boost collaboration between health services and address government and locally determined priorities. Three Health Service Partnerships cover metropolitan Melbourne, and there are five for rural and regional Victoria.

Health Service Partnerships work together on a small number of strategic system priorities that can be enhanced by working together, rather than in isolation or competition.

While the pandemic response continues, there will also be work towards recovery and reform in 2022–23. Health Service Partnerships will focus on system-wide priorities, including:

* restoring surgical activity as part of Victoria’s COVID Catch-Up Plan,and driving reforms to improve surgical outcomes and performance
* delivering Better at Home, including by meeting Health Service Partnership-level targets
* strengthening the mental health system by identifying opportunities to embed a regional focus to drive service integration within the mental health transformation plans.

Health Service Partnerships are free to continue to progress additional locally identified priorities.

In 2022–23, $4.58 million will be provided to Health Service Partnerships to support their continued establishment across the state.

A formal evaluation of the Health Service Partnership model will be conducted from mid to late 2022. The evaluation will consider delivery and outcomes from the model to date, and potential ways to enhance the model going forward to support stronger collaboration and integrated approaches to care across the health system.

#### Key Policies and Guidelines

The *Health Service Partnership Policy and Guidelines 2021* set the framework and expectations for how Health Service Partnerships operate. This includes that all members of the Health Service Partnership are expected to participate meaningfully and effectively in their partnership, to collectively achieve decision-making by consensus. This document supersedes the former Rural and Regional Health Partnerships guidelines, with relevant content for these (including in relation to Local Area Health Partnerships) now housed in the new policy and guidelines.

The policy and guidelines will be updated to reflect any improvements and changes to the Health Service Partnership model arising from the evaluation.

For more information, see the [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 patients’ 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 patients’ homes, where appropriate and preferred by the patient, through home-based and virtual care.

The program funding supports the delivery of more acute admitted, sub-acute admitted and non-admitted hospital care.

The funding will be allocated to health services based on applications submitted via Health Service Partnerships, in recognition of the benefits of health services working together to achieve transformation.

For more information, see 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 Act. For more information, visit [Chief Psychiatrist guidelines](file:///C:/Users/BridieW/AppData/Roaming/Microsoft/Word/Chief%20Psychiatrist%20guidelines) <https://www.health.vic.gov.au/key-staff/chief-psychiatrist-guidelines>.

Program management circulars articulate or clarify departmental policy on key aspects of service provision, and are available from the [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 2022–23.

As a condition of funding, organisations must adhere to all relevant regulation, safety and quality standards, and Chief Psychiatrist guidelines, relating to the funded activity. All funded clinical mental health services are required to 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 website](https://fac.dffh.vic.gov.au)[[7]](#footnote-8) <https://fac.dffh.vic.gov.au>.

More information on mental health service, programs and program guidelines can be found at [Mental health](https://www.health.vic.gov.au/mental-health) <https://www.health.vic.gov.au/mental-health>.

#### Mental Health Performance and Accountability Framework

The *Mental health performance and accountability framework* (MH PAF) 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 RCVHMS 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 RCVMHS 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.

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, and performance metrics tell us what actions have been taken to achieve outcomes.

The department is developing the new framework as a key instrument to embed an outcomes approach in system reform 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.

While this new framework is being developed, which will include a review of the current MH PAF measures for relevance and alignment against system outcomes, the MH PAF remains valid for performance and accountability requirements for services to monitor performance activity.

The new *Mental Health and Wellbeing Outcomes Framework* is expected to be finalised by the end of this year, with implementation of the framework to commence immediately after it is finalised and endorsed.

#### Alcohol and Drug services Standards and Guidelines

Service standards and guidelines that apply to funded AOD 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 (AOD) 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*.

More information and copies of the guidelines, charter and principles are available from the [Alcohol and other drugs webpage](https://www.health.vic.gov.au/alcohol-other-drugs) <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 Commonwealth Government.

#### Rights and Interests for Aged Care Residents

Health services operating PSRACS must meet Commonwealth Government 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 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 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 aligns with the Child Safe Standards, and assists all health services to meet these and other legislative requirements that are relevant to the safety and wellbeing of children.It is also 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 Victorian Forensic Paediatric Medical Services, which 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.

## Accreditation

Funded organisations have a range of obligations related to clinical service provision. These requirements have been put in place to ensure the quality of services and the safety of patients.

### Australian Health Service Safety and Quality Accreditation Scheme

Accreditation of health services falls under the Australian Health Service Safety and Quality Accreditation Scheme. Under this scheme, health services are accredited against the NSQHS Standards. Information regarding the standards can be found on the [Australian Commission on Safety and Quality in Health Care website](https://www.safetyandquality.gov.au/standards/nsqhs-standards) <https://www.safetyandquality.gov.au/standards/nsqhs-standards>.

All Victorian public health services must maintain their accreditation through the Australian Health Service Safety and Quality Accreditation Scheme. This includes:

* metropolitan (this includes specialist and denominational health services)
* regional, subregional, local and small rural
* 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.

The department, as the regulator, is responsible for monitoring and responding to the accreditation status of health service organisations.

The department’s regulatory approach to accreditation outcomes and health service responsibilities are detailed in the [Accreditation policy for Victorian public health organisations](https://www.health.vic.gov.au/publications/accreditation-policy-for-victorian-public-health-service-organisations) <https://www.health.vic.gov.au/publications/accreditation-policy-for-victorian-public-health-service-organisations>.

In cases where restrictions related to the COVID-19 pandemic affect access to health services by accrediting agencies, and an extension to the accreditation expiry date is required, health services should contact their departmental health service lead.

More information can be found on the [Australian Commission on Safety and Quality in Health Care website](https://www.safetyandquality.gov.au/standards/nsqhs-standards) <https://www.safetyandquality.gov.au/standards/nsqhs-standards>.

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.

### 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

With the exception of Victoria, ambulance services in Australia are not currently part of an accreditation or external assessment process. Ambulance Victoria has organisation-wide accreditation to the business standards ISO 9001. Ambulance Victoria is working towards accreditation to the NSQHS Standards.

### Mental Health Clinical and Community Support Services

All funded clinical mental health services must be accredited against the NSQHS Standards*.*

Organisations that receive funding for an MHCSS program are encouraged to implement the National Standards for Mental Health Services 2010.

Health services providing AOD 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 AOD 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 is also expected of organisations that will receive funding for AOD services in 2022–23.

These services are also required to 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 Commonwealth 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 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 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

To ensure the ongoing quality of services and that the program continues to best meet the needs of clients, the department will be undertaking a review of the HACC-PYP in 2022–23. Engagement with the sector will be integral to the review.

#### Other Programs Funded Under the Ageing, Aged Care and Home Support Program Output Group

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 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 Accreditation. For details, 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 health care: Victorian clinical governance framework*](https://www.safercare.vic.gov.au/support-and-training/clinical-governance) <https://www.bettersafercare.vic.gov.au/support-and-training/clinical-governance>.

#### Adverse Patient Safety Events and the Sentinel Event Program

In 2019, Safer Care Victoria published a new adverse patient safety event management policy and associated resources, specifying the requirements for all funded health services.

During 2022–23, health services will be expected to:

* notify Safer Care Victoria’s sentinel event program within three business days of becoming aware of the event
* begin and maintain an open disclosure process with affected consumers and/or their families, in line with the Statutory duty of candour legislation and the *Australian Open Disclosure Framework*
* undertake all adverse patient safety event management and sentinel event review processes, using a just culture approach
* ensure sentinel event review processes are timely, appropriately resourced and high quality (utilising human factors and systems thinking)
* ensure the review team is led by suitably qualified staff, including a consumer representative and an independent external expert
* ensure all sentinel event review reports have at least one recommendation for improvement
* apply lessons from the review to improve systems of care and patient safety
* proactively share lessons learned from adverse patient safety events, including sentinel events, both within the health service and with other health services
* work with Safer Care Victoria to continually improve the quality of sentinel event review processes in Victoria.

Sentinel event notifications and review outcomes must be submitted through the secure sentinel event portal. 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.bettersafercare.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.

Guidance on review processes and other resources can be accessed from [Sentinel events](https://www.bettersafercare.vic.gov.au/notify-us/sentinel-events) <https://www.bettersafercare.vic.gov.au/notify-us/sentinel-events>. The sentinel event program at [Safer Care Victoria can be contacted by email](mailto:sentinel.events@safercare.vic.gov.au) <sentinel.events@safercare.vic.gov.au>

#### Statutory Duty of Candour

From 30 November 2022, a new Statutory duty of candour will commence for:

* public hospitals
* public health services
* multi-purpose services
* denominational hospitals
* private hospitals
* day procedure centres
* ambulance services
* non-emergency patient transport service
* Forensicare.

When a patient suffers a Serious Adverse Patient Safety Event, these health service entities will be required to comply with the Statutory duty of candour legislation 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 re-occurrence of the event. They will also need to comply with the *Victorian duty of candour guidelines*. The duty will build on existing requirements under the *Australian Open Disclosure Framework*.

Public health service entities will be required to comply with the reporting requirements outlined within these guidelines. The requirements, including reporting commencement date, will be provided as soon as possible.

Guidance, resources and the legislation can be accessed from [Safer Care Victoria’s Duty of candour and review protections](https://www.bettersafercare.vic.gov.au/support-training/adverse-event-review-and-response/duty-of-candour#:~:text=around%20adverse%20events.-,Statutory%20duty%20of%20candour,and%20improvements%20put%20in%20place.) <https://www.safercare.vic.gov.au/support-and-training/review-and-response>.

#### Health Services Performance and Quality and Safety Reporting

The VAHI is a division of the department, which collects, analyses and reports on a range of performance and quality and safety measures to health services executives and boards, the department, and a range of other government agencies.

The information is provided as part of a suite of routine performance reports, such as Monitor and PRISM, including the recent reporting on hospital-acquired complications. VAHI also produces specialist quality and safety reports, such as the *Public Sector Residential Aged Care Quality Indicators report,* the *Quality and safety in Victorian private hospitals report,* and the *Board safety and quality report*.

Reports are generally made available for download by 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>. During 2021–22, key data for the Monitor and hospital-acquired complications reports were also made available via interactive dashboards accessed through the 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.

During 2022–23, VAHI will focus on transitioning its remaining core quality and safety products to an interactive digital format that enables online exploration, as well as appropriate exports of data and ongoing access to PDF-format material where this is valuable, for example for board papers. VAHI will consult the sector on the detail of this work through its usual mechanisms, including the Board Reporting Advisory Committee and the Private Hospitals Reporting Advisory Committee.

In 2022–23, VAHI’s hospital-acquired complications reporting will be updated to use the Australian Commission for Safety and Quality in Health Care’s version 3.0 definitions, and risk-adjusted figures will be produced using the risk models developed by the Independent Hospital and Aged Care Pricing Authority (IHACPA).

After consultation with health services and stakeholders involved in perioperative care during 2020–21, reporting on HAC 4 (surgical complications requiring unplanned visit to theatre) was paused, due to the high levels of false positives identified by the indicator. VAHI will work with the Victorian Perioperative Consultative Council to develop improved options for reporting on surgical complications during 2022–23.

For mental health services, the *Mental health performance and accountability framework* identifies key indicators. This framework has links to the SOP, PRISM and other reporting.

In addition to the work to determine an appropriate digital transition approach for the *Board Safety and Quality Report*, VAHI will focus in 2022–23 on developing reporting on new quality and safety measures that are particularly relevant to boards of local and small rural health services. This will build on work done by Colac Health services through 2021–22, to identify relevant measures and information needs.

VAHI 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, via 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>.

Through this website, the public can search and view results on a range of performance measures related to:

* number of patients treated
* emergency care
* elective surgery
* mental health
* specialist clinics
* dental care
* ambulance services
* quality, safety and patient experience.

As well as producing quality and safety reports, VAHI plays a key role in the development, testing and validation of the measures reported, including those used in the [*Performance monitoring framew*ork](https://www.health.vic.gov.au/funding-performance-accountability/performance-monitoring-framework) <https://www.health.vic.gov.au/funding-performance-accountability/performance-monitoring-framework>.

Where measures form part of the health service’s SOP, Monitor reflects the targets set for performance. Monitor is produced monthly, with some measures presented less frequently, depending on the performance policy requirements, nature of the underlying data and the measure calculation methodology.

New 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.

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 SRHSs, which instead receive a customised version of Monitor. In 2022–23 and beyond, information available in PRISM will gradually be expanded and, in some cases, replaced by information provided via the interactive tool, where this is appropriate.

VAHI’s 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.

#### 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 2022–23.

The Victorian Government is committed to ensuring data from clinical quality registries is used effectively by government agencies and the health sector to drive quality improvements.

VAHI 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 has also been linked with other data sets to better inform the development of various statewide quality and safety indicators, some of which are now reported in the *Board Safety and Quality Report* developed by VAHI.

The Clinical quality registry strategy, developed by VAHI in 2018, guides investment for identified priority areas, as well as additional operational requirements for registries funded by the Victorian Government.

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. To assist in this process, outcomes for the following measures can be found on the [VICNISS website](https://www.vicniss.org.au/healthcare-workers/performance-indicators/) <https://www.vicniss.org.au/healthcare-workers/performance-indicators>.

##### Healthcare-associated infections

VICNISS collects and analyses data from individual hospitals on risk-adjusted, procedure-specific infection rates, *Staphylococcus aureus* bacteraemia-associated infections and central line-associated bloodstream infections in intensive care units.

##### 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 is essential to reduce the risk of transmission in healthcare settings.

Health services must report healthcare workers’ influenza vaccination rates to the department annually. Information on the healthcare worker influenza immunisation program can be found at [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 one or both of the above measures. The results are shared with health services through the VICNISS online member portal, and reports are produced and distributed by the VAHI.

#### Streamlining Clinical Trial Research

The government continues to encourage clinical trial activity within health services. In particular, Victoria’s *Streamlining clinical trials and research framework* for streamlining the ethical and scientific review of multisite clinical trials is managed centrally by the Coordinating Office for Clinical Trial Research at the Department of Jobs, Precincts and Regions. Since January 2015, the scope of this framework also includes multisite health and medical research projects.

The framework includes all human research that is conducted as a single-site or multisite project. All health services participating in the framework to streamline ethical and scientific review should assist the consolidation of research activity information concerning Victoria’s public hospital sector.

This is done by using the electronic information platform nominated by the department, 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, as determined by the department and communicated through 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 inter-jurisdictional 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, including 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 Commonwealth Government Department of Health.

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>.

### 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 the:

* National Safety and Quality Primary and Community Healthcare Standards
* National Safety and Quality Health Service 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.

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 2022–23, performance monitoring of accreditation against the national standards by the department and Dental Health Services Victoria will be undertaken as per the Accreditation regulatory business rules (2019).

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.

In 2022–23, compliance against the performance standards will be monitored through an attestation from registered community health services.

## Consumer Rights and Community Participation

In August 2019, the Australian Commission for Safety and Quality in Health Care launched *My healthcare rights* – the second edition of the Australian Charter of Healthcare Rights. *My healthcare rights* include three new rights reflecting an increased focus on person-centred care and consumer empowerment. These new rights are partnership, information and providing feedback.

The commission has developed a range of resources to support the implementation and use of the new 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.

The new 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.

Safer Care Victoria and the department recommend using the new charter and resources. Victoria-specific resources are no longer available. All charter resources can be downloaded via the [Australian Commission for Safety and Quality in Healthcare website](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 new framework replaced *Doing it with us not for us: Strategic direction 2010–2013* (2011) and the *Cultural responsiveness framework – Guidelines for Victorian health services* (2009). It states the expectations Victorians have about how we can improve partnering with consumers to achieve better outcomes.

The framework comprises five domains that are interdependent, and that together, can have a cumulative effect to produce better outcomes.

The five domains are:

* personalised and holistic
* working together
* shared decision-making
* equity and inclusion
* effective communication.

Each domain can be progressed and actioned in a practical way at three levels of direct care, service and system levels. It is an iterative guide designed to bring consistency to how Victorians can participate in their own health care, it clearly describes consumer priorities for health services and Safer Care Victoria, and it aligns with the department’s priority areas.

In 2022–23, 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 30 September 2022.

More information can be found at Safer Care Victoria’s [*Partnering in healthcare framework* webpage](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>.

Under the *Carers Recognition Act 2012,* people in care relationships, and the contribution of carers, need to be recognised by:

* councils, within the meaning of the *Local Government Act 1989*
* organisations funded by government that are responsible for developing or providing policies, programs or services, which affect people in care relationships.

The Carers Recognition Act lists the principles that must be respected by councils and relevant funded organisations. These principles promote understanding of the significance of care relationships, and the people in them.

The Carers Recognition Act is supported by the Victorian charter supporting people in care relationships. 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.

More information, including legal responsibilities and obligations of local government and organisations, is available at [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

#### Victorian Healthcare Experience Survey

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.

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.

In 2021–22, following an extensive tender process, Ipsos Public Affairs was appointed to deliver the VHES program for the next three years. The new VHES program has transitioned to a predominantly electronic data collection approach, implementing newly redesigned questionnaires and several other reforms focused on delivering timely results. The reforms also seek to increase consumer participation in the program.

#### Core Victorian Healthcare Experience Program Surveys

The VHES program includes a number of surveys where data collection is conducted continuously throughout the year. These surveys include maternity, adult inpatient, adult emergency, paediatric inpatient and paediatric emergency. Data is 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. There are three indicators that form part of the *Performance Management Framework* from the adult inpatient survey. These indicators are reported on a quarterly basis in Monitor. An indicator on overall experience from the adult emergency survey is reported in the Victorian Government’s Budget Paper No.3: Service Delivery.

#### Community Health Services Victorian Healthcare Experience Survey

All community health services are expected to participate in the Community Health Services VHES. As part of their participation in the annual survey, each service will be required to identify three areas of improvement using the survey data. Community health services will report their performance under the three areas in their annual quality accounts.

#### HACC-PYP Services Victorian Healthcare Experience Survey

#### All HACC-PYP service providers are expected to participate in the HACC-PYP VHES This survey is to be delivered annually commencing in 2022–23, and is the principal source of client and carer experience information to inform continuous improvement processes.

#### Your Experience Survey

The Your Experience of Service survey is designed to collect information on consumer experience in adult mental health and wellbeing services, and selected MHCSS. This survey is delivered annually and is a key source of the patient-reported experience measure.

### Patient-Reported Outcome Measures

Patient-reported outcome measures (PROMs) are data obtained from structured surveys of patients, conveying information about patients’ assessments of their health-related quality of life. PROMs can be used to measure the health gain associated with treatment of a disease or management of a chronic condition. They are particularly useful for providing information about a patient’s health outcomes that are best known to the patient and best measured from the patient’s perspective. They differ from data obtained from patient experience surveys, which focus on patients’ experiences of care.

In 2022–23, VAHI is supporting two PROMs initiatives, covering:

* the Australian Orthopaedic Association National Joint Replacement Registry PROMs Pilot, to include all eligible Victorian public hospitals and many private hospitals, enabling broader contribution of joint replacement procedure PROMs data to the registry
* the Burns Registry of Australia and New Zealand PROMs Pilot, capturing PROMs data from patients admitted to the Victorian Adult Burns Service at The Alfred and The Royal Children’s Hospital, to determine the feasibility of implementing centralised long-term collection of PROMs as a routine component of the registry data.

The results of these initiatives, considered with outcomes from other PROMs pilot projects over 2019–21, will inform a statewide approach to PROMs.

### 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.

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. 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.

Following an extensive consultation with diverse stakeholders, inclusive of consumers, consumer groups and health service staff, the guidelines for community advisory committees was refreshed in 2020. The *Building your health community: A guide for health service community advisory committees* can be found at [Safer Care Victoria](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.

### Reporting on Quality of Care

All public health services, multipurpose services and registered community health services must produce an annual quality account. Safer Care Victoria provides guidelines on the content and submission requirements for quality accounts. For the most up-to-date information, [including contact details and recommended reporting guidelines](https://www.gs1au.org/our-services/national-product-catalogue), visit [Quality accounts](https://www.bettersafercare.vic.gov.au/support-and-training/clinical-governance/quality-accounts) <https://www.bettersafercare.vic.gov.au/support-and-training/clinical-governance/quality-accounts>.

Safer Care Victoria has suspended the requirement for public health services and registered community health services to submit a quality account for 2022–23. Services that choose to submit a quality account are encouraged to consult the previous quality account guidelines.

### 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 Primary Health Networks 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 patients, particularly those at risk of poor health outcomes.

### Primary Health Network Funding and Emergency Management

The department provides annual indexed funding of $40,552 to each of the six Primary Health Networks to support Victoria’s response to an emergency event. This funding requires networks to:

* be responsive in the event of an emergency
* support the department by participating in local, regional and health service emergency planning, in line with the State Health Emergency Response Plan
* facilitate the department’s access to general practitioners to work in a range of local, time-limited primary care settings, such as field care clinics.

The department requires Primary Health Networks to establish and enable communications with general practitioners, other primary care services, local emergency planning and response organisations, and neighbouring Primary Health Networks, as requested in an emergency. The department also requires Primary Health Networks to provide intelligence to the department on local factors affecting the delivery of general practice and other primary health care, in and around areas affected by the emergency.

The networks also help provide recovery services after an emergency and document their activity during an emergency event.

### 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 patients. 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.

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.

Under the Health Complaints Act, the Health Complaints Commissioner is actively engaged in the health sector through training in complaints handling, and the relevant laws governing health service and health records complaints. The Health Complaints Commissioner’s Complaint Handling Standards stipulate the legislative requirements for health services in effectively managing complaints. The standards are available from the [Health Complaints Commissioner website](https://hcc.vic.gov.au/providers/complaint-handling-standards) <https://hcc.vic.gov.au/providers/complaint-handling-standards>.

Under the Health Complaints Act, the Commissioner has the authority to require health service providers to report on the implementation of any undertakings given by the provider during a complaint resolution process.

The Commissioner may also make recommendations for quality improvement, following an investigation. Health service providers must report on action taken to implement the recommendations and, if a recommendation has not been implemented, give reasons why and set out a plan to address the issue dealt with in the recommendation.

Training sessions regarding the Health Complaints Act, the role of the Commissioner and the expectations of health services are provided on the [Health Complaints Commissioner website](https://hcc.vic.gov.au/resources/training-seminars) <https://hcc.vic.gov.au/resources/training-seminars>.

## 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 (HSV) and is responsible for supply chain operations, compliance and a compliance framework.

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 HSV’s distribution centre operations being a central part of the end-to-end supply chain
* support better patient outcomes by ensuring consistent access to goods and evidenced-based product selection.

To achieve these outcomes, health services participating in the HSV supply chain and logistics services are required to ensure all purchasing for goods on the HSV catalogue is undertaken via this service.

The compliance function:

* develops, implements and reviews policies and practices to promote best value and probity in relation to the supply of goods and services to health services. HSV’s purchasing policies, or the equivalent, 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 health services, and may be viewed at [Five HSV health purchasing policies](https://healthsharevic.org.au/compliance/purchasing-policies/our-policies)<https://healthsharevic.org.au/compliance/purchasing-policies/our-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 HSV 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, HSV 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, or the equivalent, and the HSV Collective Agreements
* approval and submission to HSV by the health service’s chief executive officer, or delegated officer, for inclusion in the HSV annual report.

Mandated health services must complete compliance audits to the Health Purchasing Policies, or the equivalent, 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 HSV by 30 June in the year the audit is scheduled)
* findings to be reported to the HSV Board and monitored until the health service has addressed and closed the issues. HSV must report high-risk areas of noncompliance to the Minister for Health.

Mandated health services must provide information and data on procurement activities. HSV can require the chief executive officer of a mandated health service to provide information and transparency, and probity in purchasing, tendering and contract activities.

Health services should ensure the following overlapping probity directives are met:

* Mandated health services must comply with the Health Purchasing Policies, or the equivalent, 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://www.health.vic.gov.au/data-reporting/victorian-integrated-non-admitted-health-vinah-dataset) <https://www.parliament.vic.gov.au/papers/govpub/VPARL2006-10No126.pdf> and the Victorian Auditor-General’s Office report.

Health services are also encouraged to consult with HSV 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 1986* 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 per cent 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 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[[8]](#footnote-9) 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 1994* (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*.

More information can be viewed at [*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 Central Banking System, requires all public sector entities, including public hospitals, to ensure 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 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, and 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, and 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 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.

Health services should refer to the [Asset management policy (2018)](https://www.vhba.vic.gov.au/resources/asset-management)<https://www.vhba.vic.gov.au/resources/asset-management> and the *Strategic asset management plan* (2019) and associated guidelines, for more information when developing their asset management plans.

More information on the AMAF is available from [*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>.

### 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, overall asset management planning quality and implementation.

Each health service is required to submit an annual asset management plan for 2022–23, 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 Victorian Health Building Authority (VHBA) no later than 31 December each year. The plans should cover, at a minimum, summary asset data, asset performance, current condition, asset risk, demand analysis, maintenance program, renewal forecast (operation and capital), disposal plans and 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.

More information and templates are available from [Asset management](https://www.vhba.vic.gov.au/resources/asset-management) <https://www.vhba.vic.gov.au/resources/asset-management>.

#### Reporting

As a condition of funding, all 2022–23 specific-purpose capital grant expenditure is required to be reported as part of AIMS by the end of September 2023. 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 in 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 the 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, VHBA may recall distributed funds for reallocation to other high-risk projects across the sector.

#### 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 HSV 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 the [HSV website](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, that 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, and 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 patient 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.

More information on government land policies and processes, including Crown land management, is available at [VHBA](https://www.vhba.vic.gov.au/resources/property) <https://www.vhba.vic.gov.au/resources/property>.

### 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 patient 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, see [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 VHBA, within four weeks of the incident.

### Health Service Environmental Management, Planning and Reporting

The Victorian Government’s [Climate Change Strategy](https://www.climatechange.vic.gov.au/victorias-climate-change-strategy) <https://www.climatechange.vic.gov.au/victorias-climate-change-strategy> is a roadmap to net-zero emissions and a climate-resilient Victoria by 2050. The role that climate change plays in the health and wellbeing of the community, and the contribution of hospital carbon emissions to the Victorian Government’s carbon footprint, is outlined in the department’s [Environmental sustainability strategy 2018–19 to 2022–23](https://www.health.vic.gov.au/publications/environmental-sustainability-strategy-2018-19-to-2022-23) <https://www.health.vic.gov.au/publications/environmental-sustainability-strategy-2018-19-to-2022–23>.

Direction on the department’s response to climate adaptation is in the [Health and human services climate change adaptation action plan 2022–26](https://www.health.vic.gov.au/environmental-health/climate-change-strategy) <https://www.health.vic.gov.au/environmental-health/climate-change-strategy>.

The Health and human services climate change adaptation action plan 2022–2026 was published in February 2022. The plan outlines actions that Victoria’s health and human services system will take during the next five years to address current climate change impacts, reduce barriers to adaptation planning and action, and lay the foundations for transformational adaptation.

In light of these obligations, health services are expected to consider all opportunities to decrease carbon emissions and increase climate resilience of their operations. To align with these commitments, as well as increasing operational efficiency, health services must develop and implement a whole-of-organisation environmental management plan, and report publicly on environmental performance.

The environmental management plan is to focus on the organisation’s material environmental impacts, which are likely to include energy, carbon, water, waste and procurement. The plan must include all primary sites under the health service’s operational control.

Health services are to report publicly on their environmental performance in the unaudited section of their annual report. As a minimum, environmental data relating to carbon, energy, water, waste and transport (fleet and air travel) must be included. The environmental data management system (EDMS) produces a standard report, which meets these reporting requirements.

A template environmental management plan and the environmental reporting guidelines are available at [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>.

Metropolitan health services are to implement and maintain polyvinyl chloride (PVC) recycling in (at a minimum) theatre, intensive care and dialysis departments. Implementation of PVC recycling in rural and regional health services is encouraged, where it is viable and cost effective.

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 healthcare 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 will assist in meeting expectations that health services are responding to climate change obligations.

Public hospital and health service environmental reporting requirements are detailed in section 29.11 ‘Environmental data reporting requirements’.

## Information and Communication Technology Standards

Health services are required to operate their information and communication technology (ICT) safely, securely, cost effectively, and in alignment with Victorian and national digital health strategies.

Health services have accountability and responsibility through their boards for deploying ICT and digital health technology to support service delivery within their health service, based on their local needs.

Victoria’s digital health roadmap (Roadmap) was released in 2021. It replaces Digitising health.

The Roadmap sets direction for lifting digital health maturity across the sector for the next five years. Five programs of work will continue to improve the safety and quality of health care by:

1. improving health service resilience against technology outages and cyber attacks
2. reducing the risks to patient safety associated with paper-based care processes
3. embedding patient-centred care by joining up healthcare records
4. creating more options for people to use home-based and virtual care, and care closer to home
5. giving consumers access to their own healthcare information.

The Roadmapaligns with and supports the recommendations from the *RCVMHS’s Final Report, Volume 5: Transforming the system – innovation and implementation*, particularly the chapters ‘Integrating digital technology’and‘New approaches to information management’*.*

Rural health services must participate in an ICT Alliance, as specified in the Rural public health care agencies alliances policy 2020 (amended Feb 2021).

### Governance

The department’s Digital Health branch supports Victorian public health services in their delivery of digital health solutions, including:

* lifting digital health maturity
* enhancing the safety, quality and acceptability of patient care through the digitisation of care
* 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 24/7 ICT and cyber incident management service.

The Digital Health branch also works to support Victoria’s public health sector to:

* reduce the risks to patient safety associated with paper-based care processes
* embed patient-centred care by joining up healthcare records
* optimise the patient experience through a comprehensive commitment to ‘better at home’ and virtual care
* give consumers access to more of their own healthcare information.

Digital health matters are governed via three sector bodies, with the Digital Health branch providing secretariat support.

The Victorian Health Chief Information Officer Forum, which meets monthly, 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 Digital Health branch. Health service and Rural Health ICT Alliance chief information officers (or their equivalent) are expected to attend and contribute to its working groups, which cover:

* cybersecurity (public/community health service and medical device)
* ICT operational assurance
* the Clinical Grade Network
* the standardised emergency number
* sector-wide procurement
* standards.

Working groups are established as initiatives of relevance to the sector. They are formed to assist in realising efficiencies, and in optimising security, consistency and interoperability in Victoria’s public health system.

Regular monthly meetings are also conducted with rural and regional CIOs, usually on the same day as the Victorian Health Chief Information Officer Forum, to make effective and efficient use of busy people’s time.

The Victorian Clinical Informatics Council meets three times a year. It is the sector’s peak clinical informatics advisory body for lifting digital health maturity. 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 healthcare professionals with contemporary experience and Victorian digital health professional leaders.

The Council will achieve its objectives by:

* representing the opinions of broader groups with particular expertise and experience in relevant areas
* recommending establishment of time-limited clinical advisory groups for specific initiatives
* advocating for investment and application of digital health systems and research, to achieve ongoing improvement in patient safety, quality of care and the patient experience
* keeping abreast of, sharing and disseminating emerging evidence-based digital health best practices
* advising on safety and quality risk mitigation and remediation pertaining to identified issues with clinical information systems
* identifying priorities based on clinical safety and quality needs.

### Statewide Programs

The Digital Health branch is responsible for developing, establishing and maintaining the overarching programs that:

* underpin digital health investment
* realise health reform
* optimise continuity of care.

Health services and their respective boards continue to be accountable for local digital health strategies, plans and activities. These strategies, plans and activities align with Victoria’s 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

Victoria’s Roadmap sets 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 Operational Assurance Program
* Victorian Business Impact Assessment Program.

Rural and regional health services must participate in ICT Alliances via joint venture agreements, as specified in the Rural public health care agencies’ information and communications technology (ICT) Alliance Policy 2020.

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.

#### Connecting Care

Connecting Care is one of the five programs of work that have been 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 patient 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 expansion

Connection to My Health Record across Victorian public health services is designed to enhance patient safety. During 2022–23, health services with a connection to My Health Record, which enables them to upload documents, are expected to work towards uploading:

* 50% of pathology test results to My Health Record
* 75% of discharge summaries to My Health Record.

These targets will be reviewed as the routine use of My Health Record increases.

##### 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.

##### Contemporary Information Architecture for Mental Health and Wellbeing

The RCVMHS recommended that the Victorian Government develop, fund and implement modern infrastructure for ICT systems, including a new mental health information and data exchange and repository, replacement for the department’s legacy Client Management Interface/Operational Data Store (CMI/ODS) system, and development of a consumer portal.

During 2022–23, the department will be working with providers of clinical mental health services to participate in, and provide input into, initiatives that support the design and implementation of these systems.

##### Health information sharing to include pathology

During 2022–23, public health services will be expected to participate in the design and implementation of the pathology Health Information Exchange.

##### Safer Transfer of Care

The Safer Transfer of Care Program 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 2022–23, public health services will be expected to adopt the use of eReferrals to enable sharing of information between the primary and the acute sectors, particularly as it relates to streamlining of service delivery of elective surgery workflows through Health Service Partnerships.

#### 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 Digital Health branch.

Health services must report their ICT strategies, plans and projects to the Digital Health branch. The branch has a planning and assurance role for the sector to ensure:

* minimum 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 Digital Health branch for project assurance on the full life cycle of the project.

All health service projects with an ICT component greater than $1 million are to be subjected to departmental project assurance and must be reported via the Digital Health branch to the Department of Premier and Cabinet, for inclusion in the public quarterly ICT project dashboard. All projects on this dashboard with an ICT budget exceeding $10 million are to be subjected to independent project quality assurance, commissioned by the Digital Health 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 require comprehensive assessment of health ICT maturity, to ensure digital health investment decisions have been informed by a comprehensive understanding of 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 are expected to participate in the next maturity assessment, with the expectation of participation by health services at least every two years thereafter.

### ICT Incidents and Cybersecurity

In its role as system manager, the Digital Health branch’s 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. Reporting of cybersecurity and ICT incidents can be done by calling 1300 598 686 or [emailing the Incident Management Team](mailto:Digital.Health.Incident.Notification@health.vic.gov.au) <Digital.Health.Incident.Notification@health.vic.gov.au>.

The Incident Management Team has the mandate for managing all sector-wide ICT incidents. In many cases, the Digital Health branch can help resolve incidents without referral to other third parties. Health services must have an incident management plan in place to manage local incidents. A template has been provided to health services and is available to guide development of local plans. For any health service that does not have a plan in place, the department’s Health Chief Information Security Officer and Incident Manager should be contacted for assistance.

Health services are required to use department-sponsored cybersecurity tools and must ensure they are maintained. Where a health service can demonstrate that they have an equal or more advanced tool in place, an exemption may be granted.

### Health ICT Asset Management

Health services must manage, maintain and replace assets, in accordance with the Standing Directions and the Victorian Government’s AMAF. Compliance with 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. It 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
* acquisition – procurement of assets to meet an identified service need, including the assessment of procurement options
* operation and maintenance – management and use of an asset to deliver services, including maintenance
* disposal – treatment of an asset that has either reached the end of its useful life, is considered surplus, or is underperforming.

Health services must submit ICT asset management data on a quarterly basis. The supply of data is essential in assisting with cyber incidents and provides evidence on the need for investment, which can then support the full appropriation of technology refresh grants.

The ICT assets that are in scope include:

* servers (virtual and physical)
* applications (client-side, on-premise data centre and cloud-hosted)
* databases and middleware
* 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
* security certificates
* cloud applications (SaaS)
* cloud platforms (PaaS)
* cloud infrastructure (IaaS)
* outsourced, third-party hosted and managed services
* 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:

* *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 general practitioners and specialists, and for identifying eReferral recipients
* *Clinical Information System (CIS) and Electronic Medical Record (EMR) application and interoperability standard* – articulates the minimum set of functional requirements for implementation of CIS and EMR by VPHS.
* *Patient Administration System (PAS) and Interoperability standard* – defines the minimum set of functional requirements for implementation of the patient administration system
* *Queue management and outpatient system integration principals* – 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.

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 Standards](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 webpage](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/specifications/ehealth-foundations/ep-1544-2014)<https://developer.digitalhealth.gov.au/specifications/ehealth-foundations/ep-1544-2014>, 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) 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
* Standards Australia’s [*Digital hospitals handbook*](https://www.standards.org.au/news/new-australian-publication-to-accelerate-digital-hospitals)<<https://www.standards.org.au/news/new-australian-publication-to-accelerate-digital-hospitals>>
* 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 Australian Commission on Safety and Quality in Health Care. Reference documents can be found on the [Australian Commission on Safety and Quality in Health Care website](https://www.safetyandquality.gov.au/our-work/e-health-safety) <https://www.safetyandquality.gov.au/our-work/e-health-safety>.
* 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 Standing Directions of the Minister for Finance made under the Financial Management Act. Reference to the standing directions can be found on the [AMAF webpage](https://www.dtf.vic.gov.au/infrastructure-investment/asset-management-accountability-framework) <https://www.dtf.vic.gov.au/infrastructure-investment/asset-management-accountability-framework>.

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 [resources for implementers and developers](https://digitalhealth.gov.au/implementation-resources) <https://digitalhealth.gov.au/implementation-resources>. 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 theFinancial 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 in a consistent way, some funded organisations are required under the department’s service agreement, *Standing Direction 3.7.1 of 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 a positive risk culture in the organisation is able to be demonstrated
* 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 impacted 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 must be 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 in developing an effective positive risk and organisational culture, which includes clinical and all other operational activities.

Health services should articulate how they are managing asset-related risk in their asset management strategy, as developed as part of their compliance with the AMAF.

For more information on risk management, refer to the [Risk management – guidelines](https://infostore.saiglobal.com/en-au/Standards/AS-ISO-31000-2018-1134720_SAIG_AS_AS_2680492) <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 are designed to 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, emphasising 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, access the tool at [*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 and human services sector emergency management policy

The *Health services emergency management policy* sets the direction for health services to have arrangements in place to minimise health effects and service disruption to communities from health emergencies and emergencies with health impacts.

It is expected that health services be well prepared for emergencies and can implement a response in the event of an emergency that is appropriate to the needs of their communities.

The policy supports:

* emergency preparedness obligations for health services
* access to resources and information to help prepare for emergencies.

The policy and other emergency management information is available at [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 Response Arrangements

State health emergency response arrangements comprise the *State Health Emergency Response Plan* (the Plan), alongside a suite of supporting doctrine, such as emergency-specific operational response plans, protocols and guides.

The Plan describes the arrangements for managing health emergencies in Victoria, which require a significant and coordinated effort to ensure the health system can respond effectively, while minimising any adverse health consequences for communities. It defines an integrated approach, with shared responsibility for health emergency management between the department, emergency management sector, health system and the community.

Doctrine that supports the Plan includes:

* Code Brown guidelines – each health service and facility is required to have a site-specific Code Brown plan to manage a significant surge in demand in emergency presentations resulting from an external emergency
* Emergency incident casualty data collection protocol – each health service is required to provide casualty information related to an emergency incident, when the protocol is activated by the department
* *First Wave Notification* – a method for alerting the health sector about incidents (actual or potential) that may result in widespread or catastrophic consequences on the Victorian community or health infrastructure.

The *State Health Emergency Response Plan*, the Code Brown guidelines, Emergency Incident Casualty Data Collection Protocol, *First Wave Notification guide* and other supporting doctrine are available at [State Health Emergency Response 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>.

**In August 2022, the State Health Emergency Response Plan will be superseded by the State Emergency Management Plan Health Emergencies Sub-Plan.**

### 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. A list of accredited practitioners can be found at [Fire risk management accreditation](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 (also includes protection from external threats such as bushfire), and general safety requirements that apply to any premises from which the funded organisation operates – 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 so, 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 via the [certificate’s email](mailto:FRMUCertificates@homes.vic.gov.au) <FRMUCertificates@homes.vic.gov.au>, or through their respective fire services coordinator by 1 September each year.

More information on fire risk management and annual fire safety certificates are available from [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>, or by [emailing the fire services coordinators](mailto:fireservicesteam@homes.vic.gov.au) <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, the Health Records Act 2012, and other information-sharing and privacy obligations imposed by law, codes of practice or guidelines made under those laws in performing funded services
* ensures its employees, officers, agents and subcontractors comply with the Acts and the terms of a funding agreement.

### Public Interest Disclosure

Where applicable, the funded organisation agrees to comply with and be bound by the provisions of the Public Interest Disclosures Act 2012 (formerly known as the Protected Disclosure Act 2012).

### Intellectual Property

The rights and obligations of funded organisations and the State of Victoria, regarding ownership and management of intellectual property, are set out 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, everlasting, 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), as if the State of Victoria was the owner. The licence includes the right to sublicense the Project IP, but does not include the right to transfer or assign, or to seek or enforce remedies for infringements of the Project IP against a third party. 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) 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 Project IP to the department.
* The funded organisation will properly manage the Project IP in a manner that allows the State of Victoria to enjoy the full benefit of providing the funding to the funded organisation.
* 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 agreement and 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 2022–23, 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](https://tableau.reporting.dhhs.vic.gov.au)[[9]](#footnote-10) <https://tableau.reporting.dhhs.vic.gov.au>. The department will monitor hospital cash flows, as reported monthly in the financial data (HeART) cash-flow statement.

The department will make monthly payments to community service organisations through the Service Agreement Management System. Cashflow percentages of individual payment schedules of service agreements and details of the funded activities can be found on the [Funded Agency Channel website](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 2021–22 for:

* Ambulance Victoria managers and administrative staff
* Victorian Public Mental Health employees (concurrent with a new enterprise agreement for staff employed by Forensicare, and allied health staff under a separate agreement)
* health and allied services managers and administrative workers
* medical scientists (including pharmacists, psychologists, perfusionists and others)
* maintenance employees
* doctors in training and medical specialists.

These agreements are either with the Fair Work Commission for approval, or drafting is being finalised prior to government approval and ballot.

Bargaining is expected to conclude shortly for allied health professionals.

Negotiations for new enterprise agreements are expected to commence during the 2022–23 financial year for:

* biomedical engineers
* dental therapists, general dentists and specialist dentists.

#### Wages Policy

The Victorian Government’s current *Wages policy* and *Enterprise bargaining framework* has applied since 1 January 2022. The three pillars of the *Wages policy* are:

* wages – increases in wages and conditions capped at a rate of growth of 1.5 per cent per annum
* a 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. A cap of 0.5 per cent per annum applies to such changes.

A two per cent cap applied to increases in wages and conditions prior to 1 January 2022, and transitional arrangements maintain this cap for the agreements bargained in 2021–22, referred to in section 27.2.1 ‘Expiring Agreements and Enterprise Bargaining’.

Health services are generally expected to comply with other aspects of government policy, including wages and industrial relations policy, as made from time to time.

More information is available at [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 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[[10]](#footnote-11) of its eligible agencies as follows:

* An amount equal to 2.8 per cent of defined salaries and wages is included in 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, and be used as the first call for any future settlements over and above the (current) 2.8 per cent of long service leave included in 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 sections describe the key data collection changes. For more information, visit [Annual changes](https://www.health.vic.gov.au/data-reporting/annual-changes) <https://www.health.vic.gov.au/data-reporting/annual-changes>.

### Victorian Admitted Episodes Dataset

From 1 July 2022, new data elements have been added for Medically ready for discharge date, and Unplanned return to theatre. A Funding Arrangement code has been added for National Health Reform Agreement-funded therapy and changes made to the reporting guide for Patient/Client Sex.

### Elective Surgery Information System

There are no ESIS changes for 2022–23, other than to amend the reporting guide for Patient/Client Sex.

### Agency Information Management System

From 1 July 2022:

* AIMS S10 and AIMS UCC forms both have a new patient payment status added
* PSRACS S5\_115 and S5\_129 forms are both being amended to facilitate reporting of the details required for the Commonwealth Government’s new AN-ACC that is to replace the Aged Care Funding Instrument
* AIMS S11 and S12 forms have updated the program previously known as the Family Choice Program to Complex Care (FCP)
* the AIMS S11 form also has three program streams added to report Complex Care general, HARP and PAC activity provided under the program, and one program stream is removed under Complex Care Program (FCP)
* the due date for AIMS non-admitted patient services forms S10, S11, S11A and S12 will change from the fourteenthday to the twelfth day of the following month.

### Victorian Emergency Minimum Dataset

From 1 July 2022, a new validation will apply to ambulance handover dates/times, reporting of compensable status will be mandatory for private hospitals, and changes will be made to the reporting guide for Patient/Client Sex.

### Victorian Integrated Non-Admitted Health Minimum Dataset

From 1 July 2022, changes have been made to the VINAH minimum data.

Changes to programs/streams include:

* inclusion of gender and genetic streams within the Specialist Clinics (Outpatients) (OP) Program
* the Family Choice Program renamed to Complex Care (FCP), including two new FCP streams for the Hospital Admission Risk Program (HARP) and Post-Acute Care (PAC)
* new and amended Episode Health Conditions
* Victorian Artificial Limb Program reporting to become mandatory from 1 July 2022
* descriptor and definition changes around telehealth video and home-based services.

Changes to fields include:

* a secure messaging contact delivery mode
* a mandatory contact inpatient flag for the Hospital Based Palliative Care Consultancy Teams program
* mandatory referral in clinical urgency, referral in first triage, and screening contacts for palliative care
* contact purpose codes added for reporting conservative management within the Specialist Clinics (Outpatients) (OP) Program.

### Non-Admitted Data Collection

From 1 July 2022, changes have been made to the NADC that include:

* inclusion of gender and genetics streams within the Specialist Clinics (Outpatients) (OP) Program
* the Family Choice Program (FCP) renamed to Complex Care (FCP), including two new FCP streams for HARP and PAC
* introduction of a new code (8-secure messaging) for Service Event Delivery mode
* changes to the reporting guide for Patient/Client Sex.

### Victorian Perinatal Data Collection

In 2022–23, there will be a continuing focus on reporting compliance, to ensure data is received in a timely manner, and data quality issues are identified as early as possible. This will include, but is not limited to, rejecting submissions that are not in line with defined specifications. In addition, Safer Care Victoria is leading the Enhancements to the Victorian Perinatal Data Collection (VPDC) project, which aims to improve the quality of the data submitted to the VPDC.

Eleven new data items are being introduced from 1 July 2022, with amendments to 21 existing data items, along with new and updated business rules to support data quality. Details of these changes can be found on the [VPDC webpage](file:///C:/Users/BridieW/AppData/Roaming/Microsoft/Word/VPDC%20webpage) <https://www.health.vic.gov.au/quality-safety-service/victorian-perinatal-data-collection>.

### Public Sector Residential Aged Care Services

Performance and quality improvement changes are as follows:

* The Commonwealth Government has expanded the Mandatory Aged Care Quality Indicator program to include five indicators. PSRACS are to continue to submit their quality indicator data to the department, which will then be submitted to the Commonwealth on behalf of the PSRACS.
* 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.

### Aged Care Assessment Services

Since August 2016, all aged care assessment services data is recorded in the Commonwealth Government's My Aged Care system. The Commonwealth 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 Commonwealth Government’s Qlik platform.

### Mental Health and Wellbeing Services – Client Management Interface and Operational Data Store

Since 2021-22, registration of a consumer on the CMI/ODS is required where a person receives a face-to-face mental health assessment. The process also requires a case and episode to be opened at that time. It will continue to be required in a range of other circumstances, such as when a consumer is admitted. Consistent registration practices support safety, coordinated care centred on the person, and sharing of relevant information.

In addition, a new outcome measure (Phase of Care) was introduced in 2021–22 for adults and older adults, replacing an existing measure (Focus of Care). The Phase of Care element was new for children and adolescents. Finally, services are being reminded about the importance of collecting outcome measures, as required under national agreements. Three program management circulars outlined the changes in detail.

## 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 2022–23 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 emergency department activity
* ESIS for monitoring 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 financial and statistical information
* VCDC for patient-level costs
* VPDC for births
* CMI/ODS for mental health client data.

#### Financial Data

Financial data is required to be submitted at the consolidated entity level, via the HeART[[11]](#footnote-12), for all health services and other portfolio entities (excluding cemeteries and VicHealth). The financial data submissions are required by close of business on the twelfth 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”) and estimates trial balances are required less frequently and as advised by the department.

Data submitted through the 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 re-submit this data through the HeART system. This re-submission 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
* 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 estimates trial balance due dates for sign-off will be in line with the budget update and end-of-year forecast timelines required for reporting to the Department of Treasury and Finance, which are generally:
  + an initial estimate – August
  + a mid-year estimate – 12 December (for departmental reviews) and 12 January (for any amendments and updates required for the state’s budget papers)
  + a year-end forecast – 12 April, 12 May and 5 June.

Entities will provide this information in accordance with the department's timelines, except where an extension is sought and approved. Late data submissions of trial balances will be monitored and reported through performance monitoring staff in the department.

#### Victorian Admitted Episodes Dataset

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 Government and to various research institutes.

More information on the VAED is contained in the [VAED manual](https://www.health.vic.gov.au/data-reporting/victorian-admitted-episodes-dataset) <https://www.health.vic.gov.au/data-reporting/victorian-admitted-episodes-dataset>.

##### Submission of admitted patient data

All organisations that receive funding for admitted patient services must submit data to the VAED minimum dataset.

Health services (including SRHS) will code 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.

Public health services must submit admitted patient data to the VAED, according to the timelines in Table 2. Health services may submit data more frequently than the minimum standards specified in the table.

Table 2: Victorian Admitted Episodes Dataset timelines

| VAED | Timeline |
| --- | --- |
| Admission and separation details for the month (E5, J5 and V5 records) | Must be submitted by 5.00 pm on the tenth day of the following month |
| Diagnosis and procedure, subacute and palliative details (X5, Y5, S5 and P5 records) | Must be submitted by 5.00 pm on the tenth day of the second month following separation |
| Data for the 2022–23 financial year | Must be submitted by 5.00 pm on 10 August 2023 |
| Final corrections to data for 2022–23 | Must be submitted by 5.00 pm on 24 August 2023 |

It is the health service’s responsibility to ensure that data files are submitted on or before the tenth 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 one per cent 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 one per cent 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.

A pro forma to assist this process is provided on the [VAED webpage](https://www.health.vic.gov.au/data-reporting/victorian-admitted-episodes-dataset) <https://www.health.vic.gov.au/data-reporting/victorian-admitted-episodes-dataset> and 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 tenth of the month. For assistance with the S1A, [email the HDSS helpdesk](mailto:HDSS.Helpdesk@health.vic.gov.au) <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 undertaking software migrations must undertake VAED data submission testing before resuming live VAED data submission. 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 choose to undertake the VAED data submission testing process before resuming live VAED data submission. Health services will be exempt from late data submission penalties for one month, provided the S1A form is completed on time.

#### Elective Surgery Information System

Public health services reporting to the ESIS must adhere to the minimum submission timelines in Table 3.

Table 3: Elective Surgery Information System 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 third 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 (16th and subsequent) | Must be submitted by 5.00 pm on the third 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 fourteenth day of the following month, or the prior business day |

Any corrections to 2022–23 data must be submitted before final consolidation of the ESIS database on 24 August 2023.

##### 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 3
* up to $10,000, if episodes for the full month are not submitted by the timelines specified in Table 3
* up to $10,000, if a file with all episodes for the full month contains errors by the timelines specified in Table 3.

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.

A proforma to assist this process is provided on the HDSS website under [ESIS webpage](https://www.bettersafercare.vic.gov.au/notify-us/births-and-infant-child-deaths/births) <https://www.health.vic.gov.au/data-reporting/elective-surgery-information-system-esis> and 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.

The spreadsheet is available from the [ESIS webpage](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>.

Failure to complete the manual aggregate data spreadsheet by the due date may result in late submission penalties.

##### Software upgrades and migrations

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.

#### Victorian Integrated Non-Admitted Health minimum data set

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 data to the VINAH minimum data set, including:

* Complex Care (FCP)
* Health Independence Program services
  + Sub-Acute Ambulatory Care Services
  + HARP
  + PAC
  + Residential In-reach
* Home Based Dialysis
* Home Enteral Nutrition
* Hospital Based Palliative Care Consultancy Team
* Medi-Hotel (optional)
* Palliative Care
* Specialist Clinics (Outpatients)
* Total Parenteral Nutrition
* Transition Care Program
* Victorian Artificial Limb Program
* Victorian HIV Service
* Victorian Respiratory Support Service.

More information on the VINAH minimum data set is contained 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>.

##### Submission guidelines

Health services reporting to the VINAH minimum data set will be required to adhere to the minimum submission timelines in Table 4. Health services are encouraged to submit more frequently than the minimum standards in the table.

Table 4: Victorian Integrated Non-Admitted Health minimum dataset timelines

| VINAH minimum data set | Timeline |
| --- | --- |
| Submission date for client, referral, episode and contact details for the month | Must be submitted before 5.00 pm on the tenth day of the following month |
| Clean date for client, referral, episode and contact details for the month | Must be submitted before the file consolidation at 5.00 pm on the fourteenth day of the following month, or the preceding business day if the fourteenth 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 data set 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 data set 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 tenth day of the month following the reference month.
* All errors are to be corrected in time for the VINAH minimum data set file consolidation at 5.00 pm on the fourteenth day of the month following the reference month. Complete data for the month is expected to be transmitted by the fourteenth day.

Data for the financial year must be completed in time for the VINAH minimum data set file consolidation on 24 August. Any final corrections must be received at the HealthCollect portal before the VINAH minimum data set database is finalised on 24 August 2023.

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 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 4
* 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 4.

Funded organisations that have VINAH minimum data set reporting obligations for multiple programs (for example, Sub-Acute Ambulatory Care Services, HARP and PAC), 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 undertaking software migrations must undertake VINAH data submission testing before resuming live VINAH data submission. 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 2022–23 VINAH minimum data set is transmitted completely by 24 August 2023, 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.

#### Non-admitted Data Collection

The NADC is a flat file extract for non-admitted patient-level reporting. Health services unable to report to the VINAH minimum data set 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 data set. The NADC has been developed for use in exceptional circumstances only, and service providers will require department approval to submit non-admitted activity through NADC, rather than the VINAH minimum data set.

Information about reporting this collection, including specifications and obtaining approval to report this collection, can be obtained from the [HDSS helpdesk](mailto:hdss.helpdesk@health.vic.gov.au) <hdss.helpdeks@health.vic.gov.au>.

Table 5: Non-Admitted Data Collection timelines

| NADC | Timeline |
| --- | --- |
| Submission date for all service events in the month | Must be submitted before 5.00 pm on the tenth 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 fourteenth day of the following month, or the preceding working day if the fourteenth 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 tenth 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 fourteenth day of the month following the reference month. Complete data for the month is expected to be transmitted by the fourteenth 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 2023.

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.

#### Agency Information Management System

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 public hospital user manual. Effective from 1 July 2022, the due date at the end of each reporting period will change from the fourteenth day of the following month, to the twelfth day of the following month, for:

* S10 Acute Non-Admitted Clinic Activity
* S11 Sub-Acute Non-Admitted Activity
* S11A Sub-Acute Non-Admitted MDCC patient not present
* S12 Self-delivered Non-Admitted Services.

Visit the [HealthCollect web portal](https://www.healthcollect.vic.gov.au)[[12]](#footnote-13) <https://www.healthcollect.vic.gov.au> for more information.

##### 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](mailto:hdss.helpdesk@health.vic.gov.au) <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>.

#### Victorian Cost Data Collection

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 4.1)* (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. 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 will be activity-base funded from 1 July 2013, 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 submission
* Phase 2 – file validations
* Phase 3 – linking/matching VCDC to activity
* Phase 4 – data quality assurance checks
* Phase 5 – receipt of reconciliation report.

Health services reporting VCDC data will be required to adhere to the minimum submission timelines in Table 6. Health services may submit more frequently than the minimum standards in the table.

Table 6: VCDC actions and reporting timelines

| Actions | Date |
| --- | --- |
| Submission portal open to accept submission | 23 September 2022 |
| First submission of files to VCDC – Phase 1 | 23 September to 24 October 2022 |
| Final submission of files to VCDC following completion of Phase 2 and Phase 3 | 21 November 2022 |
| The department to provide Quality Assurance (QA) reports to health services – Phase 4 | Within one week of finalising Phase 3 |
| Health services to provide comments on QA checks and conclude submission to the VCDC | 16 December 2022 |
| Health services to submit signed Reconciliation Reports and Data Quality Statements[[13]](#footnote-14) | 23 December 2022 |
| Final re-submissions completed following re-costing due to major impacts on cost data, following Phase 4 checks[[14]](#footnote-15) | 13 January 2023 |
| The department to consolidate Victorian cost database | 3 February 2023 |
| The department to provide state-wide underlying costed data to health services for use in their business intelligence tools (following receipt of consent forms) | 5 March 2023 |

##### 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 non-compliant. However, where health services are experiencing issues complying with the above timeframes, they are to inform the department via an email to VCDCassist 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, and should ensure software updates and migrations do not prevent complete VCDC transmissions by this date.

#### Victorian Perinatal Data Collection

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 Consultative Council on Obstetric and Paediatric Mortality and Morbidity, for inclusion in the VPDC. Refer to section 29.1.14 ‘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 Consultative Council.

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, neonatal morbidity, congenital anomalies and a range of other details, relating to 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*.

The VPDC manual, including data definitions, business rules and submission guidelines, is available 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>

#### Victorian Health Incident Management System

VAHI, in consultation with Safer Care Victoria and other areas of the department, is leading the VHIMS reform program, which aims to ensure that the information collected is better able to inform quality, safety and experience improvements for Victorians. Further detail about these reforms is available from the [VHIMS portal](https://vahi.vic.gov.au/ourwork/safety-and-surveillance-reporting)[[15]](#footnote-16) <https://vahi.vic.gov.au/ourwork/safety-and-surveillance-reporting>.

**VHIMS Minimum Data Set**

A key feature of the reform program is the establishment of a new VHIMS 2 Minimum Data Set (MDS), which has been developed in consultation with Victorian public health services. The VHIMS 2 MDS enables collection of meaningful statewide data on clinical incidents, occupational health and safety incidents, hazards and near misses.

From 1 July 2022, all Victorian public health services are required to report data to the VHIMS 2 MDS, in accordance with the [VHIMS Minimum Dataset Manual 2021–22](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> via the VHIMS Central Solution or the Application Programming Interface. Health services are no longer able to submit the VHIMS interim dataset.

Future VHIMS statewide reporting will rely heavily on the quality and timeliness of the VHIMS 2 MDS submissions. Reports will identify where gaps in data submission exist, including noncompliant health services.

##### Penalties for noncompliance

No penalties for late data submission of the VHIMS MDS will apply in 2022–23. However, health services are advised that the department may apply late data penalties from 1 July 2023. Further details about late data penalties will be available in the 2023–24 Policy and Funding Guidelines.

#### 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 tenth 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 Manager, Centre for Victorian Data Linkage advising of the issues experienced, the organisation’s plan for overcoming the issues and the expected submission date.

#### Victorian Healthcare Associated Infection Surveillance System

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
* hospital-identified Clostridium difficile infections
* 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. 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 Victorian State Trauma Registry 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 Victorian State Trauma Registry summary report. Annual reports are available at the [Victorian State Trauma System webpage](https://www.health.vic.gov.au/patient-care/victorian-state-trauma-system) <https://www.health.vic.gov.au/patient-care/victorian-state-trauma-system>.

#### 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.

The audit process aims to highlight system and process errors, identify trends and opportunities for improvement in surgical mortality, and report these to the Victorian Perioperative Consultative Council (VPCC) and Safer Care Victoria.

Safer Care Victoria is the contract manager and funds the Victorian Audit of Surgical Mortality program, according to conditions outlined in the contract.

#### Consultative Councils Reporting Requirements

The VPCC and the CCOPMM are ministerial advisory committees that review and report on specialised areas within health care, to reduce mortality and morbidity. The functions and reporting requirements of both councils are legislated under the Public Health and Wellbeing Act. Safer Care Victoria provides secretariat support to the councils.

The VPCC oversees, reviews and monitors perioperative care in Victoria. Health services and clinicians must report adverse events (including death) that may occur prior to, during, or following surgery, to the VPCC. The VPCC works closely with the Victorian Audit of Surgical Mortality to share information and lessons from surgical mortality.

The CCOPMM considers, investigates and reports on obstetric and paediatric mortality and morbidity in Victoria. CCOPMM is also responsible for the [VPDC](mailto:vicworkforce@dhhs.vic.gov.au), a population-based surveillance system that collects and analyses information on the health of mothers and babies.

Health services are required to report all perinatal, paediatric and maternal deaths, and Severe Acute Maternal Morbidity to CCOPMM within 28 days to identify safety and quality issues in maternity services and report the preventable harm to the Secretary of the department in a timely way.

CCOPMM is also responsible for maintaining Victorian Congenital Anomalies Register, which is a surveillance system for congenital anomalies in Victoria. The reporting is voluntary and is a register of data collected from before birth to children six years of age. CCOPMM reports to the Australian Institute of Health and Welfare on births, deaths (stillbirths, neonatal deaths, child and adolescent and maternal mortality) and congenital anomalies These data are included in national reporting.

The VPCC and CCOPMM make recommendations to help health services and clinicians improve clinical practice and systems of care, using their [annual report](https://www.bettersafercare.vic.gov.au/reports-and-publications?f%5B0%5D=agency%3A231&f%5B1%5D=topic%3A131&)s to detail the councils’ research and activities. The councils also directly advise the Minister for Health, the department and [Safer Care Victoria](https://www.health.vic.gov.au/rural-health/victorian-patient-transport-assistance-scheme-vptas) on strategies to improve clinical performance and avoid preventable harm.

#### Cardiac Surgery Registry

Since 2001, the department, and more recently Safer Care Victoria, acting through the department, have contracted the Australian and New Zealand Society of Cardiac and Thoracic Surgeons to collect data to monitor clinical performance in cardiac surgery. 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.

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 contracts managed by VAHI, stipulate that quarterly or 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 requested for the purposes of linkage to inform the development of statewide quality and safety indicators, which are reported in VAHI’s Board Safety and Quality report.

#### 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.

This registry is coordinated by Monash University’s School of Public Health and Preventive Medicine, and has the support of the Cardiac Society of Australia and New Zealand. The funding arrangements for this registry, outlined in contracts managed by VAHI, stipulate that quarterly or biannual reports of summarised data are submitted to Safer Care Victoria and/or the department.

Data in these reports are received with health services identified to better support and strategically guide statewide quality improvement activity and service planning. Registry data are also requested for the purposes of linkage to inform the development of statewide quality and safety indicators, which are reported in VAHI’s Board Safety and Quality report.

#### Australian Stroke Clinical Registry

The Australian Stroke Clinical Registry 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 contracts managed by VAHI, stipulate that quarterly or 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 requested for the purposes of linkage to inform the development of statewide quality and safety indicators, which are reported in VAHI’s Board Safety and Quality report.

#### 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 data set 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, released annually, 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.

From 1 July 2022, 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.

The department also maintains a dialysis register comprising patient-level data provided by specialist services and coordinated by Melbourne Health. The register excludes private patients dialysing in private hospitals.

#### Victorian Healthcare Experience Survey

In 2021, a new agreement was signed with Ipsos Public Affairs to deliver the VHES program for the next three years. VAHI will continue to oversee the implementation of the contract requirements, and work with Safer Care Victoria and others across the department, to maximise value from the program through analysis and reporting of healthcare experience data, to inform actionable, quality and safety improvements.

Under the new agreement, the upload procedures outlined below will continue.

##### 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 community health service survey, health services must support the census survey process.

The mental health annual ‘Your Experience of Service Survey’ is anticipated to continue as an *in-situ* paper-based survey in 2022–23. However, COVID-safe practices may warrant a review of the most appropriate arrangement. The ‘Carer Experience of Service Survey’ will require nominated health services to upload contact details of eligible patients for the nominated 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
* complete implementation of security improvements for elective surgery and emergency department ICT systems, 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 (June 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>, as they provide a guide on how health services are to ensure the integrity of data reported concerning the health system. Importantly, the guidelines also assist health services in meeting the requirements for integrity in the data provided by them when reporting their activity and performance.

The Health Data Integrity Program will continue in 2022–23, 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 VAHI and comprises a mixture of formal audits of core data sets 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 patients.

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 a number of reports across these data sets 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 Health Data Integrity Unit will 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

These 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.

Proposed changes to data collections are released for comment, and specifications for change are published by 31 December, prior to the financial year to which they apply, to enable 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 and AIMS. The bulletin is the primary method by which amendments to standards and reporting timelines are published during the year.

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, and is provided at no charge. Subscriptions may be arranged by [emailing the HDSS helpdesk](mailto:HDSS.Helpdesk@health.vic.gov.au) <HDSS.Helpdesk@health.vic.gov.au>.

#### 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 Data Set (VADS) data monthly, according to the timelines specified in Table 7.

The department will continue to work with Ambulance Victoria to validate and extend the dataset collection, including the planned Stage 3.

Until both the department and Ambulance Victoria confirm the accuracy of Victorian Ambulance Data Set 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 7.

Table 7: 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 tenth day of the month following the case date |
| VADS – Transport and patient data | Year-to-date submission to VADS to be received by the tenth day of the second month following the case date |
| Aggregate Ambulance Minimum Dataset | Indicators identified in Table 15 will be supplied to the department in spreadsheet format by the tenth day of the month following the monthly reporting period |
| All data submissions for the 2022–23 financial year | Year-to-date submission must be received before final consolidation of the VADS on 10 August 2023 |

### 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 Act
* the mental health triage minimum dataset
* reportable deaths and other notifications to the Chief Psychiatrist
* annual Mental Health Establishments collection
* quarterly data collection (MHCSS reporting)
* a quarterly MHCSS aggregate spreadsheet report
* the VAED (see section 28.1 ‘Victorian Admitted Episodes Dataset’)
* the VEMD (see section 28.4 ‘Victorian Emergency Minimum Dataset’).

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.

Mental health data and performance reporting can be found at the [Victorian Health Services Performance website](https://vahi.vic.gov.au/reports/victorian-health-services-performance/mental-health) <https://vahi.vic.gov.au/reports/victorian-health-services-performance/mental-health> and the [Mental health performance reports website](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>.

#### Client Management Interface and Operational Data Store

The statewide ODS is simultaneously updated from local CMI systems as data is captured, providing a live 24-hour, seven-day-a-week 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 client care across all designated mental health services. Data entry timeframes differ, according to the type of data being recorded (see Table 8 for details).

Table 8: Client Management Interface and Operational Data Store reporting timelines

| Data entry | Rationale | Due date |
| --- | --- | --- |
| Compulsory order/legal status | Timely information regarding compulsory/forensic/security client status | Twice daily, seven days per week |
| Admissions, transfers and separations | Statutory reporting  Maintenance of statewide bed register | Twice daily, seven days per week |
| Client registration and episode creation | Informational continuity of care | Daily, within 24 hours following mental state assessment |
| Contacts | Statutory reporting | On tenth of the month following the contact |
| Outcome measures | Statutory reporting | On tenth of the month following the measure collection |
| Electroconvulsive therapy procedures | Statutory reporting | As soon as practicably possible |
| Seclusion and restraint | Statutory reporting | On tenth of the month following the period of seclusion/restraint |
| Diagnosis | Statutory reporting | On tenth 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 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>.

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 November
* October–December: last business day February
* January–March: last business day May
* April–June: last business day August.

Outstanding validation issues for the 2022–23 financial year must be reconciled by 30 November 2023. 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.

#### Mental Health Establishments National Minimum Dataset

The Mental Health Establishments National Minimum Dataset collection captures all mental health workforce data and expenditure, and 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 the [HealthCollect web portal](https://www.healthcollect.vic.gov.au)[[16]](#footnote-17) <https://www.healthcollect.vic.gov.au>.

Reporting timelines for the Mental Health Establishments collection are outlined in Table 9.

Table 9: Mental Health Establishments collection reporting timelines

| Collection period | Reporting requirements | Due date |
| --- | --- | --- |
| 2020–21 | Stage 2: Resolution of any final issues and any additional clarification required for the Australian Institute of Health and Welfare for 2020–21. Validations and questions sent to health services must be finalised by end of July 2022 | 29 July 2022 | |
| 2021–22 | 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 2022, when the portal will close | 28 October 2022 | |
| 2021–22 | Stage 1 Validations: Resolution of services’ initial validation issues arising from the HealthCollect portal data submission | 1 March 2023 | |
| 2021–22 | 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 2023 | 28 July 2023 | |

#### 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 the [mental health triage email](mailto:triagemds@dhhs.vic.gov.au) <triagemds@dhhs.vic.gov.au>. During 2022–23, data submission will transition to the Managed File Transfer portal.

Documentation detailing the format and reporting timelines can be found at the [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>.

#### Mental Health Community Support Services

Agencies funded to deliver MHCSS activity are expected to provide data via the Quarterly Data Collection and the supplementary MHCSS Excel spreadsheet. 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 seventh of the month following the end of the quarter. The Quarterly Data Collection has a dedicated helpdesk support team to assist users. Contact the team via the [Quarterly Data Collection helpdesk email](mailto:qdchelp@dhhs.vic.gov.au) <qdchelp@dhhs.vic.gov.au>.

The aggregate supplementary Excel spreadsheet data file must be submitted by the fifteenth of the month following the end of the quarter. The file must be submitted by [emailing the Mental Health and Drugs Data team](mailto:mhcssdata@dhhs.vic.gov.au) <mhcssdata@dhhs.vic.gov.au>.

#### Reportable Deaths

The Chief Psychiatrist requires that the deaths of consumers of designated mental health services and MHCSS be reported in the following circumstances.

##### Deaths on mental health inpatient units

All deaths of mental health inpatients, including expected deaths, must be notified to the Chief Psychiatrist within 24 hours. Notifications can be made by telephone (03) 9096 7571, or by [emailing the Office of the Chief Psychiatrist](mailto:ocp@dhhs.vic.gov.au) <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.

##### Deaths in the community

The Chief Psychiatrist must be notified in writing of:

* all unexpected, unnatural or violent deaths (including suspected suicides) of community-resident persons who were registered as mental health consumers within the previous three months, who:
  + received mental health services from a mental health service provider
  + is receiving mental health services from a mental health service provider
  + was assessed by an authorised psychiatrist and was not provided with treatment
  + sought or is seeking mental health services from a mental health service provider, and was or is not provided with mental health services
* all deaths of community-resident patients under the Mental Health Act (including forensic orders).

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 MHA 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 [Safer Care Victoria 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 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. The reporting instruction and accompanying incident report form are available from the Funded Agency Channel’s [Health incidents](https://fac.dffh.vic.gov.au/incident-reporting/health) <https://fac.dffh.vic.gov.au/incident-reporting/health>.

More information on what is meant by a ‘reportable death’ and the procedures for reporting them can be found in the Chief Psychiatrist’s guideline on [Reportable deaths](https://www.health.vic.gov.au/key-staff/reportable-deaths) <https://www.health.vic.gov.au/key-staff/reportable-deaths>.

##### 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 the Safer Care Victoria sentinel event program. This includes suicides on mental health inpatient units, as well as those in other health settings, such as acute, sub-acute or rehabilitation services, or compulsory clients while on approved or non-approved leave. More information is available at [Sentinel events](https://www.safercare.vic.gov.au/notify-us/sentinel-events) <https://www.bettersafercare.vic.gov.au/notify-us/sentinel-events>.[[17]](#footnote-18)

#### Restrictive Interventions Reporting (seclusion and bodily restraint)

The Mental Health Act closely regulates the use of ‘restrictive interventions’. Part 6 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 ‘restrictive interventions’ as ‘bodily restraint or seclusion’.

All restrictive interventions are required to be reported to the Chief Psychiatrist.

In accordance with the Mental Health Act and the Chief Psychiatrist’s guideline [Restrictive interventions in designated mental health services](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. 108(1) 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. 108 of the Act).

In practice, this information is entered monthly onto the CMI database in each service, and must include information relating to restrictive interventions, which have occurred in emergency departments and other areas, where the intervention has occurred with people receiving compulsory treatment under the Act.

The service must also provide appropriate information to persons subject to restrictive interventions about their rights, including post-intervention support.

##### Episodes of extended seclusion

In addition to the routine monthly Seclusion Register reporting procedures, 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/children/youth). Should the episode of seclusion exceed 48 hours, it is expected that escalation processes, including case conferencing and second opinions, occur. Where an extended period of seclusion in excess of 48 hours is anticipated, the decision must be discussed with the authorised psychiatrist or delegate, to ensure there has been a discussion outlining the strategies aimed at reducing the behaviours, and 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 reducing behaviour and 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

Designated mental health services must notify the Chief Psychiatrist of any extended admission to a high-dependency area that is continuous and exceeds 48 hours. This report must be made **before** the episode has exceeded 48 hours.

Where an extended period of seclusion in excess of 48 hours is anticipated, the authorised psychiatrist or delegate must provide the Chief Psychiatrist with a written clinical summary and management plan, at the time of notification.

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 that occur in acute inpatient units, or secure extended care units, of designated mental health services, must be notified to the Chief Psychiatrist within 24 hours. This includes any known, suspected or alleged instances of sexual activity (including seemingly consensual sexual activity), sexual harassment or sexual assault.

This reporting requirement applies across child and adolescent, adult, and aged mental health services, with more information available at [Sexual safety notification to the Chief Psychiatrist](https://www.health.vic.gov.au/publications/sexual-safety-notification-to-the-chief-psychiatrist) <https://www.health.vic.gov.au/publications/sexual-safety-notification-to-the-chief-psychiatrist>.

#### Electroconvulsive Treatment

##### 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, but 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 using a specific form of adverse events directly related to ECT that either:

* result in death (including near-misses), serious injury or serious illness
* require transfer to an emergency department or similar setting.

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 Act regulates the use of ECT for ‘all young persons’ under the age of 18 years in Victoria, whether voluntary or involuntary, including those 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, but must be informed **in advance** of plans to administer ECT to a young person receiving mental health services from a designated mental health service.

The [Chief Psychiatrist’s guideline on electroconvulsive treatment](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

Treatment of psychiatric illness by means of neurosurgery (specifically, deep brain stimulation) must be approved by 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 Act

The Chief Psychiatrist has statutory roles and functions under the Mental Health Act(s.120 and s.121). This include assisting mental health service providers to comply with the Act, regulations made under the Act and any Codes of Practice (s.121(1)(e)).

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 the designated mental health services, including emergency departments 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](mailto:ocp@health.vic.gov.au) <ocp@health.vic.gov.au>. Where required, contact the Office of Chief Psychiatrist on (03) 9096 7571 for any 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 future occurrence of such incidents.

If the service becomes aware of an incident regarding failure to comply with the Act, through the process of a complaint investigation by the Mental Health Complaints Commissioner or other authorities, it must be reported to the Chief Psychiatrist immediately.

Designated mental health services must include this advice 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, view the [Victorian Chief Psychiatrist practice direction – Reporting of incidents where there is a failure to comply with the Mental Health Act 2014](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 VADC supports public accountability for service provision. Outputs contribute to the AOD Treatment Services National Minimum Data Set, as well as performance measurement and monitoring for Commonwealth, state and departmental purposes. All AOD treatment service providers must submit activity data via the VADC.

AOD treatment service providers must ensure client management systems can meet VADC reporting requirements. Details on data specifications, bulletins and the submission process can be found at [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 fifteenth day of the subsequent month.

#### Needle and Syringe Program Information System

The Victorian and Commonwealth Governments fund services to reduce the harms associated with AOD 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 monthly by the end of each month, via the Needle and Syringe Program Information System reporting application. Organisations using the application can generate the extract and [email it to the Needle and Syringe Program](mailto:nsp-is@dhhs.vic.gov.au) <nsp-is@dhhs.vic.gov.au>.

Paper-based surveys should be sent to the department by [emailing NSP Data collection](mailto:nspis@dhhs.vic.gov.au) <nspis@dhhs.vic.gov.au>.

#### Drugs and Poisons Information System

The department operates an electronic information system known as the drugs and poisons information system, to support its administration of the Drugs, Poisons and Controlled Substances Act 1981.

The drugs and poisons information system 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 patients. 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 the Australian Health Practitioner Regulation Agency or Victoria Police.

The drugs and poisons information system 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 patient.

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 patients who are developing signs of substance-use disorder.

The data for SafeScript is collected automatically from prescription exchange services, which currently support 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

The department conducts an opioid replacement therapy dispenser census annually. It surveys all community, correctional, health service and specialist pharmacotherapy service dispensaries, dosing opioid replacement therapy clients in Victoria.

All dispensers are emailed a link to the 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 to the Pharmacotherapy Program by the dispensing agencies directly. 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 clients who identify as Aboriginal, as of 30 June.

The data provides a count of clients 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.

### 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 10.

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 10: Ageing, aged and home care – data collection and reporting requirements

| Activity no. | Activity name | Data collection description |
| --- | --- | --- |
| 13005 | Aged Care Assessment Service | 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 collection  Forms: AIMS S5-129 for Residential aged care services data collection; AIMS Public sector residential aged care services quality indicators; and AIMS S5-115 for Aged persons’ mental health; 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](mailto:Planning&Operations@health.vic.gov.au) <planning.operations@dhhs.vic.gov.au>). Note updates from 1 July 2022 to AIMS S5\_129 and AIMS S5\_115 to report new AN-ACC data items  Public sector residential aged care services 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;[[18]](#footnote-19) 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 [VICNISS email](mailto:vicniss@mh.org.au) <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 Co-ordination Other |  |
| 13131 | RDNS[[19]](#footnote-20) 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 | My Aged Care Screening and Assessment Workforce Training Strategy 2019 |
| 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[[20]](#footnote-21) 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 11.

#### 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 the 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.

Funded organisations must submit data to the department by the third business day of each month. The department is responsible for validating monthly extracts and providing error reports to agencies. Funded organisations must correct errors in their data before the next extract of all health program dataset items is submitted.

Table 11: 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 |
| 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 |
| 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 | MDC – Community Health Nurse | Community health minimum dataset |
| 28091 | Community Asthma Program | 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 the 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* (2009) to the department. Data must be transmitted to the department by the tenth day of the following month, or the prior working day, if the tenth 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 public health services and Forensicare are eligible to receive training and development funding.

To receive funding, organisations must:

* ensure all funded programs conform to the most recent versions of guidelines (where available), including the guidelines and standards set by the Australian Health Practitioner Regulation Agency 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* indicators through the BPCLE tool.

More information regarding the *BPCLE framework,* and detailed guidelines for the training and development funding, are available at:

* [*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](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. For details of eligible activity, disciplines and courses, refer to the [*Training and Development Funding – Program Guidelines 2021–22*](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, including recording of fees in Placeright (or reporting via HealthCollect portal for agreed medical student placement activity not yet managed via Placeright).

Health services are also encouraged to:

* establish a Student Placement Agreement with all education provider partners, including uploading to Placeright, where the system is used to manage eligible funded activity
* adhere to the Standard Student Induction Protocol to ensure conformity of practices across the sector.

Note that 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. More information on these resources is available at:

* [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 filled through the statewide matching process, or by another process as determined by the department.
* Health services must report on the headcount and full-time equivalent (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) by December 2021
  + 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, refer to [[Training and development funding](https://www.health.vic.gov.au/education-and-training/training-and-development-funding)](https://www2.health.vic.gov.au/health-workforce/education-and-training/training-development-grant) <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 are excluded. Postgraduate activity, including FTE and headcount of staff who undertook postgraduate study during the calendar year, must be reported via Health Collect.

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, refer to [[Training and development funding](https://www.health.vic.gov.au/education-and-training/training-and-development-funding)](https://www2.health.vic.gov.au/health-workforce/education-and-training/training-development-grant) <https://www.health.vic.gov.au/education-and-training/training-and-development-funding>.

#### Other Targeted Workforce Training and Development Programs

##### Nursing and midwifery postgraduate scholarships

The department requires annual reporting of the value and number of scholarships allocated and the field of study undertaken. Health services receiving this stream of funding will be provided with guidelines on the allocation and reporting requirements.

##### Continuing nursing and midwifery education

The department requires the reconciliation of continuing nursing and midwifery activity that occurred in each fiscal year. A link to an online reporting form will be provided to funding recipients.

##### 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. A 2021–23 template has been provided to auspice services for completion.

##### Mental health – training and development grants

Block funding for mental health workforce development within designated mental health services is provided, to support internal resources to deliver targeted workforce development to meet local needs. There are also expectations that funding supports some contribution of these resources to a statewide calendar managed by the Centre for Mental Health Learning from 1 April 2020. Templates will be provided to mental health services in 2022–23 for completion, requesting details of learning and development resources that are supported by the funding.

Table 12: Training and development funding – reporting requirements

| Program | Reporting required by health services | Due date |
| --- | --- | --- |
| All programs | Automated reporting of seven externally reportable *BPCLE framework* indicators through the [BPCLE tool](https://www.bpcletool.net.au/accounts/login) <https://www.bpcletool.net.au/accounts/login> | 17 February 2023 |
| Professional-entry student placements | Completion of attendance for clinical placement activity in Placeright biannually  To request an exemption from using Placeright, [email VicWorkforce](mailto:vicworkforce@dhhs.vic.gov.au) <vicworkforce@dhhs.vic.gov.au> for access to the HealthCollect portal for reporting of agreed medical student clinical placements | 17 February 2023 (for July–December 2022 activity)  22 July 2023 (for activity January–June 2023) |
| Transition to practice (graduate) – allied health, medical (PGY2), nursing and midwifery | Report on the headcount and FTE hours of allied health, PGY2 and nursing and midwifery 2021 graduate positions, and planned PGY2 and nursing and midwifery 2022 positions, via the HealthCollect portal[[21]](#footnote-22)  **Note:** Allied health graduate reporting is required only for the disciplines of art therapy, audiology, exercise physiology, dietetics and nutrition, medical laboratory science, medical physics, music therapy, nuclear medicine, occupational therapy, optometry, orthoptics, physiotherapy, podiatry, prosthetics and orthotics, psychology, radiography (diagnostic imaging), radiation therapy, social work and speech pathology | 17 February 2023 |
| Postgraduate – medical specialist training | Victorian Medical Specialist Training Program acquittal of posts and positions in 2021 | 17 February 2023 |
| Victorian Basic Paediatric Consortium reporting requirements, as specified in the consortium governance arrangements, including the head count and FTE hours for trainees and accredited training posts in the statewide consortium, including the rural training stream in 2021 | 17 February 2023 |
| Basic Physician Training Consortia Program acquittal of posts and positions in 2021 | 17 February 2023 |
| Postgraduate – nursing and midwifery | Report on the headcount and FTE hours of 2021 postgraduate positions and 2022 planned positions, via the HealthCollect portal | 17 February 2023 |
| Targeted workforce training and development programs | Recipients of targeted workforce training and development programs must meet the reporting requirements, as specified for each program through the acceptance process | Annually, as specified by each program |

### Commonwealth–state reporting requirements

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 Government.

The information required, format and timelines for individual programs are detailed in the applicable agreements with the Commonwealth Government and the guidelines applicable to the appropriate Commonwealth–state programs.

### Environmental Data Reporting Requirements

As required under section 23.5 'Health service environmental management, planning and reporting’, public hospitals and health services are to upload any energy, water, waste, transport and paper data in the EDMS.

Where public hospitals and health services utilise statewide HealthShare Victoria contracts (or State Purchase Contracts) for electricity, gas, waste and paper, the department uploads this data centrally.

Where public hospitals and health services utilise the statewide VicFleet contract for vehicles, the department uploads this data centrally.

The department uploads water data, sourced direct from water retailers, and cogeneration data (under the Energy Services Agreement) centrally.

Data relating to any other energy, waste and transport services procured directly by public hospitals and health services, must be manually uploaded at least quarterly. This could include liquefied petroleum gas (LPG), small sites on retail energy contracts, non-potable water (where metered), specialist recycling streams and fleet vehicles procured outside of VicFleet.

Public hospitals and health services are to configure any behind-the-meter solar arrays to automatically feed net generation data into the EDMS. Advice on how to configure this is available on the [VHBA website](https://www.vhba.vic.gov.au/reporting-solar-photovoltaic-data) <https://www.vhba.vic.gov.au/reporting-solar-photovoltaic-data>.

The EDMS can be accessed at the [Edensuite website](https://dse.edensuite.com.au) <https://dse.edensuite.com.au>. Health service login details are available by [emailing Edensuite](mailto:edms@health.vic.gov.au) <edms@health.vic.gov.au>.

Further advice on environmental data reporting requirements is available at [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>.

Reporting requirements are changing for the 2022–23 reporting year, with the introduction of a substantially updated Financial Reporting Direction 24: Reporting of environmental data by government entities (FRD 24). This will apply new whole-of-government environmental reporting requirements to hospitals and health services.

Updated reporting guidance for hospitals and health services, including how to report against activities and indicators not currently captured by the health EDMS, will be provided. The department’s EDMS will be configured to meet the FRD 24 quantitative reporting requirements and is expected to be in place for the 2023–24 reporting year.

The department will require denominational health services under the Health Services Act to follow FRD 24 reporting requirements from the 2023–24 reporting. Further advice to these health services will be provided during the 2022–23 transition period.

## Performance Targets and Monitoring

### Health Services Covered Under the Health Services Act

Public health services and hospitals covered under the Health Services Act are subject to performance monitoring via the Victorian health services *Performance Monitoring Framework*. This 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 more information, 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> for more information.

### 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>.

Table 13: 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 |
| 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 14: 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 15: Ambulance Victoria – performance targets and monitoring

| Service plan | Activity | Measure description | Unit of measure | Reporting frequency | Status |
| --- | --- | --- | --- | --- | --- |
| Quantity – transports | Emergency road: all  Emergency road: metro  Emergency road: rural and regional  Non-emergency stretcher: all  Non-emergency stretcher: metro  Non-emergency stretcher: rural and regional  Non-emergency clinic car  Fixed-wing emergency  Fixed wing non-emergency  Rotary wing | Number of transports provided | Number | Monthly | Mandatory |
| Quantity – incidents | Emergency road: all  Emergency road: metro  Emergency road: rural and regional  Treatment without transport  Non-emergency stretcher: all  Non-emergency stretcher: metro  Non-emergency stretcher: rural and regional  Non-emergency clinic car  Fixed-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 eight 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 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 16: Mental health service – performance targets and monitoring

**Note**: Some targets are provided in the *Mental health performance and accountability framework* 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 Your Experience of Service (YES) completion | Per cent | Yes | Yes | No | 20% | Annual | Mandatory |
| Appropriateness | Percentage valid HoNOS[[22]](#footnote-23) 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[[23]](#footnote-24) | Per cent | Yes | Yes | Yes | > 85% | Quarterly | Mandatory |
| Effectiveness | Percentage of separations from an acute inpatient unit (adult, aged, CAMHS) with a subsequent readmission within 28 days | Per cent | Yes | Yes | Yes | 14% adult and CAMHS  7% CAMHS | 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 separations from an acute mental health inpatient unit with a post-discharge follow up within seven days | Per cent | Yes | Yes | Yes | 88% | Quarterly | Mandatory |
| Accessibility | Pre-admission contact | Per cent | Yes | Yes[[24]](#footnote-25) | Yes | > 61%  All age ranges | Quarterly | Mandatory |
| Accessibility | Percentage of mental health-related emergency department presentations with a length of stay in the ED of less than four hours | Per cent | Yes | Yes | Yes | tbc | 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 17: Primary, community and dental health – performance targets and monitoring

| Activity no. | Activity name | Measure description | Unit of measure | Frequency | Status | Output type |
| --- | --- | --- | --- | --- | --- | --- |
| 27019 | R 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 |
| 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 |
| 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 | Aboriginal community-controlled organisation services – Primary Health | Development of service profile | Completed service | Yearly | Mandatory | Key output measure |
| 28090 | MDC – 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 |

Table 18: 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[[25]](#footnote-26) 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 |
| 16381 | Risk management and emergency response | Report against agreed objectives | Reports | Yearly | Mandatory | Key output measure |
| 16449 | Smoking information – advice and interventions | 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 | Report against agreed objectives | Reports | Half-yearly | Mandatory | Key output measure |
| 16453 | Aboriginal health worker support | Report against agreed objectives | Reports | Half-yearly | Mandatory | Key output measure |
| 16454 | Health promotion initiatives | Report against agreed objectives | Reports | Quarterly | 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 |

## Service Standards and Guidelines

Table 19: Small rural health services – service standards and guidelines

| Activity no. | Activity name | Service standards and guidelines description |
| --- | --- | --- |
| 13031 | Small rural – aged care (residential only) | Aged Care Act (Cth) 1997 as amended  Commonwealth 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 |
| 35010 | Small rural – aged support services | Aged Care Act (Cth) as amended  Commonwealth 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 – flexible health service delivery | Small rural health services guide 2003–04 and updates |
| 35025 | Small rural – TAC[[26]](#footnote-27) – acute health | Small rural health services guide 2003–04 and updates |
| 35026 | Small rural – Department of Veterans’ Affairs – acute health | Small rural health services guide 2003–04 and updates |
| 35028 | Small rural – acute health service system development and resourcing | Small rural health services guide 2003–04 and updates |
| 35030 | Small rural – HACC-PYP Health Care and Support | Victorian HACC program manual 2013  HACC-PYP fees policy |
| 35042 | Small rural – drugs services | Alcohol and other drug program guidelines  Alcohol and other drug performance management framework  Adult AOD screening and assessment tool  Incident reporting instruction *(May 2013)*  Victorian Alcohol and Other Drug Treatment Principles  Victorian AOD client charter  Severe Substance Dependence Treatment Act 2010 |
| 35048 | Small rural – primary health flexible services | Small rural health services guide 2003–04 and updates  [Advice for public health and wellbeing planning in Victoria: planning cycle 2017–2021](https://www.health.vic.gov.au/publications/advice-for-public-health-and-wellbeing-planning-in-victoria-planning-cycle-2017-2021) <https://www.health.vic.gov.au/publications/advice-for-public-health-and-wellbeing-planning-in-victoria-planning-cycle-2017-2021>  [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 – specified services | Small rural health services guide 2003–04 and updates |

Table 20: Drug services – service standards and guidelines

| Service standards and guidelines description | Activity no. |
| --- | --- |
| AOD 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 |
| AOD withdrawal practice guidelines (2018) | 34050, 34056, 34064, 34203, 24204, 34214, 34303, 34310 |
| Alcohol in the workplace: guidelines for developing a workplace alcohol policy | 34009 |
| Assessment and intervention tool for youth AOD treatment services (prepared by Turning Point Alcohol and Drug Centre Inc. for the Department of Human Services) (2004) | 34041, 34045, 34046, 34048, 34049, 34051, 34053, 34056, 34060, 34064, 34075, 34078, 34080, 34084, 34202, 34204, 34205, 34206, 34208, 34309, 34310 |
| Adult AOD 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 Act  Commission for Children and Young People Act  Working with Children Act 2005  Protocol between drug treatment services and child protection for working with parents with AOD 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 AOD use disorders  National 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 |
| Clinical treatment guidelines for methamphetamine dependence and treatment | 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 (2016) | 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 (2003) | 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 AOD 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 |
| Victorian policy for maintenance pharmacotherapy for opioid dependence (2016)  National guidelines for medication-assisted treatment of opioid dependence (2014) | 34047, 34057 |
| The Victorian hepatitis B strategy 2016–2020  The Victorian hepatitis C strategy 2016–2020  The Victorian HIV strategy 2017–2020  Eighth national HIV strategy 2018–2022  Fourth national sexually transmissible infections strategy, 2018–2022  Fifth national Aboriginal and Torres Strait Islander blood-borne viruses and sexually transmissible infections strategy 2018–2022  Third national hepatitis B strategy 2018–2022  Fifth 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 | 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 (2015) | 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 |
| The Society of Hospital Pharmacists of Australia standards of practice for Australian poisons information centres | 34003 |
| Victorian needle and syringe program operating policy and guidelines (revised November 2008) | 34070, 34308 |

Table 21: 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 amended  My Aged Care assessment manual – for Regional Assessment Services and Aged Care Assessment Teams (2021 and addendums)  My Aged Care screening and assessment workforce training strategy (2019)  Aged Care Assessment Program style guide (2020) (Commonwealth Department of Health) |
| 13015 | HACC-PYP Linkages | Victorian HACC-PYP program manual  Victorian HACC-PYP fees policy |
| 13019 | Personal Alert Victoria | Personal Alert Victoria program and service guidelines  Personal 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 |
| 13026 | HACC-PYP Community Care | Victorian HACC-PYP program manual  Victorian HACC-PYP fees policy |
| 13031 | Public Sector Residential Aged Care Supplement | Aged Care Act, as amended  Commonwealth Department of Health resources:  [My Aged Care](https://www.myagedcare.gov.au) <https://www.myagedcare.gov.au>  [Guides and policy](https://www.health.gov.au/health-topics/aged-care) <https://www.health.gov.au/health-topics/aged-care> |
| 13035 | Support for Carers | Carers Recognition Act  A Victorian charter supporting people in care relationships and information kit – Victorian Support for Carers Program guidelines |
| 13038 | HACC-PYP Service System Resourcing | Victorian HACC-PYP program manual |
| 13043 | HACC-PYP Flexible Service Response | Victorian HACC-PYP program manual  Victorian 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 manual  Victorian HACC-PYP fees policy |
| 13063 | HACC-PYP Volunteer Co-ordination | Victorian HACC-PYP program manual |
| 13067 | Victorian Aids and Equipment | Victorian Aids and Equipment program 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 Support Program (2002)  Older Persons High Rise Support Program submission guidelines(2001)  Housing Support for the Aged Program submission guidelines(2000)  SRS Oral Health initiative service model specifications(2011) |
| 13096 | HACC-PYP Allied Health | Victorian HACC-PYP program manual  Victorian HACC-PYP fees policy |
| 13097 | HACC-PYP Delivered Meals | Victorian HACC-PYP program manual |
| 13099 | HACC-PYP Property Maintenance | Victorian HACC-PYP program manual  Victorian HACC-PYP fees policy |
| 13109 | Aged Care Assessment Service Evaluation Unit | Aged Care Act, as amended  My Aged Care assessment manual – for Regional Assessment Services and Aged Care Assessment Teams (2021) and addendums  My Aged Care screening and assessment workforce training strategy (2019)  Aged Care Assessment Program style guide (2020) (Commonwealth Department of Health) |
| 13130 | HACC-PYP Volunteer Co-ordination – Other | Victorian HACC-PYP program manual |
| 13131 | RDNS HACC-PYP Allied Health | Victorian HACC-PYP program manual  Victorian HACC-PYP fees policy |
| 13156 | Seniors Health Promotion | Victorian HACC-PYP program manual  Older Persons High Rise Support Program guidelines |
| 13223 | HACC-PYP Nursing | Victorian HACC-PYP program manual  Victorian HACC-PYP fees policy |
| 13227 | ACCO Services – HACC-PYP | Victorian HACC-PYP program manual  Victorian 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 regional assessment services and Aged Care Assessment Teams (2021) and addendums  Victorian regional assessment services operational guidelines (2022)  *My Aged Care quality framework* (2021) |
| 13301 | Aged Quality Improvement | Aged Care Act 1997, as amended  [Commonwealth Department of Health resources](https://www.agedcarequality.gov.au) <https://www.agedcarequality.gov.au>  [My Aged Care website](https://www.myagedcare.gov.au) <https://www.myagedcare.gov.au>  [Aged care resources](https://www.health.gov.au/health-topics/aged-care) <https://www.health.gov.au/health-topics/aged-care> |

Table 22: Primary, community and dental health – service standards and guidelines

| Activity no. | Activity name | Service standards and guidelines description |
| --- | --- | --- |
| 27010  27011  27017  27019  27020  27023  27024  27025  27026  27028  27029 | 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> |
| 28015  28016  28018  28050  28063  28064  28068  28067  28085  28086 | Women’s health | [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> |
| 28021  28066  28085  28086 | 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>  [Innovative Health Services for Homeless Youth](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> |
| 28033  28043  28069  28074  28080  28084  28085  28086 | 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>  [Advice for public health and wellbeing planning in Victoria: planning cycle 2017–2021](https://www.health.vic.gov.au/publications/advice-for-public-health-and-wellbeing-planning-in-victoria-planning-cycle-2017-2021) <https://www.health.vic.gov.au/publications/advice-for-public-health-and-wellbeing-planning-in-victoria-planning-cycle-2017-2021>  [*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> |
| 28048  28076  28085  28086 | Culturally and linguistically diverse groups | [Refugee health](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 superseded  Guide for the Refugee Health Nurse Program  Refugee 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 | [General practice and private providers](https://www.health.vic.gov.au/primary-care/general-practice-and-private-providers) <https://www.health.vic.gov.au/primary-care/general-practice-and-private-providers>  [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> |
| 28071  28085  28086 | 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> |
| 28072  28074  28081  28085  28086 | 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> |
| 28080  28085  28086  28212  28213 | 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 Program](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> |
| 28082  28085  28086 | Child health | 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 23: Public health – service standards and guidelines

| Activity no. | Service standards and guidelines description |
| --- | --- |
| 16373  16377  6505  16506  16507  16508  16509 | BBV/STI program guidelines for funded agencies (current edition) |
| 16454 | [Public health and wellbeing planning](https://www.health.vic.gov.au/health-strategies/public-health-and-wellbeing-planning)  <https://www.health.vic.gov.au/health-strategies/public-health-and-wellbeing-planning>  [Municipal public health and wellbeing planning](https://www.health.vic.gov.au/population-health-systems/municipal-public-health-and-wellbeing-planning) – guidance  <https://www.health.vic.gov.au/population-health-systems/municipal-public-health-and-wellbeing-planning>  [Healthy Choices: policy directive and guideliines for health services](https://www.health.vic.gov.au/publications/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> |
| 28085 | [Community Health – Health Promotion 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

Forensicare Victorian Institute of Forensic Mental Health

Targeting zero Report of the Review of Hospital Safety and Quality Assurance in Victoria

the department Department of Health

the guidelines Policy and funding guidelines 2022–23

the Roadmap Victoria’s digital health roadmap

ACAS aged care assessment services

AIMS Agency Information Management System

AMAF *Asset management accountability framework*

AN-ACC Australian National Aged Care Classification

AOD Alcohol and other drugs

BBV bloodborne virus

BPCLE *Best practice clinical learning environment* (framework)

CCOPMM Consultative Council on Obstetric and Paediatric Mortality and Morbidity

Commonwealth Cth

CCUs Community Care Units

CMI/ODS Client Management Interface and Operational Data Store

DFFH Department of Families, Fairness and Housing

DLO disability liaison officer

GenV Generation Victoria

ECT electroconvulsive treatment

EDMS Environmental data management system

EMR Electronic Medical Record

EPC Early Parenting Centre(s)

ESIS Elective Surgery Information System

FTE full-time equivalent

GST Goods and Services Tax

HACC-PYP Home and Community Care Program for Younger People

HARP Hospital Admission Risk Program

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 EngagementProgram

HSV HealthShare Victoria

ICS Integrated Cancer Service

ICT Information and communication technology

IHACPA Independent Hospital and Aged Care Pricing Authority

LPHU Local Public Health Unit

MARAM *Family violence multi-agency risk assessment and management framework*

MDSMinimum Data Set

MHCSS Mental Health Community Support Services

MH PAF *Mental health performance and accountability framework*

NADC Non-Admitted Data Collection

NATA National Association of Testing Authorities

NBCSP National Bowel Cancer Screening Program

NDIS National Disability Insurance Scheme

NSQHS National Safety and Quality Health Service

PAC Post-Acute Care

PARC Prevention and recovery care

PAV Personal Alert Victoria

PAVRS Personal Alert Victoria Response Services

PCCP Palliative Care Consultancy Program

PGY post-graduate year

PRISM Program Report for Integrated Service Monitoring

PROMs patient-reported outcome measures

PSRACS public sector residential aged care services

RCVMHS Royal Commission into Victoria’s Mental Health System

SAVVI Supporting Accommodation for Vulnerable Victorians Initiative

SCP Support for Carers Program

SECU secure extended care unit

SOP Statement of Priorities

SRHS small rural health service

STI sexually transmissible infections

TAFE Technical and Further Education

VA&EP Victorian Aids and Equipment Program

VACCHO Victorian Aboriginal Community Controlled Health Organisation

VADC Victorian Alcohol and Drug Collection

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

VINAH Victorian Integrated Non-Admitted Health minimum dataset

VPCC Victorian Perioperative Consultative Council

VPDC Victorian Perinatal Data Collection

WWCC Working with Children Check

1. *Victorian Cancer Plan 2020–2024*. [↑](#footnote-ref-2)
2. Page 10 of [Training and Development Funding – Program Guidelines 2021–22](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>. [↑](#footnote-ref-3)
3. 2022–23 State Budget, Budget Paper 3, page 62. [↑](#footnote-ref-4)
4. 2022–23 State Budget, Budget Paper 3, page 62. [↑](#footnote-ref-5)
5. Health Services are to contact finance departments to obtain the circular 23/2009 [↑](#footnote-ref-6)
6. <https://vahi.vic.gov.au/report/population-health/health-and-wellbeing-lgbtiq-population-victoria>. [↑](#footnote-ref-7)
7. A registered account with login and password is required to access the portal. [↑](#footnote-ref-8)
8. 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-9)
9. A registered account with login details is required to access the portal. [↑](#footnote-ref-10)
10. The increase excludes the impact of bond rate and probability factors (revaluations). [↑](#footnote-ref-11)
11. The HeART replaces the previously used ‘F1’ template from the July 2021 reporting period onwards. [↑](#footnote-ref-12)
12. A registered account with login details are required to access the portal. [↑](#footnote-ref-13)
13. Signed Reconciliation Templates and Data Quality Statements, including a signed attestation, are to be submitted no later than five business days after the final submission of cost data. [↑](#footnote-ref-14)
14. Any major corrections to 2021–22 submissions that will impact on the cost data must be submitted before final consolidation of the cost database on 18 February 2023. [↑](#footnote-ref-15)
15. A registered account with login details is required to access the portal. [↑](#footnote-ref-16)
16. A registered account with login details is required to access the portal. [↑](#footnote-ref-17)
17. A registered account with login details is required to access the portal. [↑](#footnote-ref-18)
18. Methicillin-resistant *Staphylococcus aureus*, Vancomycin-resistant enterococci and *Clostridium difficile* infection [↑](#footnote-ref-19)
19. Royal District Nursing Service [↑](#footnote-ref-20)
20. Aboriginal-community controlled organisation [↑](#footnote-ref-21)
21. Access to the HealthCollect portal can be requested via [HealthCollect](https://www.health.vic.gov.au/data-reporting/healthcollect) <https://www.health.vic.gov.au/data-reporting/healthcollect>. A user guide to assist those reporting training and development activity via HealthCollect is available from within the application. [↑](#footnote-ref-22)
22. 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-23)
23. 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 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-24)
24. Slight variation in definition because results are attributed to the client’s home area mental health service, not the separating area mental health service as for adults and older people. [↑](#footnote-ref-25)
25. Assisted reproductive treatment [↑](#footnote-ref-26)
26. Transport Accident Commission [↑](#footnote-ref-27)