Submission to the Review of Hospital Safety and Quality

Prepared April 2016
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Background

About Forensicare
Forensicare is the state-wide specialist provider of forensic mental health services in Victoria. Forensicare is a statutory authority governed by a nine-member Board that is accountable to Victoria’s Minister for Mental Health. It is established under the Mental Health Act 2014, unlike other health services which are constituted under the Health Services Act. However, its focus is on clinical care and in many ways operates in the same manner as other health services. The Board has a range of committees which consider quality and safety, including the Clinical Governance and Quality Committee and an Audit, Security and Risk Management Committee. The Forensicare Clinical Governance Framework is the system by which the Board, Executive, clinicians and staff share responsibility and accountability for the safety and quality of care and the Framework complies with the Victorian clinical governance policy framework: enhancing clinical care (2008). Compliance with good clinical governance is measured through accreditation mechanisms and through the Clinical Governance & Quality Committee which provides leadership and advice to the Board through the continuous assessment and evaluation of the safety and quality of clinical services.

Forensicare is committed to providing recovery-orientated mental healthcare in which the principles of hope, social inclusion, personalised care and self-management are fundamental to practice. Forensicare is the only agency in Victoria that provides clinical forensic mental health services that span the mental health and justice sectors. Forensicare therefore has a unique perspective on mental health and public safety issues and is able to provide specialist forensic mental health services tailored to meet the specific needs of both sectors.

Forensicare’s primary focus is the provision of clinical services, which includes the effective assessment, treatment and management of forensic patients, prisoners and clients. In addition, a comprehensive research program operates and specialist training and professional education is provided for our staff and the broader mental health field. Forensicare is majority funded by the Department of Health and Human Services. The prison based services are provided under a Funding and Healthcare Services Agreements with the Department of Justice and Regulation, through Justice Health or Corrections Victoria. Our clinical services are provided through the Thomas Embling Hospital, Prison Mental Health Services and the Community Forensic Mental Health Service. A more detailed description of our services and programs can be found in Appendix 2.

The focus of our submission
The Review has asked a range of questions about quality and safety in health services in Victoria. In responding to the questions, we will focus on those aspects which relate most closely to the mental health services we provide in the prison setting, at Thomas Embling Hospital and in the community.
Theme 1: Fostering continuous improvement and clinical excellence

1. Incident reporting systems are often considered an improvement tool. But, done poorly, these systems can provide more hindrance than help. How can the department make the Victorian Health Incident Management System (RiskMan) a more useful and user-friendly system?

The Victorian Health Incident Management System (VHIMS) is an important tool to assist the health service capture, analyse and report data for risk management and quality improvement purposes. However, the system interface is not ‘end-user friendly’, being time consuming for front-end staff to report incidents and quality and risk managers to ensure data quality. The current VHIMS 2 project will be beneficial as key stakeholders have been consulted in the design of the future product.

Some important features of the new product should include a streamlined incident classification data dictionary. The current Primary Incident Type (PIT) dictionary contains approximately 300 options, which is confusing for end-users and hampers data integrity. Consolidating the current data set and provision of a data-set glossary would assist end-users selecting an appropriate PIT. Forensicare has commissioned amendments to the current VHIMS, to enable a ‘better fit’ for a specialist mental health service. These amendments have included the addition of a classification field, which is linked to the data dictionary, and drop-down seclusion and restraint data fields.

More advanced user interface and reporting capabilities would greatly assist all VHIMS users. The time taken to complete a VHIMS entry is often raised by front-end users, as is the duplication of incident entry required, such as an OH&S incident relating to a clinical incident. Improved VHIMS capability would include a build in proportionality (small incidents--> small reports) and more auto population of fields across all modules.

2. How can the skills and expertise of university staff be better used to improve hospital safety and quality?

It is essential that health services maintain close ties with universities to ensure ongoing workforce development, professional development, evaluation and research, all of which contributes to improved safety and quality in hospitals and broader health services. This is particularly in the case with health services in highly specialised fields, such as forensic mental health, where there are few training programmes nationally.

The statutory functions and powers of Forensicare include the mandate “to conduct research in the fields of forensic mental health, forensic health, forensic behavioural science and associated fields” and to “promote continuous improvements and innovations in the provision of forensic mental health and related services in Victoria” (Mental Health Act 2014 s.330(g) & s.330(h)). This is reflected in the objectives set out in both our Strategic Plan 2015 – 2017 and our Research Strategy 2015 – 2017. It is notable that Forensicare received “Met with Merit” ratings for three of the four Research Governance related standards during the 2015 Accreditation.

From its inception, Forensicare has worked with a range of universities to help develop the specialist workforce and to build research capacity in forensic mental health and related fields. Forensicare has a formal link with Swinburne University of Technology through our research arm, the Centre for Forensic Behavioural Science, and established links with other tertiary organisations to support our ongoing commitment to promote knowledge and training in forensic mental health.
There are four specific ways in which the skills and expertise of university staff can be better used to improve hospital safety and quality:

a) Establishing clinical appointments jointly with universities and health services

Joint clinical-academic appointments with universities are an effective mechanism to help ensure that contemporary best-practice standards are being employed in a health service. Forensicare has a history of having joint academic appointments in psychology, psychiatry and nursing. Although formal cross-appointments are limited, approximately 8% of clinical staff members hold honorary appointments at universities.

b) The provision of professional development and supervision

Research in clinical practice development shows that the up-take of emerging best practice standards in health care is very slow; however, by having close relationships with universities and academic clinicians, information about cutting edge research and practice is more readily available. Forensicare has an ongoing program of professional development and the Centre for Forensic Behavioural Science operates many professional development training sessions in forensic mental health topics annually. The Centre also holds monthly academic seminars to which Forensicare staff members are invited. Forensicare also holds an annual research dissemination day that is attended by Forensicare staff and management as well as some external guests. Finally, Forensicare produces more than 50 peer-reviewed articles and chapters annually, to which staff have access.

In addition to exposure to research the Centre for Forensic Behavioural Science operates several post-graduate courses through Swinburne University of Technology in cooperation with Forensicare: Graduate Program in Forensic Behavioural Science (leading to the graduate certificate, diploma, or masters degree in forensic behavioural science), the Graduate Certificate in Violence Risk Assessment and Management, the Graduate Certificate/Diploma in Forensic Mental Health Nursing, the Graduate Diploma in Forensic Psychology, and the Doctor of Psychology (Clinical and Forensic). Swinburne University of Technology provide scholarships to Forensicare that enable two students to attend each of the eleven subjects offered at no cost.

c) Embed a culture of independent evaluation of services

Formal evaluation should be an integral element of all emerging clinical project and ongoing services. Project planning should include funding to support local evaluation by university partners, rather than outsourcing via external tender processes. NHMRC standards for independent evaluation and research nominate universities as being preferred agencies to conduct independent research given the academic freedom principle. Forensicare makes a commitment, through its Strategic Plan and research strategy, to evaluate new programs as well as ongoing ones. The evaluations are conducted by the Centre for Forensic Behavioural Science and funded by Forensicare or the agencies that contract Forensicare services.

d) Encourage original research to help ensure that best practice and service development

Although necessary, service evaluation alone is not sufficient to help ensure that the culture is one of ongoing improvement in the safety and quality of health services. Through the Centre for Forensic Behavioural Science, Forensicare enjoys an international reputation of excellence in research in forensic behavioural science and forensic mental health. We enjoy a steady stream of international doctoral students, research fellows, and visiting faculty who participate in the research program. As noted, the research output from the Centre for Forensic Behavioural Science and Forensicare is prolific, with our work being cited in more than 1,000 academic articles and chapters annually.
Notably, evaluation measures and intervention programmes developed by the Centre with Forensicare are used internationally. In 2015, the prestigious National Institute of Clinical Expertise of the National Health Service in the UK recognised the Dynamic Appraisal of Situational Aggress, Inpatient Version (DASA-IV), which was developed by our researchers, as representing best-practice in inpatient aggression assessment internationally. Our treatment programmes, including the Problem Behaviour Program from the Community Forensic Mental Health Service, have been adapted for use overseas (i.e., the UK) and interstate (i.e., Queensland and New South Wales).

As demonstrated, close partnerships and cooperation with universities can greatly contribute to the clinical services operated by hospital and health services. By helping to ensure that clinical staff are employing contemporary best-practice standards in their work, the ongoing improvement in safety and quality of health services becomes part of the clinical culture.
Theme 2: Improving hospital governance –
Governance by hospital boards and chief executives

1. As the terms of reference of this review note, ‘Smaller public hospitals are not of a sufficient size to have dedicated comprehensive safety and quality teams, clinical expertise in board members and often also have access to medical administration expertise.’ How should the department ensure that all boards of public health services and public hospitals are capable of providing appropriate local governance of safety and quality? Is the right solution to merge smaller boards, or would more support from the department be sufficient to ensure capability gaps are filled?

In the mid 1990’s the provision of public mental health services was transferred from State run institutions to public hospitals (often referred to as “mainstreaming”) following the release of Victoria’s Mental Health Service; The Framework for Service Delivery 1994. Forensic mental health services remained under direct government management while the Thomas Embling Hospital redevelopment project was undertaken, given its magnitude and sensitivity in comparison to other mental health service initiatives at that time.

In 1996/97 options were examined for the future of forensic mental health services in Victoria. Purchasing forensic mental health services from a larger health services was not a preferred option for the following reasons:

> lack of alignment between forensic mental health service and network health care priorities;
> the high level of specialist interaction with criminal justice system required;
> lack of experience of networks or the private sector in forensic mental health service provision;
> lack of identifiable business or service improvements such as lower costs, increased efficiency or expansion possibilities;
> forensic mental health services were a statewide service;
> the size of the new hospital development meant that economies of scale were achievable without making the service part of a larger network.

A separate statutory authority was seen as the most appropriate option for the following reasons:

> to facilitate a focus on the delivery of forensic mental health services;
> to structurally ensure effective input and interaction with critical criminal justice stakeholders;
> to heighten emphasis on efficiency and effectiveness and increased flexibility.

Since that time there have been many developments in mental health care, and the application of clinical governance, quality and safety benchmarks in mental health. It is Forensicare’s position that smaller or specialist services are capable of providing appropriate levels of clinical governance, quality and safety, without merging or being auspiced by larger entities. Forensicare is in a unique position because the governance model set out by the Mental Health Act 2014 continues the membership requirements of the Board put in place when it was established, which stipulate there should be a psychiatrist, nominees of the Minister for Corrections and the Attorney General and a person capable of representing the views of consumers and carers. This ensures there is a strong “specialist” set of competencies reflecting the fact that we operate in the mental health and justice
sectors. As a mental health service in a major metropolitan area, there have not been difficulties in attracting sufficient expertise to the Forensicare Board.

However, in the case of specialist services, we believe there is a need for the Department to recognise that funding models (be they activity based or “block” funding) need to factor in an appropriate consideration of the need to maintain robust clinical governance mechanisms, and allocation of sufficient resources to maintain quality and safety. This applies equally in the prison health or mental health setting.

More support from the Department (be it through funding, more responsive incident reporting systems or assistance in kind) would assist smaller or specialist health services to fulfil their safety and quality obligations. It is noteworthy that in the prison health arena, where the government has made a policy decision to commission health services, there is a potential inequity if a private provider is commissioned to provide health services but does not have access to the same support from the Department. It is our submission that the Department should provide the same support to all prison health service providers to ensure appropriate governance of safety and quality. Funding models for prison health and mental health provision should provide sufficient provision to ensure strong governance of safety and quality.

The development of a mental health clinical network could assist in enabling a more robust comparison of performance on safety and quality, and indeed to develop an agreed set of indicators for governance in mental health which enable monitoring of performance. Support by the Department to resource such a network and develop its capabilities would be a positive commitment to a greater emphasis on quality and safety of care in mental health.

2. How can we ensure that adequate mental health services are delivered in prisons?

The Current System

Prison health and mental health service delivery in Victoria is complex and arguably made more complex by the policy framework where these services are commissioned through a “market” mechanism, with a mix of public, denominational (St Vincent’s Health) and private providers. A detailed description of the different providers in the system is provided in Appendix 1 together with an outline of the expansion of prison mental health services in recent years.

Justice Health is a business unit of the Department of Justice & Regulation and is responsible for the delivery of health services for persons in all Victoria’s prisons. It undertakes this function by managing the contracts of those providers who deliver health and mental health services in prisons and oversight of those services in private prisons (where the service provider is contracted to the prison operator, not the Department of Justice). The contractual framework for health and mental health services requires providers to comply with the Justice Health Quality Framework. This applies to both mental health services and general health services.

By virtue of the fact that they are delivered in a closed environment, there is a risk that prison health or mental health services may not receive the same level of scrutiny in relation to performance in regards to safety and quality as similar services in the community. The Justice Health Quality Framework and reporting under it go a significant way to mitigating that risk. However, there is an argument that performance of providers of health and mental health services in prisons should be subject to similar public scrutiny as other health services. It is Forensicare’s submission that the Justice Health Quality Framework should be a publically available document. We believe there is also a case for further work to be undertaken between the Departments of Justice & Regulation, and Health & Human Services, to determine an appropriate set of indicators of prison health and mental
health service quality and safety which could be made publically available in the same way as other health service indicators in the community. This work could be pursued by the Criminal Justice and Mental Health Systems’ Planning and Strategic Co-ordination Board.

The complex mix of providers in the prison system means that there is a delineation between primary and secondary mental health care. Most prisoners receive primary mental health services through nurses or GPs employed by services other than Forensicare. Prisoners are not able to make a real choice of who provides their health or mental health services. However, the existence of a single medical file (more recently an electronic health record on the “JCare” system) provides a strong platform for quality and safety evaluation. Having the clinical governance, quality and safety processes more open to scrutiny by the Department of Health and Human Services, and publically, would enable better judgements or assessments of the quality of prisoner health service delivery.

It is important to remember that all prisoner placements and movements are subject to determinations by Corrections Victoria (CV). While all male prisoners received into the Victorian prison system are screened on reception into prison by Forensicare in relation to their mental health needs this is not true of women prisoners. Screening of prisoners on entry into the system enables more acute needs to be identified early, and in the case of men, those prisoners who need immediate care can be housed in Units with more mental health support, such as the 16-bed Acute Assessment Unit (AAU). The most mentally unwell patients are concentrated in the AAU, and they receive intensive multidisciplinary service. It is however not accurately described as an inpatient unit and it most certainly in no way resembles a hospital.

In prison the decisions of courts also impact on the ability to treat prisoners, and individuals at MAP who are on remand are often released on bail to the community after a short stay; this includes very mentally unwell individuals who are referred (sometimes under an Assessment Order) to Area Mental Health Services. The prison mental health reception system therefore acts as a safety net that identifies individuals who come into custody with the most acute mental health needs who are then prioritised for treatment whilst in prison, or who if released back to the community are referred to mainstream public mental health services for treatment.

However, in Victoria, legislation and policy determines that a prisoner who meets criteria for compulsory treatment under the Mental Health Act 2014 is transferred to a designated mental health facility to receive that treatment. The rationale for this is that compulsory treatment is most humanely and safely provided in a medical or therapeutic milieu, rather than in the coercive and punitive environment of a correctional facility. In Victoria, this is achieved by the transfer of the prisoner to Thomas Embling Hospital. At the point of entry to the hospital, jurisdiction passes and the “prisoner” becomes a “security patient” under the Mental Health Act. After a period of treatment and stabilisation, and once the person no longer satisfies the criteria for compulsory treatment, they are transferred back to prison, handed over to correctional authorities, and come under the jurisdiction of the Corrections Act.

The amount of time between when a prisoner is “certified” under the Mental Health Act and then is eventually transferred to Thomas Embling Hospital is an important indicator to measure in considering the access aspects of quality and safety of mental health care to prisoners, but it is not the only indicator of quality. Forensicare’s Statement of Priorities has a number of indicators which are already measured in this respect, but a more comprehensive framework could be put in place which applied to Forensicare and other mental health providers in prison.
Forensicare is subcontracted to the GEO Group to design and implement a comprehensive suite of forensic mental health services at the new Ravenhall Prison, due to open in November 2017. In this private prison project the State (Department of Justice & Regulation) has used a nominated subcontractor model where forensic mental health services were included in the public-private partnership scope and the documentation stipulated that Forensicare would be engaged by the winning consortium as the forensic mental health services provider.

The state-wide forensic mental health services to be delivered at Ravenhall Prison will incorporate 75 dedicated forensic mental health beds, services for prisoners ‘at risk’, a large outpatients program and a community integration program. These services will significantly increase capacity for the appropriate treatment of prisoners with a mental illness in the men’s prison system. In addition to direct service provision, Forensicare will be training all custodial and programs staff at Ravenhall Prison in understanding of mental illness, managing challenging behaviours – including self-harm, suicidal and violent behaviours and how to facilitate access for men with mental health issues to the appropriate services and programs.

Forensicare has also been nominated to provide services in the 30 bed psychosocial rehabilitation unit at Port Philip Prison from September 2017 (taking over from St Vincent’s). This will be as a subcontractor to the G4S company that runs that private prison. The change will bring all bed based mental health services in the men’s system under a single provider so that patient pathways can be integrated, in turn contributing to quality and safety outcomes.

Broader Considerations
There is a broader issue of whether the best way to ensure the safety and quality of health care services in prisons is to have this overseen by the Department of Health and Human Services. While ensuring a high standard of the safety and quality of health care delivered in prisons is not insurmountable if it is the responsibility of justice departments, there are many advantages to establishing prison health and mental health services in health departments:

a) Health departments have ongoing expertise in the oversight of health service delivery and governance.

b) The primary obligation of health departments is to provide care to ensure the ongoing health and well-being of people; whereas justice departments have as their primary goal public safety and well-being.

c) Prisoners, as a group, have higher rates of mental illness and more complex clinical presentations across mental health and physical health than people in the general community. As such, prisoner health and mental health services need to be afforded a high degree of expertise.

d) There is an inevitable tension between the obligations of health care and prisoner management in corrective services. By vesting responsibility for both corrective and health services in justice departments, there is a threat to the independence and governance of health care services.

e) Public health services have a developing culture of transparency and clinical governance while corrective services still, perhaps necessarily, have a very limited level of transparency.

Internationally, there has been a move toward integrating prisoner health cares within health departments. This has occurred in New South Wales within Australian and in England and Wales
more than 10 years ago. In 2004, a conference was held in the United Kingdom exploring these matters. The summary of proceedings concluded as follows:

“The reasons for integrating prison health with the public health service were complex but, in all four countries [England and Wales, France, Norway and New South Wales], concerns on the part of medical organisations about both the quality of care for prisoners and the role of medical staff working in prisons were influential in leading to consideration of policy change. The high number of mentally ill people in prison and the defects in their care were also important factors.

Implementing the transfer can be a complex process. Issues of conflicts between the different health and prison cultures, the affiliation of prison healthcare staff to health or custodial professional associations, ethics and data sharing all have to be resolved. In three of the countries the transfer was accompanied by a substantial injection of new resources.

However, the gains can be great. Evaluations that have been carried out indicate that the standard of care provided to prisoners has improved in all four countries. National health policy has greater awareness of the specific health needs of prisoners. Recruitment and quality of staffing has improved. Links with health services in the community have been strengthened” (Prison Health and Public Health: The integration of Prison Health Services, King’s College, London, 2004.)

This is a matter that needs to be given consideration in order to continue to improve the safety and quality of health and mental health services to prisoners.
Theme 3: Strengthening oversight of safety and clinical governance

1. What indicators should the department adopt to strengthen monitoring of safety and quality of care in mental health services, including forensic mental health?

There are existing indicators, for instance those contained in National Mental Health Strategy – Key Performance Indicators for Australian Public Mental Health Services (2013), which the department and services themselves can utilise to monitor safety and quality of care. It is important in considering what additional reporting may be required to consider those relevant KPIs which have already been developed through robust processes, including service and consumer consultation. Many of these, such as the suite of quality and safety indicators used in mental services, and ACHS clinical indicators, are applicable for forensic mental health services. Like acute mental health services, seclusion data in forensic settings is an important measure.

One significant aspect to consider is the application of different indicators in settings where patients are “long stay”, and there is potentially a need for a more refined set of indicators for long stay settings (such as the sub-acute and rehabilitation programs at Thomas Embling Hospital). For longer-stay patients, such as forensic patients, measures relating to the monitoring of metabolic side effects of antipsychotic medication and progress against agreed recovery goals could be useful quality and safety measures. Examples are:

- **Quality use of medicines indicator** – Acute mental health care – 7.4: Percentage of patients taking antipsychotic medicines who receive appropriate monitoring for the development of metabolic side effects
- **Seclusion** – two or more episodes in a specified timeframe
- **Seclusion** – duration of episodes
- Indicators which demonstrate an individual’s progress against agreed outcome/recovery goals, such as completion of therapeutic programs.

Examples of indicators for secondary (specialist) mental health services in prisons include:

- Average number of certified patients per day awaiting transfer to Thomas Embling Hospital.
- Average number of certified patients on lockdown in prison per month.
- Number of patients readmitted to residential mental health units within 28 days of discharge.
- Percentage of suicide risk reviews completed within nominated time frames.
- Percentage of ‘at risk’ reviews conducted within 2 hours of receipt.
Theme 4: Advancing transparency

1. Legislation drafted in 2015 will, if passed, require quarterly reporting against the statement of priorities to be made public. Do the current statement of priorities indicators provide sufficient insight into hospital safety and quality for public reporting of the indicators to help consumers make meaningful choices about the place of treatment?

It is arguable that the Statement of Priorities indicators are not necessarily the “go to” source for consumers when they wish to make judgements about health service performance. That said, Forensicare supports the publication of performance on quality and safety indicators on a regular basis. Our current Statement of Priorities includes some broad patient safety indicators. However, more broadly, specific quality and safety indicators should be relevant to the type of service, such as mental health, to be a more useful and appropriate measure of quality and safety.

The current “catchment” system used in Victoria for clinical mental health service delivery does not necessarily provide consumers with “choice” about the place (or service) of treatment. Almost all of Forensicare’s consumers are directed by the criminal justice system that they must receive services from us, so therefore do not have choice, and prisoners, as we have noted earlier, do not have a realistic choice of service provider. However, we believe there should be more meaningful quality and safety indicators for mental health service delivery which are publically available (on the Department’s and services’ websites). Development of which indicators these should happen in consultation with consumers and carers, so that they identify those indicators which are meaningful to them.

2. Should the department expand minimum standards around the quality and quantity of information provided in annual reports, including quality of care reports?

In recent years there has been a continued policy direction by government to be more prescriptive about content of Annual Reports to the point that they do not necessarily provide a valuable medium for disseminating quality of care information. A great deal of the content of Annual Reports is dictated by central agencies, rather than the Department. If services are required to provide more reporting in the Annual Report on clinical activity, and particularly quality and safety, then it behoves the Department to think about the “medium” and whether Annual Reports are the best vehicle for dissemination of this information.

Quality of Care Reports are a better vehicle for disseminating information on clinical performance and quality and safety indicators. The Forensicare Quality of Care Report was developed in response to the key quality and safety information and indicators identified by our Consumer Advisory Group (CAG). This collaborative approach enabled the service to provide the quality and safety data and information most relevant to the consumers within the forensic mental health environment.

3. Should there be greater transparency of the safety and quality of care (including mental health services) provided in prisons? What is the best way to deliver this?

All health and mental health services in Victorian prisons operate within the jurisdiction of the Corrections Act 1986, and in accordance with the Correctional Management Standards for Prisons in Victoria. Corrections Victoria, within the Department of Justice & Regulation (DOJR) is responsible for the administration of these standards. As noted above, Justice Health, a business unit of the DOJR, is responsible for the delivery of health services for persons in all Victoria’s prisons. Its key responsibilities are to:
set the policy and standards for health care in prisons
contract manage the health service providers in the public prisons
monitor and review health service provider performance
facilitate an integrated approach to planning and service delivery
lead health prevention and promotion activities

Appendix 1 outlines the broad health service system which operates in Victorian prisons.

In the coordination and oversight of these services, Justice Health has adopted a set of principles to underpin the delivery of health services in the Victorian prison system. These principles are articulated as policy statements in the Justice Health Quality Framework 2011. The policy statements place a strong emphasis on a quality framework that ensures consistently high-quality care is provided with compassion, confidentiality, and respect. Further, the framework provides for the availability of health promotion and disease prevention strategies to improve health outcomes for prisoners.

It is Forensicare’s position that the Justice Health Quality Framework should be a publically available document. It is our submission that all health and mental health service providers in the prison system should be required to report publically on agreed quality and safety indicators. This reporting should be available through the same media or forums as reporting on other health service performance. It is important that prisoner health service performance is scrutinised within the same performance and monitoring frameworks as other health services, as well as through Department of Justice reports or websites.
Appendix 1 - Health service provision in Victorian prisons

Health Service Providers
In Victoria, health services in prisons are contracted out to multiple providers, which are:

Correct Care Australasia provides primary health services at all public prisons and the Judy Lazarus Transition Centre, including primary mental health services at all prisons except for the Melbourne Assessment Prison (MAP).

Forensicare
- In the men’s prison system at MAP, Forensicare operates a 16-bed Acute Assessment Unit, specialist outpatient services, “At Risk” assessments, and a reception assessment program.
- A Mobile Forensic Mental Health Service operates from the Metropolitan Remand Centre, together with consultant psychiatrist, registrar and nurse practitioner clinics.
- Nurse practitioner clinics are also provided at Ararat and Loddon prisons, and clinics by visiting psychiatrists at Ararat, Barwon, Loddon, Middleton, Marngoneet and Dhurringile prisons.
- In the women’s prison system, Forensicare operates a 20-bed residential program (the Marrmak Unit), provides outreach support and an outpatient group program for women at Dame Phyllis Frost Centre, and psychiatrist clinics at Tarremgower prison.

G4S (the operator of Port Phillip Prison) sub-contracts St Vincent’s Correctional Health Services to provide primary health services, outpatient mental health services and secondary residential mental health services (through St Paul’s Psychosocial Unit) at Port Phillip Prison.

St Vincent’s Correctional Health Services also provides state-wide secondary inpatient health services delivered through St John’s at Port Phillip Prison and secondary and tertiary inpatient services from St Vincent’s Hospital.

The GEO Group Australia provides primary health and mental health services at Fulham Correctional Centre.

Alcohol and other drug treatment programs are provided by Caraniche at all public prisons, the GEO Group at Fulham Correctional Centre and G4S at Port Phillip Prison.

Forensicare’s Contract with Justice Health
Justice Health has procured the services of Forensicare to provide secondary mental health services in public prisons under a Funding and Healthcare Services Agreement (FAHSA), which took effect from 1 July 2012. The FAHSA is of five years duration, with the Department of Justice & Regulation having the option to exercise up to two by two year extensions of the FASHA.

Under the FAHSA and its associated requirements, Forensicare provides detailed monthly reporting to Justice Health in relation to service delivery obligations, key performance indicators, and outputs. In addition, detailed descriptive quarterly and annual reports are submitted and include reports against compliance with the Justice Health Quality Framework. A system of mandatory notifications exists for specified categories of critical events, under which Forensicare must report to Justice Health within specific time frames. Justice Health undertake quarterly clinical audits, and Forensicare is required to respond and report actions in relation to recommendations arising from
these audits. A Justice Health Clinical Governance committee is convened bi-monthly to review quality and safety of practice.

Forensicare Prison Service Development

Recent service expansions under Forensicare’s FAHSA have resulted in:

- Additional nursing hours in MAP outpatients, and the establishment of an Outpatient Coordinator position.
- Introduction of mental health reception assessment at MAP on Saturdays.
- Increases to the number of daily reception assessments at MAP, resulting in additional staff, and for the first time, a social work position at MAP, in addition to increased administration resources.
- A new therapeutic service for Unit 13 at MAP. (Unit 13 consists of isolation cells where prisoners at immediate risk of suicide are housed in lockdown dressed in hessian sacks.)
- Additional Consultant Psychiatry sessions at MAP, Melbourne Remand Centre (MRC) and regional prisons.
- Establishment of a Nurse Unit Manager for the Marrmak Program at the Dame Phyllis Frost Centre.
- Establishment of two Endorsed mental health Nurse Practitioner positions (conversion of two Nurse Practitioner Candidates in the original agreement) plus an additional new Nurse Practitioner Candidate.
- Design and implementation of a new and innovative program, the Mobile Forensic Mental Health Service, based at the MRC but which also including satellite psychology positions at Barwon Prison and Marrgoneet Correctional Centre.
- New additional reception assessments at the MRC
- Establishment of an Aboriginal Clinical Consultancy Service to provide cultural support and capacity building for the non-Aboriginal health and mental health workforce in Victorian prisons and assist in the development of best practice, through expert cultural advice and secondary consultations.
Appendix 2 – Forensicare: Summary of Services

Thomas Embling Hospital
A 116 bed secure hospital, consisting of seven units, providing both Acute Care and Continuing Care Programs, including a dedicated Women’s Unit. Patients are generally admitted to the Hospital from the criminal justice system under the Crimes (Mental Impairment and Unfitness to be Tried) Act 1997 (the CMIA), Mental Health Act 2014 (the MHA) or the Sentencing Act 1991. A small group of patients is admitted each year from other public mental health services under the MHA.

Prison Mental Health Service
Specialist mental health services are provided at the Melbourne Assessment Prison, the Dame Phyllis Frost Centre, the Metropolitan Remand Centre, and also the larger publicly-managed prisons.

Service provision includes:

- **Melbourne Assessment Prison** - a 16-bed Acute Assessment Unit, specialist clinics, outpatient services and a reception assessment program
- **Marrmak Unit (Dame Phyllis Frost Centre)** - a 20-bed residential program, intensive outreach program and a therapeutic day program for women
- **Metropolitan Remand Centre** – A Mobile Forensic Mental Health Service which also provides outreach to other prisons and incorporates satellite psychology services at Barwon Prison and Marrgoneet Correctional Centre.
- **State-managed prisons** – A visiting consultant psychiatric and nurse practitioner sessions at the larger state-managed regional prisons.

Community Forensic Mental Health Service
The Community Forensic Mental Health Service is a state-wide service responsible for the provision of Forensicare’s outpatient and community based programs. The service provides assessment and multidisciplinary treatment to high risk clients referred from area mental health services, community corrections, courts, the Adult Parole Board, Forensicare inpatient services, government agencies and private practitioners. Treatment and care is provided through:

Community Integration Program (CIP) consisting of two programs:

a) Through CIP, Forensicare delivers high quality assessments and integration services for high risk prisoners who return to the community. This includes initial and ongoing assessments, crisis plans, ongoing management plans, and participation in release planning. Engagement is time limited (generally 12 weeks per client) providing support and linkage assistance to people with a serious mental illness leaving prison, including in-reach activities in the prison to meet and assess clients, and post release linkage support to ensure that clients are well integrated into Area Mental Health Services and other supports as required.

b) Comprehensive psychiatric care and case management to Forensic Patients as defined by the CMIA who are in the lead up to or on Extended Leave under that Act from Thomas Embling Hospital and living in the community. For this client group participation in the program is not voluntary and is a condition of successfully applying for and participating in extended leave.

Problem Behaviour Program
A specialist program providing psychiatric and psychological consultation and treatment for people with a range of problem behaviours associated with offending, and for whom publically funded
services are not available elsewhere. Services are provided in relation to serious physical violence, stalking, threats to kill or harm others, adult sexual assault and rape, paedophilia, other problematic sexual behaviour related to offending (e.g. indecent exposure), collection and possession of child pornography, including internet child pornography, and fire-setting. The program includes assessment and secondary consultation, and accepts clients for specialist ongoing treatment. A number of related group programs are offered.

Non-Custodial Supervision Order Program
Supervision and monitoring of all persons in Victoria on a Non-Custodial Supervision Order under the CMIA and under the care of a local Area Mental Health Service. All involved service providers are required to enter into individual memoranda of understanding concerning the supervision, treatment and management of people subject to these orders.

Mental Health Court Liaison Service
The Mental Health Court Liaison Service provides expert assessment and support services to Melbourne, Broadmeadows, Dandenong, Frankston, Heidelberg, Ringwood and Sunshine Magistrates’ Courts.

Court Reports
A Court Report service operates providing pre-sentence psychiatric and/or psychological reports to Judges and Magistrates for people with mental disorders or problem behaviours to assist in sentencing dispositions, and to the Adult Parole Board to assist in decision regarding parole.

Primary and Secondary Assessments and Consultations
Expert advice and support to Area Mental Health Services and other referrers such as General Practitioners in their management of complex and high risk clients.
Supplementary Submission to the Review of Hospital Safety and Quality

Prepared April 2016
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Introduction

Forensicare provided a submission to the DHHS Review into Hospital Quality and Safety on 11 April 2016. At page 8 of our Submission, responding to the question “How can we ensure that adequate mental health services are available in prison” we noted:

The amount of time between when a prisoner is “certified” under the Mental Health Act and then is eventually transferred to Thomas Embling Hospital is an important indicator to measure in considering the access aspects of quality and safety of mental health care to prisoners, but it is not the only indicator of quality. Forensicare’s Statement of Priorities has a number of indicators which are already measured in this respect, but a more comprehensive framework could be put in place which applied to Forensicare and other mental health providers in prison.

The purpose of this supplementary submission is to provide information on how Forensicare has monitored indicator data in relation to access, as an aspect of quality and safety, through our clinical governance and management processes. This supplementary submission includes indicators of demand and need relating to male certified prisoner patients. It also summarises Forensicare’s overarching clinical governance framework and seeks to explain the data available and how it is used in the organisation to try and identify strategies which can improve access and the quality of care and reported externally.

Access to Treatment for Certified Prisoner Patients

In recent years in Victoria, increased prisoner numbers and a rise in acute mental illness presentations in prisons, combined with no increase in secure forensic mental health hospital beds, has led to a blockage in access to those beds for male prisoners requiring compulsory mental health treatment in hospital.

When Thomas Embling Hospital (TEH) was opened in 2001, the prison population in Victoria was approximately 2,500. As of 1 January 2016, it was just under 6,500. In that time, the bed capacity of TEH has remained unchanged. Over the same period the number of “forensic patients” - long term patients detained at the hospital on an order under the Crimes (Mental Impairment and Unfitness to Plead) Act 1997 (Vic) - has progressively increased. Thus the number of available beds for prisoners requiring compulsory treatment has decreased, whilst the number of prisoners meeting criteria for compulsory treatment has increased in line with the overall growth of the prison population. During 2015, at any one time there were on average ten male prisoners being held in prison, acutely unwell and refusing treatment, identified by a psychiatrist as meeting criteria for compulsory treatment under the Mental Health Act 2014, but unable to access a hospital bed.

Forensicare has been raising this issue for a number of years, and reporting data in relation to this problem of bed access to the Department of Health & Human Services and the Department of Justice & Regulation (see Obudsman’s Investigation into deaths and harm in custody March 2014 p 119ff). Internally it has been a management and Board priority since 2013.
Statement of Priorities
Our 2014-15 Statement of Priorities (SoP) contained Safety and quality performance indicators similar to other health services, focusing on inpatient experience survey, seclusion per 1000 occupied bed days and maintaining accreditation, compliance with the cleaning standards, hand hygiene rates and staff immunisation rates. Access performance was measured on number of men and women admitted to Thomas Embling Hospital, average length of stay on male acute units and percentage of male certified prisoners admitted from the Melbourne Assessment Prison (MAP) within 28 days. On this last measure we achieved a 38.6% against a target of 95%. The Board, management and staff had been considering this issue, analysing the data and seeking to improve performance well before this time.

In the 2015-2016 SoP, it was agreed with the Department that in relation to access we would monitor the number of male prisoners who had waited more than 30 days for transfer to the Hospital and also the average number of prisoners per day waiting for transfer to the Hospital.

Across both years we reported quarterly to the Department and Minister for Mental Health on performance under the Statement of Priorities and provided copies to the Department of Justice and Minister for Corrections.

Access indicators considered internally and reported externally
The following three indicators of acuity and need in this area have been reported monthly to the Forensicare Board, and in quarterly reports to DHHS under our Statement of Priorities. They are also considered and discussed at local clinical governance meetings to determine what can be done to influence them:

Indicator 1: Average number of male certified prisoners per day waiting transfer to Thomas Embling Hospital

Explanation: a count is made each day at the Melbourne Assessment Prison of prisoners who have been certified for compulsory treatment according the Mental Health Act and are awaiting transfer to TEH to receive that treatment. This indicator is the average over the month of each day’s count.

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Indicator 2: Total number of male certified prisoner days per month waiting transfer to Thomas Embling Hospital

Explanation: This indicator is the number of days each certified patient is waiting for transfer, summed across all certified patients, for an entire month. E.g. If there were 10 patients each waiting 30 days in a particular month, the indicator = 300. This is NOT the number of days waiting to be transferred.

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Total number of certified prisoner days per month waiting transfer to Thomas Embling Hospital
Indicator 3: Number of male certified prisoner days per month held in lockdown regime.

Explanation: Corrections Victoria staff may make the determination that in order to maintain the safety and good order of the prison, a prisoner with severe behavioural disturbance needs to be placed in lockdown. This involves 23 hours per day being locked in a cell. If the prisoner is also acutely suicidal, the prisoner may further be placed in a “Muirhead Cell” which is a prison seclusion cell where the prisoner is clothed in canvas and intensively monitored by CV officers and mental health staff.

This indicator is the number of days a certified prisoner was placed in lockdown, summed across all certified patients, for an entire month. E.g. If there were 5 certified patients who each spent 20 days in lockdown over the month, the indicator = 100.

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Access indicators considered internally through clinical governance processes

In addition to the above, as part of clinical governance review processes, the following three indicators have been reported to and reviewed monthly by the clinical governance committee of Forensicare’s prison service, and reported on to the Forensicare Executive. Note that this data does not include patients who were certified at MAP but who either were decertified before they could be transferred to TEH, or released to freedom before they could be transferred to TEH.
Indicator 4: Number of transfers of male certified patients to Thomas Embling Hospital by month

Explanation: Patients who are certified at MAP will be moved according to the priority of their clinical need. This is a dynamic process and involves day to day clinical review and assessment, and judgment of competing and emerging needs and issues. This indicator records any certified prisoner who is admitted to TEH during the month.

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Indicator 5: Average wait time in days for admission to Thomas Embling Hospital once certified

Explanation: This indicator is the average waiting time of all male certified prisoners who are transferred to TEH during that month. The value for an individual patient is calculated once the transfer has occurred. Arising from this definition, this indicator is subject to the influence of outliers. For example, if in a particular month, one individual who has been waiting a lengthy time for transfer actually gets transferred, the average for that month will spike. While this indicator is useful, Forensicare has moved to report as well on indicator 2 above which provides a more robust indicator of ongoing overall demand at any point in time.

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Indicator 6: Number of male certified patients who waited more than 30 days for transfer to Thomas Embling Hospital

Explanation: This indicator counts any individual certified prisoner who, if transferred to TEH during the month, is recorded as having waited more than 30 days for that transfer. This is counted once the transfer occurs.

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Indicator 7: Percentage of male certified patients transferred to Thomas Embling Hospital who waited more than 30 days for transfer

Explanation: This indicator integrates data from indicators 4 and 6 above, in reflecting the percentage of those certified prisoners transferred in any month who waited more than 30 days to be transferred. It thereby takes into account particular limits on bed access in any particular month.

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Safety Indicators considered internally

Conscious of safety for our consumers and staff, rates of aggression are monitored by the Executive and Board as an indicator of safety. The majority of aggression incidents reported in VHIMS (90.8%) are within the Thomas Embling Hospital. A particular focus is the rate of aggression within the acute units (Argyle, Atherton and Barossa) of the hospital. For reporting purposes these incidents are classified as either physical, verbal or towards property. They are considered and discussed to determine what strategies can be put in place to reduce the number of incidents. The type of data provided to the Executive and Board Clinical Governance Committee are illustrated below.
Argyle – there is a downward trend of physical incidents and an upward trend of verbal incidents reported in the quarter, whilst property incidents remain static.

Atherton – there is an upward trend of physical incidents and a downward trend of verbal incidents in the quarter, whilst property incidents show a slight upward trend.
Clinical governance processes

The Forensicare Clinical Governance Framework reflects the Victorian Clinical Governance Policy Framework (2008) and supports the National Standards for Safety and Quality Health Service (NSQHS) Standards and National Standards for Mental Health Services. The four domains of quality and safety, from the State framework, serve to provide a conceptual framework for strategies to enhance the delivery of clinical care. Our Clinical Governance Framework outlines accountabilities and responsibilities to achieve effective clinical governance by setting the strategic direction for safe and high quality care and enabling the Board, executive, managers and staff at all levels of the organisation to achieve these objectives.

The Clinical Governance structure aligns with the domains of quality and safety and the National Standards for Safety and Quality Health Service Standards. Clinical governance activity is streamed through management, program and clinical discipline structures. The committees are structured to ensure that there is standardisation of practice, policy and processes, compliance with the National Standards, mechanisms to implement and monitor key clinical risks and improvement priorities and provide a mechanism to disseminate information throughout the organisation.

Each residential unit and specialist program convenes a local clinical governance meeting each month, which includes representation of the multidisciplinary team and, in residential units, a consumer. These meetings have a standing agenda which reflects the four quality and safety domains of the State framework. These local groups, in turn, report to the larger operational clinical governance committees (hospital, prisons and community) each month where service-wide quality and safety performance and programs are monitored.

Three organisation wide clinical governance committees, reflecting the quality and safety domains, have been established. The Clinical Effectiveness & Risk Management Committee (CERM), comprising senior clinical, operational and consumer leads, was established to ensure the integration of clinical governance systems and to maintain and improve the reliability, safety and quality of care. Six specialist committees, which focus on specific NSQHS Standards (medication safety, infection control) or key areas of clinical risk (challenging behaviour, seclusion and restraint), report to the CERM. The Effective Workforce committee provides oversight of recruitment, training and performance review processes, and a Consumer and Carer Leadership committee seeks consumer involvement in clinical governance and improvement initiatives. These organisation-wide committees and senior clinical leaders report directly to the Executive Clinical Governance Committee.

The Executive committee reports to the Board, and monitors operational performance of quality, safety and risk management programs. This oversight includes policy formulation, ensuring the safety and effectiveness of quality and risk management programs, accreditation and implementation of serious adverse event recommendations. The Board Clinical Governance and Quality Committee is a formal committee of the Board, established in accordance with s.332 of the Mental Health Act 2014, and meets quarterly.
Response to the indicators of acute demand for male certified prisoners 2013-2016

Since 2013, Forensicare has undertaken a range of initiatives to respond to and manage demand and access issues, including at strategic (advocacy), governance and operational levels, and across inpatient, prison and community services. These are summarised below.

Governance level
Since 2013 in particular, the Board has been actively engaged in a range of strategic and governance considerations and activities relating to the demand for acute mental health beds in Forensicare’s prison and inpatient settings. Concerns have been formally documented with government via:

- Quarterly Reports against the Statement of Priorities
- The 2014-15 Forensicare Annual Report as tabled in parliament
- The Forensicare Strategic Plan 2015-17
- Briefings to the incoming Minister of Mental Health and the Minister for Police & Corrections in November 2014.

This activity has occurred in the context that the need for additional secure forensic mental health beds has been the subject of various recommendations by the Ombudsman, Auditor General and Victorian Law Reform Commission between 2013 and 2015.

In 2014 the Department of Health commissioned a Service Plan Review to develop a Service Plan for Forensic Services, which pointed categorically to the need for additional beds at TEH. The document was not finalised and despite repeated requests by the Board, a Final Report has not been provided to the Board. However, $9.5 million funding was provided in 2015 to build an additional 8 beds and to develop a Masterplan for Hospital expansion. This work has commenced and is continuing.

A summary of the Board’s priorities for the organisation over this period is encapsulated in the following:

- Urgent discussions with the Departments of Health & Human Services, and Justice & Regulation regarding funding additional beds at Thomas Embling Hospital (TEH), and service expansion proposals in the mental health and criminal justice sectors.
- Significant increases in service levels in prison to meet emerging demand and joint strategies with DoJ&R to mitigate the risks.
- Ensuring our inpatient and community model of care focuses on enabling bed flow and access in relation to both acute beds but also for the movement of long stay forensic patients to support consumer recovery and overall bed access at TEH.

Hospital management level
A variety of initiatives have been implemented at Thomas Embling Hospital in the last three years to address demand and access issues. These are briefly described below:

- **High Risk Panel**: In August 2013 Forensicare established a High Risk Review Panel to ensure high level planning and communication processes are in place to facilitate the safe transfer to TEH of prisoners from the Melbourne Assessment Prison and Dame Phyllis Frost Centre
who are at high risk of interpersonal violence. This panel also oversees the ongoing management plans and trajectory of complex and challenging patients.

- **Targeted recruitment**: In September 2014 a decision was taken to target and develop senior Nurse Unit Managers with experience in acute mental health patient flow into the Thomas Embling Hospital. Two unit managers have been successfully recruited. One is already managing one of the acute units. The second will take up position in June 2016.

- **Access Flow Committee**: An Access Flow Committee was established in September 2014 to increase the focus and ownership of patient/access flow within Forensicare as a whole. It acknowledges that patient/access flow is not just the domain of the Acute or MAP services though these are the areas which appear to manifest the most pressure.

- **Inpatient Clinical Governance Committee**: Chaired by the inpatient Assistant Clinical Director, this hospital wide committee also maintains a focus on individual unit reporting on mean and median lengths of stay.

- **Transition Mapping for Forensic Patients**: A review commissioned in 2015 is in process which is mapping, refining and clarifying points of transition and associated decision-making criteria for Forensic Patients in the journey from Custodial Supervision Order to Extended Leave and on to a Non-Custodial Supervision Order. This work recognises that efficient and safe progress through the hospital and into the community for forensic patients is vital from both a patient care and resourcing viewpoint. Unnecessary delays in transition is problematic for individual patients, but also creates problems in responding to acute needs from the prisons.

**Prisons Service level**

Many of the service changes and enhancements implemented in the prison system in response to the continued growth in prisoner numbers and throughput at MAP have been outlined in Appendix 1 of our original submission. Many of these have been collaboratively developed with Justice Health in response to this additional demand on mental health services. Forensicare has prepared a series of analyses and reports to Justice Health documenting trends of increasing acuity in the men’s prison system, and developed proposals for service responses.

In addition, in 2015 a detailed proposal was developed by Forensicare at the request of Justice Health for a “step down” or sub-acute bed based service at MAP in the interim period before the opening of the new prison at Ravenhall at the end of 2017, but for a variety of practical, financial and timing reasons was considered unfeasible to implement. More recently however, Justice Health have requested analysis of the number of additional acute mental health beds that are required at present in the men’s system and it is understood that they and Corrections Victoria are presently looking at options outside MAP for the housing of these patients.