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| Policy and funding guidelines 2025–26 |
| Policy guide  This policy guide sets out the operational and service delivery policy changes, obligations and standards for government-funded healthcare organisations. It aims to support a world-class healthcare system that helps all Victorians stay healthy and safe. |
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| Policy and funding guidelines 2025–26  Policy guide |
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# Overview of the Policy and funding guidelines 2025–26

The Policy and funding guidelines 2025–26(the guidelines) provide the system-wide terms and conditions for government-funded healthcare organisations (funded organisations). This includes health services and hospitals, community service organisations and other organisations, such as Ambulance Victoria.

The guidelines:

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

The guidelines comprise two separate but related publications, which are the:

* Policy guide (this document)
* Funding rules.

## Policy guide

The Policy guide provides detailed information regarding operational and service delivery policy. This includes:

* the conditions within which funded organisations operate
* the obligations, standards and requirements funded organisations are expected to adhere to.

### Part 1: Operational and service delivery policy

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

### Part 2: Obligations, standards and requirements

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

## Funding rules

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

### Part 1: Budgetary landscape and pricing arrangements

Part 1 details the funding and pricing arrangements.

### Part 2: Funding and activity levels

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

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

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

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

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

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

Service agreements are contractual arrangements between entities for the delivery of services in the community, funded by the department. For entities funded through a service agreement, visit the [Service agreement webpage](https://d.docs.live.net/031c443d5a1cf449/Documents/Business/Government/DoH-C%5e0SI/Service%20agreement%20webpage) <https://fac.dffh.vic.gov.au/service-agreement> for funding information and activity tables that underpin service agreements.

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

## Terminology

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

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

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

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

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

Part 1: Operational and service delivery policy

# National programs

## Nationally Funded Centres Program

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

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

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

## Highly specialised therapies

As set out by the National Health Reform Agreement 2020–26, highly specialised therapies (which include cell and gene therapies) are jointly funded by the Commonwealth, and state and territory governments, following approval from the Commonwealth’s Medical Services Advisory Committee. Highly specialised therapies are provided at selected public hospitals.

The *Framework for the assessment, funding and implementation of high cost, highly specialised therapies and services* has been developed with the collaboration of the Australian Government and all states and territories to ensure a nationally consistent approach to implementing, monitoring and evaluating these therapies.

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

* CAR-T cell therapy Kymriah® to treat relapsing/refractory acute lymphoblastic leukaemia in children and young adults up to the age of 25 years at The Royal Children’s Hospital, Peter MacCallum Cancer Centre and Alfred Health
* CAR-T cell therapy Kymriah® to treat relapsing/refractory diffuse large B-cell lymphoma, primary mediastinal B-cell lymphoma and transformed follicular lymphoma in adults at the Peter MacCallum Cancer Centre and Alfred Health
* CAR -T cell therapy Yescarta® as a third-line treatment for relapsing/refractory diffuse large B-cell lymphoma, primary mediastinal B-cell lymphoma and transformed follicular lymphoma, and high-grade B-cell lymphoma in adults at the Peter MacCallum Cancer Centre and Alfred Health
* CAR-T cell therapy Yescarta® as a second-line treatment for relapsing/refractory large B-cell lymphoma at the Peter MacCallum Cancer Centre and Alfred Health
* CAR-T cell therapy Tecartus® to treat relapsed/refractory mantle cell lymphoma and relapsed/refractory B-precursor acute lymphoblastic leukemia at the Peter MacCallum Cancer Centre and Alfred Health
* gene therapy Luxturna® to treat inherited retinal dystrophies, caused by confirmed biallelic RPE65 pathogenic variants, in children and adults at The Royal Victorian Eye and Ear Hospital
* immunotherapy Qarziba® to treat high-risk paediatric neuroblastoma at The Royal Children’s Hospital and Monash Children’s Hospital.

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

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

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

# Ambulance Victoria

Ambulance Victoria provides pre-hospital treatment and ambulance transport for people in urgent medical emergencies, responding by road and air from more than 250 locations across Victoria. The organisation also helps connect less-urgent callers to triple zero (000) with service providers that best meet their needs.

The Victorian Government funds Ambulance Victoria to provide free ambulance treatment and transport for concession patients, including eligible pensioners and concession card holders. Ambulance Victoria receive fees from third parties for delivery of services to other patient groups including:

* the Department of Veterans’ Affairs for eligible veterans
* the Transport Accident Commission for eligible Victorians involved in a transport accident
* WorkSafe Victoria for eligible Victorians involved in a workplace accident
* public healthcare services
* private healthcare facilities
* general patients who are not eligible under any of the other criteria and do not have an Ambulance Victoria membership subscription[[1]](#footnote-2).

Several other services provided by Ambulance Victoria are funded directly or indirectly (by government and/or through collection of fees) including provision of emergency management functions, retrieval services, and the Secondary Triage Service.

In addition to the funding provided directly to Ambulance Victoria, the government also provides funding to Victoria’s health services for the interhospital transfer of patients (for both emergency and non-emergency transfers).

For non-emergency patient transport (NEPT), health services have discretion as to which patient transport provider they choose to engage to transfer non-concessional patients – either from Ambulance Victoria or a range of private NEPT providers that are licensed by the department. Patients must require clinical monitoring, supervision or care during transport to be eligible for NEPT[[2]](#footnote-3).

## Fee structure

Ambulance Victoria’s fees for each of its service lines are based on the average cost of delivering these services. The average cost recognises all direct and indirect costs of actual service delivery.

Fees for ambulance services can be found on the department’s [Ambulance fees webpage](https://d.docs.live.net/031c443d5a1cf449/Documents/Business/Government/DoH-C%5e0SI/Ambulance%20fees%20webpage) <https://www.health.vic.gov.au/patient-care/ambulance-fees>. Additionally, fees for Ambulance Victoria’s membership subscription scheme are available on Ambulance Victoria’s [Membership webpage](https://www.ambulance.vic.gov.au/membership) <https://www.ambulance.vic.gov.au/membership>.

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

# Acute inpatient services

## Acute admitted services

In Victoria, health services are funded to provide 24/7 acute admitted care. Some health services provide specialist admitted care services (for example, intensive care) or designated statewide services (for example, trauma or transplantation).

Health services are responsible for:

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

# Acute specialist services

## Victorian Perinatal Autopsy Service

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

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

The Royal Women’s Hospital provides:

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

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

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

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

These services are then reimbursed at an agreed rate.

All public health services:

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

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

Private health services are also encouraged to use the service.

## Newborn hearing screening service

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

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

For more information, as well as guidelines for referral to the Victorian Infant Hearing Screening Program, visit the [VIHSP webpage](https://d.docs.live.net/031c443d5a1cf449/Documents/Business/Government/DoH-C%5e0SI/VIHSP%20webpage) <https://www.rch.org.au/vihsp/>.

## Organ and tissue donation

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

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

## Blood products supply funding

Funding for the Victorian blood and blood products supply will continue as per the National Blood Agreement (2003), using the Commonwealth–state government funding model of 63% and 37%, respectively. In compliance with the supply and funding arrangements in the agreement, sufficient volumes of blood and blood products will be available to public and private Victorian health services in 2025–26. This supply plan has been negotiated between the government, the National Blood Authority and the Australian Red Cross Lifeblood (previously known as the Australian Red Cross Blood Service).

Access to blood and blood products will be guided by the *Australian health provider* *blood and blood products charter*, which continues to be implemented with health providers nationally in 2025–2026. The Australian Health Ministers’ Conference Statement on National Stewardship Expectations for the Supply of Blood and Blood Products is available from the [National Blood Authority website](https://www.blood.gov.au/australian-health-ministers-conference-statement-national-stewardship-expectations-supply-blood-and-blood-products) <https://www.blood.gov.au/australian-health-ministers-conference-statement-national-stewardship-expectations-supply-blood-and-blood-products>.

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

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

Subcutaneous immunoglobulin is available to health services through the supply plan for agreed uses. Funding for subcutaneous infusion therapy – home-delivered transitions to activity-based funding under the National Health Reform Agreement Tier 2 non-admitted services national classification system from 1 July 2025.For more information about access, visit the [Subcutaneous immunoglobulin access program](https://www.health.vic.gov.au/patient-care/subcutaneous-immunoglobulin-scig-access-program) <https://www.health.vic.gov.au/patient-care/subcutaneous-immunoglobulin-scig-access-program>.

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

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

## Genetics outpatient program

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

Funding models have been reviewed for clinical genetic outpatient settings (tier 2 class 20.08, 20.56, 40.62, 40.66), with the transition to activity-based funding, in line with the National Funding Model policy and requirements.

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

Public clinical genetic services are provided through metropolitan hubs at:

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

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

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

Funding to support the Victorian Government’s initiative for genomic sequencing for children and adults with rare diseases and undiagnosed conditions is ongoing. This budget commitment facilitates access to a potential clinical diagnosis and streamlines the diagnostic process for patients. The funding supports access to genomic sequencing. Clinical care is provided at all sites.

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

Participating services must report costs to the Victorian Cost Data Collection (VCDC). Genetics clinics are also required to meet national patient-level, data-reporting requirements through the Victorian Integrated Non-Admitted Health (VINAH) minimum data set (MDS) reporting platform or Non-Admitted Data Collection (NADC).

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

## Pharmaceuticals

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

### Pharmaceutical reforms

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

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

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

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

### Highly Specialised Drugs Program

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

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

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

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

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

### Direct-acting antiviral hepatitis C treatments

The Commonwealth listed several direct-acting antivirals for treating hepatitis C on both the PBS 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 PBS have the advantage of being able to be dispensed in both hospital and community pharmacies.

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

## Public fertility care

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

The goal of the program is to improve access to fertility care for Victorians who are underserved or have limited access to the existing private services. In particular, this includes:

* people on a low income
* rural and regional Victorians
* single people
* LGBTIQA+ Victorians
* people who require testing for monogenic conditions
* people requiring fertility preservation for medical reasons, such as cancer treatment.

Victoria’s Public Fertility Care program is led by The Royal Women’s Hospital and delivered in partnership with other health services across the state operating satellite sites at Clayton, Epping, Sunshine, Bendigo, Mildura, Heidelberg, Warrnambool, Shepparton, Ballarat and Geelong, providing care closer to home.

Victorians who wish to access Public Fertility Care will require a Medicare card and a referral from their GP or relevant specialist, which is sent to The Royal Women’s Hospital. Eligible patients will then be referred to their nearest partner health service for a first consultation.

The clinical access criteria are that:

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

Providers are required to report on output performance measures through key performance indicators on a quarterly basis.

For more information, visit [Public Fertility Care](https://d.docs.live.net/031c443d5a1cf449/Documents/Business/Government/DoH-C%5e0SI/Public%20Fertility%20Care) <https://www.health.vic.gov.au/public-health/public-fertility-care-services>.

# Mental health and wellbeing services

## Transforming the mental health and wellbeing system

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

Since the Royal Commission into Victoria’s Mental Health System (RCVMHS), significant progress has been made to create a mental health and wellbeing system that better meets the needs of Victorians, including incorporating lived and living experience, and providing more access to care in communities.

In December 2024, the Minister for Mental Health released The Next Phase of Reform and the *Mental Health and Wellbeing Outcomes and Performance Framework*. The Next Phase of Reform will build on what has already been achieved. There will be greater emphasis on prevention, promotion and early intervention, and more care being delivered in the community, closer to home.

Our priorities include:

* focusing on prevention and promotion to keep people well in their communities and reduce demand on acute mental health and wellbeing services
* growing strong, safe and supported workforces, including diversifying and retaining talent, and building worker skills and capabilities
* supporting a system that embeds lived experience at every level by growing lived experience leadership, as well as embedding lived expertise and perspectives that reflect the rich diversity of the communities we serve
* delivering new and better services that are connected, inclusive and locally accessible to further improve statewide and area services (community and bed-based services)
* providing more support to the system so that it can deliver improved services for better outcomes with stronger accountability
* driving cultural change by helping the sector to align its practice with the principles of the *Mental Health and Wellbeing Act 2022*
* enriching our ways of working, including revamped sector and clinical engagement, and responding to the unique strengths and needs of diverse communities.

For more information, visit [Our plan for the next phase of reform](https://d.docs.live.net/031c443d5a1cf449/Documents/Business/Government/DoH-C%5e0SI/Our%20plan%20for%20the%20next%20phase%20of%20reform) <https://www.health.vic.gov.au/mental-health-wellbeing-reform/our-next-phase>.

### Foundations of a new integrated and responsive system

#### Mental Health and Wellbeing Act

The Mental Health and Wellbeing Act came into effect on 1 September 2023, replacing the *Mental Health Act 2014.* It resets the legislative foundations to support the transformation of Victoria’s mental health system. This Act has a range of objectives that aim to achieve the highest possible standard of mental health and wellbeing for all Victorians.

The Mental Health and Wellbeing Act’s strengthened objectives and principles promote and protect human rights, putting the views, preferences and values of people living with mental illness or psychological distress, and their families, carers and supporters at the forefront of service design and delivery.

This Act now reflects a more inclusive system with a focus on early intervention and community-based services. This means the Act covers a broader range of service providers, ensuring the guiding principles of the Act are implemented at all stages of care, from preventative to responsive treatment.

This helps to support the rights and dignity of mental health patients by aiding supported decision making with tools such as the advance statement of preferences. These allow a person to document their preferences in the event they become a compulsory patient, with nominated support persons to assist the person in expressing their views and preferences, and a new opt-out model for access to non-legal mental health advocacy support.

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

While the implementation project has been finalised after three years of focused effort, the department will continue to work with services on implementation and to ensure that the Act is supporting the delivery of services as intended.

Operational support regarding the requirements of the Mental Health and Wellbeing Act is now provided by the Office of the Chief Psychiatrist (OCP) as needed.

#### Mental Health and Wellbeing Commission

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

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

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

The Commission is able to consider complaints from families, carers and supporters in relation to their experiences.

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

#### Outcomes and performance framework

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

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

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

For more information and implementation updates, visit [Mental health and wellbeing outcomes performance framework](https://www.health.vic.gov.au/mental-health-wellbeing-reform/a-new-mental-health-and-wellbeing-outcomes-and-performance-framework) <https://www.health.vic.gov.au/mental-health-wellbeing-reform/a-new-mental-health-and-wellbeing-outcomes-and-performance-framework>.

#### Mental health and wellbeing service and capital plan

The Statewide mental health and wellbeing service and capital plan 2024–2037(Statewide Plan) responds to recommendation 47 of the RCVMHS. The scope of the first Statewide Plan prioritises Local Mental Health and Wellbeing Services (level 4) and Area Mental Health and Wellbeing Services (level 5) as the major Victorian Government-funded component of the mental health and wellbeing system.

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

The Statewide Plan is critical in:

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

#### Age streaming

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

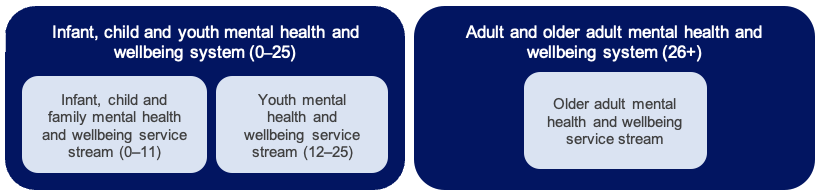
This is so that:

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

Figure 1 shows the two age-based systems set out in two boxes: the first for the infant, child and youth mental health and wellbeing system (0-25) and the second for the adult and older adult mental health and wellbeing system (26+).

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

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



Source: RCVMHS final report, vol. 1, p. 297.

The following key reform initiatives cut across service levels and will continue to progress implementation of a responsive and integrated system in 2025–26.

#### Service catchments

In line with recommendation 3.4 of the RCVMHS, mental health service catchments that have historically determined access to mental health services based on a person’s place of residence will be reviewed to enable consumer access and choice, address access inequities and avoid service discontinuity. This work intersects with multiple enabling reform priorities, such as the redesign of Level 5 community mental health and wellbeing services and access policy, and will continue into 2025–26.

While service delivery catchments will no longer be a feature of the system, clear and effective service planning areas will continue to support planning and design of the mental health and wellbeing service system that reflect natural consumer flows.

#### Redesigning level 5 community-based mental health and wellbeing services

The department is undertaking a significant reform program to redesign level 5 community-based mental health and wellbeing services delivered by Area Mental Health and Wellbeing Services, including in partnership with NGOs.

This also includes the core functions recommended by the RCVMHS, including:

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

The Community Redesign project aims to deliver a comprehensive system design and strategy to improve community-based service responses for people of all ages, with moderate to severe mental illness, who have more intensive treatment, care and support needs. This will help to improve level 5 community-based mental health and wellbeing care to make it more holistic and integrated, and to improve consistency across the state.

The government will engage with mental health and wellbeing service providers over the next 12 months to progress design and plan for the delivery of level 5 community-based mental health and wellbeing services. This will be a multiyear implementation process.

#### Access policy and triage guidelines

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

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

The mental health access and intake scale will support Victorians across the lifespan to receive timely treatment, care and support at the required level of intensity, and will also describe collaborative arrangements and examples of referral pathways between Local, Area and Statewide Mental Health and Wellbeing Services.

The initial draft of the access policy and triage guidelines was developed in 2023, with further testing and refining undertaken over the next 12 months, with Local Mental Health and Wellbeing Services and Area Mental Health and Wellbeing Services. access policy and triage guidelines sector-wide rollout in 2026.

### Six levels of an integrated and responsive system

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

Figure 2. Mental health and wellbeing six-level system

Level 1: families, carers and supporters, informal support, virtual communities, communities of place, identity and interest
Level 2: broad range of government and community services
Level 3: primary and secondary mental health and related services
Level 4: Local Mental Health and Wellbeing services
Level 5: Area Mental Health and Wellbeing services
Level 6: Statewide services

Source: RCVMHS final report, vol. 1, p. 297.

The following sections set out the 2025–26 policy and further reform activities for levels 4, 5 and 6 services, and alcohol and other drug (AOD) services.

## Level 4: Local Mental Health and Wellbeing Services

Level 4 services provide high-quality treatment, care and support to people whose needs are too intensive for Level 3 services, but do not require the crisis, complex or higher intensity support of Level 5 services.

To enable a smooth transition between different system levels, each age-based stream of Local Mental Health and Wellbeing Services requires collaboration with the networked Area Mental Health and Wellbeing Service, with the level of collaboration varying per stream. The following sections provide a more detailed description of each age-based stream of support.

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

Mental Health and Wellbeing Locals provide integrated treatment, care and wellbeing support to adults and older adults (aged 26 years and over) who are experiencing mental health concerns or wellbeing concerns – including people with co-occurring AOD treatment care needs. Support is also available to their family, carers and supporters.

For more information, visit [Mental Health and Wellbeing Locals](https://www.health.vic.gov.au/mental-health-services/mental-health-and-wellbeing-locals) <https://www.health.vic.gov.au/mental-health-services/mental-health-and-wellbeing-locals>.

Fifteen Mental Health and Wellbeing Locals are currently operating in Victoria, providing a new and additional stream of support to people with mental health and wellbeing concerns. Planning work is underway and will continue for future Mental Health and Wellbeing Locals.

Under theBilateral Schedule on Mental Health and Suicide Prevention: Victoria, the Australian Government is contributing funding towards Mental Health and Wellbeing Locals.

As per the Bilateral Schedule commitment, Mental Health and Wellbeing Locals will progressively transition consumer services from Commonwealth-funded temporary Head to Health clinics to local services with a shared objective of working towards no service gaps while Mental Health and Wellbeing Locals are established across the state.

Table 1. Mental Health and Wellbeing Locals operating in Victoria

|  |  |  |
| --- | --- | --- |
| **Local service location/s** | **Mental Health and Wellbeing Local Service name** | **Mental Health and Wellbeing Local Service zone (Local Government Area)** |
| Bairnsdale and Orbost | Bairnsdale and Orbost, servicing East Gippsland | East Gippsland Shire |
| Benalla, Wangaratta and Mansfield | Benalla, Wangaratta and Mansfield | Rural Cities of Benalla and Wangaratta, and Shire of Mansfield |
| Bendigo and Echuca | Bendigo and Echuca, servicing Greater Bendigo, Loddon and Campaspe | City of Greater Bendigo, Loddon Shire and Campaspe Shire |
| Dandenong | Dandenong, servicing Greater Dandenong | City of Greater Dandenong |
| Frankston | Frankston | City of Frankston |
| Geelong | Greater Geelong and Queenscliffe | City of Greater Geelong and Borough of Queenscliffe |
| Lilydale | Lilydale, servicing Yara Ranges | Yarra Ranges |
| Melton | Melton, servicing City of Melton | Melton City |
| Mildura | Mildura, servicing Rural City of Mildura | Rural City of Mildura |
| Morwell | Latrobe | City of Latrobe |
| Shepparton | Shepparton, servicing Greater Shepparton, Strathbogie and Moira | The City of Greater Shepparton City, Strathbogie and Moira Shires |
| South Morang | Whittlesea | City of Whittlesea |
| Sunshine | Brimbank | City of Brimbank |

Mental Health and Wellbeing Locals providers are expected to adhere to the *Local Adult and Older Adult Mental Health and Wellbeing Service: service framework* (service framework)[[3]](#footnote-4) developed and published by the department in 2022.

The service framework:

* outlines the objectives, service features and functions, service model components, and the workforce, data reporting and operational requirements for the full functionality of the Mental Health and Wellbeing Locals
* reflects the findings of the RCVMHS and promotes the overall service philosophy of ‘how can we help?’
* was developed in consultation with people with lived and living experience, and with technical and clinical advice from the mental health and wellbeing sector
* is a working document that will be adjusted and refined as the service model matures.

### Mental Health and Wellbeing Locals – young people (12–25)

These are being led by the department with the Australian Government Department of Health and Aged Care.

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

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

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

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

From October 2025, the department will implement recommendations from the first phase evaluation of the Children’s Health and Wellbeing Locals implementation, which found that the differing streams of funding and accountability created barriers to service integration. These findings have informed the transition of existing funding from three separate streams (community health, mental health and family services) to one single stream, between the department and community health lead providers. This change in funding mechanism will take place from 1 October 2025, and work to further integrate reporting via the Community Health MDS will continue into 2025–26.

## Level 5: Area Mental Health and Wellbeing Services

### Parkville Youth Mental Health and Wellbeing Service (PYMHWS)

PYMHWS was established as a public health service under the *Health Services Act* in July 2024. As a dedicated youth mental health service, the establishment of PYMHWS is a first for Victoria. On 1 July 2025, mental health and wellbeing services for 12–25-year-olds (previously known as Orygen Specialist Program) formally transferred to PYMHWS from Melbourne Health.

The RCVMHS found there were complex governance arrangements in place for public specialist mental health services for people living in northern and western metropolitan Melbourne, including young people. Over the last three years the Department of Health has worked with the Melbourne Health, Northern Health and Western Health to improve governance arrangements. The establishment of PYMHWS is a further step in this process.

PYMHWS serves a catchment area with over 200,000 young people, including four of the largest and fastest growth corridors of metropolitan Melbourne, incorporating the LGAs of:

* Wyndham
* Hobson’s Bay
* Melton
* Hume
* Brimbank
* Maribyrnong
* Moonee Valley
* Merri-Bek
* Melbourne.

During 2025-26 PYMHWS will work to update its model of care in consultation with neighbouring adult catchment areas to provide equitable and needs-based care across the target age range until the young person’s 26th birthday.

PYMHWS will continue its focus on providing early intervention to young people with severe and/or complex mental illness. Multidisciplinary teams will continue to deliver individually tailored services that comprise of:

* assessment and crisis intervention
* case management
* medication
* psychological interventions
* peer support
* family support
* inpatient care
* group work
* vocational interventions,
* educational assistance
* intensive outreach.

PYMHWS also operates the Forensic Youth Mental Health Service for the custodial sites at Parkville and Cherry Creek and community Forensic Youth Mental Health Services.

PYMHWS clinical care program offers a wide range of services, including:

* Acute services (including an inpatient unit, and a Hospital-in-the-Home program).
* Provision of specialist programs such as the Early Psychosis Program and Suicide Prevention Aftercare Service for young people (HOPE)
* Continuing care - specialised care for young people experiencing severe and/or complex mental illness, including psychotic (including young people at ‘ultra-high risk’ of psychosis), mood, personality, substance use, eating, and neurodevelopmental disorders.
* Training and consultation - support for health professionals and teams to improve their understanding of youth mental health, and to promote the capacity of services to support young people in the community.

### Bed-based services

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

#### Acute care

Acute admitted services encompass a range of distinct bed types providing services across the age streams, including:

* acute specialist: acute beds with a targeted model of care focusing on areas such as mental health, parent and infant, eating disorders and other specialist areas of mental health service provision
* acute intensive care area: mental health inpatient beds providing assessment and treatment to people who are acutely unwell, where there are concerns for the safety of the person or others.
* acute low care area: mental health inpatient beds providing short-term inpatient treatment and care during a mental health crisis, focusing on assessment, stabilisation and preparation for community-based care
* Hospital in the Home (HITH): outreach programs where a patient may still need acute care, but is clinically suitable to receive treatment in their own homes.

#### Prevention and recovery care (PARC)

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

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

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

The *YPARC statewide service framework* creates statewide consistency in the way that YPARC services are delivered, and ensures that treatment, care and support is developmentally appropriate for young people aged 16–25 years who would benefit from a community bed-based residential service. Health services operating a YPARC are expected to align their local model of care with the *YPARC statewide service framework*.

#### Community and extended care

Secure extended care units (SECUs) are inpatient services for people who need a high level of secure and intensive clinical treatment for severe and unremitting mental illness. SECUs provide long-term management and treatment services using a recovery-oriented approach. There are three metropolitan and three regional SECUs that provide services for consumers from multiple catchments. The expectation on services managing SECUs is that there is access and flow, and the SECU can maintain an appropriate throughput of patients without prolonged bed block.

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

#### Non-admitted mental health services

Community-based mental health services provided by Level 5 designated area mental health services complement the bed-based mental health services to prevent hospital admissions, reduce the burden on the acute service and provide localised early intervention and care close to home.

The RCVMHS recommended that the future system be centred around a community-based model of care where people receive the most appropriate treatment, care and support for their needs at any given point, close to where they live, to the extent that this is possible. As such, non-admitted mental health services play an increasingly more significant role in the transformation of the system.

From 1 July 2025, a proportion of the community-based mental health funding will transition to the National Funding Model. For details on the transition to activity-based funding, please refer to section 2.5 and section 3.9 of the Funding rules.

Health services are required to continue to deliver all the community-based mental health programs that were delivered in 2024–25 and, at a minimum, maintain the same volume of activity delivered in 2024–25. During the transition period, targets for community service hours will be retained in health services’ SOP to monitor maintenance of timely consumer access to existing community-based mental health services.

Table 2 lists the most common community-based mental health programs delivered by designated mental health services.

Table 2. Community-based mental health programs

| Community-based mental health program | Description |
| --- | --- |
| Crisis assessment and treatment | A 24/7 mobile crisis service that provides effective assessment and treatment in the community to people in crisis due to a mental illness. This includes assessing the most effective and least restrictive client service options and screening inpatient bed admissions |
| Community care units | Purpose-built units of up to 20 beds located in community settings with 24-hour staffing. They are designed for adults who need longer-term support, onsite clinical services and individualised rehabilitation |
| Adult continuing care | A range of community-based services that provide assessment, treatment and additional continuing care and case management for adults with a mental illness |
| Adult integrated community service | An integrated range of services that meet the client’s treatment needs, ensuring efficient and effective community-based mental health services are provided |
| Acute care – adult | Acute inpatient units provide for the short-term assessment, treatment and management of mentally ill adults aged 15–65 years. The focus is on intervention designed to reduce symptoms and promote recovery from mental illness |
| Secure extended care – adult | Long-term inpatient treatment and support for adults aged 15–65 years who have unremitting and severe symptoms, together with an associated significant disturbance in behaviour that inhibits the person’s capacity to live in the community |
| Aged persons mental health community teams | Mobile services that provide assessment, treatment, rehabilitation and case management for people with a mental illness, primarily over 65 years of age |
| Acute care – aged | Inpatient units providing short-term assessment and treatment for people aged 65 or older with acute symptoms of mental illness who cannot safely be cared for in the community |
| Child and adolescent assessment treatment | A range of services including crisis assessment, case management, individual or group therapy, family therapy, parent support and medication-based treatments for children and adolescents experiencing significant psychological distress or mental illness. Services support a timely response to referrals, including crises, delivered on an outreach basis, where appropriate |
| Intensive youth support | Mobile intensive mental health case management and support to adolescents who display substantial and prolonged psychological disturbance and have complex needs that may include challenging, at-risk and suicidal behaviours, and who have been difficult to engage using less-intensive treatment approaches |
| Acute care – specialist statewide | A range of specialist clinical inpatient mental health assessment, treatment or consultancy services that support specific and general target groups on a statewide, interregional or specific catchment area basis. The focus of these inpatient services is on clinical service provision to people with a mental illness |
| Acute care – child and adolescent | Inpatient units provide short-term psychiatric assessment and treatment for children and adolescents with severe psychological disturbance who cannot be effectively assessed or treated in a less-restrictive community-based setting |
| Forensic Community Service | Provides community-based assessment and multidisciplinary treatment services to high-risk clients referred from a range of criminal justice agencies, mental health services and private practitioners. Also provides secondary consultations and specialist training to area mental health services |
| Acute care – forensic | Inpatient services for the assessment, diagnosis and treatment of the crisis and acute phases of mentally disturbed offenders referred by the courts, prison system, police and general mental health services |
| Aged persons mental health nursing home supplement | Community residential services for aged clients who cannot be managed in the general residential system due to their level of persistent cognitive, emotional or behavioural disturbances. Services include long-term accommodation, ongoing assessment, treatment and care of residents, rehabilitation and respite care |
| Training – statewide | All activities associated with training and staff development |
| PARC | Subacute clinical bed-based treatment services option for people with a significant mental health problem requiring pre-crisis or post-acute treatment and support. PARC assists in averting acute inpatient admission and facilitates earlier discharge from inpatient units. It is not a substitute for inpatient admission |
| Homeless outreach psychiatric services | Outreach services that provide assessment, treatment, rehabilitation and case management for homeless people with a mental illness. Also includes secondary consultation and support to the homelessness service sector |
| Academic positions – health services | All activities associated with specified academic positions attached to tertiary institutions, regardless of the location of the position |
| Training – graduate year training | Funding provided to health services to support nurses and allied health staff participating in specialist mental health graduate-year programs for training, supervision, backfill and subsidy to enable reduced clinical loads during the orientation phase |
| Community specialist statewide services | Specialist clinical community mental health assessment, treatment or consultancy services that support specific and general target groups on a statewide, interregional or specific catchment area basis. The focus of these community services is on a clinical service provision to people with a mental illness |
| Statewide support – clinical services | Services including resourcing for the clinical mental health service system on a statewide, interregional or specific-purpose basis |
| Aged persons mental health hostel supplement | Hostel-based community residential services for aged clients who cannot be managed in the general residential system due to their level of persistent cognitive, emotional or behavioural disturbances. Services include long-term accommodation, ongoing assessment, treatment and care of residents, low-level nursing home or hostel care, rehabilitation and respite care |
| Consultation and liaison | Consultation liaison psychiatry is the diagnosis, treatment and prevention of psychiatric morbidity among physically ill patients who are patients of an acute general hospital. This activity includes providing psychiatric assessment, consultation, liaison and education services to non-psychiatric health professionals and their patients |
| Prevention and promotion | The development and delivery of mental health promotion and the prevention of mental health problems and disorders |
| Consumer participation | Participation of consumers, which may include employing consumer consultants to provide input into service planning, development and evaluation, establishing consumer networks and becoming involved in consumer participation plans for area mental health services |
| Ethnic consultants | Strategies that increase the accessibility of mental health services for people from culturally diverse backgrounds. This includes developing and implementing strategic plans for providing culturally sensitive services, and for establishing and maintaining partnerships with ethnic community groups and bilingual health workers |
| Research and evaluation | All activities associated with academic appointments, research and evaluation |
| Quality incentive strategy | Financial incentives for service quality in adult, aged persons and child and adolescent mental health services. The Quality incentive strategy includes measures of consumer and carer satisfaction, service responsiveness and timeliness of data reporting |
| Conduct disorder program | Services that provide prevention programs for children and young people at risk, and clinical services for those with established conduct disorder |
| Early psychosis program | Specialist treatment and improved continuity of care services for young people with an emerging disorder, particularly coexisting substance abuse problems |
| Koori liaison officers | All activities associated with the mental health Koori liaison positions |
| Community specialist statewide services – eating disorders | A range of specialist clinical community mental health assessment, treatment or consultancy services that support eating disorder groups on a statewide, interregional or specific catchment area basis. The focus of these community services is on a clinical service provision to people with a mental illness |
| Aged persons intensive community treatment | Short-term assessment and treatment for people over 65 years of age with acute symptoms of a mental illness, delivered in community settings |
| Acute care – Mother–Baby (now known as Parent and Infant services) | A range of specialist clinical inpatient mental health assessment, treatment or consultancy services that support mother and baby groups on a statewide, interregional or specific catchment area basis. The focus of these inpatient services is on clinical service provision to people with a mental illness |
| Acute care – eating disorders | A range of specialist clinical inpatient mental health assessment, treatment or consultancy services that support eating disorder groups on a statewide, interregional or specific catchment area basis. The focus of these inpatient services is on clinical service provision to people with a mental illness |
| Emergency department (ED) crisis assessment | Extended-hours coverage in EDs for mobile crisis services that provide effective assessment and treatment throughout the community to people in crisis due to a mental illness |
| Community specialist statewide services – non-government | A range of specialist clinical community mental health assessment, treatment or consultancy services delivered by NGOs that support groups on a statewide, interregional or specific catchment area basis. The focus of these community services is on clinical service provision to people with a mental illness |
| System capacity development – non-government | Block grants provided for a specified purpose or as a contribution towards a program that assists with developing system capacity. They exclude funding for clinical positions |
| Academic positions – other | All activities associated with specified academic positions attached to tertiary institutions, regardless of the location of the position |
| Workforce support | Specialist clinical inpatient mental health assessment, short-term admission and treatment services that support neuropsychiatric disorders on a statewide, interregional or specific catchment area basis |
| Suicide prevention | Programs that aim to reduce suicide among adults (26+) and young people (0–25). Programs that provide preventive support, activities and early intervention services to adults and young people, their family and friends, and the broader community. Includes the Hospital Outreach Post-suicidal Engagement (HOPE) program |
| Family violence reform  (not mental health output) | Specialist family violence program to drive family violence service development, capacity building and sector collaboration. The program increases the capacity of mental health services and AOD agencies to recognise and respond appropriately to family violence at both the agency and individual practitioner levels |
| Child clinical specialist | Improve the leadership and responsiveness in engaging, assessing and treating children (aged 0–12 years) with behaviour disorders linked to mental illness, such as conduct disorder and precursors, depression and anxiety, and their families and carers |
| PARC supplement | Improves the capacity of PARC units to accept patients being discharged from acute inpatient units by providing extra clinical input |
| Aboriginal Mental Health Traineeship Program | All activities associated with supporting full-time employment for 10 Aboriginal mental health traineeship positions, who will 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 |
| Personality Disorder Specialist Program | Assessment, treatment and support for people with severe personality disorders who are at high risk of suicide, high-lethality self-harm or violent or aggressive behaviours |
| Perinatal Emotional Health Program | Improve early detection of antenatal and postnatal depression and provide better support and treatment for expectant and new mothers experiencing depression |
| Forensic mental health in community health | Delivery of community-based mental health services and supports to forensic clients with a moderate mental health condition referred by Corrections Victoria |

### 5.3.3 Mental health community support services (MHCSS)

MHCSS provide psychosocial rehabilitation support to people aged 16–64 years, who are living with an enduring psychiatric disability that is attributable to a psychiatric condition. State-funded MHCSS are delivered across 15 service catchments, largely by NGOs.

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

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

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

### Early Intervention Psychosocial Support Response (EIPSR)

The EIPSR program is a psychosocial support model targeted to people aged 16–25 years and 26–65 years who:

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

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

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

Access is to be prioritised for:

* clients who experience barriers to accessing psychosocial support due to paranoia, challenging or antisocial behaviours, aggression when unwell, substance abuse issues, homelessness, comorbid physical health and/or co-existing cognitive issues, for example, acquired brain injury and intellectual disability
* high-risk clients with significant, enduring psychiatric disability who refuse to apply for the NDIS
* clients who have chaotic lifestyles (for example, homelessness, frequent interaction with police and the justice system, and substance misuse problems) who frequently present to an ED or acute mental health inpatient services, and require holistic support to reduce psychosocial stressors that drive ED presentations
* clients at risk of deterioration if discharged from a bed-based clinical mental health service or who are unable to be discharged without appropriate psychosocial supports
* young people with a severe mental illness and (emerging or established) psychiatric disability, with a focus on developmentally appropriate early intervention responses.

Performance targets are a set of core targets established in the provider’s contract/agreement with the health service that include:

* delivery of 98 per cent of the total client support units (per annum) that a provider is funded to deliver
* X number of support hours (client facing and non-client facing)
* a proportion of client support unit expenditure on system development related activity (up to X per cent)
* mandatory compliance with data reporting requirements
* maintenance of accreditation against an accepted accreditation standard
* compliance with incident reporting and complaints reporting requirements.

Health services are funded to deliver an EIPSR program in a contractual partnership with non-government, community-managed mental health providers. This program is to be delivered in line with the EIPSR Guidelines (2019) and the *EIPSR Performance Management Framework* (2019).

The EIPSR program is funded for the next two financial years until 30 June 2027, to support the continued work on the development of core functions, and the reform of partnerships between Area Mental Health and Wellbeing Services and NGOs, referred to in [section 5.1.2](#_Six_levels_of). Health services will be required to only take 10 per cent overhead costs and pass on the full indexation rate to their EIPSR providers.

## Level 6: Statewide services

The RCVMHS conceptualised statewide services as the sixth and final level of the new mental health and wellbeing system. These services respond to the smallest proportion of people with the highest levels of need (see Figure 2)[[4]](#footnote-5).

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

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

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

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

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

In December 2022, the department appointed a consortium of 13 organisations, including Phoenix Australia as the lead agency, to establish the Mental Health Statewide Trauma Service. This has now been formally renamed Transforming Trauma Victoria.

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

For more information and updates, visit [Recommendation 23: Establishing a new Statewide Trauma Service](https://www.health.vic.gov.au/mental-health-wellbeing-reform/recommendation-23) <https://www.health.vic.gov.au/mental-health-wellbeing-reform/mental-health-statewide-trauma-service>.

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

Clinicians or teams who require capacity building in order to deliver integrated treatment, care and support for co-occurring substance use and mental health concerns should seek support from the Hamilton Centre, the Victorian statewide service for people living with co-occurring mental illness and substance use or addiction.

Led by Turning Point as the central coordinating agency, the Hamilton Centre has partnered with a clinical network to deliver specialist addiction treatment services across the state of Victoria. Initial sites are located at St Vincent’s Hospital Melbourne, Eastern Health, Western Health, Austin Health and Goulburn Valley Health.

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

Clinicians working in mental health services can visit the [Hamilton Centre website](https://www.hamiltoncentre.org.au/#home) <https://www.hamiltoncentre.org.au/#home> or call its helpline (1800 517 383, operational Monday to Friday, 9 am to 5 pm) to receive expert advice regarding integrated treatment, care and support, and management of a consumer’s substance use or addiction needs, or for service navigation assistance and guidance between mental health and AOD services.

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

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

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

### Forensic mental health

#### Thomas Embling Hospital

Forensicare operates Thomas Embling Hospital, a 136-bed secure forensic mental health hospital providing specialist assessment, treatment and intensive, acute, subacute and extended rehabilitation for people with complex mental health needs, who often interface with the criminal justice system. The hospital also has a dedicated women’s unit for acute and subacute care.

Patients are admitted to the hospital from the criminal justice system under the Mental Health and Wellbeing Act, the *Crimes (Mental Impairment and Unfitness to be Tried) Act 1997* or the *Sentencing Act 1991*. Patients may also be admitted from the general mental health system under the Mental Health and Wellbeing Act.

#### Community Forensic Mental Health Services

Forensicare’s community forensic mental health services provide assessment and multidisciplinary treatment to high-risk consumers referred from Area Mental Health and Wellbeing Services, correctional providers, courts, the Adult Parole Board, Thomas Embling Hospital, prison services, government agencies and private practitioners.

Other community-based forensic mental health services include:

* forensic clinical specialists employed in Adult and Older Adult Area Mental Health and Wellbeing Services
* Youth Justice Mental Health Initiative clinicians employed in Infant, Child and Youth Area Mental Health and Wellbeing Services
* the Mental Health Advice and Response Service delivered onsite in Victorian Courts
* the Forensic Mental Health in Community Health program delivered by five community health services across Victoria.

## AOD services

The Victorian AOD services sector currently operates under a mixed-funding model that includes:

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

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

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

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

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

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

The Hamilton Centre delivers workforce training and education to enhance the integrated treatment, care and support capability of the AOD workforce, to support the response to people with co-occurring mental illness and substance use or addiction, who access AOD services through primary and secondary consultation, and workforce capability building activities.

## Mental health and wellbeing programs

### Suicide prevention and response

In response to the RCVMHS’s final report (Recommendation 26), Victoria’s suicide prevention and response efforts are driven by the *Victorian suicide prevention and response strategy 2024-2034*. This strategy builds an evidence-informed, systems-based, whole-of-government and community-wide approach to suicide prevention and response.

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

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

### SuicideLine Victoria

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

### HOPE program

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

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

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

### Aftercare service for LGBTIQA+ people

In recognition that LGBTIQA+ people are at higher risk of suicide, often due to stigma, discrimination and an inability to access inclusive and safe supports and services, a new aftercare service model tailored to meet the needs of LGBTIQA+ people has been co-designed (Recommendation 27.2).

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

Mind Australia is delivering an interim peer-led LGBTIQA+ aftercare service for people living in metropolitan Melbourne. More information is available on the [Mind website](https://www.mindaustralia.org.au/services/aftercare) <https://www.mindaustralia.org.au/services/aftercare>.

### Distress brief support program

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

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

### Statewide peer call-back service

The RCVMHS recommended that the Victorian Government establish a statewide peer call-back service for families, carers and supporters caring for people experiencing suicidal behaviour (recommendation 31.2). A new service model has been developed through a co-design process with people with lived and living experience.

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

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

### Aboriginal-led suicide prevention and response

The RCVMHS identified the urgent need to address mental illness and suicide in Aboriginal communities. The RCVMHS’s vision is for a mental health and wellbeing system where Aboriginal self-determination is respected and upheld in the design and delivery of treatment, care and support. This includes Aboriginal people being able to choose to receive care within Aboriginal community-controlled organisations, within mainstream services or in a mix of both.

Irrespective of where treatment, care and support are delivered for Aboriginal people, communities and families, it is fundamental that it is safe, inclusive, respectful and responsive.

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

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

### Supporting Aboriginal social and emotional wellbeing

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

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

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

Balit Murrup domains for action include:

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

Priorities for 2025–26 include:

* expanding Aboriginal social and emotional wellbeing teams in 25 ACCHOs – with statewide coverage by 2026. This expansion incorporates four Aboriginal social and emotional wellbeing demonstration projects, and 10 clinical and therapeutic positions, formerly established through Balit Murrup
* continuing to work with ACCHOs to transition to outcomes-based funding and reporting. This will embed greater self-determination into how the department supports ACCHOs to deliver social and emotional wellbeing services
* providing resources for ACCHOs to commission culturally appropriate, family-oriented, social and emotional wellbeing services for children and young people
* delivering the Aboriginal social and emotional wellbeing scholarship program, which supports Aboriginal students to access high-quality education and training to complete a mental health-related qualification
* expanding the Koori Mental Health Liaison Officer program across 10 Infant, Child and Youth Area Mental Health and Wellbeing Services. This includes employing 10 Koori Mental Health Liaison Officers during this year. This will help improve access to acute mainstream mental health services for Aboriginal infants, children and young people, and their families
* continuing support for the Balit Durn Durn Centre, established by VACCHO in May 2022
* funding 13 Infant, Child and Youth Area Mental Health and Wellbeing Services to undertake cultural safety training to improve practice and support Aboriginal young people and their families
* continuing to deliver the Aboriginal Mental Health Traineeship Program. This three-year traineeship program is building a skilled and qualified Aboriginal clinical mental health workforce in Adult Area Mental Health and Wellbeing Services. It provides full-time ongoing employment to Aboriginal people living in Victoria who successfully undergo supervised workplace training and clinical placements over three years, while concurrently completing a three-year, full-time Bachelor of Health Science (Mental Health) degree at Charles Sturt University. In 2025 the program will have a cohort of 8 Aboriginal mental health trainees employed at Bendigo Health, Alfred Health, Peninsula Health, Monash Health, Mildura Base Hospital and Forensicare.

For more information on the work underway to support Aboriginal social and emotional wellbeing, visit the [Victorian Aboriginal Health and Wellbeing Partnership Agreement and Action Plan 2023–25](https://www.vaccho.org.au/ahwpf/) <https://www.vaccho.org.au/ahwpf/> and the [Balit Murrup: Aboriginal social emotional wellbeing-framework 2017–2027](https://www.health.vic.gov.au/publications/balit-murrup-aboriginal-social-emotional-wellbeing-framework-2017-2027) <https://www.health.vic.gov.au/publications/balit-murrup-aboriginal-social-emotional-wellbeing-framework-2017-2027>.

### Gambling harm prevention and response

The department provides funding to partner agencies for local delivery of gambling harm prevention, early intervention, treatment and support programs.

Specialist supports are funded for First Nations and multicultural communities, and for those with lived and living experience of gambling harm, including family and friends.

Collectively, these programs aim to minimise the individual personal, health, social and financial harms that arise from gambling, and to improve individual and community capability to reduce gambling related harm.

For more information on the specific programs funded, visit the [Gambler’s Help program guidelines](https://www.health.vic.gov.au/publications/gamblers-help-program-guidelines) <https://www.health.vic.gov.au/publications/gamblers-help-program-guidelines>.

# Ageing, aged and home care services

## Aged Care Assessment (ACA)

As part of the aged care reforms, the Australian Government implemented the Single Assessment System in December 2024, with new performance requirements. In Victoria, this included the integration of the former Aged Care Assessment Services (ACAS) and Regional Assessment Services (RAS) into ACA.

ACA conducts aged care needs assessments (home support, comprehensive and hospital assessments) to assess the care needs of older people in Victoria and to determine supports for those who wish to remain living in their home and community. This includes determining eligibility for services under the *Aged Care Act 2024* (Cth), including residential aged care, residential respite care, the Transition Care Program, the Commonwealth Home Support Program and Home Care Program packages.

The national 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 ACA. The department continues to support ACA and health services to deliver high-quality and timely comprehensive assessments for people needing access to health and aged care services.

## Home and Community Care Program for Younger People (HACC PYP)

The HACC PYP is for people aged from birth to 65 years (and Aboriginal people from birth to 50 years) who need assistance with daily activities due to chronic illness, mental health issues, disability or other conditions. The program supports clients to maintain or regain their independence in their homes and communities, and optimise their health and wellbeing.

HACC PYP funding provides access and assessment, health supports, personal and in-home supports, and social and community engagement.

Priority groups have been identified to support HACC PYP services to prioritise access during times where demand for services is high, and to identify those who require additional support to participate in the program.

Priority groups include:

* Aboriginal people, including children and young people
* refugees and people seeking asylum
* people, including children and young people, who are homeless or at risk of homelessness
* children in care, child protection and Orange Door (replacing Child FIRST) clients.

Eligibility means that the person is assessed as being in the HACC PYP program target group. Eligible Victorians are prioritised for service, as HACC PYP providers may not be able to meet demand. Service providers are required to regularly reassess and prioritise existing and new clients.

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

## Victorian Aids and Equipment Program (VA&EP)

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

Assistive technology programs and schemes funded under the program include:

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

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

## Aged support services

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

### Personal Alert Victoria

Personal Alert Victoria is a daily monitoring and duress response service for frail older people and people with a disability, who have high ongoing health and support needs, mostly live alone and are at risk of falls. It aims to support clients to live independently for as long as possible.

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

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

### Victorian Eyecare Service

The Victorian Eyecare Service provides low-cost eye care services and visual aids (glasses and contact lenses) to people experiencing disadvantage or other barriers to accessing eye care services. The service is delivered by the Australian College of Optometry Eye Health through dedicated clinics in metropolitan Melbourne and through selected private practice optometrists in regional Victoria.

The Victorian Aboriginal Spectacles Subsidy Scheme is available to Aboriginal Victorians, and provides an added subsidy to the Victorian Eyecare Service that makes visual aids available for a client contribution of $10.

### Public sector residential aged care

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

In 2025–26, the department will continue to provide funding to designated PSRACS to support the viability of small rural services, services supporting residents with specialised care needs and additional costs of the public sector workforce. This includes continuation of the unit-priced funding approach for high-care and low-care beds in designated services, which was introduced in 2011–12.

In 2022–23, the Australian Government introduced the Australian National Aged Care Classification (AN-ACC), a new funding model that provides revenue to PSRACS. The department is monitoring and modelling the revenue effects of the AN-ACC on PSRACS throughout 2025–26. It may change the allocation of Victorian funding to PSRACS in response to revenue changes caused by the AN-ACC and other aged care reform funding changes.

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

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

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

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

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

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

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

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

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

### Low-cost accommodation support

Low-cost accommodation support programs are a group of outreach programs for older and vulnerable Victorians with unmet complex needs, who are homeless or living in insecure or low-cost accommodation. The programs link clients to relevant health, community care and welfare services to improve their health and social wellbeing.

They include three subprograms that are:

* the Community Connections Program
* Housing Support for the Aged
* the Older Persons High Rise Program.

# Rural and regional health

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

## SRHS

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

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

SRHS can use funds provided through the ‘Small rural services – acute health’ and ‘Small rural services – primary care’ outputs flexibly to deliver admitted and non-admitted services that meet the needs of their community. This includes acute care, subacute care, primary health care, HACC PYP, health promotion and prevention activities. Funding arrangements for PSRACS are outlined in [section 6.5.3](#_Public_sector_residential).

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

## Bush nursing centres

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

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

Bush nursing centres are responsible for accurate and timely submission of quarterly performance data for funded services. The agencies must ensure that the information systems used comply with the department’s reporting requirements, as outlined in the [Community-health-minimum-data-set-submission-guidelines-2024–25](https://www.health.vic.gov.au/community-health/community-health-data-reporting) <https://www.health.vic.gov.au/community-health/community-health-data-reporting>.

Bush nursing centres are required to be accredited under the Australian Commission of Safety and Quality in Health Care’s [National Safety and Quality Primary and Community Healthcare Standards](https://www.safetyandquality.gov.au/standards/primary-and-community-healthcare) <https://www.safetyandquality.gov.au/standards/primary-and-community-healthcare>.

[Refer to section 19.1](#_Australian_Health_Service) regarding the reporting and monitoring of performance against the relevant safety and quality accreditation standards.

During 2025–26, the department will continue to work with bush nursing centres to ensure service delivery continues to align with government policy and standardised performance monitoring oversight mechanisms are in place.

## 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.

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

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

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

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

## Improving access to primary care in rural and remote areas

The Victorian Government has a current memorandum of understanding with the Commonwealth (in effect until 30 June 2025) for the Council of Australian Governments (COAG) section 19(2) exemption initiative to improve access to primary healthcare for Victorians living in eligible rural and remote communities. The initiative aims to support improved access to primary care by increasing access to the Medicare Benefits Schedule (MBS) to those living in eligible rural and remote areas.

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

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

# Primary, community and dental health

## Primary health services

### Community health program

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

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

The program’s priority population groups are:

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

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

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

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

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

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

The 2018 audit of the Community Health Program also made recommendations for a new funding model. The new pricing and funding arrangements commenced from 1 January 2024.

A single unit price was introduced for the ‘Community health’, ‘Small rural primary health – flexible services’, and ‘Integrated Chronic Disease Management’ activities delivered by registered and integrated community health services. From 1 July 2025, the single unit price will be extended to include all community health activities and service providers.

Community health program funding is activity-based and the activity measure is service hours. The single unit price for community health is based on one hour of service delivery, and this includes the direct and indirect costs of delivering that service.

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

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

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

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

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

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

Agencies receiving specific initiative funding must demonstrate that funds are targeted to meet the aims of the initiative. This is achieved through reporting requirements ([see section 8](#_Primary,_community_and)).

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

### Urgent Care Clinics (UCCs)

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

UCCs aim to:

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

UCC services are:

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

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

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

#### Medicare UCCs

Victoria works in partnership with the Commonwealth to deliver UCCs as part of the national Medicare Urgent Care Clinic program. The Commonwealth is now funding 17 of Victoria’s UCCs to June 2026. These clinics are branded as Medicare UCCs.

Funding and associated arrangements for the Medicare UCCs are governed by a Federation Funding Agreement.

### NURSE-ON-CALL

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

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

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

## Dental health services

The public dental program delivers public dental care to eligible Victorians through the Royal Dental Hospital Melbourne, and more than 40 integrated and registered community health services, and ACCHOs across Victoria.

New pricing and funding arrangements for public dental services were introduced from 1 July 2021. The transition grant component of agency budgets associated with the implementation of these pricing arrangements will cease from 2025–26.

### Dental Health Program fees policy

Fees for public dental services apply to:

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

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

### Participation in Commonwealth initiatives

The Child Dental Benefits Schedule is a means-tested benefits scheme (Family Tax Benefit A) for children aged up to 17 years, covering preventive and basic dental treatment. Public sector access to the Child Dental Benefits Schedule is currently available until 31 December 2026.

For more information about eligibility and benefit caps, visit [Child Dental Benefits Schedule](https://www.servicesaustralia.gov.au/child-dental-benefits-schedule) <https://www.servicesaustralia.gov.au/child-dental-benefits-schedule>.

### School dental program (Smile Squad)

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

For further information, visit [Smile Squad](https://www.health.vic.gov.au/smile-squad) <https://www.health.vic.gov.au/smile-squad>.

### Administration of fluoride varnish by Aboriginal health practitioners

Pursuant to Regulation 160 of the Drugs, Poisons and Controlled Substances Regulations 2017, the Chief Officer, Drugs and Poisons Regulation and Delegate to the Secretary of the Department of Health and Human Services, approved the Schedule 4 poison (fluoride varnish) for possession and administration by dental assistants, dated 4 October 2018. Condition 4 of the approval states that the dental assistant administers the fluoride varnish to children in the Victorian child fluoride varnish program within the department’s public dental program.

Similarly, Pursuant to Regulation 160 of the Drugs, Poisons and Controlled Substances Regulations 2017, the Director, Medicines and Poisons Regulation and Delegate to the Secretary of the Department of Health, approved the Schedule 4 poison (fluoride varnish) for possession and administration by registered Aboriginal and Torres Strait Islander health practitioners to children aged 3–17 years, dated 21 July 2022.

As of 19 March 2024, an addendum to the Secretary’s approval, published in the Victorian Government Gazette, now authorises dental assistants and Aboriginal and Torres Strait Islander health practitioners to administer fluoride varnish to people of all ages.

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

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

## Early parenting centres

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

Early parenting centres recognise the importance of the health and wellbeing of parents and the whole family for the health, wellbeing and development of the child.

Nine early parenting centres are currently operational. A significant early parenting centre service expansion is under way across the state, with a further three early parenting centres to be established across 2026 and 2027.

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

In addition, a dedicated early parenting centre for Aboriginal children and families in Frankston opened in late 2024. It is funded to deliver day-stay programs, group-based programs, and telehealth and/or outreach support.

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

# Public health

## Public health and prevention

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

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

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

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

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

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

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

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

The ten health and wellbeing priorities for Victoria are:

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

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

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

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

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

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

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

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

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

### Chronic disease prevention

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

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

The standards cover health priority areas, such as healthy eating, physical activity, and mental health and wellbeing. Once the settings and benchmarks for the health priority areas have been met, the organisations can apply for Victorian Government recognition.

For more information, visit [The Achievement Program](https://www.achievementprogram.health.vic.gov.au/) <https://www.achievementprogram.health.vic.gov.au>.

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

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

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

The department requires public health services to complete reporting on the Healthy Choices policy directive during September each year. With the support of the Healthy Eating Advisory Service (see further below), as at the end of 2024, 99% of health services met the food and drinks requirements.

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

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

When implementing Healthy Choices, funded organisations and key settings are encouraged to also integrate environmentally sustainable food procurement practices to ensure that food and drinks purchased with government funds not only promote health and wellbeing, but also drive social and environmental outcomes.

For more information visit [Healthy and more sustainable food procurement](https://www.health.vic.gov.au/public-health/healthy-and-more-sustainable-food-procurement) <https://www.health.vic.gov.au/public-health/healthy-and-more-sustainable-food-procurement>.

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

The service provides:

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

For more information, visit [Improving wellbeing through healthy eating](https://d.docs.live.net/031c443d5a1cf449/Documents/Business/Government/DoH-C%5e0SI/Improving%20wellbeing%20through%20healthy%20eating) <https://heas.health.vic.gov.au>.

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

The actions of the Vic Kids Eat Well campaign align with or provide a significant step towards healthy eating policies, including the Healthy Schools Achievement Program benchmarks for healthy eating, Healthy Choices policyguidelines, and the Canteens, healthy eating and other food services policy.

For more information, visit [All kids deserve a healthy start](https://www.vickidseatwell.health.vic.gov.au/) <https://www.vickidseatwell.health.vic.gov.au>.

The Victorian Health Promotion Foundation (VicHealth) is a key partner in the statewide public health system. VicHealth plays a key role in driving health promotion and prevention initiatives to improve community wellbeing and reduce the burden of disease.

As a state-funded statutory authority, VicHealth works collaboratively with government, community organisations, researchers and businesses to create healthier environments and policies that support active living, mental wellbeing, health eating, and reduced harm from alcohol and tobacco.

VicHealth’s strategic directions are outlined in the VicHealth strategy 2023–2033*.* This strategy focuses on a systems lens across neighbourhood and built systems, commercial and economic systems, and food systems, as well as being aligned with the Victorian Public Health and Wellbeing Plan priorities. The strategy reflects the vision for a healthier, fairer Victoria where all Victorians benefit from good health and have the opportunity to thrive.

### *Life!* program

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

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

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

### Cancer screening program pathways

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

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

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

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

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

#### Colposcopy arising from a positive National cervical screening program test

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

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

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

These guidelines and the rollout of universal cervical screening self-collection have been incorporated into gynaecology statewide referral criteria for gynaecology medical specialist clinics, which can be found on the [Statewide referral criteria for specialist clinics](https://d.docs.live.net/031c443d5a1cf449/Documents/Business/Government/DoH-C%5e0SI/Statewide%20referral%20criteria%20for%20specialist%20clinics) <https://src.health.vic.gov.au>.

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

#### Victorian breast screening program

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

BreastScreen Victoria provides services through screening clinics, mobile vans, and reading and assessment services. For more information, visit [BreastScreen Victoria](http://www.breastscreen.org.au) <www.breastscreen.org.au>.

### Sexual and reproductive health and viral hepatitis

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

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

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

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

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

The seven plans in the strategy are the:

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

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

### Tobacco and e-cigarettes

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

Together, these programs provide:

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

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

## Public health and health protection

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

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

* *Public Health and Wellbeing Act 2008*
* *Food Act 1984*
* *Safe Drinking Water Act 2003*
* *Radiation Act 2005*
* *Health (Fluoridation) Act 1973*.

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

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

The Victorian Chief Health Officer is the lead public health advisor to the Minister for Health and the Victorian Government, and they are the state’s spokesperson on public health issues. The Chief Health Officer has statutory powers under the Public Health and Wellbeing Act to protect the health and wellbeing of Victorians.

The Chief Health Officer is involved in overseeing policy, strategy and operations in health protection, coordinating investigations and management of public health risks, and undertaking risk communication with stakeholders, including the Victorian public. The Chief Health Officer works closely with areas of the department to deliver on these public health and health protection responsibilities, including the Public Health Protection, Practice and Response and Health Regulator branches, as well as with Local Public Health Units (LPHUs).

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

### Victorian Tuberculosis Program

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

The department has developed performance measures for Melbourne Health, which are outlined in the Victorian Tuberculosis Program service objectives and scope document. Health services should also refer to [Section 12.2](#_Medicare-ineligible_patients_and) in relation to tuberculosis treatment.

### Migrant Screening Service (Tuberculosis Health Undertaking)

Western Health (Footscray Hospital) is funded by the department to provide the Migrant Screening Service. This service operates the Tuberculosis Health Undertaking for Victoria, an assessment of onshore applicants with abnormal chest x-rays referred by the Migration Medical Services Provider, Bupa Medical Visa Services, the Australian Government’s contracted provider.

The Migrant Screening Service acts as a triage service, seeing each person once and referring those who need further assessment to health services for continued surveillance and clinical management. Migrants aged 16 years and over are seen at the Migrant Health Service, and children are referred to The Royal Children’s Hospital Immigrant Health Service. Health services should also refer to [Section 12.2](#_Medicare-ineligible_patients_and) in relation to tuberculosis treatment.

### Public health laboratories

The department funds two microbiology reference and public health laboratories; the Microbiological Diagnostic Unit Public Health Laboratory and the Victorian Infectious Diseases Reference Laboratory, which is operated by Melbourne Health.

Public health laboratories have statutory responsibilities as defined in the Public Health and Wellbeing Regulations 2019. Each laboratory provides specialised services that cover the breadth of communicable diseases, testing pathogens posing a known and/or emerging public health risk to the Victorian population. Both laboratories are located at The Peter Doherty Institute for Infection and Immunity.

The department has developed laboratory-specific service level agreements, which outline their funding, service delivery and reporting requirements.

### Immunisation

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

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

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

## LPHUs

The department funds nine health services (Albury Wodonga Health, Austin Health, Barwon Health, Bendigo Health, Grampians Health, Goulburn Valley Health, Latrobe Regional Health, Monash Health and Western Health) to operate an LPHU.

LPHUs work with the department to keep their local communities healthy, safe and well. They use local knowledge, community-based relationships and direct engagement to effectively tailor and deliver public health initiatives and respond to notifiable diseases, incidents and issues within their local area. Each LPHU has responsibilities for public health activities and outcomes within their catchment.

For more information, visit [LPHUs](https://d.docs.live.net/031c443d5a1cf449/Documents/Business/Government/DoH-C%5e0SI/LPHUs) <https://www.health.vic.gov.au/local-public-health-units>.

# Health workforce training and development

## Training and development funding

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

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

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

For a detailed overview of the department’s training and development funding, visit [Training and Development Funding](https://www.health.vic.gov.au/education-and-training/training-and-development-funding) <www.health.vic.gov.au/education-and-training/training-and-development-funding>.

In 2025–26, modelled allocations and associated funding adjustments to Victorian public health services are based on planned 2025 calendar year activity, in line with the current Training and Development Funding program guidelines.

### Professional-entry student placements

#### Student clinical placements

The department is committed to supporting efficient growth in clinical placement activity for students enrolled in a professional-entry course of study in medicine, nursing (registered and enrolled), midwifery, paramedicine or allied health (including allied health assistants).

Funded activity is aligned with the minimum efficient pathway standards. A discount weighting is applied to activity associated with courses that have clinical placement requirements above the minimum efficient pathway. A list of minimum efficient pathways and current course pathways for education providers is provided in the current Training and Development Funding program guidelines.

For further information, Victorian public health services should refer to the revised [Fee schedule for clinical placement in public health services](https://www.health.vic.gov.au/education-and-training/fee-schedule-for-clinical-placement-in-public-health-services) <https://www.health.vic.gov.au/education-and-training/fee-schedule-for-clinical-placement-in-public-health-services>. The revised schedule is effective from 1 July 2025, for activity occurring from 1 January 2026.

#### Registered undergraduate students of nursing and midwifery

In 2025–26, there is dedicated supplemental funding for health services to continue to engage registered undergraduate students of nursing (RUSON) and midwifery (RUSOM) positions. Funding is interchangeable between RUSON and RUSOM positions.

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

Transition-to-practice programs are defined as formalised education and support programs offered by employers for graduates in their first year of practice. They are workplace-based programs designed to consolidate knowledge, skills and competence, and to assist the transition from student to competent, confident and accountable professional.

The Transition-to-practice (graduate) funding stream includes four programs of:

* graduate nurses and midwives
* allied health graduates
* hospital pharmacy interns
* medical officers Year 1 (post-graduate year (PGY)1) and Year 2 (PGY2).

To access Transition-to-practice funding, the following criteria must be met:

* Transition-to-practice (graduate) positions must be filled through participation in the Postgraduate Medical Council of Victoria (PMCV) statewide match process or via another process approved by the department.
* Health services must allocate adequate training and supervision to each position.
* Health services must ensure access to a clinical educator and/or clinical support staff.
* No fees may be charged to graduates applying for, undertaking or exiting from Transition-to-practice (graduate) programs.

### Postgraduate programs – medical, nursing and midwifery

The Postgraduate funding stream includes seven programs of:

* **Postgraduate Nurses and Midwives** –health services apply to the department for funding based on planned calendar year eligible activity
* **Victorian Medical Specialist Training** –the department uses an Expression of Interest process to allocate funding to health services under this program
* **Victorian Basic Paediatric Training Consortium** –all hospitals that are accredited for basic paediatric training in Victoria are members of the consortium, which has replaced the former Victorian Paediatric Training Program. Under the Victorian Basic Paediatric Training Consortium program, the department provides funding for the governance of the consortium and annual funding for 30 training positions across 16 sites
* **Basic Physician Training Consortia** –accredited physician training positions are made available through this program via a matching process undertaken annually by PMCV
* **Victorian Rural Generalist Program** –recruitment to rural generalist training positions under this program are undertaken via the statewide match process managed by PMCV
* **Continuing Nursing and Midwifery Education** –allocation of funding for this program will be prioritised to rural and regional health services
* **Postgraduate Nursing and Midwifery Scholarships** –funding is based on a full-time equivalent (FTE) methodology. Individuals in receipt of a postgraduate scholarship or grant from the Victorian Government are not eligible for a second or subsequent scholarship or grant from this fund.

### Other targeted workforce training and development programs

#### Allied Health Leadership Program

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

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

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

#### Maternity Connect Program

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

#### Rural Clinical Academic Program

Funding for this program supports rural and regional health services that, in conjunction with Rural Clinical Schools, provide academic teaching and regional coordination for medical students who are hosted at the health service for a period longer than six weeks.

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.

#### Rural health workforce support

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

#### Mental health – training and development grants

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

Commencing in 2018–19 and expanded to deliver on recommendations from the RCVMHS, Area and Statewide Mental Health and Wellbeing Services were additionally funded to deliver graduate and transition to mental health practice programs. The latter programs are for already qualified clinical staff without mental health qualifications wanting to transition to work in mental health settings. Funding for 2025–26 includes mental health nurses, allied health and psychiatry registrars, as well as for junior medical officers to undertake mental health rotations.

#### Mental Health Workforce Scholarship Program

Scholarships are offered annually to mental health nurses, allied health, AOD, and lived and living experience workers working in mental health and/or AOD services. These scholarships are offered to help support retention and support continued learning and development to help build skills, knowledge, capabilities and career satisfaction, and improved outcome for consumers and their family, carers and supporters accessing mental health services.

Partial (for example, up to $3,000 for a mental health nursing scholarship and up to $13,000 for a lived and living, allied health and AOD scholarship) and full-fee (mental health nurse) scholarships are offered.

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

Multiple Area Mental Health and Wellbeing Services and university academic partners receive recurrent funding to deliver mental health academic chair positions. Funding includes appointment of a senior mental health academic and additional funding for program support. Funded academics include psychiatry, mental health nursing, carer and consumer academics, and their broader research program staff.

Funded academic positions work in partnership with other health service and university staff to conduct applied research that builds understanding and improved treatments, therapies and other interventions to improve outcomes for mental health consumers and family, carers and supporters, and the workforces that support them.

### Funding conditions and allocation

Health services that receive training and development grant funding should ensure they meet eligibility and reporting requirements, as detailed in the current [Training and Development Funding – Program Guidelines 2024–25](https://www.health.vic.gov.au/education-and-training/training-and-development-funding) <www.health.vic.gov.au/education-and-training/training-and-development-funding>.

Nursing and midwifery program areas must comply with the [*Safe Patient Care (Nurse to Patient and Midwife to Patient Ratios) Act 2015*](https://www.legislation.vic.gov.au/in-force/acts/safe-patient-care-nurse-patient-and-midwife-patient-ratios-act-2015/011) <www.legislation.vic.gov.au/in-force/acts/safe-patient-care-nurse-patient-and-midwife-patient-ratios-act-2015/011>. Where the department is made aware of non-compliance with this Act, training and development grant funding may be withheld or recovered.

All programs supported through training and development funding must conform to the most recent versions of guidelines (where available). This includes the guidelines and standards set by the [Australian Health Practitioner Regulation Agency (Ahpra)](https://www.ahpra.gov.au/) <www.ahpra.gov.au> and [The National Registration and Accreditation Scheme](https://www.ahpra.gov.au/About-Ahpra/What-We-Do/The-National-Registration-and-Accreditation-Scheme.aspx) <www.ahpra.gov.au/About-Ahpra/What-We-Do/The-National-Registration-and-Accreditation-Scheme.aspx>.

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

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

For more information, visit [Health Workforce](https://d.docs.live.net/031c443d5a1cf449/Documents/Business/Government/DoH-C%5e0SI/Health%20Workforce) <https://www.health.vic.gov.au/health-workforce> or download the [Training and Development Funding – Program guidelines 2024–25](https://www.health.vic.gov.au/education-and-training/training-and-development-funding) <https://www.health.vic.gov.au/education-and-training/training-and-development-funding>.

# Capital funding programs

The department oversees multiple minor capital programs to support health services with the cost of medical equipment and engineering infrastructure renewal and upgrades, and hospital infrastructure replacement needs. These include the:

* Infrastructure Renewal Contribution Grant (IRCG)
* Regional Health Infrastructure Fund (RHIF)
* Minor Capital Renewal: Medical Equipment and Engineering Infrastructure
* Mental Health Capital Renewal Fund.

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

The department is responsible for ensuring the program scope and outputs align with system needs and priorities. The department is adopting a structured approach to plan, allocate and manage funds to address critical asset risks across the system using health services asset management plans, in line with the *Asset Management Accountability Framework* (AMAF) requirements. The Victorian Health Building Authority (VHBA) provides project management support to the programs on behalf of the department.

Where investments are unable to be completed and acquitted within a two-year period, allocations may be recalled and reappropriated to other priority investments.

## IRCG

In 2025–26, $40 million will be distributed to public hospitals, including rural and SRHS, to assist health services with the costs of replacing hospital ageing infrastructure and addressing critical risks in a prioritised manner. The IRCG should be used to address urgent and critical infrastructure risk and asset replacement needs outlined in the annual asset management plan. The $40 million will be appropriated at 50 per cent in July 2025. The remaining funds will be distributed in February 2026 to health services that submit their updated asset management plan.

The asset management plans must include an appendix outlining the planned allocation for the current financial year of the IRCG. The plan will also need to outline the IRCG expenditure of the previous financial year. Asset management plans must be received by 31 December 2025 by emailing the [Asset Planning in System Planning Division](mailto:assetmanagement@health.vic.gov.au) <assetmanagement@health.vic.gov.au>.

## RHIF

The $300 million RHIF 2022–23 state budget funding has been providing funding for rural and regional health services in a bid-based process and will continue to run through until the end of the financial year. It is administered by the Victorian Health Building Authority to address high-risk asset and capacity issues.

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

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

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

Funds are available for:

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

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

## Minor Capital Renewal Program: Medical Equipment Replacement Program

The 2025–26 $114 million Minor Capital Renewal Program provides funding for critical high-risk medical equipment and systems ($52.250 million) and engineering infrastructure ($61.750 million) that support acute and sub-acute clinical service delivery.

In line with the department’s commitment to applying the AMAF requirements for strategic asset planning, the Minor Capital Renewal Program is continuing to transition from submission-based to direct allocation. Direct allocations will be provided for prioritised assets and systems identified by the department as at critical risk of failure. Critical risks are identified through analysis of health service asset management plans, asset registers and the department’s asset information management system.

In 2025–26, health services with identified eligible investments will be contacted via letter to their chief executive officer (CEO) by 1 September 2025.

In-scope assets that are considered critical-risk priorities, and not identified for direct allocation, will remain eligible for the submission-based program and specific purpose capital grant.

Health services are strongly encouraged to continuously improve their asset planning capabilities and to develop comprehensive asset management plans that clearly identify investment needs, prioritise projects, and outline risk mitigation and maintenance strategies.

#### The Mental Health Capital Renewal Fund

This fund responds directly to recommendations from the RCVMHS. It aims to address physical safety and wellbeing risks in Victoria’s mental health facilities. The 2024–25 State Budget included a further $10 million investment to improve mental health infrastructure across the state, building on previous state budget investments.

The funding will deliver minor infrastructure works. Individual grants of up to $1 million will be available for renewal, reconfigurations and refurbishments to health facilities.

# Health service compensable and ineligible patients

## Interstate patients

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

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

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

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

## Medicare-ineligible patients and international patients

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

Exemptions from charging fees include that:

* health services are required to provide Medicare-ineligible asylum seekers with full medical care, under the same arrangements that apply to all Victorian residents. Patients in this category are not to be billed. Funding for these patients is provided by the department as part of normal public patient throughout. For more information, visit [Hospital access for people seeking asylum](https://www.health.vic.gov.au/publications/hospital-access-for-people-seeking-asylum) <https://www.health.vic.gov.au/publications/hospital-access-for-people-seeking-asylum>.
* tuberculosis patients are eligible to receive publicly funded services for tuberculosis-related treatment. For more information, visit [Hospital provision of tuberculosis and leprosy services](https://www.health.vic.gov.au/public-health/hospital-provision-of-tuberculosis-and-leprosy-services) <https://www.health.vic.gov.au/public-health/hospital-provision-of-tuberculosis-and-leprosy-services>.
* visitors from a country that has a Reciprocal Health Care Agreement with Australia are eligible for medically necessary treatment. Refer to Hospital Circular 23/2009[[5]](#footnote-6) for more information.

### Medicare-ineligible patients

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

They include that:

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

### International patients seeking health services

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

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

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

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

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

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

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

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

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

Part 2: Obligations, standards and requirements

# Notification obligations

## Issues of public concern

The Health Services Act, *Ambulance Services Act 1986* and Mental Health and Wellbeing Act specify the functions of health service boards and CEOs.

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

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

## Changes to range or scope of activities

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

## Exceptional events

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

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

## Public health escalations

A health service that operates an LPHU or the Victorian Tuberculosis Program, must notify the Chief Health Officer or delegate as soon as practicable (or no longer than 24 hours from becoming aware of the risk or issue) if they recognise a public health risk that:

* meets escalation criteria as per statewide policies, protocols, or guidelines; or
* is, or has the potential to go, beyond the LPHU’s or program’s scope of operations.

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

# Standards

## Public sector values and employment principles

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

There are seven core public sector values of:

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

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

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

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

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

# Safety

## Pre-employment safety screening

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

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

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

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

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

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

## Staff safety and wellbeing in Victorian health services

All funded organisations are responsible for the safety of their staff, patients and visitors. Funded organisations must have systems and processes in place to enable them to identify, assess and control occupational health and safety risks. This is in accordance with their obligations pursuant to the [*Occupational Health and Safety Act 2004*](https://www.legislation.vic.gov.au/in-force/acts/occupational-health-and-safety-act-2004/044) <https://www.legislation.vic.gov.au/in-force/acts/occupational-health-and-safety-act-2004/044>.

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

## Child safety

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

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

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

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

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

### Child Safe Standards

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

The standards drive changes in organisational culture to embed child safety in everyday thinking and practice.

The Child Safe Standards were updated on 1 July 2022 to better align with the [National Principles for Child Safe Organisations](https://childsafe.humanrights.gov.au/national-principles). Victoria is the only jurisdiction to include a child safe standard that requires organisations to establish a culturally safe environment for Aboriginal children and young people (Child Safe Standard 1).

Changes to the Child Wellbeing and Safety Act came into effect on 1 January 2023, providing a broad suite of compliance and enforcement powers for regulators, and creating a new regulatory framework, with six sector or integrated sector regulators responsible for applicable entities, as summarised in Table 3.

Table 3. New regulatory arrangements – sector regulators and regulated entities

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

For more information about the Child Safe Standards, visit [Child Safe Standards](https://d.docs.live.net/031c443d5a1cf449/Documents/Business/Government/DoH-C%5e0SI/Child%20Safe%20Standards) <https://www.health.vic.gov.au/childsafestandards>.

## Patient and client safety

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

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

Organisations that provide services on behalf of the department, may be subject to alternative incident reporting requirements. Funded organisations should refer to the relevant Activity Description or program guidelines to confirm incident reporting requirements for specific funded activities and programs. In some instances, department-funded organisations will be required to report incidents through the Client Incident Management System administered by the Department of Families Fairness and Housing. For more information, visit [Client incident management system](https://providers.dffh.vic.gov.au/cims) <https://providers.dffh.vic.gov.au/cims> for more information.

The [Incident Reporting Instruction, 2013](https://www.health.vic.gov.au/publications/department-of-health-incident-reporting-instruction-2013) <https://www.health.vic.gov.au/publications/department-of-health-incident-reporting-instruction-2013> provides guidance for reporting incidents or alleged incidents that involved or impacted patients or clients during service delivery. It does not replace an organisation’s own incident management systems and processes, which may be reviewed as part of the department’s routine contract and performance management arrangements.

The department has implemented a critical incident reporting pathway for registered community health services to enable timely notification to the department when serious incidents occur. The critical incident reporting pathway reduces the reporting burden for registered community health services and replaces the need for manual reporting.

For more information on reporting requirements for registered community health services, visit [Incident reporting for community health services](https://www.health.vic.gov.au/incident-reporting-community-health-services) <https://www.health.vic.gov.au/incident-reporting-community-health-services>.

# Meeting the needs of all Victorians

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

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

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

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

* [Safe and strong: a Victorian gender equality strategy](https://www.vic.gov.au/safe-and-strong-victorian-gender-equality) <https://www.vic.gov.au/safe-and-strong-victorian-gender-equality>
* [Victoria’s anti-racism strategy 2024–2029](https://www.vic.gov.au/victorias-anti-racism-strategy-2024-2029) <https://www.vic.gov.au/victorias-anti-racism-strategy-2024-2029>
* [Multicultural Health Action Plan 2023–27](https://www.health.vic.gov.au/multicultural-health-action-plan-2023-27) <https://www.health.vic.gov.au/multicultural-health-action-plan-2023-27>
* [Multicultural policy statement](https://www.vic.gov.au/multicultural-policy-statement) <https://www.vic.gov.au/multicultural-policy-statement>
* [Inclusive Victoria: state disability plan (2022–2026)](https://www.vic.gov.au/state-disability-plan) <https://www.vic.gov.au/state-disability-plan>
* [Victorian Autism Plan](https://d.docs.live.net/031c443d5a1cf449/Documents/Business/Government/DoH-C%5e0SI/Victorian%20Autism%20Plan) < https://www.vic.gov.au/victorian-autism-plan>
* [Pride in our future: Victoria’s LGBTIQA+ strategy 2022–32](https://www.vic.gov.au/victorian-lgbtiq-strategy) <https://www.vic.gov.au/victorian-lgbtiq-strategy>
* [Our promise, your future: Victoria’s youth strategy 2022–2027](https://www.vic.gov.au/victorias-youth-strategy-2022-2027) <<https://www.vic.gov.au/victorias-youth-strategy-2022-2027>>
* [Ageing Well Action Plan](https://d.docs.live.net/031c443d5a1cf449/Documents/Business/Government/DoH-C%5e0SI/Ageing%20Well%20Action%20Plan) <https://www.vic.gov.au/ageing-well-action-plan>
* [Victorian Aboriginal health and wellbeing partnership agreement 2023–2033](https://www.vaccho.org.au/ahwpf/) <https://www.vaccho.org.au/ahwpf/>
* [Victorian Aboriginal health and wellbeing partnership action plan 2023–25](https://www.vaccho.org.au/ahwpf/) <https://www.vaccho.org.au/ahwpf/>
* [Aboriginal and Torres Strait Islander cultural safety framework](https://www.health.vic.gov.au/health-strategies/aboriginal-and-torres-strait-islander-cultural-safety) <<https://www.health.vic.gov.au/health-strategies/aboriginal-and-torres-strait-islander-cultural-safety>>
* [Healthcare that counts: a framework for improving care for vulnerable children in Victorian health services](https://www.health.vic.gov.au/publications/healthcare-that-counts) <https://www.health.vic.gov.au/publications/healthcare-that-counts>
* [Diversity on Victorian Government Boards Guidelines](https://www.vic.gov.au/diversity-victorian-government-board-guidelines) <https://www.vic.gov.au/diversity-victorian-government-board-guidelines>.

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

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

* [Designing for Diversity](https://d.docs.live.net/031c443d5a1cf449/Documents/Business/Government/DoH-C%5e0SI/Designing%20for%20Diversity) <https://www.health.vic.gov.au/populations/designing-for-diversity>
* [Partnering in healthcare framework](https://www.bettersafercare.vic.gov.au/support-and-training/partnering-with-consumers/pih) <https://www.bettersafercare.vic.gov.au/support-and-training/partnering-with-consumers/pih>.

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

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

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

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

### Governance and priority setting

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

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

One of the priorities was developing a 10-year Victorian Aboriginal Health and Wellbeing Partnership Agreement (the Agreement). This was endorsed in 2023 and strongly aligned to Victoria’s commitments under the National Agreement on Closing the Gap. The statewide Agreement is a commitment from AHWPF members to work together to implement key reforms. This includes prioritising prevention and early intervention funding for Aboriginal community-controlled organisations, delivering self-determined, culturally safe healthcare and funding sustainability of the Aboriginal community-controlled health sector[[6]](#footnote-7).

Developing and implementing two-year Aboriginal health and wellbeing partnership action plans is a key driver for delivering these reforms.

For more information and to download the signed agreement, visit [Agreement and Action Plan](https://www.vaccho.org.au/ahwpf/) <https://www.vaccho.org.au/ahwpf/>.

Health services have particular responsibility for the priority to ‘Strengthen cultural safety in the mainstream health service system’, which entails mandatory cultural safety training that is delivered by a relevant Aboriginal organisation, culturally safe service standards, and improved identification, discharge plans and referral pathways. These core expectations are reflected below.

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

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

## Culturally safe services for Aboriginal people living in Victoria

All Victorian public health services are required to deliver culturally safe care to Aboriginal patients and families, and to provide culturally safe workplaces for Aboriginal employees, as articulated in the SOP.

For more information, visit [Aboriginal cultural safety fixed grant requirements](https://www.health.vic.gov.au/publications/aboriginal-cultural-safety-fixed-grant-guidelines-cultural-safety-planning-and) <https://www.health.vic.gov.au/publications/aboriginal-cultural-safety-fixed-grant-guidelines-cultural-safety-planning-and>.

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

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

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

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

The Aboriginal and Torres Strait Islander cultural safety framework supports mainstream Victorian health, human and community services, along with the department, to create culturally safe environments, services and workplaces.

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

Training must be high quality, with a strong preference towards in-person over online learning. It must align with the *Aboriginal and Torres Strait Islander cultural safety framework*. The training should be delivered by independent, expert, community-controlled organisations (or a Kinaway or Supply Nation-certified Aboriginal business) able to safely challenge established organisational thinking and practices[[7]](#footnote-8).

For more information, visit [Aboriginal and Torres Strait Islander cultural safety framework](https://www.health.vic.gov.au/publications/aboriginal-and-torres-strait-islander-cultural-safety-framework-part-1) <https://www.health.vic.gov.au/publications/aboriginal-and-torres-strait-islander-cultural-safety-framework-part-1>.

#### Expectations of First Peoples Employment Plans

The Victorian Health Workforce Strategy commits to significantly expanding First Nations representation within mainstream professions and leadership roles, to an overall level equal to the Victorian population by 2034[[8]](#footnote-9).

To achieve this, First Peoples employment plans are mandatory for all health services receiving Aboriginal Cultural Safety Fixed Grants, and for smaller health services that serve a significant local Aboriginal population.[[9]](#footnote-10) Plans must be aligned to the five-year Aboriginal employment strategy for the Victorian public sector, Barring Djinang[[10]](#footnote-11), and include an employment target that is reflective of local First Peoples populations, noting these vary across the state.

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

#### Culturally safe and equitable care

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

These include:

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

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

* CEO and executive leadership that drives cultural safety and Aboriginal self-determination
* partnerships with ACCHOs, respected Aboriginal leaders and Elders, and Aboriginal communities to deliver healthcare improvements, including through:
  + partnering to develop and deliver plans to identify and prioritise the health, wellbeing and service needs of the Aboriginal catchment population and service users
  + reporting and discussing the progress and outcomes of these plans.

These requirements align with the National Safety and Quality Health Service (NSQHS) Standards, which health services are encouraged to review[[11]](#footnote-12). For more information, guidance, tools and resources for health services, visit:

* [Aboriginal and Torres Strait Islander cultural safety](https://www.health.vic.gov.au/health-strategies/aboriginal-and-torres-strait-islander-cultural-safety) <https://www.health.vic.gov.au/health-strategies/aboriginal-and-torres-strait-islander-cultural-safety>
* [VACCHO accreditation programs](https://www.vaccho.org.au/cultural-safety-services/accreditation-programs/) <https://www.vaccho.org.au/cultural-safety-services/accreditation-programs>.

## Inclusive and accessible healthcare for LGBTIQA+ communities

Discrimination, stigma and exclusion continue to drive poorer health outcomes for LGBTIQA+ communities in Victoria[[12]](#footnote-13).

Pride in our future: Victoria’s LGBTIQA+ strategy 2022–*32* provides a vision and plan for LGBTIQA+ equality and inclusion. It states that Victorian health and community services should be approachable, welcoming, safe and inclusive for LGBTIQA+ Victorians. It also states that LGBTIQA+ people must be able to access services that meet their needs. Their health and care service experience should result in improved life outcomes.

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

For more information, visit [*Pride in our future: Victoria’s LGBTIQA+ strategy 2022–32*](https://www.vic.gov.au/victorian-lgbtiq-strategy) <https://www.vic.gov.au/victorian-lgbtiq-strategy>.

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

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

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

The Rainbow Tick guides organisations through a cycle of self-assessment and review by external assessors. This process determines the extent to which the organisation (or a service within the organisation) meets the needs of LGBTIQA+ consumers. The *2023–24 State Budget* provided $22.5 million over four years to help deliver Pride in our Future, including funding to expand Rainbow Tick in Victorian health services.

For more information, visit [Rainbow Health Australia](https://rainbowhealthaustralia.org.au/) <https://rainbowhealthaustralia.org.au/>.

A whole-of-government LGBTIQA+ Taskforce, supported by a departmental Health and Wellbeing Working Group and Expert Advisory Groups, and the Commissioner for LGBTIQA+ Communities, provides advice to the department on the delivery of inclusive and accessible healthcare. Funded organisations can engage these groups by emailing the [LGBTIQ Secretariat](mailto:LGBTIQ%20Secretariat) <LGBTIQSecretariat@health.vic.gov.au>.

### Trans and gender diverse people

Gender diverse is an umbrella term for a range of different genders. A transgender person is someone whose gender does not exclusively align with their sex recorded at birth. A non-binary person is someone whose gender sits outside the spectrum of man or woman or male or female. There are many other terms that gender diverse people may use to describe themselves, including genderfluid, genderqueer, gender non-conforming, trans masculine or trans feminine.

Trans and gender diverse people are part of the broader LGBTIQA+ community. They have distinct healthcare and social support needs, particularly during the process of questioning, defining and affirming their gender identity.

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

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

For more information, visit [Development of trans and gender diverse services in Victoria](https://www.health.vic.gov.au/populations/trans-and-gender-diverse-health-and-wellbeing) <https://www.health.vic.gov.au/populations/trans-and-gender-diverse-health-and-wellbeing>.

Data-reporting changes that commenced on 1 July 2024 mean Victorian hospitals are required to report sex at birth and gender across key health service data collections. This data will help health services and the department monitor service uptake and outcomes for trans and gender diverse Victorians. It will also support the development of targeted programs and funding.

For more information on specifications for revisions to data collections, visit [Annual changes process](https://www.health.vic.gov.au/data-reporting/annual-changes) <https://www.health.vic.gov.au/data-reporting/annual-changes>. For guidance on implementing this change see [Inclusive collection and reporting of sex and gender data](https://www.health.vic.gov.au/publications/inclusive-collection-and-reporting-of-sex-and-gender-data) <https://www.health.vic.gov.au/publications/inclusive-collection-and-reporting-of-sex-and-gender-data> linked above.

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

In Victoria, paediatric gender affirming care is guided by the Australian Standards of Care and Treatment Guidelines for Trans and Gender Diverse Children and Adolescents, and a multidisciplinary assessment of pubertal status, medical/mental health needs and social context. It includes non-medical pathways for gender expression and medical treatment, where clinically and legally appropriate. The National Health and Medical Research Council is currently undertaking a review of the Standards and is developing new national guidelines.

The *2024–25 State Budget* committed $2 million over four years towards the Trans and Gender Diverse in Community Health Program, which delivers peer navigator support, two multidisciplinary clinics in Preston and Ballarat, and statewide trans and gender diverse health training.

For more information, visit [Trans and Gender Diverse Services](https://www.yourch.org.au/service-access/trans-and-gender-diverse-health) <https://www.yourch.org.au/service-access/trans-and-gender-diverse-health>.

### People with variations in sex characteristics

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

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

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

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

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

For more information, visit [(i) am equal: Future directions for Victoria’s intersex community](https://www.health.vic.gov.au/publications/i-am-equal) <https://www.health.vic.gov.au/publications/i-am-equal>.

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

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

For more information, guidelines and resources on the health needs and on supporting people with an intersex variation, visit [Health of people with intersex variations](https://www.health.vic.gov.au/populations/health-of-people-with-intersex-variations) <https://www.health.vic.gov.au/populations/health-of-people-with-intersex-variations>.

## Supporting health access and outcomes for people with disability

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

The Inclusive Victoria: state disability plan 2022–2026 sets out whole-of-government commitments to improve the lives of Victorians with disability, including priority actions related to inpatient care, sexual and reproductive health, mental health and health service capability.

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

For more information, visit [Inclusive Victoria: state disability plan 2022–2026](https://www.vic.gov.au/state-disability-plan) <https://www.vic.gov.au/state-disability-plan>.

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

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

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

DLOs are driving longer-term health service and system improvement projects in line with Inclusive Victoria. They also develop disability competency within health services and support the delivery of Disability Action Plans.

For more information see [Disability Liaison Officer program](https://www.betterhealth.vic.gov.au/health/servicesandsupport/disability-liaison-officer-program) <https://www.betterhealth.vic.gov.au/health/servicesandsupport/disability-liaison-officer-program>, contact the DLO at your health service or [email the DLO Coordinator](mailto:DLOcoordinator@dhhs.vic.gov.au) <DLOcoordinator@dhhs.vic.gov.au>.

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

### Multicultural communities

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

The department’s Multicultural health action plan 2023–27 outlines commitments and actions to improve the health and wellbeing of multicultural communities in Victoria, particularly through embedding cultural competency into all services, programs and policies.

For more information, visit [Multicultural health action plan 2023–27](https://www.health.vic.gov.au/multicultural-health-action-plan-2023-27) <https://www.health.vic.gov.au/multicultural-health-action-plan-2023-27>.

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

The Victorian Government’s commitment to multiculturalism is outlined in [Victoria’s anti-racism strategy 2024–2029](https://www.vic.gov.au/victorias-anti-racism-strategy-2024-2029) <https://www.vic.gov.au/victorias-anti-racism-strategy-2024-2029>.

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

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

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

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

A Victorian Culturally and Linguistically Diverse Health Advisory Group was established in 2020 to provide representatives from Victoria’s multicultural communities and health sector with a forum to advise the Victorian Government on community insights, experience and expertise related to health priorities for Victoria.

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

### Refugees and people seeking asylum

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

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

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

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

For more information, visit:

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

### Language services

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

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

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

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

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

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

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

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

## Accessible and equitable health services for women

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

Specifically, the initiatives being delivered include:

* 10,800 additional laparoscopies over four years to help diagnosis and treat endometriosis, which can be debilitating and affects up to one in every nine women, many of whom are undiagnosed
* establishment of 20 new clinics over the four-year program as well as the establishment of an Aboriginal women’s health clinic
* research initiatives that will directly benefit women’s health, including data support and research funding, an inquiry into women’s pain and work to develop a business case for a Women’s Health Research Institute.
* establishment of nine additional sexual and reproductive health hubs, expanding on the 11 existing hubs to a total of 20 hubs, including 12 in regional Victoria
* establishment of the mobile and virtual women’s health clinics to improve access for women in rural and regional Victoria
* women’s health specialist scholarships across 2023-24–2024-25 to ensure our workforce are supported with the skills and knowledge they need.

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

For more information, visit [Women’s health and wellbeing program](https://www.health.vic.gov.au/public-health/womens-health-wellbeing-program) <https://www.health.vic.gov.au/public-health/womens-health-wellbeing-program>.

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

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

For more information on processes for determining and monitoring capability levels, visit [Service capability frameworks for Victoria](https://www.health.vic.gov.au/health-system-design-planning/service-capability-frameworks-for-victoria) <https://www.health.vic.gov.au/health-system-design-planning/service-capability-frameworks-for-victoria>.

# Service capability frameworks

## Service capability frameworks and levels

Service capability frameworks are comprehensive guidelines developed for Victoria's health system to support the delivery of optimal care. The frameworks outline the essential elements required for clinical services to function safely and effectively, and categorise these services into different levels of capability.

Capability frameworks delineate care across six levels of complexity. Levels range from 1 (being the least complex care, broadly available) to level 6 (being the most complex care, only available at major hospitals).

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

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

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

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

### Determining and monitoring capability levels

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

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

For more information on processes for determining and monitoring capability levels, visit [Service capability frameworks for Victoria](https://www.health.vic.gov.au/health-system-design-planning/service-capability-frameworks-for-victoria) <https://www.health.vic.gov.au/health-system-design-planning/service-capability-frameworks-for-victoria>.

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

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

## Future service capability frameworks

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

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

* critical care
* urgent, emergency and trauma care.

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

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

# Expectations, policies and performance

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

## Acute and specialist care

### Surgical and procedural services

All Victorian health services are expected to fully implement the Planned surgery access policy 2024 by June 2026. This policy provides guidance to the financial, administrative support staff, managers and executives of all public health services that provide planned surgery.

For more information about surgical policies and reporting requirements, visit:

* [Planned surgery access policy 2024](https://www.health.vic.gov.au/surgical-services/planned-surgery-access-policy-2024) <https://www.health.vic.gov.au/ surgical-services/planned-surgery-access-policy-2024>
* [Surgical services](https://d.docs.live.net/031c443d5a1cf449/Documents/Business/Government/DoH-C%5e0SI/Surgical%20services) <https://www.health.vic.gov.au/patient-care/surgical-services>
* [Elective Surgery Information System (ESIS)](https://www.health.vic.gov.au/data-reporting/elective-surgery-information-system-esis) <https://www.health.vic.gov.au/data-reporting/elective-surgery-information-system-esis>.

### Planned surgery reform

Significant steps to drive planned surgery recovery and reform have been realised through the delivery of the COVID Catch-Up Plan (announced in April 2022 and ceased in June 2024). This program of work laid out a foundation for system recovery and pathway for sustainable reform.

To this end, the [Planned Surgery Reform Blueprint](https://www.health.vic.gov.au/planned-surgery-reform-blueprint) <https://www.health.vic.gov.au/planned-surgery-reform-blueprint> was released in October 2023.

Informed by 18 months of extensive research and engagement, the Blueprint sets out a systematic approach to system-wide reform. It is forward looking and provides streamlined direction setting and advice to ensure improvements and innovations to planned surgery are consistently delivered across the public surgery system, with the aim to ensure that all Victorians can access timely planned surgery or non‑surgical treatment, when they need it, and experience safe and equitable outcomes, now and into the future.

To achieve this aim, the Blueprint mobilises four key pillars of change and 10 reforms of:

* Pilar 1: Positive patient experiences and outcomes:
  + Reform 1: Expand same-day models of care
  + Reform 2: Increase the availability of non-surgical treatment pathways
  + Reform 3: Enhance integration of primary care in the perioperative journey
* Pillar 2: Sustainable healthcare workforce:
  + Reform 4: Expand advanced scope of practice roles and create novel roles
  + Reform 5: Strengthen the workforce for the future
* Pillar 3: Optimal health service efficiency:
  + Reform 6: Scale high-throughput approaches (such as high-intensity theatre lists)
  + Reform 7: Digitise referral pathways and establish data-sharing platforms
  + Reform 8: Expand virtual care delivery
  + Reform 9: Regionalise planned surgery preparation list management
* Pillar 4: Strong system stewardship:
  + Reform 10: Build robust data and intelligence infrastructure.

The Blueprint signals an ongoing commitment to transforming the planned surgery system. The department continues to support and collaborate with health services to implement the 10 reforms, now and into the future.

### Non-admitted specialist services

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

### Victorian endoscopy categorisation guidelines

Victorian health services that provide endoscopy services should ensure clinicians use the Colonoscopy categorisation guidelines 2017 and the Upper gastrointestinal endoscopy categorisation guidelines for adults 2018. The Victorian Endoscopy Categorisation Decision Support Tool is available for these guidelines to provide automated clinical urgency categorisation and accompanying rationale, including guidance on whether a procedure is recommended when assessing a patient referred for an endoscopy procedure.

For more information and to access the categorisation guidelines and decision support tool, visit [Specialist clinics – resources](https://www.health.vic.gov.au/patient-care/specialist-clinics-resources) <https://www.health.vic.gov.au/patient-care/specialist-clinics-resources>.

### Cardiac care

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

### Admitted palliative care

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

Palliative care is provided:

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

Admitted palliative care at home models can also be established. These models must include oversight of all patients by a palliative medicine specialist, with input from a specialist palliative care interdisciplinary team, access to after-hours care and health-service-endorsed escalation pathways to support safe return to hospital where required.

The model must be endorsed by the department prior to commencement. There must be clear reporting structures in place to inform attribution of activity and outcomes by the care setting (hospital/home). Admitted care in the home models must not duplicate existing state-funded community palliative care programs.

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

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

Designated services can elect to submit Clinical Indictors for Pain via the HealthCollect data portal.

#### Day hospice

Some health services are funded to provide day hospice.

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

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

### Maternity and newborn services

Maternity and newborn services are to be provided in accordance with the principals outlined in the *Capability frameworks for Victorian maternity and newborn services*:

* Maternity care is guided by a wellness model designed around the needs of each woman and her family.
* Models of maternity care focus on the individual woman’s needs and preferences, collaboration and continuity of care.
* Each woman is provided with individualised information about maternity care and supported to access culturally safe and responsive care with the care provider of her choice. Her care is underpinned by respectful communication and collaboration among health professionals.
* Cultural competency is embedded and prioritised in health services to support and improve equitable access to, and quality of, maternity and newborn services.
* Provision of appropriate and culturally safe maternity and newborn services is determined by Aboriginal people, embedding the principles of self-determination.
* All health professionals support each woman to make evidence-based and informed decisions and choices about her care that reflect her physical, emotional, psychosocial, spiritual and cultural needs.
* Maternity and newborn care is provided as close to home as is safe and practicable, and includes prompt transfer to local and specialised services as appropriate.
* The aim is to keep mother and baby together as a priority, where safe and appropriate, in line with each capability level.
* A network of services that are working collaboratively, with an enduring commitment to safety and quality, provide the foundation of Victoria’s maternity and newborn service system.
* Service delivery is focused on the continuum of care, from pregnancy care through to birthing, postnatal care, discharge and transition of care.
* Consultation, referral and transfer processes are established to support clinical decision-making. These processes are agreed and documented by health services within appropriate geographical boundaries.
* Health service campuses’ capability is clearly communicated to women and families accessing the service, the community and other service providers.

#### Maternal and perinatal mortality and morbidity review

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

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

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

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

For more information and to access the guidelines, visit [Regional Maternal and Perinatal Morbidity and Mortality Committee guidelines](https://www.health.vic.gov.au/patient-care/capability-frameworks-for-maternity-and-newborn-care-in-victoria) <https://www.health.vic.gov.au/patient-care/capability-frameworks-for-maternity-and-newborn-care-in-victoria>.

#### Generation Victoria (GenV)

GenV is led by the Murdoch Children’s Research Institute and The Royal Children’s Hospital. It is partially funded by the Victorian Government.

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

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

For more information, visit [GenV](https://www.genv.org.au/) <https://www.genv.org.au>.

#### Incentivising better patient safety

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

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

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

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

Health services that operate an adult or paediatric critical care unit must submit data to the Adult Patient Database and the Australian and New Zealand Paediatric Intensive Care Registry, administered by the [Australian and New Zealand Intensive Care Society (ANZICS) Centre for Outcome and Resource Evaluation (CORE)](https://d.docs.live.net/031c443d5a1cf449/Documents/Business/Government/DoH-C%5e0SI/Australian%20and%20New%20Zealand%20Intensive%20Care%20Society%20(ANZICS)%20Centre%20for%20Outcome%20and%20Resource%20Evaluation%20(CORE)) <https://www.safetyandquality.gov.au/acsqhc-arcr-294>

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

#### Retrieval and Critical Health Information System capacity

To facilitate statewide access to critical care beds, all health services providing adult, newborn and paediatric critical care services are required to update bed occupancy data on the [Retrieval and Critical Health Information System](https://d.docs.live.net/031c443d5a1cf449/Documents/Business/Government/DoH-C%5e0SI/Retrieval%20and%20Critical%20Health%20Information%20System) <https://reach.vic.gov.au/#/portal/home> four times a day.

For more information, login to the [Retrieval and Critical Health Information System manual](https://reach.vic.gov.au/#/guidelines/home) <https://reach.vic.gov.au/#/guidelines/home>.

#### Koori Maternity Services and culturally safe maternity care

Victoria’s 14 Koori Maternity Services provide culturally safe, flexible and holistic sexual and reproductive health care, pregnancy and postnatal care. Aboriginal women and women having Aboriginal babies are eligible to access care through a Koori Maternity Service. These services are an integral component of Victoria’s maternity service system and ensure cultural safety, cultural strength and wellbeing for women having Aboriginal babies and their families.

Koori Maternity Services are a partnered service delivery model provided by Aboriginal community-controlled organisations (ACCOs) and public health services. Strong and effective partnerships between these services underpin good perinatal outcomes for Aboriginal women, babies and their families.

Services providing Koori Maternity Services (see Table 4) deliver these in line with the [Koori Maternity Services Guidelines](https://www.health.vic.gov.au/patient-care/aboriginal-maternity-services) <https://www.health.vic.gov.au/patient-care/aboriginal-maternity-services>. These guidelines also outline data collection requirements for these services.

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

The key Koori Maternity Services partnerships for public health services are outlined in Table 4.

Table 4. Koori Maternity Services birthing and referral partners

|  |  |  |
| --- | --- | --- |
| Region | Koori Maternity Service | Birthing and referral partners |
| North and West Metropolitan | Victorian Aboriginal Health Service  Western Health (Sunshine Hospital)  Northern Health (The Northern Hospital) | The Royal Women’s Hospital  Northern Hospital (Northern Health)  Mercy Hospital for Women (Heidelberg) |
| Southern Metropolitan | Dandenong and District Aboriginal Cooperative  Peninsula Health (Frankston Hospital) | Monash Health (Dandenong Hospital, Monash Medical Centre, Casey Hospital)  Frankston Hospital (Peninsula Health) |
| Barwon South West | Wathaurong Aboriginal Health Service  Gunditjmara Aboriginal Cooperative | University Hospital Geelong  Warrnambool (South West Healthcare)  Sunshine Hospital (Western Health)  Royal Women’s Hospital |
| Hume | Rumbalara Aboriginal Cooperative  Mungabareena Aboriginal Cooperative | Goulburn Valley Health  Albury Wodonga Health  Northeast Health Wangaratta  Royal Women’s Hospital  Mercy Hospital for Women (Heidelberg) |
| Gippsland | Gippsland and East Gippsland Aboriginal Co-operative  Central Gippsland Aboriginal Health Service | Bairnsdale Regional Health Service  Central Gippsland Health Service (Sale)  Latrobe Regional Hospital (Traralgon)  West Gippsland Healthcare Group (Warragul)  Monash Medical Centre (Monash Health) |
| Loddon Mallee | Mallee District Aboriginal Service (Mildura and Swan Hill)  Swan Hill Aboriginal Health Service  Njernda Aboriginal Corporation | Mildura Base Hospital  Swan Hill District Health  Echuca Regional Health  Bendigo Health  Sunshine Hospital (Western Health) |

Where health services do not have a local Koori Maternity Service, they are still expected to liaise with local ACCOs for optimal maternity care/family care. A list of ACCOs and their locations can be found at [VACCHO](https://www.vaccho.org.au/members/) <https://www.vaccho.org.au/members/> and [First Peoples’ Health and Wellbeing](https://www.fphw.org.au/) <https://www.fphw.org.au>.

For more information, visit:

* [Koori Maternity Services](https://d.docs.live.net/031c443d5a1cf449/Documents/Business/Government/DoH-C%5e0SI/Koori%20Maternity%20Services) <https://www.health.vic.gov.au/patient-care/aboriginal-maternity-services>
* [VACCHO](https://www.vaccho.org.au/kms-2/) <https://www.vaccho.org.au/kms-2/>.

### Victorian Paediatric Rehabilitation Service

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

The Victorian Paediatric Rehabilitation Service consists of:

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

The service’s statewide appointments provide support, leadership of the network, research 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. All participating health services should be represented and participate in the statewide network advisory group.

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

### HITH

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

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

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

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

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

For more information, visit [HITH guidelines](https://d.docs.live.net/031c443d5a1cf449/Documents/Business/Government/DoH-C%5e0SI/HITH%20guidelines) <https://www.health.vic.gov.au/patient-care/hospital-in-the-home>. These guidelines will be refreshed in 2025–26.

### Specialist clinics

Health services are expected to comply with the Access to non-admitted services in Victoria policy. All health services providing specialist clinic services must ensure their procedures and policies align with the objectives and principles of current policies.

For more information, visit [Access to non-admitted services in Victoria](https://www.health.vic.gov.au/patient-care/access-to-specialist-clinics-in-victoria)<https://www.health.vic.gov.au/patient-care/access-to-specialist-clinics-in-victoria>.

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

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

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

SRHS and multipurpose services that are currently reporting specialist clinics activity only through the Agency Information Management System (AIMS) S10, will progress their capability to report patient-level specialist clinics data to the VINAH MDS or the NADC.

Health services that submit patient-level non-admitted data to the VINAH MDS or the NADC will cease reporting aggregate non-admitted activity using the AIMS S10 form from 1 July 2025. Only health services not reporting specialist clinics activity to the VINAH MDS or NADC must continue to report aggregate data for 2025–26 using the AIMS S10 form.

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

### Virtual care

Virtual care is a broad term. It includes telehealth (telephone and video-enabled) and remote monitoring. It supports self-management, and it can be provided in different settings and geographies. It is used to provide care and connects consumers, families and carers with clinicians and other people caring for them. It supports multidisciplinary care, specialist consultations between clinicians, professional development and peer support.

The [Virtual Care Strategy](https://d.docs.live.net/031c443d5a1cf449/Documents/Business/Government/DoH-C%5e0SI/Virtual%20Care%20Strategy) <https://www.health.vic.gov.au/victorian-virtual-care-strategy/overview> outlines that virtual care:

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

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

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

It is expected that health services align local virtual care strategies with the Virtual Care Strategy. To support this, Victorian health services must consult with the Virtual Care Advisory Group before making investments in virtual care capability and tools.

HealthdirectVideo Call is the preferred platform for virtual/telehealth care consulting for Victorian public health services (such as hospitals, community health services and maternal health services). It provides a secure, reliable service that uses consumer grade devices (such as a mobile phone, tablet or computer) that complement clinical workflows familiar to providers and patients.

Consultation with the department is required where health services intend to use a video consulting platform that is not Healthdirect.

Telehealth can be a direct method of service delivery (for example, for specialist consultations) or as an adjunct to in-person care (for example, remote medical consultations complementing home visits for patients receiving HITH). Telehealth activity in specialist clinics, Ambulance Victoria triage, or as part of acute and subacute admissions, is funded through existing funding models for these services.

While both phone and video consulting can be used, video consulting is preferred and is the only mode of telehealth that meets the Criteria for Admission for reporting to the VAED for inpatient care. Non-admitted care is reported to the VINAH MDS, noting delivery mode (telephone or telehealth video). As the statewide provider, only the VVED reports virtual activity to the Victorian Emergency MDS (VEMD).

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

For more information, visit [MBS Telehealth Services <](https://www.mbsonline.gov.au/internet/mbsonline/publishing.nsf/Content/Factsheet-Telehealth-Updates-April%202023)https://www.mbsonline.gov.au/internet/mbsonline/publishing.nsf/Content/Factsheet-Telehealth-Updates-April%202023>.

### Integrated hepatitis C services

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

In 2025–26, health services are to continue realigning their service to focus on the effective use of primary care and targeted use of hospital specialist services.

This includes:

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

#### Direct-acting antiviral hepatitis C treatments

The Australian Government lists several medicines to treat hepatitis C on the PBS and the Highly Specialised Drugs Program.

Nurse practitioners experienced in the care and management of people living with HIV and hepatitis B in the community, and hepatitis C in corrective services settings, are now eligible to prescribe s.100 medicines. The relevant medicines listed for prescribing by nurse practitioners are identified by ‘NP’ in the PBS Schedule.

For more information, visit:

* [National Health (Highly Specialised Drugs Program) Special Arrangement 2021](https://www.legislation.gov.au/Details/F2022C00177) <https://www.legislation.gov.au/Details/F2022C00177> that came into effect on 1 February 2022 about these arrangements
* [Hepatitis C Medicines](https://www.pbs.gov.au/info/publication/factsheets/hep-c/hepc-factsheet-hospital-prescribers-dispensers) <https://www.pbs.gov.au/info/publication/factsheets/hep-c/hepc-factsheet-hospital-prescribers-dispensers>.

Integrated hepatitis C services activity is reported as part of the VINAH MDS.

Community health services report using the NADC. For more information, [email the Health Data Standards and Systems (HDSS) helpdesk](mailto:hdss.helpdesk@health.vic.gov.au) <hdss.helpdesk@health.vic.gov.au>.

Health services that are funded to provide integrated hepatitis C services must provide aggregate data on the numbers of patients attending clinics, waiting times and the numbers of patients being transitioned to community providers, to the department on request.

For more information, visit:

* [Victorian Health Services Performance](https://vahi.vic.gov.au/reports/victorian-health-services-performance) <https://vahi.vic.gov.au/reports/victorian-health-services-performance>
* [Hepatitis C](https://d.docs.live.net/031c443d5a1cf449/Documents/Business/Government/DoH-C%5e0SI/Hepatitis%20C) <https://www.betterhealth.vic.gov.au/health/conditionsandtreatments/hepatitis-c>.

### Disability and the NDIS

Health services should deliver high-quality care that is accessible, welcoming, safe and effective to all Victorians, including people with disability, wherever they are treated. People with disability should receive treatment and care, and the application of patient rights and responsibilities, that are afforded to any person in the community receiving health care with the same or similar clinical needs.

Consistent with person-centred care, aids (such as Auslan) should be used where necessary to overcome communication difficulties, and to promote active participation of people with disability in decisions about their treatment and care.

The *Inclusive Victoria: state disability plan 2022–2026* sets out six systemic reforms for making things fairer for people with disability, including:

* co-design with people with disability
* Aboriginal self-determination
* intersectional approaches
* accessible communications and universal design
* disability-confident and inclusive workforces
* effective data and outcomes reporting.

Health services are required to develop disability action plans to improve the quality of care for people with disability, share these with their community and report on outcomes annually.

For more information, visit [*Inclusive Victoria: state disability plan 2022–2026*](https://www.vic.gov.au/state-disability-plan) <https://www.vic.gov.au/state-disability-plan>.

#### Working with the NDIS

Health and community services are responsible for effective interaction with the NDIS, to enable timely access to support and services for people with disability, who have new or changed needs following a hospital admission.

Health and community services are required to operate effectively in the market-based environment that is presented by the NDIS for delivering disability services:

* Health services should have processes in place to identify NDIS participants, or those eligible to become participants.
* When providing care to NDIS participants, health services should ensure NDIS-eligible activity and equipment is billed to the NDIS.
* NDIS participants may access health and community services to seek care that is funded in their NDIS support plan. It may be that health services are their provider of choice for specialist services, or the provider of last resort in areas where markets are developing.

Health services should consider registering as an NDIS service provider. This will enable health services to access additional revenue by billing the NDIS for funded activities for eligible clients. In regional areas, this will ensure access to certain NDIS-eligible allied health and nursing interventions for NDIS participants, where these services may otherwise not be available locally.

For more information, visit: [NDIS Quality and Safeguards Commission](https://www.ndiscommission.gov.au/providers/becoming-registered-provider) <https://www.ndiscommission.gov.au/providers/becoming-registered-provider>.

#### Admitted patients

The NDIS employs health liaison officers (HLOs) to assist NDIS participants to move through the NDIS pathway while in hospital. They are essential contacts for health services for engaging with the NDIS, specifically relating to discharge planning and escalation of protracted discharge delays.

Their role includes:

* promoting understanding of the NDIS within health services to support hospital discharge, such as understanding the hospital discharge participant pathway from access to pre-planning, plan development and implementation
* promoting awareness of the scope of supports and services provided by the NDIS
* linking directly with health clinicians and allied health professionals to provide support and coordination for discharge planning, case conferences and information exchange
* engaging directly with NDIS participants (patients) to problem solve barriers to discharge
* escalation of protracted and complex discharges to the NDIS Hospital Interface Branch for prioritisation.

NDIS-funded HLO positions support all health services throughout Victoria. NDIS offers a targeted hospital discharge pathway that differs from the NDIS pathway available to existing and prospective NDIS participants in the community. Hospitals that do not have an allocated HLO can refer and seek support by emailing the [National Disability Insurance Agency’s (NDIA) central HLO inbox](mailto:health.liaison.officer@ndis.gov.au) <health.liaison.officer@ndis.gov.au>.

Referrals will be triaged and allocated to a HLO that supports the local health network.

#### Hospital admission and discharge

When an existing or prospective NDIS participant is admitted to hospital:

* with patient consent, the health service must notify the NDIS at the earliest convenience, if changes to the patient's NDIS plan may be required to support their discharge. This will trigger the NDIS to commence planning for delivery of an interim discharge plan within 15–30 days of the health service’s notification of admission
* the NDIS participant referral form and the NDIS consent form should be completed and emailed to the NDIA’s central HLO inbox, to share information to support planning for the participant’s discharge as soon as practicable
* inpatient allied health assessments to support discharge are to be completed by the health service
* the health service must provide the NDIS with the relevant evidence to support NDIS access requests and participant plan variations and reassessments. This can be done by submitting the NDIS discharge assessment form or the health service’s equivalent template
* the health service must report the NDIS participant number to the VAED.

#### 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 post-discharge, as required by a patient for a safe and effective discharge, where the aids and equipment are considered necessary for recuperation and to prevent unnecessary continued hospitalisation or readmission. This will be at no cost to the patient, excluding a refundable deposit, if applicable. This includes the provision of domiciliary oxygen and continence aids, except for existing VA&EP and NDIS clients receiving domiciliary oxygen or continence aids.

At the end of the 30-day post-discharge period, health services may charge patient fees for these aids and equipment or 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. The NDIS will not provide assistance to a NDIS participant if the participant requires aids or equipment that are not related to the person’s disability.

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. This shall be at no cost to the patient for a period of 30 days unless, at the hospital discretion, a refundable deposit is required.

For more information about fees and charges for providing aids, equipment and domiciliary oxygen, visit [Patient fees and charges for public health services](https://www.health.vic.gov.au/hospitals-and-health-services/patient-fees-and-charges-for-public-health-services) <https://www.health.vic.gov.au/hospitals-and-health-services/patient-fees-and-charges-for-public-health-services>.

## Subacute and non-acute care

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

Subacute services can be delivered as either admitted or ambulatory care, and should be delivered in the home, whenever it is safe, appropriate, consistent with the patient’s preference and compliant with Victorian funding policy. Admitted subacute services should be delivered in the home, with reference to the same guidance for HITH (see [section 18.1.9](#_HITH)).

Health services are delineated to provide rehabilitation and geriatric evaluation, and management (GEM) services, through the [*Subacute planning framework*](https://www.health.vic.gov.au/patient-care/subacute-planning-framework)<https://www.health.vic.gov.au/patient-care/subacute-planning-framework>. Health services should align their services with the department’s published capability level at all times.

Health services providing rehabilitation, GEM and Health Independence Program services should ensure they align their services based on their service capability level. Local health services delineated as level 2 will provide and report maintenance care.

### Rehabilitation, GEM and maintenance care

#### Rehabilitation

Rehabilitation care is when the primary clinical purpose or treatment goal is improvement in the functioning of a consumer with impairment, activity limitation or participation restriction, due to a health condition. The consumer will be capable of actively participating in rehabilitation.

Rehabilitation care is always:

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

#### GEM

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

GEM is always:

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

An evaluation of the GEM program in Victoria has been undertaken. For information about this program and to read the report, visit [Evaluation of the GEM program in Victoria](https://www.health.vic.gov.au/patient-care/evaluation-of-the-geriatric-evaluation-and-management-program-in-victoria) <https://www.health.vic.gov.au/patient-care/evaluation-of-the-geriatric-evaluation-and-management-program-in-victoria>.

The evaluation sought to:

* understand the extent to which GEM is delivering an efficient and effective service
* understand how GEM supports the broader health service system, including interfaces within health services, and with external community and aged care services
* identify the current and future challenges and enablers for GEM, and how it needs to evolve to meet the needs of older Victorians now and into the future.

#### Maintenance care

Maintenance care is care in which the primary clinical purpose or treatment goal is supporting a consumer with impairment, activity or participation restriction, due to a health condition. Following assessment or treatment, the consumer does not require further complex assessment or stabilisation.

It is not intended that maintenance care substitutes for other forms of non-acute care. It should emphasise a restorative approach to care after treatment.

#### Admitted GEM and rehabilitation – reporting requirements

All health services providing inpatient rehabilitation and GEM services must report a functional independence measure score on admission and separation (excluding paediatric rehabilitation). This is a mandatory VAED reporting requirement. Relevant records submitted to the department without a functional independence measure score will be rejected.

A ‘Program identifier for specialist acquired brain injury rehabilitation service’ (code 09) is to be reported for patients in the two designated specialist acquired brain injury rehabilitation services located at Caulfield Hospital, Alfred Health and the Royal Talbot Rehabilitation Centre, Austin Health.

A ‘Program identifier for specialist spinal rehabilitation service’ (code 10) is to be reported for patients in the two designated specialist spinal rehabilitation services located at Caulfield Hospital, Alfred Health and the Royal Talbot Rehabilitation Centre, Austin Health.

For program details and service model information, visit [Rehabilitation and complex care](https://www.health.vic.gov.au/patient-care/rehabilitation-and-complex-care) <https://www.health.vic.gov.au/patient-care/rehabilitation-and-complex-care>.

### Transition Care Program

The Transition Care Program is a national specialist aged care program legislated by the Aged Care Actand the Aged Care Rules pursuant to that Act. It is jointly funded by the Commonwealth and state and territory governments through per diem contributions. The [Transition Care Program guidelines](https://www.health.gov.au/resources/publications/transition-care-programme-guidelines) <https://www.health.gov.au/resources/publications/transition-care-programme-guidelines> updated in 2022, govern the program.

The Commonwealth is implementing national aged care reforms in 2025–26. As outlined in these reforms, health services funded to deliver the Transition Care Program must be registered providers of aged care services and conform with registration requirements in the [appropriate category](https://www.agedcarequality.gov.au) <https://www.agedcarequality.gov.au>. Care and services delivered as part of the Transition Care Program must conform to both the Strengthened Aged Care Standards and the NSQHS Standards.

As a specialist aged care program, places are allocated by the Commonwealth through state and territory governments, rather than direct to individuals. Health services must notify the department if they wish to change their Transition Care Program service model. This includes changes to the number of allocated program places and their operational location.

Where funding is affected by service changes, the service must seek the department’s agreement on the effective date and any associated funding adjustments.

Transition Care Program providers are expected to implement continuous improvements and participate in projects and activities that improve the care, safety and experience of individuals in the program.

For more information, visit [Transition Care Program](https://www.health.vic.gov.au/patient-care/transition-care-program) <https://www.health.vic.gov.au/patient-care/transition-care-program>.

### Health Independence Program

Health Independence Program services aim to provide hospital substitution and diversion services by supporting people in the community, in ambulatory settings and in their homes, which may include residential facilities. Health Independence Program services focus on improving and optimising people’s function and participation in activities of daily living, to allow them to maximise their independence and return to, or remain in, their usual place of residence.

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

For more information, visit [Health Independence Program guidelines](https://www.health.vic.gov.au/patient-care/health-independence-program-guidelines) <https://www.health.vic.gov.au/patient-care/health-independence-program-guidelines>.

#### Health Independence Program service delivery components

The components of the program that a consumer receives will be based on their assessed needs and will assist them to meet their identified goals.

This may consist of one or more of:

* non-admitted rehabilitation (such as rehabilitation at home or in a community rehabilitation centre)
* care coordination – short-term or complex
* consumer self-management, education and support
* access to specialist services, including specialist assessment (such as linking to residential in-reach services, a specialist medical clinic or specialist subacute clinic, such as chronic pain management, falls and balance, or continence clinics)
* short-term supports (such as post-acute care)
* complex psychosocial issues management.

#### Reporting requirements

Organisations must transmit data to the VINAH MDS if they receive funding under:

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

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

* contact account class Public Eligible (MP) or Reciprocal Health Care Agreement (MA)
* contact client present status where either the patient, their carer, or both, are present (10, 11, 12, 13 or 20)
* contact delivery mode that is direct (1, 2, 3, 4,5 or 8)
* contact delivery setting that is not the ED (13)
* contact inpatient flag does not equal I (Inpatient/Admitted).

Health services that submit patient-level non-admitted data to the VINAH MDS or the NADC will cease reporting non-admitted activity to the AIMS S11 form from 2025–26. Only health services not reporting subacute non-admitted activity to the VINAH MDS or NADC must continue to report aggregate data for 2025–26 using the AIMS S11 form.

Hospitals are expected to report patient-level cost data (or aggregate where patient-level cannot be obtained) for all subacute and non-acute activity to the VCDC, as detailed in [section 29.1.8](#_VCDC).

For more information, visit:

* [*Planning the future of Victoria’s subacute service system: a capability and access planning framework – 2013*](https://www.health.vic.gov.au/publications/planning-the-future-of-victorias-subacute-service-system-a-capability-and-access) <https://www.health.vic.gov.au/publications/planning-the-future-of-victorias-subacute-service-system-a-capability-and-access>
* [Health Independence Program guidelines](https://www.health.vic.gov.au/patient-care/health-independence-program-guidelines) <https://www.health.vic.gov.au/patient-care/health-independence-program-guidelines> – these will continue to guide health service and departmental directions for these services in 2025–26.

### Community palliative care

Designated community palliative care services provide end-of-life and palliative care to clients and carers that is responsive, multidisciplinary and evidence-based. Care is tailored to the preferences, values and goals of the individual, and to their stage of illness, and can be early or late in the illness trajectory. Care includes complex pain and symptom management, and assistance with physical, spiritual, social and cultural concerns related to life-limiting illness and bereavement.

Practical help includes respite and financial assistance for equipment that supports the safety of clients, carers and staff in the home.

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

The department will monitor community palliative care services progress against episode targets (see Funding rules, part 2: Funding and activity levels).

#### After hours

Outside business hours (usually between 7 am and 5 pm Monday to Friday, excluding public holidays), all designated community palliative care services must provide or arrange a minimum level of service to their clients that includes:

* specialist palliative care telephone advice to clients, carers and families primarily (but not only) about symptom management if required – this may include secondary consultation with a specialist palliative care provider where relevant
* a health professional visit if required, based on the client’s, carer’s or family’s needs (if it is safe for staff to undertake the visit)
* any other after-hours care negotiated between clients, their carers and the community palliative care service on an individual basis.

#### Reporting requirements

All designated community palliative care services must report activity using the program and stream element, as described in the VINAH MDS, which includes that:

* contacts will be reported to the VINAH MDS as per the standard VINAH MDS reporting requirements
* health services reporting data to the VINAH MDS will cease reporting via the AIMS S11 form from 2025–26
* only health services not reporting data to the VINAH MDS must continue reporting aggregate data for 2025–26 using the AIMS S11 form
* funded services can elect to submit quarterly Clinical Indictors for Pain data, via the HealthCollect data portal
* funded services must participate in the annual palliative care experience module of the Victorian Healthcare Experience Survey (VHES)
* patient-level cost data (or aggregate where patient-level cannot be obtained) for community palliative care activity are to be reported to the VCDC.

### Palliative care consultancy teams

Funding allocations for hospital-based and regional specialist palliative care consultancy form part of the health service modelled budgets in their acute and subacute allocation.

#### Hospital-based palliative care consultancy teams

Hospital-based palliative care consultancy teams provide specialist advice and support to other clinicians in their hospital and, in certain instances, direct care. They are to report patient-level data to the VINAH MDS.

#### Regional palliative care consultancy teams

Regional palliative care consultancy teams provide a combination of direct care and secondary consultations to other clinicians within their designated rural region or subregion.

#### Reporting requirements

All hospital-based and regional palliative care consultancy services must report activity using the program and stream element, as described in the VINAH MDS manual, which includes that:

* contacts will be reported to the VINAH MDS as per the standard VINAH MDS reporting requirements
* health services reporting data to the VINAH MDS will cease reporting via the AIMS S11 form from 2025–26
* only health services not reporting data to the VINAH MDS must continue reporting aggregate data for 2025–26 using the AIMS S11 form
* the AIMS Palliative Care Consultancy Program (PCCP) form will continue to be required to report for accountability and service planning (number of contacts, number of referrals, active episodes, number of episodes opened and closed, and number of patients)
* palliative care consultancy teams are to work closely with costing personnel in their service so that their activity is correctly recorded and apportioned within the service, and appropriately captured and attributed in the VCDC.

### Statewide consultancy services

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

* the Victorian Paediatric PCCP
* Very Special Kids
* the Statewide Specialist Bereavement Service provided through Grief Australia
* Motor Neurone Disease Association Victoria.

#### Reporting requirements

Statewide palliative care services are to report patient-level data to the VINAH MDS or the NADC (see [section 29.1](#_Key_systems)).

The AIMS PCCP form will continue to be reported for accountability and service planning (number of contacts, number of referrals, active episodes, number of episodes opened and closed, and number of patients).

Health services reporting data to the VINAH MDS will cease reporting via the AIMS S11 form from 2025–26. Only health services not reporting data to the VINAH MDS must continue reporting aggregate data for 2025–26 using the AIMS S11 form.

For more information about palliative care consultancy services, including the Victorian Paediatric PCCP business rules, visit the [Palliative Care Program](https://www.health.vic.gov.au/patient-care/palliative-care-program) <https://www.health.vic.gov.au/patient-care/palliative-care-program>.

### Palliative care consortia

Palliative care consortia support the department to implement *Victoria’s end of life and palliative care framework* across the state. Consortia play an important role in regional education and training activities, and linking palliative care into the regional health and community care system.

Each consortium receives funding to support the manager role and contribute to consortium activities. One member organisation of each consortium acts as the fund holder, noting that:

* all funding grants for consortia are allocated to the nominated fund holder organisations
* each Consortium Executive Committee is responsible for allocating funds to consortium activities in its region.

Each consortium is required to submit an annual report to the department before 30 September 2025. The report should outline their key achievements and activities for 2024–25 and include a financial statement that accounts for expenditure throughout the financial year.

For more information about palliative care consortia, visit the [Palliative Care Program](https://www.health.vic.gov.au/patient-care/palliative-care-program) <https://www.health.vic.gov.au/patient-care/palliative-care-program>.

### Victorian Artificial Limb Program

Victorian Artificial Limb Program services must report as a non-admitted subacute service to the VINAH MDS. Health services reporting data to the VINAH MDS will cease reporting via the AIMS S11 form from 2025–26. Only health services not reporting data to the VINAH MDS must continue reporting aggregate data for 2025–26 using the AIMS S11 form.

Hospitals are expected to report patient-level cost data (or aggregate where patient-level cannot be obtained) for all Victorian Artificial Limb Program activity to the VCDC.

Services expected to provide artificial limbs under the Victorian Artificial Limb Program in 2024–25 include:

* The Royal Children’s Hospital
* Peninsula Health
* Melbourne Health
* Alfred Health
* Barwon Health
* Grampians Health Ballarat
* Austin Health
* St Vincent’s Health
* Latrobe Regional Hospital
* Bendigo Health
* South West Healthcare.

People accessing the Victorian Artificial Limb Program service and equipment may be eligible for the NDIS. Health services are expected to identify NDIS participants, or those eligible to become participants, who are accessing their Victorian Artificial Limb Program services, and ensure NDIS-eligible activity and equipment is billed to the NDIS.

### Victorian Respiratory Support Service

The Victorian Respiratory Support Service is required to report contacts to the VINAH MDS. Health services reporting data to the VINAH MDS will cease reporting via the AIMS S11 and S12 forms from 2025–26. Only health services not reporting data to the VINAH MDS must continue reporting aggregate data for 2025–26 using AIMS S11 and S12.

Health services are expected to report patient-level cost data (or aggregate where patient-level cannot be obtained) for all Victorian Respiratory Support Service activity to the VCDC.

### Total parenteral nutrition

Five health services provide total parenteral nutrition services for non-admitted consumers who self-administer total parenteral nutrition at home. The services are Austin Health, Melbourne Health, Monash Health, St Vincent’s Health and The Royal Children’s Hospital.

Activity is to be reported to the VINAH MDS. Health services reporting data to the VINAH MDS will cease reporting via the AIMS S12 form from 2025–26. Only health services not reporting data to the VINAH MDS must continue reporting aggregate data for 2025–26 using the AIMS S12 form.

Cost data reported must be reported via the VCDC and should consider the cost of consumables, equipment, maintenance and overheads. It should not include the cost of consultations with a health professional.

Health services should count and report consultations with health professionals separately.

### Home enteral nutrition

Activity is to be reported to the VINAH MDS. Health services reporting data to the VINAH MDS will cease reporting via the AIMS S12 form from 2025–26. Only health services not reporting data to the VINAH MDS must continue reporting aggregate data for 2025–26 using the AIMS S12 form.

Cost data reported must be reported via the VCDC and should consider the cost of consumables, equipment, maintenance and overheads. It should not include the cost of consultations with a health professional.

Health services should count and report consultations with health professionals separately.

## System improvements

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

Prescribed health services are expected to embed a whole-of-hospital model for responding to family violence to meet the requirements of the [CISS](https://d.docs.live.net/031c443d5a1cf449/Documents/Business/Government/DoH-C%5e0SI/CISS) <https://www.vic.gov.au/child-information-sharing-scheme> and the [FVISS](https://d.docs.live.net/031c443d5a1cf449/Documents/Business/Government/DoH-C%5e0SI/FVISS) <https://www.vic.gov.au/family-violence-information-sharing-scheme>, and align to the [*Family Violence Multi-Agency Risk Assessment and Management Framework*](https://www.vic.gov.au/family-violence-multi-agency-risk-assessment-and-management) (MARAM) <https://www.vic.gov.au/family-violence-multi-agency-risk-assessment-and-management>.

For more information, visit [Appendix 1: Prescribed organisations](https://www.vic.gov.au/report-implementation-family-violence-risk-assessment-and-management-framework-2021-22/appendix-1) <https://www.vic.gov.au/report-implementation-family-violence-risk-assessment-and-management-framework-2021-22/appendix-1>.

The Royal Women’s Hospital and Bendigo Health are the statewide leads for the SHRFV initiative in 2025–2026. SHRFV statewide leads will work to embed the SHRFV initiative at their health services and build partnerships to support other health services in the region to implement the SHRFV whole-of-hospital service model to meet the requirements of FVISS and CISS, and align to MARAM.

SHRFV statewide leads are required to promote access to appropriate training and resources for the health services they support. Public-funded hospitals are expected to actively participate in the SHRFV community of practice and provide quarterly data to SHRFV, as part of the program reporting requirements.

SHRFV statewide lead health services are required to actively mentor health services they support to roll out and embed FVISS, CISS and MARAM reforms, inclusive of the family violence workplace support. They are also required to report funding expenditure on a biannual basis to SCV and to acquit SHRFV funds at the end of the financial year.

To access the SHRFV Tool Kit, visit [SHRFV Tool Kit](https://www.thewomens.org.au/health-professionals/clinical-resources/strengthening-hospitals-response-to-family-violence) <https://www.thewomens.org.au/health-professionals/clinical-resources/strengthening-hospitals-response-to-family-violence>.

For more information, visit [Information sharing and MARAM reforms](https://www.vic.gov.au/information-sharing-schemes-and-the-maram-framework) <<https://www.vic.gov.au/information-sharing-schemes-and-the-maram-framework>>.

### Prevent and respond to risks of occupational violence and aggression, and bullying and harassment

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

The department and SCV will continue to work with health services in 2025–26 to implement initiatives to better prevent and respond to risks of occupational violence and aggression, and bullying and harassment.

For more information about these initiatives, visit [Worker health and wellbeing in Victorian health services](https://www.health.vic.gov.au/health-workforce/worker-health-and-wellbeing-in-victorian-health-services) <https://www.health.vic.gov.au/health-workforce/worker-health-and-wellbeing-in-victorian-health-services>. Health services are expected to regularly refer to this information.

They are also expected to implement the guidance and resources, including the:

* [*Framework for preventing and managing occupational violence and aggression*](https://www.health.vic.gov.au/publications/framework-for-preventing-and-managing-occupational-violence-and-aggression-2017) <https://www.health.vic.gov.au/publications/framework-for-preventing-and-managing-occupational-violence-and-aggression-2017>
* [*Framework for promoting a positive workplace culture: preventing bullying, harassment and discrimination in health services*](https://www.health.vic.gov.au/publications/framework-for-promoting-a-positive-workplace-culture-preventing-bullying-harassment) <https://www.health.vic.gov.au/publications/framework-for-promoting-a-positive-workplace-culture-preventing-bullying-harassment>, as well as minimum standards for training and security.

The department requires that all Victorian public health services undertake the Victorian Public Sector Commission’s People Matter Survey in 2025, including the ‘Negative behaviour’ section.

Health services must publicly report all incidents of occupational violence and aggression in their annual report. The department and SCV will continue to work with health services and boards in 2025–26 to improve reporting and support risk management.

### Medical treatment planning and decisions, and advance care planning

The *Medical Treatment Planning and Decisions Act 2016* ensures people are provided with medical treatment that is consistent with their preferences and values. It clarifies the legal effect of an advance care directive, and provides a single process for identifying who should make decisions on behalf of a person and a process for making these decisions.

If a registered health practitioner fails to act in accordance with relevant provisions of this Act, it will constitute unprofessional conduct.

Health services are required to have processes in place that:

* include systematic implementation of advance care planning and identification of medical treatment decision-makers
* include advance care planning as a parameter in assessment of outcomes, such as mortality and morbidity review reports, patient experience and other routine data collection
* enable and promote the use of My Health Record to support communication of advance care plans.

Advance care planning should be embedded into the usual care that health services provide, resulting in an increase in the number of both admitted and non-admitted consumers with an advance care directive or plan alert, and an identified medical treatment decision maker. This will be measured through mandatory VAED, VEMD and VINAH MDS items.

For more information, visit [Advance care planning](https://www.health.vic.gov.au/patient-care/advance-care-planning-1) <https://www.health.vic.gov.au/patient-care/advance -care-planning-1>.

## Integrated cancer services

All health services that treat cancer patients are expected to be active members of the Integrated Cancer Service (ICS) for their area, and to support the implementation of the network’s purpose to promote the development of a cohesive, integrated and multidisciplinary approach to the provision of cancer care.

ICSs will help achieve the goals stated in the Victorian cancer plan 2024–2028, which are to:

* achieve equitable outcomes for all Victorians
* halve the proportion of Victorians diagnosed with potentially preventable cancers
* ensure Victorians have the best possible experience of the cancer treatment and care system
* increase one- and five-year survival of Victorians with cancer.

A continuing focus for the ICSs in 2025–26 is to work in collaboration with relevant cancer services to progress and streamline service improvement priorities within and across the ICS regions. The ICSs are expected to participate in statewide initiatives to support improvement in cancer outcomes and progress priorities under the Victorian cancer plan 2024–2028.

This includes working with the department to ensure successful implementation of the National Lung Cancer Screening Program and having a greater focus on improving access and timeliness of cancer care, in accordance with the nationally endorsed [Optimal Care Pathways](https://www.cancervic.org.au/get-support/for-health-professionals/optimal-care-pathways) <https://www.cancervic.org.au/get-support/for-health-professionals/optimal-care-pathways>.

Host organisations are required to hold funds on behalf of the ICS and act as employers for ICS program staff. Host organisations need to ensure appropriate human resource management (including annual performance appraisals), fiscal management processes and accounting procedures are in place. A senior executive should be nominated as the key management contact regarding these matters.

The ICS governance committees, with clinician and consumer input, are responsible for:

* decision-making about using funds in accordance with both local and statewide priorities for cancer reform
* accountability for ICS funding
* ensuring value for money
* ensuring sound project management and evaluation processes are employed.

Host organisations and the ICS governance committees must agree to any charges levied by the host for infrastructure support. These charges must be reflective of actual costs incurred and should be reported in the ICS budget.

The accountability requirements of the ICS governance committees are to:

* report progress against the current Victorian ICS Implementation Plan and their local workplan
* provide half-yearly financial statements (for periods ending 31 December and 30 June)
* participate in the department’s cancer reform meetings and workshops
* provide an annual report for public dissemination
* submit a log of clinical indicator outliers quarterly identified via the Statewide Cancer Indicator Platform application
* participate in processes to evaluate the impact of cancer reform activities, including reporting outcomes against targets and milestones.

The department reserves the right to conduct an ICS program office performance and financial audit.

For more information, visit [Integrated Cancer Services](https://www.health.vic.gov.au/health-strategies/integrated-cancer-services) <https://www.health.vic.gov.au/health-strategies/integrated-cancer-services>.

## Perinatal services performance indicators

SCV publishes an annual report of Victorian perinatal services performance indicators. The report contains individual hospital (or campus) level data, allowing comparison with the statewide average. The report aims to improve outcomes for Victorian women and babies, by reporting on benchmarking data. SCV works directly with health services to understand their results to improve outcomes.

Health services use this report to:

* track their own performance and trends, using raw local health service data, as required
* compare results with services of a similar profile (size and capability)
* undertake ongoing local audits, including adverse event reviews, through their perinatal mortality and morbidity committees
* perform local analysis of specific groups or cohorts of cases, such as age profiles
* identify priority areas for focus and plan for performance improvement within a continuous framework
* evaluate improvement programs and provide feedback to relevant stakeholders
* disseminate results internally to build engagement with the maternity team
* provide education and support to staff and local communities
* collaborate with neighbouring health services and community-based healthcare providers to improve local practice, referral systems and performance.

Selected indicators have recommended strategies for improvement, which should be undertaken by health services that are looking to improve or have suboptimal outcomes.

These indicators include:

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

SCV will work with health services to identify future improvement priorities for 2025–26.

For more information, visit [Victorian perinatal services performance indicators 2020–21](https://www.safercare.vic.gov.au/publications/victorian-perinatal-services-performance-indicators-2020-21) <https://www.safercare.vic.gov.au/publications/victorian-perinatal-services-performance-indicators-2020-21>.

## Blood Matters Program

The Blood Matters Program assists health services to monitor patient blood management and transfusion practices, in line with guidelines and standards, to provide recommendations and support for best practice.

Health service performance reporting is required through participation in audits and surveys on practice and governance.

Participation in the Blood Matters Program’s Serious Transfusion Incident Reporting program is expected, as it supports national healthcare standards. Reporting of serious adverse events related to blood or blood components is required, including clinical reactions and procedural events.

These include:

* near-miss incidents
* events related to RhD immunoglobulin
* cell salvage.

Health services are expected to align blood management and transfusion practices with national guidelines, standards and strategies, including the:

* [National Stewardship Program](https://www.blood.gov.au/supply-system/managing-blood-supply/national-stewardship-program#:~:text=all%20blood%20products%20are%20used,the%20wastage%20of%20blood%20products) <https://www.blood.gov.au/supply-system/managing-blood-supply/national-stewardship-program#:~:text=all%20blood%20products%20are%20used,the%20wastage%20of%20blood%20products>
* [Patient blood management](https://www.blood.gov.au/clinical-guidance/patient-blood-management) <https://www.blood.gov.au/clinical-guidance/patient-blood-management>
* [NSQHS Standards](https://www.safetyandquality.gov.au/standards/nsqhs-standards)<https://www.safetyandquality.gov.au/standards/nsqhs-standards>
* [National Blood Management Improvement Strategy 2018–2024](https://www.blood.gov.au/national-blood-management-improvement-strategy-2018-2024) <https://www.blood.gov.au/national-blood-management-improvement-strategy-2018-2024>.

The department established the transfusion nurse/trainer/safety officer and patient blood management role across Victoria. It continues to financially support these positions. Health services are expected to have roles in place to ensure compliance with national guidelines and the NSQHS Standards. Services are funded to achieve this through acute admitted funding.

Health services are expected to support compliance with the national guidelines and the NSQHS Standards through activities that include:

* employing an appropriately trained nurse or scientist who, where able, holds a Specialist Certificate in Blood Management Foundations and/or Graduate Certificate of Transfusion Practice
* ensuring the role operates within an effective health service blood management and quality governance structure
* incorporating patient blood management practices – that is, a patient-centred approach to safe and appropriate transfusion practice, in line with national clinical guidelines, standards and strategies (NSQHS blood management standard 7)
* participating in Blood Matters Program audits, educational forums and other activities.

For more information, visit [About the Blood Matters Program](https://www.health.vic.gov.au/patient-care/about-the-blood-matters-program) <https://www.health.vic.gov.au/patient-care/about-the-blood-matters-program>.

## Pathology reform

In December 2024, the Victorian Government agreed to a revised model of consolidating public pathology services, with all existing public pathology services consolidated into business units within two major Victorian public health services.

The network's goals will ensure Victoria’s public pathology system can continue delivering high-quality pathology services and facilitate sharing pathology results, while also meeting the increasing demand for pathology services.

The goals of pathology reform are to deliver high-quality, sustainable and effective public pathology services for Victoria through a connected and scalable system that provides person-centred services from an engaged workforce, and ensures all Victorians can achieve good health by accessing the right service at the right time and in the right place.

Time-limited funding has been made available to the two lead health services of each network to support establishment costs before becoming operational.

As the implementation and operational guideline arrangements are being finalised, networks are working with health service staff to consider optimal operating arrangements and identify opportunities for closer collaboration across the laboratories that are coming together.

Work is continuing on implementation of the new integrated laboratory information systems, one for each network, that will facilitate the sharing of pathology information between laboratories and offer advanced decision-making support to clinicians.

Timelines for implementing and operating the networks are being agreed on between networks and the department, alongside the implementation of laboratory information systems, recognising the significant work required to disaggregate existing pathology services from within individual hospitals and collaborating on implementing a shared pathology service.

## Safer Care for Kids

In 2021–22, SCV saw an increase in sentinel events related to patient deterioration, particularly in children and young people. In response, SCV proactively brought together more than 100 healthcare leaders, clinicians, patients and families to explore challenges encountered and improvements to accessing paediatric emergency healthcare in Victoria.

The See Me, Hear Me Improving the Safety of Care for Victorian children: White paper series No 1 was the key output of this consultation, published in November 2023. The white paper included three priority recommendations to improve safety for children in Victorian healthcare services.

These recommendations are to:

* deliver a statewide family and carer escalation of patient deterioration process
* implement a 24/7 system of virtual paediatric emergency consultation
* mandate the use of the Victorian Children’s Tool for Observation and Response (ViCTOR) chart, wherever children and young people have vital signs recorded.

The recommendations were endorsed by the Minister for Health, and the Safer Care for Kids project was launched to co-design and implement the recommendations in close partnership with affected families, the health sector and the department.

For more information, visit [See Me, Hear Me Improving the Safety of Care for Victorian children](https://www.safercare.vic.gov.au/publications/see-me-hear-me-improving-the-safety-of-care-for-victorian-children) <https://www.safercare.vic.gov.au/publications/see-me-hear-me-improving-the-safety-of-care-for-victorian-children>.

### Mandated use of the ViCTOR chart wherever children and young people have vital signs recorded

Victorian health services providing paediatric healthcare are required to use the updated ViCTOR chart that now includes a family and carer concern question to be asked when vital signs are recorded, by June 2026. This is in alignment with the mandate in the SOP 2023–24.

Reporting requirements for ViCTOR usage will be incorporated into the [*Performance Monitoring Framework*](https://www.health.vic.gov.au/funding-performance-accountability/performance-monitoring-framework)<https://www.health.vic.gov.au/funding-performance-accountability/performance-monitoring-framework>, ensuring comprehensive safety and quality oversight at a system level. Led by SCV, this initiative demonstrates an ongoing commitment to enhancing care and improving outcomes for children and families. SCV will continue to collaborate with health services and partners to support the statewide implementation of ViCTOR charts.

### Implement a 24/7 system of virtual paediatric emergency consultation

SCV and the department will progress plans in tandem with ongoing system reforms to ensure this recommendation is met. This includes progressing opportunities to:

* enhance awareness of the paediatric consultation services currently available at [VVED](https://www.vved.org.au/) <https://www.vved.org.au/> and [Paediatric Infant Perinatal Emergency Retrieval](https://www.health.vic.gov.au/patient-care/emergency-referral-and-retrieval-for-pregnant-women-newborns-and-children) <https://www.health.vic.gov.au/patient-care/emergency-referral-and-retrieval-for-pregnant-women-newborns-and-children>
* promote escalation pathways, including:
  + UCCs continuing to access VVED for virtual consultation for less unwell to moderately unwell children, with clear escalation pathways to Paediatric Infant Perinatal Emergency Retrieval
  + that care of critically unwell children is escalated via Paediatric Infant Perinatal Emergency Retrieval.

### Deliver a statewide family and carer escalation of patient deterioration process

The Urgent Concern Helpline aims to reduce preventable harms and deaths of children and young people, by ensuring the concerns of consumers, families and carers are heard and acted on. It provides an escalation system for children who are experiencing a deterioration in health in circumstances where the patient, their family and/or carers feel their concerns are not being heard by treating clinicians.

The Urgent Concern Helpline provides an additional point of advocacy and support to children, families and carers; it does not replace existing local escalation processes. The Urgent Concern Helpline is being piloted at select health services in 2025–26. Insights from this pilot will inform further expansion across the system.

The Urgent Concern Helpline is delivered by the VVED.

For more information, visit [Safer Care for Kids](https://www.safercare.vic.gov.au/safer-care-for-kids) <https://www.safercare.vic.gov.au/safer-care-for-kids>, or [email](mailto:culture.capability@safercare.vic.gov.au) <[culture.capability@safercare.vic.gov.au](mailto:culture.capability@safercare.vic.gov.au)>.

## VVED

The VVED is delivered by Northern Health in collaboration with other health services. It allows any person in Victoria to receive virtual video assessments, 24/7, from emergency doctors and nurses.

The VVED improves access to emergency care across Victoria and plays a critical role in reducing unnecessary ED presentations at Victorian hospitals. The VVED provides virtual emergency care services through four core pathways of:

* **self-referral** – any person in Victoria can self-refer for non-life-threatening emergencies via the online web portal and receive a virtual consultation with an emergency trained nurse or doctor
* **Ambulance Victoria** – paramedics and other Ambulance Victoria staff can access clinical assessment, medical advice, treatment and, when required, local referrals to appropriate services for patients when infield or via Secondary Triage Services.
* **residential aged care facilities** – the VVED provides assessments, treatment and develops management plans for ongoing treatment while patients remain at their residence.
* **healthcare professionals** – theVVED also supports a range of other health professional pathways including NURSE-ON-CALL, UCCs, NEPT and Remote Area Nurse services.

The service is funded to provide emergency virtual care to 1,000 patients every day in 2025–26.

For more information, visit [VVED](https://www.vved.org.au) <https://www.vved.org.au>.

## Local Health Service Networks

Twelve Local Health Service Networks will be established on 1 July 2025. At this time, Health Service Partnerships will cease, and health services are expected to work collaboratively in their Local Health Service Network.

Local Health Service Networks group health services within a geographical region and are responsible for planning and managing care across their region, tackling issues that are challenging for health services to address in isolation.

Overarching guidelines for Local Health Service Networks are set out in the new *Local Health Service Network Policy Framework*. Detailed requirements for each Local Health Service Network are outlined in their Statement of Expectations.

All health services are expected to implement the *Local Health Service Network Policy Framework*, including to:

* sign their Local Health Service Network Statement of Expectations and meet all objectives outlined therein
* establish a Local Health Service Network underpinning agreement outlining collaboration arrangements to support the partnership
* collaboratively develop and agree to their Local Health Service Network three-year strategy and annual plan
* work collectively to determine how funding is allocated across Local Health Service Network projects
* demonstrate achievement of milestones and joint targets in their Local Health Service Network’s annual report
* actively partner with other Local Health Service Network members to drive a collaborative approach in meeting the community’s health needs.

As part of their Local Health Service Network, health services are initially expected to deliver initiatives across four priority areas of:

* access, equity and flow
* workforce
* safety and quality
* shared services.

As Local Health Service Networks mature, they will be expected to focus on additional priority areas, including population health, research and innovation, and integrating care across the continuum.

For more information, visit [Local Health Service Networks](https://www.health.vic.gov.au/health-services-plan-reform/local-health-service-networks) <https://www.health.vic.gov.au/health-services-plan-reform/local-health-service-networks>.

## Better at Home

Better at Home increases the delivery of health care within consumers’ homes, where clinically appropriate and preferred by the consumer.

The *2022–23 State Budget* provided $698 million over four years to deliver more health care within consumers’ homes, through the use of home-based and virtual care. This was in addition to the $120.9 million over three years that was announced in the *2020–21 State Budget*.

The funding supports the delivery of more acute admitted, subacute admitted and non-admitted home-based care. This delivers better consumer outcomes and experience, improves access to care and supports health system sustainability.

For more information, visit [Better at Home initiative](https://www.health.vic.gov.au/patient-care/better-at-home-initiative) <https://www.health.vic.gov.au/patient-care/better-at-home-initiative>.

## Standards for Safe and Timely Ambulance and Emergency Care for Victorians

The Standards for Safe and Timely Ambulance and Emergency Care for Victorians will support practices across Ambulance Victoria and public hospitals so that patients arriving via ambulance receive timely care and paramedics are available to respond to people in the community.

There are 10 Standards, covering both shared and respective responsibilities for hospitals and Ambulance Victoria. The Standards are structured around the patient care journey and outline expectations related to:

* before paramedics transport patients and arrive at hospital
* the transfer of patient care from a paramedic to hospital staff
* the patient experience through an ED and an inpatient ward.

The Standards also focus on organisational leadership and operational processes.

The department developed the Standards through extensive consultation, including with clinicians, operational staff and health sector leaders across health services and Ambulance Victoria.

The Standards set out best practice for all public hospitals with an ED and Ambulance Victoria.

The department’s focus on implementation of the Standards initially will be on major metropolitan and regional public hospital's[[13]](#footnote-14) EDs and Ambulance Victoria

For more information, visit [Standards for Safe and Timely Ambulance and Emergency Care for Victorians](https://www.health.vic.gov.au/patient-care/standards-for-safe-and-timely-ambulance-and-emergency-care-for-victorians) <https://www.health.vic.gov.au/patient-care/standards-for-safe-and-timely-ambulance-and-emergency-care-for-victorians>.

## Timely Emergency Care (TEC) 2 Program

The TEC2 Program is a three-year initiative aimed at enhancing hospital-wide patient flow and reducing delays in emergency care across Victoria. Building on the success of the initial TEC Collaborative, the TEC2 Program continues to support health services through targeted improvement funding, expert guidance, and collaborative learning opportunities.

Key objectives of the TEC2 Program include:

* optimising hospital-wide patient flow – testing high-impact change ideas to streamline hospital operations and reduce patient (ED and inpatient) length of stay
* improving access to TEC – fostering a culture of continuous improvement to provide timely, efficient and high-quality emergency care for all Victorians
* collaborative improvement – bringing together health service teams to share best practices and innovations, supported by local and international experts in patient flow and improvement science.

The TEC2 Program is delivered in partnership with the Institute for Healthcare Improvement and involves 28 Victorian health service sites and Ambulance Victoria.

For more information, contact the department by emailing [TEC2](mailto:tec2@health.vic.gov.au) <tec2@health.vic.gov.au>.

## Mental health and wellbeing services

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

One of the RCVMHS’s guiding principles was for people with lived and living experience of mental health challenges, substance use and addiction (consumers, families, carers, supporters and communities) to be central to planning and delivery of mental health services.

The RCVMHS envisaged lived and living experience to be central to the decision-making processes, including:

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

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

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

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

The department will work with services to support plans to embed lived experience leadership and workforce throughout 2025–26. ‘

### Key policies and guidelines

The Chief Psychiatrist guidelines provide specialist advice on operational and clinical practice in relation to the Mental Health and Wellbeing Act. For more information, visit [Chief Psychiatrist guidelines](https://www.health.vic.gov.au/key-staff/chief-psychiatrist-guidelines) <https://www.health.vic.gov.au/key-staff/chief-psychiatrist-guidelines>.

On 1 September 2023, new compliance requirements took effect in specific areas of clinical practice overseen by the Chief Psychiatrist. These changes respond to the expanded jurisdiction of the Chief Psychiatrist under the Mental Health and Wellbeing Act*.* They relate to the oversight of chemical restraint and mental health and wellbeing services in custodial settings. On 1 April 2024, new compliance requirements also took effect in the emergency departments and urgent care centres of designated mental health services. These requirements relate to the oversight of restrictive interventions in those settings. Information about these changes can be found on the [Office of the Chief Psychiatrist website](https://www.health.vic.gov.au/chief-psychiatrist/office-of-the-chief-psychiatrist-reform-activities-and-news) <https://www.health.vic.gov.au/chief-psychiatrist/office-of-the-chief-psychiatrist-reform-activities-and-news>.

Program management circulars articulate or clarify departmental policy on key aspects of service provision. These are available from the [Office of Chief Psychiatrist](https://www.health.vic.gov.au/practice-and-service-quality/chief-psychiatrist) <https://www.health.vic.gov.au/practice-and-service-quality/chief-psychiatrist>.

All funded clinical mental health services must be accredited against the NSQHS Standards (2nd edition) in 2025–26.

As a condition of funding, organisations must adhere to all relevant regulations, safety and quality standards, and Chief Psychiatrist guidelines relating to the funded activity. All funded clinical mental health services must comply with the department’s program guidelines, which are available from the Mental Health and Wellbeing Division.

Organisations can obtain copies of the relevant standards and guidelines from their department program and service advisor or, in some instances, through the department’s [Funded Agency Channel[[14]](#footnote-15)](https://fac.dffh.vic.gov.au) <https://fac.dffh.vic.gov.au>.

For more information on mental health services, programs and program guidelines, visit [Mental health](https://www.health.vic.gov.au/mental-health) <https://www.health.vic.gov.au/mental-health>.

### The Mental Health Performance and Accountability Framework (MHPAF)

The MHPAF specifies the department’s current performance and accountability requirements for funded clinical mental health services. It outlines how the department will measure, monitor and assess performance at the agency, service and program levels. This framework provides a key mechanism for monitoring whether a mental health service is delivering services that are consistent with the department’s requirements.

The RCVMHS recognised that achieving good outcomes for individuals, including people with lived experience of mental illness or psychological distress, families, carers and supporters, for the workforce and the wider community, is fundamentally important and foundational to the system’s reform agenda.

The RCVMHS recommended a new *Mental health and wellbeing outcomes framework* be developed that adopts a broad view of mental health and wellbeing outcomes, which is used to drive system reform and improvement. The RCVMHS also called for a new *Performance monitoring and accountability framework*. The department has integrated these two recommendations into the *Mental health and wellbeing outcomes and performance framework*.

Within an outcomes approach, outcomes and performance are inextricably linked. Outcomes measure the achievement of intended goals, or the actual change or difference resulting from an intervention. Performance metrics tell us what actions have been taken to achieve outcomes.

This new framework is a key instrument to help embed an outcomes approach in system reform, improvement and accountability. It will support evolution of the mental health and wellbeing system using a whole-of-system approach, enabling service providers, regions, communities and all levels of government to collaborate and drive positive change.

Now published, the first year of implementation (through to June 2026) will run in parallel to the current MHPAF, enabling services to continue reporting and using data to inform practice improvements, while the initial implementation of the framework takes place. After this initial year, the new Framework and related measures will be in force and will replace the MHPAF.

For more information, implementation updates and links, visit[*Mental Health and Wellbeing Outcomes and Performance Framework*](https://www.health.vic.gov.au/mental-health-wellbeing-reform/a-new-mental-health-and-wellbeing-outcomes-and-performance-framework) <https://www.health.vic.gov.au/mental-health-wellbeing-reform/a-new-mental-health-and-wellbeing-outcomes-and-performance-framework>.

### AOD services 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 [Funded Agency Channel](https://d.docs.live.net/031c443d5a1cf449/Documents/Business/Government/DoH-C%5e0SI/Funded%20Agency%20Channel) <https://fac.dffh.vic.gov.au>.

Organisations must deliver services in line with the:

* [AOD program guidelines](https://www.health.vic.gov.au/aod-service-standards-guidelines/alcohol-and-other-drug-program-guidelines)<https://www.health.vic.gov.au/aod-service-standards-guidelines/alcohol-and-other-drug-program-guidelines>
* [AOD client charter and resources](https://www.health.vic.gov.au/aod-service-standards-guidelines/alcohol-and-other-drug-client-charter-and-resources) <https://www.health.vic.gov.au/aod-service-standards-guidelines/alcohol-and-other-drug-client-charter-and-resources>
* [AOD treatment principles](https://www.health.vic.gov.au/aod-service-standards-guidelines/alcohol-and-other-drug-treatment-principles) <https://www.health.vic.gov.au/aod-service-standards-guidelines/alcohol-and-other-drug-treatment-principles>.

For more information and copies of the guidelines, charter and principles, visit [AODs](https://d.docs.live.net/031c443d5a1cf449/Documents/Business/Government/DoH-C%5e0SI/AODs) <https://www.health.vic.gov.au/alcohol-other-drugs>.

## Ageing, aged and home care services

Service standards and guidelines that apply to funded aged and community care services are listed in [section 31](#_Service_standards_and). 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 in [section 30.1.2](#_Performance_tables).

### Public sector residential aged care – infection prevention and control

The department provides funding to PSRACS to assist with operational expenses. PSRACS are funded to provide a specified number of available bed days and to meet set targets for resident occupancy.

Health services must report on the aged care infection control module to the Victorian Healthcare Associated Infection Surveillance System (VICNISS) Coordinating Centre to monitor infection prevention and control practices, and antimicrobial use in PSRACS.

PSRACS must have appointed infection prevention and control lead nurses, as required by the Australian Government.

### Rights and interests for aged care residents

Health services operating PSRACS must meet Commonwealth legislative requirements relating to protecting consumers’ rights and interests.

This includes meeting obligations for:

* minimising restrictive practices
* the Statement of Rights
* consumers’ accommodation agreements
* prudential standards
* aged care quality and safety standards
* police checks for key personnel, staff and volunteers
* mandatory reporting of incidents, as per the Serious Incident Response Scheme.

## Proactive management of primary, community and dental health

### Community health

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 service standards and guidelines that apply to the community health program are listed in [section 31](#_Service_standards_and). The performance targets and monitoring requirements for community health are outlined in [section 30.1.2](#_Performance_tables).

### Identifying and managing vulnerable children

*Healthcare that counts: a framework for improving care for vulnerable children in Victorian health services* articulates the role of all Victorian health services in the early identification and effective response to vulnerable children.

This framework is a quality improvement and best-practice guide that should be implemented in all hospitals, health services and community service organisations delivering health programs in Victoria. It includes five action areas to guide system improvement, as well as indicators of best practice. This will enable health services to annually benchmark and self-assess their implementation progress, using the accompanying self-assessment tool.

For more information, visit [Healthcare that counts](https://d.docs.live.net/031c443d5a1cf449/Documents/Business/Government/DoH-C%5e0SI/Healthcare%20that%20counts)<https://www.health.vic.gov.au/publications/healthcare-that-counts>.

The framework aligns with the Victorian Child Safe Standards and is supported by free online training at the [Children at Risk Learning Portal](https://vulnerablechildren.kineoportal.com.au) <https://vulnerablechildren.kineoportal.com.au> and the [Vulnerable Children website](https://www.health.vic.gov.au/populations/vulnerable-children) <https://www.health.vic.gov.au/populations/vulnerable-children>, where copies of the framework and other resources are available.

### Victorian Forensic Paediatric Medical Service

The Royal Children’s Hospital is the statewide governing body for the Victorian Forensic Paediatric Medical Service. Paediatric forensic services are provided by The Royal Children’s Hospital, Monash Medical Centre and all regional health services. A key function of the service is to provide a forensic assessment of injury and neglect to children from birth to 18 years, where there is suspected child abuse and neglect.

The Royal Children’s Hospital is responsible for providing leadership, professional development and clinical guidance for the statewide service.

All regional health services are expected to provide appropriate 24/7 clinical forensic services for these children, in line with the clinical guidance available at [Victorian Forensic Paediatric Medical Service](https://www.rch.org.au/vfpms/) <https://www.rch.org.au/vfpms>.

## LPHUs

### Service delivery obligations

#### Overview of LPHU program delivery

LPHUs are part of Victoria’s statewide public health network, funded to enhance public health in their catchment by effectively tailoring and delivering public health initiatives, and responding to incidents and issues within their local area. LPHUs engage and build partnerships with community and local stakeholders to implement statewide programs and to co-design locally based public health initiatives.

LPHUs are bound by system-specific agreements, protocols, documents and guidance that are available on the Public Health Unit Information Hub.

LPHUs are required to actively support and strengthen the networked approach to improving public health in Victoria by contributing to system-wide governance meetings, and leading or participating in quality assurance and continuous improvement initiatives.

LPHUs are required to embed Aboriginal cultural safety capability within their operations, including culturally safe recruitment, employment and retention practices for Aboriginal staffing, and engage with ACCOs to prioritise self-determining approaches that meet the public health needs of Aboriginal communities in their catchment.

#### Health protection

LPHUs are responsible for case and outbreak investigation and management of all notifiable conditions (except tuberculosis, blood lead and anaphylaxis). The nine lead health services that operate an LPHU must abide by condition-specific protocols, outbreak-specific guidelines, system-specific agreements and quick-entry guide documents.

Communicable disease protocols and associated operational documents guide Victoria’s public health response to notifiable disease incidents, outbreaks and events. The protocols outline the expected public health actions to which LPHUs must adhere to ensure delivery of the minimum standards for infectious disease and outbreak notification, surveillance, follow-up and case/contact management.

LPHU directors must follow any directions from the Chief Health Officer and their deputies regarding prioritising public health risk and delivering statewide public health priorities. This includes responding to public health emergencies of statewide significance.

As a collective program, the LPHU network provides responses to notifiable diseases and human biosecurity risks 24/7.

LPHUs are responsible for supporting environmental and public health emergencies by providing local intelligence and enhancing communication through tailored, community-specific messaging.

#### Health advancement

LPHUs prepare and implement regional population health catchment plans in line with the priorities of the *Victorian public health and wellbeing plan 2023–2027*, taking into consideration local municipal public health and wellbeing plans and the *LPHU* *population health catchment planning framework*.

LPHUs foster a partnership-based approach to the delivery of prevention and health promotion activities tailored to the specific needs, priorities, challenges and resources of their respective catchment. This includes engagement with the community and key stakeholders to understand local health and wellbeing needs, and collaboration with partners, including local councils, ACCOs, community health and NGOs to align priorities and activities, and enhance the effectiveness of health promotion efforts.

#### Authorised Officers

Each LPHU must ensure it has Authorised Officers to exercise powers under the Public Health and Wellbeing Act.

Health service staff appointed as Authorised Officers under s.30 of the Act must comply with the provisions of the *Authorised* *officer governance and accountability framewor*k. They must meet individual mandatory training, qualification and competency requirements, and maintain an understanding of legal and regulatory provisions that relate to their statutory role.

Under s.30(6) of the Act, the Secretary (or delegate) may give a direction to an Authorised Officer appointed by the Secretary (or delegate) in relation to the performance of the Authorised Officer's functions or duties or the exercise of the Authorised Officer's powers.

Authorised Officers must comply with obligations set out under the Public Health and Wellbeing Act when exercising powers.

#### Aboriginal health and cultural safety

Aboriginal health improvement and cultural safety capability and capacity building should be embedded within LPHU operations, in line with Aboriginal engagement principles, and statewide and local Aboriginal self-determined needs and priorities.

LPHUs should build their cultural capabilities through a continuous improvement reflective approach, as outlined in the [*Aboriginal and Torres Strait Islander cultural safety framework*](https://www.health.vic.gov.au/publications/aboriginal-and-torres-strait-islander-cultural-safety-framework-part-1) <https://www.health.vic.gov.au/publications/aboriginal-and-torres-strait-islander-cultural-safety-framework-part-1>.

Genuine engagement and partnerships with local Aboriginal communities and ACCOs are required to deliver equitable and effective public health services that meet the needs and priorities of local Aboriginal communities. Refer to the Guidelines for engagement between LPHUs and the Aboriginal Community-Controlled Health Sectorlocated *o*n the Public Health Unit Information Hub.

LPHU operations related to Aboriginal health should be built on local Aboriginal partnerships, the priorities of local ACCOs and their strategic plans, the principles and domains of the AHWPF, the Aboriginal Health and Wellbeing Partnership Agreement 2023–2033, and the self-determined priorities and actions in the Victorian Aboriginal Health and Wellbeing Partnership Agreement action plan 2023–25. These activities will support LPHUs to establish mechanisms towards Aboriginal self-determination in public health operations.

For more information, visit [AHWPF Agreement and Action Plan](https://d.docs.live.net/031c443d5a1cf449/Documents/Business/Government/DoH-C%5e0SI/AHWPF%20Agreement%20and%20Action%20Plan) <https://www.vaccho.org.au/ahwpf/>.

LPHUs should adopt reporting mechanisms available through the AHWPF Action Plan and local ACCO strategic plans to effectively monitor and evaluate LPHU progress towards outcomes that meet the public health needs of Aboriginal communities in their catchment.

Health services that operate an LPHU must consider the cultural safety of their operations, both internally and externally, as outlined in the [Aboriginal cultural safety fixed grant guidelines](https://www.health.vic.gov.au/publications/aboriginal-cultural-safety-fixed-grant-guidelines-cultural-safety-planning-and) <https://www.health.vic.gov.au/publications/aboriginal-cultural-safety-fixed-grant-guidelines-cultural-safety-planning-and> and how this can appropriately support the cultural safety of LPHU operations. LPHUs can access the guidance notes (page 18) of the guidelines to inform their cultural safety capabilities.

#### *Statewide public health network outcomes framework*

The Statewide public health network outcomes framework outlines the department’s expectations related to public health activities performed by LPHU and departmental collaborators. The framework supplements the content in this guide. Reporting against this framework provides a transparent approach to monitoring and assessing the effectiveness of statewide strategies and public health interventions. This is part of program funding requirements and the collective efforts to improve public health outcomes for Victorians.

The department continues to revise and strengthen the Statewide public health network outcomes *framework.* Ongoing consultation with LPHUs iteratively identifies the most relevant indicators and measures for the current funding period, and reflects the network’s outcomes-based approach to public health activities. This framework will support further evolution of the public health network and will be reviewed with other public health frameworks and plans to ensure a coherent, whole-of-system approach.

### LPHU reporting requirements

LPHUs are required to complete quarterly reporting as per the Statewide public health network outcomes *framework* and this is to be emailed to the [public health secretariat](mailto:publichealth.secretariat@health.vic.gov.au) <publichealth.secretariat@health.vic.gov.au> on the fourteenth day following each quarter.

LPHUs provide quarterly financial acquittal through the Health Agencies Reporting Tool (HeART) (cost centre code M1549 for health protection funding (Core Operations) and via M1546 for Health Advancement funding), also due on the fourteenth day following each quarter.

In addition to providing the department with a written quarterly report, the LPHU director/s must attend quarterly performance meetings with relevant departmental stakeholders.

#### HeART

Complete and accurate financial data on public health activity is required to be submitted via HeART (see [section 29.1.1](#_Financial_data)) using codes specified for funded activities. For funding related to LPHUs, data submitted through HeART is used as a basis for performance monitoring and for whole-of-government reporting.

Table 5. LPHU cost centres

|  |  |  |
| --- | --- | --- |
| HeART cost centre code | Name of cost centre | Comments |
| M1549 | LPHU core operations | Core fixed-term (from July 2025 to June 2026) funding for LPHUs to deliver operational obligations, including health protection. (Grant provided via MAPS ID 1437) |
| M1546 | LPHU prevention | Ongoing LPHU prevention (i.e. health advancement) funding. (Grant provided via MAPS ID 1349) |
| M1588-98 | LPHU additional grants | This cost centre range is to be used for reporting on ad hoc grants. A single cost centre within the range will be assigned and communicated in grant funding letters |

## Capital Projects

### Relationship Agreement

For health Capital Projects, a health service must enter into and comply with a Relationship Agreement with the department. Relevant Capital Projects are determined by the department with reference to Budget Paper 4: State Capital Program.

The Relationship Agreement outlines the respective obligations of the department and a health service across the lifecycle of Capital Projects, with the aim of supporting effective governance, accountability and service delivery outcomes.

It reaffirms a commitment of the department and a health service to work collaboratively, constructively and in good faith, to ensure that major health infrastructure investment delivers the greatest possible benefit by balancing clinical priorities, asset needs, community expectations and government policy within the realities of project constraints.

The Relationship Agreement applies to Capital Projects from project inception to commissioning, and sets out details including:

* principles of collaboration, expected behaviour of parties, and roles and responsibilities
* funding and financial arrangements
* project governance and oversight
* stakeholder engagement and communications
* risk management and system assurance processes
* confidentiality and information sharing requirements.

The Relationship Agreement does not apply to grant programs.

The Relationship Agreement may be updated and agreed by the department and a health service as required.

# Accreditation

Funded organisations have obligations related to clinical service provision. These requirements ensure the quality of services and the safety of consumers.

## Australian Commission on Safety and Quality in Health Care (ACSQHC)

The ACSQHC is responsible for formulating and administering national accreditation schemes for healthcare services that relate to healthcare safety and quality matters.

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

All Victorian public health services must maintain their accreditation through the ACSQHC, where they are accredited against the NSQHS Standards.

This includes:

* public health services, including denominational services
* public hospitals
* multipurpose services
* clinical mental health services provided by public health services (including Forensicare)
* public dental housed within health or community health services
* bush nursing centres (accredited against the National Safety and Quality Primary and Community Healthcare Standards).

The department and SCV must be notified of noncompliance against either accreditation scheme within 24 hours of becoming aware, in line with the [Performance monitoring framework](https://www.health.vic.gov.au/funding-performance-accountability/performance-monitoring-framework) <https://www.health.vic.gov.au/funding-performance-accountability/performance-monitoring-framework>. Notification must occur via the health service’s relevant Director Performance, Hospitals and Health Services. Performance against accreditation will be reviewed as part of the department’s performance monitoring processes.

The regulatory response will be based on the outcome of the accreditation assessment and allow for escalation of monitoring and intervention, including possible action under the Health Services Act or the Mental Health Act.

For more information, visit [ACSQHC Standards](https://d.docs.live.net/031c443d5a1cf449/Documents/Business/Government/DoH-C%5e0SI/ACSQHC%20Standards) <https://www.safetyandquality.gov.au/standards>.

## Pathology services

The National Association of Testing Authorities (NATA) is the national accreditation body recognised by government for accrediting pathology laboratories.

Victoria has made an undertaking to NATA that any:

* laboratory operated by a health service whose principal function is to conduct pathology services, must obtain and maintain accreditation from NATA or the Royal College of Pathologists of Australasia for the pathology services it provides
* pathology service required for a public, private or compensable admitted patient of a health service, must only be requested from a laboratory that holds accreditation from NATA or the Royal College of Pathologists of Australasia for the type of service required
* pathology service required for a patient attending an outpatient clinic of a health service, must only be requested from a laboratory that holds accreditation from NATA or the Royal College of Pathologists of Australasia for the type of service required.

The conduct of any pathology service provided for a health service that is not under the direct management of a pathology laboratory accredited by NATA or the Royal College of Pathologists of Australasia (for example, services provided by research laboratories, specialist clinical laboratories or at the point of care), must be overseen by a pathology laboratory that is accredited by NATA or the Royal College of Pathologists of Australasia for the relevant scope of services.

All public health services are required to adhere to these undertakings as a condition of funding.

## Mental health and AOD clinical and community support services

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

Organisations that receive funding for Mental Health and Wellbeing Locals must be accredited against relevant standards, as per the service agreement, which could include the National Standards for Mental Health Services 2010.

Organisations that receive funding for MHCSS programs must be accredited against relevant standards, as per the service agreement. This includes the National Standards for Mental Health Services 2010.

Implementation of the new NSQHS Standards for community-managed organisations commenced in 2024. Health services providing AOD treatment services must be accredited against the NSQHS Standards.

Organisations that receive funding for AOD services must establish and implement plans to deliver services that are consistent with the *Victorian AOD charter*. The ongoing implementation of plans to deliver services consistent with the charter, and in alignment with the *National Quality Framework For Drug And Alcohol Treatment Services*, is also expected of organisations that will receive funding for AOD services in 2025–26.

These services must continue to be accredited within existing generic accreditation frameworks by an entity certified by either the International Society for Quality in Health Care, or the Joint Accreditation System of Australia and New Zealand.

## Aged care

### Public sector residential aged care service accreditation and quality approach

The Australian Government has the primary responsibility for funding and regulating residential aged care services under the Aged Care Act. In accordance with this legislation, all Victorian PSRACS are expected to comply with minimum aged care quality and safety standards at all times, in order to maintain their registration with the Commonwealth.

The monitoring, assessment and accreditation of residential aged care services against the aged care quality and safety standards, is undertaken by the Aged Care Quality and Safety Commission.

The department actively supports PSRACS to provide high-quality care to residents. The department encourages and supports PSRACS to excel in the delivery of evidence-based, best-practice, person-centred, safe, effective, appropriate, integrated and coordinated services, so that a good quality of life is experienced by every resident, every day.

### HACC PYP

In 2025–26, the department will be continuing service improvement of HACC PYP to support the program to meet the needs of clients and provide high-quality care.

### Other programs funded under the Ageing, Aged Care and Home Support Program outputs

Providers that receive less than $100,000 in funds to deliver Ageing, Aged Care and Home Support Program supports will not be independently assessed. Those organisations that receive the bulk of their funding from the health or primary health outputs, and that undergo accreditation in line with the requirements associated with the output, are not required to undergo further accreditation.

For governance and management standards, other providers can choose an accreditation body, which offers standards that are consistent with the governance and management requirements of the Social Services Standards accreditation.

For more information, visit [Social Services Standards](https://d.docs.live.net/031c443d5a1cf449/Documents/Business/Government/DoH-C%5e0SI/Social%20Services%20Standards) <https://providers.dffh.vic.gov.au/human-services-standards>.

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

# Clinical governance

## Health service clinical governance

All health services and funded organisations must ensure their clinical governance policies and frameworks comply with the current [*Delivering high-quality healthcare: Victorian clinical governance framework*](https://www.safercare.vic.gov.au/support-and-training/clinical-governance) <https://www.safercare.vic.gov.au/support-training/clinical-governance>.

### Partnering to deliver a safe health system

Delivering healthcare is inherently complex. High-quality care requires an ongoing commitment from the entire workforce to pursue and maintain excellence, and ensure patient safety.

SCV provides independent advice and support to health services. SCV can facilitate clinical expertise to assist health services to respond to serious quality and safety concerns. SCV promotes open and transparent communication, and respects the confidentiality and privacy of individuals. Where there are significant concerns about issues impacting patient safety that are not addressed at the local level, health service personnel should reach out for advice from SCV.

SCV has established processes to review, investigate, monitor and engage with health services. SCV is empowered to initiate formal review and response mechanisms where safety issues are identified, and make recommendations to prevent similar events from reoccurring.

### Adverse patient safety events, including sentinel events

During 2025–26, health service entities, as described in the *Health Legislation Amendment (Quality and Safety) Act 2022* and bush nursing centres are in scope of SCV’s [Policy and guideline for adverse patient safety events](https://www.safercare.vic.gov.au/publications/policy-adverse-patient-safety-events#goto-download) <https://www.safercare.vic.gov.au/publications/policy-adverse-patient-safety-events#goto-download>. As such, they will be expected to identify and review adverse patient safety events (including sentinel events) according to the policy, the Victorian sentinel event guide and associated resources.

Sentinel event notifications and review outcomes must be submitted through the secure Sentinel event portal <www.vhimscentral.vic.gov.au>. Health service staff must be onboarded to the portal prior to sentinel event notification and report submission.

For more information and resources to support the notification and review of sentinel events, visit [Notify and review a sentinel event](https://www.safercare.vic.gov.au/notify-us/sentinel-events/notify-and-review-a-sentinel-event) <www.safercare.vic.gov.au/notify-us/sentinel-events/notify-and-review-a-sentinel-event>.

Sentinel event review reports that do not meet the above expectations will be referred back to the health service. SCV will provide advice and support to assist the health service to meet these expectations, before resubmission of the final sentinel event review report.

For more information and to access guidance on review processes and other resources, visit [Sentinel events](https://d.docs.live.net/031c443d5a1cf449/Documents/Business/Government/DoH-C%5e0SI/Sentinel%20events) <https://www.safercare.vic.gov.au/notify-us/sentinel-events>, email SCV’s [Sentinel Events team](mailto:sentinel.events@safercare.vic.gov.au) <sentinel.events@safercare.vic.gov.au> or telephone 1300 543 916 during business hours.

### Statutory duty of candour

Relevant health services are to undertake statutory duty of candour (SDC) processes when a serious adverse patient safety event (SAPSE) occurs. Health service entities must refer to the Health Services (Quality and Safety) Regulations 2020 to view the SAPSE definition, which is also equivalent to incident severity rating (ISR) 1 and 2 events in the VHIMS MDS.

The scope of the SDC includes ‘health service entities' under the Health Services Act, as well as any services under their governance.

These include:

* public hospitals
* public health services
* multipurpose services
* denominational hospitals
* private hospitals
* day procedure centres
* ambulance services within the meaning of the Ambulance Services Act
* NEPT services within the meaning of the *Non-Emergency Patient Transport and First Aid Services Act 2003*
* Youth Mental Health and Wellbeing Victoria
* Forensicare.

When a patient suffers a SAPSE, these health service entities are required to comply with the SDC by providing an apology, a written account of the facts, a description of the health service entity’s response and the steps taken to prevent reoccurrence of the event. They also need to comply with the [Victorian Duty of Candour Guidelines](https://www.safercare.vic.gov.au/support-training/adverse-event-review-and-response/duty-of-candour) <https://www.safercare.vic.gov.au/support-training/adverse-event-review-and-response/duty-of-candour>.

The SDC AIMS form is available via the [HealthCollect portal](https://www.healthcollect.vic.gov.au) <https://www.healthcollect.vic.gov.au> (health service staff members reporting this data will need a login to the HealthCollect portal).

For more information about the AIMS data collections, including the AIMS manual, visit [AIMS](https://www.health.vic.gov.au/data-reporting/agency-information-management-system-aims) <https://www.health.vic.gov.au/data-reporting/agency-information-management-system-aims>.

For SDC reporting guidelines, training modules and additional resources, visit [Statutory Duty of Candour and protections for SAPSE reviews](https://www.safercare.vic.gov.au/support-training/adverse-event-review-and-response/duty-of-candour) <https://www.safercare.vic.gov.au/support-training/adverse-event-review-and-response/duty-of-candour>. Email the [SDC team](mailto:dutyofcandour@health.vic.gov.au) <dutyofcandour@health.vic.gov.au>.

### Monitoring high-quality and safe care

Monitoring healthcare quality and safety performance is critical to ensuring patient safety and for driving system improvements. The *Clinical Governance Framework* outlines health service responsibilities for collecting, reporting and reviewing performance data on clinical risks, care processes and outcomes. Analysis of data is used to identify areas of risk and opportunities for improvement, and track progress towards excellence across clinical services.

Quality and safety core performance measures are based on priority healthcare indicators, clinical governance, legislated and regulatory policy, and government priorities. Health service results are reported quarterly in the *Performance Monitoring Framework* SOP and the PRISM.

SCV reviews health service quality and safety measures as part of health service performance monitoring. Core measures are reviewed quarterly against targets and risk factors. Comparative data provide a benchmark for expected performance and support the identification of both strong performance and areas requiring improvement. Additional data sources are used to analyse complex clinical issues.

### Health services quality and safety data and reporting

The eHealth division of the department collects, analyses and reports performance and quality, and safety measures to health services, the department, SCV and other government agencies. From February 2024, the entity formerly known as the Victorian Agency for Health Information (VAHI) has been incorporated into the eHealth division; however, reporting products distributed outside the department continue to use the VAHI brand for continuity.

Information is provided to health services as part of a suite of routine performance reports, such as the Victorian health services performance monitor, the PRISM, [Mental health performance reports](https://www.health.vic.gov.au/research-and-reporting/mental-health-performance-reports) <https://www.health.vic.gov.au/research-and-reporting/mental-health-performance-reports>, and a series of specialist quality and safety reports to support performance and safety and quality monitoring, and promote service improvement.

Interactive reports and dashboards are made available to authorised users in the sector via the [VAHI portal](https://vahi.vic.gov.au/) <https://vahi.vic.gov.au/>. The dashboards provide enhanced capacity for health services to interrogate, explore and export the data, as well as being useful visualisations of indicators over time.

Key interactive dashboards include:

* Health Services Performance Monitoring Dashboard (digital version of the Victorian Health Services Performance Monitor report)
* a suite of Surgery Recovery and Reform dashboards
* a Mental Health and Wellbeing Regional Dashboard
* a suite of quality and safety dashboards including, Hospital Acquired Complications, Cardiovascular Quality and Safety, Maternity and Newborn Safety, and Public Sector Residential Aged Care Quality Indicators
* a range of program-specific performance dashboards, including Emergency Care, Palliative Care and Health Independence Program.

eHealth is also responsible for providing the Victorian community with information about health services quality, safety and performance, through the publication of a range of performance measures provided every quarter at [Victorian Health Services Performance](https://vahi.vic.gov.au/reports/victorian-health-services-performance) <https://vahi.vic.gov.au/reports/victorian-health-services-performance>.

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

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

As well as developing and reporting quality and safety measures, eHealth plays a key role in the developing, testing and validating measures used in the [*Performance monitoring framework*](https://www.health.vic.gov.au/funding-performance-accountability/performance-monitoring-framework) <https://www.health.vic.gov.au/funding-performance-accountability/performance-monitoring-framework>. In 2025–26, eHealth will contribute to measure and report development as part of the new [*Mental health and wellbeing outcomes and performance framework*](https://www.health.vic.gov.au/mental-health/research-and-reporting/mental-health-and-wellbeing-outcomes-and-performance-framework) *<https://www.health.vic.gov.au/mental-health/research-and-reporting/mental-health-and-wellbeing-outcomes-and-performance-framework>*.

VAHI reports all rely on data submitted by health services, and its capacity to provide timely and accurate information relies greatly on the quality of the coding, and the timeliness and completeness of the data submitted by health services.

For more information about performance, safety and quality metrics, reports and dashboards managed by eHealth, including requests for access to the VAHI portal, [email VAHI](mailto:vahi@vahi.vic.gov.au) <vahi@vahi.vic.gov.au>.

### Clinical quality registries

Clinical quality registries collect information to drive improvements in the quality and safety of health care through the analysis of clinical data to identify benchmarks for clinical performance and related variation in clinical outcomes. Victorian public health services and clinicians currently contribute data to approximately 50 health-related national and state-based clinical registries.

The Victorian Government provided funding for nine clinical quality registries in 2024–25. It is committed to ensuring data from clinical quality registries are used effectively by government agencies and the health sector to drive quality improvements.

The department works in partnership with registry custodians and key stakeholders to help registries meet contractual arrangements and associated funding obligations. The contracts stipulate that quarterly or biannual reports of summarised data are submitted to SCV and/or the department.

Data in these reports identify individual Victorian public health services and are used to inform statewide quality improvement activity and service planning. Data from clinical registries are used by SCV for the purpose of recognising system vulnerabilities and key risks, to identify improvement opportunities and to monitor delivery of improvements.

Registry data have been linked with other datasets to better inform the development of various statewide quality and safety indicators for the:

* [Victorian State Trauma Registry (VSTR)](https://www.health.vic.gov.au/victorian-state-trauma-system/about-the-victorian-state-trauma-system) <https://www.health.vic.gov.au/victorian-state-trauma-system/about-the-victorian-state-trauma-system> (Section 29.1.13)
* [Australian and New Zealand Society of Cardiac and Thoracic Surgeons (ANZSCTS) Database](https://anzscts.org/database/) <https://anzscts.org/database/> (Section 29.1.16) Registry
* [ANZICS CORE Registries](https://www.anzics.org/anzics-registries/) <https://www.anzics.org/anzics-registries/> (Section 29.1.19)
* [Victorian Cardiac Outcomes Registry](https://www.monash.edu/medicine/sphpm/vcor) <https://www.monash.edu/medicine/sphpm/vcor> (Section 29.1.17)
* [Australian Stoke Clinical Registry](https://auscr.com.au/) <https://auscr.com.au/> (Section 29.1.18) (requires login).

It is mandatory for public health services covering procedures captured by these registries to provide data to these collections.

### Infection prevention and control reporting

The effective prevention and control of infection are an integral part of the quality, safety and clinical risk management operations at all health services.

All public health services are required to provide data for mandatory reporting. Health service reporting requirements depend on the size and type of services.

Infection prevention and control data are collected and reported through two third-party surveillance initiatives, being the:

* VICNISS Coordinating Centre
* National Hand Hygiene Initiative.

#### Healthcare-associated infections

Health services’ monitoring of the occurrence and rate of infections, and comparing these with peer services, provides useful information on how the service is performing and can guide improvement.

The VICNISS Coordinating Centre collects and analyses data from individual hospitals, including data on risk-adjusted, procedure-specific infection rates (surgical site infections), *Staphylococcus aureus* bacteraemia-associated infections and central-line-associated bloodstream infections in intensive care units (ICUs).

VICNISS provides a list of mandatory and voluntary [surveillance activities in hospitals](https://www.vicniss.org.au/about/surveillance-activities-in-our-hospitals/) <https://www.vicniss.org.au/about/surveillance-activities-in-our-hospitals/>.

#### Healthcare worker influenza immunisation

Health services must take all reasonable steps to ensure staff are protected against vaccine-preventable diseases. High coverage rates for immunisation in healthcare workers are essential to reduce the risk of transmission in healthcare settings.

Health services must audit and report healthcare workers’ influenza vaccination rates annually. Audit data is collated by the VICNISS Coordinating Centre and reported to the department. Annual results are published in the PRISM.

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

#### Hand hygiene compliance

Hand hygiene is a national quality and safety priority. Its importance is underscored by Standard 3 of the NSQHS Standards, which requires all Australian health services to participate in the National Hand Hygiene Initiative.

The initiative was developed by the ACSQHC to improve hand hygiene practices and implement a consistent national approach. The program includes Australian hand hygiene guidelines, a national education strategy, defined outcome measures, auditing tools and electronic data collection via the Hand Hygiene Compliance Application.

ACSQHC is the national coordinator of the National Hand Hygiene Initiative. In Victoria, SCV is the jurisdictional lead and monitors health service data collection and reporting in the Hand Hygiene Compliance Application. After each audit period, data are validated and results reported to the department.

There are three continuous national audit periods each year. Audit 1 and Audit 3 are mandatory for Victorian health services. Health services must submit an exemption request through SCV for approval by the department if they cannot participate. Audit 2 is voluntary, but strongly encouraged. From 1 April 2023, Audit 2 became optional to allow health service organisations additional time for quality improvement activities.

Hand hygiene is included in the *Victorian Health Services Performance Monitoring Framework*, with performance results reviewed after each reported audit period. Results are publicly reported at the state level in the department’s annual report, and nationally on the ACSQHC’s [Safety in Health Care](https://www.safetyinhealthcare.gov.au/) <[www.safetyinhealthcare.gov.au](https://www.safetyinhealthcare.gov.au)>.

### Streamlining clinical trial research

The government encourages health services to pursue clinical trial activity. The Coordinating Office for Clinical Trial Research in SCV manages the *Streamlining clinical trials and research framework* for the ethical and scientific review of multisite clinical trials.

The framework includes health and medical research conducted as a single-site or multisite project. All health services participating in the framework should assist the consolidation of research activity information concerning Victoria’s public hospital sector.

This is done using an electronic information platform to enter data for all ethics applications (both single and multisite), and research governance and site-specific assessments for single-site and multisite studies involving human subjects.

Additional data collection may be required at health services. This will be determined by SCV via the Coordinating Office for Clinical Trial Research.

Health services that participate in the *Streamlining clinical trials and research framework*, including 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 a single ethics review or intra- and interjurisdictional ethical review, certified with the National Health and Medical Research Council and accredited by the department in Victoria, and comply with any additional accreditation requirements.

It is expected that health services participating in the streamlining of ethical and scientific review of multisite research will comply with all matters agreed in the memorandum of understanding. This includes acceptance of a single ethics review decision by an accredited and certified human research ethics committee, reporting requirements and research governance obligations associated with the conduct of a research project. They must also ensure that electronic data is captured for national reporting of clinical trial activity, under the directive of the Australian Government Department of Health and Aged Care.

Health services hosting a Victorian-accredited and National Health and Medical Research Council-certified human research ethics committee that reviews multisite clinical trials, and health and medical research, must demonstrate sufficient ethical reviews to maintain expertise.

For more information, visit [Clinical Trials and Research](https://www.clinicaltrialsandresearch.vic.gov.au/) <https://www.clinicaltrialsandresearch.vic.gov.au>.

For information about conducting research in relation to Aboriginal health and wellbeing, visit [marra ngarrgoo, marra goorri: The Victorian Aboriginal health, medical and wellbeing research accord](https://d.docs.live.net/031c443d5a1cf449/Documents/Business/Government/DoH-C%5e0SI/marra ngarrgoo, marra goorri: The Victorian Aboriginal health, medical and wellbeing research accord)<https://www.vaccho.org.au/accord/>.

## Community health clinical governance

Funded organisations receiving community health program funding are expected to have strong clinical governance systems and practices in place, to ensure the quality and safety of services. Organisations must review their clinical governance structures and have adequate internal documentation, to ensure consistency and compliance with the department’s clinical and quality governance policy frameworks.

Accreditation is a key measure of the performance of organisational clinical governance and the management systems that underpin good governance.

Organisations that receive funding through primary health output group activities must be accredited by a body or entity that is accredited by the International Society for Quality in Health Care or the Joint Accreditation System of Australia and New Zealand.

For registered community health services, applicable standards include the:

* National Safety and Quality Primary and Community Healthcare Standards
* NSQHS Standards
* Quality Improvement Council Health and Community Services Standards
* EQuiP
* ISO 9001:2015.

Integrated community health services are subject to the accreditation requirements of their parent health service and are required to comply with NSQHS Standards.

Registered community health services are also guided by the *Community services quality governance framework* and with SCV’s *Clinical governance framework.*

All public dental services must be assessed against either the NSQHS Standards or the National Safety and Quality Primary and Community Healthcare Standards.

In accordance with the Health Services Act, registered community health services are required to comply with performance standards (also known as gazetted standards) in the five areas of:

* governance
* management
* financial management
* risk management
* quality accreditation and service delivery.

Compliance against the performance standards is monitored through an attestation from registered community health services. Registered community health services that have organisation-wide accreditation against either the National Safety and Quality Primary and Community Healthcare Standards or the NSQHS Standards, and have met all service agreement financial accountability requirements, are able to provide evidence of their accreditation status in lieu of completing the attestation.

# Consumer rights and community participation

The ACSQHC maintains the second edition of the Australian Charter of Healthcare Rights, reflecting an increased focus on person-centred care, and empowers consumers to take an active role in their health care. The charter describes the rights that all consumers can expect when receiving health care. These rights apply to all people in all places where health care is provided in Australia.

ACSQHC has developed a range of resources to support the implementation and use of the charter, including a poster and an infographic for consumers. Other resources include an Easy English version, an Auslan video, large print and Braille versions, and translations in 19 community languages. Healthcare organisations can also adapt the resources to their specific context.

SCV and the department recommend using the new charter and associated resources. To download all charter resources, visit [Help to understand the Charter](https://www.safetyandquality.gov.au/consumers/working-your-healthcare-provider/australian-charter-healthcare-rights/supportive-resources-second-edition-australian-charter-healthcare-rights) <https://www.safetyandquality.gov.au/our-work/partnering-consumers/australian-charter-healthcare-rights/help-understand-charter>.

Organisations can now also adapt resources to specific contexts via the ACSQHC Partnering with Consumers team.

## Consumer, carer and community participation

SCV developed the *Partnering in healthcare framework* in 2019 to support health services with practical strategies for consumer participation, and partnerships between consumers and health professionals, to deliver higher-quality care that is safe, equitable and clinically effective.

The framework comprises five interdependent domains that work together to produce better outcomes.

The five domains are:

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

In 2025–26, each health service must identify at least two domains and priorities on which to focus, complete a Statement of Intent and submit these to SCV by 31 October 2025.

For more information, visit [*Partnering in healthcare framework*](https://www.bettersafercare.vic.gov.au/support-and-training/partnering-with-consumers/pih) <https://www.bettersafercare.vic.gov.au/support-and-training/partnering-with-consumers/pih>.

All funded organisations must actively support and promote consumer, carer and community participation at all levels of health care, including support for community advisory committees. In achieving the baseline requirements of the policy, health services will be required to meet the second edition of the [NSQHS Standards](https://www.safetyandquality.gov.au/standards/nsqhs-standards) <https://www.safetyandquality.gov.au/standards/nsqhs-standards>.

The *Carers Recognition Act 2012* outlines the requirements to support people in care relationships. The Act encourages organisations and services to better respect the important role carers have in our community.

Councils and relevant funded organisations must report on how they have met their obligations under the Act in their annual report. This may be as simple as including a paragraph detailing the actions taken during the year to comply with the Act.

For more information, including legal responsibilities and obligations of local government and organisations, visit [Support for Carers program](https://www.health.vic.gov.au/supporting-independent-living/supporting-people-in-care-relationships) <https://www.vic.gov.au/support-carers-program>.

## Victoria’s health experience

The VHES program surveys recent users of Victorian public health services to collect feedback about their experience of care. The program includes inpatient, ED, maternity, mental health client and carer surveys.

The surveys are designed around the five domains of SCV’s *Partnering in healthcare framework*. Results from the VHES program are shared with Victorian public health services, SCV and the department. They provide actionable insights that support improvement in patient-centred care and service delivery.

The VHES program has transitioned to predominantly electronic data collection, providing the opportunity to invite more Victorians to share their experiences of care, and delivering more timely insights to health services, the department and SCV.

The department will consult the sector and stakeholders on future directions for the program during 2025–26.

### Core VHES program surveys

The core VHES program includes maternity, adult and paediatric inpatient, and adult and paediatric emergency surveys. These surveys run continuously throughout the year, with data finalised on a quarterly basis.

All Victorian publicly funded health services, where relevant and funded to deliver a particular service, are expected to participate in these surveys. Patient experience indicators in the *Performance management framework* are sourced from the inpatient survey. These indicators are reported on a quarterly basis in the Victorian Health Services Performance Monitor.

Overall inpatient and ED patient experience measures are also reported in the Victorian Government’s *Budget Paper No.3: Service delivery*.

### Your Experience of Service (YES) survey and the Carer Experience Survey (CES)

The YES survey and the CES are national tools designed to collect information on the experiences of consumers and their families, carers and supporters accessing adult mental health and wellbeing services, and selected MHCSS. The surveys are delivered as part of the VHES program and are, at present, the only standardised self-reported consumer and carer experience measures available.

YES survey and CES results provide services with contemporary lived experience insights. Health services should use them to develop service improvement responses in partnership with lived experience leadership. Services should embed key YES survey and CES indicators in local outcomes frameworks to ensure performance is measured against the perspectives and experiences of consumers and families, carers and supporters.

The YES survey and CES are essential components of public monitoring and reporting service system improvement against the new *Mental health and wellbeing outcomes and performance framework*. Services are encouraged to invest in the ongoing implementation of the YES survey and CES to ensure experience data is meaningful and actionable to drive continuous improvement.

## Health service community advisory committees

Victoria has a statutory requirement that each public health service board (listed under Schedule 5 of the Health Services Act) establishes a community advisory committee. Boards have a responsibility to ensure that community advisory committees are integrated with the health service and are representative of their communities. Community advisory committees are at the heart of consumer, patient and carer participation in the design and delivery of health services.

Health services should undertake relevant planning with the community advisory committee to ensure that consumers, carers and community members are actively involved and supported to participate in service development, planning and quality improvement.

Community advisory committees are one part of a strategy to help health services involve consumers under the *Partnering in healthcare framework*. The aim is to offer care that is safe, effective, person-and-family-centred, equitable and clinically effective.

For more information and to download the guidelines, visit [Building your healthy community: A guide for health service community advisory committees](https://www.bettersafercare.vic.gov.au/publications/a-guide-for-health-service-community-advisory-committees) <https://www.bettersafercare.vic.gov.au/publications/a-guide-for-health-service-community-advisory-committees>.

### Primary care and population health advisory committees

Under the Health Services Act, public health services must have a primary care and population health advisory committee. Health services should continue to work through these committees to consider the broader needs of the community.

## Partnerships

All funded organisations are encouraged to participate in locally relevant partnerships, local collaboratives, and alliances with other health and human services organisations, where appropriate.

Commonwealth-funded PHNs are charged with improving access to primary care services and ensuring better coordination of care with local healthcare providers. They do not deliver services, but they do commission and integrate local services to increase the efficiency and effectiveness of medical services for consumers, particularly those at risk of poor health outcomes.

## Complaint management

All funded organisations must have effective and responsive complaint management systems in place that are timely, appropriate and lead to improvements in quality and safety. All hospitals must have an appropriately resourced role that is responsible for addressing patient concerns, and is visible and accessible to consumers.

The contact details for the identified role should be readily accessible (including on the hospital’s website). There should be a variety of inclusive mechanisms for consumers to provide feedback to health services.

Health services should have systems for aggregating complaints data and addressing issues, as part of their continuous improvement. This includes, but is not limited to, mechanisms for identifying potential SAPSE, clinical incidents and near misses, to provide more robust systems for using complaint and incident data as a safety signal, in accordance with SDC legislative requirements.

Health services are expected to demonstrate compliance with the *Health Complaints Act 2016 Complaint Handling Standards* as published on the [Health Complaints Commissioner website](https://hcc.vic.gov.au/providers/complaint-handling-standards) *<*https://hcc.vic.gov.au/providers/complaint-handling-standards*>,* and regularly review their complaints management procedures, as part of their ongoing quality and safety governance process.

The Health Complaints Commissioner is an independent and impartial statutory body that derives their powers and functions from the *Health Complaints Act 2016*. They resolve complaints about health care and the handling of health information in Victoria. They can also investigate matters and review complaints data to help health service providers improve the quality of their service. The Commissioner acts independently and impartially.

The Commissioner also actively engages in the health sector through training in complaints handling, and the relevant laws governing health service and health records complaints.

For more information, visit [Health Complaints Commissioner](https://hcc.vic.gov.au/) <https://hcc.vic.gov.au>.

## Historical forced adoption

The 2021 Inquiry into Responses to Historical Forced Adoption in Victoria requires all public hospitals directly involved in historical forced adoptions to develop a specific application form for mothers and people who are adopted to request their hospital records.

If a hospital record cannot be located or is unavailable, public hospitals must make every effort to explain to information applicants why a hospital record cannot be located, including details of when and how records were destroyed, if possible. A template application form has been shared with public hospitals directly involved in historical forced adoptions.

# Financial requirements

## Health service procurement and purchasing requirements

Health Purchasing Victoria, a body corporate established under the Health Services Act, is undertaking its statutory functions as HealthShare Victoria, and is responsible for supply chain operations and purchasing policy compliance.

Supply chain operations:

* improve the collective purchasing power for Victorian public health services and hospitals, by establishing statewide supply agreements for health-related goods and services
* manage the bulk purchasing, and efficient supply and distribution of medical consumables for Victoria’s public health services, with HealthShare Victoria’s distribution centre operations being a central part of the end-to-end supply chain
* support better patient outcomes by enabling consistent access to goods and evidenced-based product selection.

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

The compliance function:

* develops, implements and reviews policies and audits to promote best value and probity, in relation to the supply of goods and services to health services. HealthShare Victoria’s purchasing policies establish a procurement policy framework for health services and incorporate the strategic approach and guidance of the Victorian Government Purchasing Board policies. These policies are mandated for all Schedule 1 and 5 (of the Health Services Act) health services, and may be viewed at [HealthShare Victoria Purchasing Policies](https://healthsharevic.org.au/purchasing-policies-and-compliance/hsv-health-purchasing-policies/)<https://healthsharevic.org.au/purchasing-policies-and-compliance/hsv-health-purchasing-policies/>. This ensures probity is maintained in purchasing, tendering and contracting activities in health services
* provides advice, employee training and consultancy services, in relation to the supply of goods and services to the health sector
* monitors health service compliance with purchasing policies and HealthShare Victoria directions, and reports irregularities to the Minister for Health.

### Compliance framework

To meet its responsibilities in monitoring health service compliance with purchasing policies, and to promote probity among health service management and employees with procurement responsibilities, HealthShare Victoria has developed a compliance framework that includes support and prevention activities, such as education, training, advice and guidance, and monitoring.

Mandated health services must complete an annual compliance self-assessment requiring:

* compliance with the Health Purchasing Policies and the HealthShare Victoria Collective Agreements
* approval and submission to HealthShare Victoria by the health service’s CEO for inclusion in the HealthShare Victoria annual report.

Mandated health services must complete compliance audits to the Health Purchasing Policies requiring:

* the CEO of a mandated health service to audit compliance as per the Health Services Act
* an audit once every three years (health services must provide the final audit report to HealthShare Victoria by 30 June in the year the audit is scheduled)
* findings to be reported to the HealthShare Victoria Board and monitored until the health service has addressed and closed the issues. HealthShare Victoria must report high-risk areas of noncompliance to the Minister for Health.

Mandated health services must provide information and data on contracting and procurement activities, as requested by HealthShare Victoria. HealthShare Victoria can require the CEO of a mandated health service to provide information, and transparency and probity in purchasing, tendering and contract activities.

The overlapping probity directives that health services should ensure they meet include that:

* mandated health services must comply with the Health Purchasing Policies to support best-value procurement
* health services must ensure their probity controls take into consideration recommendations contained in the [Victorian Ombudsman’s report Probity controls in public hospitals for the procurement of non-clinical goods and services](https://www.austlii.edu.au/cgi-bin/viewtoc/au/other/VicOmbPRp/2008/) < https://www.austlii.edu.au/cgi-bin/viewtoc/au/other/VicOmbPRp/2008/> and the Victorian Auditor-General’s Office report.

Health services are also encouraged to consult with HealthShare Victoria on any high-value or high-risk procurement activities.

## Compliance with financial requirements

### Borrowing approval

Section 30(2) of the Health Services Act requires registered funded agencies to obtain approval from both the Minister for Health and the Treasurer before seeking financial accommodation. An approved borrower may obtain financial accommodation, whether within or outside Victoria, secured or arranged in a manner and for a period approved by the Treasurer. These borrowings are guaranteed by the state.

Section 44 of the Ambulance Services Act requires an ambulance service to obtain approval from the Treasurer before seeking financial accommodation. An approved borrower may obtain financial accommodation, within Australia, secured or arranged in a manner and for a period approved by the Treasurer.

All registered funded agencies and ambulance services must obtain the appropriate approvals before seeking to borrow funds from third parties, and before entering into third-party finance arrangements for any overdrafts, borrowings or finance leases. These funds may be for purposes such as capital works and equipment expenditure.

The Standard motor vehicle policy, issued under the authority of the Minister for Finance, now mandates the acquisition of new vehicles through VicFleet, which is funded through the government’s finance lease facility. Under these requirements, all registered funded agencies and ambulance services are approved borrowers for the purpose of motor vehicle finance leases obtained through VicFleet.

### Capital expenditure

Registered funded agencies and ambulance services must not enter into any expenditure related to equipment purchases, capital works, or purchase or disposal of real property, where the estimated total costs, real property value or total end costs of the works exceed 10 per cent of the annual revenue of the agency or health service, or $5 million (whichever is the lesser amount), unless the:

* agency or health service has provided a detailed business plan relating to the proposed expenditure to the Secretary to the department
* expenditure has been approved by the Secretary to the department.

The Secretary’s approval in relation to any expenditure referred to in the above clauses does not imply or in any way obligate the Secretary or the department to provide any financial support for the works.

### Leases

Compliance with Australian Accounting Standard *AASB16 Leases* requires most operating leases (the exceptions being low-value asset leases, with an individual leased asset less than $10,000, and leases of less than 12 months duration) to be reported on the balance sheet.

All balance sheet leases must be recorded in the BDO Lead software provided by the department and reported in trial balances submitted via HeART. Exceptions are motor vehicle leases with VicFleet, and leases attributable to public-private partnership arrangements, which are not required to be recorded in the BDO Lead software.

The 30 June lease liabilities that funded agencies submit through their estimates trial balance submissions[[15]](#footnote-16) via HeART will contribute to an overall lease-borrowing cap that is provided to the Department of Treasury and Finance for approval, and will constitute the agency’s borrowing cap for the year. Each entity must manage its lease liability within this lease-borrowing cap, and actual balances as at 30 June will be compared with the entity’s approved cap to assess compliance.

An entity should seek approval from the Treasurer, through the department, for any lease contracts that will cause the overall lease liabilities to exceed the lease-borrowing cap approved through the estimates trial balance submission process, to avoid a breach of the Standing Directions 2018 under the *Financial Management Act 1994* (Standing Directions).

All leases must be assessed to determine whether they include a financial accommodation, as defined by the *Borrowing and Investment Powers Act 1987* (which is referenced in the Health Services Act), and health services must follow the existing processes for approving a lease that includes a financial accommodation (borrowing).

Even though the accounting distinction between operating and finance leases no longer exists, there is still a legal distinction between operating and finance leases, based on the transfer of rights between the lessor and lessee. This means that the definition of financial accommodation under the Borrowing and Investment Powers Act does not include operating leases. As such, there is no change to the processes for approving operating leases and borrowings for health agencies.

Lease commitments should continue to be undertaken in accordance with the *Victorian Government risk management framework*.

For more information, visit [*Victorian Government risk management framework*](https://www.dtf.vic.gov.au/planning-budgeting-and-financial-reporting-frameworks/victorian-risk-management-framework-and-insurance-management-policy) <https://www.dtf.vic.gov.au/planning-budgeting-and-financial-reporting-frameworks/victorian-risk-management-framework-and-insurance-management-policy>.

### Investments

Standing Direction 3.7.2 Treasury management, including the Central Banking System, requires all public sector entities, including public hospitals, to ensure that all financial assets, subject to the exceptions identified in the Standing Direction, be deposited within the Central Banking System, unless an exemption has been provided by the Assistant Treasurer under Standing Direction 1.5(b).

The Standing Direction 3.7.2 provides details of the requirements for financial assets and should be referred to, including definitions and specific exceptions.

## Goods and services tax (GST)

Funded organisations must register for an Australian Business Number and register for GST, where required under the *Goods and Services Tax Act 1999*. Each funded organisation is responsible for its own tax compliance and liabilities.

Public hospitals and Ambulance Victoria are government-related entities under ss.8 and 41 of the *Australian Business Number Act 1999.* Funding between one government-related entity and another government-related entity that is sourced from appropriations and for non-commercial activity, is outside the scope of GST, pursuant to ss.9–17(3) of the Goods and Services Tax Act.

# Asset and environmental management

Asset management involves coordinated activities across an asset’s entire life cycle to maximise its value in supporting service delivery objectives. This requires balancing costs, risks, opportunities and performance outcomes. Health services are required to manage, maintain and replace their assets in line with the Standing Directions and the Victorian Government’sAMAF.

Under the Standing Directions, the CEO of each funded organisation (health service) must attest in their annual report that the organisation complies with the requirements of the AMAF.

To support compliance, the department requires health services to submit annual asset management plans, and maintain accurate asset registers, covering all physical asset classes under their control. This responsibility applies across the entire asset lifecycle including planning, acquisition, operation and maintenance, and disposal.

CEOs must assign clear responsibility, accountability and reporting arrangements for asset management. They are also required to establish and maintain management processes to plan, monitor, report on and assess assets under their control.

Health services are encouraged to build asset capability by participating in the Victorian Health Asset Management Communities of Practice facilitated by the department, as well as other asset management forums.

Consistent with Victorian Government policy, the department expects asset management governance planning and practices to be scaled appropriately to the size and complexity of the health service.

Health service boards should be regularly informed about the performance of the asset management system, key asset performance indicators, any material risks, and the planned timing of significant investment or disinvestment decisions.

For more information, visit [AMAF](https://www.dtf.vic.gov.au/infrastructure-investment/asset-management-accountability-framework) <https://www.dtf.vic.gov.au/infrastructure-investment/asset-management-accountability-framework>.

Environmental management refers to the actions taken by an organisation to meet the requirements of environmental legislation and improve sustainability performance.

## Asset management strategy and planning

Health services must systematically identify service delivery and asset needs over time, and develop plans to manage their entire asset base, including renewal forecasting and the management of individual assets across their life cycle.

A key requirement of the AMAF is the development of an asset management strategy that addresses both strategic (Strategic Asset Management Plan) and tactical (Asset Management Plan) levels of asset management.

Effective asset management planning depends on strong governance, aligned leadership, and the involvement of key stakeholders and specialist groups across the health service. It also requires ongoing performance monitoring and strategic oversight to support effective risk assessment, asset prioritisation, and the quality and implementation of asset management planning.

Each health service is required to submit an annual asset management plan detailing how they are managing their asset base as outlined in [section 11](#_Capital_funding_programs).

### Asset management plans

As part of the requirements under the AMAF for appropriate management of assets, health services must submit an annual asset management plan to the Asset Planning unit in the System Planning Division.

At a minimum, the plan should include:

* summary data of the asset holding within control
* key asset performance measures
* current asset condition assessments
* a prioritised list of asset risks
* demand analysis
* a planned maintenance program
* a renewal forecast for both operational and capital needs
* a list of funding allocations to address prioritised risks (across all capital funding sources, including the IRCG)
* asset disposal plans
* an overview of asset management resourcing and capability.

Asset management plans must be submitted by 31 December each year, in order to receive full appropriation of the IRCG.

As outlined in [section 11.1](#_IRCG), to be eligible for the IRCG, health services must include an appendix that identifies how the IRCG will be allocated to address infrastructure risks and asset replacement needs.

### Reporting

As a condition of funding, all 2025–26 specific-purpose capital grant expenditure must be reported as part of the department’s AIMS by the end of September.

Reporting must align with the health service’s submitted asset management plan, demonstrating effective asset management planning and the prioritised replacement of in-scope assets. This annual reporting supports financial and asset accountability, including compliance for potential audits, and confirms that critical asset risks are being appropriately mitigated.

Health services must also demonstrate that assets are appropriately maintained, asset performance is actively monitored, and any critical asset failures are reported to the department.

### Planning and implementation

Health services should outline in their asset management plans how they prioritise asset replacement to address critical risks, and guide investment of minor capital renewal programs at the health-service level.

Forecasting renewal requirements in health service asset management allows informed strategic decisions that prioritise the elimination of unacceptable disruptions to clinical services and prevents critical failures. It also gives the department visibility of critical risks across the system to support future capital planning and program allocation.

Asset management plans should identify high-value engineering equipment, systems, embedded infrastructure and medical equipment requiring replacement over a four-year period, outlining the high-level cost estimates and activities required for successful implementation.

### 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. Minor capital and grants program reporting will be used for both accountability and policy, and practice development purposes.

The level of grant is conditional on meeting funding requirements – risk-based prioritisation of investment aligned with health service asset management plans.

Where health services have not fully acquitted received capital funding, the department may recall distributed funds for reallocation to other high-risk projects across the sector, as per the system needs determined by the department.

### Procurement of assets

Health services must comply with government policies and guidelines in their procurement activities.

The department requires health services to engage early and work collaboratively with HealthShare Victoria to maximise value-for-money procurement of medical equipment and deliver the most efficient purchasing arrangements, including standardisation and bulk purchasing, and achievement of economies of scale. Health services are also required to comply with AMAF requirements around asset acquisition.

For more information about compliance and health purchasing policies, visit [HealthShare Victoria](https://healthsharevic.org.au) <https://healthsharevic.org.au> (requires login).

### Disposal of assets

Planning for disposal should start well before the economic life of the asset has ended or the need for service has finished. It should incorporate consideration of unplanned disposals or destruction of assets.

Health services must comply with relevant approval processes and, where possible, select a disposal method, including retirement, replacement, renewal or redeployment, which maximises the financial benefits associated with the disposal, as per AMAF asset disposal requirements.

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

## Property portfolio management

Property portfolio management supports the delivery of services from real property assets. In this context, ‘real property’ means both the land and the buildings attached to that land.

Health services must actively manage their property portfolios to ensure real property assets under their control or ownership are fully utilised and realise full-service delivery potential.

Health services must:

* maintain an accurate dataset of all real property assets and annually review landholdings, in accordance with the Victorian Government’s landholding policy
* ensure formal tenure agreements are executed on all land that is department-owned or controlled (such as Crown land committees of management)
* ensure all real property transactions undertaken comply with the requirements of all relevant legislation, ministerial directions and Victorian Government policy (such as the Land transactions policy and guidelines)
* provide biannual reports to the department on property disposals, including advance notification of properties to be declared as surplus to requirements.

Real property assets under health service management should be zoned appropriately for current or proposed use. Health services should consolidate multiple freehold parcels held under separate titles, to simplify future property management activities.

As funded organisations seek to best match services to consumer needs, service agreements with third parties will require legal tenure agreements relating to the occupation of premises that adequately address legislative and service requirements, and related risks. Where tenure agreements are proposed for premises located on Crown land, funded organisations must ensure they have the right to enter into such agreements, and must comply with legislative requirements and government policy regarding their implementation.

## Asset maintenance

Clause 3.4.3 of the AMAF requires health services to establish systems and processes for undertaking maintenance activities and monitoring asset performance.

Maintenance refers to ‘a combination of all technical, administrative and managerial actions during the lifecycle of an item intended to retain it in, or restore it to, a state in which it can perform the required function’.

Effective asset maintenance enables timely, cost-effective interventions to keep assets safe, reliable and operational at the lowest long-term cost.

Health services are responsible for monitoring asset performance and providing appropriate maintenance activity within the right frequency for assets under their direct or indirect control.

This supports the mitigation or elimination of asset risks to:

* maintain assets in suitable condition for service delivery
* prevent service interruptions and quality risks
* minimise consumer safety and occupational health and safety risks
* sustain long-term service performance.

For a set of general and additional maintenance standards that should be applied to all critical areas in hospitals and health services, visit [Maintenance standards for critical areas in Victorian health facilities](https://www.health.vic.gov.au/publications/maintenance-standards-for-critical-areas-in-victorian-health-facilities) <https://www.health.vic.gov.au/publications/maintenance-standards-for-critical-areas-in-victorian-health-facilities>.

The department is currently updating the maintenance standards and guidance document, and will communicate these to health services once completed.

## Critical asset service failure

Clause 3.1.5 of the AMAF requires appropriate risk management strategies and processes to support the establishment of asset management, including processes to identify and maintain assets that are at risk of critical service failure.

Within business continuity plans, health services must define critical assets and recovery procedures for systems, as well as processes for the management of emergency events and issues, within its operational context, capability and associated risk.

In the event of a critical asset service failure, or incidents that lead to interruption of clinical services, such as operating theatres or bed closures, health services must provide a summary incident report detailing the critical asset service failure and the corrective action to the Asset Planning Team in the System Planning Division by [emailing the team](https://encoded-592c9deb-987b-4562-aa3c-9fa3d37d83e9.uri/mailto%3aemailing%2520the%2520team) <assetmanagement@health.vic.gov.au>, within four weeks of the incident.

## Health service environmental management and sustainability

Health services have environmental obligations under a range of legislation, including the:

* *Environment Protection Act 2017* (Vic)
* *Climate Change Act 2017* (Vic)
* *National Greenhouse and Energy Reporting Act 2007* (Cth).

In addition to legislative requirements, health services as public sector organisations have obligations to:

* reduce greenhouse gas emissions and improve climate resilience in accordance with the Victorian Government’s [Victoria’s Climate Change Strategy](https://www.climatechange.vic.gov.au/victorias-climate-change-strategy) <https://www.climatechange.vic.gov.au/victorias-climate-change-strategy> and the associated:
  + [Victorian Government action on climate change](https://www.climatechange.vic.gov.au/victorian-government-action-on-climate-change) <https://www.climatechange.vic.gov.au/victorian-government-action-on-climate-change>
  + [Health and human services climate change adaptation action plan](https://www.health.vic.gov.au/environmental-health/climate-change-strategy) <https://www.health.vic.gov.au/environmental-health/climate-change-strategy>[[16]](#footnote-17)
* publicly report on environmental performance, in accordance with [FRD 24 Reporting of environmental data by government entities](https://www.climatechange.vic.gov.au/victorian-government-action-on-climate-change/government-environmental-reporting) <https://www.climatechange.vic.gov.au/victorian-government-action-on-climate-change/government-environmental-reporting>. More information on environmental reporting requirements can be found in [section 29.11](#_Environmental_data_and)
* incorporate sustainability principles into their procurement activities, as outlined in the [*Social Procurement Framework*](https://www.buyingfor.vic.gov.au/social-procurement-framework) <https://www.buyingfor.vic.gov.au/social-procurement-framework>.

### Environmental management plan requirements

Health services are required to prepare an environmental management plan that addresses legislative requirements and key sustainability risks and opportunities. Health services must email finalised environmental management plans to the [Climate Health Victoria team](mailto:Climate%20Health%20Victoria%20team) <chv@health.vic.gov.au>.

Environmental management plans are to include:

* an assessment of environmental and climate risks, including current and potential controls (see [section 25](#_Risk_management) for guidance on risk management[[17]](#footnote-18))
* assigned responsibilities for environmental management and reporting
* a plan to improve environmental performance identifying key initiatives to be implemented.

The Environment Protection Act has a general environmental duty that requires all organisations to reduce the risk of harm to human health and the environment, so far as is reasonably practical. Recognising this requirement, the breadth and detail of the environmental management plan should be commensurate to each health service’s risk.

Health services can choose:

* to call their environmental management plan by another name (for example, sustainability strategy), so long as it includes the elements identified above
* the time period covered by their environmental management plan, so long as it is not greater than five years.

More guidance on developing an environmental management plan is accessible via Climate Health Victoria’s SharePoint site. Email [chv@health.vic.gov.au](mailto:chv@health.vic.gov.au) for access.

### Sustainability requirements in capital works

All capital works funded directly by health services, regardless of the funding source, are to meet the business-as-usual requirements in the department’s [Guidelines for sustainability in capital works](https://www.vhba.vic.gov.au/guidelines-sustainability-capital-works) <https://www.vhba.vic.gov.au/guidelines-sustainability-capital-works>.

The department expects the inclusion of a sustainability budget of 2.5% of total construction costs, which will assist in meeting expectations that health services are responding to climate change obligations.

### Guidance

In addition to the documents already referenced in previous sections, health services may also wish to have regard to:

* any guidance material on environmental management plans and health portfolio environmental priorities, as published by the department on its website
* guidance material prepared on [Directors’ duties with respect to climate risk](https://www.boards.vic.gov.au/directors-duties-respect-climate-risk) <https://www.boards.vic.gov.au/directors-duties-respect-climate-risk>
* guidance from the [VMIA](https://www.vmia.vic.gov.au/tools-and-insights/climate-change/understanding-victorian-risk-management-expectations) <https://www.vmia.vic.gov.au/tools-and-insights/climate-change/understanding-victorian-risk-management-expectations> on how Victorian public sector agencies should approach climate change risk management
* guidance contained within the [Clinical and related waste guidance – supplement for healthcare staff](https://www.health.vic.gov.au/environmental-health/waste) <https://www.health.vic.gov.au/environmental-health/waste>. This document outlines waste management strategies that may assist health services to satisfy waste-related requirements under the Environment Protection Act and associated regulations. This includes establishing separate waste streams for pharmaceutical and clinical wastes
* the [National Australian Built Environment Rating System Sustainable Portfolios Index](https://www.nabers.gov.au/news/nabers-sustainable-portfolios-index-2024-confirms-top-performers) <https://www.nabers.gov.au/news/nabers-sustainable-portfolios-index-2024-confirms-top-performers> which (from April 2024) includes energy and water ratings for Victoria’s public hospitals. The rating system’s public hospitals ratings set benchmarks for the energy and water performance of buildings, and provide an incentive for public hospitals to improve performance over time
* the draft [Environmental Sustainability and Climate Resilience Healthcare Module](https://www.safetyandquality.gov.au/standards/environmental-sustainability-and-climate-resilience-healthcare-module) <https://www.safetyandquality.gov.au/standards/environmental-sustainability-and-climate-resilience-healthcare-module> of the NSQHS Standards, which outlines a framework of actions for improving safety and quality of care, while addressing the health impacts of climate change.

# Digital health

Health services are required to operate safe, secure and cost-effective ICT and digital health programs, in alignment with the *Security of Critical Infrastructure Act 2018* when applicable, and both Victorian and national digital health strategies.

Health services are responsible for deploying secure ICT and digital health technology to support safe provision of care within their health service and protect patient information. Accountability rests with health service boards.

The Australian Government Department of Health and Aged Care released its [Digital Health Blueprint and Action Plan 2023–2033](https://www.health.gov.au/resources/publications/the-digital-health-blueprint-and-action-plan-2023-2033?language=en) <https://www.health.gov.au/resources/publications/the-digital-health-blueprint-and-action-plan-2023-2033?language=en> in December 2023. The blueprint recognises that digital health technologies enable more efficient and collaborative health care for both patients and healthcare providers. Digital health technologies make health care more affordable, convenient and accessible to more people.

Complementing the blueprint, the Australian Digital Health Agency has released the:

* [National Digital Health Strategy 2023–2028](https://www.digitalhealth.gov.au/national-digital-health-strategy) <https://www.digitalhealth.gov.au/national-digital-health-strategy>
* [Connecting Australian Healthcare: National Healthcare Interoperability Plan 2023–2028](https://www.digitalhealth.gov.au/about-us/strategies-and-plans/national-healthcare-interoperability-plan)<https://www.digitalhealth.gov.au/about-us/strategies-and-plans/national-healthcare-interoperability-plan>.

These three foundation documents provide a vision for a more connected healthcare system across Australia. They will inform the development of Victoria’s 10-year vision for a digitally-enabled health system and the future direction of [Victoria’s digital health roadmap](https://www.health.vic.gov.au/publications/victorias-digital-health-roadmap) <https://www.health.vic.gov.au/publications/victorias-digital-health-roadmap>.

## Governance

The department supports Victorian public health services in their delivery of digital health solutions, including:

* lifting digital health maturity
* enhancing the safety and quality of patient care through digitisation
* safe guarding patient privacy through strengthening of data governance
* risk reduction in the health sector through investment in cybersecurity, ICT infrastructure, resilience planning and best practice
* operating health sector applications and ICT services
* providing a 24/7 ICT and cyber incident management service.

The department’s eHealth Division supports Victoria’s public health sector to:

* reduce paper-based care processes and associated patient safety risks
* embed patient-centred care by joining up healthcare records
* extend and enhance ‘better at home’ and virtual care programs
* improve consumer access to their own healthcare information.

Implementation of the digital health roadmap and safe operation of digital health programs and projects are advised by two sector-based bodies, being:

* Victoria’s Health Chief Information Officer Forum
* the Victorian Clinical Informatics Council.

In addition, specific governance forums inform and steer major projects, such as health service consolidation, implementation of statewide health information sharing and, in collaboration with the Mental Health Division and sector, the statewide electronic mental health and wellbeing record.

The Victorian Health Chief Information Officer Forum meets monthly. It is the sector’s primary ICT information-sharing and decision-making forum, seeking to achieve a consistent and interoperable public health system for Victoria.

The forum is chaired by a health service chief information officer, with secretariat support provided by the chair. Health service, Rural Health ICT Alliance and regional health service chief information officers (or their equivalent) are expected to attend these monthly meetings and contribute to its working groups.

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

These include the:

* Public Health Cybersecurity Working Group and ICT Operations Assurance Working Group
* Community Health Cybersecurity and ICT Operations Assurance Working Group
* Medical Device Security Working Group.

Health services are required to participate in all relevant working groups.

The Victorian Clinical Informatics Councilmeets six times a year. It is the sector’s peak clinical informatics advisory body. Its role is to identify and promote best practice in digital health adoption, and to support realisation of the digital health roadmap.

The council is co-chaired by a senior clinician with expertise in digital health and the department’s chief digital health officer. Membership is drawn from the health sector, representing all relevant clinical and informatics bodies.

The council:

* represents the opinions of broader groups with particular expertise and experience in relevant areas of health
* provides advice and direction on the development and realisation of the department’s 10-year vision for a digitally enabled health system and the digital health roadmap
* recommends establishment of time-limited clinical advisory groups for specific initiatives
* advocates for and endorses innovative digital health initiatives that will achieve ongoing improvement in patient safety, quality of care and the patient experience
* advises the department on safety and quality, risk mitigation and remediation pertaining to identified issues with clinical information systems.

## Statewide programs

The eHealth Division is responsible for developing, establishing and maintaining the overarching programs that:

* underpin digital health investment
* realise health reform
* optimise continuity of care
* operate core applications to connect records, and optimise the security and resilience of health sector ICT applications and services.

Health services and their respective boards are accountable for local digital health strategies, plans and activities that align with the 10-year vision for a digitally-enabled health system, the digital health roadmapand statewide programs.

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

### Secure and resilient systems

The roadmapsets out a program of work to improve the reliability and resilience of healthcare information systems.

Health services are required to participate in a number of statewide programs, including the:

* Victorian Health Sector Cybersecurity Assurance Program
* Victorian ICT Operations Assurance Program
* Digital Health Maturity Model biennial assessments
* rollout of the department’s health information-sharing program of work, including My Health Record, national digital health initiatives (for example, national healthcare identifiers), unique patient identification, health information exchange and recommendation 62 of the RCVMHS.

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

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

#### Cybersecurity

eHealth’s 2025–2029 Victorian Health Sector Cybersecurity Strategy will outline an overarching statewide vision and plan to protect systems, data and trust, strengthen partnerships, and operate efficiently and effectively. The cybersecurity strategy will ensure all future cyber investment is based on defined and agreed priorities and outcomes.

Health services are required to align their strategic cyber or information security priorities and programs with the cybersecurity strategy. Specifically, health services are required to:

* use department-sponsored cybersecurity tools and must ensure they are maintained. If a health service wishes to use an alternative, they are required to work with the department, demonstrate that it meets or exceeds the protection of the department-funded tool, and seek a formal exemption. Health services will not receive funding for non-department sponsored tools
* develop a local health service cyber strategy and share it with the department on an annual basis
* implement the *Health Sector Cybersecurity Maturity Framework* and the *Medical Device Cybersecurity Framework*, which include mandated cybersecurity controls for ICT systems and medical devices. These frameworks and controls ensure public health services and community health services have measures to protect their systems, medical devices and patient/client data, from a range of adversaries
* regularly attest cybersecurity and medical device security controls through online self-assessments (facilitated through the Victorian Managed Assurance Authority) in a timely manner, and to participate in cybersecurity audits when directed by the department
* have processes in place to report their self-assessed results to their executive management team and board
* be responsible for the cybersecurity risk management of their third-party suppliers. This includes the responsibility to work with third parties to identify, assess, prioritise and implement proportionate cybersecurity controls to protect against cyber-attack and disruption in the supply chain
* contribute and participate meaningfully in Victorian health sector cybersecurity working groups
* report on cybersecurity metrics as directed by eHealth Division.

#### ICT recovery planning

Health services must develop and maintain their business impact analysis (BIA) and conduct their disaster recovery tests regularly. Recovery testing results are to be reported to the department’s eHealth Division every two years, commencing in 2023–24.

In its 2016–17 audit of public hospitals, the Victorian Auditor-General stated that ‘by not resolving long-standing IT systems control issues, public hospitals are at continual significant risk of their systems and data becoming unreliable’. Common unresolved IT systems issues include incomplete policies for managing IT systems, such as disaster recovery and business continuity plans.

Requirements for ICT recovery planning (the process for recovering ICT systems) can be derived from the BIA. The BIA lays the cornerstone of a standards-based approach to all business continuity management practices, including establishing requirements for developing ICT disaster recovery solutions.

Interdependencies between ICT systems and operational technology, including medical devices, should be considered in the BIA.

Resilience initiatives need to consider how the context of the health service operating environment is subject to constant change.

Some examples include:

* susceptibility to hazards from physical, natural (including extreme weather events and climate change), supply chain and personnel to cyber and information security[[18]](#footnote-19)
* technological advances and increased connectivity, which fosters efficiencies, but also increases the likelihood and impact of disruptions
* an increasingly complex, challenging and changing security environment that will become more dynamic, more diverse and more degraded. Threat actors from nation states routinely try to explore and exploit Australia’s critical infrastructure networks, almost certainly mapping systems so they can lay down malware or maintain access in the future[[19]](#footnote-20).

#### Service recovery and ICT dependencies

Capturing the relationship between healthcare delivery and ICT systems is central to designing and specifying the recovery requirements of new ICT solutions and services. A key attribute of all activities assessed during the BIA is the recovery time objective (RTO).

Activities that have highly effective manual workarounds and a low reliance on ICT systems being available can be sustained for longer periods and will likely have a longer ICT RTO. Activities that have no (or relatively ineffective) manual workarounds, quickly generate large backlogs, and have a high reliance on ICT systems being available, cannot be sustained for long periods, and will have a shorter ICT RTO.

## Connecting care

Connecting care is one of the five programs of work identified in the digital health roadmap. The objective of Connecting care is to securely enable continuity of care to support Victorians in their journey across health settings and providers.

Joining up consumer and client care requires commitment from the department and health services to participate in and jointly deliver the following pieces of work.

### My Health Record

Connection to My Health Record across Victorian public health services is designed to enhance patient safety. The Health Legislation Amendment (Modernising My Health Record—Sharing by Default) Bill 2024 passed in February 2025. Changes were made to the *My Health Records Act 2012* (Cth) and the Health Insurance Act. This requires health services to automatically upload specified clinical documents to a patient's My Health Record, unless the patient actively requests that the document not be uploaded or has restricted access to their My Health Record.

To support the changes in the legislation, the Australian Government will release documented rules detailing what information and/or clinical documents must be added to the My Health Record system by default. Initially, the rules will specify that pathology and diagnostic imaging reports be the first clinical documents that must be uploaded, however, this list will expand over time. Once published, all health services are expected to comply with the rules.

To enable the upload of clinical documents to the My Health Record system, health services will have to uplift their clinical systems to enable the use of the three National Healthcare Identifiers, being:

* IHI: Individual Healthcare Identifier
* HPI-I: Healthcare Provider Identifier – Individual
* HPI-O: Healthcare Provider Identifier – Organisation.

The Australian Digital Health Agency had provided health services with a rolling exemption enabling them to use a local identifier, rather than the HPI-I. This enabled them to meet the defined accreditation requirement (Action 1.17[[20]](#footnote-21)and 1.18[[21]](#footnote-22)) of the NSQHS Standards. This exemption ceased in June 2024 and health services have been working to build capacity to validate and store their healthcare provider’s HPI-I.

The department has built a technical solution to support health services to retrieve and use HPI-I. Health services must have programs of work to uplift their clinical systems and use the national identifiers. Those unable to comply with this requirement by December 2025 must contact the department for advice.

### Unique patient identification

Unique patient identification provides a unified view of patient details and identifiers across Victorian health services, as recommended in *Targeting zero*. The system provides a foundation for clinical information sharing across health services and provides a valuable tool to health services for the management of patient identification.

Sharing and linking of patient information is integral to the provision of timely, accurate, relevant and reliable data, and is fundamental to the efficient and effective use of Victoria’s health information sharing platform (CareSync Exchange).

All Victorian public health services are required to connect to Victoria's unique patient identification service, to enable clinical information sharing at the point of care through the CareSync Exchange.

Victorian public health services are also responsible for implementing patient registration processes that ensure any current, previous and future health care records relating to an individual are linked and only associated with that individual.

Victorian public health services should ensure patient identification and registration processes are monitored for data quality, including the incidence of duplicate registrations and incorrect patient matches, and adopt methods to reduce duplicate registrations and procedures to resolve potential duplicates.

Patient registration and unique patient identification training materials developed by the department are available by emailing [HIEprogram@health.vic.gov.au](mailto:HIEprogram@health.vic.gov.au) <HIEprogram@health.vic.gov.au>.

### Contemporary information architecture for mental health and wellbeing

The RCVMHS recommended that the Victorian Government develop, fund and implement modern infrastructure for ICT systems.

This includes:

* a statewide mental health and wellbeing record
* a mental health information and data exchange and repository
* replacement of the department’s legacy Client Management Interface/Operational Data Store (CMI/ODS) system
* development of a consumer portal.

In December 2023, Data Capture Experts were engaged by the department to deliver the new Victorian Mental Health and Wellbeing Client Management System. This system will be rolled out progressively over the next three years and replace the CMI/ODS.

In 2025–26, the department will finalise the system’s design and build, and subsequently commence the roll out to Mental Health and Wellbeing Local Services.

Area Mental Health Services will be engaged to prepare for the future roll out, anticipated to commence from July 2026 onwards in a staged manner. Concurrently, where appropriate, the department will be working with health services to integrate and enhance health service Electronic Medical Records (EMRs) with the Mental Health and Wellbeing Client Management System.

### Health information sharing

The department’s centralised and secure health information sharing system, CareSync Exchange, enables public hospitals and other specified health services to share specific patient health information for the purpose of providing medical treatment to patients.

Public health services are required to participate in the design, implementation, training and adoption of CareSync Exchange.

Public health services introducing new or replacement systems must ensure they are compatible with and aligned to the department’s investment in statewide information-sharing capability through CareSync Exchange. Health services are required to use CareSync Exchange to share clinical information with other health services.

The department manages CareSync Exchange and provides training and resources for the clinicians who use it.

For more information, visit [CareSync Exchange](https://www.health.vic.gov.au/caresync-exchange) <https://www.health.vic.gov.au/caresync-exchange>.

### Safer transfer of care

The Safer Transfer of Care Program[[22]](#footnote-23) aims to expand the use of electronic referrals (eReferrals) to reduce or eliminate the use of printed letters and faxed documents between the primary and acute health sectors. During 2025–2026, public health services will be encouraged to adopt the use of eReferrals, particularly as it relates to streamlining of service delivery of planned (elective) surgery workflows across Local Health Service Networks.

### Health information exchange privacy management

The Health Legislation Amendment (Information Sharing) Act, which commenced on 7 February 2024 and amended the Health Services Act, enables the establishment of a secure Victorian Electronic Patient Health Information Sharing System, also referred to as CareSync Exchange.

The legislation required the Minister to establish a *Privacy Management Framework* for CareSync Exchange, which outlines the roles, obligations and governance involved in protecting Victorian health consumers’ privacy in the system.

The framework was developed following extensive consultation with clinicians, consumers, health services and other relevant stakeholders, including privacy regulators, industry and representative bodies.

The Health Services Act requires authorised users of the system to comply with the Privacy Management Framework, which includes clinicians, health services and the department.

The

For more information about CareSync Exchange and the framework, visit [CareSync Exchange](https://d.docs.live.net/031c443d5a1cf449/Documents/Business/Government/DoH-C%5e0SI/CareSync%20Exchange) <https://www.health.vic.gov.au/caresync-exchange> or email the [Health Information Sharing Team](mailto:Health%20Information%20Sharing%20Team) <HIEprogram@health.vic.gov.au>.

### Strategic ICT investments

Strategic ICT investments refer to the deliberate allocation of resources towards technology-enabled projects that are designed to significantly enhance the operational capabilities, efficiency and effectiveness of health services. Strategic projects should align with the digital health roadmap and, where appropriate, leverage statewide platforms and solutions*.* Where there is ambiguity or where the scope of the project impacts another health service, health services must seek approval from the Digital Health Branch.

Health services must report their ICT strategies, plans and projects to the eHealth Division. The branches have planning and assurance roles for the sector to ensure:

* prescribed levels of ICT and cybersecurity capability are in place to support safe clinical care, mitigate risk of unplanned outages and cyber threats, and provide a standard approach to incident management and resolution of issues
* appropriate project governance and planning is in place to support the delivery of successful ICT-enabled health service projects
* engagement with the Strategy, Cybersecurity and Assurance Branch for project assurance on the full lifecycle of the project.

All health service projects with an ICT component greater than $1 million are to be subjected to departmental project assurance. These must be reported via the Strategy, Cybersecurity and Assurance Branch to the Department of Government Services for inclusion in the public quarterly ICT project dashboard.

Projects managed by a Rural Health ICT Alliance are to be reported by the alliance. Alliance member projects are also to be reported via the designated project reporting coordinator for submission. All projects on this dashboard with an ICT budget exceeding $10 million are to be subject to independent project quality assurance, commissioned by the Strategy, Cybersecurity and Assurance Branch.

Health services must ensure that all ICT procurements are conducted in a manner consistent with the relevant Victorian Government Purchasing Board best-practice procurement guidelines and HealthShare Victoria health-purchasing policies. Exemption from these guidelines and policies requires approval from the Secretary of the department.

Health services should leverage the Australian Digital Health Agency’s [Digital Health Procurement Guidelines](https://www.digitalhealth.gov.au/healthcare-providers/initiatives-and-programs/digital-health-standards/digital-health-standards-guidelines/get-started) <https://www.digitalhealth.gov.au/healthcare-providers/initiatives-and-programs/digital-health-standards/digital-health-standards-guidelines/get-started> to inform requirements associated with digital health procurements as detailed in [section 24.6](#_Digital_health_foundations).

#### Assessment using Victoria’s digital health maturity model

The Victorian Auditor-General’s 2017 report, ICT strategic planning in the health sector, recommended that the department comprehensively assess the health sector’s ICT maturity to ensure digital health investment decisions have been informed by clinical ICT maturity.

In 2019, Victoria’s digital health maturity model was developed and maturity assessments across health services were conducted.

During 2022–23, public health services participated in the second cycle of maturity assessment. Health services are required to self-assess against the model at least every two years. The next cycle is due in 2025–26.

For more information, visit [Victoria's digital health maturity model](https://www.health.vic.gov.au/quality-safety-service/victorias-digital-health-maturity-model) <https://www.health.vic.gov.au/quality-safety-service/victorias-digital-health-maturity-model>.

## ICT and cybersecurity incidents

In its role as system manager, the eHealth Incident Management Team must be informed of significant ICT incidents within the hour, when they occur in health services or their third-party providers. All cybersecurity incidents, including data breaches, regardless of severity, must be reported to the Incident Management Team as soon as the intrusion is detected or suspected. Health services must follow the eHealth ICT and cyber communications protocol.

Notification of ICT incidents and cybersecurity incidents must be done by calling 1300 598 686, then providing a report of the incident by [emailing the Incident Management Team](mailto:Digital.Health.Incident.Notification@health.vic.gov.au) <Digital.Health.Incident.Notification@health.vic.gov.au>.

Health services are responsible for reporting cybersecurity incidents and data breaches from third party suppliers to the eHealth Incident Management Team.

Depending on the type of incident, health services may need to consider national reporting obligations, such as to the Office of the Australian Information Commissioner, and the Department of Home Affairs under the Security of Critical Infrastructure Act*.*

Health services are required to work with the eHealth Incident Management Team throughout the life cycle of ICT incidents and cybersecurity incidents. This means department staff must attend incident management meetings and be provided with incident documentation, reporting and planning.

The department manages the reporting and engagement with the Department of Government Services Cyber Incident Response Service and aligns with the Victorian Government’s [Cyber Security Incident Management Plan](https://www.vic.gov.au/cyber-incident-management-plan) <https://www.vic.gov.au/cyber-incident-management-plan>.

## Health ICT asset management

Health services must manage, maintain and replace assets, in accordance with the Standing Directions and the AMAF. Compliance with the AMAF applies to ICT assets.

Asset management refers to an organisation’s coordinated activities to realise the full value of assets in delivering service delivery objectives such as improving patient care, enhancing data security or increasing operational efficiency. This process is carried out over the whole asset life cycle.

The four key stages of the asset life cycle are:

* planning – determination of asset requirements, based on an assessment of both service delivery needs and the capability of the existing asset base to meet these needs. This could involve evaluating current ICT infrastructure, identifying gaps and forecasting future needs
* acquisition – procurement of assets to meet an identified service need, including the assessment of procurement options such as leasing, purchasing or developing in-house
* operation and maintenance – management and use of an asset to deliver services, including routine maintenance tasks, software updates and monitoring system performance
* disposal – treatment of an asset that has either reached the end of its useful life, is considered surplus or is underperforming. This could involve selling, recycling or decommissioning the asset.

Health services must submit ICT asset management data on a quarterly basis. This data should include detailed information about the asset type, asset category and usage. The supply of data is essential in assisting with cybersecurity incidents and provides evidence on the need for investment, which can then support the full appropriation of technology refresh grants.

Effective ICT asset management is crucial for health services to deliver their service objectives. Regular assessment and updating of ICT asset records, along with timely data submission, can help in managing cyber incidents.

Health services should consult the Medical Device Security Practice Areas for management of cybersecurity risk for medical devices across the device life cycle. The practice areas provide guidance in a security context for risk management, acquisition, network design, operation and monitoring, vulnerability management, legacy management and security incident response.

The ICT hardware assets that are in scope include:

* servers (virtual and physical)
* network appliances (wi-fi access points, firewalls, switches, routers, bridges, gateways, modems, repeaters and hubs)
* personal computers (PCs) (laptops and desktops)
* mobile devices, smartphones, tablets, and SIM cards issued by the department or agency
* business-critical intellectual property (IP) phones and phone lines, and cloud phone systems
* networked multifunction devices, printers, scanners and faxes
* internet of things
* operational technology (including control systems)
* medical devices.

The ICT software assets that are in scope include:

* applications (client-side, on-premise data centre and cloud-hosted)
* databases and middleware
* security certificates
* cloud applications
* cloud platforms
* cloud infrastructure.

The ICT services assets that are in scope include outsourced, third-party hosted and managed services.

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

These include the:

* IRCG
* RHIF
* Metropolitan Health Infrastructure Fund
* Medical Equipment Replacement Program
* Engineering Infrastructure Replacement Program.

Health ICT asset management should align with the principles of these programs, since ICT is a dependency for hospital equipment and infrastructure. Further information is available in [section 11](#_Capital_funding_programs).

## Digital health foundations

Victorian public health services must apply statewide and national digital health ICT standards and guidelines in their programs of care.

Statewide standards include the:

* Virtual care standard and guide – articulates the minimum requirements to successfully implement and maintain virtual care services in Victorian public health services
* eReferral standard – articulates the principles and design considerations required to successfully implement and manage effective transition of care
* Governance and use of the National Health Service Directory – describes how to upload data into the directory, and how to upload its data to health applications. The National Health Service Directory is the primary source for services directory and location information. Health services use this directory as the primary source for practitioner information, for the purposes of distributing discharge summaries to GPs and specialists, and for identifying eReferral recipients
* Clinical Information System and EMR Application and Interoperability Standard – articulates the minimum set of functional requirements for implementation of the Clinical Information System and EMRs by Victorian public health services
* Patient Administration System and Interoperability Standard – defines the minimum set of functional requirements for implementation of the patient administration system (PAS)
* Queue management and outpatient system integration principles – provides the recommended approach for interoperability between an outpatient appointment booking system and an outpatient queue management application
* Medications management interface standard – describes the approach for interfacing of an electronic prescribing system to a pharmacy application.
* Digital health unified implementation guide – assists health services with definitive usage of the HL7 2.4 Standard for applications that send HL7 messages to, and receive HL7 messages from, digital health applications.

For more information, visit [Digital health standards and guidelines](https://www.health.vic.gov.au/quality-safety-service/digital-health-standards-and-guidelines) <https://www.health.vic.gov.au/quality-safety-service/digital-health-standards-and-guidelines>.

National standards include:

* standard national clinical documents, including eReferral, discharge summary, shared health summary and event summary, accessed at [Australian Digital Health Agency’s Clinical documents](https://developer.digitalhealth.gov.au/topic/clinical-documents) <https://developer.digitalhealth.gov.au/topic/clinical-documents>
* national terminology for enterprise-wide EMR implementations, accessed at [Australian standard terminology and the Australian medicines terminology](https://www.digitalhealth.gov.au/newsroom/product-releases) <https://www.digitalhealth.gov.au/newsroom/product-releases>
* interactions with My Health Record are cited in Actions 1.17 and 1.18 of the [NSQHS Clinical Governance Standard](https://www.safetyandquality.gov.au/our-work/clinical-governance/clinical-governance-standard) <https://www.safetyandquality.gov.au/our-work/clinical-governance/clinical-governance-standard>
* the Fast Healthcare Interoperability® core standards that set the minimum requirements to support consistent capture and sharing of health information. These standards are being developed by the Commonwealth Scientific and Industrial Research Organisation (CSIRO) as a deliverable of the [National Digital Health Strategy](https://www.digitalhealth.gov.au/national-digital-health-strategy) <https://www.digitalhealth.gov.au/national-digital-health-strategy>. Health services will be actively encouraged to commence planning to adopt the standards where appropriate
* provision of clinical documents to My Health Record and provision of viewing access to clinical staff, to enhance the safety and continuity of patient care, and meet the requirements of the *My Health Record Act 2012* (Cth) – this includes the ability to apply national individual healthcare identifiers for patients, healthcare provider identifiers for individual clinicians and healthcare provider identifiers for organisations, as well as other requirements under the *Healthcare Identifiers Act 2010* (Cth)
* the *National product catalogue* and associated standards and specifications, which are specified by GS1 at the [National product catalogue](https://www.gs1au.org/our-services/national-product-catalogue) <https://www.gs1au.org/our-services/national-product-catalogue>
* the [*National eHealth Security And Access Framework*](https://developer.digitalhealth.gov.au/resources/national-ehealth-security-and-access-framework-v4-0)<https://developer.digitalhealth.gov.au/resources/national-ehealth-security-and-access-framework-v4-0>, which is maintained by the Australian Digital Health Agency through its national Cybersecurity Centre
* the *Health Records Act 2001 Health Privacy Principles*, for security of health information, and for storing personal and sensitive information outside of Victoria
* the [Digital Health Procurement Guidelines](https://www.digitalhealth.gov.au/healthcare-providers/initiatives-and-programs/digital-health-standards/digital-health-procurement-guidelines) *<*https://www.digitalhealth.gov.au/healthcare-providers/initiatives-and-programs/digital-health-standards/digital-health-procurement-guidelines> developed by the Australian Digital Health Agency, which support a coordinated and consistent approach to purchasing technology in Australia. They will help to bring about a change in the market, where interoperability, global standards and best practice are built into procurement processes. Health services are encouraged to build interoperability as a core requirement into any new procurements that are undertaken
* compliance and alignment with the Baseline Cybersecurity Controls based on the Australian Signals Directorate (ASD) Essentials 8, Centre for Internet Security, and the *National Institute of Standard and Technology cybersecurity framework*. These controls outline the minimum security controls that public health services and community health centres must implement, to protect their systems and their patient/client data against a range of adversaries
* the National Guidelines for On-Screen Presentation of Discharge Summaries, which aim to improve the presentation of discharge summaries prepared and shared electronically. They provide recommendations on the clinical content and layout of information that should be contained within a discharge summary, thereby improving the overall safety and quality of patients' continuity of care. The Guidelines are maintained by the [ACSQHC](https://www.safetyandquality.gov.au/publications-and-resources/resource-library/national-guidelines-screen-presentation-discharge-summaries) <https://www.safetyandquality.gov.au/publications-and-resources/resource-library/national-guidelines-screen-presentation-discharge-summaries>
* the Royal College of Pathologists of Australasia’s Standardised Pathology Informatics in Australia – for guidelines and associated information models and terminology reference sets, visit [Pathology terminology and information standardisation](https://www.rcpa.edu.au/Library/Practising-Pathology/PTIS) <https://www.rcpa.edu.au/Library/Practising-Pathology/PTIS>
* the AMAF, which applies to non-current assets (physical and intangible), but not financial assets, controlled by government departments, agencies, corporations, authorities and other bodies that are captured by the [Financial Management Act standing directions](https://www.vic.gov.au/tafe-toolkit-financial-management-act-standing-directions) <https://www.vic.gov.au/tafe-toolkit-financial-management-act-standing-directions>.

The Australian Digital Health Agency website is a useful source of reference material for digital health planning. Technical specifications can be found on the [Digital Health Developer Portal](https://developer.digitalhealth.gov.au/?from=corporate) <https://developer.digitalhealth.gov.au/?from=corporate>. The information contained on this website is subject to change.

# Risk management

## Risk management and assurance

Risk management and assurance activities are essential components of good corporate governance for all funded organisations. These activities will facilitate better service outcomes and quality care, and minimise claims and losses.

### Risk management

The Health Services Act, Public Administration Act and the Financial Management Act require funded organisations to have effective and accountable risk management systems and strategies in place.

Health service management and boards are responsible for their organisation’s governance, risk management and control processes. Internal auditors assist both management and the audit committee by examining, evaluating, reporting and recommending improvements to the adequacy, efficiencies and effectiveness of these processes.

To ensure risks are being managed consistently, some funded organisations are required under the department’s service agreement, Standing Direction 3.7.1of the *Standing Directions of the Minister for Finance* and the *Victorian Government risk management framework* to attest annually that the responsible body is satisfied that:

* the organisation has a risk management framework in place, consistent with AS ISO 31000:2018 Risk Management – Guidelines
* the risk management framework is reviewed annually to ensure it remains current and is enhanced as required, and that the organisation demonstrates a positive risk culture
* the organisation defines its risk appetite
* it is clear who is responsible for managing each risk
* shared risks are identified and managed through communication, collaboration and/or coordination, by the affected agencies
* the organisation contributes to the identification and management of state-significant risks, as appropriate
* strategic and business planning and decision-making processes embed risk management and demonstrate consideration of the organisation’s material risks
* adequate resources are assigned to risk management
* the organisation’s risk profile and risk appetite is reviewed at least annually.

An organisation’s risk management framework can consist of:

* a risk management policy and plan that integrates with corporate and business planning
* risk appetite statements
* risk registers and profiles
* an incident management system
* risk management tools, templates and training
* business continuity, cybersecurity and emergency management plans
* compliance and quality systems
* a fraud and corruption control plan.

These components assist funded organisations to develop an effective positive risk and organisational culture, which includes clinical and all other operational activities.

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

For more information, visit [AS ISO 31000:2018 Risk management](https://infostore.saiglobal.com/en-au/Standards/AS-ISO-31000-2018-1134720_SAIG_AS_AS_2680492) <https://infostore.saiglobal.com/en-au/Standards/AS-ISO-31000-2018-1134720\_SAIG\_AS\_AS\_2680492> and [RHB 158-2010 Risk management – principles and guidelines](https://infostore.saiglobal.com/en-au/Standards/HB-158-2010-129591_SAIG_AS_AS_274229) <https://infostore.saiglobal.com/en-au/Standards/HB-158-2010-129591\_SAIG\_AS\_AS\_274229>.

### Assurance activities

Assurance activities provide a degree of confidence regarding the outcome of the evaluation or measurement of the subject matter against predetermined criteria.

The subject matter can take many forms, such as:

* corporate governance practices
* management of risk
* effectiveness and efficiency of operations
* systems, processes, people and performance
* data reliability, completeness, integrity and availability
* accreditation and certifications
* patient or client outcomes and satisfaction
* compliance with laws, regulations and contracts.

Internal and external audits (which are independent), second-line reviews, attestations, accreditations and surveys are some categories of assurance activities, which funded organisations may use to provide reasonable assurance to their board, audit committee and management that they are on track to achieve their objectives.

An organisation’s assurance framework can consist of:

* an assurance strategy aligned to the internationally accepted three-lines model
* an internal audit function aligned to internal audit standards
* an assurance map detailing the sources of all assurance activities
* registers and reports to track implementation progress of management actions to address issues and recommendations
* key performance indicators of assurance activities.

### Integrity governance

Publicly funded health services are expected to use resources in a responsible and ethical manner that delivers value for money. All health services must have the appropriate assessment and mitigation strategies in place to ensure robust integrity practice across their organisation. The *Integrity governance framework* and assessment tool has been developed as a good practice assessment and reporting tool to guide and support robust integrity practice.

The framework is aimed at health service leaders of all levels, including team leaders, managers, executive management and the board. It emphasises the important role that leadership plays in managing integrity risks, and that risks can occur at any level of an organisation.

The tool focuses on four domains of integrity risks within a health service, being:

* employment principles and personnel procurement
* contract and project management
* finance
* governance.

For more information and to access the tool, visit [Integrity governance framework and assessment tool](https://www.health.vic.gov.au/funding-performance-accountability/integrity-governance-framework-and-assessment-tool) <https://www.health.vic.gov.au/funding-performance-accountability/integrity-governance-framework-and-assessment-tool>.

Health services are required to report to the department on integrity governance practices in their organisations in quarter three of the financial year. This will include reviewing performance in relation to integrity questions in the annual People Matter Survey.

Health services are required to attest in their annual report that appropriate internal controls exist to review and address integrity, fraud and corruption risks.

## Emergency management

### Health Emergencies Sub-Plan

The State Emergency Management Plan (SEMP) Health Emergencies Sub-Plan sets out the arrangements for the department as both a control agency and a support agency in the management of health emergencies in Victoria.

It details the coordination of roles and responsibilities, and provides guidance on mitigation, preparedness, response, relief and recovery arrangements. The Sub-Plan outlines an integrated and coordinated approach to minimising the impact of emergencies on the health system and the health and wellbeing of Victorians.

The Sub-Plan is currently under review and is expected to be endorsed by the State Crisis and Resilience Council in August 2025. Once endorsed, it will take effect and supersede the current Sub-Plan.

For more information on the current Sub-Plan , visit [SEMP Health Emergencies Sub-Plan](https://www.emv.vic.gov.au/responsibilities/state-emergency-management-plan-sub-plans/semp-health-emergencies-sub-plan) <https://www.emv.vic.gov.au/responsibilities/state-emergency-management-plan-sub-plans/semp-health-emergencies-sub-plan>.

### Code Brown guidelines

The Code Brown guidelines have been developed to help health services and facilities prepare their Code Brown plans by providing some information about the purpose of a Code Brown plan.

To access the guidelines, visit [Code Brown guidelines](https://www.health.vic.gov.au/publications/code-brown-guidelines) <https://www.health.vic.gov.au/publications/code-brown-guidelines>.

## Fire risk management

Funded organisations are responsible for ensuring they comply with the Department of Families, Fairness and Housing’s[Fire risk management procedures and guidelines](https://providers.dffh.vic.gov.au/fire-risk-management-procedures-and-guidelines) <https://providers.dffh.vic.gov.au/fire-risk-management-procedures-and-guidelines> that are relevant to the premises they operate.

Any building surveyor, fire safety engineer or auditor appointed for any works must be accredited by the Department of Families, Fairness and Housing. For the list of accredited practitioners, visit [Fire risk management accreditation](https://providers.dffh.vic.gov.au/fire-risk-management-accreditation) <https://providers.dffh.vic.gov.au/fire-risk-management-accreditation>.

Funded organisations are responsible for ensuring they comply with all laws, regulations and mandatory standards relating to fire and life safety in buildings (which also includes protection from external threats such as bushfire), and general safety requirements that apply to any premises from which the funded organisation operates. This is irrespective of whether the relevant regulatory requirements place the obligation on the owner or occupier of those premises.

Key fire risk management requirements include that funded organisations must:

* ensure appropriate operational readiness measures are developed, implemented and reviewed. In doing this, funded organisations should prepare for, respond to and recover from emergencies, in accordance with the ‘all hazards’ approach. This includes bushfire, flood, relocation and evacuation, and prolonged service interruption
* ensure essential services are maintained
* comply with the Department of Families, Fairness and Housing’s Capital Development Guidelines – Series 7 on fire risk management
* ensure that (at the time of client placement in any premises) the premises comply with all laws relating to fire protection, fire safety, health and general safety that apply to any premises from which the organisation operates
* ensure the premises are suitable for efficient client evacuation, taking into account the fire systems installed, and the relocation and evacuation capacities of the client. If any relevant change occurs that may affect a client’s ongoing ability to evacuate safely, the organisation’s Emergency Planning Committee must be informed and appropriate action taken.

Health services funded by the department must comply with the Department of Families, Fairness and Housing’s guidelines on fire risk management, and must complete and email an Annual Fire Safety Certificate to the [Fire Services Team](mailto:FRMUCertificates@homes.vic.gov.au) <FRMUCertificates@homes.vic.gov.au>, or through their respective fire services coordinator by 1 September each year.

For more information on fire risk management and annual fire safety certificates, visit [Fire risk management and procedures](https://providers.dffh.vic.gov.au/fire-risk-management-procedures-and-guidelines) <https://providers.dffh.vic.gov.au/fire-risk-management-procedures-and-guidelines> or email the [Fire Services Team](mailto:fireservicesteam@homes.vic.gov.au) <fireservicesteam@homes.vic.gov.au>.

# Legal obligations

## Privacy

Funding is provided on the condition that the funded organisation:

* complies with the provisions of the *Privacy and Data Protection Act 2014* (Vic), the Health Records Act, and other applicable information-sharing and privacy obligations imposed by law, codes of practice or guidelines made under those laws (collectively the Privacy Legislation) in performing funded services
* ensures its employees, officers, agents and subcontractors comply with the terms of any funding agreement(s) between the department and the funded organisation, including any Privacy Legislation, where applicable.

## Public interest disclosures and mandatory notifications

Where applicable, the funded organisation agrees to comply with and be bound by the provisions of the *Public Interest Disclosures Act 2012* (Vic) (formerly known as the *Protected Disclosure Act 2012* (Vic) and the mandatory notification obligation under s. 57 of the *Independent Broad-based Anti-corruption Commission Act 2011* (Vic).

For guidance provided by the Independent Broad-based Anti-corruption Commission, visit [Mandatory notifications](https://d.docs.live.net/031c443d5a1cf449/Documents/Business/Government/DoH-C%5e0SI/Mandatory%20notifications) <https://www.ibac.vic.gov.au/mandatory-notifications>.

## IP

The rights and obligations of funded organisations and the State of Victoria, regarding ownership and management of IP, reflect the *Whole of Victorian Government intellectual property policy* and are set out briefly below.

Funding is provided with the following conditions:

* All IP developed by a funded organisation with funding provided by the department (Project IP) vests in the funded organisation, unless the department advises the funded organisation in writing, prior to the delivery of all or part of the funded services, that the State of Victoria will own the Project IP.
* The funded organisation grants to the State of Victoria a non-exclusive, worldwide, perpetual, irrevocable, royalty-free licence to exercise all rights in relation to the Project IP (including background and third-party IP incorporated into Project IP) to enable the State of Victoria to enjoy the full benefit of the services. The licence includes the right to sublicense Project IP. For the avoidance of doubt, the rights conferred on the State of Victoria under the licence include, without limitation, the right to use, reproduce, adapt, broadcast, publish, communicate to the public and otherwise disseminate the Project IP for the benefit of the Victorian public.
* The funded organisation will ensure it obtains all necessary consents (including moral rights consents and consents from owners of third-party IP) to enable the State of Victoria to exercise all the rights conferred on the State of Victoria referred to above.
* Immediately following a written request, the funded organisation will provide all material containing Project IP to the department, to enable the department to exercise its rights under the licence.
* The funded organisation will properly manage the Project IP in a manner that allows the State of Victoria to enjoy the full benefit of the funded services.
* The funded organisation must not accept co-funding, or involve any person in the delivery of the services, on terms that would jeopardise or limit any licence to be granted to the State of Victoria, without obtaining the department’s prior consent in writing.

Where a funded organisation has a service agreement with the department, the department’s service agreement more fully records the parties’ rights with respect to Project IP and takes precedence over these guidelines.

# Payments and cash flow

## Payments to funded organisations

In 2025–26, 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://d.docs.live.net/031c443d5a1cf449/Documents/Business/Government/DoH-C%5e0SI/Tableau) <https://tableau.reporting.dhhs.vic.gov.au> (requires login). The department will monitor hospital cash flows, as reported monthly in the financial data (HeART) cashflow statement.

The department will make monthly payments to community service organisations through the Service Agreement Management System. For cashflow percentages of individual payment schedules of service agreements and details of the funded activities, login to My Agency via the [Funded Agency Channel](https://fac.dffh.vic.gov.au) <https://fac.dffh.vic.gov.au>. The department will monitor community service organisation performance and financial sustainability.

Payments may be adjusted for recall, loans, enterprise bargaining agreements, indexation, awards and prepayments.

## Enterprise bargaining

### Expiring agreements and enterprise bargaining

Negotiations for new enterprise agreements were finalised in 2024–25 for:

* public health sector nurses and midwives
* Ambulance Victoria paramedics
* Public health sector dental therapists
* Geelong Cemeteries Trust
* Greater Metropolitan Cemeteries Trust.

Negotiations for new enterprise agreements are occurring during the 2025–26 financial year for:

* Ambulance Victoria administration and management
* Breast Screen Victoria
* Public health sector mental health professionals
* Public health sector managers and administrative workers
* Public health sector health professionals
* Public health sector medical scientists, pharmacists and psychologists
* Public health sector medical specialists
* Public health sector doctors in training
* Forensicare.

### Wages policy

The Victorian Government’s current Wages policyand the *Enterprise bargaining framework* have applied since 4 April 2023.

The three pillars of the Wages policy are:

* wages – increases in wages and conditions capped at a rate of growth of 3.0% per annum and cash payment(s) distributed across the workforce to a value not exceeding 0.5% of the value of wages and allowances
* best-practice employment commitment – public sector agencies are to outline measures to operationalise elements of the government’s public sector priorities that reflect good practice, and can be implemented operationally or without significant cost
* additional strategic changes – changes to allowances and other conditions will only be allowed if the government agrees that the changes will address key operational or strategic priorities.

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

For more information, visit [Wages policy and the *Enterprise bargaining framework*](https://www.vic.gov.au/wages-policy-and-enterprise-bargaining-framework) <https://www.vic.gov.au/wages-policy-and-enterprise-bargaining-framework>.

### Budgeting for new agreements

Enterprise bargaining settlements are rarely timed to coincide with the beginning of a financial year. Therefore, there may be part-year cost effects in any given financial year, relating to both expiring and new enterprise bargaining outcomes. In contrast, budget indexation applies on a full financial year basis.

Health services must identify and account for indexation as it relates to supporting increased wage and salary costs. The baseline wage increases contained in the applicable wages policy must be funded by health services before any additional supplementation is sought from the Department of Treasury and Finance.

When new enterprise agreements take effect, or are likely to take effect in a financial year, health services must keep funding equal to these amounts available for such increases. This remains true, even when enterprise bargaining processes become protracted or complex, and remain unresolved at the end of the financial year in which settlement was expected to occur and have cost effect.

Health services must also ensure enterprise agreement costs are properly attributed to other relevant revenue sources, where existing employment costs are met from those other sources.

## Long service leave

The department assumes the liability arising from the net increase in the long service leave provision for public hospitals, denominational hospitals and some statutory authorities (‘eligible agencies’), except for changes to the long service leave provision due to any subsequent recognition of gains or losses on revaluation, which is in accordance with the Department of Treasury and Finance’s *Resource management framework*.

All agencies must, however, reflect the movements in the long service leave provision associated with the revaluations in their long service leave provision, in accordance with accounting standards.

The department funds the annual increase in the long service leave provision[[23]](#footnote-24) of its eligible agencies where:

* an amount equal to 2.8% of defined salaries and wages is included in the price and paid as grants to the department’s eligible agencies (with a few exceptions)
* a grant payable to the department’s eligible agencies is recognised for the balance not paid as the grant described above (a debtor in respect of this non-cash grant will be recognised by each eligible agency).

Eligible agencies will continue to manage their long service leave and cash requirements. Long service leave funding paid by the department in excess of actual long service leave payouts during the current and prior financial years should be maintained and managed by eligible agencies. It should also be used as the first call for any future settlements over and above the (current) 2.8% of long service leave included in the price.

## Medical indemnity insurance

The department has developed the medical indemnity risk-rated premium model, in consultation with, and on the advice of, the VMIA and its actuaries. The medical indemnity risk-rated premium model allocates a share of the statewide medical indemnity insurance premium to individual hospitals and health services.

# Data collection changes

The following subsections describe data collection changes. For more information, visit [Annual changes process](https://www.health.vic.gov.au/data-reporting/annual-changes) <https://www.health.vic.gov.au/data-reporting/annual-changes>.

## VAED

From 1 July 2025, the changes made to the VAED include:

* a new data element for reporting of Diagnosis Cluster Identifier
* a new Admitting/Discharge Unit/Specialty code for early parenting centres
* an updated definition, code set and reporting guide for the Triage Score on Admission.

Victorian health services must ensure their software can create a submission file, in accordance with the *Updated specifications for revisions to the VAED for 2025–26* at [Annual changes process](https://d.docs.live.net/031c443d5a1cf449/Documents/Business/Government/DoH-C%5e0SI/Annual%20changes%20process) <https://www.health.vic.gov.au/data-reporting/annual-changes> and ensure reporting capability is achieved to maintain compliance with reporting timeframes.

## ESIS

From 1 July 2025, the changes made to the ESIS include:

* a new data element for reporting patient NDIS participant identifier
* a new data element for reporting ASA score
* that the reporting surgeon identifier will cease.

Victorian health services must ensure their software can create a submission file in accordance with the *Specifications for revisions to the ESIS for 2025–26* at [Annual changes process](https://d.docs.live.net/031c443d5a1cf449/Documents/Business/Government/DoH-C%5e0SI/Annual%20changes%20process) <https://www.health.vic.gov.au/data-reporting/annual-changes> and ensure reporting capability is achieved to maintain compliance with reporting timeframes.

## AIMS

For reporting activity occurring from 1 July 2025, the changes made to AIMS data collections include:

* additional funding source categories (columns) added for reporting of urgent care activity on the AIMS ‘Urgent care centre’ form
* health services reporting non-admitted data to the VINAH MDS or the NADC:
* will cease reporting aggregate non-admitted data using the AIMS data collections for: S10 Acute Non-Admitted Clinic Activity; S11 Sub Acute Non-Admitted Activity; S11A Sub Acute Non-Admitted Multidisciplinary case conferences (MDCC) when patient not present; S12 Self-delivered Non-admitted Services
* must report aggregate data when reporting of patient-level data cannot be completed via the VINAH MDS/NADC
* health services not reporting non-admitted activity through the VINAH MDS or NADC must continue to report in 2025–26 using AIMS S10, S11, S11A and/or S12 as relevant
* amendments to the Quality Indicators for PSRACS data collection to capture the Commonwealth’s new indicator for allied health services were implemented for reporting from quarter 4 of 2024–25 and will be ongoing.
* reporting of the Maternity Demand Booking data collection ceased from July 2024.

Health services must ensure relevant AIMS data collections are completed by the due date, as set out in the [AIMS manual](https://www.health.vic.gov.au/data-reporting/agency-information-management-system-aims) <https://www.health.vic.gov.au/data-reporting/agency-information-management-system-aims>. Refer also to the Specifications for revisions to data collections for 2025–26 on [Annual changes process](https://d.docs.live.net/031c443d5a1cf449/Documents/Business/Government/DoH-C%5e0SI/Annual%20changes%20process) <https://www.health.vic.gov.au/data-reporting/annual-changes> .

## VEMD

From 1 July 2025, the changes made to the VEMD include:

* an introduced new data element Funding Source and retired Compensable Status data element
* the retired concept for Telehealth and updated concepts for Virtual Care, ED Presentation and Registration
* an updated definition, code set and reporting guide for the Service Type data element
* updated reporting guidance for Arrival date/time, Arrival Transport Mode, Departure Status, Departure Date and Patient Location data elements
* updated several business rules and input validations to support the above changes.

Victorian health services must ensure their software can create a submission file, in accordance with the *Specifications for revisions to the VEMD for 2025–26* at [Annual changes process](https://d.docs.live.net/031c443d5a1cf449/Documents/Business/Government/DoH-C%5e0SI/Annual%20changes%20process) <https://www.health.vic.gov.au/data-reporting/annual-changes> and ensure reporting capability is achieved to maintain compliance with reporting timeframes.

## VINAH MDS

From 1 July 2025, the changes made to the VINAH MDS include:

* new Referral In/Referral Out Service Type codes for VVED
* ceasing of reporting Message Visit Indicator Code ‘V – Client Service Event (Visit)’
* new and amended Contact Purpose codes for conservative management and optimisation of pathways for surgery.

Victorian health services must ensure their software can create a submission file, in accordance with the *Specifications for revisions to the VINAH MDS for 2025–26* at [Annual changes process](https://d.docs.live.net/031c443d5a1cf449/Documents/Business/Government/DoH-C%5e0SI/Annual%20changes%20process) <https://www.health.vic.gov.au/data-reporting/annual-changes> and ensure reporting capability is achieved to maintain compliance with reporting timeframes.

## NADC

From 1 July 2025, the change that has been made to the NADC is an amendment to existing data element Referral In Service Type to identify patient(s)/client(s) referred from the VVED.

## Victorian Perinatal Data Collection (VPDC)

In 2025–26, there will be a continuing focus for the VPDC on reporting compliance. This will ensure data is received in a timely manner and data quality issues are identified as early as possible.

The data items reported to the VPDC will remain the same for 2025–26 as for 2024-25. Reporting obligations and timeframes are specified in the Public Health and Wellbeing Act and Regulations.

The Specifications for revisions to the VPDC for 1 July 2024 are applicable for the 2025–26 collection. This is accessible at [VPDC](https://d.docs.live.net/031c443d5a1cf449/Documents/Business/Government/DoH-C%5e0SI/VPDC) <https://www.health.vic.gov.au/quality-safety-service/victorian-perinatal-data-collection>.

## Public sector residential aged care

Performance and quality improvement changes are that:

* PSRACS are expected to consider recommendations from the Royal Commission into Aged Care Quality and Safety, and how they can apply these to improve quality and safety for consumers
* over 2025–26, the department will work with PSRACS to implement recommendations from the Royal Commission into Aged Care Quality and Safety. It is expected that PSRACS will participate in projects and activities to progress implementation of the recommendations
* PSRACS must continue to implement continuous improvements that demonstrate a systematic ongoing effort to improve the quality of care and services and meet the Aged Care Quality and Safety Standards.

## ACA

Since August 2016, all ACA data, including referrals issued and associated workflow, is recorded in the Australian Government's My Aged Care system. The Australian Government provides access to performance data to the department and ACA providers, via the Australian Government’s Qlik platform.

As part of the national aged care reforms, the Australian Government Department of Health and Aged Care implemented the Single Assessment System to assess eligibility for all aged care services. This replaced assessment services delivered by ACAS and RAS. ACAS and RAS transitioned to the Single Assessment model in December 2024 with new performance requirements.

# 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 2025–26 versions of data collection manuals, and any other amending documents prepared by the department.

## Key systems

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

* HeART/Common Chart of Accounts
* VAED for admitted patient activity
* VEMD for designated ED activity
* ESIS for monitoring planned (elective) surgery waiting lists
* VINAH MDS for non-admitted patient activity
* NADC for non-admitted patient activity
* AIMS used primarily to collect summary-level statistical information
* VCDC for patient-level costs
* VPDC for births
* CMI/ODS for mental health client data.

### Financial data

Financial data must be submitted at the consolidated entity level, via HeART[[24]](#footnote-25),for all health services and other portfolio entities (excluding cemeteries and VicHealth) by close of business on the seventh working day after the end of the month to which the financial data relates.

Financial data must be submitted in a timely manner, as the month will be closed for further updates once ‘rolled over’ to the next month. Data relating to approved budgets (‘SOP budget’, ‘FTE budget’, and ‘Activity targets’) and estimates trial balances are required reporting, and they are outlined in more detail below.

The data elements required every month are a:

* trial balance
* cash flow statement (including tied and committed funds)
* monthly cash flow forecast to 30 June (including tied and committed funds)
* actual FTE
* estimated activity for the month that aligns with financial reporting.

Data submitted through HeART will be used each month as a basis for performance monitoring and for whole-of-government reporting. This collective data is reported to the Department of Treasury and Finance and must be complete and accurate. If the data submitted is inaccurate or incomplete, entities may be required to amend and resubmit it through the HeART system. This resubmission must occur in a timely manner.

Entities are also required to report both an approved budget (‘SOP Budget’), and estimate trial balances (end-of-year forecast) to the department through the HeART system, noting that:

* the submitted approved budget (‘SOP Budget’) should match the agreed SOP. The FTE and activity budgets/targets are also required to be submitted, once the SOP is signed
* estimates are to be in the form of a full end-of-year trial balance and reflect the most up-to-date forecast across the trial balance. By the dates outlined below, the estimate trial balance submissions must be accompanied by a chief financial officer sign-off (a template will be provided by the department).

The trial balance estimates for sign-off are:

* October – updated end-of-financial-year estimate, including September actuals, due to be submitted on 23 October 2025
* December – updated end-of-financial-year estimate, including November actuals, due to be submitted on 19 December 2025
* February – updated end-of-financial-year estimate, including January actuals, due to be submitted on 26 February 2026
* March – updated end-of-financial-year estimate where revenue and or expenditure has moved by 2%, due to be submitted on 20 March 2026
* April – updated end-of-financial-year estimate, including March actuals, due to be submitted on 24 April 2026
* May – updated end-of-financial-year estimate, including April actuals, due to be submitted on 22 May 2026
* June – updated end-of-financial-year estimate where revenue and or expenditure has moved by 2%, due to be submitted on 19 June 2026.

Entities will provide this information in accordance with the department's timelines. Late data submissions of trial balances will be monitored and reported through the performance monitoring staff in the department, along with the Data Quality Assurance Program.

### VAED

The VAED contains the core set of clinical, demographic, administrative and financial data for admitted patient episodes occurring in Victorian health services. Maintaining the accuracy of the VAED is essential to ensuring accurate and equitable funding outcomes, supporting health services’ planning, policy formulation, quality and safety monitoring, program evaluation and epidemiological research.

Analyses and consolidated activity data are provided from the VAED to meet the department’s reporting obligations to the Commonwealth and to various research institutes.

For more information on the VAED and to download the VAED manual, visit [VAED](https://d.docs.live.net/031c443d5a1cf449/Documents/Business/Government/DoH-C%5e0SI/VAED) <https://www.health.vic.gov.au/data-reporting/victorian-admitted-episodes-dataset>.

The department publishes the VAED manual on the HDSS website to provide clarity on reporting requirements for health services and information for data users.

Health services are expected to audit and reconcile their VAED data regularly throughout the year.

#### Submission guidelines

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

Health services (including SRHS) will assign clinical codes to patient episodes reported to the VAED using the current ICD-10-AM/ACHI classification, in accordance with Australian Coding Standards, along with Victorian additions to the Australian Coding Standards, national coding advice, and coding advice issued by the department through the Victorian ICD Coding Committee (Victoria’s jurisdictional coding advisory committee).

Public health services must submit admitted patient data to the VAED, according to the timelines in Table 6. Health services may submit data more frequently than the minimum standards specified in the table.

Table 6. VAED timelines

|  |  |
| --- | --- |
| VAED | Timeline |
| Admission and separation details for the month (E5, J5 and V5 records) | Must be submitted by 5 pm on the tenth day of the following month |
| Diagnosis and procedure, subacute and palliative care details (X5, Y5, S5 and P5 records) | Must be submitted by 5 pm on the tenth day of the 2nd month following separation |
| Data for the 2025–26 financial year | Must be submitted by 5 pm on 10 August 2026 |
| Final corrections to data for 2025–26 | Must be submitted by 5 pm on 24 August 2026 |

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

#### Penalties for noncompliance

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

* up to $20,000 per month, if more than 1% of admission and separation details (E5, J5) for a given month are submitted after the timeline specified
* up to $20,000 per month, if more than 1% of episodes for a given month are submitted without diagnosis, procedure, subacute or palliative care details (X5, Y5, S5, P5) by the deadline specified
* up to $2,000 per episode, if there is a significant number of episodes that are ‘dummy coded’ or do not meet the VAED business rules.

The above requirements apply to all account classes, including the Department of Veterans’ Affairs.

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

#### Exemptions from penalties

Health services seeking exemption from penalties for late data must notify the department and complete a Late data exemption request form, indicating the nature of the difficulties, remedial action being taken and the expected submission date. Exemptions will be granted at the department’s discretion.

To access the VAED late data exemption request form, visit [VAED](https://www.health.vic.gov.au/data-reporting/victorian-admitted-episodes-dataset) <https://www.health.vic.gov.au/data-reporting/victorian-admitted-episodes-dataset>. This form must be submitted if a health service cannot meet the reporting deadline.

Requests for an exemption from late penalties will only be considered if received prior to the relevant deadlines, and if the manual aggregate data (AIMS S1A form) has been completed by the due date. Extensions or exemptions are not issued in advance. Late submissions penalties are assessed after the end-of-year consolidation deadline, taking into account the health service’s compliance performance for the financial year.

For any full-month period that the health service is unable to supply unit record data, the health service is required to submit aggregate data using the AIMS S1A form submitted via HealthCollect. The health service must complete the AIMS S1A form by the tenth of the month.

For assistance with the S1A, email [HDSS helpdesk](mailto:HDSS%20helpdesk) <hdss.helpdesk@health.vic.gov.au>. Failure to complete the S1A form by the due date may result in late submission penalties.

#### Software upgrades and migrations

Health services are required to notify the department by email to the [HDSS helpdesk](mailto:hdss.helpdeks@health.vic.gov.au) <hdss.helpdesk@health.vic.gov.au> as soon as a decision is made to implement new software applications that will affect VAED reporting.

Multiple health services often implement new software at the same time, and the department is frequently asked for advice on data migration, to support testing and so forth. To ensure the department can provide sufficient support, early notification is appreciated. Please advise the software being changed and whether it is a PAS or an EMR, the data collections involved, migration plans, go-live dates and the main health service contacts.

Health services implementing software migrations must undertake VAED data submission testing before resuming VAED data submissions to the production (live) environment. Health services will be exempt from late data submission penalties for an agreed period of no more than two months, provided the S1A form is completed on time.

Health services undertaking software upgrades may also choose to undertake the VAED data submission testing process before resuming VAED data submissions to the production (live) environment. Health services will be exempt from late data submission penalties for one month, provided the S1A form is completed on time.

#### Statement of Assurance

As the provision of timely, accurate and reliable data is critical to the department fulfilling its functions, health services will be required to submit a Statement of Assurance attesting to the completeness and accuracy of 2025–26 data submitted to the VAED.

The Statement of Assurance is to include commentary on:

* explanations on any significant changes in activity from the prior financial year
* steps taken to promote completeness and accuracy of activity data (for example, audit tools or programs, and third-party reviews)
* other information that may be relevant to users of the data.

### VEMD

The VEMD contains de-identified demographic, administrative and clinical data detailing ED presentations at Victorian public hospitals.

For more information on the VEMD and to download the VEMD manual, visit <https://www.health.vic.gov.au/data-reporting/victorian-emergency-minimum-dataset-vemd> <https://www.health.vic.gov.au/data-reporting/victorian-emergency-minimum-dataset-vemd>.

The department publishes the VEMD manual on the HDSS website to provide clarity on reporting requirements for health services and information for data users.

Health services are expected to audit and reconcile their VEMD data regularly throughout the year.

#### Submission guidelines

Public health services reporting to the VEMD must adhere to the timelines in Table 7.

Table 7. VEMD timelines

|  |  |
| --- | --- |
| VEMD | Timeline |
| All presentations to be submitted every weekday | All presentations must be supplied by 5 pm on the following business day |
| All presentations for the full month without errors | Must be complete and correct – that is, zero rejections and notifiable edits by 5 pm on the tenth day of the following month, or the prior business day |

Any corrections to 2025–26 data must be submitted before final consolidation of the VEMD on 27 July 2026.

#### Penalties for noncompliance

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

* up to $5,000 per month, if presentations for the first 14 days of the month are not submitted by the timelines specified in Table 7
* up to $10,000 per month, if presentations for the full month are not submitted by the timelines specified in Table 7
* up to $10,000 per month, if a file with all presentations for the full month contains errors by the timelines specified in Table 7.

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

#### Exemptions from penalties

Health services seeking exemption from penalties for late data must notify the department and complete a Late data exemption request form indicating the nature of the difficulties, remedial action being taken and the expected submission date. Exemptions will be granted at the department’s discretion.

To access the VEMD Late data exemption request form, visit [VEMD](https://www.health.vic.gov.au/data-reporting/victorian-emergency-minimum-dataset-vemd) <https://www.health.vic.gov.au/data-reporting/victorian-emergency-minimum-dataset-vemd>. This form must be submitted if a health service cannot meet the reporting deadline.

Requests for an exemption from late penalties will only be considered if received prior to the relevant deadlines, and if the manual aggregate data spreadsheet has been completed by the due date. Extensions or exemptions are not issued in advance. Late 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 that is available from the [VEMD](https://www.health.vic.gov.au/data-reporting/victorian-emergency-minimum-dataset-vemd) <https://www.health.vic.gov.au/data-reporting/victorian-emergency-minimum-dataset-vemd>. The health service must submit the completed spreadsheet by the tenth of the month.

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

#### Software upgrades and migrations

Health services are required to notify the department by email to the [HDSS helpdesk](mailto:emailing%20the%20HDSS%20helpdesk) <hdss.helpdesk@health.vic.gov.au> as soon as a decision is made to implement new software applications that will affect VEMD reporting.

Multiple health services often implement new software at the same time, and the department is frequently asked for advice on data migration, to support testing and so forth. To ensure the department can provide sufficient support, early notification is appreciated. Please advise the software being changed, whether it is a PAS or an EMR, the data collections involved, migration plans, go-live dates and the main health service contacts.

Health services undertaking software migrations must undertake VEMD data submission testing before resuming live VEMD data submission. Health services will be exempt from late data submission penalties for an agreed period of up to two months, provided the manual aggregate data spreadsheet is completed on time.

Health services undertaking software upgrades will be exempt from late data submission penalties for one month, provided the manual aggregate data spreadsheet is completed on time.

### ESIS

The ESIS is a patient-level collection of planned (elective) surgery waiting list data from approved Victorian public healthcare services.

For more information on the ESIS and to download the ESIS manual, visit [ESIS](https://www.health.vic.gov.au/data-reporting/elective-surgery-information-system-esis) <https://www.health.vic.gov.au/data-reporting/elective-surgery-information-system-esis>.

The department publishes the ESIS manual on the HDSS website to provide clarity on reporting requirements for health services and information for data users.

Health services are expected to audit and reconcile their ESIS data regularly throughout the year.

#### Submission guidelines

Public health services reporting to the ESIS must adhere to the minimum submission timelines in Table 8.

Table 8. ESIS timelines

|  |  |
| --- | --- |
| ESIS | Timeline |
| All activity (registrations, removals, readiness, urgency and scheduling events) for the first 15 days of the month | Must be submitted by 5 pm on the third business day after the fifteenth of the reporting month |
| All activity (registrations, removals, readiness, urgency and scheduling events) for the remaining days of the month (sixteenth and subsequent) | Must be submitted by 5 pm on the third business day of the following month |
| All activity for the full month without errors | Must be complete and correct – that is, zero rejections, notifiable or correction edits – by the fourteenth day of the following month, or the prior business day |

Any corrections to 2025–26 data must be submitted before final consolidation of the ESIS database on 24 August 2026.

#### Penalties for noncompliance

Where health services are noncompliant with the timelines specified above, the department may apply a penalty of:

* up to $5,000 per month, if episodes for the first 15 days are not submitted by the timelines specified in Table 8
* up to $10,000, if episodes for the full month are not submitted by the timelines specified in Table 8
* up to $10,000, if a file with all episodes for the full month contains errors by the timelines specified in Table 8.

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

#### Exemptions from penalties

Health services seeking exemption from penalties for late data must notify the department and complete a Late data exemption request form indicating the nature of the difficulties, remedial action being taken and the expected submission date. Exemptions will be granted at the department’s discretion.

To access the ESIS late data exemption request form, visit [ESIS](https://www.health.vic.gov.au/data-reporting/elective-surgery-information-system-esis) <https://www.health.vic.gov.au/data-reporting/elective-surgery-information-system-esis>. This form must be submitted if a health service cannot meet the reporting deadline.

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

For any full-month period that the health service is unable to supply unit record data, the health service is required to submit aggregate data using the manual aggregate data spreadsheet. The health service must submit the completed spreadsheet by the fourteenth of the month.

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

To access the spreadsheet, visit [ESIS](https://www.health.vic.gov.au/data-reporting/elective-surgery-information-system-esis) <https://www.health.vic.gov.au/data-reporting/elective-surgery-information-system-esis>.

#### Software upgrades and migrations

Health services are required to notify the department by email to the [HDSS helpdesk](mailto:hdss.helpdeks@health.vic.gov.au) [<hdss.helpdesk@health.vic.gov.au](mailto:%3chdss.helpdeks@health.vic.gov.au)> as soon as a decision is made to implement new software applications that will affect ESIS reporting.

Multiple health services often implement new software at the same time, and the department is frequently asked for advice on data migration, to support testing and so forth. To ensure the department can provide sufficient support, early notification is appreciated. Please advise the software being changed, whether it is a PAS or an EMR, the data collections involved, migration plans, go-live dates and the main health service contacts.

Health services undertaking software migrations must undertake ESIS data submission testing before resuming live ESIS data submission. Health services undertaking software migrations will be exempt from late data submission penalties for an agreed period of up to two months, provided the manual aggregate data spreadsheet is completed on time.

Health services undertaking software upgrades will be exempt from late data submission penalties for one month, provided the manual aggregate data spreadsheet is completed on time.

### VINAH MDS

The VINAH MDS is a patient-level reporting system that is built around a generic framework suitable for reporting a wide range of non-admitted patient-level data.

Organisations that receive funding under any of the following programs must transmit valid and complete data to the VINAH MDS, including:

* complex care
* early parenting centres
* health independence program
* infusion therapy
* subacute ambulatory care services
* hospital admission risk program
* post-acute care
* residential in reach
* home-based dialysis
* home enteral nutrition
* medi-hotel (optional)
* palliative care
* palliative care consultancy
* specialist clinics (outpatients)
* total parenteral nutrition
* transition care program
* Victorian artificial limb program
* Victorian HIV and sexual health services
* Victorian respiratory support service.

For clarity on reporting requirements for health services, and information for data users, more information is provided in the [VINAH MDS manual](https://www.health.vic.gov.au/data-reporting/victorian-integrated-non-admitted-health-vinah-dataset) <https://www.health.vic.gov.au/data-reporting/victorian-integrated-non-admitted-health-vinah-dataset>.

Health services are expected to audit and reconcile their VINAH MDS data regularly throughout the year.

#### Submission guidelines

Health services reporting to the VINAH MDS will be required to adhere to the minimum submission timelines in Table 9.

Health services are encouraged to submit more frequently than the minimum standards in the table. It is the funded organisation’s responsibility to ensure data files are submitted in time to meet the processing schedule detailed below, regardless of the actual day of the week.

Table 9. VINAH MDS timelines

|  |  |
| --- | --- |
| VINAH MDS | Timeline |
| Submission data for client, referral, episode and contact details for the month | Must be submitted before 5 pm on the tenth day of the following month |
| Clean data for client, referral, episode and contact details for the month | Must be submitted before the file consolidation at 5 pm on the fourteenth day of the following month, or the preceding business day if the fourteenth falls on a weekend or public holiday, when data must be complete – that is, zero rejections |

Data for the financial year must be completed in time for the VINAH MDS file consolidation on 24 August. Any final corrections must be received at the HealthCollect portal before the VINAH MDS database is finalised on 24 August 2026.

#### 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 9
* 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 9.

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

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

#### Exemptions from penalties

Organisations seeking exemption from penalties for late data must complete a Late data request form (available on the HealthCollect portal) advising of the issues experienced, the organisation’s plan for overcoming the issues and the expected submission date. Exemptions will be granted at the department’s discretion.

Organisations unable to complete non-admitted patient level reporting via the VINAH MDS/NADC by the due date must submit aggregate data using the manual aggregate data form by the due date.

#### Software upgrades and migrations

Health services are required to notify the department by email to the [HDSS helpdesk](mailto:emailing%20the%20HDSS%20helpdesk) <hdss.helpdesk@health.vic.gov.au> as soon as a decision is made to migrate to new software applications that will affect VINAH MDS reporting.

Multiple health services often implement new software at the same time, and the department is often asked for advice on data migration, to support testing and so forth. To ensure the department can provide sufficient support, early notification is appreciated. Please advise the software being changed, whether it is a PAS or an EMR, the data collections involved, migration plans, go-live dates and the main health service contacts.

Health services undertaking software migrations must undertake VINAH MDS submission testing before resuming live VINAH MDS submissions. Health services undertaking software migrations will be exempt from late data submission penalties for three months.

Health services undertaking software upgrades will be exempt from late data submission penalties for one month.

Health services must ensure their 2025–26 VINAH MDS is transmitted completely by 24 August 2026 and should ensure software updates and migrations do not prevent complete VINAH MDS transmissions by this date, as no extensions will be possible.

### NADC

The NADC is a flat file extract for non-admitted patient-level reporting. Health services unable to report data to the VINAH MDS may request to report this collection, which includes a limited number of data items based on the IHACPA ABF Non-Admitted Patient Care Patient Level Specifications and meets the department’s national reporting obligations.

Health services are mandated to report non-admitted activity data through the VINAH MDS. The NADC has been developed for use in exceptional circumstances only. Service providers will require department approval to submit non-admitted activity through NADC, rather than through the VINAH MDS.

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

Table 10. NADC timelines

|  |  |
| --- | --- |
| NADC | Timeline |
| Submission date for all service events in the month | Must be submitted before 5 pm on the tenth day of the following month |
| Clean date for all service events for the month | Must be submitted before the NADC file consolidation at 5 pm on the fourteenth day of the following month, or the preceding working day if the fourteenth falls on a weekend or public holiday when data must be complete – that is, zero rejections |

Funded organisations must meet the following minimum requirements:

* Funded organisations must make at least one submission for the reference month, by no later than 5 pm on the tenth day of the month following the reference month.
* All errors are to be corrected in time for the NADC file consolidation at 5 pm on the fourteenth day of the month following the reference month. Complete data for the month is expected to be transmitted by the fourteenth day.

Data for the financial year must be completed in time for the NADC file consolidation on 24 August. Any final corrections must be received before the NADC database is finalised on 24 August 2026.

It is the funded organisation’s responsibility to ensure the department receives the data in time to meet the processing schedule detailed above, regardless of the actual day of the week.

Penalties and exemptions for penalties are in line with the VINAH MDS.

### AIMS

Health services will provide AIMS data to the department electronically via the HealthCollect web portal, and in accordance with the timelines specified in the AIMS manual.

The data collections within AIMS have different due dates and reporting intervals, as documented in the AIMS manual. AIMS data submissions are made through the [HealthCollect portal](https://www.healthcollect.vic.gov.au/desktopdefault.aspx?ReturnUrl=%2f)<https://www.healthcollect.vic.gov.au> (login required).

#### Penalties for noncompliance

If health services are noncompliant with these timelines, the department may apply a penalty of up to $5,000 for each return that is not submitted by the due date specified in the AIMS manual.

Organisations seeking exemption from penalties for late data must email the [HDSS help desk](mailto:hdss.helpdesk@health.vic.gov.au) <hdss.helpdesk@health.vic.gov.au>, advising of the issues experienced, the organisation’s plan for overcoming the issues and the expected submission date.

For more information, visit [AIMS](https://www.health.vic.gov.au/data-reporting/agency-information-management-system-aims) <https://www.health.vic.gov.au/data-reporting/agency-information-management-system-aims>.

### VCDC

Victorian public hospitals are required to report costs for all hospital activity, regardless of funding source, and are expected to maintain patient-level costing systems that monitor service provision to patients and determine accurate patient-level costs.

Victorian health services are required to adhere, where possible, to the Australian Hospital Patient Costing Standards (v 4.2) (or the most recent version, in the instance that a successor becomes available), in conjunction with VCDC documentation, guidelines, specifications and business rules, and any other guidance provided by the department in the coming year.

#### Format and scope

The cost data submission to the department must comply with the VCDC file specifications and reporting requirements.

For more information, visit [VCDC](https://d.docs.live.net/031c443d5a1cf449/Documents/Business/Government/DoH-C%5e0SI/VCDC) <https://www.health.vic.gov.au/data-reporting/victorian-cost-data-collection-vcdc>.

The cost data submitted should be quality assured and cover all areas of hospital activity undertaken by the health service, including (but not limited to) four broad categories of:

* admitted – a patient who undergoes a hospital's admission process to receive treatment and/or care. This treatment and/or care is provided over a period of time, and can occur in hospital and/or in the person's home (for HITH patients), and include acute, subacute and mental health
* emergency – a dedicated area in a hospital that is organised and administered to provide emergency care (including reception, triage, initial assessment and management) to people who perceive the need for, or are in need of, acute or urgent care
* non-admitted – a patient who does not undergo a hospital’s formal admission process. There are several categories of non-admitted patient: ED, outpatient, subacute and other non-admitted patient (treated by hospital employees off the hospital site, which includes community/outreach services)
* specialist clinical mental health – a dedicated area in a hospital that delivers a range of hospital and community-based clinical mental health services. This includes both admitted and non-admitted (community) patients.

The National Health Reform Agreement specifies that these areas are activity-base funded and cost data is required from all these services to support development of national weights.

#### Reconciliation and data integrity

Health services are expected to:

* audit and reconcile their data before, during and after the allocation of their patients’ costs
* examine and review their current cost data for completeness across all services
* conduct data quality assurance of their data that provides a level of understanding of the usefulness of the patient-level data for development of funding models, and interpretation for analysis and reporting.

#### Submission and timeframes

The VCDC submission involves a five-phase process to ensure the data submitted meets the requirements specified in the documentation.

The five phases include:

* phase 1 – receipt of a submission
* phase 2 – file validations
* phase 3 – linking/matching VCDC to activity
* phase 4 – data quality assurance checks
* phase 5 – receipt of a reconciliation report and data quality statement.

Health services reporting VCDC data will be required to adhere to the minimum submission timelines in Table 11.

Health services may submit more frequently than the minimum standards in the table.

Table 11. VCDC actions and reporting timelines

|  |  |
| --- | --- |
| Actions | Date |
| VCDC Secure Data Exchange portal open | 22 September |
| First submission of files to VCDC – phase 1 | 23 October |
| Following provision of report(s) – complete phase 2 and phase 3 (validation and linking) | 27 November |
| Following provision of report(s) – complete phase 4 (quality assurance checks) | 24 December |
| Following final file – complete phase 5 (submission of reconciliation report and data quality statement) | 9 January |
| Department of Health to consolidate Victorian cost database | 16 January |

#### Penalties for noncompliance

Health services will be assessed to have complied with the department’s data requirements if they have:

* provided the data required as specified in the data request
* provided the data in the timeframes requested.

If a health service does not meet both these requirements, they will be regarded as being noncompliant. However, where health services are experiencing issues complying with the above timeframes, they are to inform the department via an email to [VCDC assist](mailto:vcdcassist@health.vic.gov.au) <vcdcassist@health.vic.gov.au> before the submission is required.

In this instance, the department’s VCDC Team will work with the health service to improve the data submission process over time.

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

* up to $20,000 per month, if cost data is not submitted by the timeline specified
* up to $2,000 per episode, if there are a significant number of episodes that do not meet the VCDC business rules.

#### Exemptions from penalties

Health services seeking exemption from penalties for not meeting reporting timelines must notify the department and complete a Late data exemption request form indicating the nature of the difficulties, remedial action being taken and the expected submission date. Exemptions will be granted at the department’s discretion.

To access the VCDC late data exemption request form, visit [VCDC](https://www.health.vic.gov.au/data-reporting/victorian-cost-data-collection-vcdc) <https://www.health.vic.gov.au/data-reporting/victorian-cost-data-collection-vcdc>. This form must be submitted if a health service cannot meet the reporting deadlines.

#### Software upgrades and migrations

Health services undertaking software migrations must undertake VCDC data submission testing prior to resuming live VCDC data transmissions. Health services must ensure their VCDC is transmitted by the due date. They should ensure software updates and migrations do not prevent complete VCDC transmissions by this date.

### VPDC

Health services where births occur (or the midwife or medical practitioner who attends a birth that does not occur in a health service) are required to report information about the birth, in the form approved by the CCOPMM, being the data custodians), for inclusion in the VPDC (see [section 28.7](#_Victorian_Perinatal_Data)).

Under the Public Health and Wellbeing Regulations 2019, VPDC data is to be submitted within 30 days of the birth, unless otherwise specified by the CCOPMM.

The VPDC is a population-based surveillance system for collecting and analysing comprehensive information on, and in relation to, the health of mothers and babies, to contribute to improvements in their health outcomes. It contains information on obstetric conditions, procedures and complications, birth outcomes, neonatal morbidity, congenital anomalies and a range of other details, and must be reported for every birth in Victoria. The definition of a birth for this purpose means a birth or stillbirth that is required to be registered under the *Births, Deaths and Marriages Registration Act 1996*.

For the VPDC manual, including data definitions, business rules and submission guidelines, visit [VPDC](https://www.health.vic.gov.au/quality-safety-service/victorian-perinatal-data-collection) <https://www.health.vic.gov.au/quality-safety-service/victorian-perinatal-data-collection>.

### VHIMS MDS

The department, in consultation with SCV, administers the VHIMS MDS, which is a standardised dataset for the collection and classification of clinical, occupational health and safety incidents (also known as adverse events), near misses and hazards.

The VHIMS MDS is subject to the department’s annual review and change cycle. All Victorian public health services and registered community health services, and services under their governance structures, are required to report data to the VHIMS 2 Version 2 MDS, in accordance with the current [VHIMS Data Manual](https://www.health.vic.gov.au/publications/victorian-health-incident-management-system-minimum-dataset) <https://www.health.vic.gov.au/publications/victorian-health-incident-management-system-minimum-dataset>.

Health services are no longer able to submit the VHIMS interim dataset.

#### Near-real-time reporting

The department and SCV require near-real-time incident data to support monitoring and surveillance activities, including timely identification of new and emerging patient and workforce safety risks.

In-scope health services are required to submit all new and updated incidents to the department daily, via the VHIMS Central Solution or the VHIMS Application Programming Interface. Reports identify where gaps in data submission exist, including noncompliant health services.

In 2024−25, registered community health services are exempt from near real-time reporting requirements. These services are required to submit all closed incidents to the department weekly, with the transition to near real-time reporting expected from 1 July 2025. Registered community health services may choose to implement near-real-time reporting prior to 1 July 2025 at their discretion.

#### Penalties for noncompliance

No penalties for late data submission of the VHIMS MDS will apply in 2025–26 while health services are implementing the VHIMS 2 Version 2 MDS. However, health services are advised that the department may apply late data penalties from 1 July 2026.

### Better Patient Dataset

The Better Patient Dataset contains a core set of demographic information about every patient who has been treated in a Victorian health service. Regular updates of the Better Patient Dataset are essential for optimum health services’ planning, policy formulation, program evaluation and epidemiological research.

Health services will provide the Better Patient Dataset to the department electronically for each month, in accordance with departmental specifications, by the tenth day of the following month, or as otherwise requested by the department due to changed circumstances.

#### Penalties for noncompliance

If health services are noncompliant with these timelines, the department may apply a penalty of up to $3,800 for each return that is not submitted by the due date specified above.

Organisations seeking exemption from penalties for late data must write to the Specialist Manager, Centre for Victorian Data Linkage, advising of the issues experienced, the organisation’s plan for overcoming the issues and the expected submission date.

### VICNISS

All public health services are required to participate in the VICNISS Coordinating Centre’s hospital acquired infection surveillance program. Mandatory reporting requirements by individual health services are determined by the size of the health service and type of services provided.

Infection surveillance reporting for health services 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
* healthcare-associated bloodstream infection including *Staphylococcus aureus* bacteraemia.
* healthcare worker seasonal influenza vaccination.

Further infection surveillance activities can be undertaken by health services on a voluntary, as needs basis.

Health services with a statistically significant higher rate than the aggregate are notified and requested to provide information on actions that are being taken to reduce this rate. Continued occurrence of higher-than-expected results may lead to a formal outlier review process by SCV.

A limited number of healthcare-associated infections performance indicators are reported publicly at [Victorian Health Services Performance](https://vahi.vic.gov.au/reports/victorian-health-services-performance) <https://vahi.vic.gov.au/reports/victorian-health-services-performance>.

Rates for Staphylococcus aureus bacteraemia and compliance with the National Hand Hygiene Initiative guidelines are publicly reported at [Hospitals](https://d.docs.live.net/031c443d5a1cf449/Documents/Business/Government/DoH-C%5e0SI/Hospitals) <https://www.aihw.gov.au/hospitals >.

### VSTR

All public health services, including the three designated major trauma services, must participate in the VSTR. The key requirement is the delivery of trauma data, in the form requested by the registry, to the registry on time. The department contracts the VSTR to collect data on major trauma patients from health services.

The performance and effectiveness of the Victorian State Trauma System is monitored via the registry. The failure to deliver data on time affects the governance of the Victorian State Trauma System and the ability of the registry to deliver reports to health services. State aggregate data is reported every year in the VSTR summary report.

To access these reports, visit [About the Victorian State Trauma System](https://www.health.vic.gov.au/patient-care/victorian-state-trauma-registry) <https://www.health.vic.gov.au/patient-care/victorian-state-trauma-registry>.

### Victorian Audit of Surgical Mortality

The Victorian Audit of Surgical Mortality is a peer-review audit of deaths associated with surgical care, which is undertaken through the Royal Australasian College of Surgeons Victorian Office. Surgeon participation in the audit is a requirement of the college’s continuing professional development program. It is funded by the department and SCV is the contact manager.

The audit strengthens relationships with the department as a recommendation of [Targeting zero: the review of hospital safety and quality assurance in Victoria](https://www.health.vic.gov.au/publications/targeting-zero-the-review-of-hospital-safety-and-quality-assurance-in-victoria) <https://www.health.vic.gov.au/publications/targeting-zero-the-review-of-hospital-safety-and-quality-assurance-in-victoria>.

The formation of the Perioperative Mortality Committee has further strengthened information-sharing arrangements with the Victorian Perioperative Consultative Council (VPCC) being included in Commonwealth Qualified Privilege legislation.

Two ministerial advisory councils, VPCC and CCOPMM, were established to monitor, analyse, review, investigate and report on matters on specialised areas within health care, to identify preventable harm, and reduce mortality and morbidity. Please refer to [section 18.5](#_Perinatal_services_performance) for perinatal services performance indicators.

The councils make recommendations to help health services and clinicians improve clinical practice and systems of care, using their annual reports to detail councils’ research and activities. The councils also directly advise the Minister for Health, the department and SCV on strategies to improve clinical performance and avoid preventable harm.

### Consultative councils reporting requirements

#### VPCC

The VPCC oversees, reviews and monitors perioperative care in Victoria. Health services and clinicians report adverse events (including death) that may occur prior to, during or following surgery, to the VPCC.

For more information, visit [VPCC](https://d.docs.live.net/031c443d5a1cf449/Documents/Business/Government/DoH-C%5e0SI/VPCC) <https://www.safercare.vic.gov.au/councils/vpcc>.

#### CCOPMM

The CCOPMM considers, investigates and reports on obstetric and paediatric mortality and morbidity in Victoria.

The CCOPMM is also responsible for the:

* VPDC, a population-based surveillance system that collects and analyses information on the health of mothers and babies during the birth episode. Refer to [section 28.7](#_Victorian_Perinatal_Data) for data collection changes
* Victorian Congenital Anomalies Register, which is a surveillance system for congenital anomalies in Victoria.

CCOPMM reviews and identifies preventable harm for these mortality and morbidity cases. It must report any preventable harm identified in its review process to the Secretary of the department and the CEO of SCV.

For more information, visit [CCOPMM](https://d.docs.live.net/031c443d5a1cf449/Documents/Business/Government/DoH-C%5e0SI/CCOPMM) <https://www.safercare.vic.gov.au/councils/CCOPMM>.

### Cardiac Surgery Registry

The Cardiac Surgery Database Project is coordinated by Monash University’s School of Public Health and Preventive Medicine. SCV expects all Victorian public health services that perform cardiac surgery to participate. This project is an initiative of the ANZSCTS and is overseen by the ANZSCTS Cardiac Surgery Database Steering Committee.

The Cardiac Surgery Database Project includes maintaining a comprehensive clinical registry, statistical analysis and report generation. These components enable a structured peer-review process that can identify variation in performance at the practitioner and health service levels.

The funding arrangements for this registry, outlined in a contract managed by eHealth, stipulate that quarterly reports of summarised data are submitted to SCV and/or the department.

The Cardiac Surgery Database Project is a part of this extensive effort to leverage clinical registries for benchmarking and quality improvement in health care at both national and jurisdictional levels. Data in these reports are received with Victorian public health services identified by name, to better support and strategically guide statewide quality improvement activity and service planning. Registry data are also received for linkage to inform the development of statewide quality and safety indicators.

For more information, including annual reports and specific contact details for inquiries, visit [Monash Clinical Registries](https://d.docs.live.net/031c443d5a1cf449/Documents/Business/Government/DoH-C%5e0SI/Monash%20Clinical%20Registries) <https://www.monash.edu/medicine/sphpm/registries>. Detailed data and insights are also available at [ANZSCTS](https://d.docs.live.net/031c443d5a1cf449/Documents/Business/Government/DoH-C%5e0SI/ANZSCTS) <https://anzscts.org/database/about/>.

### Victorian Cardiac Outcomes Registry

The department has supported the development and implementation of a cardiac outcomes registry that aims to help improve the safety and quality of health care provided to cardiovascular patients in Victoria. All Victorian public health services that perform percutaneous coronary interventions must provide this data to the Victorian Cardiac Outcomes Registry.

This registry is coordinated by Monash University’s School of Public Health and Preventive Medicine. It has the support of the Cardiac Society of Australia and New Zealand. The funding arrangements for this registry, outlined in a contract managed between the department and Victorian Cardiac Outcomes Registry, stipulate that quarterly reports of summarised data are submitted to SCV and/or the department.

Data in these reports are received with Victorian public health services identified by name to better support and strategically guide statewide quality improvement activity and service planning. Registry data are also received for linkage to inform the development of statewide quality and safety indicators.

### Australian Stroke Clinical Registry

The Australian Stroke Clinical Registry is a collaborative national effort to monitor, promote and improve the quality of acute stroke care. It is a prospective, multicentre, observational outcomes database that is designed to collect data on the demographics, presentation, diagnosis, treatment and outcomes of hospitalised patients with stroke. SCV promotes the implementation of the registry at all metropolitan and regional stroke units.

The registry funding arrangements, outlined in a contract managed between the department and Australian Stoke Clinical Registry by VAHI, stipulate that biannual reports of summarised data are submitted to SCV and/or the department.

Data in these reports are received, with Victorian public health services identified by name, to better support and strategically guide statewide quality improvement activity and service planning. Registry data are also received for linkage to inform the development of statewide quality and safety indicators.

### ANZICS CORE registries

The ANZICS CORE has provided a bi-national peer review and quality assurance program to provide audit and benchmarking services for ICUs across Australian and New Zealand since 1992. Data submitted to the registries is used for comparative benchmarking by the ICU peer groups with reports provided to submitting units’ ICUs and jurisdictional funders.

The registry funding arrangements, outlined in a contract managed between the department and ANZICS, stipulate that reports of summarised data are submitted to SCV and/or the department.

Data in these reports are received, with Victorian ICUs (public, private and paediatric) identified by name, to better support and strategically guide statewide quality improvement activity and service planning. Data is also reported to the Intensive Care Data Committee

### Radiotherapy services reporting

Radiotherapy providers must report monthly to:

* the Victorian Radiotherapy MDS
* AIMS form S8 for consultations only
* AIMS form S10 only for campuses not reporting this non-admitted activity via the VINAH MDS from 1/7/2025; for health services reporting patient-level activity via the VINAH MDS or NADC, AIMS S10 reporting will cease from 2025–26
* the VINAH MDS or the NADC for patient-level reporting.

The department contributes data from the Victorian Radiotherapy MDS to other agencies, as required. The data is included in the Victorian Cancer Registry’s annual cancer incidence report and the quarterly PRISM report, which presents waiting times at providers of public radiotherapy and forms part of reporting to the relevant health service.

### Renal dialysis reporting

All health services that provide facility dialysis must report public and private admitted activity at the unit record level to the VAED. This includes activity in all facilities.

Health services are required to report episode-level activity to the VINAH MDS for all patients enrolled in the home-based dialysis program.

### VHES

The existing agreement with Ipsos Public Affairs to deliver the VHES program has been continued for 2025−26. The department will continue to oversee the implementation of the contract requirements, and work with SCV to analyse and report healthcare experience data to inform actionable, quality and safety improvements.

Health service upload procedures are outlined below.

#### Upload procedures

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

In 2025−26, the mental health YES Survey has transitioned to a continuous digital data collection model. The CES has also transitioned to a continuous data collection model. Health services must upload contact details of eligible consumers to the contractor by the fifteenth of the month following discharge/contact.

Data transfers occur in a secure online environment through the [Project Control Portal](https://www.vhes.com.au/Account/Login?ReturnUrl=%2f) <https://www.vhes.com.au/Account/Login?ReturnUrl=%2f> (requires login). The portal provides access to the *Data upload manual* and the template required for submission.

Quarterly reports are available online at [VHES results](https://results.vhes.com.au) <https://results.vhes.com.au>. These results are currently only available to registered health services and departmental staff.

## Data integrity

Accurate data is important for funding purposes, performance monitoring, reporting, policy development and planning, and for maintaining public confidence in the health system.

Health service boards of management are accountable for the accuracy of reported data. Boards are expected to make data integrity the responsibility of their audit committee and ensure that data accuracy is subject to appropriate controls, including regular internal audits.

Health services are required to:

* maintain board and board audit committee scrutiny of data integrity practices
* continue with implementation of security improvements for all health service systems where data is collected and stored, including implementation of unique user identity and password controls, and routinely reviewing ICT system transaction logs
* implement recommendations from audits conducted at their health services
* provide a data quality attestation in the health service’s annual report.

Health services should refer to the [Data integrity guidelines for health services 2018](https://vahi.vic.gov.au/ourwork/health-data-integrity-program/data-integrity-guidelines-health-services) <https://vahi.vic.gov.au/ourwork/health-data-integrity-program/data-integrity-guidelines-health-services>. These provide guidance for health services to ensure the integrity of data reported. Importantly, they also assist health services to meet the requirements for integrity in the data provided by them when reporting their activity and performance.

The Health Data Integrity Program will continue in 2025–26, incorporating the same core health data collections previously subject to regular review, including the:

* VAED
* ESIS
* VEMD
* VCDC
* VINAH MDS
* Admitted Subacute Care data reported to VAED.

The program is led by the Health Data Integrity Unit in eHealth and comprises a mixture of formal audits and reviews of core datasets based on established audit protocols.

The program ensures that health data collections accurately reflect health service policy intent, service provision and the care that was provided to consumers.

The program seeks to increase confidence in the accuracy of health services’ data by:

* reviewing data recording and reporting practices, and health service compliance with department policies and business rules
* monitoring, reporting on and strengthening internal controls used in health services
* monitoring, detecting, reporting on and mitigating the risks and consequences of inaccurate health data
* providing stakeholders with an accurate picture of the strengths, weaknesses and threats related to health data integrity, and recommending opportunities to improve it.

The Health Data Integrity Program may be expanded to additional health service data collections, based on stakeholder priorities and analytics.

The Health Data Integrity Unit has also developed a monitoring and analytical system, comprising several reports across these datasets to monitor changes in data through a targeted approach, based on data analytics and risk assessment. It is anticipated that where potential data integrity issues are flagged, the unit will continue to consult with the relevant health services on these issues.

The VAED Audits recommenced in 2024–25 and are expected to continue in 2025–26.

Health services are expected to actively participate in the program, including reviewing reports on findings and recommendations. Unresolved issues that warrant escalation may be referred for further consideration, as part of the health service performance monitoring process.

### System updates

The VAED, VEMD, ESIS, VINAH MDS, NADC, VCDC, AIMS and VPDC data collections are reviewed annually to ensure they are relevant for performance monitoring against current operational priorities, as well as to provide up-to-date indicators of ongoing clinical activity trends.

The department remains committed to balancing the resources required to collect and report data against the need for quality data for monitoring, planning and fulfilment of the department’s own reporting obligations. These aims are achieved through various consultative committees and reference groups, for specific data collections and feedback received through specific departmental program areas and SCV.

Proposed changes to data collections are released for comment, and specifications for change are distributed by 31 December and published by 15 January, prior to the financial year to which they apply, to give health services sufficient time to plan and implement the specified changes.

Updates to VPDC reporting are directed to health service stakeholders by email and relevant documents are published on the [VPDC website](https://www.health.vic.gov.au/quality-safety-service/victorian-perinatal-data-collection) <https://www.health.vic.gov.au/quality-safety-service/victorian-perinatal-data-collection>.

The HDSS Bulletin provides advice on data quality issues to health services that contribute to the VAED, VEMD, ESIS, VINAH MDS, NADC and AIMS. The bulletin is the primary method by which amendments to standards and reporting timelines for these data collections are published during the year.

Health services should ensure that appropriate staff subscribe to the HDSS Bulletin to remain up to date with any changes. The HDSS Bulletin is issued electronically via both web and email. It is provided at no charge. Subscriptions may be arranged by visiting [HDSS forms](https://www.health.vic.gov.au/data-reporting/subscribe) <https://www.health.vic.gov.au/data-reporting/subscribe> or emailing the [HDSS helpdesk](mailto:HDSS%20helpdesk) <HDSS.Helpdesk@health.vic.gov.au>. Changes of contacts for the VPDC should be emailed to the HDSS Helpdesk.

### Penalties for noncompliance

If health services are noncompliant with the timelines specified in these guidelines, penalties may apply. Refer to the relevant dataset for more information.

## Ambulance Victoria data reporting requirements

Ambulance Victoria will continue to submit the Victorian Ambulance Dataset (VADS) data monthly, according to the timelines specified in Table 15.

Until both the department and Ambulance Victoria transition to the use of VADS data for the purposes of public reporting and performance monitoring, Ambulance Victoria will be required to continue aggregate Ambulance MDS reporting, as specified in Table 12.

Table 12. Ambulance Victoria data reporting and timelines

|  |  |
| --- | --- |
| Data reported | Description and submission timeline |
| VADS – Request for service and response data | Year-to-date submission to VADS to be received by the tenth day of the month following the case date |
| VADS – Transport and patient data | Year-to-date submission to VADS to be received by the tenth day of the 2nd month following the case date |
| Aggregate Ambulance MDS | Indicators identified in Table 22 will be supplied to the department in spreadsheet format by the tenth day of the month following the monthly reporting period |
| All data submissions for the 2024–25 financial year | Year-to-date submission must be received before final consolidation of the VADS on 10 August 2025 |

## Mental health services data reporting requirements

Information about clinical mental health services that is relevant to funding, activity and performance monitoring is collected by the department through a range of channels, including:

* the CMI/ODS, which captures service activity data and aspects of mental health care required under the Mental Health and Wellbeing Act
* the mental health Triage MDS
* reportable deaths and other notifications to the Chief Psychiatrist
* the annual Mental Health Establishments collection
* quarterly data collection (MHCSS reporting)
* a quarterly MHCSS aggregate spreadsheet report
* a monthly Mental Health and Wellbeing Locals aggregate collection
* a monthly Mental Health and Wellbeing Connect Centre aggregate collection
* the VAED (see [section 29.1.2](#_VAED))
* the VEMD (see [section 29.1.3](#_VEMD)).

The collections underpin public accountability for service provision, quality and safety, with the outputs contributing to a range of national datasets, and performance measurement and monitoring for Commonwealth, state and departmental purposes.

For mental health data and performance reporting, visit [Mental health](https://vahi.vic.gov.au/reports/victorian-health-services-performance/mental-health) <https://vahi.vic.gov.au/reports/victorian-health-services-performance/mental-health> and [Mental health performance reports](https://www.health.vic.gov.au/research-and-reporting/mental-health-performance-reports) <https://www.health.vic.gov.au/research-and-reporting/mental-health-performance-reports>.

### CMI/ODS

The statewide ODS is simultaneously updated from local CMI systems as data is captured, providing a live, 24/7 statewide view of the transactional history of mental health services.

Health services are expected to use the CMI/ODS to record clinical mental health activity, to ensure statewide visibility of consumer care across all designated mental health services. Data entry timeframes differ, according to the type of data being recorded (see Table 13 for details).

Table 13. CMI/ODS reporting timelines

|  |  |  |
| --- | --- | --- |
| Data entry | Rationale | Due date |
| Compulsory order/legal status | Timely information regarding compulsory/forensic/security client status | Twice daily, 7 days per week |
| Admissions, transfers and separations | Statutory reporting  Maintenance of statewide bed register | Twice daily, 7 days per week |
| Client registration and episode creation | Informational continuity of care | Daily, within 24 hours following mental state assessment |
| Contacts | Statutory reporting | On tenth of the month following the contact |
| Outcome measures | Statutory reporting | On tenth of the month following the measure collection |
| Electroconvulsive therapy procedures | Statutory reporting | As soon as practicably possible |
| Restrictive interventions | Statutory reporting | On tenth of the month following the period of the restrictive intervention (seclusion, physical/bodily and chemical restraint) |
| Diagnosis | Statutory reporting | Inpatients: On the tenth of the month following the diagnosis event |

Departmental circulars and bulletins detail the business rules for key data requirements and guidelines for data recording practices.

Business rules for data recording can be found under CMI/ODS under the heading of Data Quality at [Reporting requirements and business rules for clinical mental health services](https://www.health.vic.gov.au/research-and-reporting/reporting-requirements-and-business-rules-for-clinical-mental-health) <https://www.health.vic.gov.au/research-and-reporting/reporting-requirements-and-business-rules-for-clinical-mental-health>, as well as mental health bulletins and program management circulars.

Regular meetings are held with hospital mental health system administrators to discuss system and data issues. 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 at a minimum on a quarterly basis. Validation reports are updated monthly.

Quarterly returns are to be submitted by:

* July–September: 27 October
* October–December: 27 January
* January–March: 28 April
* April–June: 27 July.

Outstanding validation issues for the 2025–26 financial year must be reconciled by 24 August 2026.

#### Electroconvulsive therapy

The Chief Psychiatrist requires that all occasions of electroconvulsive therapy (ECT) be reported to the OCP. All ECT course details and procedures are to be recorded on the CMI/ODS, as soon as practicably possible after each procedure.

### National Mental Health Establishments Database

The National Mental Health Establishments Database collection captures all mental health workforce data and expenditure. It is compiled to meet the Mental health services annual report and national mental health reporting requirements.

The data collection for the previous financial year begins in October each year, with health services, residential service providers and departmental divisions required to submit a return.

As has been the practice in previous years, the Mental Health Establishments collection for 2023–24 will be pre-populated with health service activity data from the CMI/ODS when available. This information is subject to health service review and amendment as required.

For more information, visit [HealthCollect](https://www.healthcollect.vic.gov.au) <https://www.healthcollect.vic.gov.au> (login required).

Reporting timelines for the Mental Health Establishments collection are outlined in Table 14.

Table 14. Mental Health Establishments collection reporting timelines

|  |  |  |
| --- | --- | --- |
| Collection period | Reporting requirements | Due date |
| 2023–24 | Stage 2: Resolution of any final issues and any additional clarification required for the Australian Institute of Health and Welfare for 2023–24. Validations and questions sent to health services must be finalised by end of July 2025 | 25 July 2025 |
| 2024–25 | New financial year data submission opens through the HealthCollect portal and remains open for one month. Data entry by health services is to be finalised by end of October 2025, when the portal will close | 31 October 2025 |
| 2024–25 | Stage 1 Validations: Resolution of services’ initial validation issues arising from the HealthCollect portal data submission | 27 February 2026 |
| 2024–25 | Stage 2: Resolution of any final issues and any additional clarification required for the Australian Institute of Health and Welfare. Validations and questions sent to health services must be finalised by end of July 2026 | 31 July 2026 |

### Mental health triage MDS

Triage MDS submissions are to be provided in the prescribed format on a monthly basis by the fifteenth of each month. The data file must be submitted via the Managed File Transfer portal. For documentation detailing the format and reporting requirements, visit [Mental health triage service](https://www.health.vic.gov.au/practice-and-service-quality/mental-health-triage-service) <https://www.health.vic.gov.au/practice-and-service-quality/mental-health-triage-service>.

### MHCSS

Agencies funded to deliver MHCSS activities are expected to provide data quarterly. Compliance with these reporting requirements is a key accountability requirement to be used as part of the ongoing review and monitoring processes.

Quarterly Data Collection data must be submitted by the seventh of the month following the end of the quarter by emailing [MHCSS](mailto:MHCSS) <mhcss@health.vic.gov.au>.

The supplementary MHCSS Excel spreadsheet is an aggregate data collection. It must be submitted by the fifteenth of the month following the end of the quarter. The file must be submitted via the [MHCSS data email](mailto:mhcssdata@health.vic.gov.au) <mhcssdata@health.vic.gov.au>.

#### Mental Health and Wellbeing Locals

Currently, providers of Mental Health and Wellbeing Locals are required to collect and report aggregate data, submitted to the department using the HealthCollect online platform. The submission of aggregate data is a requirement of funding. Monthly data is to be submitted by the tenth day of the following month.

Recommendation 62 of the RCVMHS recommended that the Victorian Government develop, find and implement modern infrastructure for ICT systems, including a statewide mental health and wellbeing record (see [section 24.3.3](#_Contemporary_information_architectu)). The department is working with providers of mental health and wellbeing services to develop and implement these systems, and Mental Health and Wellbeing Locals will be required to work with the department in support of this work.

#### Reportable deaths

1. All clinical mental health service providers, including specialist mental health services in custodial settings, must report deaths to the Chief Psychiatrist.

#### Deaths on mental health inpatient units

Any inpatient death at a designated mental health service or a bed-based mental health unit in a custodial setting is to be reported, regardless of legal status, cause or location of death. Initial notification should be made by emailing the [OCP](mailto:OCP) <<mailto:>ocp@health.vic.gov.au> and submitting a MHWA125 form submitted to the OCP via the [SharePoint portal](https://dhhsvicgovau.sharepoint.com/sites/OCP) <https://dhhsvicgovau.sharepoint.com/sites/OCP>.

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 of compulsory patients

All deaths of compulsory patients under the Mental Health and Wellbeing Act at a designated mental health service or a bed-based mental health unit in a custodial setting must be reported to the OCP by submitting a MHWA125 form via the [SharePoint portal](https://dhhsvicgovau.sharepoint.com/sites/OCP) <https://dhhsvicgovau.sharepoint.com/sites/OCP> (requires login).

#### Non-inpatient and non-compulsory consumer deaths

The Chief Psychiatrist requires all unexpected, unnatural or violent deaths (including suspected suicides) to be reported if a person:

* is a current registered consumer of a designated mental health and wellbeing service
* has been discharged from a designated mental health service within the previous three months
* is seeking mental health care from a designated mental health service, but is not registered.

People are considered to be mental health consumers until their case is closed and they have been notified of this closure, or the service has made all reasonable efforts to do so.

Designated mental health services and MHCSS must notify the Chief Psychiatrist of a consumer’s death using the MHWA 125 form submitted via the [SharePoint portal](https://dhhsvicgovau.sharepoint.com/sites/OCP) <https://dhhsvicgovau.sharepoint.com/sites/OCP> (requires login).

For more information on what is meant by ‘reportable deaths’ and the procedures for reporting them, visit [Reportable deaths](https://www.health.vic.gov.au/chief-psychiatrist/reportable-deaths-mental-health-and-wellbeing-act-2022) <https://www.health.vic.gov.au/chief-psychiatrist/reportable-deaths-mental-health-and-wellbeing-act-2022>.

#### Sentinel event reporting of suicides

Suspected suicide or serious self-harm within a healthcare setting is categorised as a sentinel event (that is, unexpected healthcare incidents that result in death or serious disability) and should be notified to SCV’s Sentinel event program. This includes suicides on mental health inpatient units, as well as those in other health settings, such as acute, subacute or rehabilitation services, or compulsory clients while on approved or non-approved leave.

For more information, visit [Sentinel events](https://www.safercare.vic.gov.au/notify-us/sentinel-events) <https://www.bettersafercare.vic.gov.au/notify-us/sentinel-events>[[25]](#footnote-26).

#### Incident reporting and community service organisations

Victorian public health and community service organisations that provide services on behalf of the department (such as MHCSS), and report patient, resident or client safety incidents through VHIMS, are subject to the overarching [Policy: Adverse patient safety events](https://www.safercare.vic.gov.au/publications/policy-adverse-patient-safety-events) <https://www.bettersafercare.vic.gov.au/publications/policy-adverse-patient-safety-events> and supporting framework.

Community organisations that provide services on behalf of the department and do not report incidents through VHIMS are still subject to the department’s incident reporting instruction. The reporting instruction can be found at [Incident reporting](https://fac.dffh.vic.gov.au/incident-reporting) <https://fac.dffh.vic.gov.au/incident-reporting>. The accompanying incident report form can be found at [Incident report form](https://fac.dffh.vic.gov.au/incident-report-form-complete-hand) <https://fac.dffh.vic.gov.au/incident-report-form-complete-hand>.

#### Restrictive interventions reporting (seclusion, bodily restraint or chemical restraint)

1. The Mental Health and Wellbeing Act regulates the use of restrictive interventions. Part 3.7 of the Act outlines when restrictive interventions can be used, who can authorise them and the monitoring of restrictive interventions when used. Section 3 of the Act defines a ‘restrictive intervention’ as ‘seclusion, bodily restraint or chemical restraint’. Chemical restraint is newly defined in the Act; its regulation commenced on 1 September 2023.
2. All restrictive interventions must be reported to the Chief Psychiatrist.
3. In accordance with the Mental Health and Wellbeing Act and the [Chief Psychiatrist’s guideline for restrictive interventions](https://www.health.vic.gov.au/key-staff/reducing-restrictive-interventions) <https://www.health.vic.gov.au/key-staff/reducing-restrictive-interventions>, an Authorised Psychiatrist must give a written report to the Chief Psychiatrist on the use of any restrictive intervention (s.118 of the Act). This report must contain the details required by the Chief Psychiatrist and be submitted within the time stipulated (s.118 of the Act).
4. In practice, services record restrictive interventions contemporaneously into the CMI database, with the OCP using the CMI database to monitor the use of restrictive interventions across Victoria. If the use of restrictive interventions exceeds a benchmark, services must complete an exceeded benchmark report and submit it to the OCP via the [SharePoint portal](https://dhhsvicgovau.sharepoint.com/sites/OCP) <<https://dhhsvicgovau.sharepoint.com/sites/OCP>> (requires login).
5. For more details on reporting requirements, visit [Restrictive interventions](https://www.health.vic.gov.au/chief-psychiatrist/chief-psychiatrists-restrictive-interventions) <https://www.health.vic.gov.au/chief-psychiatrist/chief-psychiatrists-restrictive-interventions>.
6. Restrictive interventions must also be reported to the Chief Psychiatrist when they are used on people receiving a mental health and wellbeing service in the EDs and urgent care centres of designated mental health services, and when they are used on people who are receiving compulsory treatment under the Mental Health and Wellbeing Act. All restrictive interventions must be recorded and reported, regardless of the person’s status under the Mental Health and Wellbeing Act.
7. Services are obligated to provide appropriate information to people subjected to restrictive interventions about their rights, including post-intervention support.

#### Episodes of extended seclusion

Designated mental health services must provide a clinical report to the Chief Psychiatrist of any episode of seclusion that exceeds 12 hours for adults, and four hours for aged and young people under 18 years of age.

Should the episode of seclusion exceed 48 hours, it is expected that escalation processes, including case conferencing and second opinions, occur within their designated mental health service. Where an extended period of seclusion in excess of 48 hours is anticipated, it must be discussed with the Authorised Psychiatrist or delegate, to outline strategies aimed at reducing the behaviours and avoiding the need for a restrictive intervention.

When seclusion is used for extended periods of time or on a recurrent basis, it is good clinical practice for mental health services to undertake case conferencing and a second opinion, external to the treating team, to develop a care plan that outlines strategies for behavioural change and avoiding the need for seclusion. If the seclusion episode exceeds seven consecutive days, the Authorised Psychiatrist or delegate must contact the Chief Psychiatrist and provide a clinical report and care plan.

#### Extended admission to a high-dependency area

1. Mental health services will be required to present evidence of an active case-conferencing process to assist in bringing the admission to conclusion for any admission to a high-dependency area exceeding 30 consecutive days and at any time on request thereafter.

#### Sexual safety reporting

1. All sexual safety incidents occurring in bed-based designated mental health services and bed-based mental health and wellbeing services in custodial settings must be reported via [VHIMS](https://d.docs.live.net/031c443d5a1cf449/Documents/Business/Government/DoH-C%5e0SI/VHIMS) <https://vahi.vic.gov.au/>.
2. Services are required to extract information from VHIMS into the Excel template provided by the OCP and submit it to the OCP on a monthly basis via the [SharePoint portal](https://dhhsvicgovau.sharepoint.com/sites/OCP) <https://dhhsvicgovau.sharepoint.com/sites/OCP> (login required).
3. Sexual safety incidents are alleged, witnessed or suspected occurrences of sexual activity, sexual harassment and sexual assault.
4. Serious sexual safety incidents that are assigned an ISR of 1 or 2 through VHIMS must also be reported directly to the OCP within 24 or 72 hours respectively. The OCP reviews all ISR 1 and 2 incidents and works closely with services to ensure that incidents are responded to thoroughly and that risks are addressed.
5. While the reporting of sexual safety incidents to the OCP is an important part of governance, services must also have strong local governance processes to ensure that sexual safety is addressed, prevention strategies are embedded and risks can be eliminated.
6. For detailed information about reporting requirements for sexual safety, visit [Chief Psychiatrist’s directive for sexual safety reporting](https://www.health.vic.gov.au/chief-psychiatrist/improving-sexual-safety) <https://www.health.vic.gov.au/chief-psychiatrist/improving-sexual-safety>.

#### ECT

##### Treatment reporting

Designated mental health services must report the use of ECT to the Chief Psychiatrist. The information to be submitted includes:

* the date, name, UR number, sex and age of each person
* the names of the doctors giving the anaesthetic and ECT
* treatment laterality, pulse width and stimulus level
* a clinical outcome measure
* the nature of the consent given for treatment.

The Authorised Psychiatrist is responsible for ensuring reporting is undertaken. However, the Authorised Psychiatrist may designate a staff member, preferably the ECT coordinator, to undertake this function.

Reporting takes place through the CMI-database and must be completed within a month of treatment.

##### Adverse events

The Chief Psychiatrist must be notified about adverse events directly related to ECT that either:

* result in death (including near misses), serious injury or serious illness
* require transfer to an ED or similar setting.

These notifications must be made using an ECT serious adverse event report form.

Other incidents and near misses should be reported to the service’s own ECT committee and safety-monitoring bodies.

##### People under the age of 18 years

The Mental Health and Wellbeing Act regulates the use of ECT for all young people under the age of 18 years in Victoria, whether voluntary or compulsory. This includes young people in public mental health services, and private hospitals and clinics, even when the young person has given informed consent to treatment.

A psychiatrist must apply to the Mental Health Tribunal to perform a course of ECT, even if the young person provides informed consent.

The Chief Psychiatrist does not make decisions concerning treatment. However, the Chief Psychiatrist must be informed of plans to administer ECT to a young person.

The [ECT – Chief Psychiatrist’s guideline](https://www.health.vic.gov.au/publications/chief-psychiatrists-guideline-on-electroconvulsive-treatment) <https://www.health.vic.gov.au/publications/chief-psychiatrists-guideline-on-electroconvulsive-treatment> provides guidance about the prescription and performance of ECT in Victorian public mental health services.

#### Neurosurgery for mental illness

1. Neurosurgery for mental illness can only be performed with the informed consent of the person and the approval of the Mental Health Tribunal.
2. Following treatment, the Authorised Psychiatrist treating the person must provide a written report to the Chief Psychiatrist, which includes a description of the treatment’s outcome within three months after the surgery is performed, and again within 12 months after the surgery is performed.

#### Reporting of incidents where there is failure to comply with the Mental Health and Wellbeing Act

The Chief Psychiatrist has statutory roles and functions under the Mental Health and Wellbeing Act(Part 6.3). This includes providing clinical leadership to clinical mental health service providers in relation to their obligations under the Act, the regulations and any Codes of Practice (s.267(1)(d).

Where there is a failure to comply with the Act, designated mental health services should report it to the Chief Psychiatrist. This includes incidents anywhere within designated mental health services, including EDs, urgent care centres and general hospital wards.

The report should be completed in writing by the Authorised Psychiatrist, or their delegate, within three business days. The report can be emailed to the [OCP](mailto:OCP) <ocp@health.vic.gov.au>. Where required, contact the OCP on 1300 767 299 for further guidance.

The report should include:

* demographic details of the people affected by the failure to comply
* circumstances of the incident, including the consumer’s legal status under the Act
* whether an open disclosure has been completed with the person and/or carers and family members, including supports provided to the person
* any remedial action to prevent a future occurrence of such incidents.

If the service becomes aware of an incident involving a failure to comply with the Act through a complaint investigation by the Mental Health and Wellbeing Commission or other authorities, it must be reported to the Chief Psychiatrist immediately.

Designated mental health services must include this reporting requirement in their local policies and procedures. They should ensure that it is communicated to all clinical staff to enable them to comply with the Act.

For more information, visit [Reporting a failure to comply with the Mental Health and Wellbeing Act 2022](https://www.health.vic.gov.au/publications/victorian-chief-psychiatrist-practice-direction-reporting-of-incidents-where-there-is) <https://www.health.vic.gov.au/chief-psychiatrist/reporting-a-failure-to-comply-with-the-mental-health-and-wellbeing-act-2022>.

### Victorian Alcohol and Drug Collection (VADC)

The VADC supports public accountability for service provision. Outputs contribute to the AOD Treatment Services National MDS, as well as performance measurement and monitoring for Commonwealth, state and departmental purposes. All AOD treatment service providers must submit activity data via the VADC.

AOD treatment service providers must ensure client management systems can meet VADC reporting requirements. For details on data specifications, bulletins and the submission process, visit [VADC](https://www.health.vic.gov.au/funding-and-reporting-aod-services/victorian-alcohol-and-drug-collection-vadc) <https://www.health.vic.gov.au/funding-and-reporting-aod-services/victorian-alcohol-and-drug-collection-vadc>.

VADC data must be submitted monthly, with data due by the fifteenth day of the subsequent month. Data for the prior financial year must be finalised before the consolidation date of 1 January.

### Needle and Syringe Program portal

The Commonwealth and the Victorian Government fund services to reduce the harms associated with AOD use. The harm reduction services data collection records the level of activity in these services, such as contacts, service provision (for example, needles provided and returned, education and referrals), and responses to harm reduction questions. Information about the free provision of a range of injecting and safe-sex equipment, and the disposal of returned waste, is also recorded.

Harm reduction services data is provided by:

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

All primary needle and syringe program providers and recipients of Ice Action Plan funding must report via the Needle and Syringe Program portal. Email [AOD enquries](mailto:AOD.enquiries@health.vic.gov.au) <[AOD.enquiries@health.vic.gov.au](mailto:AOD.enquiries@health.vic.gov.au)> for more information about the portal.

For more information about the program, visit [Needle and Syringe program operating policy and guidelines](https://www.health.vic.gov.au/publications/victorian-needle-and-syringe-program-operating-policy-and-guidelines) <https://www.health.vic.gov.au/publications/victorian-needle-and-syringe-program-operating-policy-and-guidelines>.

### 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 medicines and poisons industry licensing scheme under the Drugs, Poisons and Controlled Substances Act 1981.

The Drugs and Poisons Information System is a standalone system that records licences and permits issued to organisations or individuals who have a legitimate need to use, possess, manufacture or supply medicines and poisons, as part of their practice or business (such as pharmaceutical wholesalers, research, educational or industrial organisations, or health services). The information system also records the payment of fees relating to these licences and permits.

### SafeScript – Victoria’s real-time prescription monitoring system

SafeScript is computer software that allows prescription records for certain high-risk medicines to be transmitted in real time to a centralised database, which can then be accessed by medical practitioners, nurse practitioners and pharmacists, during a consultation with a consumer.

SafeScript provides practitioners and pharmacists with a clinical tool to make safer decisions about whether to prescribe or dispense a high-risk medicine. It facilitates early identification, treatment and support for consumers who are developing signs of substance-use disorder.

The data for SafeScript is collected automatically from prescription exchange services, which currently support ePrescribing, the electronic transfer of prescriptions from medical clinics to pharmacies.

When a prescription is issued at a medical clinic or dispensed at a pharmacy, the prescription exchange service sends a record of the prescription in real time to SafeScript. No additional data entry is necessary to record a prescription in SafeScript.

It is mandatory for medical practitioners, nurse practitioners and pharmacists to take all reasonable steps to check SafeScript before prescribing or dispensing a medicine monitored in SafeScript, unless exempted under the Drugs, Poisons and Controlled Substances Regulations 2017.

Commencing Q3 2024, a SafeScript enhancement now provides the department with the ability to receive, process and record treatment permits issued to doctors prescribing Schedule 8 drugs to consumers. This includes Schedule 8 permits for opioid replacement therapy (pharmacotherapy). It also allows processing and recording of notifications of drug dependence made by prescribers, and warrants to prescribe certain Schedule 4 medicines.

SafeScript is also used to assist with prescription-monitoring activities and during investigative processes. Interventions are initiated if unlawful or possibly unsafe prescribing is identified. Noncompliant health practitioners may be subject to further action, ranging from educational counselling to prosecution. Where applicable, offending is referred to Ahpra, the Veterinary Practitioners Registration Board of Victoria or Victoria Police.

Authorised departmental officers may also access SafeScript as part of their regulatory role in ensuring the safe supply of medicines in the community.

SafeScript has joined the National Data Exchange, as part of a Commonwealth system. Victoria is working with the Australian Digital Health Agency to enable data sharing between the jurisdictions.

### Opioid replacement therapy dispenser census

#### Opioid replacement therapy dispenser census

The department conducts an opioid replacement therapy dispenser census collection, also known as the National Opioid Pharmacotherapy Statistics Annual Data collection. It surveys all relevant service dispensaries that provide opioid replacement therapy in Victoria (this includes correctional facilities).

All dispensers are emailed a link to an electronic survey for completion and return. The survey collects demographic information, including details of opioid replacement therapy drug type and formulation, via a series of questions emailed and returned directly to the Mental Health and Wellbeing Division by the dispensing agencies.

Aggregated data is used for policy and planning purposes, such as identifying gaps in treatment areas for focused access improvements. Finally, it collects data of consumers who identify as Aboriginal, as at 30 June for the reporting period.

The data provides a count of consumers being dosed at a given time. This allows patterns of opioid replacement therapy access to be monitored across the state, which in turn, informs departmental sector support activities. This data is then aggregated at a national level to determine opioid replacement therapy access trends nationally.

## Public health data reporting requirements

For mutual visibility of performance in relation to health protection functions, and to comply with data collection requirements, LPHUs complete the minimum required fields on these statewide systems related to the investigation of cases and outbreaks, and the management of notifiable conditions. These are described in condition-specific protocols, outbreak-specific guidelines, system-specific agreements and quick-entry guide documents.

These data support a coordination of the networked public health system to perform public health functions. Collection, analysis and reporting from these systems is used to track notifiable conditions under the Public Health and Wellbeing Act and Regulations (2019).

### Public Health Event Surveillance System

The department has licensed the Maven EnhancedDisease Surveillance System, known locally as the Public Health Event Surveillance System (PHESS), for the purpose of notifiable condition notification, surveillance, management and analysis in Victoria. LPHUs will accurately complete the minimum required fields on PHESS related to the case and outbreak investigation, and management of notifiable conditions, as per condition-specific protocols, outbreak-specific guidelines, system-specific agreements and quick-entry guide documents.

The Victorian Tuberculosis Program is responsible for data entry into PHESS for cases, contacts of cases and outbreaks related to tuberculosis.

As well as being used to monitor and manage notifiable conditions across Victoria, these data are required for statewide reporting to the National Interoperable Notifiable Diseases Surveillance System under a national agreement.

These national and jurisdictional data and reporting requirements are mandated under the *National Health Security Act 2007* (Cth) and its National Notifiable Disease List instrument, the National Health Security Agreement (2008), and the World Health Organization’s International Health Regulations (2005).

### Public Health Operational Response Management System

The department provides access to the Public Health Operational Response Management System (Noggin platform) to allow a coordinated approach to data management to perform public health functions in respect to legionellosis, and facilitate visibility of environmental and case investigations.

LPHUs will complete the minimum required fields on the Noggin platform related to the management of case, outbreak or cluster investigations of legionellosis, as per the legionellosis protocol.

## Aged care data reporting requirements

Data collection requirements and timelines for ageing, aged and carer support, and aids and equipment services, are provided in Table 15.

Information on performance is collected through a range of channels, including the:

* VCSS MDS for the HACC–PYP and low-cost accommodation program
* Victorian aids and equipment reporting template
* HACC PYP fees data collection
* HACC PYP annual service activity reports
* residential aged care services data collection.

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

Table 15. Ageing, aged and home care – data collection and reporting requirements

| Activity no. | Activity name | Data collection description |
| --- | --- | --- |
| 13005 | ACA | Quarterly report on audit of assessments and client satisfaction |
| 13015 | HACC PYP Linkages Packages | VCSS (formerly HACC) MDS |
| 13024 | HACC PYP Assessment | VCSS (formerly HACC) MDS |
| 13026 | HACC PYP Community Care | VCSS (formerly HACC) MDS |
| 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 AN-ACC Residential aged care services data collection; AIMS Public sector residential aged care services quality indicators; and AIMS S5-115 AN-ACC Aged persons’ mental health residential aged care services data collection; PSRACS financial data submitted to the department to HeART must be submitted using the Campus codes allocated to each health service (for assistance, email [Planning and Operations](mailto:planning.operations@health.vic.gov.au) <planning.operations@health.vic.gov.au >  PSRACS VICNISS infection control module; participation in the annual Aged Care National Antimicrobial Prescribing Survey; monitoring and reporting on significant organisms, such as MRSA, VRE and CDI[[26]](#footnote-27), resident vaccination rates for influenza, herpes zoster and pneumococcal; staff vaccination rates for influenza (for assistance, contact the VICNISS Coordinating Centre on (03) 9342 9333 or by emailing [VICNISS](mailto:VICNISS) <vicniss@mh.org.au>)  PSRACS are to continue to enter their quality indicator data via AIMS, and data will be submitted to the Commonwealth on behalf of the PSRACS |
| 13038 | HACC PYP Service System Resourcing | VCSS (formerly HACC) MDS – available on request |
| 13038 | HACC PYP Service System Resourcing | HACC PYP Annual Service Activity Report – available on request |
| 13043 | HACC PYP Flexible Service Response | HACC PYP Annual Service Activity Report as relevant |
| 13043 | HACC PYP Flexible Service Response | VCSS (formerly HACC) MDS as relevant |
| 13056 | HACC PYP Planned Activity Group | VCSS (formerly HACC) MDS |
| 13063 | HACC PYP Volunteer Co-ordination | VCSS (formerly HACC) MDS |
| 13096 | HACC PYP Allied Health | VCSS (formerly HACC) MDS |
| 13097 | HACC PYP Delivered Meals | VCSS (formerly HACC) MDS |
| 13099 | HACC PYP Property Maintenance | VCSS (formerly HACC) MDS |
| 13131 | RDNS[[27]](#footnote-28) HACC PYP Allied Health | VCSS (formerly HACC) MDS |
| 13210 | ACA Training and Development | My Aged Care Workforce Learning Strategy 2023 |
| 13223 | HACC PYP Nursing | VCSS (formerly HACC) MDS |
| 13223 | HACC PYP Nursing | HACC PYP Annual Service Activity Report – available on request |
| 13227 | ACCO Services – HACC PYP | VCSS (formerly HACC) MDS |
| 13227 | ACCO Services – HACC PYP | HACC PYP fees data collection |
| 13227 | ACCO Services – HACC PYP | HACC PYP Annual Service Activity Report – available on request |
| 13229 | HACC PYP Access and Support | VCSS (formerly HACC) MDS |
| 13229 | HACC PYP Access and Support | A&S activity annual report |
| 35030 | Small rural – HACC PYP Health Care and Support | Annual HACC PYP fee report – available on request |
| 35030 | Small rural – HACC PYP Health Care and Support | HACC PYP Annual Service Activity Report, where relevant |

## Primary, community and dental health data reporting requirements

A summary of reporting requirements for primary, community and dental health is shown in Table 20.

### Community health services

All funded organisations receiving community health program funding must submit data that outline service delivery performance against targets. Agencies are responsible for accurate and timely submission of data, as per the documented reporting requirements.

The Community health program data submission guidelines are available from [Community health data reporting](https://www.health.vic.gov.au/community-health/community-health-data-reporting) <https://www.health.vic.gov.au/community-health/community-health-data-reporting>.

Community health data must be submitted quarterly, with data due by the fifteenth of the month following the end of each quarter.

All health services receiving community health program funding must ensure that:

* information systems comply with the department’s reporting requirements
* service information remains up to date on the National Health Services Directory.

Additional evidence may be required from time to time, to demonstrate that funding has been used appropriately.

### Dental health services

The department requires a quarterly 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.

The department is responsible for validating quarterly extracts and providing error reports to Oral Health Victoria.

Table 16. Primary, community and dental health – data collection and reporting requirements

| Activity no. | Activity name | Data collection description |
| --- | --- | --- |
| 27017 | Oral health – health promotion | Report against agreed deliverables linked to the Victorian action plan to prevent oral disease 2020–30 |
| 27019 | Royal Dental Hospital Melbourne dental care | Dental health program dataset |
| 27023 | Community dental care | Dental health program dataset |
| 28000 | Health Self-Help (Band 1) | Annual activity report |
| 28015 | Family and Reproductive Rights Education Program | Community health MDS |
| 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 | Community Health Language Services | Community health MDS  Funding acquittal |
| 28050 | Women’s health – health promotion | Report against health promotion plan |
| 28055 | Health support for children in care | Community health MDS |
| 28063 | Family planning – education and training | Quarterly report |
| 28064 | Family planning – clinical services and training | Community health MDS |
| 28066 | Innovative Health Services for Homeless Youth | Community health MDS |
| 28068 | Family planning | Community health MDS |
| 28071 | Aboriginal services and support | Local reporting |
| 28072 | Integrated Chronic Disease Management | Community health MDS |
| 28074 | Diabetes Connect | Community health MDS  Manual Data Collection |
| 28076 | Refugee and asylum seeker health services | Community health MDS |
| 28080 | Healthy Mothers Healthy Babies | Community health MDS |
| 28081 | National Diabetes Services Scheme | Monthly report |
| 28085 | Community health – health promotion | Report against health promotion plan |
| 28086 | Community health | Community health MDS |
| 28088 | ACCO services – primary health | Roundtable reporting |
| 28090 | Multi-disciplinary Centre – Community Health Nurse | Community health MDS |
| 28091 | Community Asthma Program | Community health MDS |
| 28092 | Infant Child and Family health and Wellbeing Hubs | Community health MDS |
| 35048 | Small rural – Primary Health Flexible Services | Community health MDS or other relevant data collection, if funding is used for another allowable purpose |

## Workforce data reporting requirements

Reporting is required against workforce programs and datasets to inform statewide policy, planning and funding, and to ensure effective investment in the development of Victoria’s future workforce.

### Health services payroll and workforce minimum employee dataset

Health services must transmit information detailed in the Health Services Payroll And Workforce Minimum Employee Dataset – Data Dictionary to the department. Data must be transmitted to the department by the tenth day of the following month, or the prior working day, if the tenth day of the following month falls on a weekend or public holiday. Payroll data is required monthly, while workforce information is required biannually, covering the periods ending 31 December and 30 June each year.

Where health services undertake their own payroll processing, they must transmit the information directly to the department. In cases where health services engage a payroll bureau to process their payroll, health services may authorise the bureau to transmit the data to the department on their behalf. However, health services remain responsible for the accuracy of the data transmitted.

Where a health service decides to change payroll providers, it will be necessary to complete an accreditation process, prior to the change, to ensure continuity of data transmission to the department will not be compromised.

## Training and development funding reporting and eligibility requirements

### Eligibility requirements

All Victorian public health services are eligible to receive training and development funding.

To receive funding, organisations must:

* ensure all funded programs conform to the most recent version of the Training and Development Funding – Program Guidelines, including the guidelines and standards set by Ahpra and the national health practitioner boards
* comply with specific eligibility and reporting requirements for each stream (described below)
* report against the externally reportable *Best Practice Clinical Learning Environment Framework* measures.

For more information regarding the framework, and eligibility requirements detailed in the current Training and Development Funding – Program Guidelines, visit:

* [*Best Practice Clinical Learning Environment Framework*](https://www.health.vic.gov.au/education-and-training/best-practice-clinical-learning-environment-bpcle-framework) <https://www.health.vic.gov.au/education-and-training/best-practice-clinical-learning-environment-bpcle-framework>
* [Training and Development Funding](https://www.health.vic.gov.au/education-and-training/training-and-development-funding) <https://www.health.vic.gov.au/education-and-training/training-and-development-funding>.

### Professional-entry student placements

Professional-entry student placement funding is provided for eligible clinical placement days reported for eligible disciplines and courses at Victorian public health services. Eligible activity, disciplines and courses are detailed in the current [Training and Development Funding – Program Guidelines](https://www.health.vic.gov.au/education-and-training/training-and-development-funding) <https://www.health.vic.gov.au/education-and-training/training-and-development-funding>.

To access the professional-entry student placement subsidy, health services must:

* plan and report clinical placement activity through Placeright biannually (or via the HealthCollect portal for agreed medical placement activity not yet managed via Placeright)
* adhere to the Standardised Schedule of Fees for clinical placement of students in Victorian public health services for 2025.

Health services are also encouraged to:

* establish a Student Placement Agreement with all education provider partners, including uploading it to Placeright, where the system is used to manage eligible funded activity
* adhere to the Standard Student Induction Protocol to ensure conformity of practices across the sector.

Templates provided by the department have been updated by a sector-led working group and reflect industry expectations for clinical placements in health services.

For more information on these resources, visit:

* [Fee schedule for clinical placement in public health services](https://www.health.vic.gov.au/education-and-training/fee-schedule-for-clinical-placement-in-public-health-services) <https://www.health.vic.gov.au/education-and-training/fee-schedule-for-clinical-placement-in-public-health-services>
* [Placeright](https://www.health.vic.gov.au/education-and-training/placeright) <https://www.health.vic.gov.au/education-and-training/placeright>
* [Student Placement Agreement](https://www.health.vic.gov.au/education-and-training/student-placement-agreement) <https://www.health.vic.gov.au/education-and-training/student-placement-agreement>
* [Standardised Student Induction Protocol](https://www.health.vic.gov.au/education-and-training/standardised-student-induction-protocol) <https://www.health.vic.gov.au/education-and-training/standardised-student-induction-protocol>.

### Transition to Practice (graduate) positions

To access Transition to Practice funding for allied health, medical (year one and two), and nursing or midwifery graduates, the following criteria must be met:

* Transition to Practice (graduate) positions for medical, nursing and midwifery **are attempted to be filled** through the PMCV statewide match process, or another process as determined by the department.
* Health services must report on the headcount and FTE of new graduates for the previous calendar year, and a projection for the forthcoming year.
* Health services must allocate adequate training and supervision to each position, and meet the accreditation requirements where relevant, and must advise the department if a graduate does not commence, or complete, an allocated position.
* No fees may be charged to graduates applying for, undertaking or exiting from Transition to Practice programs.
* Funding is available to health services for accredited PGY1 and PGY2 positions filled by a PGY1 or PGY2 doctor respectively. Note, rural and regional health services are expected to offer two-year prevocational training contracts to PGY1 doctors who undertake a 12-month internship.

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

### Postgraduate programs – medical, nursing and midwifery

All health services must reconcile actual activity at the completion of the calendar year.

All health services receiving funding for the Victorian Medical Specialist Program, Victorian Basic Paediatric Training Program and Basic Physician Training Consortia Program must complete the relevant program reports. This includes providing confirmation at each stage of training, including at recruitment, resignation, completion or any other change in the training pathway.

Funded postgraduate nursing and midwifery programs must lead to an award classification at graduate certificate, graduate diploma or master level. Where students are enrolled in a master-level program with exit points at graduate certificate or graduate diploma level, only the graduate certificate or graduate diploma components are eligible.

Master-level studies that lead to endorsement as a nurse practitioner may be eligible. However, individuals receiving Nurse Practitioner Candidate Support Packages, as part of the Making It Free to Study Nursing and Midwifery initiative or the Women’s Health stream, are excluded. Postgraduate activity, including FTE and headcount are excluded. Postgraduate activity, including FTE and headcount of staff who undertook postgraduate study during the calendar year, must be reported via HealthCollect.

Eligible postgraduate education programs must include a requirement for supervised clinical support.

Postgraduate (entry-to-practice) clinical placement model midwifery studies are not eligible for this stream of the training and development grant, but are eligible for a professional-entry student placement subsidy.

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

### Other targeted workforce training and development programs

For programs supported through this funding stream, refer to [section 10.1.4](#_Other_targeted_workforce).

For details on reporting and eligibility requirements, visit [Training and Development Funding – Program Guidelines](https://www.health.vic.gov.au/education-and-training/training-and-development-funding) <https://www.health.vic.gov.au/education-and-training/training-and-development-funding>.

## Commonwealth–state reporting requirements

### Intergovernmental agreements

Funded organisations may receive payments arising from Commonwealth–state agreements outside of the National Health Reform Agreement, including Commonwealth own-purpose expenditure and intergovernmental agreements.

Funding received under such arrangements is subject to each program’s specific conditions of funding. Organisations funded under Commonwealth–state programs must submit regular reports, as required for the Commonwealth. In most cases, the department will submit these reports to the Commonwealth.

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

### National Health Information Agreement

Under the National Health Information Agreement, states and territories provide Public Hospital Establishment and Local Health Network data, in addition to public hospital activity data, to the Australian Institute of Health and Welfare for inclusion in national MDSs.

## Environmental data and reporting requirements

Financial Reporting Direction 24 (FRD 24) introduced new whole-of-government reporting requirements for the 2022–23 reporting year, including new reporting obligations for Victorian public hospitals, health services and cemeteries. Data reported through the FRD 24 process is used to inform environmental indicators and associated commentary in health service annual reports.

The department’s Environmental Data Management System (EDMS) has been configured to meet the FRD 24 quantitative reporting requirements with routine updates made to the platform to ensure reporting fields correspond to reporting requisites. FRD 24 provides flexibility for the reporting period, with the department moving to an annual reporting period of 1 April to 31 March from 2023–24 reporting year onwards.

For reporting guidance for hospitals and health services, visit:

* [Health service environmental requirements and environmental management planning](https://www.health.vic.gov.au/publications/public-environmental-reporting-guidelines) <https://www.health.vic.gov.au/publications/public-environmental-reporting-guidelines>
* [Government environmental reporting](https://www.climatechange.vic.gov.au/victorian-government-action-on-climate-change/government-environmental-reporting) <https://www.climatechange.vic.gov.au/victorian-government-action-on-climate-change/government-environmental-reporting>.

Public hospitals and health services are required to upload data on procured services for electricity, natural gas, water, waste, transport services (including air travel) in the EDMS to meet environmental reporting requirements on a quarterly basis (see [section 23.5](#_Health_service_environmental_1)). This can include liquefied petroleum gas, small sites on retail energy contracts, non-potable water (where metered), and specialist recycling streams.

For all operational vehicles, health services will need to provide details for non VicFleet vehicles. Please note the department has access to information on VicFleet vehicles and this does not need to be provided by health services. Public hospitals and health services are to configure any behind-the-meter solar arrays to automatically feed net generation data into the EDMS.

For advice on how to configure this, visit [Reporting solar photovoltaic data](https://www.vhba.vic.gov.au/reporting-solar-photovoltaic-data) <https://www.vhba.vic.gov.au/reporting-solar-photovoltaic-data>.

For access to the EDMS, visit [Eden Suite](https://dse.edensuite.com.au/cas/login?service=https%3A%2F%2Fdse.edensuite.com.au%2FCarbonInsight%2Fj_spring_cas_security_check) <https://dse.edensuite.com.au> (requires login). Eden Suite is the software used to host the department’s EDMS.

For more information concerning manual uploading requirements for health services, visit [Public environmental reporting guidelines](https://www.health.vic.gov.au/publications/public-environmental-reporting-guidelines) <https://www.health.vic.gov.au/publications/public-environmental-reporting-guidelines>.

The department will upload electricity, gas and waste data centrally, where public hospitals and health services utilise statewide HealthShare Victoria contracts (or State Purchase Contracts), water data sourced direct from water retailers, and cogeneration data (under the Energy Services Agreement) centrally.

# Performance targets and monitoring

## Health services covered under the Health Services Act

The *Performance monitoring framework* describes the contextual, strategic and operational aspects of monitoring and improvement for health services’ performance in core areas, such as clinical quality and safety, timely access to care and patient experience.

For information on coverage and more, visit [*Performance monitoring framework*](https://www.health.vic.gov.au/funding-performance-accountability/performance-monitoring-framework) <https://www.health.vic.gov.au/funding-performance-accountability/performance-monitoring-framework>.

### Services provided under a service agreement

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

For those organisations funded through service agreements, you can search for activity descriptions by referring to the department’s [Activity Index](https://fac.dffh.vic.gov.au/dffh-and-dh-activity-index) <https://fac.dffh.vic.gov.au/dffh-and-dh-activity-index.

### Performance tables

Table 17. HACC PYP – performance targets and monitoring

| Activity no. | Activity name | Measure description | Unit of measure | Frequency | Status | Output type |
| --- | --- | --- | --- | --- | --- | --- |
| 13015 | HACC PYP Linkages – case management | Number of hours of service | Hours of case management | Quarterly | Mandatory | Key output measure |
| 13015 | HACC PYP linkages | Number of hours of service | Hours | Quarterly | Mandatory | Non-KPOM |
| 13023 | HACC PYP Service Development Grant | One electronic project report submitted | Report | Yearly | On request | Key output measure |
| 13024 | HACC PYP Assessment | Number of hours of service | Hours | Quarterly | Mandatory | Key output measure |
| 13026 | HACC PYP Community Care | Number of hours of service | Hours | Quarterly | Mandatory | Key output measure |
| 13038 | HACC PYP Service System Resourcing | Number of events, services, hours as relevant | Number of relevant items | Quarterly | Mandatory | Non-KPOM |
| 13038 | HACC PYP Service System Resourcing | HACC PYP Annual Service Activity Report as relevant | Report | Yearly | On request | Key output measure |
| 13043 | HACC PYP Flexible Service Response | HACC PYP Annual Service Activity Report as relevant | Report | Yearly | On request | Key output measure |
| 13043 | HACC PYP Flexible Service Response | Number of hours of service, meals as relevant, reported in Flexible Service Response MDS Outlet | Hours | Quarterly | Non-mandatory | Non-KPOM |
| 13056 | HACC PYP Planned Activity Group | Number of hours of service (provided to clients) | Hours | Quarterly | Mandatory | Key output measure |
| 13063 | HACC PYP Volunteer Co-ordination | Number of hours of coordinator time | Hours | Yearly | Mandatory | Key output measure |
| 13063 | HACC PYP Volunteer Co-ordination | Number of hours of service to clients | Hours | Quarterly | Non-mandatory | Non-KPOM |
| 13096 | HACC PYP Allied Health | Number of hours of service | Hours | Quarterly | Mandatory | Key output measure |
| 13097 | HACC PYP Delivered Meals | Number of meals (funding is a subsidy for meal delivery only) | Meals | Quarterly | Mandatory | Key output measure |
| 13099 | HACC PYP Property Maintenance | Number of hours of service | Hours | Quarterly | Mandatory | Key output measure |
| 13103 | Language Services | Number of occasions of service | Occasions of service | Monthly | Mandatory | Key output measure |
| 13130 | HACC PYP Volunteer Co-ordination Other | Investment activity | n/a | n/a | n/a | n/a |
| 13131 | RDNS HACC PYP Allied Health | Number of hours of service | Hours | Quarterly | Mandatory | Key output measure |
| 13156 | Seniors Health Promotion | Report against agreed objectives | Reports | Yearly | On request | Key output measure |
| 13223 | HACC PYP Nursing | Number of hours of service | Hours | Quarterly | Mandatory | Key output measure |
| 13223 | HACC PYP Nursing | HACC PYP Annual Service Activity Report as relevant | Report | Yearly | On request | Non-KPOM |
| 13227 | ACCO Services – HACC PYP | Number of hours of service, meals as relevant | Hours | Quarterly | Mandatory | Non-KPOM |
| 13227 | ACCO Services – HACC PYP | HACC PYP Annual Service Activity Report as relevant | Report | Yearly | On request | Key output measure |
| 13229 | HACC PYP Access and Support | Number of hours of service | Hours | Quarterly | Mandatory | Key output measure |
| 13229 | HACC PYP Access and Support | HACC PYP Access and Support annual narrative | Report | Yearly | On request | Non-KPOM |
| 35030 | Small Rural HACC PYP Health Care and Support | Number of hours of service | Hours | Quarterly | Mandatory | Non-KPOM |
| 35030 | Small Rural HACC PYP Health Care and Support | HACC PYP Annual Service Activity Report as relevant | Report | Yearly | On request | Key output measure |

Table 18. Ageing, aged and home care – performance targets and monitoring

| **Activity no.** | **Activity name** | **Measure description** | **Unit of measure** | **Frequency** | **Status** | **Output type** |
| --- | --- | --- | --- | --- | --- | --- |
| 13005 | ACA | Number of assessments | Number | Quarterly | Mandatory | Key output measure |
| 13019 | Personal Alert Victoria | Number of units allocated | Number of units | Quarterly | Mandatory | Key output measure |
| 13053 | Victorian Eyecare Service | Number of occasions of service (metropolitan) | Occasions of service | Quarterly | Mandatory | Key output measure |
| 13053 | Victorian Eyecare Service | Number of occasions of service (outreach) | Occasions of service | Yearly | Mandatory | Other standard measure |
| 13053 | Victorian Eyecare Service | Number of occasions of service (rural) | Occasions of service | Yearly | Mandatory | Other standard measure |
| 13067 | VA&EP | Number of clients receiving aids and equipment | Clients | Quarterly | Mandatory | Key output measure |
| 13067 | VA&EP | Applications acknowledged in writing within 10 working days of applications | Per cent | Quarterly | Mandatory | Key output measure |
| 13067 | VA&EP | Clients satisfied with the aids and equipment system | Per cent | Annual | Mandatory | Key output measure |
| 13082 | Low-cost accommodation support | Number of clients assisted | Clients | Quarterly | Mandatory | Key output measure |
| 13083 | Aged training and development | Number of filled positions (academic) | Positions | Quarterly | Mandatory | Key output measure |
| 13083 | Aged training and development | Number of filled positions (training) | Positions | Quarterly | Non-mandatory | Other standard measure |
| 13100 | Aged research and evaluation | Report against agreed objectives | Reports | Yearly | Mandatory | Key output measure |
| 13103 | Language services | Number of occasions of service | Occasions of service | Monthly | Mandatory | Key output measure |
| 13210 | ACAS training and development | Funds expended on training needs of staff | Dollars | Yearly | Mandatory | Key output measure |
| 13301 | Aged quality improvement | Current authorisations for information exchange between the department and the Commonwealth Department of Health and Aged Care Quality and Safety Commission | Signed documents | Yearly | Mandatory | Other standard measure |

Table 19. Ambulance Victoria – performance targets and monitoring

| **Service plan** | **Activity** | **Measure description** | **Unit of measure** | **Reporting frequency** | **Status** |
| --- | --- | --- | --- | --- | --- |
| Quantity – transports | Emergency road: all  Emergency road: metro  Emergency road: rural and regional  Non-emergency stretcher: all  Non-emergency stretcher: metro  Non-emergency stretcher: rural and regional  Non-emergency clinic car  Fixed-wing emergency  Fixed wing non-emergency  Rotary wing | Number of transports provided | Number | Monthly | Mandatory |
| Quantity – incidents | Emergency road: all  Emergency road: metro  Emergency road: rural and regional  Treatment without transport  Non-emergency stretcher: all  Non-emergency stretcher: metro  Non-emergency stretcher: rural and regional  Non-emergency clinic car  Fixed-wing emergency | Number of Triple Zero (000) calls or planned events to which one or more ambulance resources are dispatched | Number | Monthly | Mandatory |
| Patient experience | Patient experience | Percentage of respondents who rated care, treatment, advice and/or transport received from the ambulance service as ‘good’ or ‘very good’  Percentage of respondents who rated care and treatment received from paramedics as ‘good’ or ‘very good’ | Per cent | Annual | Mandatory |
| Governance, leadership and culture | Safety culture | Composite of safety culture score, based on eight safety culture items in the People Matter Survey | Per cent | Annual | Mandatory |
| Safety and quality | Healthcare worker immunisation – influenza | Healthcare worker immunisation – influenza | Per cent | Annual | Mandatory |
| Safety and quality | Pain reduction | Adult patients who achieved a meaningful reduction in pain | Per cent | Quarterly | Mandatory |
| Safety and quality | Stroke patients transported | Adult patients suspected of having a stroke, who were transported within 60 minutes to a health service with the capability to deliver intravenous thrombolysis | Per cent | Quarterly | Mandatory |
| Safety and quality | Trauma patients transported | Trauma patients transported to the highest-level trauma service within 45 minutes, or transported by air directly to a major trauma service | Per cent | Quarterly | Mandatory |
| Safety and quality | Cardiac arrest survived event rate | Adult VF/VT patients with vital signs at hospital | Per cent | Quarterly | Mandatory |
| Safety and quality | Cardiac arrest survived event rate | Adult VF/VT patients surviving to hospital discharge | Per cent | Quarterly | Mandatory |
| Access | Response time state wide | Emergency Code 1 incidents responded to within 15 minutes | Per cent | Monthly | Mandatory |
| Access | Response time state wide | Emergency Code 1 incidents responded to within 15 minutes (modified Secondary Triage call start time) | Per cent | Monthly | Mandatory |
| Access | Response time state wide | Emergency Priority 0 incidents responded to within 13 minutes | Per cent | Monthly | Mandatory |
| Access | Response time urban | Emergency Code 1 incidents responded to within 15 minutes, in centres with a population >7,500 | Per cent | Monthly | Mandatory |
| Access | Average response time | Average time to respond to Emergency Code 1 incidents | Minutes | Monthly | Mandatory |
| Access | Clearing time at hospital | Average ambulance hospital clearing time | Minutes | Monthly | Mandatory |
| Access | Call referral | Events where a Triple Zero (000) caller receives advice or service from another health service provider, as an alternative to emergency ambulance response | Per cent | Monthly | Mandatory |
| Access | 40-minute transfer | Proportion of patients transferred from paramedic care to hospital emergency care, within 40 minutes of ambulance arrival | Per cent | Weekly | Mandatory |

**Note**: Additional measures will be developed and included in the data submissions.

Table 20. Primary, community and dental health – performance targets and monitoring

| Activity no. | Activity name | Measure description | Unit of measure | Frequency | Status | Output type |
| --- | --- | --- | --- | --- | --- | --- |
| 27019 | The Royal Dental Hospital of Melbourne 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 | Community Health Language Services | Submission of reports | Reports | Quarterly | Mandatory | Key output measure |
| 28050 | Women’s Health – Health Promotion | Report against health promotion plan | Reports | Yearly | Mandatory | Other standard measure |
| 28055 | Health Support for Children in Care | Number of hours of service | Hours | Quarterly | Mandatory | Key Output measure |
| 28063 | Family Planning – Education and Training | Number of hours of service | Hours | Quarterly | Mandatory | Key output measure |
| 28064 | Family Planning – Clinical Services and Training | Number of hours of service | Hours | Quarterly | Mandatory | Key output measure |
| 28066 | Innovative Health Services for Homeless Youth | Number of hours of service | Hours | Quarterly | Mandatory | Key output measure |
| 28067 | Women’s Health | Number of clients | Clients | Quarterly | Mandatory | Key output measure |
| 28068 | Family Planning | Number of hours of service | Hours | Quarterly | Mandatory | Key output measure |
| 28071 | Aboriginal Services and Support | Number of hours of service | Hours | Quarterly | Mandatory | Other standard measure |
| 28071 | Aboriginal Services and Support | Report against agreed objectives | Reports | Yearly | Mandatory | Key output measure |
| 28072 | Integrated Chronic Disease Management | Number of hours of service | Hours | Quarterly | Mandatory | Key output measure |
| 28074 | Diabetes Connect | Number of hours of services | Hours | Quarterly | Mandatory | Key output measure |
| 28076 | Refugee and Asylum Seeker Health Services | Number of hours of service | Hours | Quarterly | Mandatory | Key output measure |
| 28080 | Healthy Mothers Healthy Babies | Numbers of hours of service | Hours | Quarterly | Mandatory | Key output measure |
| 28081 | National Diabetes Services Scheme | Number of packs of needles and syringes | Needles and syringes | Monthly | Mandatory | Key output measure |
| 28085 | Community Health – Health Promotion | Report against health promotion plan | Reports | Yearly | Mandatory | Other standard measure |
| 28086 | Community Health | Number of hours of service | Hours | Quarterly | Mandatory | Key output measure |
| 28088 | ACCO services – Primary Health | Development of service profile | Completed service | Yearly | Mandatory | Key output measure |
| 28090 | Multidisciplinary Centre – Community Health Nurse | Number of hours of service | Hours | Quarterly | Mandatory | Key output measure |
| 28091 | Community Asthma Program | Number of hours of service | Hours | Quarterly | Mandatory | Key Output measure |
| 28092 | Infant Child and Family Health and Wellbeing Hubs | Number of hours of service | Hours | Quarterly | Mandatory | Key Output measure |

Table 21. Public health – performance targets and monitoring

| Activity no. | Activity name | Measure description | Unit of measure | Frequency | Status | Output type |
| --- | --- | --- | --- | --- | --- | --- |
| 16038 | Tuberculosis Screening-Management | To provide for services and activities related to tuberculosis management in Victoria | Persons screened for prevention and early detection of health conditions – pulmonary tuberculosis screening | Quarterly | Mandatory | Key output measure |
| 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[[28]](#footnote-29) 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 | Yearly | Mandatory | Key output measure |
| 16449 | Smoking information – advice and interventions by Quit Victoria | Research reports | Reports | Yearly | Mandatory | Key output measure |
| 16450 | Diabetes prevention | Report against agreed objectives | Reports | Quarterly | Mandatory | Key output measure |
| 16452 | Aboriginal health advancement by VACCHO | Report against agreed objectives | Reports | Yearly | Mandatory | Key output measure |
| 16453 | Aboriginal health worker support ACCHOs | Report against agreed objectives | Reports | Yearly | Mandatory | Key output measure |
| 16454 | Health promotion initiatives inclusive of public health unit catchment planning, eye health, healthy kid advisers, Working together for health | Report against agreed objectives | Reports | Yearly | Mandatory | Key output measure |
| 16460 | Targeted recruitment for screening programs | Report against agreed deliverables | Reports | Yearly | Mandatory | Key output measure |
| 16505 | BBV and STI – training and development | Report against agreed deliverables | Reports | Yearly | Mandatory | Key output measure |
| 16506 | BBV and STI – research | Report against agreed deliverables | Reports | Yearly | Mandatory | Key output measure |
| 16507 | BBV and STI – laboratory services | Report against agreed deliverables | Reports | Reports | Mandatory | Key output measure |
| 16508 | BBV and STI – health promotion and prevention | Report against health promotion plan | Reports | Yearly | Mandatory | Key output measure |
| 16509 | BBV and STI – community-based care and support | Report against agreed deliverables | Reports | Yearly | Mandatory | Key output measure |
| 16513 | Screening and preventative messages | Report against agreed deliverables | Reports | Yearly | Mandatory | Key output measure |
| 16514 | Screening service development | Report against agreed deliverables | Reports | Yearly | Mandatory | Key output measure |
| 16515 | Education and training in screening programs | Report against agreed deliverables | Reports | Yearly | Mandatory | Key output measure |
| 16516 | Screening counselling and support | Number of occasions of service | Occasions of service | Yearly | Mandatory | Key output measure |
| 16517 | Cancer and screening registers | Statistical report within an agreed timeline and publicly available | Reports | Yearly | Mandatory | Key output measure |
| 16518 | Cancer and screening intelligence | Report against agreed objectives | Reports | Yearly | Mandatory | Key output measure |
| 16519 | Screening tests and assessments | Percentage of target population screened over an agreed period | Percentage | Yearly | Mandatory | Other standard measure |
| 16519 | Screening tests and assessments | Number of clients screened | Clients | Yearly | Mandatory | Key output measure |

Table 22. LPHUs – performance targets and monitoring

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Domain | Function | Measure description | Assessment method | Reporting frequency | Status |
| Health Protection | Receive and document notifications of urgent notifiable conditions | Public health responses initiated for urgent notifications within 24 hours | Review the time of urgent notification received against the time the case was entered on the statewide database for a stratified random sample of cases | Annual | Mandatory |
| Health Protection | Manage cases of notifiable conditions, in accordance with statewide protocols | Percentage of case investigations\* undertaken for cases, in accordance with statewide protocols | Review of a stratified random sample of cases from the statewide database against the applicable protocols for adherence to minimum standard | Quarterly | Mandatory |
| Health Protection | Respond to cases of notifiable conditions in a timely manner | Percentage of case investigations undertaken for cases within timeframes specified in statewide protocols | Review a stratified random sample of cases entered onto statewide databases against the applicable statewide protocols for compliance | Quarterly | Mandatory |
| Health Protection | Respond to local outbreaks in a timely manner | Percentage of investigations into outbreaks initiated within the timeframes specified in statewide protocols | Review a stratified random sample of cases entered onto statewide databases against the applicable statewide protocols for compliance | Quarterly | Mandatory |
| Health Protection | Accurately complete cases of notifiable conditions on statewide databases, in accordance with guidelines | Percentage of case follow up marked as completed for allocated cases on statewide databases, in accordance with quick entry guides and statewide protocols | Review a stratified random sample of cases entered onto statewide databases against minimum standard quick entry guide for compliance\*\* | Quarterly | Mandatory |
| Population Health | Align to the priorities of the Victorian Public Health and Wellbeing Plan 2023–2027 | LPHU Population Health Catchment Plan developed that reflects priorities of the Victorian Public Health and Wellbeing Plan and local Municipal Public Health and Wellbeing Plans | Catchment Plan (target 100%) | Six-year plan from 2023  Two-year review 2025 | Mandatory |
| Population Health | Align to the priorities of the Victorian Public Health and Wellbeing Plan 2023–2027 | Report against LPHU Population Health Catchment Plan, describing achievements, in accordance with the LPHU *Population Health Catchment Planning Framework* | Report against Population health catchment plan | Annual | Mandatory |
| Emergency Management | Provide support and public health expertise for public health risks | Report against activities undertaken for emergencies, in accordance with the [SEMP health emergencies sub-plan](https://www.emv.vic.gov.au/responsibilities/state-emergency-management-plan-sub-plans/semp-health-emergencies-sub-plan) <https://www.emv.vic.gov.au/responsibilities/state-emergency-management-plan-sub-plans/semp-health-emergencies-sub-plan> and the [SEMP viral (respiratory) pandemic sub-plan](https://www.emv.vic.gov.au/responsibilities/semp-sub-plans/semp-viral-respiratory-pandemic-sub-plan) <https://www.emv.vic.gov.au/responsibilities/semp-sub-plans/semp-viral-respiratory-pandemic-sub-plan> | Distribute Public Health Communication before and during an event  Public health surveillance and monitoring  Participate and contribute to After-Action Reviews in the LPHU catchment | Quarterly, where an emergency response exists | Mandatory |

Note: The performance targets and monitoring described in this table are exclusively applicable to lead health services that operate a LPHU.

# Service standards and guidelines

Table 23. SRHS – service standards and guidelines

|  |  |  |
| --- | --- | --- |
| Activity no. | Service standards and guidelines description | Service standards and guidelines |
| 13031  35010 | Aged Care Act as amended (residential only)  Aged Care Act as amended: support services | Aged Care Act *as* amended  Commonwealth Department of Health and Aged Care resources:  [My aged care](https://www.myagedcare.gov.au/resources) <https://www.myagedcare.gov.au>  [Aged care resources](https://www.health.gov.au/health-topics/aged-care/aged-care-resources) <https://www.health.gov.au/health-topics/aged-care/aged-care-resources>  [Small Rural Health Services Guide 2003–04 and updates](https://www.health.vic.gov.au/publications/small-rural-health-services-guide-2003-2004) <https://www.health.vic.gov.au/publications/small-rural-health-services-guide-2003-2004> |
| 35024 | Small Rural Health Services Guide 2003–04 and updates: rural – flexible health service delivery | [Small Rural Health Services Guide 2003–04 and updates](https://www.health.vic.gov.au/publications/small-rural-health-services-guide-2003-2004) <https://www.health.vic.gov.au/publications/small-rural-health-services-guide-2003-2004> |
| 35025  35026  35028  35052 | * Small Rural Health Services Guide 2003–04 and updates: rural – Transport Accident Commission – acute health * Small Rural Health Services Guide 2003–04 and updates: rural – Department of Veterans’ Affairs – acute health * Small Rural Health Services Guide 2003–04 and updates: rural – acute health service system development and resourcing * Small Rural Health Services Guide 2003–04 and updates: specified services | [Small Rural Health Services Guide 2003–04 and updates](https://www.health.vic.gov.au/publications/small-rural-health-services-guide-2003-2004) <https://www.health.vic.gov.au/publications/small-rural-health-services-guide-2003-2004> |
| 35030 | HACC PYP interim guidelines | [HACC PYP interim guidelines](https://www.health.vic.gov.au/home-and-community-care/hacc-program-for-younger-people) <https://www.health.vic.gov.au/home-and-community-care/hacc-program-for-younger-people>  [HACC PYP fees policy](https://www.health.vic.gov.au/home-and-community-care/hacc-pyp-fees-policy-and-schedule-of-fees) <https://www.health.vic.gov.au/home-and-community-care/hacc-pyp-fees-policy-and-schedule-of-fees> |
| 35048 | Small Rural Health Services Guide 2003–04 and updates primary health flexible services | [Small Rural Health Services Guide 2003–04 and updates](https://www.health.vic.gov.au/publications/small-rural-health-services-guide-2003-2004) <https://www.health.vic.gov.au/publications/small-rural-health-services-guide-2003-2004>  [Victorian health and wellbeing plan](https://www.health.vic.gov.au/victorian-health-and-wellbeing-plan) <https://www.health.vic.gov.au/victorian-health-and-wellbeing-plan>  [Community Health Integrated Program guidelines](https://www.health.vic.gov.au/community-health/community-health-integrated-program-chip-guidelines) <https://www.health.vic.gov.au/community-health/community-health-integrated-program-chip-guidelines> |

Table 24. Ageing, aged and home care – service standards and guidelines

|  |  |  |
| --- | --- | --- |
| Activity no. | Activity name | Service standards and guidelines description |
| 13005 | ACA | * Aged Care Act, as amended * Department of Health and Aged Care My Aged Care Assessment Manual Version 7.2 – 26 February 2025 and addendums * My Aged Care – Integrated Assessment Tool (IAT) User Guide and addendums * Aged Care Assessment Quality Framework July 2024 Version 5.0 * Principles and Guidelines for a Younger Person’s Access to Commonwealth funded Aged Care Services May 2023 * My Aged Care Screening and Assessment Workforce Training Strategy 2023 * My Aged Care Style Guide Single Assessment Workforce (approved 30 October 2024 Australian Government ) * Department of Health and Aged Care policy and program guides related to assessment services <[https://myagedcare.gov.au/resources](https://myagedcare.gov.au/resources/publications/) > * [*Aged Care Diversity Framework* action plans](https://www.health.gov.au/resources/collections/aged-care-diversity-framework-action-plans) <https://www.health.gov.au/resources/collections/aged-care-diversity-framework-action-plans> * My Aged Care Style Guide Single Assessment Workforce (approved 30 October 2024 Australian Government ) * Victorian Department of Health policy and funding guidelines |
| 13015  13023  13024  13026  13056  13096  13097  13099  13130  13223  13227  13229 | * HACC PYP Linkages * HACC PYP Service Development Grant * HACC PYP Assessment * HACC PYP Community Care * HACC PYP Planned Activity Group * HACC PYP Allied Health * HACC PYP Delivered Meals * HACC PYP Property Maintenance * HACC PYP Volunteer Co-ordination Other * HACC PYP Nursing * HACC PYP ACCO Services * HACC PYP Access and Support | [HACC PYP Interim Guidelines](https://www.health.vic.gov.au/home-and-community-care/hacc-program-for-younger-people) <https://www.health.vic.gov.au/home-and-community-care/hacc-program-for-younger-people> |
| 13019 | Personal Alert Victoria | * Personal Alert Victoria program and service guidelines * Personal Alert Victoria response service guidelines |
| 13031 | Public Sector Residential Aged Care Supplement | Aged Care Act, as amended  Commonwealth Department of Health and aged Care resources:   * [My Aged Care](https://www.myagedcare.gov.au) <https://www.myagedcare.gov.au> * [Aged care guides and policies](https://www.health.gov.au/health-topics/aged-care) <https://www.health.gov.au/health-topics/aged-care> |
| 13038 | HACC PYP Service System Resourcing | Victorian HACC PYP program manual |
| 13043 | HACC PYP Flexible Service Response | * Victorian HACC PYP program manual * Victorian HACC PYP fees policy |
| 13053 | Victorian Eyecare Service | Victorian Eyecare Service program guidelines |
| 13063 | HACC PYP Volunteer Co-ordination | Home and Community Care Program for Younger People Interim Guidelines [HACC PYP Interim Guidelines](https://www.health.vic.gov.au/home-and-community-care/hacc-program-for-younger-people) <https://www.health.vic.gov.au/home-and-community-care/hacc-program-for-younger-people> |
| 13067 | Victorian Aids and Equipment | VA&EP guidelines |
| 13082 | Low-cost Accommodation Support | * Community Connection Program submission guidelines, 2001 * Flexible Care Fund guidelines, 2015 * Older persons high rise program submission guidelines, 2001 * Housing Support for the Aged program submission Metro guidelines, 2001 * Housing Support for the Aged program submission Rural guidelines, 2001 |
| 13109 | ACA Evaluation Unit | * Aged Care Act, as amended * Department of Health and Aged Care My Aged Care Assessment Manual Version 7.2 – 26 February 2025 and addendums * My Aged Care – Integrated Assessment Tool User Guide and addendums * Aged Care Assessment Quality Framework July 2024 Version 5.0 * Principles and Guidelines for a Younger Person’s Access to Commonwealth funded Aged Care Services May 2023 * My Aged Care Screening and Assessment Workforce Training Strategy 2023 * My Aged Care Style Guide Single Assessment Workforce (approved 30 October 2024 Australian Government) * [Department of Health and Aged Care policy and program guides related to assessment services](https://www.myagedcare.gov.au/resources) <https://www.myagedcare.gov.au/resources> * [*Aged Care Diversity Framework* action plans](https://www.health.gov.au/resources/collections/aged-care-diversity-framework-action-plans) <https://www.health.gov.au/resources/collections/aged-care-diversity-framework-action-plans> * My Aged Care Style Guide Single Assessment Workforce (approved 30 October 2024 Australian Government) * Victorian Department of Health policy and funding guidelines |
| 13156 | Seniors Health Promotion | * Victorian HACC PYP program manual * Older persons high-rise program guidelines |
| 13301 | Aged Quality Improvement | Aged Care Act, as amended  Commonwealth Department of Health and Aged Care resources:   * [My Aged Care](https://www.myagedcare.gov.au) <https://www.myagedcare.gov.au> * [Aged care guides and policies](https://www.health.gov.au/health-topics/aged-care) <https://www.health.gov.au/health-topics/aged-care> |

Table 25: Primary, community and dental health – service standards and guidelines

|  |  |  |
| --- | --- | --- |
| Activity no. | Activity name | Service standards and guidelines description |
| 27010, 27011, 27017, 27019, 27020, 27023, 27024, 27025, 27026, 27028, 27029 | Dental health | [Dental health](https://www.health.vic.gov.au/primary-and-community-health/dental-health) <https://www.health.vic.gov.au/primary-and-community-health/dental-health> |
| 28015, 28016, 28018, 28050, 28063, 28064, 28068, 28067, 28085, 28086 | Women’s health | [Women’s health and Wellbeing Program](https://www.health.vic.gov.au/populations/improving-womens-health) <https://www.health.vic.gov.au/public-health/womens-health-wellbeing-program>  [Health promotion](https://www.health.vic.gov.au/population-health-systems/health-promotion) <https://www.health.vic.gov.au/population-health-systems/health-promotion> |
| 28021  28066  28085  28086 | Young people | [Community Health Integrated Program guidelines](https://www.health.vic.gov.au/community-health/community-health-integrated-program-chip-guidelines) <https://www.health.vic.gov.au/community-health/community-health-integrated-program-chip-guidelines>  [Children, youth and families](https://www.health.vic.gov.au/community-health/children-youth-and-families) <https://www.health.vic.gov.au/community-health/children-youth-and-families>  [Young people who are homeless or at risk](https://www.health.vic.gov.au/community-health/young-people-who-are-homeless-or-at-risk) <https://www.health.vic.gov.au/community-health/young-people-who-are-homeless-or-at-risk> |
| 28033  28043  28069  28074  28080  28084  28085  28086 | Community health | [Community Health Integrated Program guidelines](https://www.health.vic.gov.au/community-health/community-health-integrated-program-chip-guidelines) <https://www.health.vic.gov.au/community-health/community-health-integrated-program-chip-guidelines>  [Victorian health and wellbeing plan](https://www.health.vic.gov.au/victorian-health-and-wellbeing-plan) <https://www.health.vic.gov.au/victorian-health-and-wellbeing-plan>  [*Victorian Aboriginal Affairs Framework 2018–23*](https://www.firstpeoplesrelations.vic.gov.au/victorian-aboriginal-affairs-framework-2018-2023) <https://www.firstpeoplesrelations.vic.gov.au/victorian-aboriginal-affairs-framework-2018-2023>  [Healthy choices: policy directive and guidelines for health services](https://www.health.vic.gov.au/publications/healthy-choices-policy-directive-and-guidelines-for-health-services) (applicable to integrated community health services) <https://www.health.vic.gov.au/publications/healthy-choices-policy-directive-and-guidelines-for-health-services>  [Registration, accreditation and governance of community health centres](https://www.health.vic.gov.au/community-health/registration-and-governance-of-community-health-centres)  <https://www.health.vic.gov.au/community-health/registration-and-governance-of-community-health-centres>  [Community Health Demand Management Toolkit](https://www.health.vic.gov.au/community-health/managing-demand-for-community-health-services)  <https://www.health.vic.gov.au/community-health/managing-demand-for-community-health-services>  [Community Health Program access policy](https://www.health.vic.gov.au/community-health/community-health-program-access-policy)  <https://www.health.vic.gov.au/community-health/community-health-program-access-policy> |
| 28048  28076  28085  28086 | Culturally diverse groups | [Refugee Health Program](https://www.health.vic.gov.au/community-health/refugee-health-program) <https://www.health.vic.gov.au/community-health/refugee-health-program> includes the:   * Guide to asylum seeker access to health and community services in Victoria – these standards should be referenced until superseded * Guide for the Refugee Health Nurse Program * Refugee and asylum seeker health services: Guidelines for the community health program   [Refugee and asylum seeker health and wellbeing](https://www.health.vic.gov.au/populations/refugee-and-asylum-seeker-health-and-wellbeing) <https://www.health.vic.gov.au/populations/refugee-and-asylum-seeker-health-and-wellbeing> includes the Refugee and Asylum Seekers Health Action Plan 2014–18  [Cultural responsiveness framework – Guidelines for Victorian health services](https://www.health.vic.gov.au/publications/cultural-responsiveness-framework-guidelines-for-victorian-health-services) <https://www.health.vic.gov.au/publications/cultural-responsiveness-framework-guidelines-for-victorian-health-services> outlines the government’s approach to cultural responsiveness in health services  [Language services policy](https://www.health.vic.gov.au/publications/language-services-policy) <https://www.health.vic.gov.au/publications/language-services-policy>  [Health Translations Directory](http://www.healthtranslations.vic.gov.au) <https://www.healthtranslations.vic.gov.au> |
| 28054 | Partnerships and system support | [Working with general practice](https://www.health.vic.gov.au/primary-care/working-with-general-practice) <https://www.health.vic.gov.au/primary-care/working-with-general-practice> |
| 28071  28085  28086 | Aboriginal health | [Community Health Integrated Program guidelines](https://www.health.vic.gov.au/community-health/community-health-integrated-program-chip-guidelines) <https://www.health.vic.gov.au/community-health/community-health-integrated-program-chip-guidelines>  [Aboriginal health](https://www.health.vic.gov.au/health-strategies/aboriginal-health) <https://www.health.vic.gov.au/health-strategies/aboriginal-health>  [*Victorian Aboriginal Affairs Framework 2018–23*](https://www.firstpeoplesrelations.vic.gov.au/victorian-aboriginal-affairs-framework-2018-2023) <https://www.firstpeoplesrelations.vic.gov.au/victorian-aboriginal-affairs-framework-2018-2023> |
| 28072  28074  28081  28085  28086 | People with chronic disease | [Community Health Integrated Program guidelines](https://www.health.vic.gov.au/community-health/community-health-integrated-program-chip-guidelines) <https://www.health.vic.gov.au/community-health/community-health-integrated-program-chip-guidelines> |
| 28080  28085  28086  28212  28213 | Maternal health | [Community Health Integrated Program guidelines](https://www.health.vic.gov.au/community-health/community-health-integrated-program-chip-guidelines) <https://www.health.vic.gov.au/community-health/community-health-integrated-program-chip-guidelines>  [Healthy Mothers, Healthy Babies](https://www.health.vic.gov.au/community-health/healthy-mothers-healthy-babies) <https://www.health.vic.gov.au/community-health/healthy-mothers-healthy-babies>  [Sleep and settling](https://www.health.vic.gov.au/maternal-child-health/sleep-and-settling) <https://www.health.vic.gov.au/maternal-child-health/sleep-and-settling> |
| 28082  28085  28086 | Child health | [Child health services: Guidelines for the community health program](https://www.health.vic.gov.au/publications/child-health-services-guidelines-for-the-community-health-program) <https://www.health.vic.gov.au/publications/child-health-services-guidelines-for-the-community-health-program>  [Child health teams](https://www.health.vic.gov.au/community-health/child-health-teams) <https://www.health.vic.gov.au/community-health/child-health-teams>.  **Note**: Organisations receiving funds regarding 28085/28086 should note these funds can be applied flexibly across the range of initiatives to meet community needs |

Table 26: Public health – service standards and guidelines

|  |  |
| --- | --- |
| Activity no. | Service standards and guidelines description |
| 16373,16505, 16506,16507, 16508,16509 | BBV/STI program guidelines for funded agencies (current edition) |
| 16454 | [Victorian health and wellbeing plan](https://www.health.vic.gov.au/victorian-health-and-wellbeing-plan) <https://www.health.vic.gov.au/victorian-health-and-wellbeing-plan>  [Municipal public health and wellbeing planning](https://www.health.vic.gov.au/population-health-systems/municipal-public-health-and-wellbeing-planning) <https://www.health.vic.gov.au/population-health-systems/municipal-public-health-and-wellbeing-planning>  [Healthy choices](https://d.docs.live.net/031c443d5a1cf449/Documents/Business/Government/DoH-C%5e0SI/Healthy%20choices) <https://www.health.vic.gov.au/preventive-health/healthy-choices>  [Healthy Choices: policy directive and guideliines for health](https://www.health.vic.gov.au/publications/healthy-choices-policy-directive-and-guidelines-for-health-services) services <https://www.health.vic.gov.au/publications/healthy-choices-policy-directive-and-guidelines-for-health-services> |
| 28085 | [Community Health – Health Promotion program 2021–25](https://www.health.vic.gov.au/publications/community-health-health-promotion-2021-25) <https://www.health.vic.gov.au/publications/community-health-health-promotion-2021–25> |

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# Glossary and acronyms

| Term | Definition |
| --- | --- |
| ACAS | aged care assessment services |
| ACCHO | Aboriginal Community Controlled Health Organisation |
| ACCO | Aboriginal community-controlled organisation |
| ACSQHC | Australian Commission on Safety and Quality in Health Care |
| Ahpra | Australian Health Practitioner Regulation Agency |
| AHWPF | Aboriginal Health and Wellbeing Partnership Forum |
| AIMS | Agency Information Management System |
| AMAF | Asset management accountability framework |
| AN-ACC | Australian National Aged Care Classification |
| ANZICS | Australian and New Zealand Intensive Care Society |
| ANZSCTS | Australian and New Zealand Society of Cardiac and Thoracic Surgeons |
| AOD | alcohol and other drugs |
| ASA | American Society of Anaesthesiologists |
| BBV | blood-borne virus |
| BIA | Business Impact Analysis |
| CCOPMM | Consultative Council on Obstetric and Paediatric Mortality and Morbidity |
| CCUs | Community Care Units |
| CEO | chief executive officer |
| CES | Carer Experience Survey |
| CISS | Child Information Sharing Scheme |
| CMI/ODS | Client Management Interface and Operational Data Store |
| Cth | Commonwealth |
| the department | Department of Health |
| DLO | disability liaison officer |
| ECT | electroconvulsive treatment |
| ED | emergency department |
| EDMS | Environmental data management system |
| EIPSR | Early Intervention Psychosocial Support Response |
| EMR | Electronic Medical Record |
| eReferral | electronic referral |
| ESIS | Elective Surgery Information System |
| Forensicare | Victorian Institute of Forensic Mental Health |
| FRD 24 | Financial Reporting Direction 24 |
| FTE | full-time equivalent |
| funded organisation | government-funded healthcare organisation |
| FVISS | Family Violence Information Sharing Scheme |
| GEM | geriatric evaluation and management |
| GenV | Generation Victoria |
| GP | general practitioner |
| GST | Goods and Services Tax |
| HACC PYP | Home and Community Care Program for Younger People |
| HDSS | Health Data Standards and Systems |
| HeART | Health Agencies Reporting Tool |
| HITH | Hospital in the Home |
| HIV | human immunodeficiency virus |
| HLO | health liaison officer |
| HOPE program | Hospital Outreach Post-suicidal Engagement program |
| ICS | Integrated Cancer Service |
| ICT | Information and communication technology |
| ICU | intensive care unit |
| IP | intellectual property |
| IRCG | Infrastructure Renewal Contribution Grant |
| ISR | incident severity rating |
| LPHU | Local Public Health Unit |
| MARAM | Family violence multi-agency risk assessment and management framework |
| MBS | Medicare Benefits Schedule |
| MDS | minimum data set |
| MHCSS | Mental Health Community Support Services |
| MHPAF | Mental health performance and accountability framework |
| NADC | Non-Admitted Data Collection |
| NATA | National Association of Testing Authorities |
| NBCSP | National Bowel Cancer Screening Program |
| NDIA | National Disability Insurance Agency |
| NDIS | National Disability Insurance Scheme |
| NEPT | Non-Emergency Patient Transport |
| NGO | non-government organisation |
| NSQHS | National Safety and Quality Health Service |
| OCP | Office of the Chief Psychiatrist |
| PARC | Prevention and recovery care |
| PAS | Patient Administration System |
| PBS | Pharmaceutical Benefits Scheme |
| PCCP | Palliative Care Consultancy Program |
| PCs | personal computers |
| PGY | postgraduate year |
| PHESS | Public Health Event Surveillance System |
| PHN | Primary Health Network |
| PMCV | Postgraduate Medical Council of Victoria |
| PRISM | Program Report for Integrated Service Monitoring |
| PSRACS | public sector residential aged care services |
| RAS | Regional Assessment Services |
| RCVMHS | Royal Commission into Victoria’s Mental Health System |
| RHIF | Regional Health Infrastructure Fund |
| RTO | recovery time objective |
| SAPSE | serious adverse patient safety events |
| SCV | Safer Care Victoria |
| SDC | Statutory Duty of Candour |
| SECU | secure extended care unit |
| SEMP | State Emergency Management Plan |
| SHRFV | Strengthening Hospital Responses to Family Violence |
| SOP | Statement of Priorities |
| SRHS | small rural health services |
| STI | sexually transmissible infections |
| TEC | Timely Emergency Care |
| the guidelines | Policy and funding guidelines 2025–26 |
| UCC | Urgent Care Clinic |
| VA&EP | Victorian Aids and Equipment Program |
| VACCHO | Victorian Aboriginal Community Controlled Health Organisation |
| VADC | Victorian Alcohol and Drug Collection |
| VADS | Victorian Ambulance Dataset |
| VAED | Victorian Admitted Episodes Dataset |
| VAHI | Victorian Agency for Health Information |
| VCDC | Victorian Cost Data Collection |
| VCSS | Victorian Community Support Services (formerly HACC) |
| VEMD | Victorian Emergency Minimum Dataset |
| VHES | Victorian Healthcare Experience Survey |
| VHIMS | Victorian Health Incident Management System |
| VICNISS | Victorian Healthcare Associated Infection Surveillance System |
| ViCTOR | Victorian Children’s Tool for Observation and Response |
| VIHSP | Victorian Infant Hearing Screening Program |
| VINAH | Victorian Integrated Non-Admitted Health |
| VMIA | Victorian Managed Insurance Authority |
| VPAS | Victorian Perinatal Autopsy Service |
| VPCC | Victorian Perioperative Consultative Council |
| VPDC | Victorian Perinatal Data Collection |
| VVED | Victorian Virtual Emergency Department |
| YES | Your Experience of Service |
| YPARC | youth prevention and recovery care |

1. Ambulance Victoria’s membership subscription scheme insures patients against the costs of ambulance services. [↑](#footnote-ref-2)
2. NEPT eligibility is determined in accordance with the Non-Emergency Patient Transport Regulations 2016. [↑](#footnote-ref-3)
3. <https://www.health.vic.gov.au/publications/local-adult-older-adult-mental-health-wellbeing-service-framework> [↑](#footnote-ref-4)
4. State of Victoria 2021, *RCVMHS final report*, vol. 1: A new approach to mental health and wellbeing in Victoria, Parl. Paper No. 202, Session 2018–21 (document 2 of 6), p. 249. [↑](#footnote-ref-5)
5. Health services are to contact finance departments to obtain the circular 23/2009. [↑](#footnote-ref-6)
6. To support sustainability of the Aboriginal community-controlled sector, the department has commenced transitioning ACCOs to outcomes-based funding, starting with the delivery of multi-year (four-year) recurrent funding cycles from July 2023. [↑](#footnote-ref-7)
7. Note that health services should not rely solely on their Aboriginal Cultural Safety Fixed Grants for this training. Cultural safety is a critical quality and safety issue, and health services need to consider broad budgets, such as corporate Learning and Development budgets. [↑](#footnote-ref-8)
8. See [Victorian health workforce strategy](https://www.health.vic.gov.au/victorian-health-workforce-strategy) <https://www.health.vic.gov.au/victorian-health-workforce-strategy>. [↑](#footnote-ref-9)
9. Those health services will be directly notified of this expectation by the department. [↑](#footnote-ref-10)
10. See [*Barring Djinang: First Peoples Workforce Development Framework*](https://vpsc.vic.gov.au/workforce-programs/first-peoples-workforce/barring-djinang-first-peoples-workforce-development-framework/) < https://vpsc.vic.gov.au/workforce-programs/first-peoples-workforce/barring-djinang-first-peoples-workforce-development-framework/>. [↑](#footnote-ref-11)
11. [NSQHS Standards User guide for Aboriginal and Torres Strait Islander health](https://www.safetyandquality.gov.au/publications-and-resources/resource-library/nsqhs-standards-user-guide-aboriginal-and-torres-strait-islander-health) <https://www.safetyandquality.gov.au/publications-and-resources/resource-library/nsqhs-standards-user-guide-aboriginal-and-torres-strait-islander-health>. [↑](#footnote-ref-12)
12. [The health and wellbeing of the LGBTIQ+ population in Victoria: findings from the Victorian Population Health Survey 2017](https://dhhsvicgovau.sharepoint.com/sites/Accountability/Shared%20Documents/PFG%202025-26/PFG%202025-26%20-%20Divisions/Hospitals%20and%20Health%20Services/The%20health%20and%20wellbeing%20of%20the%20LGBTIQ+%20population%20in%20Victoria:%20findings%20from%20the%20Victorian%20Population%20Health%20Survey%202017) <https://vahi.vic.gov.au/report/population-health/health-and-wellbeing-lgbtiq-population-victoria>. [↑](#footnote-ref-13)
13. The in-scope hospitals are: Albury Hospital, The Alfred Hospital, Austin Hospital, University Hospital Geelong, Bendigo Hospital, Box Hill Hospital, Maroondah Hospital, Shepparton Hospital, Ballarat Hospital, Latrobe Regional Hospital, Werribee Mercy Hospital, Monash Medical Centre – Clayton, Casey Hospital, Dandenong Hospital, Northern Hospital, Frankston Hospital, The Royal Melbourne Hospital, St Vincent’s Hospital, Sunshine Hospital and Footscray Hospital. [↑](#footnote-ref-14)
14. A registered account with login and password is required to access the portal. [↑](#footnote-ref-15)
15. Final cut-off dates for the estimates trial balance submission that will contribute to the 30 June year-end cap will be communicated separately. These submissions will contribute to the determination of the current financial year revised budget numbers, as part of the State of Victoria Budget Papers preparation process. [↑](#footnote-ref-16)
16. The Whole of Victorian Government pledge and Health and human services climate change adaptation action plan are updated every five years. An update of the pledge is expected in 2025. This may have additional requirements applicable to health services. [↑](#footnote-ref-17)
17. Note: Climate Health Victoria will be releasing climate risk assessment guidance for health services in mid-2025. Email [chv@health.vic.gov.au](mailto:chv@health.vic.gov.au) to access. [↑](#footnote-ref-18)
18. Cyber and Infrastructure Security Centre, [*Critical Infrastructure Annual Risk Review*](https://apo.org.au/node/328968), Second Edition, November 2024, accessible at <https://apo.org.au/node/328968>. [↑](#footnote-ref-19)
19. Australian Security Intelligence Organisation, [Director-General's Annual Threat Assessment 2025](https://www.asio.gov.au/director-generals-annual-threat-assessment-2025), accessible at <https://www.asio.gov.au/director-generals-annual-threat-assessment-2025>. [↑](#footnote-ref-20)
20. [Action 1.17 Heathcare records](https://www.safetyandquality.gov.au/standards/nsqhs-standards/clinical-governance-standard/patient-safety-and-quality-systems/action-117) <https://www.safetyandquality.gov.au/standards/nsqhs-standards/clinical-governance-standard/patient-safety-and-quality-systems/action-117>. [↑](#footnote-ref-21)
21. [Action 1.18 Healthcare records](https://www.safetyandquality.gov.au/standards/nsqhs-standards/clinical-governance-standard/patient-safety-and-quality-systems/action-118) <https://www.safetyandquality.gov.au/standards/nsqhs-standards/clinical-governance-standard/patient-safety-and-quality-systems/action-118>. [↑](#footnote-ref-22)
22. Initiative 3.4 in [Victoria’s digital health roadmap](https://www.health.vic.gov.au/publications/victorias-digital-health-roadmap) <https://www.health.vic.gov.au/publications/victorias-digital-health-roadmap>. [↑](#footnote-ref-23)
23. The increase excludes the impact of bond rate and probability factors (revaluations). [↑](#footnote-ref-24)
24. The HeART replaces the previously used ‘F1’ template from the July 2021 reporting period onwards. [↑](#footnote-ref-25)
25. A registered account with login details is required to access the portal. [↑](#footnote-ref-26)
26. Methicillin-resistant *Staphylococcus aureus (MRSA)*, vancomycin-resistant enterococci (VRE) and *Clostridium difficile* infection (CDI). [↑](#footnote-ref-27)
27. Royal District Nursing Service (RDNS). [↑](#footnote-ref-28)
28. Assisted reproductive treatment [↑](#footnote-ref-29)