Policy and funding guidelines 2020–21

Policy guide

The Policy guide sets out the operational and service delivery policy changes relevant to, and obligations and standards required of, government-funded healthcare organisations in delivering high-quality, safe care to Victorians.

VICTORIA State Government | Health and Human Services

The *Policy and funding guidelines 2020–21* (the guidelines) represent the system-wide terms and conditions for those government-funded healthcare organisations (funded organisations) primarily funded pursuant to a Statement of Priorities.

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

Hospital circulars also provide updates on changes that affect funded organisations. These are available at Hospital circulars <https://www2.health.vic.gov.au/about/news-and-events/hospitalcirculars>.

Funded organisations should always refer to the guidelines' website 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 and Human Services (the department) or the Secretary to 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>.

For those entities funded by a service agreement, they can search for activity descriptions by visiting Health and human service activity search <https://providers.dhhs.vic.gov.au/human-services-activity-search>.

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Where the term 'Aboriginal' is used it refers to both Aboriginal and Torres Strait Islander people.

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Contents

Overview of the Policy and funding guidelines 2020–21

The *Policy and funding guidelines 2020–21* (the guidelines) represent the system-wide terms and conditions for government-funded healthcare organisations (funded organisations), which includes health services and hospitals, and other organisations such as Ambulance Victoria, primarily funded pursuant to a Statement of Priorities (SOP).

The guidelines:

- reflect the Department of Health and Human Services' (the department) role 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 and
- consist of the following two separate, although interconnected, publications.

Policy guide

The Policy guide articulates 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 funded organisations are expected to adhere to.

Part 1: Operational and service delivery policy

Not intended to be a complete, holistic guide to operational and service delivery policy in Victoria; Part 1 instead, provides an annual publication identifying and highlighting to health services the novel policy changes for a range of delivered services.

Part 2: Obligations, standards and requirements

Outlines relevant standards and obligations that funded organisations must adhere to, ensuring the delivery of safe, high-quality services and responsible financial management.

Funding rules (separate publication)

The Funding rules iterate the budgetary and funding parameters that funded organisations are expected to work to and within.

Part 1: Budgetary landscape and pricing arrangements

Details the budget highlights and outputs, and funding and pricing arrangements.

Part 2: Funding and activity levels

Provides funding and activity tables detailing the modelled budgets, as well as the 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 specified otherwise.

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, Mildura Base Hospital 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, this refers to the Department of Health and Human Services, unless specified otherwise.

Part 1: Operational and service delivery policy

1 National programs

1.1 Nationally Funded Centres Program

The objective of the Nationally Funded Centres Program is to ensure there is optimal access for all Australians to high-cost but low-volume technologies and procedures. While the program operates nationally, funding for this program is only provided by state and territory governments.

Health services that provide Nationally Funded Centres Program services will be funded based on estimated annual activity and the cost per procedure as determined by the Nationally Funded Centres Program and the Australian Health Ministers' Advisory Council. This figure is then adjusted after the financial year to reflect actual activity.

The health services that host Nationally Funded Centres Program services in Victoria are Alfred Health, The Royal Children's Hospital, Monash Health and St Vincent's Hospital Melbourne.

1.2 Access to CAR T-cell therapy and other highly specialised therapies

CAR T-cell therapy is a new form of immunotherapy treatment for those with certain types of cancers that are not responding to usual cancer care, specifically for relapsing/remitting:

(i) acute lymphoblastic leukaemia in children and young adults up to the age of 25 years and

(ii) diffuse large B-cell lymphoma in adults.

Currently, CAR T-cell therapy is only approved in Australia for acute lymphoblastic leukemia. Current information on CAR T-cell therapy is available from CAR T-Cell Cancer Therapy to Save Lives <https://www.premier.vic.gov.au/car-t-cell-cancer-therapy-to-save-lives>

To ensure the safe and high-quality provision of high-cost, highly specialised therapies that are rolled out across Victoria, the department will determine provider sites for high-cost treatments such as CAR T-cell therapy and for specified clinical indications. Provision of CAR T-cell therapy is limited to sites meeting specific accreditation and capability requirements in Victoria.

2 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 not be indexed this year and will remain at 2019–20 prices. A single 12-month membership will remain at $48.35 for 2020–21, with a family 12-month membership staying at $96.10.

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.

2.1 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 fees webpage <https://www2.health.vic.gov.au/hospitals-and-health-services/patient-care/ambulance-and-nept/ambulance-fees>.

Several additional services provided through Ambulance Victoria will be funded directly or are included as 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 Ambulance Victoria or from 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.

3 Acute inpatient services

3.1 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 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, clean facilities), the required clinical support services (for example, allied health, pharmacists and medicines, blood management and blood products, pathology) and other support services (for example, infection prevention, language services, clinical trial support, culturally safe environments for Aboriginal and Torres Strait Islander people)
- providing prosthetics, devices, medicines and wound care consumables prescribed during the 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 via telehealth, with the required cultural and linguistic support
- ensuring discharge planning and service coordination with other health service programs (for example, rehabilitation, the Health Independence Program) 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 that may reduce demand for admitted services
- 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 patients who are ineligible for Medicare and
- 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 and
  - support home-delivered admitted care.

4 Acute specialist services

4.1 Perinatal autopsy service

The Victorian Perinatal Autopsy Service is a specialist perinatal pathology service available for Victorian families that 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 the three level 6 maternity services (and 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 to provide expert advice on maternal and perinatal outcomes.

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

4.2 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 for health services to employ clinical staff dedicated to organ and tissue donation. Medical and nursing organ and tissue donation specialists are based in several metropolitan and regional health services. The Australian Organ and Tissue Donation Authority also provides additional support funding for health services to cover the extra costs associated with organ donation.

Read more about organ and tissue donation <https://www2.health.vic.gov.au/hospitals-and-health-services/patient-care/speciality-diagnostics-therapeutics/organ-tissue-donation>.

4.3 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 63-37 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 2020–21. 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 2020–21 will be more than $120 million.

Access to blood and blood products will be guided by the *Blood and blood products charter*, which continues to be implemented with health providers nationally in 2020–21. 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>.

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 a lack of sufficient evidence of efficacy as demonstrated by the literature or specialist clinical consensus.

More information about intravenous immunoglobulin is available from Criteria for Immunoglobulin Use in Australia <https://www.blood.gov.au/igcriteria-version3>.

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 page <https://www2.health.vic.gov.au/hospitals-and-health-services/patient-care/speciality-diagnostics-therapeutics/blood-matters/scig-implementation-program>.

Normal immunoglobulin is subject to national governance arrangements. More information about normal immunoglobulin is available from Access to Normal Human Immunoglobulin (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://www2.health.vic.gov.au/hospitals-and-health-services/patient-care/speciality-diagnostics-therapeutics/national-blood-authority>.

4.4 Genetics outpatient program

Public genetic outpatient services in Victoria provide a range of clinical consultations and laboratory testing. Services are provided in outpatient settings with hospital ward consultations provided as needed. This program does not fund genetic or genomic tests for admitted patients. As genetics and genomics become more integrated with routine health care in both the acute and outpatient settings, funding and policy models will be reviewed for both inpatient (WIES) and outpatient settings (tier 2 class 20.08).

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:

- Parkville – the Victorian Clinical Genetics Services, The Royal Children's Hospital, The Royal Melbourne Hospital, The Royal Women's Hospital and the Peter MacCallum Cancer Centre; an Ocular Genetics Clinic based at the Royal Victorian Eye and Ear Hospital also operates through a partnership with The Royal Melbourne Hospital
- Clayton – Monash Medical Centre and
- Heidelberg – the Austin Hospital and the Mercy Hospital for Women.

These hubs also provide periodic clinical outreach clinics to other metropolitan, regional and rural 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 2017–18, the Victorian Government allocated an additional $8.3 million over four years for genomic sequencing for children and adults with rare diseases and undiagnosed conditions. This budget commitment facilitates access to a potential clinical diagnosis, therefore avoiding the costly and lengthy diagnostic odyssey that these patients currently undergo. This funding supports access to genomic sequencing not funded under Medicare. The clinical care is provided through the hubs, including in regional and rural Victoria through outreach clinics

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 outpatients clinic activity on the AIMS S10 form and report costs using the VCDC. From 2020–21, genetics clinics are also required to be reported to the VINAH.

Read more about genetic services in Victoria <https://www2.health.vic.gov.au/hospitals-and-health-services/patient-care/speciality-diagnostics-therapeutics/genetic-services>.

4.5 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.

4.5.1 Pharmaceutical reform

Pharmaceutical reforms are designed to make it safer, easier and more convenient for patients to receive adequate medication, and to bring public health services onto 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.

Read more about the pharmaceutical reforms <https://www2.health.vic.gov.au/hospitals-and-health-services/patient-care/speciality-diagnostics-therapeutics/pharmaceuticals/public-hospital-pbs>.

4.5.2 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 and
- 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.

Read more about the Highly Specialised Drugs Program <https://www2.health.vic.gov.au/hospitals-and-health-services/patient-care/speciality-diagnostics-therapeutics/pharmaceuticals/highly-specialised-drug-program>.

4.5.3 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>.

5 Mental health services

5.1 Mental health services - programs

Clinical mental health services in Victoria are delivered to three specific age groups:

- children and adolescents (0–18 years)
- adults (16–64 years)
- aged persons (65 years or older).

Youth-specific mental health services have also been developed for adolescents and young people (16–25 years) and are delivered largely through adult mental health services.

5.1.1 Clinical mental health services for children and adolescents (0–18 years)

Child and adolescent mental health services (CAMHS) provide specialist mental health treatment and care to children and adolescents. These services assess and treat children and adolescents experiencing moderate to severe mental health problems and disorders and assist those with less severe problems with advice and information about where and how to access help. Vulnerable children and young people, particularly those involved with statutory services such as child protection, are prioritised.

There are 13 health services that provide CAMHS services across the system. The CAMHS acute inpatient service units are located in general hospitals and mostly admit young people aged 13–18 years of age:

- The Royal Children's Hospital admits young people aged 13–17 years of age from its local catchment
- Orygen Youth Health admits young people aged 18–25 years of age from its local catchment.

Austin Health's child mental health inpatient unit is a specialist statewide service for children aged under 13 years. Monash Children's Hospital's specialist statewide inpatient service is for children up to 12 years of age.

Each Area Mental Health Service has referral relationships with CAMHS inpatient services across the state.

5.1.2 Young people's mental health services (16–25 years)

- Youth program – early psychosis services are for young people who are experiencing a first episode of psychosis. These services are provided statewide as a subspecialty program in some specialist adult mental health services (Melbourne Health).
- Orygen Youth Health (Melbourne Health) provides a specialised youth mental health clinical service for young people 15–25 years old, with a focus on early intervention and youth-specific approaches.
- Youth prevention and recovery centres are for young people experiencing significant mental health problems who are either leaving an acute hospital inpatient admission or who would benefit from 24-hour support to avoid a hospital admission. Youth prevention and recovery centres are located in Dandenong, Bendigo and Frankston are intended to support regional accesses.

5.1.3 Adult mental health services (16–64 years)

Seventeen health services constitute the Victorian adult clinical mental health system. Adult specialist mental health services are provided for people experiencing severe mental illness (for example, schizophrenia). People may also present in situational crisis that may lead to self-harm or inappropriate behaviour towards others.

Clinical adult area mental health services generally include the following:

Inpatient treatment services

- Acute inpatient services provide a range of therapeutic interventions and programs to patients and their families during an acute episode to learn more about the impact of the illness, explore ways to better manage the illness, improve coping strategies and move towards recovery.
  - All the age-based mental health services provide acute inpatient services for people who cannot be assessed and treated safely and effectively in the community.
- Consultation and liaison psychiatry deliver mental health services to people who have a primary medical condition admitted to general hospital settings that may be associated with a mental illness. The Victorian Government funds 14 health services to provide consultation and liaison psychiatry.
- Psychiatric assessment and planning units deliver fast access to short-term specialist psychiatric assessment and treatment for people experiencing an acute episode of mental illness.

Residential treatment services

- Secure extended care units provide medium- to long-term inpatient treatment and rehabilitation for people who have unremitting and severe symptoms of mental illness or disorder. These units are located in hospital settings. Because these units are not in all catchments, cross-area access arrangements have been established.
- Community care units provide medium- to long-term clinical care and rehabilitation services in a homelike environment. They support the recovery and rehabilitation of people seriously affected by mental illness to develop or relearn skills in self-care, communication and social skills in a community-based residential facility with the aim of returning to the community.
- Adult prevention and recovery care services are community-based, short-term supported residential services for people experiencing a mental health problem, but who do not need (or no longer require) a hospital admission.

Outpatient treatment services (community-based clinical treatment)

- Acute community intervention services provide urgent advice, referral and treatment to people with a mental illness who are acutely ill or in crisis. These services are provided through telephone triage, mental health care in emergency departments and in community mental health.
- Continuing care services provide non-urgent assessments, treatment, case management, support and continuing care services in the community. This is the largest component of adult community-based services.

5.1.4 Aged persons mental health services (65 years or older)

Fourteen health services constitute the Victorian aged clinical mental health system. These are specialist mental health services for people with longstanding mental illness or for those who have developed a functional illness such as depression, a mood disorder, anxiety or schizophrenia later in life. Services include inpatient units located in general hospitals or with other aged care facilities, and specialist residential care.

5.1.5 Statewide, area-based and specialist mental health services

There are a range of specialist mental health services that are specifically targeted to Victorians with severe and complex illnesses that are offered in a smaller number of health services and support the needs of a broader area catchment or the state.

- Eating disorder services are delivered by a number of health services, with specialists beds at Melbourne Health, Austin Health and Monash Health.
- A personality disorder service (Spectrum, based at Eastern Health) works with local area-based clinical services to provide treatment for those aged 16–64 years with a personality disorder, focusing on people who are at risk from serious self-harm or suicide and who have complex needs. Spectrum receives referrals from area-based clinical services and primary health providers such as general practitioners and private psychiatrists.
- Parent and infant mental health services (previously Mother and Baby Units) provide support for parents experiencing severe mental illness in the antenatal or postnatal period. Six health services have specialist parent and infant units that provide a residential setting for psychiatric treatment, assessment and support for parents experiencing severe mental illness and their infants aged up to 12 months. The units are located at hospitals from the following funded entities: Austin Health, Bendigo Health, Ballarat Health, Latrobe Regional Hospital, Mercy Health and Monash Health.
- The brain disorder service, located at Austin Health, is for people with acquired brain injury or neurogenerative conditions with associated psychiatric conditions. Services include inpatient, residential and community programs, outreach services and secondary consultation.
- A statewide specialist neuropsychiatry service specialises in mental illnesses associated with disorders of the nervous system. The service is located at The Royal Melbourne Hospital (Melbourne Health).
- The Victorian Dual Disability Service is located at St Vincent's Hospital Melbourne and works with specialist mental health services across Victoria to assess, treat and support people with a dual disability. A person with a dual disability has an intellectual disability or autism spectrum disorder, as well as a mental illness.
- Dual diagnosis services aim to improve treatment outcomes for individuals who have co-existing mental health and substance use issues. Services include education and training for Area Mental Health Services, drug and alcohol and MHCSS staff, support to organisations to develop dual diagnosis capabilities, and clinical consultations in collaboration with primary case managers. The service is auspiced by Melbourne Health, St Vincent's Hospital Melbourne, Eastern Health and Monash Health.
- Victorian Transcultural Mental Health supports area-based clinical services and MHCSS to work with consumers, carers and communities from diverse cultural backgrounds. It is a nonclinical unit administered by St Vincent's Hospital Melbourne and provides education and training, clinician support through an external enquiries service, consultation and service development and research.
- Torture and trauma counselling is provided by the Victorian Foundation for Survivors of Torture ('Foundation House') to Victorian adults and children who have experienced torture, persecution or war-related trauma before arriving in Australia. Foundation House receives direct referrals to its services and also works to improve the skills and competency of healthcare services providing other treatment and support to refugees.

5.1.6 Other key programs

There are a range of other programs provided by health services:

- In the Hospital Outreach Post-Suicidal Engagement (HOPE) program, mental health professionals provide one-on-one support to people who have attempted suicide and make sure they get the support they need to recover.
  - Current sites are located at Albury Wodonga Health, St Vincent's Hospital Melbourne, Maroondah Health, Barwon Health, Peninsula Health, Alfred Health, Latrobe Regional Hospital, Sunshine Hospital, Casey Hospital, Ballarat Health Services including Horsham, Werribee Mercy Health and Bendigo Health Service including Mildura.
  - The Royal Commission into Victoria's Mental Health System released its *Interim report* <https://rcvmhs.vic.gov.au> on 28 November 2019. The report includes recommendations for suicide prevention and follow-up care by:
    - expanding the HOPE program to all area mental health services
    - broadening access to include referrals from community-based mental health teams
    - extending service hours outside standard business hours and
    - developing and evaluating a new child and youth HOPE model of care.
- People presenting at emergency departments with acute mental health and alcohol and other drug issues will be supported with an enhanced mental health and AOD assessment and treatment response across three pathways: non admitted, short stay hub and 28-day assertive outreach, providing them with the right support sooner and easing pressure on emergency departments. Mental health and alcohol and other drug hubs will be located at Monash Medical Centre, St Vincent's Hospital Melbourne, The Royal Melbourne Hospital, University Hospital Geelong, Sunshine Hospital and Frankston Hospital and will progressively come online from 2020–21.

5.1.7 Aboriginal-specific programs

- The Aboriginal Mental Health Traineeship Program provides full-time ongoing employment to Aboriginal people living in Victoria who successfully undergo supervised workplace training and clinical placements over three years while concurrently completing 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.
- Improving mental health outcomes for Aboriginal and Torres Strait Islander People with moderate to severe mental illness (Demonstration Projects) initiative – four consortia demonstration projects are being funded to deliver integrated, culturally safe mental health services that are designed to meet the mental health and social and emotional wellbeing needs of their local Aboriginal communities. The four demonstration sites are at Ballarat and District Aboriginal Co-operative (in partnership with Ballarat Health), Mallee District Aboriginal Services (in partnership with Mildura Base Hospital and Mallee Family Care), Victorian Aboriginal Health Service (in partnership with St Vincent's Health, Austin Health, North Western Mental Health) and Wathaurong Aboriginal Co-operative (in partnership with Barwon Health).
- The Koori Mental Health Liaison Officer program 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 are at 10 Aboriginal community-controlled organisations across rural and metropolitan areas. The initiative aims to increase the 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. 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.
- Five Koori mental health beds at St Vincent's Hospital Melbourne are managed in conjunction with the Victorian Aboriginal Health Service.

5.1.8 Joint Regional Planning for Integrated Regional Mental Health and Suicide Prevention

Commonwealth, state and territory governments have agreed that Public Health Services and Primary Health Networks will develop and publicly release joint mental health and suicide prevention plans by 2020, with comprehensive plans to be released by 2022.

Joint regional mental health and suicide prevention planning is vital to embed integrated mental health and suicide prevention pathways for people with, or at risk of, mental illness or suicide through a whole-of-system approach.

5.1.9 Forensic mental health

Forensicare delivers inpatient and community forensic mental health services across Victoria. 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*. Forensicare provides adult mental health services in Victoria for people involved in the criminal justice system, or who are at high risk of offending.

Services include the:

- Thomas Embling Hospital, a 134-bed secure hospital for people from the criminal justice system who need specialist psychiatric assessment and treatment, and patients from the public mental health system who require specialised management
- Community Forensic Mental Health Service, providing assessment and multidisciplinary treatment to high-risk consumers referred from area mental health services, correctional providers, courts, the Adult Parole Board, Thomas Embling Hospital, prison services, government agencies and private practitioners.

5.2 Mental health acute admitted

Best practice mental health clinical care provides for accessible treatment 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 2020–21, 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 an additional supplementary transition grant.

5.2.1 Acute (child and adolescent, adult, aged and specialist bed availability component)

In 2020–21, acute (child and adolescent, adult, aged and specialist) care provided by health 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 health 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 consolidation work on achieving a single price, a supplementary transition grant, to ensure existing funding is maintained, will continue to be provided.

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.

5.2.2 Transition funding

As funding for admitted mental health care progresses towards a single price, and to ensure budget stability for health services, a transition grant (block funding) has been applied in 2020–21. This transition grant is under review.

5.2.3 Costing patients

It is expected that health services maintain and report mental health acute admitted patient-level costing data to the VCDC.

5.3 Mental health non-admitted

In Victoria, 18 health services, including Mildura Base Hospital and Forensicare, are funded on a service hours basis to provide mental health clinical non-admitted services. Victoria's non-admitted mental health care encompasses clinical (ambulatory) community care and non-admitted bed-based treatment services (prevention and recovery care services, community care units and aged care residential beds). Statewide targets associated with mental health non-admitted care are set out in *Victorian State Budget Paper No. 3*.

5.3.1 Clinical community care

Clinical community (ambulatory) care consists of a range of community-based clinical services, including bed substitution programs provided to people with a mental illness.

5.3.2 Intensive community mental health packages

Mental health services will receive additional funding packages in 2020–21 to provide more community care for their most severe group of adult community-based mental health consumers.

The purpose of the intensive community mental health packages is to provide more hours of treatment, focusing on evidence-based multidisciplinary therapeutic interventions for a cohort of adults with serious mental illness and high needs being treated in the community. The funding targets adult consumers whose diagnosis and wellbeing assessments indicate they are at risk of recurring acute episodes and associated hospital admissions without more intensive therapeutic intervention.

This targeting reflects development work on an activity-based funding model appropriate to mental health that can allocate resources for adult community mental health services based on the severity and complexity of consumers' needs, and the associated volume and intensity of service responses. The funding model will be linked to developments in performance monitoring and clinical guidelines outlining expected levels and types of service responses for consumers of varying levels of need for treatment and care.

An initial care classification for ambulatory mental health consumers, based on a modified version of the Australian Mental Health Care Classification, has been developed. This classification will be used to shadow fund community mental health services according to an activity-based funding model in 2021–22.

5.3.3 Mental health outputs

Targets for the number of service hours to be provided are set per health service. They are calculated on the hours of service provided per clinician and adjusted for historical and projected service levels. The funding rate per service hour has been used in setting ambulatory targets.

5.3.4 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. In metropolitan Melbourne there are nine catchments. The non-metropolitan area is divided into seven catchments. Delivered largely by non-government organisations, MHCSS provide psychosocial rehabilitation support to people aged 16–64 years old 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. All other MHCSS activity is block-funded.

Funding provided to service providers will be indexed consistent with the government's annual determination for community service organisations.

Funding commitment to in-scope MHCSS programs fully transitioned to the 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.

5.3.5 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 living with a severe mental illness and associated psychiatric disability who are either:

- not eligible for the NDIS because they do not have significant, permanent functional impairment(s) associated with their mental health condition, or
- are eligible for the NDIS and are waiting for an access decision and their NDIS plan to begin.

The service model will provide 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 provider/s.

5.3.6 Performance targets

Funding for MHCSS activities is output-based. Statewide targets are set out in *Victorian State Budget Paper No. 3*. targets for MHCSS activities are listed in the Funding and Service Agreement and these represent the minimum deliverables expected for the funding provided. See section 18.7 ‘Mental health services’ for more information.

5.3.7 Costing patients

It is expected that health services maintain and report mental health non-admitted patient-level costing data to the VCDC.

6 Alcohol and drug services

6.1 Alcohol and drug services

The Victorian alcohol and drug services sector currently operates under a mixed funding model:

- Residential services and most adult community-based services are funded via drug treatment activity units
- Aboriginal and youth-specific services and some out-of-scope community-based services are funded based on episodes of care and
- Other drug treatment activities such as research, drug prevention and control, local initiatives and pharmacotherapy programs 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.

7 Ageing, aged and home care services

7.1 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 intends to implement a new streamlined assessment model to assess eligibility for all aged care services. This will replace assessment services currently delivered by ACAS. This was anticipated to commence in April 2021; however, this will not occur. The Commonwealth has agreed to undertake more work with state and territories. Existing arrangements will continue for 2020–21.

7.2 Regional assessment services

Regional assessment services conduct home support assessments for older people who require entry-level home support and assistance to keep living independently at home and in their community. My Aged Care is the central point for referrals for a home support assessment.

The Commonwealth intends to implement a new streamlined assessment model to assess eligibility for all aged care services. This will replace assessment services currently delivered by regional assessment services. This was anticipated to commence in April 2021; however, this will not occur. The Commonwealth has agreed to undertake further work with state and territories. Existing arrangements will continue for 2020–21.

7.3 Home and Community Care Program for Younger People

Targeted to people aged under 65 (and Aboriginal people aged under 50) who need assistance with daily activities due to physical or psychosocial functional impairment related to disability (for which they are not eligible for the NDIS), chronic illness and short-term health needs and their carers. The Home and Community Care Program for Younger People (HACC-PYP) is funded by the Victorian Government to provide a range of services in the home or community. The goal of the program is to allow participants to continue living in their homes and communities.

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 HACC minimum dataset on a quarterly basis. Recurrent funds may be recalled from service providers. Find detailed information about *HACC-PYP reporting and data guidelines* <https://www2.health.vic.gov.au/ageing-and-aged-care/home-and-community-care/reporting-and-data>.

Read the *fees policy for HACC-PYP services* <https://www2.health.vic.gov.au/about/publications/policiesandguidelines/hacc-schedule-of-fees>.

7.4 Victorian Aids and Equipment Program

The Victorian Aids and Equipment Program (VA&EP) assists eligible clients to enhance their independence and participate in the community, and supports families and carers to maintain care arrangements through 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 a profound/severe deafness
- 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.

7.5 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.

7.5.1 Supported residential services and accommodation support

A range of community service organisations receive funding for initiatives that aim to improve the viability of pension-level supported residential services and the quality of life of the residents using the services (through the Supporting Accommodation for Vulnerable Victorians Initiative or ‘SAVVI’). The department will continue supporting service organisations through a partnerships management model and to implement the Pension Level Projects initiative in other pension-level SRS.

7.5.2 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.

7.5.3 Support for Carers Program

The Support for Carers Program provides services for people in care relationships where other services are not available or where clients are not eligible for other services. Services may include respite, information, advice, counselling and subsidised goods and equipment. Eligibility criteria were expanded in January 2019 to include carers of all ages.

7.5.4 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 or Torres Strait Islander are eligible for the Victorian Aboriginal Spectacles Subsidy Scheme, which is an additional subsidy to the Victorian Eyecare Service. It aims to improve access to visual aids and eyecare to Aboriginal Victorians by further reducing the client contribution to $10. Key performance indicators and outcome measures will be developed for the Victorian Eyecare Service in 2020–21.

7.5.5 Dementia services

Delivered as part of the Support for Carers Program, carers of people with dementia (including young people with dementia) can access counselling, education and training, as well as respite in public sector residential aged care.

7.5.6 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 2020–21 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.

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 to PSRACS in the following situations:

- a PSRACS provider deciding 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 seeking to convert residential aged care places to other care types or programs (such as transition care)
- 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 Performance and Improvement Rural Health branch departmental representative in the first instance (the representative will liaise with the program area), and metropolitan Melbourne services should notify the Residential Aged Care 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, 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 additional costs can be covered from other income.

If services obtain additional residential aged care places though the Commonwealth’s Aged Care Approvals Round 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.

7.6 Seniors programs and participation

Seniors community programs projects will be funded through grant applications. Agencies providing elder abuse prevention, response and information will be funded through Funding and Service Agreements.

7.7 Public health services response to elder abuse

Over 2020–21 a statewide elder abuse identification and response policy will be developed for public health services. Public health services will be invited to participate in a consultation for the development of the policy.

8 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, small rural health services, including multipurpose services, and bush nursing centres.

8.1 Rural and regional health partnerships

The *Statewide design, service and infrastructure plan for Victoria's health system 2017–2037* emphasises the importance of regional and local partnerships to Victoria's future health system. It outlines an ambitious vision for a more connected and networked service system supported by close and effective partnerships between Victoria's regional and rural health services. These partnerships would:

- improve the safety and quality of care to patients
- increase the capacity and accessibility of care and regional self-sufficiency
- strengthen the sustainability of rural services and their workforce.

The plan articulates 13 Local Area Health Partnerships that make up six larger Regional Partnership Areas.

The *Rural and regional health partnership guidelines 2020* were released in December 2019, requiring partnership members to sign a memorandum of understanding that emphasises shared decision-making and outlines the scope of works for health partnerships across three key activity areas:

- clinical governance support
- workforce planning, recruitment and development
- corporate effectiveness.

Regional and Local Health Partnerships will create a platform for long-term and systemic collaboration on service planning, delivery and coordination by health services. The department is actively working with both Regional and Local Area Health Partnerships to embed and expand their functions in line with the guideline expectations.

8.2 Small rural health services

There are 38 small rural health services (SRHS), including seven multipurpose services in Victoria. The funding model for SRHS is intended to support eight key principles:

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

SRHS can use funds provided through the Small Rural Services – Acute Health and Small Rural Services – Primary Care outputs flexibly to deliver 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.

Funding arrangements for PSRACS are outlined in section 7.5.6 'Public sector residential aged care'.

Multipurpose services can flexibly utilise funding as per small rural health services; however, under the tripartite agreement with the Commonwealth Department of Health, they are also able to flexibly utilise aged care funding to deliver both residential and home-based aged care services.

8.3 Bush nursing centres

Bush nursing centres are funded under the Small Rural Health funding model and can flexibly utilise their funding to deliver a range of community and home-based services to meet the needs of rural isolated communities in consultation with the department.

During 2020–21, 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 and administration, with oversight mechanisms that enable safety and quality. This includes where accredited bush nursing centres choose to implement the Rural Isolated Practice endorsed nursing model in their community.

8.4 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.

The Victorian Patient Transport Assistance Scheme guidelines <https://www2.health.vic.gov.au/hospitals-and-health-services/rural-health/vptas-how-to-apply> includes an online claim form to support electronic banking for travel and accommodation subsidy payments. This will mean Victorians who are eligible to receive this financial assistance will receive the subsidy faster than if being paid by cheque.

The current eligibility criteria and subsidy rates include:

- private vehicle costs reimbursement at a rate of 21 cents per kilometre
- a maximum of $49.50 per night including GST for a patient and an approved escort staying in accommodation
- entitlement to two escorts if the travelling patient is a newborn infant (up to six months of age)
- entitlement for up to two escorts (parents, guardians or family members) when the patient requires treatment or admission to a hospital over two or more consecutive days for patients over six months of age and under the age of 18 years
- being available to living organ donors from other Australian states or territories who travel to Victoria to participate in a transplant procedure where the recipient is a Victorian resident. This includes travel for donor screening, specialist assessment and transplant procedures.

9 Primary, community, public and dental health

9.1 Primary health services

9.1.1 Community health program

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

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 that are socially or economically disadvantaged, experience poorer health outcomes and have complex care needs, or have limited access to appropriate healthcare services.

The program's priority population groups are:

- Aboriginal and Torres Strait Islander people
- people with an intellectual disability
- refugees and people seeking asylum
- homeless people and people at risk of homelessness
- people with a serious mental illness and
- children in out-of-home care.

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

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

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

Community health services are also funded to also 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 the following programs:

- The Refugee Health Program – this 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 – this program provides pregnancy, resilience and antenatal material support. It aims to improve the health outcomes for pregnant vulnerable women and their babies. The Victorian Budget 2018–19 invested $1.2 million (over two years) to continue the program through community health services in rural and regional locations
- Early Intervention in Chronic Disease – this 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 Nurse Program in Sexual Assault Multidisciplinary Centres – this program provides health needs identification, holistic direct care planning and support and referral to appropriate services to children and adults who have experienced sexual assault and their non-offending family members. More recently, nurses now also support clients of family violence referrals

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 from Community health fees policy <https://www2.health.vic.gov.au/primary-and-community-health/community-health/community-health-program/community-health-fees-policy>.

9.1.2 Supercare Pharmacies

The Victorian Government committed $28.7 million over four years from the 2015–16 State budget to introduce 20 Supercare Pharmacies by 2018. An additional $25.7 million was provided in 2016–17 to further support the rollout of the Supercare Pharmacies initiative.

Supercare Pharmacies are open 24 hours a day, seven days a week, with a nurse on site from 6.00pm to 10.00pm 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.

Five Supercare Pharmacies began operating in June 2016, with a further seven commencing in June 2017. The final eight Supercare Pharmacies opened in June 2018. This brings the number of Supercare Pharmacies across Victoria to 20, in line with the government's commitment. Six Supercare Pharmacies are located in regional areas.

Pharmacies and nursing services in the initiative are engaged through fixed-price contracts with the department. Out-of-hours service delivery must be in line with key performance indicators set out in these contracts. These performance indicators include access, and safety and quality measures, and are reviewed and monitored by the department on an ongoing basis.

Activities to further embed the initiative in the primary health sector have included significant communication work and marketing activities to increase awareness of the initiative. In late 2019, the department arranged for experts to evaluate the initiative. The evaluation recommendations will inform the future policy direction of Supercare Pharmacies after 30 June 2020 and this work is in progress.

9.1.3 Health Condition Support Grants Program

Peer support helps decrease the overall burden of disease by encouraging better health outcomes for 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 Health Conditions Support Grants <https://www2.health.vic.gov.au/primary-and-community-health/primary-care/health-conditions-support-grants>.

9.1.4 Primary Care Partnerships

Twenty-eight Primary Care Partnerships operate across Victoria. The partnerships are established networks of local health and human service organisations primarily funded by the department. The partnerships work together to improve the health and wellbeing of their local communities.

The focus for Primary Care Partnerships is to align priorities to the department's strategic focus on place-based efforts, prevention and population health, family violence, the integration of health and social care and strategic partnership development or chronic disease management, where this work is already occurring or has been identified as a local need.

Read more about Primary Care Partnerships <https://www2.health.vic.gov.au/primary-and-community-health/primary-care>.

9.2 Dental health services

The Dental Health Program funding model is activity-based, using the Australian Dental Association service item codes, rather than courses of care. Performance is measured in terms of dental weighted activity units, calculated using weighted Australian Dental Association item codes. Funding is aligned to dental weighted activity units to ensure that state activity targets are met.

9.2.1 Participation in Commonwealth initiatives

The Child Dental Benefits Schedule is a means-tested benefit scheme (Family Tax Benefit A) for children aged between two and 17 years, covering preventative and basic dental treatment. Eligible children have access to a benefit cap of $1,000 over a two-calendar-year period. A three-year extension to public sector access to the Child Dental Benefits Schedule until 31 December 2022 was announced in the 2019–20 Commonwealth budget.

9.2.2 Dental Health Program fees policy

Fees for public dental services apply to:

- people aged 18 years or older who are health care or pensioner concession card holders or dependants of concession card holders
- children aged from birth to 12 years who are not health care 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://www2.health.vic.gov.au/primary-and-community-health/dental-health>.

9.3 Early Parenting Centres

Early Parenting Centres (EPCs) 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 supporting families that includes maternal and child health services, supported playgroups and community-based parenting programs. The role of EPCs recognise the importance of the health and wellbeing of the mother, father and the whole family on the health, wellbeing and development of the child.

10 Public health

10.1 Health promotion 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 that 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. Ten health and wellbeing priorities for Victoria are identified:

- 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.

Community health services and some small rural health services are funded to deliver place-based primary prevention (under the activity names 'Community health – health promotion' and 'Small rural – primary health flexible services'). It is expected that their local prevention effort is coordinated with councils, the department and other local partners to establish a common approach to preparing local health and wellbeing plans, and 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 in *Advice for public health and wellbeing planning in Victoria: planning cycle 2017–2021* <https://www2.health.vic.gov.au/about/publications/policiesandguidelines/public-health-wellbeing-planning-advice-2017-2021>.

10.1.1 Chronic disease prevention

The Victorian Government funds a range of strategies to reduce the risk factors for chronic disease.

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. The 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>.

Reducing risk factors for chronic disease through a place-based approach to prevention also includes increasing access to healthy food and drinks in places where people spend their time. 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. The 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 integrating the Healthy Choices policy guidelines into their retail food service and vending contracts.

The Healthy Choices policy guidelines <https://www2.health.vic.gov.au/public-health/preventive-health/nutrition/healthy-choices-for-retail-outlets-vending-machines-catering> have 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.

Funded by the Victorian Government and delivered by Nutrition Australia Vic Division, the Healthy Eating Advisory Service provides free support for implementing the Healthy Choices policy guidelines. It supports organisations to develop the skills and knowledge needed to remove sugary drinks and increase healthy food choices in their retail food outlets, vending and catering. The Healthy Eating Advisory Service is available to health services, as well as early childhood services, schools, workplaces, sport and recreation facilities, parks and universities. It provides: email and phone implementation advice from qualified dietitians; comprehensive online resources, recipes, tips, factsheets and case studies; FoodChecker – an online food and drink assessment tool; and online and face-to-face training, including a mentorship program. More information is available from the Healthy Eating Advisory Service website <https://heas.health.vic.gov.au>.

10.1.2 Life! Helping you prevent diabetes, heart disease and stroke program

Funding is provided to deliver the Life! program and associated activities aimed at people with a high risk of diabetes and cardiovascular disease.

The program includes group courses and telephone coaching aimed at addressing the risk factors for diabetes and cardiovascular disease. Associated activities include evaluation and continuous quality improvement of the program as part of the prevention system in Victoria.

Results for participants in the Life! program are collected quarterly. Funding for the Life! program is recalled per participant target not met.

10.1.3 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 Commonwealth 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.

Victorian public hospitals providing colonoscopy are allocated a separate NBCSP WIES target. This funding is provided in addition to the funding provided for other activity and is paid according to actual activity. The WIES target is aligned with prior year activity and growth resulting from the NBCSP. A prior year adjustment process will reconcile NBCSP activity with targets. Variation in activity against the NBSCP WIES target will be recalled or paid at the full WIES rate. It is not part of public and private WIES for determining recall and throughput.

To be admitted for a colonoscopy under the NBCSP, with or without gastroscopy, a patient must have been referred for the procedure due to a positive faecal occult blood test as a result of participating in the NBCSP. Other patients admitted for a procedure to investigate a positive faecal occult blood test, for surveillance or for follow-up colonoscopies, are not eligible for admission under the NBCSP funding arrangement. Patients admitted for an NBCSP colonoscopy may elect to be public or private according to the usual election procedure. WIES for the episode will be calculated accordingly.

NBCSP participants must be coded under funding arrangement Code 8 and will be funded under the WIES funding model. It is expected that most episodes will be grouped to Australian Refined Diagnosis Related Groups G48C colonoscopy, same-day or G46C complex endoscopy, same-day. A small number of episodes may group to other diagnosis-related groups where the patient has required an overnight stay or other circumstances have arisen.

NBCSP activity will be paid against the health service's NBCSP WIES target based on actual throughput. Reconciliation for under, or over, activity will be adjusted at the end of 2020–21.

The department may ask hospitals to confirm episodes with unusual diagnosis-related groups to ensure correct coding or that the patient was a participant in the NBCSP.

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

- provide services in accordance with the *Victorian colonoscopy categorisation guidelines 2017* <https://www2.health.vic.gov.au/about/publications/policiesandguidelines/colonoscopy-categorisation-guidelines>, which indicates a timeframe of 30 days for colonoscopy following a positive screening test
- report all NBCSP colonoscopies to the VAED under funding arrangement Code 8
- report NBCSP colonoscopy and histopathology data to the National Cancer Screening Register. The register 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.

Read more about the National Bowel Cancer Screening Program <http://www.cancerscreening.gov.au/internet/screening/publishing.nsf/Content/bowel-screening-1>.

Colposcopy arising from a positive National Cervical Screening Program test

Several health services deliver public colposcopy services for women who have had a positive test in the National Cervical Screening Program within acute specialist clinics.

Some health services are experiencing an anticipated spike in demand as a result of changes to the National Cervical Screening Program. In November 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 self-collection test.

These changes and referral pathways are documented in *National Cervical Screening Program: guidelines for the management of screen-detected abnormalities, screening in specific populations and investigation of abnormal vaginal bleeding 2016* <https://wiki.cancer.org.au/australia/Guidelines:Cervical_cancer/Screening>.

Some health services are implementing strategies to meet this increased demand, including scheduling additional clinics, service re-design or implementing nurse-led triaging processes. The department continues to support health services to provide quality and timely public colposcopy services for Victorian women.

Read more about the National Cervical Screening Program <http://www.cancerscreening.gov.au/internet/screening/publishing.nsf/Content/cervical-screening-1>.

10.1.4 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 HIV, 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 program guidelines for funded agencies* will shortly be published, which will outline reporting requirements against funded activity with all agencies funded for BBV/STI activities required to acquit funding using the guidelines. Standard contract management processes apply, including performance output monitoring, regular reporting and face-to-face meetings.

For more information read the *Victorian HIV strategy 2017–2020* <https://www2.health.vic.gov.au/public-health/preventive-health/sexual-health>, *Hepatitis B strategy 2016–2020* <https://www2.health.vic.gov.au/about/publications/policiesandguidelines/victorian-hepatitis-b-strategy-2016-2020> and *Hepatitis C strategy 2016–2020* <https://www2.health.vic.gov.au/about/publications/policiesandguidelines/victorian-hepatitis-c-strategy-2016-2020>.

10.1.5 Tobacco control

To reduce the burden of smoking on the community, the Victorian Government funds non-government organisations, such as Quit Victoria, the Victorian Aboriginal Community Controlled Health Organisation 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.

10.1.6 Victorian Tuberculosis Program

The department funds Melbourne Health to provide the Victorian Tuberculosis Program. The program is 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.

10.2 Health protection

The Victorian Chief Health Officer leads the Health Protection branch, is the lead public health adviser to the Minister for Health and the Victorian Government and is the state's spokesperson on public health issues. The Chief Health Officer also leads the department's response to climate change, including chairing the Climate Change Reference Group and having overarching responsibility for delivering the department's climate change adaptation plan and emissions reduction plan under the *Climate Change Act 2017.* 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 accessible at Chief Health Officer <https://www2.health.vic.gov.au/about/key-staff/chief-health-officer>.

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

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.

11 Health workforce training and development

11.1 Training and development funding

Training and development funding is provided to public health services to recognise the additional costs 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 2020–21, the department will be confirming training and development funding for ongoing recurrent programs earlier in the fiscal 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.

11.1.1 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 and health information management).

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 pharmacy, medical imaging (radiography), nuclear medicine, radiation therapy, medical biophysics, medical laboratory science and employment model midwifery.

In 2020–21, the department will continue to provide additional funding on a time-limited basis to increase clinical placements to support the Victorian Government's commitment to expanding enrolled nurse training through the offer of free training with Victorian Technical and Further Education (TAFE) providers. Health services will be advised of the conditions of funding to provide placements in 2021 through an application process.

11.1.2 Transition to practice – (graduate) positions

The aim of this stream of funding is to ensure new graduates make a positive transition into the public sector health workforce and are encouraged to stay working within the sector.

The transition-to-practice funding stream includes five program areas:

- allied health graduates
- allied health interns
- nurse and midwifery graduates
- medical graduates (year 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 the first two years for approved medical graduate positions. For all program areas, subsidies are approved and allocated based on each health service's activity as a proportion of total reported transition to practice (graduate) positions.

Allied health graduates

Allied health graduate disciplines of audiology, psychology, exercise physiology, dietetics and nutrition, occupational therapy, optometry, orthoptics, orthotics and prosthetics, physiotherapy, podiatry, social work and speech pathology and are eligible for transition-to-practice training and development funding.

Allied health intern program

Training and development subsidies are available to health services employing medical biophysics, medical laboratory science, medical radiations (nuclear medicine, radiography and radiation therapy) and pharmacy interns completing industry-based learning for a set number of positions in each respective discipline group.

Medical prevocational training

In 2020, the department is piloting two-year (PGY1 and PGY2) medical prevocational training contracts at the following regional health services:

- Albury Wodonga Health
- Ballarat Health Services
- Barwon Health
- Bendigo Healthcare Group
- Goulburn Valley Health
- Latrobe Regional Hospital.

To facilitate the delivery of this pilot, the department has allocated additional PGY2 training and development funding to some of these health services to enable them to align their prevocational training opportunities so that they are able to offer two-year prevocational training contracts to medical interns commencing in 2020.

Regional and rural 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 programs

In 2020–21, the Enrolled Nursing 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 eligible for funding are expected to deliver workplace-based programs that will be 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 and will complement the government's free TAFE initiative by providing employment pathways for enrolled nurses completing a Diploma of Nursing.

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

In 2020–21, transition to practice (graduate) nursing and midwifery funding will be eligible/able to be used to fund registered undergraduate students of nursing in health services, above ratios.

Funding may be used beyond graduate nurse and midwife programs to support the registered undergraduate students of nursing workforce model; however, funding will *not exceed* the funding that is allocated specific to nursing and midwifery graduate numbers.

11.1.3 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. The program is being reviewed in 2019–20 to ensure it is the best model to improve the supply and distribution of Australian trained medical specialists.

Funding allocation for the program is determined through an expression of interest process that occurs once every two years.

Victorian Basic Paediatric Training Consortium

The Victorian Basic Paediatric Training Consortium has been established following stakeholder consultation, replacing the former Victorian Paediatric Training Program. All hospitals that are accredited for basic paediatric training in Victoria are members of the consortium. The aim of the consortium is to support equitable access to specialist paediatric 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 and multi-year contracts.

The consortium will offer rural training streams for accredited basic paediatric training in Victoria that enables trainees to undertake most of their training in regional and rural locations, and thereby encourage improved recruitment and retention of paediatricians in regional and rural 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 comprising all Victorian hospitals with accredited physician training positions to support distribution and management of basic physician trainees, address workforce shortages, and improve the quality of education and training in rural Victoria. The program is being reviewed in 2019–20 to ensure it is the best model to support the required development of physicians.

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 subsidies for postgraduate studies that lead to an award classification of graduate certificate, graduate diploma or master-level studies.

In 2020–21, 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*.

11.1.4 Other targeted workforce training and development programs

Allied Health Leadership Program

The Allied Health Leadership Program is underpinned by the *Allied health leadership development framework*, which identifies stages of scaffolded leadership development across the career continuum. The delivery of targeted allied health leadership capacity building initiatives is informed by this framework.

Allied health research translation and clinical educator roles

To support allied health workforce development, 10 senior allied health research and translation roles and 10 clinical education 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 that maintains and improves the skills and knowledge of nurses and midwives employed in their organisation.

Funding is allocated on the bases of total nursing/midwifery full-time equivalent staff.

Nursing and midwifery postgraduate scholarships

Postgraduate scholarships are allocated to registered nurses and midwives working in Victorian public health services 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 calculated based on nursing/midwifery full-time equivalent staff.

Maternity Connect Program

The Maternity Connect Program provides funding that supports 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.

Nuclear Medicine Intern Cluster Program

St Vincent's Hospital Melbourne will receive funding to provide centralised clinical education support for workplaces aligned to the Nuclear Medicine Intern Cluster Program. This funding facilitates the continued employment of up to one full-time equivalent statewide nuclear medicine clinical educator.

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 per intern position. In addition, rural and regional health services 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 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 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 Victoria. The program supports regional and rural 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. This helps ensure Victorian rural generalists are well equipped to work across rural and general practice and hospital settings. The program will support specific rural generalist positions across the training pathway:

- 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 training will provide trainees with the opportunity to gain broad experience in rural and regional general practice and health services including advanced skills in areas such as obstetrics, anaesthetics, emergency medicine, paediatrics, Aboriginal health and mental health. Participants must be enrolled in general practice training to undertake advanced skills training.

In addition to trainees, fully qualified general practitioners can undertake advanced skills training through a lateral entry pathway.

The Victorian Rural Generalist Program will be supported by rural generalist coordinators based in health services across the regions, who will provide case management support to trainees on the program. The program will be 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. Funding in 2020–21 will be allocated to provide locum support and to support professional development for the rural medical and allied health workforces.

11.1.5 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 eligibility requirements’.

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.

Allocation of the training and development funding is limited by the total grant pool. Funding allocations for professional-entry student placements, transition-to-practice and postgraduate programs are based on weighted prior year activity and depend on appropriate reporting of all activity by health services.

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 equal to the length of the rotation.

For further details regarding these funding streams refer to Health Workforce <https://www2.health.vic.gov.au/health-workforce> or download the *Training and development program guidelines 2020–21* from Training and Development Funding <https://www2.health.vic.gov.au/health-workforce/education-and-training/training-development-grant>.

12 Capital funding programs

The department administers several capital grant programs to assist health services with the costs of hospital infrastructure. The Infrastructure Renewal Contribution Grant, Regional Health Infrastructure Fund, Medical Equipment Replacement Program and Engineering Infrastructure Replacement Program 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 coordinated approach to allocating and managing funds from these four separate sources. Where projects are unable to be completed and acquitted within a two-year period, allocations may be recalled and reappropriated to other priority projects.

Read more about the programs at Medical equipment and engineering infrastructure <https://www2.health.vic.gov.au/hospitals-and-health-services/planning-infrastructure/medical-equipment>.

12.1 Infrastructure Renewal Contribution Grant

In 2020–21, $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 as at 50 per cent in July with remaining funds distributed in January 2021 to those health services that submit their asset management plan by 31 December 2020 to the Victorian Health and Human Services Building Authority by emailing Asset Management Submissions <assetmanagement@dhhs.vic.gov.au>. This grant was previously appropriated monthly from July.

Read more about asset management plans at Asset Management <http://www.capital.health.vic.gov.au/Asset_property_management_and_operations>.

12.2 Regional Health Infrastructure Fund

The $350 million Regional Health Infrastructure Fund provides for regional and rural health services on a bid-based process and is managed by the department centrally based on delivery risk.

Investment is targeted to:

- construction, remodelling and refurbishment projects;
- equipment (including furniture, fittings);
- medical equipment;
- engineering infrastructure and plant;
- information and communications technology; and
- new technologies, including systems to reduce usage and increase efficiencies of power or water.

Applications are assessed on readiness of the project, demand for services, compliance risk, clinical risk and fitness of purpose for assets.

13 Health service compensable and ineligible patients

13.1 Interstate patients

The *National Health Reform Agreement* allows jurisdictions to enter into agreements to adjust for costs incurred where admitted patient services are provided to eligible residents of other states or territories.

In Victoria, health services provide admitted acute, subacute, mental health emergency and non-admitted services to eligible residents of other jurisdictions as public patients (if the patient chooses) and at no charge as required under the Medicare principles and the *National Health Reform Agreement*.

Residents from other jurisdictions who elect to be treated as a private patient will be admitted and treated subject to the normal private patient admission requirements. A private admitted patient will be responsible for paying doctors' medical fees and any charges levied by the hospital for their stay. Private health insurance may cover all or part of these costs depending on the type of insurance policy the patient holds.

The services provided by Victorian health services to residents of other Australian jurisdictions (who are not normally a Victorian resident) are part of a health service's normal throughput targets and are not counted as additional throughput or funded separately.

13.2 Medicare-ineligible patients 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 are as follows:

- 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, except for some non-admitted services. Funding for these patients is provided by the department as part of normal public patient throughout. Refer to Hospital Circulars 27/2005 and 29/2008 for more information
- Tuberculosis (TB) patients are eligible to receive publicly funded services for TB-related treatment. Refer to Hospital Circular 06/2014 for more information
- Visitors from a country that has a Reciprocal Health Care Agreement (RHCA) with Australia are eligible for medically necessary treatment. Refer to Hospital Circular 23/2009 for more information.

For further information, see section 18.2.11 'MBS billing policy framework and best practice guidelines', which are due for publication later in 2020.

13.2.1 Medicare-ineligible patients

The following principles provide a guide to making decisions regarding the treatment of Medicare-ineligible patients with these principles applying to all Medicare-ineligible patients treated in Victorian public hospitals:

- 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.

13.2.2 International patients seeking health services

Additional 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, the board must assure themselves that the following principles will be met:

- 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 that 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.

Health services can email the department's International Health team <internationalhealth@dhhs.vic.gov.au> for advice or assistance in relation to treating international patients.

Part 2: Obligations, standards and requirements

14 Notification obligations

14.1 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 and Ambulance Services or Mental Health) and Secretary are advised about significant board decisions and are promptly informed about any issues of public concern or risks that affect or may affect the health service (*Health Services Act 1988* ss. 65S(2)(i), 33(2)(i) and 115E(2)(l); *Ambulance Services Act 1986* s. 18(1)(i); *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 Act 1988* ss. 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)).

14.2 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 may significantly alter its services.

14.3 Exceptional events

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

15 Standards

15.1 Public sector values and employment principles

The *Public Administration Act 2004* <https://www.legislation.vic.gov.au/in-force/acts/public-administration-act-2004/076> 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 Act. More information about public sector values is available from Public Sector Values <http://vpsc.vic.gov.au/ethics-behaviours-culture/public-sector-values>.

Section 8 of the Act outlines the principles of the public sector 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 Act 2006*, 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.

16 Safety

16.1 Pre-employment screening

All health practitioners registered with the Australian Health Practitioners Regulation Authority must meet pre-employment screening requirements. Pre-employment screening of medical practitioners with independent responsibility for patient care is subject to the requirements of the *Credentialing and defining scope of clinical practice for senior medical practitioners policy* <https://bettersafercare.vic.gov.au/reports-and-publications/credentialing-and-scope-of-clinical-practice-for-senior-medical-practitioners-policy>.

Before undertaking any relevant pre-employment and pre-placement police record checks, the department and all funded organisations must undertake identity checks on all applicants to minimise the risk of employing unsuitable or unqualified people. Safety screening may also include a Working with Children Check, which is a mandatory screening process for people who work with children.
Referee checks should be undertaken by direct contact with nominated referees. The bona fides of the referees should be considered.

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://www2.health.vic.gov.au/public-health/immunisation/adults/vaccination-workplace/vaccination-healthcare-workers>.

16.2 Staff safety in Victorian health services

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 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>.

The department is committed to working collaboratively with health services to enhance the health, safety and wellbeing of health service 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.

16.3 Child safety

16.3.1 Commission for Children and Young People

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

The commission provides guidance across systems to ensure child-friendly and child-safe practices. The commission's objective is to promote continuous improvement and innovation in policies and practices relating to the safety and wellbeing of children and young people and in providing out-of-home care services for children.

The commission's functions include conducting inquiries into the deaths of children known to child protection; monitoring out-of-home care services and Working with Children Checks; administering the

Victorian Reportable Conduct Scheme; overseeing and enforcing compliance of organisations with the Child Safe Standards; and conducting inquiries into individual cases involving:

- child protection clients
- youth justice clients
- young people under the age of 21 who have or are leaving the care of the Secretary to the department to live independently
- children who die from abuse or neglect
- children who are, or whose primary family carer is, receiving or has received services from registered community services such as out-of-home care or community-based child and family services.

The commission may also initiate or undertake inquiries, on referral by the Minister for Families and Children, into services provided to children and their primary carers such as health, human and educational services where systemic or recurring issues have been identified that impact on a child's safety or wellbeing.

16.3.2 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, the following must be considered:

- protecting the child from harm
- protecting the child's rights
- promoting the child's development.

There are numerous other principles that, where they are relevant to the decision or action, must also be considered. 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. They draw attention to critical dimensions of a child's experience, which may be affected by their family dynamics and circumstances, and 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 only where there is unacceptable risk of harm.

Departmental and community services must also consider various decision-making principles when making decisions 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, all services must adopt an approach to practice that is child-centred and family-focused.

The *Children, Youth and Families Act 2005* 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, and balances these powers with comprehensive safeguards, including judicial oversight, and accountability procedures to protect the rights of children and parents.

This 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's child protection program.

The legislation also provides for the department 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.

16.3.3 Child Wellbeing and Safety Act

The Victorian Government's *Children Legislation Amendment (Information Sharing) Act 2018* amends the *Child Wellbeing and Safety Act 2005* to create the Child Information Sharing scheme to enable prescribed workers to share information to promote children's wellbeing and safety. The Act also authorises the creation of Child Link, an IT platform that will extract and collate a thin layer of information about children's enrolment in universal services, as well as the presence of child protection orders and out-of-home care status. Child Link will be accessible to a subset of prescribed professionals working directly with children and will assist in forming a full picture of a child's service history and identifying potential risks early on.

The scheme promotes earlier intervention to prevent harm to children, as well as enabling better collaboration between government agencies and funded services. The scheme responds to several child death inquiries and is consistent with the recommendations of the Royal Commission into Institutional Responses to Child Sexual Abuse. The scheme began operation in September 2018 in alignment with related family violence reforms and was accompanied by comprehensive guidelines and an implementation strategy. The scheme is being introduced in a phased approach, with a further phase of professionals being prescribed in the scheme in 2020.

16.3.4 Working with Children Act

The *Working with Children Act 2005* ensures that only people with a valid Working with Children Check are engaged in child-related work (where a child is under the age of 18 years).

It is the department's expectation that the places and occupations that require a Working with Children Check are those that involve regular and direct contact with children. Though the facility may not have a paediatric-specific ward, if the ward has regular or planned admissions of patients under the age of 18 years, this is considered non-incidental contact and all staff including the admissions, theatre, recovery, ward, cleaning and food services staff would require a Working with Children Check. Read more about the Working with Children Check <https://www.workingwithchildren.vic.gov.au>.

16.3.5 Child Safe Standards

The Child Safe Standards aim to improve the way organisations, which provide services for children, prevent and respond to child abuse that may occur within their organisation.

The standards are compulsory for organisations providing services to children and aim to drive cultural change in organisations so that protecting children from abuse is embedded in the everyday thinking and practice of leaders, staff and volunteers. This will assist organisations to:

- prevent child abuse
- encourage reporting of any abuse that does occur
- improve responses to any allegations of child abuse.

The standards are a central feature of the Victorian Government's response to the Family and Community Development Committee's *Betrayal of Trust: Inquiry into the Handling of Child Abuse by Religious and Other Non-Government 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 2005* 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. The commission and department play important complementary roles in promoting and overseeing compliance with the standards.

The *Child Safe Standards compliance monitoring framework* <http://providers.dhhs.vic.gov.au/child-safe-standards-compliance-monitoring-framework-2018-2019-word> sets out the department's approach to monitoring compliance of in-scope organisations with the standards. The framework is supported by a maturity assessment model that provides guidance to in-scope organisations about their obligations in

implementing the standards and focuses on continuous improvement following an identified noncompliance. The *Child Safe Standards compliance monitoring framework* and *Child Safe Standards compliance assessment model* are available at Resources for Child Safe Standards <http://providers.dhhs.vic.gov.au/resources-child-safe-standards>.

16.3.6 Reportable Conduct Scheme

The Reportable Conduct Scheme is set out under Part 5A of the *Child Wellbeing and Safety Act 2005* and aims to improve oversight of how organisations respond to allegations of child abuse and child-related misconduct.

The scheme requires certain organisations with a high level of responsibility for children to ensure the person in a relevant position of authority (such as a chief executive officer) in an organisation is made aware of and reports any allegations of reportable conduct made against a worker or volunteer to the Commission for Children and Young People. The scheme also requires in-scope organisations to ensure appropriate investigation of the allegations and report any findings and the reasons for the outcome of an investigation to the commission. Read more about the Reportable Conduct Scheme <https://ccyp.vic.gov.au/reportable-conduct-scheme/about-the-reportable-conduct-scheme/#TOC-1>.

16.4 Culturally safe environments for Aboriginal and Torres Strait Islander people

Aboriginal communities are culturally diverse, with rich and varied heritages and histories both pre- and post-colonisation. Aboriginal communities in Victoria were heavily affected by colonisation and past discriminatory policies, which continue to have an impact on the health and wellbeing of Aboriginal people today and how Aboriginal people access and interact with services.

Victorian Aboriginal people have been significantly impacted by the policy and practices that gave rise to the Stolen Generation, with nearly half of the current population having a relative that was forcibly removed from their family. This trans-generational trauma, along with racism, is a key driver of the poorer health outcomes for Aboriginal people.

Aboriginal health, wellbeing and safety is everyone's business. The department recognises the interconnectedness of physical, social and emotional health and recognises that health interventions need to be culturally responsive and based in Aboriginal understanding of health, wellbeing and safety.

Evidence demonstrates that there has been limited progress in the improvement of health and wellbeing of Aboriginal people. The gap between Aboriginal people and non-Aboriginal people in health and wellbeing is continuing despite investment and policy commitment. Aboriginal people continue to experience racism, discrimination and culturally unsafe services and practices which is linked to poor self-assessed health status, psychological distress and other risk factors.

Aboriginal cultural safety is a key determinant of improved access to health services and health outcomes for Aboriginal Victorians.

16.4.1 Aboriginal cultural safety – Responsibilities and guidelines

Cultural safety is about creating an environment that is safe for Aboriginal and Torres Strait Islander people. This means there is no assault, challenge or denial of their identity and experience. Cultural safety is about a shared respect, meaning and shared knowledge, and is the experience of learning together and truly listening. Cultural safety requires strategic and institutional reform to remove barriers to the health, wellbeing and safety of Aboriginal people, and requires individuals, organisations and systems to ensure their cultural values do not negatively impact on Aboriginal people.

How health services can be culturally safe for Aboriginal people is best understood in terms of how Aboriginal people understand this. Cultural safety for Aboriginal people means feeling connected to culture, community and country when entering a health service.

This may be through symbolic gestures such as the flying of the Aboriginal and Torres Strait Islander flags, or plaques acknowledging Traditional Owners, but also needs to be supported by systemic change and actions that build respect and trust between Aboriginal communities and mainstream organisations, and service providers and Aboriginal patients. Cultural safety enables Aboriginal people to have trust and confidence that service providers understand their needs and culture, that being Aboriginal is an accepted part of their identity, a willingness to identify as being Aboriginal, and confidence to ask questions, and to seek the services and help they are entitled to.

Funded organisations have a responsibility to provide a culturally safe environment for their Aboriginal and Torres Strait Islander patients and clients. Services should develop local policies and procedures in consultation with local Aboriginal staff and community members. This includes:

- being respectful of cultural protocols
- offering patients or clients the opportunity to access male or female staff as required
- preventing stigmatism and racial discrimination.

It also includes a responsibility for developing an understanding about what cultural safety means for managers, staff, patients and clients. All staff should undertake cultural safety training specific to their region.

The department has developed the following to provide guidance to health services in adhering to these responsibilities:

- *Korin Korin Balit-Djak: Aboriginal health, wellbeing and safety strategic plan 2017–2027 (Korin Korin Balit Djak)* <https://www2.health.vic.gov.au/about/health-strategies/aboriginal-health/korin-korin-balit-djak>, which provides an overarching framework for action to improve the health, wellbeing and safety of Victoria's Aboriginal people and communities. Korin Korin Balit Djak acknowledges the importance of applying a cultural determinants approach as an effective way to improve the health and wellbeing of Aboriginal people and
- *Aboriginal and Torres Strait Islander cultural safety guidelines* <https://www2.health.vic.gov.au/about/health-strategies/aboriginal-health/aboriginal-torres-strait-islander-cultural-safety>, which includes the *Aboriginal and Torres Strait Islander cultural safety framework* <https://www.dhhs.vic.gov.au/publications/aboriginal-and-torres-strait-islander-cultural-safety-framework>, which has been developed to help mainstream Victorian health, human and community services, and the department to create culturally safe environments, services and workplaces. The framework provides a continuous quality improvement model to strengthen the cultural safety of individuals and organisations.

Refer also to:

- the Aboriginal culturally informed addendum to *the* *Department of Human Services Standards Evidence Guide (September 2015)* <https://providers.dhhs.vic.gov.au/human-services-standards-evidence-guide-word>.
- *Cultural Respect Framework 2016–2026 for Aboriginal and Torres Strait Islander health: a national approach to building a culturally respectful health system* <http://www.health.gov.au/internet/main/publishing.nsf/Content/indigenous-crf>.

16.4.2 Improving Care for Aboriginal and Torres Strait Islander Patients (ICAP) program

Aboriginal cultural safety is a requirement of all Victorian health services as articulated in the SOP and underpins the Improving Care for Aboriginal Patients (ICAP) program. Health services are required to demonstrate Aboriginal cultural safety strategies and associated outcomes across their organisation.[1]

[1] Statements of priorities webpage <https://www2.health.vic.gov.au/hospitals-and-health-services/funding-performance-accountability/statement-of-priorities>

More specifically, the ICAP program requires health services to improve the cultural safety of their health service and employ an Aboriginal Hospital Liaison Officer (AHLO). The ICAP program has four key result areas:

1. Engagement and partnerships
2. Organisational development
3. Workforce development
4. Systems of care.

National Safety and Quality Health Service Standards

The National Safety and Quality Health Service Standards aligns with the ICAP program and requires health services to adhere to six actions across three standards, with the objective to improve access and outcomes for Aboriginal peoples.[2] The purpose of the standards is to ensure that health services:

- Increase the recruitment and retention of Aboriginal people
- Develop career pathways for Aboriginal people working in clinical and non-clinical roles
- Develop and strengthen partnerships between both Aboriginal communities and community-controlled organisations
- Improve the cultural safety for Aboriginal workers and service users.

Aboriginal WIES loading

The Aboriginal WIES loading is a policy lever intended to cover both the excess clinical costs for Aboriginal patients not fully covered by the Activity Based Funding model and to cover cultural safety costs.

In Victoria, the Aboriginal WIES loading is tied to the ICAP program for implementation of strategies to improve patient identification, employ AHLOs, and deliver organisation-wide systemic strategies to improve Aboriginal cultural safety.

A review of the Aboriginal WIES loading has identified an alternative Aboriginal health funding model to achieve better accountability and cultural safety of health services. Further consultation with the sector will be undertaken to discuss the design and implementation of an alternative Aboriginal health funding model.

16.5 Safe environments for people who are trans or gender diverse or have intersex variations

Funded organisations have a responsibility to provide a safe and inclusive environment for people who are trans or gender diverse or have intersex variations. In response to increasing service access and demand by trans and gender diverse people and people with intersex variations, the department expects all funded services to develop local policies, procedures and appropriate training for staff to competently and respectfully engage in gender and body-diverse sensitive practice.

This includes using pronouns and names preferred by the individual, providing non-gendered facilities where possible, minimising potentially embarrassing encounters with other patients, and avoiding assumptions about gender and sex-specific health issues such as the need for cervical or breast/chest screening for women and some trans and gender diverse people. For trans and gender diverse people, it also means providing respectful, supportive advice on access to health services associated with gender affirmation.

[2] *User Guide for Aboriginal and Torres Strait Islander Health* available from Australian Commission on Safety and Quality in Health Care website <https://www.safetyandquality.gov.au/topic/user-guide-aboriginal-and-torres-strait-islander-health>

To support these policy priorities, an LGBTIQ Taskforce and Commissioner for Gender and Sexuality have been established. The Taskforce's Health and Human Services Working Group is working to support safe environments for people who are trans or gender diverse or have intersex variations and has identified the following priorities:

- inclusive practices within hospitals and health services
- implementation of the new trans and gender diverse health initiative, which will expand the health system's capacity to support and better meet the needs of trans and gender diverse Victorians (visit Populations <https://www2.health.vic.gov.au/about/populations>)
- developing a suite of health policies and resources to support and enhance the wellbeing of people with intersex variations (visit Health of people with intersex variations <https://www2.health.vic.gov.au/about/populations/lgbti-health/health-of-people-with-intersex-variations>).

Following an inquiry undertaken by the Health Complaints Commissioner into 'gay conversion therapy' in 2018, the Victorian Government announced new legislation will be developed and introduced to ban this practice in Victoria. In addition, the Victorian Government has committed to developing mental health supports needed for survivors (including lesbian, gay, bisexual and trans and gender diverse Victorians). See the *Executive Summary of the Health Complaints Commissioner Inquiry into gay conversion therapy* <https://hcc.vic.gov.au/file/permalink/7019>.

The Victorian Government has developed the following documents to provide guidance to services:

- *Rainbow eQuality: a guide to LGBTI inclusive practice for health and human services* <https://www2.health.vic.gov.au/rainbowequality>
- *Service guideline for gender sensitivity and safety* <https://www2.health.vic.gov.au/about/publications/policiesandguidelines/service-guideline-for-gender-sensitivity-and-safety>
- *Development of trans and gender diverse services in Victoria* <https://www2.health.vic.gov.au/about/populations/lgbti-health/trans-gender-diverse>.
- *LGBTIQ 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 LGBTI consumers.

Further information is available from Rainbow Health <https://www.rainbowhealthvic.org.au>.

16.6 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 VHIMS are subject to the new overarching Safer Care Victoria policy *Adverse patient safety events* <https://www.bettersafercare.vic.gov.au/reports-and-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 (former) Department of Health'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.dhhs.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. Organisations' incident management policies and processes may be reviewed as part of the department's routine contract and performance management arrangements.

For community health services a dedicated incident reporting webpage hosts health and human services incident reporting instructions and forms. Visit Incident reporting arrangements for community health services <https://www2.health.vic.gov.au/primary-and-community-health/community-health/community-health-program/incident-reporting> for more information.

16.7 Supported Residential Services

Supported Residential Services (SRS) are privately operated services, not funded by the department. SRS are registered with the department, which has responsibility for administering the legislation governing SRS under the *Supported Residential Services (Private Proprietors) Act 2010* and a regulatory responsibility under the *Supported Residential Services (Private Proprietors) Regulations 2012*.

Effective from 10 April 2014, the incident reporting process for SRS is as follows:

- Prescribed reportable incidents in SRS are detailed in the Act and Regulations. Authorised officers are responsible for recording prescribed reportable incidents through a separate and independent database, the Compliance Reporting and Monitoring System.
- SRS authorised officers are no longer required to report SRS incidents via the Category One reporting process.

16.8 Meeting the needs of all Victorians

The government is committed to pursuing a safe and secure Victoria, good health and wellbeing, full participation in society, cultural connection and genuine equality for every Victorian. The department promotes an intersectional approach in designing services and developing policies, which recognises that communities are not homogenous and that services must ultimately be designed to the unique needs of individuals.

The pursuit of these outcomes is reflected in the following policy documents: *Safe and strong: a Victorian gender equality strategy*, *Victorian. And proud of it: Victoria's Multicultural Policy Statement* and *Absolutely everyone: state disability plan 2017–2020*. The Premier's Circular on Good Board Governance (from Victoria's multicultural policy statement) also outlines the government's drive to obtain more equitable gender and cultural representation on boards.

The department is focused on improving the lives of all Victorians, especially those vulnerable and at risk. In addition to the whole-of-government policies, this focus is reflected in the department's plans and resources including:

- Designing for Diversity: Policy and service design resources <https://www2.health.vic.gov.au/about/populations/designing-for-diversity>
- *Delivering for diversity: cultural diversity plan 2016–2019* <https://www2.health.vic.gov.au/about/publications/policiesandguidelines/dhhs-delivering-for-diversity-cultural-diversity-plan-2016-19>
- *Language services policy* <https://www.dhhs.vic.gov.au/publications/language-services-policy-and-guidelines> and the supporting guidelines: *How to work with interpreting and translating services* <https://www.dhhs.vic.gov.au/publications/language-services-policy-and-guidelines>
- *Rainbow eQuality: a guide to LGBTI inclusive practice for health and human services* <https://www2.health.vic.gov.au/rainbowequality>
- *Development of trans and gender diverse services in Victoria* available at Trans and gender diverse health and wellbeing <https://www2.health.vic.gov.au/about/populations/lgbti-health/trans-gender-diverse>

- *Victoria's 10-year mental health plan* <https://www2.health.vic.gov.au/mental-health/priorities-and-transformation/mental-health-plan> including the *Balit Murrup: Aboriginal social and emotional wellbeing framework* <https://www.dhhs.vic.gov.au/publications/balit-murrup-aboriginal-social-and-emotional-wellbeing-framework>
- *Korin Korin Balit-Djak: Aboriginal health, wellbeing and safety strategic plan 2017–2027 (Korin Korin Balit Djak)* <https://www2.health.vic.gov.au/about/health-strategies/aboriginal-health/korin-korin-balit-djak>

Some of these policies require reporting for some types of services – for example, when arranging language services and, for public sector bodies, when developing a disability action plan.

Services should consider the effectiveness of the ways in which they respond to the diversity in the Victorian community.

16.9 Language services

Language service provision is an important aspect of the department's efforts to deliver accessible, person-centred services that respond to the needs of culturally diverse and deaf communities. Language services are a key component in achieving our strategic directions of person-centred services and care, and in advancing quality, safety and innovation.

Failure to provide an appropriately qualified and credentialed interpreter or have important health and human services' information translated accurately into community languages can have significant negative impacts, including reduced or adverse health and wellbeing outcomes.

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. Government and its agencies can fulfil their duty of care by taking reasonable steps to actively identify whether language assistance is required and acting accordingly.

The department's *Language services policy* <https://www.dhhs.vic.gov.au/publications/language-services-policy-and-guidelines> and the supporting guidelines: *How to work with interpreting and translating services* <https://www.dhhs.vic.gov.au/publications/language-services-policy-and-guidelines> reflects the priority the department places on ensuring quality interpreting and translating is provided to support Victorians. It identifies critical points for language service provision and details implementation support measures to ensure people with low English proficiency, or who use a form of sign such as Auslan, have access to those services.

The policy also stipulates appropriately qualified and credentialed interpreters and translators should be used to ensure the provision of high-quality language services. The use of automated interpreting and translating technologies in place of qualified and credentialed interpreters and translators is not supported, noting the duty to ensure translations are accurate, culturally appropriate, not likely to cause harm and communicate concepts effectively. To that end, the policy also states that requesting family or friends, especially minors, to act in place of an accredited interpreter is not appropriate.

The department expects all those involved in the planning, funding and delivery of funded health and human services to familiarise themselves with this policy and to ensure quality language services are an integral part of their service response. Services should also ensure frontline staff are familiar with language services policy and procedures, and receive training on how to work effectively with interpreters.

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.

For more information on remuneration rates and conditions visit Victorian Multicultural Commission minimum remuneration rates for interpreters <https://www.multicultural.vic.gov.au/images/2018/Victorian-Government-Minimum-Rates-for-Interpreters---1-July-2018.pdf>.

17 Capability frameworks

17.1 Maternity and newborn capability levels

The *Capability frameworks for Victorian maternity and newborn services (2019)* describe the requirements for providing safe and high-quality maternity and newborn care across six levels. Health services must operate within their agreed and published maternity and newborn capability level.

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.

The Capability levels, including the frameworks, are published at Maternity and newborn care in Victoria <https://www2.health.vic.gov.au/hospitals-and-health-services/patient-care/perinatal-reproductive/maternity-newborn-services/maternity-newborn-care>.

17.1.1 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.

Rural services that are unable to provide care at the determined level for short periods 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 this change, advise the department (Manager, Performance, Governance and Quality, Rural and Regional 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, Performance, Governance and Quality, Rural and Regional Health.

The frequency and duration of service provision outside the determined capability level will be monitored by the department and (along with other factors) will inform decision-making about ongoing capability levels for the service.

17.2 New capability frameworks

In addition to the existing capability frameworks for maternity and newborn services, subacute services and palliative care, and in line with the recommendations of *Targeting Zero*[3] and the *Statewide design, service and infrastructure plan*,[4] the department will release new capability frameworks in 2019–20 and 2020–21.

The new frameworks are for the following clinical service streams:

- cardiac care
- surgical and procedural services
- urgent, emergency and trauma care
- renal care.

In addition, capability frameworks will be released for the following core service streams:

- critical care
- anaesthetics
- pharmacy
- pathology
- diagnostic imaging.

Note the existing palliative care capability framework is being reviewed and a draft will be available for consultation in 2020.

For each service stream, there are six capability levels that describe complexity from level 1 (lowest complexity of care) to level 6 (highest complexity of care). As a rule, each service level builds on the preceding service level.

The department has worked with health services and other key stakeholders to develop the service descriptors and service requirements for each level of complexity for each of these service streams.

In 2019–20, the department began a process to assess health services' current capability levels and service gaps for renal care, and surgical and procedural services. This step will be the baseline to assist health services to develop action plans to meet the service requirements in each clinical stream capability framework. Work will continue in 2020–21 on urgent, emergency and trauma care and cardiac care capability frameworks.

Health services must 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.

[3] A key recommendation of *Targeting Zero* was that 'within three years, the department has expanded its capability frameworks to cover all major areas of hospital clinical practice, be monitoring adherence to them (across public and private hospitals) and sharing information on adherence with hospitals and boards' – recommendation 2.12.2. *Targeting Zero* is available from Review of hospital safety and quality assurance in Victoria <https://www2.health.vic.gov.au/hospitals-and-health-services/quality-safety-service/hospital-safety-and-quality-review>.

[4] The department's *Statewide design, service and infrastructure plan for Victoria's health system 2017–2037* <https://www2.health.vic.gov.au/about/publications/policiesandguidelines/statewide-design-service-infrastructure-plan-2017-37> commits to developing capability frameworks to ensure that:

- patients are treated at facilities that can appropriately manage their level of clinical risk
- within each capability level, health services are providing the same quality of care, regardless of location.

18 Expectations, policies and performance

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

18.1 Acute and specialist

18.1.1 Surgical and procedural services

All Victorian health services are to meet the requirements of Victoria's *Elective surgery and planned procedures: access policy*. This new policy will be released in 2020 and provide guidance to the clinical, administrative support staff, managers and executives of all public health services that provide surgery and other planned procedures.

For more information about surgical policies and reporting requirements, view Surgical services <https://www2.health.vic.gov.au/hospitals-and-health-services/patient-care/acute-care/surgical-services> and Elective Surgery Information System <https://www2.health.vic.gov.au/hospitals-and-health-services/data-reporting/health-data-standards-systems/data-collections/esis>.

18.1.2 Non-admitted specialist services

An updated access policy for non-admitted specialist services in Victorian public hospitals will be released in 2020. This new policy builds on and replaces the previous version of the specialist clinic 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.

18.1.3 Victorian endoscopy categorisation guidelines

Victorian health services that provide endoscopy services should ensure clinicians use the Victorian endoscopy categorisation guidelines.

Victoria's colonoscopy and upper gastrointestinal endoscopy categorisation guidelines can be accessed at Specialist clinics – resources <https://www2.health.vic.gov.au/hospitals-and-health-services/patient-care/specialist-clinics/specialist-clinics-program/specialist-clinics-resources>.

18.1.4 Bariatric surgery

Bariatric surgery is limited to three designated centres: The Alfred, the Austin Hospital and Western District Health Service. In 2020–21, there will be a review of the current service model, including referral and eligibility criteria, and services requirements.

18.1.5 Cardiac care

The department will continue to implement the priority actions from the *Design, service and infrastructure plan for Victoria's cardiac system (2016)* <https://www2.health.vic.gov.au/hospitals-and-health-services/health-system-design-planning/cardiac-design-service-and-infrastructure-plan> and health services are required to support the activities of this work.

18.1.6 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 and
- 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 an interdisciplinary team. The model must be endorsed by the department prior to commencement and have clear reporting structures in place to help inform attribution of activity and outcomes by care setting (hospital/home). Admitted care in the home models must not duplicate existing funded programs.

All designated palliative care inpatient units must provide care in line with the *Conditions of funding for admitted palliative care* <https://www2.health.vic.gov.au/hospitals-and-health-services/patient-care/end-of-life-care/palliative-care/palliative-care-conditions-funding>

All health services providing admitted palliative care must report data elements linked to the Australian National Subacute and Non-Acute Patient (AN-SNAP) 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 and Clinical Indicators for Breathlessness audit data via the HealthCollect data portal, and participate in the annual palliative care experience module of the 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 using the AIMS form, VINAH and cost data to the VCDC.

18.1.7 Maternity and newborn services

Maternal and perinatal mortality and morbidity committees

All health services providing maternity services must regularly review all maternal and perinatal deaths and morbidity. The hospital's processes should align with the *Perinatal Society of Australia and New Zealand: Clinical practice guideline for perinatal mortality*. For more information view PSANZ Guidelines <http://www.psanz.com.au/guidelines>.

Following a staged transition, the six regional level 5 maternity services and Rural and Regional Health Partnerships provide leadership, management 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.

Generation Victoria

All health services providing maternity services are encouraged to support women to participate in Generation Victoria (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, ensuring 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.

From 2018, health services providing planned birthing services (levels 2–6 maternity capability) should be working towards achieving 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 (REACH) 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 Retrieval and Critical Health Information System (REACH) <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: Delivering culturally responsive and high-quality care* <https://www2.health.vic.gov.au/about/publications/policiesandguidelines/koori-maternity-services-guidelines-mar-2017> 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 Service 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	The Royal Women's Hospital
	Western Health (Sunshine Hospital)	Sunshine Hospital (Western Health)
	Northern Health (The Northern Hospital)	The Northern Hospital (Northern Health)

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

Public health services funded to provide a Koori Maternity Service (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://www2.health.vic.gov.au/hospitals-and-health-services/patient-care/perinatal-reproductive/maternity-newborn-services/aboriginal-maternity-services>.

18.1.8 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.

An advisory group comprises members of all Victorian Paediatric Rehabilitation Services and departmental representatives.

Activity is reported through the VAED and VINAH respectively. Cost data is reported at the patient level through the VCDC.

18.1.9 Hospital in the Home

Treatment provided to patients at home as Hospital in the Home (HITH) is funded at an equivalent rate to in-hospital acute care.

Due to the superior outcomes and experience often achieved through care at home, this should be the default setting of care for patients whenever 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, *Victorian Admitted Episode Dataset: Criteria for Reporting* <https://www2.health.vic.gov.au/hospitals-and-health-services/data-reporting/health-data-standards-systems/data-collections/vaed>.

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 WIES-funded acute admitted care must be in the health record.

HITH separations and bed days are reported in *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 through the VCDC.

For more, see the *Hospital in the Home guidelines* <https://www2.health.vic.gov.au/hospitals-and-health-services/patient-care/acute-care/hospital-in-the-home>. These guidelines will be refreshed in 2020–21.

18.1.10 Specialist clinics

Health services currently in scope to report specialist clinics data through the VINAH are expected to comply with the policy, *Specialist Clinics in Victorian Public Hospitals Access* <https://www2.health.vic.gov.au/hospitals-and-health-services/patient-care/specialist-clinics/access-policy>.

All health services providing specialist clinic services must ensure their procedures and policies align with the objectives and principles of current policies. The specialist clinic access policy is under review and a new policy will be published in 2020–21.

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.

In specialist clinics, telehealth should be the default mode of care delivery whenever safe, appropriate and consistent with patient preference.

Hospitals must provide patient-level specialist clinics data to the VINAH. Those health services currently reporting specialist clinics activity only through AIMS will progress their capability to report patient-level specialist clinics data through the VINAH.

Hospitals are expected to report patient-level cost data for all specialist clinic activity through the VCDC. All health services are expected to continue to improve their AIMS and cost data.

18.1.11 Telehealth

Health services should continue to drive choice and better patient experience through increased use of telehealth (video consulting) to deliver acute and specialist services in 2020–21. These consults should particularly target patient cohorts that are underserviced by the conventional face-to-face service model irrespective of the clinic/specialty. This includes people from rural areas, Aboriginal Victorians, the elderly and people with mobility issues or disabilities.

The commitment to deliver an additional 500,000 specialist appointments to rural and regional patients over four years began in 2019–20. Health services will be expected to increase telehealth activity to support this commitment. Telehealth should be the default mode of care if safe, appropriate and consistent with patient preference.

Telehealth activity in specialist clinics and emergency departments is funded through existing funding models for acute care.

Services provided via telehealth video consultations in specialist clinics must align to the advice in the factsheet *VINAH and Telehealth consultations* <https://telehealthvictoria.org.au/wp-content/uploads/2017/09/VINAH-Telehealth-consulations.pdf>. The telehealth activity must be reported through the VINAH as described in the VINAH manual for 2020–21.

Services provided via telehealth video consultations in emergency departments to patients located in other Victorian public emergency departments, urgent care centres, Victorian subregional government or non-government residential aged care services must align with the *Reporting telehealth video consultations in Victorian emergency departments* <https://www2.health.vic.gov.au/hospitals-and-health-services/rural-health/telehealth/about-telehealth>. Emergency department telehealth services must be reported through the VEMD as described in the VEMD manual for 2020–21.

More information on telehealth is available at Telehealth <https://www2.health.vic.gov.au/hospitals-and-health-services/rural-health/telehealth>.

18.1.12 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 2020–21, health services are to continue to realign 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 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 Amendment (Authorised Nurse Practitioners) Instrument 2020* <https://www.legislation.gov.au> and *explanatory statement* <https://www.legislation.gov.au> outlines these changes. Find more information at Nurse practitioners eligible to prescribe <http://www.pbs.gov.au/info/news/2020/04/authorised-nurse-practitioners-now-eligible-to-prescribe>. For more information visit hepatitis C treatments <https://www.pbs.gov.au/info/publication/factsheets/hep-c/hepc-factsheet-hospital-prescribers-dispensers>.

Medicare Benefits Scheme telehealth and telephone items have been introduced to support the response to coronavirus (COVID-19). Fact sheets with information on these items can be found on the Temporary telehealth items page <http://www.mbsonline.gov.au/internet/mbsonline/publishing.nsf/Content/Factsheet-TempBB>. These items are aimed at those with chronic conditions, the elderly and Aboriginal Victorians. For more information visit Medicare Benefits Scheme <http://www.mbsonline.gov.au>.

Integrated hepatitis C services activity is reported as part of the VINAH. For community health centres with integrated hepatitis C services, activity is reported through the Service Agreement Management System to the Community Health Minimum Dataset.

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 further information please visit:

- Community Health Minimum Dataset <https://www2.health.vic.gov.au/primary-and-community-health/community-health/community-health-program/community-health-data-reporting>.
- 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>.

18.1.13 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.

Absolutely everyone: state disability plan 2017–2020 recognises the opportunities for Victoria as we transition to the NDIS. The plan sets out 10 key priorities for the state public and private sectors to ensure people with disability can participate in everyday life.

Health services are encouraged to develop disability action plans to improve the quality of care for people with a disability.

Access more information on Absolutely everyone <https://www.statedisabilityplan.vic.gov.au> and view Guidance on developing disability action plans <https://providers.dhhs.vic.gov.au/disability-action-plans>.

Working with the NDIS

Health services are responsible for effective interaction with the NDIS to enable timely access to supports and services for people with disability that have new or changed needs following a hospital admission. Health services are expected to understand and operate effectively in the new 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 are expected 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 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 in relation to 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.

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 see the *Patient fees and charges for public health services* <https://www2.health.vic.gov.au/hospitals-and-health-services/patient-fees-charges>.

18.2 Subacute and non-acute

The primary treatment goal of subacute and non-acute care is to optimise a patient's functioning and quality of life.

Admitted subacute services should be delivered in the home whenever it is safe, appropriate, consistent with the patient's preference, and compliant with Victorian funding policy.

18.2.1 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 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.

A review of existing admitted rehabilitation and geriatric evaluation and management funding streams and program guidelines will be undertaken to improve clarity regarding:

- when care should be provided on an admitted versus a non-admitted basis
- the criteria for a patient to qualify for either service, consistent with Victorian funding policy
- the minimum level of clinical and medical services a patient should receive under each model of care.

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 and should emphasise a restorative approach to care after treatment.

Health services are delineated to provide rehabilitation and geriatric evaluation and management services through *Planning the future of Victoria's subacute service system: a capability and access planning framework* <https://www2.health.vic.gov.au/hospitals-and-health-services/patient-care/rehabilitation-complex-care/subacute-planning>. 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.

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 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 more information, see *Planning the future of Victoria's subacute service system: a capability and access planning framework* <https://www2.health.vic.gov.au/hospitals-and-health-services/patient-care/rehabilitation-complex-care/subacute-planning>.

For program details and service model information refer to Patient care <https://www2.health.vic.gov.au/hospitals-and-health-services/patient-care>.

18.2.2 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 1997* and the Aged Care Principles pursuant to the Act. The *Transition Care Program guidelines* (2019) govern the program.

For the guidelines and more information, see Transition Care Program <https://www2.health.vic.gov.au/hospitals-and-health-services/patient-care/rehabilitation-complex-care/transition-care-program>.

18.2.3 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. Telehealth should be the default mode of care if 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 Health Independence Program guidelines <https://www2.health.vic.gov.au/hospitals-and-health-services/patient-care/rehabilitation-complex-care/health-independence-program/hip-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 the following:

- 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

Health services must report their non-admitted subacute costing data to the VCDC as detailed in section 29.2.7 'Victorian Cost Data Collection'.

The definition of a Health Independence Program contact is provided in the VINAH business rules. The program's counting unit will be 'direct non-admitted contacts', which are defined as contacts where all of the following VINAH characteristics are met:

- 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).

Organisations that receive funding under any of the following programs must transmit data to the VINAH:

- Health Independence Program:
  - subacute ambulatory care services (including paediatric rehabilitation)
  - Hospital Admission Risk Program
  - post-acute care
  - residential in-reach service
- community-based palliative care.

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 VINAH data for all subacute program streams will be able to cease providing AIMS data once agreement has been reached with the department.

Hospitals are expected to report patient-level cost data for all subacute and non-acute activity through the VCDC.

For more information review:

- *Planning the future of Victoria's subacute service system: a capability and access planning framework (2013)* <https://www2.health.vic.gov.au/about/publications/policiesandguidelines/Planning-the-future-of-Victorias-subacute-service-system-A-capability-and-access-planning-framework---February-2013>
- *Health Independence Program guidelines* <https://www2.health.vic.gov.au/hospitals-and-health-services/patient-care/rehabilitation-complex-care/health-independence-program/hip-guidelines> – these will continue to guide health service and departmental directions for these services in 2020–21.

18.2.4 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*, available from End-of-life care <https://www2.health.vic.gov.au/hospitals-and-health-services/patient-care/end-of-life-care>.

After hours

Outside business hours (usually between 7.00am and 5.00pm Monday to Friday, excluding public holidays), all designated community palliative care services must provide or arrange the following minimum level of service to their clients:

- 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 carer 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 data collection system:

- Contacts will be reported through VINAH as per the standard VINAH reporting requirements
- The AIMS form will continue to be required to report service events for commonwealth reporting processes
- Funded services must submit quarterly Clinical Indictors for Pain and Clinical Indictors for Breathlessness audit data via the HealthCollect data portal
- Funded services must participate in the annual palliative care experience module of the VHES
- Patient-level cost data for community palliative care activity are to be reported through the VCDC.

18.2.5 Palliative care consultancy teams

Hospital-based consultancy teams

Reporting requirements

Hospital-based consultancy programs must report patient-level data using the VINAH and aggregate activity via AIMS for 2020–21.

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.

Reporting requirements

In 2020–21, regional consultancy programs are to continue using the AIMS form to report aggregate activity counts that comply with the definition of a service event.

Regional consultancy teams must report:

- number of contacts
- number of referrals
- active episodes
- number of episodes opened
- number of episodes closed
- number of patients.

Services must report AIMS data by the 14th of each month.

As of 1 July 2021, regional palliative care consultancy teams will be required to report patient-level data.

The department will focus on improving the coverage of the VINAH as well as investigating complementary systems to collect non-admitted patient activity.

Statewide consultancy services

A range of statewide services are funded to provide specialist advice in relation to particular diagnoses or population groups:

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

Funding allocations for palliative care statewide consultancy services are included in the organisation's acute and subacute allocation. Recall does not apply to statewide palliative care consultancy services in 2020–21.

Reporting requirements

Statewide consultancy programs are to continue reporting data via AIMS in 2020–21. Services should report:

- number of contacts
- number of referrals
- active episodes
- number of episodes opened
- number of episodes closed
- number of patients.

Hospitals are expected to report patient-level cost data for all statewide consultancy program activity through the VCDC.

As of 1 July 2021, statewide palliative care consultancy services will be required to report patient-level data.

The department will focus on improving the coverage of the VINAH as well as investigating complementary systems to collect non-admitted patient activity.

For more information about palliative care consultancy services including the Victorian Paediatric Palliative Care Consultancy Program business rules go to Palliative care <https://www2.health.vic.gov.au/hospitals-and-health-services/patient-care/end-of-life-care/palliative-care>.

18.2.6 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 their region.

Each consortium is required to submit an annual report to the department before 30 September 2020. The report should outline their key achievements and activities for 2019–20 and include a financial statement that accounts for expenditure throughout the financial year.

The department is reviewing the role of regional palliative care consortia in 2020 to inform the future direction of this resource. For more information about palliative care consortia visit Palliative care <https://www2.health.vic.gov.au/hospitals-and-health-services/patient-care/end-of-life-care/palliative-care>.

18.2.7 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.

Services expected to provide artificial limbs under the Victorian Artificial Limb Program in 2020–21 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 and South West Healthcare.

A funding review of the Victorian Artificial Limb Program is currently underway.

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, accessing their Victorian Artificial Limb Program services and ensure NDIS-eligible activity and equipment is billed to the NDIS.

18.2.8 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 VINAH. They are also required to report patient-level cost data through the VCDC.

18.2.9 Total parenteral nutrition

In 2020–21, 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.

All non-admitted patient sessions performed in a single month will be bundled and counted as one, non-admitted service event. A recall/throughput adjustment will be applied for health services whose activity is below or over target.

Health services funded to provide total parenteral nutrition will be required to report activity and cost data to the department in 2020–21.

Activity is to be reported via the AIMS S12 form by the 14th day following the end of month and to be reported to VINAH. 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 professional separately.

For more information refer to the 'Home enteral nutrition' section below.

18.2.10 Home enteral nutrition

Funding is provided to support home enteral nutrition services given to non-admitted patients who self-administer enteral nutrition at home. All non-admitted patient sessions performed in a single month will be bundled and counted as one, non-admitted service event. A recall/throughput adjustment will be applied for health services whose activity is below or over target.

Health services funded to provide home enteral nutrition must report activity and cost data to the department in 2020–21.

Activity is to be reported via the AIMS S12 form by the 14th day following the end of month and to be reported to VINAH. 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 professional separately.

For more information about subacute non-admitted services, see:

- *Planning the future of Victoria's subacute service system: a capability and access planning framework (2013*) <https://www2.health.vic.gov.au/about/publications/policiesandguidelines/Planning-the-future-of-Victorias-subacute-service-system-A-capability-and-access-planning-framework---February-2013>.
- the *VINAH manual* <https://www2.health.vic.gov.au/hospitals-and-health-services/data-reporting/health-data-standards-systems/data-collections/vinah>.

18.2.11 MBS billing policy framework and best practice guidelines

The MBS billing policy framework and best practice guidelines will be released in 2020.

The *MBS billing policy framework: Victorian public hospitals* is an update to the 2011 policy in the document *Specialist clinics in Victorian public hospitals: A resource kit for MBS-billed services* (and the 2019 errata to the publication) with departmental guidance on best practice for MBS billing provided as a separate document.

These two documents will be updated in the context of the *National Health Reform Agreement* (and the addendum to this agreement) and the Victorian Auditor-General's 2019 report, *Managing Private Medical Practice in Public Hospitals*.

18.3 System improvements

18.3.1 Strengthening hospital responses to family violence

Health services are expected to progressively roll out and embed a whole-of-hospital model for responding to family violence. They should implement a train-the-trainer approach to staff education, actively participate in the community of practice, coordinate reporting and be prepared to meet the requirements for the Child Information Sharing Scheme, the Family Violence Information Sharing Scheme and the Multi-Agency Risk Assessment and Management Framework.

Lead health services are expected to actively mentor and support their nominated health services to roll out and embed their whole-of-hospital model.

The project is managed by The Royal Women's Hospital and Bendigo Health, and reporting requirements are outlined by the project managers. The project toolkit is available from Strengthening Hospital Responses to Family Violence <https://www.thewomens.org.au/health-professionals/clinical-resources/strengthening-hospitals-response-to-family-violence>.

For more information, visit Family violence reform <https://www.vic.gov.au/familyviolence.html>.

18.3.2 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 will continue to work with health services in 2020–21 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://www2.health.vic.gov.au/health-workforce/worker-health-wellbeing>. 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 2020–21. The department requires that all Victorian public health services undertake the Victorian Public Sector Commission's People Matter Survey in 2020, including the Diversity and Inclusion and Sexual Harassment modules.

Health services must publicly report all incidents of occupational violence in their annual report. The department will be working with health services and boards in 2020–21 to improve the reporting and support risk management.

For more information about occupational violence and aggression, and bullying and harassment resources visit Worker health and wellbeing in Victorian health services <https://www2.health.vic.gov.au/health-workforce/worker-health-wellbeing>.

18.3.3 Medical Treatment Planning and Decisions

The *Medical Treatment Planning and Decisions Act 2016* ensures people are provided with medical treatment that is consistent with their preferences and values.

The Act 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 the Act, this will constitute unprofessional conduct.

Health services should have processes in place to:

- 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, an initiative of the Commonwealth, to support communication of advance care plans.

Advance care planning delivery should be embedded into the usual care 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 data items.

More information is available from Advance care planning <https://www2.health.vic.gov.au/hospitals-and-health-services/patient-care/end-of-life-care/advance-care-planning>.

18.4 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 support the implementation of the network's vision to improve patient experiences and outcomes by coordinating cancer care and driving best practice.

ICS will help achieve the following goals stated in the Victorian cancer plan; 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 ICS in 2020–21 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.

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, 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 2020. 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 strategic plan
- 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 2020–21) 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.

Find more information about Victoria's Integrated Cancer Services <https://www2.health.vic.gov.au/about/health-strategies/cancer-care>.

18.5 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 quality improvement 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.

Each indicator has a list of recommended actions that should be undertaken by health services that are looking to improve services or that have suboptimal outcomes. These include:

- an assessment of their capability and the processes to support regular clinical audits and the provision of performance data feedback to clinicians
- a multidisciplinary review of local clinical practice guidelines and protocols to ensure they are based on current evidence and research
- a review of organisational barriers that constrain continual practice improvement
- benchmarking with peer group services
- engaging with other health services to achieve better outcomes that support local and regional improvement (this may include referral of results to their regional perinatal morbidity and mortality committee for expert multidisciplinary consideration)
- identifying improvement goals, including timelines, and working with Safer Care Victoria to monitor performance and improvement initiatives over time.

Safer Care Victoria will work with health services to identify future improvement priorities for 2020–21. For more information visit perinatal services indicators report <https://bettersafercare.vic.gov.au/reports-and-publications/victorian-perinatal-services-performance-indicators-reports>.

18.6 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 strongly encouraged and supports national healthcare standards. It is expected that serious adverse events related to blood or blood components are reported. These are clinical reactions and procedural events including:

- 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 such as:

- *National Stewardship Expectations for the Supply of Blood and Blood Products* <https://www.blood.gov.au/document/national-stewardship-expectations-supply-blood-and-blood-products-pdf> and the *National Patient Blood Management Guidelines Modules 1–6* <https://www.blood.gov.au/pbm-guidelines>
- *National Safety and Quality Health Service (NSQHS) Standards (2nd edition)* available at Assessment to the NSQHS Standards – Australian Commission on Safety and Quality in Health Care <https://www.safetyandquality.gov.au/our-work/assessment-to-the-nsqhs-standards>
- National wastage and haemovigilance strategies, available at the National Blood Authority <https://www.blood.gov.au>.

The department established the transfusion nurse/trainer/safety officer, 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
- providing annual progress reports to the Blood Matters Program.

Learn more about the Blood Matters Program <https://www2.health.vic.gov.au/hospitals-and-health-services/patient-care/speciality-diagnostics-therapeutics/blood-matters> from the department's website.

18.7 Mental health services

18.7.1 Key policies and guidelines

The Chief Psychiatrist's guidelines provide specialist advice on operational and clinical practice in relation to the *Mental Health Act 2014*. For more, see the *Chief Psychiatrist's guidelines* <https://www2.health.vic.gov.au/about/key-staff/chief-psychiatrist/chief-psychiatrist-guidelines>.

Program management circulars articulate or clarify departmental policy on key aspects of service provision and are available from Chief Psychiatrist <https://www2.health.vic.gov.au/about/key-staff/chief-psychiatrist>.

All funded clinical mental health services must be accredited against the *NSQHS Standards (2nd edition)* in 2020–21.

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.

See also the *Guidelines for joint regional planning for integrated mental health and suicide prevention services* <http://www.health.gov.au/internet/main/publishing.nsf/Content/mental-health-intergrated-reg-planning>.

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.

Standards and guidelines are available at the Funded Agency Channel website <http://www.dhs.vic.gov.au/funded-agency-channel>.

More information on mental health service, programs and program guidelines can be found at Mental health <https://www2.health.vic.gov.au/mental-health>.

18.7.2 Mental health performance and accountability framework

The *Mental health performance and accountability framework* will specify the department's 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. In this regard, the framework will provide a key mechanism for monitoring whether a mental health service is delivering services consistent with the department's requirements.

The purpose of the framework is to provide a structure for regular monitoring of mental health policy implementation, the performance of clinical mental health services, and the individual outcomes of people receiving mental health treatment and care. Performance frameworks and indicators are a key strategy for facilitating a culture of continuous quality improvement in mental health service delivery, to improve outcomes for consumers and carers.

18.8 Alcohol and drug services

18.8.1 Key standards and guidelines

Service standards and guidelines that apply to funded alcohol and drug services are listed in section 31 'Service standards and guidelines'. Where organisations receive funding for an activity or service, it is a condition of funding that they adhere to the service standards and guidelines listed under the relevant activity.

Organisations can obtain copies of the relevant standards and guidelines from their departmental program and service advisor or, in some instances, through the department's Funded Agency Channel.

Standards and guidelines are available at the Funded Agency Channel website <http://www.dhs.vic.gov.au/funded-agency-channel>.

Organisations must deliver services in line with the Victorian *Alcohol and other drug (AOD) program guidelines* <https://www2.health.vic.gov.au/alcohol-and-drugs/aod-service-standards-guidelines/aod-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://www2.health.vic.gov.au/alcohol-and-drugs>.

18.9 Ageing, aged and home care services

Service standards and guidelines that apply to funded aged 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'.

18.9.1 Public sector residential aged care – infection 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 VICNISS Coordinating Centre to monitor infection control practices and antimicrobial use in PSRACS.

18.9.2 Aged residents' rights and interests

Health services operating PSRACS must meet Commonwealth Government legislative requirements relating to protecting consumers' rights and interests. This includes meeting obligations for minimising restraint, consumers accommodation agreements, aged care quality standards, police checks for key personnel, staff and volunteers, compulsory reporting for reportable assaults and unexplained absences, and proactive management of complaints including those lodged through the Aged Care Complaints Commissioner.

18.10 Primary, community and dental health

18.10.1 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'.

18.10.2 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. The 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.

Healthcare that counts 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 relevant to the safety and wellbeing of children. *Healthcare that counts* is also supported by free online training at the Children at Risk Learning Portal <https://vulnerablechildren.kineoportal.com.au> and the Vulnerable Children website <https://www2.health.vic.gov.au/about/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. Services are provided by The Royal Children's Hospital, Monash Medical Centre and all regional health services. A key function of the service is to provide a forensic assessment of injury and neglect to children from birth to 18 years where there is suspected child abuse and neglect. The Royal Children's Hospital is responsible for providing leadership and clinical guidance for the statewide service and all regional health services are expected to provide appropriate 24-hour clinical forensic services for these children.

19 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.

19.1 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 (2nd edition)*. Information regarding the standards can be found on the NSQHS Standards – Australian Commission on Safety and Quality in Health Care website <https://www.safetyandquality.gov.au/our-work/assessment-to-the-nsqhs-standards/nsqhs-standards-second-edition>.

All Victorian public health services, including metropolitan (this includes specialist and denominational health services), regional, subregional, local and small rural and multipurpose services, clinical mental health services provided by public health services (including Forensicare), public dental housed within health or community health services, and bush nursing centres, must maintain their accreditation through the Australian Health Service Safety and Quality Accreditation Scheme.

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 publicly funded health organisations* <https://www2.health.vic.gov.au/hospitals-and-health services/quality-safety-service/hospital-accreditation>.

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 1988*, the *Mental Health Act 2014*.

19.2 Pathology services

Victoria entered into a memorandum of understanding with the National Association of Testing Authorities (NATA) in September 2004, in recognition of NATA's role as the national authority in Australia for accrediting laboratories and as an accreditor of inspection bodies.

One of the undertakings made in the memorandum of understanding is that Victoria will encourage all service providers to adhere to the principles of good laboratory practice, which are contained in NATA's relevant accreditation criteria.

NATA and Victoria's Chief Health Officer (on behalf of the department) entered into an additional memorandum of understanding that specifically relates to pathology laboratories. It embodies the spirit of cooperation between the department and NATA in relation to protecting public health.

Based on these undertakings, the conditions of funding are 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.

19.3 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.

19.4 Mental health clinical and community support services

All funded clinical mental health services must be accredited against the *NSQHS Standards (2nd edition)*.

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

Health services providing alcohol and other drug treatment services must be accredited against the NSQHS Standards (see section 19.1 ‘Australian Health Service Safety and Quality Accreditation Scheme’).

Organisations that receive funding for alcohol and other drug services must establish and implement plans to deliver services consistent with the *Victorian alcohol and other drug charter*. The ongoing implementation of plans to deliver services consistent with the Victorian charter is also expected of organisations that will receive funding for alcohol and other drug services in 2020–21.

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.

19.5 Aged care

19.5.1 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 1997*. 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.

The focus of initiatives to be progressed in 2020–21 include:

- piloting performance measures to improve safety and quality, and oversight of this in PSRACS
- continued support for PSRACS to meet Commonwealth regulatory requirements
- better use of evidence in practice to reduce care variation
- piloting of a tool and training to support PSRACS' organisational readiness for consumers with dementia and memory and other cognitive issues.

19.5.2 Home and Community Care Program for Younger People

Organisations funded under Home and Community Care Program for Younger People (HACC-PYP) that also have funds under the Commonwealth Home Support Programme must meet certain quality review requirements. These organisations must provide the department with a copy of the *Home Care Standards: final quality review report* and/or Plan for Continuous Improvement and/or Timetable for Improvement, following their review by the Australian Aged Care Quality Agency.

The Home Care Standards are common to both the Home Support Programme and the Victorian HACC-PYP. Therefore, the Australian Aged Care Quality Agency quality review results against the Home Care Standards will meet quality reporting requirements for HACC-PYP-funded organisations.

The department will provide more information about quality review arrangements for providers funded under HACC-PYP in due course.

19.5.3 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 won't 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. Visit Human Services Standards <https://dhhs.vic.gov.au/publications/human-services-standards> for details.

Relevant quality standards could include the National Standards for Disability Services, EQuIP, ISO 9001:2015, the NSQHS Standards and the Quality Improvement Council Standards.

20 Clinical governance

20.1 Health service clinical governance

All health services and funded organisations must ensure their clinical governance policies and frameworks comply with the current *Delivering high-quality healthcare: Victorian clinical governance framework* <https://bettersafercare.vic.gov.au/our-work/governance/clinical-governance>.

20.1.1 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 2020–21, health services will be expected to:

- notify Safer Care Victoria's Sentinel Event program within the specified timeframes
- begin and maintain an open disclosure process with affected consumers and/or their families
- 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 learnings 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 – visit the Sentinel Events Program webpage <https://bettersafercare.vic.gov.au/our-work/incident-response/sentinel-events>.

Sentinel event notifications and review outcomes must be submitted by emailing Safer Care Victoria <sentinel.events@safercare.vic.gov.au>.

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 additional resources can be accessed from Sentinel events <https://bettersafercare.vic.gov.au/our-work/incident-response/sentinel-events>.

20.1.2 Health services quality and safety reporting

VAHI reports on a range of quality and safety measures and other performance indicators as part of a suite of reports such as *Monitor*, *PRISM*, *Inspire* and the *Board safety and quality report*. Additionally, VAHI produces a quarterly aged care quality indicator report and, twice yearly, both the *Quality and safety in Victorian private hospitals* report and a statewide report about incidents reported on VHIMS. It also reports on a range of health service performance measures to the public every quarter.

In the *Performance monitoring framework* <https://www2.health.vic.gov.au/hospitals-and-health-services/funding-performance-accountability/performance-monitoring>, the department identifies performance measures relating to high-quality and safe care, strong governance, leadership and culture, timely access to care and effective financial management.

VAHI reports these measures in *Monitor*, and the measures reflect the targets set for performance in each health service's SOP.

The audience for *Monitor* is public health services executives and the department. In 2020, *Monitor* was expanded to include all measures outlined in the *Performance monitoring framework*, not just those captured in the SOP.

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

PRISM reports on health services' performance at a more granular level and across a range of access, quality, safety, operational and financial performance measures not reported in *Monitor*. The audience for *PRISM* is also public health service executives and the department. In 2020, additional measures were included in *PRISM* relating to Aboriginal health, mental health consumer experience, emergency surgery and a modified measure reporting on unplanned readmissions for paediatric tonsillectomy and adenoidectomy to any hospital.

Further updates to several existing measures are anticipated including transitioning the remainder of readmission measures to capture readmissions to 'any hospital' and a refreshed risk adjustment model for all currently reported mortality measures.

A new 30-day in-and-out-of-hospital mortality measure relating to acute myocardial infarction will be introduced in the 2020–21 *PRISM* replacing the in-hospital acute myocardial infarction mortality measure.

VAHI is also undertaking work to align the hospital-acquired complication measures to the national *Australian Commission on Safety and Quality in Health Care (v 2.0)* measures and is looking to report on all 15 reportable hospital-acquired complication measures as of the 2020–21 reporting cycle.

Inspire is a report series packaged specifically for clinical leaders across the public health system. For the future, each issue of *Inspire* will present quality and safety information by specific clinical speciality areas (for example, mental health, palliative and end-of-life care).

The *Board safety and quality* report is released every six months and now reports on a range of quality and safety measures aligned to Safer Care Victoria's *Clinical governance framework*.

The *Residential aged care quality indicator* report provides PSRACS with information on a suite of quality indicators including pressure injuries, falls/fractures, use of physical restraint, use of nine or more medicines and unplanned weight loss.

The Victorian health services performance data <https://vahi.vic.gov.au/reports/victorian-health-services-performance>, displayed on the VAHI Portal, provides Victorians with an accurate picture of the performance of health services in their local area. The Portal provides greater transparency and a better understanding of Victoria's public hospital, health service and ambulance service performance. The Portal is accessible to the public to search and view reports on patients treated, emergency care, elective surgery, mental health, specialist clinics, dental care, ambulance services, and quality, safety and patient experience. VAHI updates the Victorian health services performance data every quarter.

20.1.3 Clinical quality registries

Clinical registries collect information to drive improvements in the quality and safety of health care. Victorian public health services and clinicians currently contribute data to approximately 50 health-related national and state-based clinical registries. The Victorian Government provided direct or indirect funding for 17 clinical registries in 2019–20, eight of which met the criteria as clinical quality registries.

The Victorian Government is committed to ensuring data from clinical quality registries is better used by the government 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 and VAHI as the contract managers.

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 is also requested for the purposes of linkage to inform the development of statewide quality and safety indicators that will be reported in VAHI Victorian public health service reports.

The *Clinical quality registry strategy*, developed by VAHI, will guide future investment for identified priority areas, as well as additional operational requirements for registries funded by the Victorian Government. Any policy implications will be clearly communicated to Victorian public health services regarding any changed data collection requirements for identified priority clinical registries funded by the Victorian Government. It is noted that for the State Trauma Registry, the Cardiac Surgery Registry and the Australian and New Zealand Intensive Care Society Adult Patient Database, it is mandatory for public health services, covering procedures captured by these registries, to provide data to these collections.

20.1.4 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 of any health service.

Health services monitoring the occurrence and rate of infections, and comparing these with peer services, provides information on how the service is faring. The following measures to assist in this process can be found on the VICNISS website <http://www.vicniss.org.au>.

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://www2.health.vic.gov.au/public-health/immunisation/adults/vaccination-workplace/vaccination-healthcare-workers>. In 2020–21, it is expected that 90 per cent of all healthcare workers and 100 per cent of frontline healthcare workers will receive an influenza vaccination annually.

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 more of the above measures. This data is then submitted to the department for monitoring against the *Performance monitoring framework* <https://www2.health.vic.gov.au/hospitals-and-health-services/funding-performance-accountability/performance-monitoring> and associated *National Health Reform Agreement* performance measures. The results are shared with health services through the *Monitor*, *PRISM* and *Inspire* reports.

20.1.5 Streamlining clinical trial research

The government continues to encourage clinical trial activity within health services. In particular, the department's framework for streamlining the ethical and scientific review of multisite clinical trials is managed centrally by the Coordinating Office for Clinical Trial Research. Since January 2015, the scope of this framework also includes multisite health and medical research projects. The streamlining framework includes all human research that is conducted as a single site or multisite project. All health services participating in the Victorian 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/site-specific assessments for single 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, 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 Council of Australian Governments Health Council.

Health services hosting an accredited and certified human research ethics committee that reviews multisite clinical trials and health and medical research must demonstrate sufficient ethical reviews to maintain expertise. More information is available at Clinical trial research <https://www2.health.vic.gov.au/about/clinical-trials-and-research/clinical-trial-research>.

20.2 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 governance and management standards, community health services can choose an accreditation body that offers standards that are consistent with the governance and management requirements of the Human Services Accreditation. Visit the Human Services Standards webpage <https://dhhs.vic.gov.au/publications/human-services-standards> for details.

Relevant quality standards could include the National Standards for Disability Services, EQuIP, ISO 9001:2015, the National Safety and Quality Health Service Standards and the Quality Improvement Council 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 the NSQHS Standards.

Performance monitoring of accreditation against the national standards by the department and Dental Health Services Victoria in 2020–21 will be undertaken as per the *Accreditation: performance monitoring and regulatory approach business rules* (2013).

21 Consumer rights and community participation

The Australian Commission for Safety and Quality in Healthcare launched *My healthcare rights* – the second edition of the Australian Charter of Healthcare rights in August 2019. *My healthcare rights* includes three new rights reflecting an increased focus on person-centred care and consumer empowerment. These new rights are partnership, information and provide 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 developed included 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/australian-charter-healthcare-rights>. Organisations can now also adapt resources to specific contexts via the commission's Partnering with Consumers team.

21.1 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; and effective communication. Each domain can be progressed and actioned in a practical way at three levels: the 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 and clearly describes consumer priorities for health services and Safer Care Victoria and aligns with the department's priority areas.

In 2020–21, 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 June 2021. Further information can be found at Partnering in healthcare – Better Safer Care website <https://www.bettersafercare.vic.gov.au/resources/tools/partnering-in-healthcare>.

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/our-work/assessment-to-the-nsqhs-standards/nsqhs-standards-second-edition>.

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 that affect people in care relationships.

The *Carers Recognition Act 2012* 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 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://www2.health.vic.gov.au/ageing-and-aged-care/supporting-independent-living/supporting-people-in-care-relationships>.

21.2 Victoria's health experience

21.2.1 Victorian Healthcare Experience Survey

The Victorian Healthcare Experience Survey (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 and community health services.

Results from the VHES program are shared with Victorian public health services, Safer Care Victoria and the department and provide actionable insights that support improvement in patient-centred care and service delivery.

Following consultation with stakeholders, in 2020–21 VAHI will transition the VHES program to a new operating model. Reforms focus on delivering more timely results and increasing patient participation in the program and include implementing an electronic platform for data collection and redesign of the survey questionnaire.

VAHI will continue to consult with Victorian public health services to inform the implementation of program reforms.

21.2.2 Community Health Services Victorian Healthcare Experience Survey

All community health services are expected to participate in the Community Health Services Victorian Healthcare Experience Survey. 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.

21.2.3 Your Experience of Service Survey

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

21.3 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 a 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 2019–20, VAHI ran three PROMs initiatives:

- Utility of PROMs in Cancer Care, collected through a VHES survey program instrument
- Closing the data feedback loop utilising Clinical Quality Registry Patient Reported Outcomes (PROs) data in the area of stroke
- Australian Orthopaedic Association National Joint Replacement Registry PROMs Pilot.

The National Joint Replacement Registry PROMs pilot will be expanded in 2020–21 to include all Victorian public hospitals contributing joint replacement procedure data to the registry. The Cancer Patients' Experiences of Care Chemotherapy Survey, inclusive of six PROMs questions, was sent to 12,000 patients between March and May 2020. The analysed results from this collection of PROMs will be available on the VHES portal in 2020–21. The evaluated results of all three initiatives will inform the statewide approach to PROMs.

21.4 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 1988*) 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.

21.4.1 Primary care and population health advisory committees

Under the *Health Services Act 1988*, 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.

21.5 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, visit Quality accounts <https://bettersafercare.vic.gov.au/our-work/governance/quality-accounts>.

21.6 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.

The focus for state-funded Primary Care Partnerships is in prevention, access, equity and integration. The work of Primary Care Partnerships should align with the department's focus on place-based efforts, prevention and population health, family violence, the integration of health and social care, and strategic partnership development or chronic disease management, where this work is already occurring or has been identified as a local need.

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 commission and integrate local services to increase the efficiency and effectiveness of medical services for patients, particularly those at risk of poor health outcomes.

The department has entered into a memorandum of understanding with the six Victorian Primary Health Networks and the Victorian Primary Health Network Alliance to strengthen collaborative working arrangements. The memorandum of understanding will support and enable the successful implementation of national and state health policies, including for mental health and alcohol and other drugs, and will provide governance to support key joint initiatives.

The Coordinated Care Bilateral Agreement between the Victorian and Commonwealth governments aims to improve the delivery of care for patients with chronic and complex conditions to improve health outcomes and reduce avoidable demand for health services through system integration and reform activities. Primary Health Networks have been implementing stepped models of care in mental health and look to build the capacity and capability of the mental health workforce and development of more effective mental health services.

21.7 Primary Health Network funding and emergency management

The department provides annual indexed funding of $15,484 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 and support the department by participating in local, regional and health service emergency planning in line with the *State health emergency response plan* and to facilitate the department's access to general practitioners to work in a range of local, time-limited primary care settings, such as field primary 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.

21.8 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 identified person who is responsible for addressing patient concerns and who is visible and accessible to patients. The contact details for the identified person should be readily accessible (including on the hospital's website) and consumers must be able to meet with them in person within a week of initial contact.

Under the *Health Complaints Act 2016*, 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>.

Under the Act, the Health Complaints 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 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>.

22 Financial requirements

22.1 Health service procurement and purchasing requirements

Under the *Health Services Act 1988*, Health Purchasing Victoria is responsible for:

- developing, implementing and reviewing policies and practices to promote best value and probity in relation to the supply of goods and services to health services, along with the management and disposal of goods
- ensuring probity is maintained in purchasing, tendering and contracting activities in health services
- providing advice, staff training and consultancy services in relation to the supply of goods and services to the health sector
- monitoring compliance by health services with purchasing policies and Health Purchasing Victoria directions and to report irregularities to the Minister for Health.

Health Purchasing Victoria's purchasing policies establish a procurement policy framework for health services incorporating 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 HPV policies – Health Purchasing Victoria website <https://www.hpv.org.au/compliance/purchasing-policies/our-policies>.

To meet its responsibilities in monitoring health service compliance with purchasing policies and reporting irregularities to the Minister for Health, Health Purchasing Victoria has developed a compliance framework that includes support and prevention activities such as education, training, advice and guidance, as well as monitoring. All mandated health services must:

- complete an annual compliance self-assessment requiring:
  - compliance with the Health Purchasing Policies and the Health Purchasing Victoria Collective Agreements
  - the self-assessment to be approved and submitted to Health Purchasing Victoria by the health service chief executive officer or delegated officer for inclusion in the Health Purchasing Victoria annual report
- complete compliance audits to the Health Purchasing Policies requiring:
  - the chief executive officer of a mandated health service to audit compliance as per the Act
  - an audit once every three years (Health services must provide the final audit report to Health Purchasing Victoria by 30 June in the year the audit is scheduled)
  - findings to be reported to the Health Purchasing Victoria Board and monitored until the health service has addressed and closed the issues (Health Purchasing Victoria must report high-risk areas of noncompliance to the Minister for Health)
- provide information and data on procurement activities:
  - Health Purchasing Victoria can require the chief executive officer of a mandated health service to provide information and openness 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 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.ombudsman.vic.gov.au/Publications/Parliamentary-Reports/Probity-controls-in-public-hospitals-for-the-procu> and the Victorian Auditor-General's report *Procurement practices in the health sector* <https://www.audit.vic.gov.au/report/procurement-practices-health-sector>.

All health services are encouraged to complete Health Purchasing Victoria's probity training for health service management and staff with procurement responsibilities. Health services are also encouraged to consult with Health Purchasing Victoria on any high-value or high-risk procurement activities.

22.2 Compliance with financial requirements

Section 30(2) of the *Health Services Act 1988* 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.

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 exceeds 10 per cent of the annual revenue of the agency or health service or $2 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.

22.2.1 Leases

From 1 July 2019, compliance with AASB16 Leases requires most operating leases (the exceptions being low-value asset leases with individual lease 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 reported in the BDO Lead software provided by the department. The other exceptions to this reporting requirement are motor vehicle leases with VicFleet and leases attributable to public-private partnership arrangements.

The lease liability for all leases will contribute to an overall borrowing cap for each portfolio entity. Each entity must manage its lease liabilities and any other approved borrowings within this borrowing cap and include this amount in the revised estimates provided to the department – this is the borrowing amount that is reported to the Department of Treasury and Finance and upon which each entity's cap will be based.

An entity should seek approval from the Minister for Health and the Treasurer, through the department, for any lease contracts causing the overall lease liabilities to exceed the borrowing cap in the revised estimates, to avoid a breach of the Standing Directions of the Minister for Finance 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 1988*), 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 1987* 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* (2015). The framework adopts the *Australian and New Zealand Standard AS/NZS ISO 31000:2009 Risk Management – Principles and Guidelines*, which provides a generic, internationally accepted basis for best practice risk management.

All agencies must fully comply with the requirements of Standing Direction 3.7.1 'Risk management framework and processes', and are responsible for appropriately identifying, assessing and managing all risks to which they are exposed. Agencies should establish and maintain effective risk governance that includes an appropriate internal management structure and oversight arrangements for managing risk. The responsible bodies are directly accountable for their organisation's risk management obligations.

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>.

22.2.2 Investments

Standing Direction 3.7.2 'Treasury management' requires all public sector entities, including public hospitals, to ensure all money, subject to the exceptions identified in the Standing Direction, be deposited within the Central Banking System (CBS) unless an exemption has been provided by the Treasurer. Within 3.7.2 there is automatic exemption for money held on trust by the agency for, and repayable to, a known beneficiary pursuant to a statutory function. A specific exemption can also be obtained by obtaining the Treasurer's approval under Standing Direction 1.5(b).

In recommending the establishment of the CBS (and as subsequently approved by the Treasurer) the Department of Treasury and Finance specifically addressed the issue of money receipted by agencies from a specific donation (a bequest, parents and friends or hospital auxiliaries). This meant that Funds raised by hospital auxiliaries or community fundraising are not required to be transferred to the Central Banking System.

On the establishment of the CBS, investments held with the Victorian Funds Management Corporation (VFMC) were permitted to remain outside of the CBS where these investments were in accord with the previous version (February 2016) of the Standing Directions. The Department of Treasury and Finance committed to review all investments held with VFMC and Standing Directions and continue to be in consultation with the department. The review is expected to be completed by quarter 2 of 2020/21 and will provide more clarity on the reporting requirements and treatment of financial assets.

22.3 Goods and services tax

Funded organisations must register for an Australian Business Number and register for goods and services tax (GST) if required. Each funded organisation is responsible for its own tax compliance and liabilities.

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 1999*. Funding from the department to non-government organisations are taxable supplies. Public hospitals and Ambulance Victoria are government-related entities under ss. 8 and 41 of the *Australian Business Number Act 1999*.

23 Asset and environmental management

Asset management is the coordinated activities, carried out over the asset's whole lifecycle, 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 lifecycle, 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 active participation 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.vhhsba.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>.

23.1 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 lifecycle.

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 was required to submit an asset management plan for 2019–20 detailing how they are managing their asset base.

23.1.1 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 and Human Services Building Authority (VHHSBA) no later than at the end of October 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 the Asset management webpage <http://www.capital.health.vic.gov.au/Asset_property_management_and_operations/Asset_management>.

23.1.2 Reporting

As a condition of funding, all 2019–20 specific-purpose capital grant expenditure is required to be reported as part of AIMS by the end of September 2020. 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 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.

More information is available from the Asset management webpage <http://www.capital.health.vic.gov.au/Asset_property_management_and_operations/Asset_management>.

23.1.3 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.

23.1.4 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 upon 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, VHHSBA may recall distributed funds for reallocation to other high-risk projects across the sector.

23.1.5 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 Health Purchasing Victoria to maximise value-for-money procurement of medical equipment and deliver the most efficient purchasing arrangements, including standardisation and bulk purchasing and achievement of economies of scale.

For more information, refer to procurement and purchasing requirements and the Health Purchasing Victoria website <http://www.hpv.org.au>.

23.1.6 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.

The asset status should be updated in the asset management plan and asset register.

23.2 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*).

Real property assets under health service management should be zoned appropriately for current or proposed use and health services 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 from Property management – Related legislation, policies and guidelines <https://www.vhhsba.vic.gov.au/resources/property>.

23.3 Asset maintenance

Clause 3.4.3, 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 to ensure asset risks are being mitigated or eliminated during the lifecycle 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 please view *Maintenance standards for critical areas in Victorian health facilities* <https://www2.health.vic.gov.au/about/publications/researchandreports/maintenance-standards-for-critical-areas-in-victorian-health-facilities>.

23.4 Critical asset service failure

Clause 3.1.5, 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, 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 VHHSBA within four weeks of the incident.

23.5 Health service environmental management and planning and reporting

The Victorian Government acknowledges the effects of climate change and has legislated commitments through the *Climate Change Act 2017* to achieve net zero carbon by 2050 and adapt to the effects of climate change. 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 VHHSBA's *Environmental sustainability strategy 2018–19 to 2022–23* <https://www.vhhsba.vic.gov.au/sites/default/files/2019-10/VHHSBA-Environmental-sustainability-strategy-2018-19-to-2022-23.pdf>.

In addition, direction on the department's response to climate adaptation is in the *Pilot health and human services climate change adaptation action plan 2019–21* <https://www2.health.vic.gov.au/public-health/environmental-health/climate-weather-and-public-health/climate-change-and-health/strategy>.

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 as follows:

- 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 services 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 produces a standard report, which meets these reporting requirements.

A template environmental management plan and the environmental reporting guidelines are available at Environmental management planning and reporting <https://www2.health.vic.gov.au/hospitals-and-health-services/planning-infrastructure/sustainability/planning-reporting>.

Metropolitan health services are to implement and maintain PVC recycling in (at a minimum) theatre, intensive care and dialysis departments. Implementation of PVC recycling in regional and rural 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.vhhsba.vic.gov.au/guidelines-sustainability-capital-works>. The inclusion of a sustainability budget of 2.5 per cent of total construction cost is encouraged to support initiatives beyond standard practice.

Health services are to report any energy, water, waste, transport and paper data (that is not already centrally uploaded) in the environmental data management system. The reporting of medical gases and refrigerant data is encouraged but is not mandated for the 2020–21 reporting year. The environmental data management system can be accessed at the Edensuite website <https://dse.edensuite.com.au>.

24 Information and communication technology standards

The Digital Health branch, through the department's health systems manager role, aims to ensure health services operate their 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.

The *Digitising health* strategy identifies the basis for investment in health information and related technologies. It aims to ensure alignment with the desired outcome of a person-centred system where the individual is at the centre of improved health and wellbeing outcomes. *Digitising health* was endorsed by the Minister for Health in November 2016.

In 2019, the Digital Health branch, in consultation with the health sector and other key stakeholders, developed Victoria's *Digital health investment roadmap*, which supplements *Digitising health*. The roadmap outlines five work programs to achieve digital health maturity within Victoria over the next five years.

A primary focus of both the roadmap and the strategy is on ensuring health care is delivered through reliable and resilient systems. In practice, this means reducing the risk of network outages, downtime and cyber incidents by removing the vulnerabilities associated with continued use of aged, legacy technical infrastructure and uplifting the sector's capability to mitigate cybersecurity intrusions.

Health services must work with the branch to develop and agree digital health initiatives that:

- align to the *Digitising health* strategy
- optimise cybersecurity and ICT operational robustness
- adhere to interoperability standards that enable the sharing of clinical information across the health sector.

Rural health services must participate in an ICT Alliance, as specified in the *Rural public health care agencies alliances policy* (2008). The policy is currently being updated, with the revised policy scheduled to take effect from 1 July 2020. The requirement for participation in an ICT Alliance remains unchanged.

24.1 Governance

The Victorian Health Chief Information Officer Forum, which meets monthly, is the sector's primary 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
- ICT operational assurance
- Microsoft licensing
- the Clinical Grade Network
- image sharing
- the standard 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.

24.2 Statewide programs

As 'system manager', the Digital Health branch is responsible for developing, establishing and maintaining the overarching programs and standards that will:

- 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, with these strategies, plans and activities aligning with the *Digitising health* roadmap, strategy and statewide programs.

This model of two-tiered accountability facilitates information sharing, protects patient and clinical data, mitigates risk and leverages aggregated purchasing power.

Health services are currently expected to align with and participate in the following statewide programs:

- Unique Patient Identification
- Victorian Health Service Cyber Security Program
- Victorian ICT Operational Assurance Program
- Victorian Business Impact Assessment Program
- connection to My Health Record, and provision of viewing capability for clinical staff.

Rural and regional health services must participate in ICT Alliances via joint venture agreements, as specified in the *Rural public health care agencies alliances policy*.

Non-participation in any of these programs puts at risk the integrity of healthcare delivery and requires approval from the health service board and negotiation with the Digital Health branch.

24.2.1 Strategic investments

Prior to approaching the market for strategic ICT investments, health services must seek approval from the Secretary to the department. Strategic projects should align with the *Digitising health* strategy and roadmap. Where there is ambiguity, health services should 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.

All health service projects with an ICT component greater than $1 million must be reported via the branch to the Department of Premier and Cabinet for inclusion in the quarterly ICT project dashboard. Additionally, all projects on this dashboard with an ICT budget exceeding $10 million are to be subjected to independent project quality assurance.

24.3 ICT incidents

In its role as system manager, the Digital Health branch must be informed of critical or major ICT and cybersecurity incidents when they occur in health services. In many cases, the branch and the department's Health Technology Solutions team can help resolve incidents.

'Critical incidents' are those that affect the delivery of quality and safe care to patients. These are to be reported to the department within one hour of the incident occurring.

Critical incidents also include data breaches and cyber incidents. Health services should have an incident management plan in place to manage local incidents. (A template is provided to help develop local plans). Further detail on the template and its use is available from the Health Services Cybersecurity Working Group.

'Major incidents' are those that place the delivery of patient safety and care at risk. Incidents that may have a significant clinical impact on business processes are also included in this classification. Major incidents are to be reported within two hours of occurrence.

24.4 Health ICT standards

Adoption of health ICT health standards enhances patient safety and supports continuity of care across settings, as specified in the *Statewide health strategic ICT framework (2015)* <https://www2.health.vic.gov.au/about/publications/policiesandguidelines/Statewide-Health-ICT-Strategic-Framework>.

The health ICT standards cited below are specified in Digital Health Standards and Guidelines <https://www2.health.vic.gov.au/hospitals-and-health-services/quality-safety-service/digital-health/dh-standards-guidelines>.

Funded health services must comply or align with these standards when planning or implementing digital health and ICT projects:

- national terminology for enterprise-wide electronic medical record implementations – Australian standard terminology and the Australian Medicines Terminology
- the prevailing Australian version of the Health Level 7 (HL7), as referenced on *Digital design unified implementation guide* <https://www2.health.vic.gov.au/hospitals-and-health-services/quality-safety-service/digital-health/dh-standards-guidelines/digital-design-unified-implementation-guide> for use in Victoria (currently the recommended Victorian standard is HL7 v 2.4)
- provision of clinical documents to the My Health Record system 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)
- interactions with My Health Record, which are also cited in Actions 1.17 and 1.18 of the NSQHS Standards <https://www.nationalstandards.safetyandquality.gov.au/1.-clinical-governance/patient-safety-and-quality-systems/healthcare-records>
- standard national clinical documents including *eReferral*, *Discharge summary*, *Shared health summary* and *Event summary*, which are specified at Clinical documents – Australian Digital Health Agency <https://developer.digitalhealth.gov.au/specifications/clinical-documents>
- the *National Product Catalogue* and associated standards and specifications, which are specified by GS1 at the National Product Catalogue website <https://www.gs1au.org/our-services/national-product-catalogue>
- the *National Health Services Directory* as the primary source for services directory and location information

- the *National ehealth security and access framework* <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 Victoria's *Cybersecurity uplift strategy*, with 72 cybersecurity controls[5] broken down in two categories for ease of implementation:
  - 38 **foundational** controls, of which 18 are mandatory controls
  - 34 **advanced** controls
- Standards Australia's *Digital hospitals handbook* <https://www.standards.org.au/news/new-australian-publication-to-accelerate-digital-hospitals>
- *Electronic medications management systems: a guide to safe implementation*, maintained by the Australian Commission on Safety and Quality in Health Care and
- National guidelines for on-screen display of medicines information and the National guidelines for on-screen display of discharge summaries, maintained by the Australian Commission on Safety and Quality in Health Care.

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/safety-in-e-health>.

The Australian Digital Health Agency website is a useful source of reference material for digital health planning. Technical specifications can be found at the agency's Resources for Implementers and Developers webpage <https://digitalhealth.gov.au/implementation-resources>. The information contained on the site is subject to changes in both standards and their policy settings.

Health services must continually review the information on the Digital Health branch website. This references information from the Australian Digital Health Agency but also includes specific Victorian extensions and other local information that take account of the Victorian legislative and policy framework.

[5] The 72 baseline cybersecurity controls are derived from the National Institute of Standards and Technology's *Cybersecurity framework* and have alignment with other international standards for cybersecurity: ISO 27001/2 and ISO 27018.

25 Risk management

25.1 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.

25.1.1 Risk management

The *Health Services Act 1988, Public Administration Act 2004* and the *Financial Management Act 1994* 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 on 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 supports the development of a positive risk culture within the organisation
- the risk management processes are effective in managing risks to a satisfactory level
- it is clear who is responsible for managing each risk
- inter-agency risks are addressed, and the organisation contributes to the management of shared risks across government, as appropriate
- the organisation contributes to the identification and management of state significant risks, as appropriate
- risk management is incorporated in the organisation's corporate and business planning processes
- adequate resources are assigned to risk management
- the organisation risk profile has been reviewed within the past 12 months.

An organisation's risk management framework can consist of the following components:

- a risk management policy and plan that integrates with corporate planning
- risk registers and profiles
- an incident management system (refer to section 16.6 'Patient and client safety')
- risk management tools, templates and training
- business continuity and emergency management plans
- compliance and quality systems
- a fraud and corruption control plan.

These components assist funded organisations in developing an effective risk-aware culture that 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 *AS ISO 31000:2018 Risk Management – guidelines* <https://infostore.saiglobal.com/en-au/Standards/AS-ISO-31000-2018-1134720_SAIG_AS_AS_2680492> and *HB 158:2010 Delivering assurance based on ISO 31000:2009: Risk management – principles and guidelines* <https://infostore.saiglobal.com/en-au/Standards/HB-158-2010-129591_SAIG_AS_AS_274229>.

25.1.2 Assurance activities

Assurance activities are designed to provide independent conclusions and 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
- 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.

Attestations, internal and external audits, accreditations and surveys are some categories of assurance activities that funded organisations may use to provide independent and 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 the following components:

- an assurance strategy and internal audit charter linked to organisational objectives
- an assurance map detailing the sources of all assurance activities
- a risk-based assurance and audit plan outlining planned activities
- registers and reports to track implementation progress of recommendations
- key performance indicators of assurance activities.

25.1.3 Integrity governance

All health services must have the appropriate assessment and mitigation strategies in place to ensure better integrity practice across their organisation. The *Integrity governance framework and assessment tool* has been developed as a better practice assessment and reporting tool to guide and support better integrity practice.

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://www2.health.vic.gov.au/hospitals-and-health-services/funding-performance-accountability/integrity-governance-framework>.

Health services will also be required to attest that appropriate internal controls exist to review and address integrity, fraud and corruption risks in their annual reports.

25.2 Emergency management

25.2.1 Health and human services sector emergency preparedness policy

The department's *Health and human services sector emergency preparedness policy 2018–19* supports the health and human services sector to maximise the health, wellbeing and safety of Victorians who access their services before, during and after emergencies.

The policy requires the health and human services sector to prepare for, and respond to, emergencies. It achieves a consistent sector-wide approach to preparing for emergencies, while considering the need for local flexibility and individual client needs.

Compliance requirements of funded agencies are outlined in the policy.

The policy and other emergency management information relevant to funded organisations is available at Emergency management <https://providers.dhhs.vic.gov.au/emergency-management>.

25.2.2 Vulnerable people in emergencies policy

The *Vulnerable people in emergencies policy* assists funded organisations to improve the safety and wellbeing of people who are at greater risk in emergencies.

The policy outlines the responsibilities of funded organisations to support personal emergency preparedness planning and administration of client records on vulnerable persons registers.

The policy applies to in-home and community-based services that are delivered within the 64 municipal council areas wholly or partly covered by Country Fire Authority districts.

The *Vulnerable people in emergencies policy* and relevant guidelines are available from Emergency management <https://providers.dhhs.vic.gov.au/emergency-management>.

25.2.3 State health emergency response arrangements

The *State health emergency response plan* is a subplan of the *Victorian state emergency response plan.* It outlines the arrangements for coordinating the health response to emergency incidents that require significant and coordinated effort to ensure that the health system can respond effectively, while easing any adverse health consequences for communities.

Under these arrangements, the department's key health responsibilities include Control Agency for public health emergencies and managing the health response during any emergency.

The *State health emergency response plan* is supported by a suite of operational response plans and protocols that provide additional detail to support the health sector before during and after emergencies.

The health emergency response plan and the operational response plans, protocols and guidelines make up the State Health Emergency Response Arrangements and are available at State Health Emergency Response Arrangements <https://www2.health.vic.gov.au/emergencies/shera>.

Plans relevant to health services include:

- *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.

Copies of the health emergency response plan, the *Code Brown guidelines*, *Emergency incident casualty data collection protocol* and the *First wave notification factsheet* are available at State Health Emergency Response Arrangements <https://www2.health.vic.gov.au/emergencies/shera>.

25.3 Fire risk management

Funded organisations are responsible for ensuring they comply with the department's *Capital development guidelines on fire risk management* <http://providers.dhhs.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. A list of accredited practitioners can be found at Fire risk management accreditation <https://providers.dhhs.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 the following, 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's capital development guidelines on fire risk management.
- ensure (at the time of client placement in any premises) the premises comply with all laws relating to fire protection, 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 organisations Emergency Planning Committee must be informed, and appropriate action taken.

Health services funded by the department must comply with the department's guidelines on fire risk management and must complete and return an Annual Fire Safety Certificate to the department's Fire Services Team via the certificates email <FRMUCertificates@dhhs.vic.gov.au>, or through their respective fire services coordinator by 30 September each year.

More information on fire risk management and annual fire safety certificates are available from Fire risk management procedures and guidelines <http://providers.dhhs.vic.gov.au/fire-risk-management-procedures-and-guidelines> or by emailing the fire services coordinators <fireriskmanagementunit@dhhs.vic.gov.au>.

26 Legal obligations

26.1 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.

26.2 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*).

26.3 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, world-wide, 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, including the right to sublicense. 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.

27 Payments and cash flow

27.1 Payments to funded organisations

In 2020–21, 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>. The department will monitor hospital cash flows as reported monthly in the financial data (F1) cash flow statement.

The department will make monthly payments to community service organisations through the Service Agreement Management System. Cash flow 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.dhhs.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.

27.2 Enterprise bargaining

27.2.1 Expiring agreements and enterprise bargaining

Negotiations for an enterprise agreement for Ambulance Victoria paramedics were settled on 3 March 2020, and for Nurses and Midwives on 17 April 2020, with heads of agreement entered into for each. Four other enterprise agreements will expire in the 2019–20 financial year (covering Ambulance Victoria administrative staff, mental health, Victorian Institute of Forensic Mental Health and allied health staff).

27.2.2 Wages policy

The Victorian Government's current *Wages policy* and *Enterprise bargaining framework* commenced on 17 April 2019. The *Wages policy* has three pillars:

- wages – increases in wages and conditions capped at a rate of growth of 2 per cent per annum
- best practice employment commitment – public sector agencies are to outline measures to operationalise elements of the government's Public Sector Priorities that reflect good practice and can be implemented operationally or without significant cost
- additional strategic changes – changes to allowances and other conditions will only be allowed if the government agrees that the changes will address key operational or strategic priorities

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

More information on the *Enterprise bargaining framework* is available at wages policy and the enterprise bargaining framework <https://www.vic.gov.au/wages-policy-and-enterprise-bargaining-framework>.

27.2.3 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 being sought from Treasury. 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.

27.3 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*. Eligible agencies must, however, reflect the movements in the long service leave provision associated with the revaluations in their long service leave provision.

The department funds the annual increase in the long service leave provision[6] 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.

27.4 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.

[6] The increase excludes the impact of bond rate and probability factors (revaluations).

28 Data collection changes

The following sections describe the key data collection changes. Please also refer to data collection changes <https://www2.health.vic.gov.au/hospitals-and-health-services/data-reporting/health-data-standards-systems/annual-changes>.

28.1 Victorian Admitted Episodes Dataset

The department will progress a proof of concept project during 2020–21 to investigate the feasibility of collecting clinical data from health service clinical systems instead of from the VAED. This project will focus on key data elements already in the VAED and may provide an alternative for health services that record VAED-related data outside of their patient administration systems.

28.2 Elective Surgery Information System

There will be limited changes to the ESIS from 1 July 2020, with the only change to proceed relating to the order of fields in the extract file.

28.3 Agency Information Management System

From 1 July 2020, HACC Program for Younger People – Annual Fee Report will be removed.

28.4 Victorian Emergency Minimum Dataset

From 1 July 2020, correctional service telehealth presentations will be included within the scope of the VEMD.

28.5 Victorian Ambulance Dataset

From 1 July 2021, the Victorian Ambulance Dataset will be broadened to include quality and safety data at the patient level to enable the replacement of the quality and safety measures in the Monthly Data Set provided by Ambulance Victoria.

28.6 Victorian Integrated Non-Admitted Health minimum dataset

The department will focus on improving the coverage of VINAH in 2020–21, as well as investigating complementary systems to collect non-admitted patient activity. Additional programs and health services that are not currently in scope for VINAH reporting will be investigated and a plan for implementation will be developed.

28.7 Victorian Perinatal Data Collection

Health services where births occur (or where a midwife or medical practitioner attends a birth not in a health service) are required to report the information set out in the birth report specified by the Consultative Council on Obstetric and Paediatric Mortality and Morbidity for inclusion in the Victorian Perinatal Data Collection (VPDC). Refer to section 29.2.13 ‘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 to collect and analyse 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 and congenital anomalies relating to every birth in Victoria from 20 weeks’ gestation. 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 are available from Notifying the VPDC <https://bettersafercare.vic.gov.au/about-us/about-scv/councils/ccopmm/notifying-the-vpdc>.

In 2020–21, there will be a continuing focus on data 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.

28.8 Public sector residential aged care services

Performance and quality improvement changes are as follows:

- Services should note that during 2019–20 a set of expanded performance measures for PSRACS began being piloted, with a sector-wide rollout expected in 2021–22
- PSRACS are expected to consider the interim and forthcoming recommendations from the Royal Commission into Aged Care Quality and Safety and how they can apply these to improve quality and safety for consumers
- 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 Standards.

28.9 Aged care assessment services

On 7 March 2016, Victorian aged care assessment services transitioned to operating in the national My Aged Care gateway. The former ACE database has been decommissioned. Since August 2016, all aged care assessment services data is being recorded in the My Aged Care system. The Commonwealth provides monthly performance reports to the department.

29 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 2020–21 versions of data collection manuals and any other amending documents prepared by the department.

29.1 Data integrity

Accurate data is critical 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 information technology 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.

Data integrity guidelines for health services are available to assist health services in meeting the requirements for integrity in data they provide to the department.

A new *Health data integrity program plan* detailing the health data integrity program will commence in 2020–21. The program will incorporate the same core health data collections previously subject to regular review including the:

- VAED (and admitted subacute data reported to VAED)
- ESIS
- VEMD
- VCDC
- VINAH – Specialist clinics.

The program comprises a mix of formal audit of core datasets based on established audit protocols and a targeted approach based on data analytics and risk assessment. The program ensures 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 recommend opportunities to improve it.

The health data integrity program may be expanded to additional health service data collections based on stakeholder priorities and analytics.

Health services are expected to actively participate in the program of system-wide inspections, checks and reviews of their health service data and related processes, including responding to data analytics queries.

29.1.1 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.

The *Health Data Standards and Systems (HDSS) bulletin* provides advice on data quality issues to health services that contribute to the VAED, VEMD, ESIS, VINAH 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 free. Subscriptions may be arranged by emailing the Health data standards and systems helpdesk <HDSS.Helpdesk@dhhs.vic.gov.au>.

29.1.2 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.

29.2 Key systems

The department operates several data collections on different aspects of health service activity. Key systems include:

- F1/Common Chart of Accounts
- Portfolio Financial Reporting
- the VAED for admitted patient activity
- the VEMD for designated emergency department activity
- the ESIS for monitoring elective surgery waiting lists
- the VINAH minimum dataset for non-admitted patient activity
- AIMS, used primarily to collect summary-level financial and statistical information
- the VCDC for patient-level costs
- the VPDC for births
- Client Management Interface and Operational Data Store (CMI/ODS) for mental health client data.

29.2.1 Financial data

F1 financial returns for all health services and other portfolio entities (excluding cemeteries and VicHealth), at the entity level, are required by close of business on the 12th calendar day after the end of the month to which the financial data relates (for example, the F1 for July is required by close of business on 12 August). Data relating to approved budgets and revised estimates are required less frequently and as advised by the department.

A timetable for the portfolio financial reporting requirements for whole-of-government will be released separately. F1 submitted data will be used each month as a basis for further data requirements in the portfolio financial reporting system that is used for whole-of-government reporting. This collective data is then 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, hospitals will be required to amend and re-submit this data through the F1. This re-submission must occur in a timely manner.

Public hospitals are also required to report both an approved budget and a revised estimate (end-of-year forecast) to the department through the F1; the:

- submitted approved budget should match the agreed SOP and only be amended when agreed with the department
- revised estimate is to be in the form of a full end-of-year trial balance and reflect the most up to date forecast result and financial position. At certain dates, as advised separately by the department, the revised estimate submissions must be accompanied by a chief financial officer sign-off (a template will be provided by the department). The revised estimates 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:
  - initial estimate – 12 August
  - mid-year estimate – 12 December (for departmental reviews) and 12 January (for any amendments and updates required for the state's budget papers)
  - year-end forecast – 12 April, 12 May and 5 June.

Public hospitals 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 for both the F1 and portfolio financial report will be monitored and reported through performance monitoring staff in the department.

29.2.2 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 critical to ensuring accurate and equitable funding outcomes, supporting health services' planning, policy formulation, program evaluation and epidemiological research. Analyses and consolidated activity data are provided from the VAED to meet the department's reporting obligations to the Commonwealth and to various research institutes.

Further information on the VAED is contained in the VAED manual <https://www2.health.vic.gov.au/hospitals-and-health-services/data-reporting/health-data-standards-systems>.

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 small rural health services) will code patient episodes reported to the VAED in accordance with the current *Australian Coding Standards*, along with Victorian additions, and any amending documents 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 10th 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 10th day of the second month following separation
Data for the 2020–21 financial year	Must be submitted by 5.00 pm on 10 August 2021
Final corrections to data for 2020–21	Must be submitted by 5.00 pm on 24 August 2021

It is the health service's responsibility to ensure that data files are submitted on or before the 10th of each month regardless of the actual day of the week.

Penalties for noncompliance

Where health services are noncompliant with the timelines specified above, the department may apply the following penalties:

- up to $20,000 per month if more than 1 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 1 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 Department of Veterans' Affairs.

Exemptions for late submission 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 submission schedule.

A pro forma to assist this process is provided on the HDSS website <https://www2.health.vic.gov.au/hospitals-and-health-services/data-reporting/health-data-standards-systems>.

If difficulties prevent the reporting of patient-level data to the VAED, the health service must complete the AIMS S1A form by the 10th of the month. The AIMS S1A form is submitted via HealthCollect. For assistance with the S1A, email the HDSS helpdesk <hdss.helpdesk@dhhs.vic.gov.au>. Failure to complete the S1A form by the due date will 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.

29.2.3 Victorian Emergency Minimum Dataset

Emergency departments must submit data to the VEMD according to the timelines in Table 3.

Table 3: Victorian Emergency Minimum Dataset timelines

VEMD	Timeline
All presentations to be submitted every weekday	Until further notice, all presentations must be supplied by 5.00 pm of the following working day
All presentations for the full month without errors	Must be complete and correct – that is, zero rejections and notifiable edits by 5.00 pm on the 10th day of the following month, or the prior business day

Any corrections to 2020–21 data must be submitted before final consolidation of the VEMD on 27 July 2021.

Penalties for noncompliance

If health services are noncompliant with these timelines, the department may apply the following penalties:

- up to $5,000 per month, if a file containing presentations for the first 14 days of the month is not submitted by the timelines specified in Table 3.
- up to $10,000 per month, if a file containing presentations for the full month is not submitted by the timelines specified in Table 3.
- up to $10,000 per month, if a file with all presentations for the full month contains errors by the timelines specified in Table 3.

Data flagged as unfit for reporting and analysis will be regarded as noncompliant and penalties as above will 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 Health data standards and systems website <https://www2.health.vic.gov.au/hospitals-and-health-services/data-reporting/health-data-standards-systems>.

Requests for an exemption from late penalties will only be considered if received prior to the relevant deadlines and if the manual aggregate data spreadsheet has been completed by the due date. Extensions or exemptions are not issued in advance. Late submissions penalties are assessed after the end-of-year consolidation deadline, taking into account the health service's compliance performance for the financial year.

For any full month period that the health service is unable to supply unit record data, the health service is required to submit aggregate data using the manual aggregate data spreadsheet. The spreadsheet is available from the VEMD webpage <https://www2.health.vic.gov.au/hospitals-and-health-services/data-reporting/health-data-standards-systems/data-collections/vemd>.

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

Data resubmissions for previous months

Health services wishing to resubmit data for a previous period must complete a VEMD data resubmission request as soon as the health service is aware of the circumstances requiring resubmission. The request form must be submitted prior to the resubmissions. Resubmissions received without the request form will not be processed.

The pro forma is available on the VEMD webpage <https://www2.health.vic.gov.au/hospitals-and-health-services/data-reporting/health-data-standards-systems/data-collections/vemd>.

Software upgrades and migrations

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.

29.2.4 Elective Surgery Information System

Health services reporting to the ESIS must adhere to the minimum submission timelines in Table 4.

Table 4: Elective Surgery Information System timelines

ESIS	Timeline
First 15 days of the month	At least one submission must be received by the third working day after the 15th of the reporting month
The remaining days of the month (16th and subsequent)	Data for the remainder of the month must be supplied by the third working day of the following month
All activity for the full month without errors	Data must be complete – that is, zero rejections, notifiable or correction edits by the 14th day of the following month, or the prior business day

Any corrections to 2020–21 data must be submitted before final consolidation of the ESIS database on 24 August 2021.

Penalties for noncompliance

If health services do not comply with these timelines, the department may apply a penalty of:

- up to $5,000 per month if a file containing episodes for the first 15 days is not submitted by the timelines specified in Table 4.
- up to $10,000 if a file containing episodes for the full month is not submitted by the timelines specified in Table 4.
- up to $10,000 if a file with all episodes for the full month contains errors by the timelines specified in Table 4.

Data that is flagged as unfit for reporting and analysis will be regarded as noncompliant and penalties as above will apply.

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.

A pro forma to assist this process is provided on the ESIS webpage <https://www2.health.vic.gov.au/hospitals-and-health-services/data-reporting/health-data-standards-systems/data-collections/esis>.

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 spreadsheet is available from the ESIS webpage <https://www2.health.vic.gov.au/hospitals-and-health-services/data-reporting/health-data-standards-systems/data-collections/esis>.

Requests for an exemption from late penalties will only be considered if it is received prior to the relevant deadlines and the manual aggregate data spreadsheet is completed.

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

Software upgrades and migrations

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.

29.2.5 Victorian Integrated Non-Admitted Health minimum dataset

The VINAH is a patient-level reporting system 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:

- specialist clinics (outpatient)
- Health Independence Program
  - subacute ambulatory care services (including paediatric rehabilitation)
  - Hospital Admission Risk Program
  - post-acute care
  - residential in-reach service
- community-based palliative care
- palliative care day hospice
- Family Choice Program
- home enteral nutrition
- total parenteral nutrition
- Victorian HIV Service
- Victorian Respiratory Support Service
- medi-hotel (optional)
- Transition Care Program
- hospital-based palliative care consultancy teams.

More information on VINAH is contained in the VINAH manual <https://www2.health.vic.gov.au/hospitals-and-health-services/data-reporting/health-data-standards-systems/data-collections/vinah>.

Note that from 1 July 2021, regional and statewide palliative care consultancy services will be required to report activity in VINAH.

Submission guidelines

Health services reporting VINAH will be required to adhere to the minimum submission timelines in Table 5. Health services may submit more frequently than the minimum standards specified below.

Table 5: Victorian Integrated Non-Admitted Health timelines

VINAH	Timeline
Submission date for client, referral, episode and contact details for the month	Must be submitted before 5.00 pm on the 10th day of the following month
Clean date for client, referral, episode and contact details for the month	Must be submitted before the VINAH file consolidation at 5.00 pm on the 14th day of the following month, or the preceding working day if the 14th falls on a weekend or public holiday data must be complete – that is, zero rejections

Funded organisations are encouraged to transmit VINAH data frequently and may transmit as often as desired. Funded organisations must meet the following minimum requirements:

- VINAH data 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 manual, must be transmitted as specified below
- Funded organisations must make at least one submission to the HealthCollect portal for the reference month by no later than 5.00 pm on the 10th day of the month following the reference month
- All errors are to be corrected in time for the VINAH file consolidation at 5.00 pm on the 14th day of the month following the reference month. Complete data for the month is expected to be transmitted by the 14th.

Data for the financial year must be completed in time for the VINAH file consolidation on 24 August. Any final corrections must be received at the HealthCollect portal before the VINAH database is finalised on 24 August 2021.

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 5
- 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 5.

Funded organisations that have VINAH reporting obligations for multiple programs (for example, subacute ambulatory care services, Hospital Admission Risk Program, post-acute care) should note that the above penalties apply per program.

Data that is flagged as unfit for reporting and analysis will be regarded as noncompliant and penalties as above will 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 and episodic non-admitted activity via the AIMS S12 form.

Software upgrades and migrations

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 2020–21 VINAH data is transmitted completely by 24 August 2021 and should ensure software updates and migrations do not prevent complete VINAH transmissions by this date, as no extensions will be possible.

29.2.6 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 *Agency Information Management System (AIMS) public hospital user manual*. Visit the HealthCollect web portal <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 not submitted by the due date specified in the AIMS manual.

Organisations seeking exemption from penalties for late data must notify the Health data standards and systems helpdesk <hdss.helpdesk@dhhs.vic.gov.au>, advising of the issues experienced, the organisation's plan for overcoming the issues and the expected submission date.

Read more about AIMS <https://www2.health.vic.gov.au/hospitals-and-health-services/data-reporting/health-data-standards-systems/data-collections/aims>.

29.2.7 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 4.0)* (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. See VCDC specifications and requirements <https://www2.health.vic.gov.au/hospitals-and-health-services/data-reporting/health-data-standards-systems/data-collections/vcdc>.

The cost data submitted should be fit-for-purpose and cover all areas of hospital activity undertaken by the health service. Including (but not limited to) four broad categories:

- Admitted – A patient who undergoes a hospital's admission process to receive treatment and/or care. This treatment and/or care are provided over a period of time and can occur in hospital and/or in the person's home (for hospital-in-the-home 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 – 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 and
- 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 specified below.

Table 6: VCDC actions and reporting timelines

Actions	Date
Submission portal open to accept submission	23 September 2020
First submission of files to VCDC – Phase 1	23 September to 30 October 2020
Final submission of files to VCDC following completion of Phase 2 and Phase 3	20 November 2020
DHHS to provide Quality Assurance (QA) reports to health services – Phase 4	27 November 2020
Health services to provide comments on QA checks and conclude submission to the VCDC	23 December 2020
Health services to submit signed Reconciliation Reports and Data Quality Statements[7]	31 December 2020
Re-submissions completed following re-costing due to major impacts on cost data following Phase 4 checks[8]	15 January 2021
DHHS to consolidate Victorian cost database	5 February 2021
DHHS to provide benchmark tool and underlying data to health services (following receipt of consent forms)	5 March 2021

[7] 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.

[8] Any major corrections to 2019–20 submissions that will impact on the cost data, must be submitted before final consolidation of the cost database on 8 February 2021.

Penalties for noncompliance

Where health services are noncompliant with the format or timelines specified above, the department may apply the following penalties:

- 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 are 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.

29.2.8 Victorian Health Incident Management System

VAHI is leading the VHIMS reform program to ensure information collected is better able to inform quality, safety and experience improvements for Victorians. These reforms are detailed on VHIMS <https://bettersafercare.vic.gov.au/our-work/incident-response/VHIMS>.

The VHIMS Minimum Data Set (VHIMS MDS) was developed in consultation with stakeholders and has been finalised for implementation. Data from 39 mostly smaller Victorian public health and community services comprising VHIMS Central, which have their arrangements subsidised by the Victorian Government, submit this data automatically via the VHIMS Central Solution (VHIMS CS).

Please note that feedback (compliments, complaints and suggestions) is not yet part of the VHIMS MDS. The Feedback module will be added in the future.

By 1 July 2021, all Victorian public health services are expected to submit the new VHIMS MDS to VAHI to enable accurate statewide reporting of clinical, occupational health and safety and hazard incidents and near misses. Data from the VHIMS MDS will be submitted automatically if Victorian public health services join the VHIMS CS or via an application programming interface if Victorian public health services pursue other options for their VHIMS arrangements.

A VHIMS MDS data manual will be available in 2020–21. The manual will include a data dictionary, business rules and summary guides. In the meantime, interim reporting arrangements have been designed and established to support the collection of a minimum dataset from the current VHIMS for statewide reporting.

Health services and other relevant funded organisations (including registered community health services) must submit quarterly VHIMS extract data to the department's Secure Data Exchange or other secure data delivery method according to the timelines in Table 7.

Table 7: Victorian Health Incident Management System quarterly reporting timelines

2019–20 VHIMS reporting	Quarterly extract due
Quarter 1	1st working day in November 2020
Quarter 2	1st working day in February 2021
Quarter 3	1st working day in May 2021
Quarter 4	1st working day in August 2021

29.2.9 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 via the Secure Data Exchange in accordance with departmental specifications by the 10th day of the following month.

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 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.

29.2.10 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.

Mandatory reporting requirements exist for indicators that are included in Part B of the SOP. These 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.

A limited number of healthcare-associated infections performance indicators are reported publicly on the Victorian Health Services Performance website <https://performance.health.vic.gov.au/Home.aspx>.

Rates for *Staphylococcus aureus* bacteraemia and compliance with the National Hand Hygiene Initiative guidelines are publicly reported on the MyHospitals website <https://www.myhospitals.gov.au>.

29.2.11 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://www2.health.vic.gov.au/hospitals-and-health-services/patient-care/acute-care/state-trauma-system>.

29.2.12 Victorian Audit of Surgical Mortality

The Victorian Audit of Surgical Mortality is a peer-review audit of deaths associated with surgical care that 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.

29.2.13 Consultative councils reporting requirements

Consultative councils are ministerial advisory committees that review and report on specialised areas within health care to reduce mortality and morbidity. The councils' functions and reporting requirements are legislated under the *Public Health and Wellbeing Act 2008*.

29.2.14 Cardiac surgery registry

Since 2001, the department, and more recently Safer Care Victoria acting through the department, has 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 Preventative 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 and VAHI as the contract managers. 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 is also requested for the purposes of linkage to inform the development of statewide quality and safety indicators, which will be reported in VAHI's Victorian public health service reports.

29.2.15 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. Safer Care Victoria supports and promotes active participation of all cardiology sites in the registry. The funding arrangements for this registry, outlined in contracts managed by VAHI, stipulate that quarterly or biannual reports of summarised data are submitted to SCV and/or the department and VAHI as the contract managers. 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 is also requested for the purposes of linkage to inform the development of statewide quality and safety indicators, which will be reported in VAHI's Victorian public health service reports.

29.2.16 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 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 and VAHI as the contract managers. 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 is also requested for the purposes of

linkage to inform the development of statewide quality and safety indicators, which will be reported in VAHI's Victorian public health service reports.

29.2.17 Radiotherapy services reporting

Radiotherapy providers must report monthly to:

- the Victorian Radiotherapy Minimum Dataset
- AIMS form S8 for consultations only
- AIMS form S10.

The department continues to contribute data from the Victorian Radiotherapy Minimum Dataset to the Australian Institute of Health and Welfare, along with other jurisdictions. The data is included in the institute's report *Radiotherapy in Australia*, released annually. The report presents waiting times at public radiotherapy providers by state or territory. Waiting times for private providers are amalgamated into a national figure.

29.2.18 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 2020, health services will be required to report episode-level activity to VINAH 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.

29.2.19 Victorian Healthcare Experience Survey

The VHES program is currently under review and a statewide tender is in progress to appoint a new survey administrator, anticipated in 2020–21. Until the new administrator is appointed, the existing upload procedures as outlined below will continue.

Victorian public health services will be kept informed of any changes as they arise.

Upload procedures

For continuous surveys, health services must upload contact details of eligible consumers to the contractor by the 15th of the month following discharge. This upload includes the service received, which determines the type of questionnaire sent.

For the annual specialist clinics survey, nominated health services must upload contact details of eligible consumers for the three months nominated for survey collection.

For the annual ambulance services surveys (planned and emergency), nominated health services 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 cancer patient survey will not run in 2020–21, therefore no upload of patient contact details will be required.

Data transfers occur in a secure online environment through the Project Control Portal <https://www.vhes.com.au/depthealth>. The Project Control 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>. These results are currently only available to registered health services and departmental staff.

29.3 Subacute data reporting requirements

For all subacute program data reporting requirements, please refer to section 18.2 'Subacute and non-acute'.

29.4 Ambulance Victoria data reporting requirements

Stage 1 of the Victorian Ambulance Data Set became operational in 2015–16. The department will continue to work with Ambulance Victoria to validate and extend the dataset collection. Ambulance Victoria will be required to continue existing reporting requirements 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 supply data to the department according to the timelines specified in Table 8. Existing ambulance data collections are shown in Table 9.

Table 8: Victorian Ambulance Data Set timelines

VADS	Timeline
Request for service and response data	Year-to-date submission to be received by the 10th day of the month following the case date
Transport and patient data	Year-to-date submission to be received by the 10th day of the second month following the case date
Data for the 2019–20 financial year	Year-to-date submission must be received before final consolidation of the Victorian Ambulance Data Set on 10 August 2021

Table 9: Existing ambulance data collections

Collection	Description and submission timeline
Aggregate Ambulance Minimum Dataset	Indicators identified in Table 17 will be supplied to the department in spreadsheet format by the 10th day of the month following the monthly reporting period
Ambulance membership movements	Changes in Ambulance Victoria membership in spreadsheet format to be emailed to a nominated departmental contact on the seventh day of each month following the end of the monthly reporting period

29.5 Mental health services data reporting requirements

Information about clinical mental health services 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 2014*
- 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)
- quarterly MHCSS aggregate spreadsheet report
- the VAED (see section 29.2.2 'Victorian Admitted Episodes Dataset')
- the VEMD (see section 29.2.3 '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> and the

Mental health performance reports website <https://www2.health.vic.gov.au/mental-health/research-and-reporting/mental-health-performance-reports>.

29.5.1 Client Management Interface and Operational Data Store

The statewide Operational Data Store (ODS) is simultaneously updated from local Client Management Interface (CMI) systems as data are 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 10 for details).

Table 10: 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
Contacts	Statutory reporting	10th of the month following the contact
Outcome measures	Statutory reporting	10th of the month following the measure collection
Electroconvulsive therapy procedures	Statutory reporting	As soon as practicably possible
Seclusion and restraint	Statutory reporting	10th of the month following the period of seclusion/restraint
Diagnosis	Statutory reporting	10th 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 for clinical mental health services <https://www2.health.vic.gov.au/mental-health/research-and-reporting/reporting-requirements-for-clinical%20mental-health-services>.

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 the following due dates:

- July–September 2020: 30 November 2020
- October–December 2020: 26 February 2021
- January–March 2021: 31 May 2021
- April–June 2021: 31 August 2021.

Outstanding validation issues for the 2020–21 financial year must be reconciled by 30 November 2021. 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.

29.5.2 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 (stage 1) begins in September 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 2019–20 will be pre-populated with health service activity data from the CMI/ODS. This information is subject to health service confirmation or amendment as required.

Health service finance data from the F1 return is available on request to assist with completion of organisation-level finance information. Further advice will be provided prior to the HealthCollect portal opening for the stage 1 2019–20 data submission.

For more information, visit the HealthCollect web portal <https://www.healthcollect.vic.gov.au>.

Reporting timelines for the Mental Health Establishments National Minimum Dataset are outlined in Table 11.

Table 11: Mental Health Establishments National Minimum Dataset reporting timelines

Collection period	Reporting requirements	Due date
2018–19	Stage 2: Resolution of final validation issues identified by the Australian Institute of Health and Welfare for 2018–19. Validations to be finalised by health services by 30 August 2020 when the HealthCollect portal will close.	30 August 2020
2019–20	Stage 1: Data submission opens through the HealthCollect portal and remains open for one month. Data entry by health services to be finalised by 12 October 2020 when the portal will close.	12 October 2020
2019–20	Stage 1: Resolution of services' initial validation issues arising from the HealthCollect portal.	26 April 2021
2019–20	Stage 2: Resolution of final issues identified by the Australian Institute of Health and Welfare for 2018–19. Validations from health services must be finalised by 30 August 2021 when the HealthCollect portal will close.	16 August 2021

29.5.3 Mental health triage minimum dataset

Triage minimum dataset submissions are to be provided in the prescribed format on a monthly basis by the 15th of each month. The data file must be sent to the mental health triage email <triagemds@dhhs.vic.gov.au>.

Documentation detailing the format and reporting timelines can be found at the Reporting requirements for clinical mental health services <https://www2.health.vic.gov.au/mental-health/research-and-reporting/reporting-requirements-for-clinical%20mental-health-services>.

29.5.4 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 7th 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 <qdchelp@dhhs.vic.gov.au>.

The aggregate supplementary Excel spreadsheet data file must be submitted by the 15th of the month following the end of the quarter. The file must be submitted by emailing the Mental Health and Drugs Data team <mhcssdata@dhhs.vic.gov.au>.

29.5.5 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 8124, or by emailing the Office of the Chief Psychiatrist <ocp@dhhs.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 or who had sought service from a mental health provider within that period and not been provided with service
- all deaths of community-resident patients under the *Mental Health Act 2014* (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 notify the Chief Psychiatrist of a consumer's death using the MHA 125 'Notice of Death' form.

VHIMS-reporting community service organisations providing MHCSS programs must report the incident in accordance with the Safer Care Victoria policy *Adverse patient safety events* <https://www.bettersafercare.vic.gov.au/reports-and-publications/policy-adverse-patient-safety-events>. Non-VHIMS reporting community service organisations providing MHCSS must report the incident in accordance with the *Incident reporting instruction 2013*.

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://www2.health.vic.gov.au/about/key-staff/chief-psychiatrist/chief-psychiatrist-guidelines/reportable-deaths>.

Suicides on other hospital wards

Suicides on any inpatient unit (including medical and surgical units) are categorised nationally as sentinel events (that is, unexpected healthcare incidents that result in death or serious disability). Safer Care Victoria manages the Sentinel Events Program <https://www.bettersafercare.vic.gov.au/our-work/incident-response/sentinel-events>.

29.5.6 Restrictive interventions reporting (seclusion and bodily restraint)

The *Mental Health Act 2014* closely regulates the use of 'restrictive interventions'. Part 6 of the Act outlines when restrictive interventions can be used, who can authorize 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 Act and the Chief Psychiatrist's guidelines *Restrictive interventions in designated mental health* services, 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 Client Management Interface (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.

29.5.7 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://www2.health.vic.gov.au/about/publications/formsandtemplates/sexual-safety-notification-to-the-chief-psychiatrist>.

29.5.8 Electroconvulsive therapy

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 and
- 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 are now 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, serious illness or
- 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 2014* regulates the use of ECT for 'all young persons' under the age of 18 years in Victoria, whether voluntary or involuntary, including those in both 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.

29.5.9 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 including 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.

29.5.10 Reporting of incidents where there is failure to comply with the *Mental Health Act 2014*

The Chief Psychiatrist has statutory roles and functions under the *Mental Health Act 2014* (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 include 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 his/her delegate within three business days. The report can be emailed to the Office of Chief Psychiatrist <ocp@dhhs.vic.gov.au>. Where required, contact the Office of Chief Psychiatrist on 9096 7571 for any further guidance.

The report should include the following information:

- 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

Should the service become 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 Chief Psychiatrist's guidelines <https://www2.health.vic.gov.au/about/key-staff/chief-psychiatrist/chief-psychiatrist-guidelines>

29.5.11 Victorian Alcohol and Drug Collection

The Victorian Alcohol and Drug Collection (VADC) supports public accountability for service provision. Outputs contribute to the Alcohol and Other Drug Treatment Services National Minimum Data Set, as well as performance measurement and monitoring for Commonwealth, state and departmental purposes. All alcohol and drug treatment service providers must submit activity data via the VADC.

Alcohol and other drug treatment service providers must ensure client management systems can meet VADC reporting requirements. Details on data specifications, bulletins and the submission process can be found at reporting for AOD services <https://www2.health.vic.gov.au/alcohol-and-drugs/funding-and-reporting-aod-services/reporting-for-aod-services/data-collection>.

VADC data must be submitted monthly, with data due by the 15th day of the subsequent month.

29.5.12 Needle and Syringe Program Information System

The Victorian and Commonwealth governments fund services to reduce the harms associated with alcohol and other drug use. The harm reduction services data collection records the level of activity in these services in terms of contacts, service provision (for example, needles provided and returned, education and referrals) and responses to harm reduction questions, as well as information about the free provision of a range of injecting and safe-sex equipment and the disposal of returned waste.

Harm reduction services data is provided by:

- needle and syringe programs
- mobile overdose response services
- mobile drug safety workers.

All primary needle and syringe program providers and recipients of *Ice action plan* funding must report monthly by the end of each month via the Needle and Syringe Information System Agency Reporting application. Organisations using the application can generate the extract and email it to the Needle and Syringe Program <nsp-is@dhhs.vic.gov.au>.

Paper-based surveys should be sent to the department by emailing NSP Data Collection <nsp-is@dhhs.vic.gov.au>, or posted to:

NSP Data Collection
Mental Health & Drugs Data unit
Department of Health and Human Services
GPO Box 4541
Melbourne VIC 3001

29.5.13 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 record treatment permits issued to doctors prescribing Schedule 8 drugs to patients. This includes methadone and buprenorphine prescriptions for opioid replacement therapy (pharmacotherapy).

The system is additionally 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 or other disciplinary action. More serious offending (for example, trafficking) will commonly be the subject of joint investigations involving departmental officers and 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 for research, industrial or health services). The information system also records the payment of fees relating to such licences and permits associated with the possession of drugs and poisons.

29.5.14 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 doctors, nurse practitioners and pharmacists during a consultation with a patient.

SafeScript provides these practitioners with a clinical tool to make safer decisions about whether to prescribe or dispense a high-risk medicine, as well as facilitating 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.

From April 2020, it will be mandatory for doctors, nurse practitioners and pharmacists to check SafeScript before prescribing or dispensing a medicine monitored in SafeScript.

29.5.15 Opioid replacement therapy dispenser census

The department conducts the 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 faxed the survey form, to be returned by fax, recording the number of clients being dosed with respective opioid replacement therapy medications. It also records the numbers of opioid replacement therapy clients on a minimal supervision regimen and people who are eligible for departmental dispensing support, or with interstate prescriptions. Finally, it collects data of clients who identify as Aboriginal and/or Torres Strait Islander 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.

29.6 Aged care data reporting requirements

Data collection requirements and timelines for ageing, aged and carer support, and aids and equipment services are provided in Table 12. Information on performance is collected through a range of channels including:

- the HACC minimum dataset for the HACC-PYP and the Victorian Support for Carers Program
- Victorian aids and equipment reporting template
- HACC-PYP fees data collection
- HACC-PYP annual service activity reports
- Victorian Support for Carers Program annual report
- residential aged care services data collection.

The *Carers Recognition Act 2012* sets out obligations for councils and organisations covered by that Act, including the obligation to raise awareness and understanding of the care relationship principles as set out in the Act. Relevant organisations must report on their compliance against these obligations in their annual report. Specific requirements can be found in ss. 5, 11 and 12 of the Act.

Table 12: Ageing, aged and home care – data collection and reporting requirements

Activity no.	Activity name	Data collection description
13005	Aged Care Assessment Service	Quarterly report on Aged Care Assessment Program operations
13005	Aged Care Assessment Service	Six-monthly report on Aged Care Assessment Program staffing
13015	HACC[9] Linkages Packages	HACC minimum dataset
13015	HACC Linkages Packages	Annual HACC-PYP fee report
13023	HACC Service Development Grant	Electronic project report

[9] Where 'HACC' is referred to, the activity name relates to the Home and Community Care Program for Younger People (HACC-PYP)

Activity no.	Activity name	Data collection description
13024	HACC Assessment	HACC minimum dataset
13026	HACC Domestic Assistance	HACC minimum dataset
13026	HACC Domestic Assistance	Annual HACC-PYP fee report
13027	HACC Respite	HACC minimum dataset
13027	HACC Respite	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 for the F1 data collection must be submitted using the Campus codes allocated to each Health Service (for assistance, email Planning and Operations <Planning&Operations@health.vic.gov.au>) 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;[10] resident vaccination rates for influenza, herpes zoster and pneumococcal; staff vaccination rates for influenza (for assistance contact the VICNISS Coordinating Centre on 9342 9333 or VICNISS email <vicniss@mh.org.au>)
13038	HACC Service System Resourcing	HACC-PYP Annual Service Activity Report
13043	HACC Flexible Service Response	HACC-PYP Annual Service Activity Report
13043	HACC Flexible Service Response	HACC minimum dataset where relevant
13043	HACC Flexible Service Response	Annual HACC-PYP fee report, where relevant
13056	HACC Planned Activity Group – Core	Annual HACC-PYP fee report
13056	HACC Planned Activity Group – Core	HACC minimum dataset
13057	HACC Planned Activity Group – High	HACC minimum dataset
13057	HACC Planned Activity Group – High	Annual HACC-PYP fee report
13063	HACC Volunteer Co-Ordination	HACC-PYP Annual Service Activity Report
13063	HACC Volunteer Co-Ordination	HACC minimum dataset where relevant
13096	HACC Allied Health	HACC minimum dataset
13096	HACC Allied Health	Annual HACC-PYP fee report
13097	HACC Delivered Meals	HACC minimum dataset
13099	HACC Property Maintenance	HACC minimum dataset
13099	HACC Property Maintenance	Annual HACC-PYP fee report
13130	HACC Volunteer Co-Ordination Other	HACC-PYP Annual Service Activity Report
13131	RDNS[11] HACC Allied Health	HACC minimum dataset

[10] Methicillin-resistant *Staphylococcus aureus*, Vancomycin-resistant enterococci and *Clostridium difficile* infection

[11] Royal District Nursing Service

Activity no.	Activity name	Data collection description
13131	RDNS HACC Allied Health	Annual HACC-PYP fee report
13210	ACAS Training and Development	My Aged Care Screening and Assessment Workforce Training Strategy 2019
13223	HACC Nursing	HACC minimum dataset
13223	HACC Nursing	Annual HACC-PYP fee report
13223	HACC-PYP Nursing	HACC-PYP Annual Service Activity Report, where relevant
13226	HACC Personal Care	HACC minimum dataset
13226	HACC Personal Care	Annual HACC-PYP fee report
13227	ACCO[12] Services – HACC	HACC minimum dataset
13227	ACCO Services – HACC	HACC-PYP fees data collection,
13227	ACCO Services – HACC	HACC-PYP Annual Service Activity Report, where relevant
13229	HACC Access & Support	HACC minimum dataset
13229	HACC Access & Support	A&S activity six-monthly report
13230	Commonwealth Regional Assessment Service	Quarterly report on audit of home support assessment and client satisfaction Biannual report on regional assessment services operations
35030	Small rural – HACC- Health Care and Support	HACC minimum dataset
35030	Small rural – HACC Health Care and Support	Annual HACC-PYP fee report, where relevant
35030	Small rural – HACC Health Care and Support	HACC-PYP Annual Service Activity Report, where relevant

29.7 Primary, community and dental health data reporting requirements

A summary of reporting requirements is shown in Table 13.

29.7.1 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://www2.health.vic.gov.au/primary-and-community-health/community-health/community-health-program/community-health-data-reporting>.

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. Community health services can also contribute to the Primary Care Partnerships reporting, as outlined in section 21.6 'Partnerships'.

[12] Aboriginal-community controlled organisation

29.7.2 Primary Care Partnerships

Primary Care Partnerships must report annually to demonstrate progress in achieving strategic outcomes. Primary Care Partnerships are responsible for the timely submission of reports as per the documented reporting requirements.

A key objective of Primary Care Partnership activity is to strengthen integration across health and human services sectors. Reporting should demonstrate meaningful engagement and partnership with organisations from both these sectors and provide an overview of their key activities in prevention. Primary Care Partnership reporting should reflect partnerships with Primary Health Networks and other locally relevant collaboratives and networks to progress this work.

E-referral reporting is used to report annually to the Department of Treasury and Finance on the number of referrals made using electronic referral systems. Reporting provides an indication of the level of participation of health and human services in securely sharing standardised consumer information electronically. Work is ongoing to replace this outdated measure. Updates to Primary Care Partnerships reporting requirements will be provided as changes occur. Primary Care Partnerships must submit their annual financial statement in accordance with the department's monitoring framework.

Primary Health Networks reporting requirements for state-funded programs and priorities are adhered to as outlined in their service agreements with the department.

29.7.3 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 13: Primary, community and dental health – data collection and reporting requirements

Activity no.	Activity name	Data collection description
27017	Oral health – health promotion	Report against agreed deliverables linked to the *Victorian action plan to prevent oral disease 2019–23*
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
28062	Telephone counselling	Regional report
28063	Family planning – education and training	Quarterly report

Activity no.	Activity name	Data collection description
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	Community health minimum dataset
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
28087	Primary Care Partnerships	Report against Primary Care Partnership planning and reporting guidelines
28088	ACCO services – primary health	Round table 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 used for another allowable purpose

29.8 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.

29.8.1 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 10th day of the following month, or the prior working day if the 10th day of the following month falls on a weekend or public holiday. Payroll data is required monthly, while workforce information is required biannually, covering the periods ending 31 December and 30 June each year.

Where health services undertake their own payroll processing, they must transmit the information directly to the department. In cases where health services engage a payroll bureau to process their payroll, health services may authorise the bureau to transmit the data to the department on their behalf. Notwithstanding such an arrangement, 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.

29.9 Training and development funding reporting and eligibility requirements

29.9.1 Eligibility requirements

All public health services, Mildura Base Hospital 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 via the following links:

- *BPCLE framework* <https://www2.health.vic.gov.au/health-workforce/education-and-training/building-a-quality-health-workforce/bpcle-framework>.
- Training and development funding <https://www2.health.vic.gov.au/health-workforce/education-and-training/training-development-grant>.

29.9.2 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 guidelines* <https://www2.health.vic.gov.au/health-workforce/education-and-training/training-development-grant>.

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 using 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 using 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 via the following links:

- Fee schedule for clinical placement in public health services <https://www2.health.vic.gov.au/health-workforce/education-and-training/student-placement-partnerships/fee-schedule-for-clinical-placement-in-public-health-services>
- Placeright <https://www2.health.vic.gov.au/health-workforce/education-and-training/student-placement-partnerships/placeright>
- Student Placement Agreement <https://www2.health.vic.gov.au/health-workforce/education-and-training/student-placement-partnerships/student-placement-agreement>

- Standardised Student Induction Protocol <https://www2.health.vic.gov.au/health-workforce/education-and-training/student-placement-partnerships/standardised-student-induction-protocol>.

29.9.3 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, and medical radiations 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 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 2020
  - 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://www2.health.vic.gov.au/health-workforce/education-and-training/training-development-grant>.

29.9.4 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 and Victorian Paediatric Training Programs and the Basic Physician Training Consortia Program must provide confirmation at each stage of training, including at recruitment, resignation, completion or any other change in the training pathway by completing program reports.

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.

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://www2.health.vic.gov.au/health-workforce/education-and-training/training-development-grant>.

29.9.5 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 a reporting template and 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 for health services to complete will be provided to participating health services.

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 2019–20 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 as at 1 April 2020. Templates will be provided to mental health services in 2020–21 for completion, requesting details of learning and development resources that are supported by the funding.

Table 14: 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>	19 February 2021
Professional-entry student placements	Completion of attendance for clinical placement activity in Placeright biannually. To request an exemption from using Placeright, email VicWorkforce <vicworkforce@dhhs.vic.gov.au> for access to the HealthCollect portal for reporting of agreed medical student clinical placements.	19 February 2021 (for July–December 2020 activity) 23 July 2021 (for activity January–June 2021)

Program	Reporting required by health services	Due date
Transition to practice (graduate) – allied health, medical (PGY2), nursing and midwifery	Report on the headcount and full-time equivalent hours of allied health, PGY2 and nursing and midwifery 2020 graduate positions and planned PGY2 and nursing and midwifery 2021 positions via the HealthCollect portal.[13] **Note:** Allied health graduate reporting required only for the disciplines of audiology, psychology, exercise physiology, dietetics and nutrition, occupational therapy, optometry, orthoptics, orthotics and prosthetics, physiotherapy, podiatry and social work	19 February 2021
Postgraduate – medical specialist training	Victorian Medical Specialist Training Program acquittal of posts and positions in 2020.	19 February 2021
	Victorian Basic Paediatric Consortium reporting requirements as specified in the consortium governance arrangements, including the head count and full-time equivalent hours for trainees and accredited training posts in the statewide consortium including rural training stream in 2020.	19 February 2021
	Basic Physician Training Consortia Program acquittal of posts and positions in 2020.	19 February 2021
Postgraduate – nursing and midwifery	Report on the headcount and full-time equivalent hours of 2020 postgraduate positions and 2021 planned positions via the HealthCollect portal.	19 February 2021
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

29.10 Commonwealth–state reporting requirements

Funded organisations may receive payments arising from Commonwealth–state 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 statistical and financial reports for the monitoring of activity, payment of grants and acquittal to the Commonwealth.

The information required, format and timelines for individual programs are detailed in the relevant Intergovernmental Agreements with the Commonwealth and the guidelines applicable to the appropriate Commonwealth–state programs.

[13] Access to the HealthCollect portal can be requested via HealthCollect <https://www2.health.vic.gov.au/hospitals-and-health-services/data-reporting/health-data-standards-systems/health-collect>. A user guide to assist those reporting training and development activity via HealthCollect is available from within the application.

30 Performance targets and monitoring

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, please visit the service agreement website <https://fac.dhhs.vic.gov.au/service-agreement>.

For those organisations funded through service agreement, you can search for activity descriptions by visiting Health and human service activity search <https://providers.dhhs.vic.gov.au/human-services-activity-search>.

Table 15: HACC-PYP – performance targets and monitoring

Activity no.	Activity name	Measure description	Unit of measure	Frequency	Status	Output type
13015	HACC Linkages	Number of hours of service	Hours	Quarterly	Mandatory	Key output measure
13023	HACC Service Development Grant	One electronic project report submitted	Reports	Yearly	Mandatory	Key output measure
13024	HACC Assessment	Number of hours of service	Hours	Quarterly	Mandatory	Key output measure
13026	HACC Domestic Assistance	Number of hours of service	Hours	Quarterly	Mandatory	Key output measure
13027	HACC Respite	Number of hours of service	Hours	Quarterly	Mandatory	Key output measure
13031	Public sector residential aged care supplement	Number of occupied bed days	Occupied bed days	Monthly	Mandatory	Key output measure
13038	HACC Service System Resourcing	HACC-PYP Annual Service Activity Report	Reports	Yearly	Mandatory	Key output measure
13043	HACC Flexible Service Response	HACC-PYP Annual Service Activity Report	Reports	Yearly	Mandatory	Key output measure
13043	HACC Flexible Service Response	Number of hours of service	Hours	Quarterly	Non-Mandatory	Other standard measure
13056	HACC Planned Activity Group – Core	Number of hours of service (provided to clients)	Hours	Quarterly	Mandatory	Key output measure
13057	HACC Planned Activity Group – High	Number of hours of service (provided to clients)	Hours	Quarterly	Mandatory	Key output measure
13059	Residential aged care complex care supplement	Number of occupied bed days	Occupied bed days	Monthly	Mandatory	Key output measure
13063	HACC Volunteer Co-Ordination	Number of hours of coordinator time	Hours	Yearly	Mandatory	Key output measure
13063	HACC Volunteer Co-Ordination	Number of hours of service	Hours	Quarterly	Non mandatory	Other standard measure
13096	HACC Allied Health	Number of hours of service	Hours	Quarterly	Mandatory	Key output measure
13097	HACC Delivered Meals	Number of meals (funding is a subsidy only)	Meals	Quarterly	Mandatory	Key output measure

Activity no.	Activity name	Measure description	Unit of measure	Frequency	Status	Output type
13099	HACC 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
13107	Rural small high-care supplement	Number of occupied bed days	Occupied bed days	Monthly	Mandatory	Key output measure
13130	HACC Volunteer Co-Ordination Other	HACC-PYP Annual Service Activity Report	Reports	Annual	Mandatory	Key output measure
13131	RDNS HACC 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 Nursing	Number of hours of service	Hours	Quarterly	Mandatory	Key output measure
13226	HACC Personal Care	Number of hours of service	Hours	Quarterly	Mandatory	Key output measure
13227	ACCO Services – HACC	Development of service profile	Completed service profile	Yearly	Mandatory	Key output measure
13229	HACC Access & Support	Number of hours of service	Hours	Quarterly	Mandatory	Key output measure
35030	Small Rural HACC Health Care and Support	Development of service profile	Completed service profile	Yearly	Mandatory	Key output measure

Table 16: Ageing, aged and home care – performance targets and monitoring

Activity no.	Activity name	Measure description	Unit of measure	Frequency	Status	Output type
13005	Aged Care Assessment Service	Number of assessments	Number	Quarterly	Mandatory	Key output measure
13005	Aged Care Assessment Service	Percentage of priority 1, 2 and 3 clients assessed on time	Percentage	Quarterly	Mandatory	Other standard measure
13005	Aged Care Assessment Service	Percentage of referrals actioned within 3 calendar days	Percentage	Quarterly	Mandatory	Other standard measure
13005	Aged Care Assessment Service assessment	Percentage of assessments and support plans are of appropriate quality	Percentage	Quarterly	Mandatory	Other standard measure
13005	Aged Care Assessment Service 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
13031	Public sector residential aged care supplement	Number of occupied bed days	Occupied bed days	Monthly	Mandatory	Key output measure
13035	Support for Carers Program	Number of carers	Carers	Yearly	Mandatory	Key output measure
13035	Support for Carers Program	Number of hours of service	Hours	Quarterly	Mandatory	Other standard 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
13059	Residential aged care complex care supplement	Number of occupied bed days	Occupied bed days	Monthly	Mandatory	Key output measure
13067	Aged community grants	Number of projects	Projects	Yearly	Mandatory	Key output 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

Activity no.	Activity name	Measure description	Unit of measure	Frequency	Status	Output type
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
13107	Rural small high-care supplement	Number of occupied bed days	Occupied bed days	Monthly	Mandatory	Key output measure
13155	Dementia services	Number of contacts	Contacts	Yearly	Mandatory	Other standard measure
13155	Dementia services	Number of hours of service	Hours	Yearly	Mandatory	Key output measure
13155	Dementia services	Number of sessions	Sessions	Yearly	Mandatory	Other standard measure
13156	Seniors health promotion	Report against agreed objectives	Reports	Yearly	Mandatory	Key output measure
13210	Aged Care Assessment Service 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 are 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 • Aged Care Quality and Safety Commission	Signed documents	Yearly	Mandatory	Other standard measure
13302	SRS Supporting Accommodation for Vulnerable Victorians Initiative (SAVVI)	Number of facility cost relief expenditure plans developed and implemented	Plans	Yearly	Mandatory	Key output measure

Activity no.	Activity name	Measure description	Unit of measure	Frequency	Status	Output type
13302	SRS Supporting Accommodation for Vulnerable Victorians Initiative (SAVVI)	Number of facility cost relief cluster plans developed and implemented	Plans	Yearly	Mandatory	Other standard measure
13302	SRS Supporting Accommodation for Vulnerable Victorians Initiative (SAVVI)	Number of proprietors of assisted SRS that meet accountability and reporting requirements for facility cost relief	Proprietors	Yearly	Mandatory	Other standard measure
13303	SAVVI Supporting Connections	Number of clients	Clients	Yearly	Mandatory	Key output measure
13352	Victorian Seniors Festival	Number of events and participants	Events Participants	Yearly	Non-mandatory	Other standard measure
13354	Elder abuse prevention and response	Number of telephone calls	Calls	Six-monthly	Non-mandatory	Other standard measure
13354	Elder abuse prevention and response	Number of professional education sessions attendees	Events participants	Six-monthly	Non-mandatory	Other standard measure
13354	Elder abuse prevention and response	Number of community education sessions	Events	Six-monthly	Non-mandatory	Other standard measure
13355	Seniors community programs	Number of projects	Reports	Quarterly	Non-mandatory	Other standard measure
13356	Information and lifelong learning	Number of information requests/contacts	Contacts	Quarterly	Non-mandatory	Other standard measure
13356	Information and lifelong learning	New programs New U3As	Programs U3As	Six-monthly	Non-mandatory	Other standard measure

Table 17: 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 satisfaction	Proportion of respondents to VHES question reporting a ‘good’ or ‘very good’ response to overall ambulance experience	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	HCWI – influenza	Healthcare worker immunisation – influenza	Percentage	Annual	Mandatory
	Pain reduction	Adult patients who achieve a meaningful reduction in pain	Percentage	Quarterly	Mandatory
	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
	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

Service plan	Activity	Measure description	Unit of measure	Reporting frequency	Status
	Cardiac arrest survived event rate	Adult VF/VT patients with vital signs at hospital	Percentage	Quarterly	Mandatory
		Adult VF/VT patients surviving to hospital discharge	Percentage	Quarterly	Mandatory
Access	Response time statewide	Emergency Code 1 incidents responded to within 15 minutes	Percentage	Monthly	Mandatory
		Emergency Priority 0 incidents responded within 13 minutes	Percentage	Monthly	Mandatory
	Response time urban	Emergency Code 1 incidents responded to within 15 minutes in centres with population > 7,500	Percentage	Monthly	Mandatory
	Average response time	Average time to respond to Emergency Code 1 incidents	Minutes	Monthly	Mandatory
	Clearing time at hospital	Average ambulance hospital clearing time	Minutes	Monthly	Mandatory
	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
	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 18: Mental health service – performance targets and monitoring

Note: Some targets will be provided in the *Mental Health Performance and Accountability Framework* (due for publication later in 2020) and related processes. Said 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	tbc	Quarterly	Mandatory
	Seclusion duration – all ages	Hours	Yes	Yes	Yes	-	Quarterly	Mandatory
	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 'very good' or 'excellent' overall experience of care in the last 3 months or less	Per cent	Yes	Yes	No	tbc	Annual	Mandatory
	Rate of Your Experience of Service (YES) completion	Per cent	Yes	Yes	No	tbc	Annual	Mandatory
	Percentage valid HoNOS[14] compliant – all inpatient, all ages	Per cent	Yes	Yes	Yes	> 85%	Quarterly	Mandatory
	Percentage valid HoNOS compliant – ambulatory, all ages	Per cent	Yes	Yes	Yes	> 85%	Quarterly	Mandatory
	Percentage self-rating measures completed BASIS for adults and aged, SDQ for children and young people 4–17 years[15]	Per cent	Yes	Yes	Yes	> 85%	Quarterly	Mandatory

[14] 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.

[15] 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.

Domain	Measure or indicator	Unit	Adult report	CAMHS report	Older person report	Government target	Frequency	Status
Effectiveness	Percentage of separations from an acute inpatient unit (adult, aged, CAMHS) with a subsequent readmission within 28 days	Per cent	Yes	Yes	Yes	tbc	Quarterly	Mandatory
	Percentage of closed community cases re-referred within 6 months (lagged)	Per cent	Yes	Yes	Yes	tbc	Quarterly	Mandatory
	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	tbc	Quarterly	Mandatory
Accessibility	Pre-admission contact	Per cent	Yes	Yes[16]	Yes	> 61% All age ranges	Quarterly	Mandatory
	Percentage of mental health-related ED presentations with a length of stay in the emergency department of less than 4 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
	Trimmed average length of acute mental health inpatient stay ≤ 50 days	Days	No	No	Yes	< 30 days	Quarterly	Mandatory

[16] 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.

Table 19: Primary, community and dental health – performance targets and monitoring

Activity no.	Activity name	Measure description	Unit of measure	Frequency	Status	Output type
27019	RDHM Dental Care	Number of clients	Clients	Yearly	Mandatory	Key output measure
27023	Community Dental Care	Number of clients	Clients	Yearly	Mandatory	Key output measure
28015	Family and Reproductive Rights Education Program	Number of hours of service	Hours	Quarterly	Mandatory	Key output measure
28016	Family and Reproductive Rights Education Program – Health Promotion	Report against health promotion plan	Reports	Yearly	Non-mandatory	Other standard measure
28018	Family Planning – Health Promotion	Report against health promotion plan	Reports	Yearly	Non-mandatory	Other standard measure
28021	Innovative Health Services for Homeless Youth – Health Promotion	Report against health promotion plan	Reports	Yearly	Non-mandatory	Other standard measure
28048	Language Services	Number of occasions of service	Occasions of service	Monthly	Mandatory	Key output measure
28050	Women's Health – Health Promotion	Report against health promotion plan	Reports	Yearly	Non-mandatory	Other standard measure
28062	Telephone Counselling	Number of calls answered	Calls	Quarterly	Mandatory	Key output measure
28062	Telephone Counselling	Percentage of calls answered	Calls	Quarterly	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

Activity no.	Activity name	Measure description	Unit of measure	Frequency	Status	Output type
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
28087	Primary Care Partnerships	Report against Primary Care Partnership planning and reporting guidelines	Reports	Yearly	Mandatory	Key output measure
28088	ACCO 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 20: 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[17] 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
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	Annual	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
16507	BBV and STI – laboratory services	Report against agreed deliverables	Reports	Reports	Mandatory	Key output measure

[17] Assisted reproductive treatment

Activity no.	Activity name	Measure description	Unit of measure	Frequency	Status	Output type
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

31 Service standards and guidelines

Table 21: 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 1997* as amended Commonwealth Department of Health resources: MyAged Care website <https://www.myagedcare.gov.au> 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 1997* as amended Commonwealth Department of Health resources: MyAged Care website <https://www.myagedcare.gov.au> 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[18] – 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 Health Care and Support	*Victorian HACC program manual* *Small rural health services guide 2003–04* and updates
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://www2.health.vic.gov.au/about/publications/policiesandguidelines/public-health-wellbeing-planning-advice-2017-2021>
35052	Small rural – specified services	*Small rural health services guide 2003–04* and updates

[18] Transport Accident Commission

Table 22: Drug services – service standards and guidelines

Service standards and guidelines description	Activity no.
Alcohol and other drug program guidelines	34041, 34045, 34046, 34048, 34049, 34051, 34053, 34056, 34060, 34064, 34074, 34078, 34080, 34084, 34202, 34204, 34205, 34206, 34208, 34006, 34009, 34021, 34040, 34041, 34042, 34044, 34045, 34046, 34047, 34048, 34049, 34050, 34053, 34057, 34060, 34061, 34062, 34066, 34069, 34070, 34078, 34079, 34082, 34084, 34200, 34202, 34203, 34205, 34209, 34211, 34212, 34213, 34214, 34300, 34301, 34303, 34304, 34305, 34306, 34307, 34308, 34309, 34310
Alcohol and other drug withdrawal 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 alcohol and drug 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 2005	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 2005 *Commission for Children and Young People Act 2012* *Working with Children Act 2005* Protocol between drug treatment services and child protection for working with parents with alcohol and drug issues	34003, 34004, 34006, 34009, 34021, 34040, 34041, 34042, 34044, 34045, 34046, 34047, 34048, 34049, 34050, 34053, 34056, 34057, 34060, 34061, 34062, 34064, 34066, 34069, 34070, 34071, 34078, 34079, 34080, 34082, 34084, 34200, 34202, 34203, 34204, 34205, 34206, 34207, 34209, 34211, 34212, 34213, 34214, 34300, 34301, 34303, 34304, 34305, 34306, 34307, 34308, 34309, 34310
Clinical treatment guidelines for alcohol and drug clinicians: co-occurring acquired brain injury/cognitive impairment and alcohol and drug 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

Service standards and guidelines description	Activity no.
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
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 1981	34061, 34308, 34070
Health Complaints Act 2016	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

Service standards and guidelines description	Activity no.
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 2010	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
SHPA standards of practice for Australian poisons information centres	34003
Victorian needle and syringe programs operating policy and guidelines (revised November 2008)	34070, 34308

Table 23: Ageing, aged and home care – service standards and guidelines

Activity no.	Activity name	Service standards and guidelines description
13005	Aged Care Assessment	*Aged Care Act 1997*, as amended *My Aged Care assessment manual – for Regional Assessment Services and Aged Care Assessment Teams* (2018) and addendums My Aged Care screening and assessment workforce training strategy (2019) *Aged Care Assessment Program style guide* (2016) (Commonwealth Department of Health)
13015	HACC Linkages	*Victorian HACC 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 Service Development Grant	*Victorian HACC program manual*
13024	HACC Assessment	*Victorian HACC program manual* *Framework for assessment in the HACC program in Victoria*
13026	HACC Domestic Assistance	*Victorian HACC program manual* *Victorian HACC-PYP fees policy*
13027	HACC Respite	*Victorian HACC program manual* *Victorian HACC-PYP fees policy*
13031	Public Sector Residential Aged Care Supplement	*Aged Care Act 1997*, as amended Commonwealth Department of Health resources: MyAged Care website <https://www.myagedcare.gov.au> Factsheets <https://www.health.gov.au/health-topics/aged-care> Guides and policy <https://www.health.gov.au/health-topics/aged-care>
13035	Support for Carers	*Carers Recognition Act 2012* *A Victorian charter supporting people in care relationships and information kit – Victorian Support for Carers Program guidelines*
13038	HACC Service System Resourcing	*Victorian HACC program manual*
13043	HACC Flexible Service Response	*Victorian HACC program manual* *Victorian HACC-PYP fees policy*
13053	Victorian Eyecare Service	*Victorian Eyecare Service program guidelines* (2015, interim)
13056	HACC Planned Activity Group – core	*Victorian HACC program manual* *Victorian HACC-PYP fees policy*
13057	HACC Planned Activity Group – High	*Victorian HACC program manual* *Victorian HACC-PYP fees policy*
13063	HACC- Volunteer Co-Ordination	*Victorian HACC program manual*

Activity no.	Activity name	Service standards and guidelines description
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 Allied Health	*Victorian HACC program manual* *Victorian HACC-PYP fees policy*
13097	HACC Delivered Meals	*Victorian HACC program manual*
13099	HACC Property Maintenance	*Victorian HACC program manual* *Victorian HACC-PYP fees policy*
13109	Aged Care Assessment Service Evaluation Unit	*Aged Care Act 1997*, as amended *My Aged Care assessment manual – for Regional Assessment Services and Aged Care Assessment Teams* (2018) and addendums *My Aged Care screening and assessment workforce training strategy* (2019) *Aged Care Assessment Program style guide* (2016) (Commonwealth Department of Health)
13130	HACC Volunteer Co-Ordination – Other	*Victorian HACC program manual*
13131	RDNS HACC Allied Health	*Victorian HACC program manual* *Victorian HACC-PYP fees policy*
13155	Dementia Services	*Carers Recognition Act 2012* *Program guidelines: Support for carers of people with dementia including younger people with dementia guidelines* (updated 2013) Support and Links Service program statement
13156	Seniors Health Promotion	*Victorian HACC program manual* *Older Persons High Rise Support Program guidelines*
13223	HACC Nursing	*Victorian HACC program manual* *Victorian HACC-PYP fees policy*
13226	HACC Personal Care	*Victorian HACC program manual* *Victorian HACC-PYP fees policy*
13227	ACCO Services – HACC	*Victorian HACC program manual* *Victorian HACC-PYP fees policy*
13229	HACC Access & Support	*Victorian HACC program manual*
13230	Commonwealth Regional Assessment Services	*My Aged Care assessment manual – for regional assessment services and Aged Care Assessment Teams* (2018) and addendums *Victorian regional assessment services operational guidelines* (2019) *My Aged Care quality framework* (2018)

Activity no.	Activity name	Service standards and guidelines description
13301	Aged Quality Improvement	*Aged Care Act 1997,* as amended Commonwealth Department of Health resources <https://www.agedcarequality.gov.au> My Aged Care website <https://www.myagedcare.gov.au> Aged care resources <https://www.health.gov.au/health-topics/aged-care>
13302	Supporting Accommodation for Vulnerable Victorians Initiative (SAVVI)	*SRS supporting accommodation for vulnerable Victorians guidelines* (2012)
13303	SAVVI Supporting Connections	*SRS supporting accommodation for vulnerable Victorians guidelines* (2012) *SAVVI Supporting Connections flexible funds guidelines* (2010) *SAVVI Supporting Connections services specifications* (2008)
13352	Victorian Seniors Festival	*Victorian Seniors Festival Community Grants Program guidelines*
13354	Elder Abuse Prevention and Response	*Contract guidelines and schedules*
13355	Seniors Community Programs	*Funded program guidelines*
13356	Information and Lifelong Learning	*Funded program guidelines*

Table 24: 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://www2.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://www2.health.vic.gov.au/about/populations/womens-health> Health promotion <https://www2.health.vic.gov.au/public-health/population-health-systems/health-promotion>
28021 28066 28085 28086	Young people	*Community health integrated program guidelines: direction for the community health program* <https://www2.health.vic.gov.au/primary-and-community-health/community-health/community-health-program/chip-guidelines> Child, youth and family health <https://www2.health.vic.gov.au/primary-and-community-health/community-health/population-groups/children-youth-and-families> Innovative Health Services for Homeless Youth (IHSHY) <https://www2.health.vic.gov.au/primary-and-community-health/community-health/population-groups/children-youth-and-families>
28033 28043 28069 28074 28080 28084 28085 28086	Community health	*Community health integrated program guidelines: direction for the community health program* <https://www2.health.vic.gov.au/primary-and-community-health/community-health/community-health-program/chip-guidelines> *Advice for public health and wellbeing planning in Victoria: planning cycle 2017–2021* <https://www2.health.vic.gov.au/about/publications/policiesandguidelines/public-health-wellbeing-planning-advice-2017-2021> *Victorian Aboriginal affairs framework 2018–23* <https://www.aboriginalvictoria.vic.gov.au/victorian-aboriginal-affairs-framework-2018-2023>

Activity no.	Activity name	Service standards and guidelines description
28048 28076 28085 28086	Culturally and linguistically diverse groups	Refugee health <https://www2.health.vic.gov.au/primary-and-community-health/community-health/population-groups/refugee-health-program>. Includes: • *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://www2.health.vic.gov.au/about/populations/refugee-asylum-seeker-health>. Includes the *Refugee and Asylum Seekers Health Action Plan 2014–18* *Cultural responsiveness framework: guidelines for Victorian health services* <https://www2.health.vic.gov.au/about/publications/policiesandguidelines/Cultural-responsiveness-framework---Guidelines-for-Victorian-health-services> outlines the government's approach to cultural responsiveness in health services. *Language services policy* <https://www.dhhs.vic.gov.au/publications/language-services-policy-and-guidelines> Health Translations Directory <https://www.healthtranslations.vic.gov.au>
28054 28087	Partnerships and system support	Primary Care Partnerships <https://www2.health.vic.gov.au/primary-and-community-health/primary-care/primary-care-partnerships> *Primary Care Partnerships (PCP) 2019-20 reporting requirements* <https://www2.health.vic.gov.au/primary-and-community-health/primary-care/primary-care-partnerships/pcp-reporting> Service coordination <https://www2.health.vic.gov.au/primary-and-community-health/integrated-care/service-coordination> General practice and private providers <https://www2.health.vic.gov.au/primary-and-community-health/primary-care/general-practice-private-providers> *Working with general practice* <https://www2.health.vic.gov.au/primary-and-community-health/primary-care/working-with-general-practice>
28071 28085 28086	Aboriginal health	*Community health integrated program guidelines: direction for the community health program* <https://www2.health.vic.gov.au/primary-and-community-health/community-health/community-health-program/chip-guidelines> Aboriginal health – various other publications <https://www2.health.vic.gov.au/about/health-strategies/aboriginal-health>
28072 28074 28081 28085 28086	People with chronic disease	*Community health integrated program guidelines: direction for the community health program* <https://www2.health.vic.gov.au/primary-and-community-health/community-health/community-health-program/chip-guidelines> HealthLinks: Chronic Care <https://www2.health.vic.gov.au/primary-and-community-health/integrated-care/healthlinks>
28080 28085 28086 28212 28213	Maternal health	*Community health integrated program guidelines: direction for the community health program* <https://www2.health.vic.gov.au/primary-and-community-health/community-health/community-health-program/chip-guidelines> Healthy Mothers, Healthy Babies Program <https://www2.health.vic.gov.au/primary-and-community-health/community-health/population-groups/children-youth-and-families/healthy-mothers-healthy-babies> Sleep and settling <https://www2.health.vic.gov.au/primary-and-community-health/maternal-child-health/sleep-settling>
28082 28085 28086	Child health	*Child health services: Guidelines for the community health program* Child health teams <https://www2.health.vic.gov.au/primary-and-community-health/community-health/population-groups/children-youth-and-families>. **Note**: Organisations receiving funds regarding 28085 / 28086 should note these funds can be applied flexibly across the range of initiatives to meet community needs.

Table 25: Public health – service standards and guidelines

Activity no.	Service standards and guidelines description
16373 16377 16505 16506 16507 16508 16509	*BBV/STI program guidelines for funded agencies* (current edition)
16454	*Community Health Integrated Health Promotion Program: planning guidelines 2013–17* *Community Health and Women's Health Integrated Health Promotion: reporting guidelines 2013–17* *Guide to municipal public health and wellbeing planning* (2013) (including the *Environments for health framework*)
28085	*Advice for public health and wellbeing planning in Victoria: planning cycle 2017–2021* <https://www2.health.vic.gov.au/about/publications/policiesandguidelines/public-health-wellbeing-planning-advice-2017-2021>

List of tables

Acronyms and initialisms

ACCO	Aboriginal community-controlled organisation
ACAS	aged care assessment services
AIMS	Agency Information Management System
AMAF	*Asset management accountability framework*
BBV	bloodborne virus
BPCLE	*Best practice clinical learning environment* (framework)
CMI/ODS	Client Management Interface and Operational Data Store
ECT	electroconvulsive treatment
EPC	Early Parenting Centre(s)
ESIS	Elective Surgery Information System
HACC	Home and Community Care
HACC-PYP	Home and Community Care Program for Younger People
HITH	Hospital in the Home
ICS	Integrated Cancer Service
MHCSS	mental health community support services
NATA	National Association of Testing Authorities
NBCSP	National Bowel Cancer Screening Program
NDIS	National Disability Insurance Scheme
PAV	Personal Alert Victoria
PAVRS	Personal Alert Victoria Response Services
PRISM	program report for integrated service monitoring
PROMs	patient-reported outcome measures
PSRACS	public sector residential aged care service
SAVVI	Supporting Accommodation for Vulnerable Victorians Initiative
SCP	Support for Carers Program
SRHS	small rural health service
SRS	Supported Residential Service(s)
STI	sexually transmissible infections
VA&EP	Victorian Aids and Equipment Program
VADC	Victorian Alcohol and Drug Collection
VAED	Victorian Admitted Episodes Dataset
VAHI	Victorian Agency for Health Information
VCDC	Victorian Cost Data Collection
VEMD	Victorian Emergency Minimum Dataset
VES	Victorian Eyecare Service
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
VPDC	Victorian Perinatal Data Collection
WIES	weighted inlier equivalent separation