AMA Victoria's submission to the Discussion Paper on "*A review of hospital safety and quality assurance in Victoria*"

15 April 2016

The Australian Medical Association (Victoria)

AMA Victoria welcomes the opportunity to provide input into the Discussion Paper *A review of hospital safety and quality assurance in Victoria.*

The Discussion Paper raises many important questions and issues that could lead to long-term, meaningful, improvements across the health system. However, if the Government is seeking to ensure detailed and robust feedback from the health sector and Victorian public the allocated time for consultation and final reporting is not sufficient.

Improving quality and safety across the health sector requires a detailed and complex response and plan of action. The timeframe allocated for this Review does not reflect the importance of the issues being raised. It is extremely disappointing to see that this Review has not been given the time that it needs.

AMA Victoria's input to this discussion paper focuses on the four themes raised in the paper and details key areas for improvement across the system.

In order to improve safety and quality it is vital to look at the health system as a whole. Activities in one area of the health system influence the operation and performance of other areas and so the system cannot be separated into individual parts.

Health professionals are under enormous and increasing pressure in all parts of the system. Tightening fiscal situations, increased presentations and complexity, growing and ageing populations, ageing fabric and increased expectations all impact on the level and quality of services that can be provided. THIS CAN NOT BE EMPHASISED ENOUGH>

Proper resources and support across the entire health system is needed to ensure that health workers have the skills, time and ability to implement a process of continual improvement. These requirements should form the basis of minimum acceptable standards across the system.

Theme 1: Fostering continuous improvement and clinical excellent

Theme one considers how clinicians can be engaged and empowered to ensure a culture of continuous clinical improvement.

It is important to provide an environment where clinicians, and other health professionals, can get together and openly discuss how to improve safety and quality.

Health sector resourcing

Long-term inadequate resourcing of the health system has likely contributed to a breakdown in quality and safety processes. Doctors, and other health workers, are under increasing pressure from government, hospital administration, patients and the public to provide better, faster care within a rapidly tightening fiscal environment.

The occupational health and wellbeing of doctors is key to improving hospital safety and quality. Inadequate staffing, increased and excessive patient load and decreased quality of care are key sources of workplace stress and dissatisfaction[1] and are currently being experienced by clinicians today and are linked to increased risk and reductions in patient safety and quality of care. [2] [3]

Doctors must be assured of having sufficient time and resources to complete all aspects of patient care, particularly the non-face-to-face tasks. Work including updating patient files, reviewing results and detailed clinical handovers is often simply "fit-in" because the health system is not adequately resourced to allow dedicated time for these processes.

Adequate time, training and resources must be provided to facilitate good communication across care settings.

Clinical engagement processes

Clinical input and decision making must be at the forefront of any service in a healthcare setting as it improves the ability of the organisation to maintain quality care, puts clinical governance at the heart of healthcare and is central to good practice.[4] Active staff physician involvement in governance leads to a significant positive effect on board activity in quality improvement. [5]

AMA Victoria believes that all health services should be required to have a medical engagement protocol in place. This protocol should include a properly constituted medical staff association which is recognised in the hospitals governance procedures. The chair of this association should attend appropriate governing council meetings and be available as an adviser to the board and CEO as required.

Best practice would also ensure that board members and CEO's regularly attend meetings with medical staff across their organization and that appropriate processes are in place to ensure engagement at all levels.

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[1] Lindy, C., & Schaefer, F. (2010). Negative workplace behaviours: an ethical dilemma for nurse managers. *Journal of Nursing Management*, *18*(3), 285-292.
[2] Sergeant, J., & Laws-Chapman, C. (2012). Creating a positive workplace culture: Nurses' mental and physical health affect how they care for patients. *Nursing management*, *18*(9), 14-19.
[3] Schwartz, Richard W., and Thomas F. Tumblin. "The power of servant leadership to transform health care organizations for the 21st-century economy." *Archives of Surgery* 137, no. 12 (2002)
[4] Cockram I, E., & Hicks, S. (2013). Clinical Decision Making. Advanced Practice in Healthcare: Skills for Nurses and Allied Health Professionals, 21.
[5] Weiner, B. J., Alexander, J. A., & Shortell, S. M. (1996). Leadership for quality improvement in health care: Empirical evidence on hospital boards, managers, and physicians. *Medical Care Research and Review*, *53*(4), 397-416.

Organisational culture

Breakdowns in communication, lack of coordination and a culture of disregard can lead to poor patient outcomes.[6]

Organisational culture must be fostered to ensure appropriate engagement in audits, sharing of information and ensuring that all health professionals feel comfortable reporting issues of concern.

A key driver of system improvement is the ability of doctors to feel they have influence and recognition in the system. Too often doctors feel that their issues and concerns are not taken seriously because of a lack of communication.

Reporting processes and organizational culture and structure must ensure that doctors and other clinicians are encouraged to report issues or concerns, those concerns are taken seriously and followed-up and that this is communicated to the relevant people. These systems should be safe, secure and, where appropriate, confidential. They should be designed to support and encourage engagement in reporting processes. Doctors should also be directly engaged by hospital governance structures to implement improvements and provided with the necessary levels of responsibility and support to do so.

Bullying and harassment in the health sector can act as a barrier to good communication and engagement. AMA Victoria's submission to the Victorian Auditor General's Office's Audit on bullying and harassment in the health sector[7] outlines several opportunities to improve workplace culture and foster a safe environments where reporting is encouraged.

Good healthcare leaders show their commitment to patient safety through their words and actions and foster a culture of safety that pays due regard to risks and encourages the reporting of mistakes.[8] Hospital boards should be responsible for leading this as they are in a position to establish strong leadership and the organisational culture required to ensure that health professionals are able to deliver safe and effective services.[9]

Training and education

Significant investment in training and education needs to be made by the Department of Health and Human Services (DHHS).

Exposure to the concepts and responsibilities of patient safety and quality must begin at university level where medical students are introduced to the issues of clinical safety and quality assurance. By the time students undertake clinical placements they should have a solid understanding of their role and responsibilities into relation to improving patient safety.

[6] Künzle, B., Kolbe, M., & Grote, G. (2010). Ensuring patient safety through effective leadership behaviour: a literature review. *Safety Science*, *48*(1), 1-17.
[7] http://amavic.com.au/page/Member_Services/Policy_and_Media/Policy_Submissions/Submission_to_the_Victorian_Auditor-General%E2%80%99s_Office_Audit_on_Bullying_and_Harassment_in_the_Health_Sector/
[8] Clarke, J. R., Lerner, J. C., & Marella, W. (2007). The role for leaders of health care organizations in patient safety. *American Journal of Medical Quality*, *22*(5), 311-318.
[9] Bismark, M. M., & Studdert, D. M. (2014). Governance of quality of care: a qualitative study of health service Boards in Victoria, Australia. *BMJ quality & safety*, *23*(6), 474-482.

Hospitals have a responsibility to ensure their staff are fully equipped for their roles. It is therefore the responsibility of hospitals to ensure leadership medical staff are given access to clinical leadership training with appropriate leave.

Opportunities for education and training must continue throughout the entire career pathway, from internship to retirement. Specialist Colleges should integrate clinical governance learning into their training pathways and funding mechanisms must be in place to ensure clinicians have the time and flexibility to undertake this training.

Strong and effective leadership in healthcare is vital and is important for patient safety. [10] A key aspect of this training and education must be focused on leadership skills. In many cases clinicians are promoted to positions of substantial influence and responsibility without being given the skills to manage those positions effectively. Being an excellent clinician does not automatically qualify someone as a leader; these are skills that must be taught.

Inter-professional education can improve healthcare processes and outcomes[11] has been shown to foster collaborative work between health care professionals[12] and to improve the quality of team behaviours.[13] To encourage greater uptake of training and education clinicians should have access to CPD accredited training and points. AMA Victoria, given appropriate funding, is in a unique position to provide clinicians with training and education sessions in a multi-profession format.

No fault insurance

Whilst it is sometimes argued that the threat of civil action helps reduce medical errors and maintain high standards, there's no objective empirical evidence for this. However there is evidence that the threat of litigation increases medical costs by promoting defensive medicine leading to higher health care costs. AMA Victoria cautiously welcomes the opportunity for a serious and detailed examination of a comprehensive no-fault compensation scheme for medical injuries.

Information communication technology (ICT)

Victoria's health sector ICT is woefully inadequate and compromises the safety and quality of care provided to patients.

Currently health services have a mismatched suite of equipment and software. Whilst some hospitals have made considerable gains in the implementation of electronic health systems many hospitals and health settings are still working with outdated computers and software systems which are no longer supported.

The Australian Medical Association Victoria has repeatedly called on successive governments to prioritise ICT investment. Our previous Budget Submissions and 2014 Election Manifesto[14] outline out key priorities for ICT improvement.

[10] Künzle, B., Kolbe, M., & Grote, G. (2010). Ensuring patient safety through effective leadership behaviour: a literature review. *Safety Science*, *48*(1), 1-17.
[11] Zwarenstein, M., Goldman, J., & Reeves, S. (2009). Interprofessional collaboration: effects of practice-based interventions on professional practice and healthcare outcomes. *Cochrane Database Syst Rev*, *3*(3).
[12] Freeth D, Hammick M, Koppell I, Reeves S, Barr H. 2002. A critical review of evaluations of inter professional Education, CAIPE. London: LTSN Centre for Health Sciences and Practice.
[13] Reeves, S., Zwarenstein, M., Goldman, J., Barr, H., Freeth, D., Hammick, M., & Koppel, I. (2008). Interprofessional education: effects on professional practice and health care outcomes. *Cochrane Database of systematic reviews*, *1*.
[14]http://amavic.com.au/page/Member_Services/Policy_and_Media/Policy_Submissions/AMA_Victorias_State_Election_Manifesto_2014/

Enabling better communication between hospitals and community based settings will improve the safety and quality of care provided to the patient and increase efficiencies within the care setting because relevant, current, trusted information is available in a timely manner.

To truly improve patient safety and quality of care these systems must be able to share information beyond simple quality reporting measures and allow optimal sharing of patient information such as test results, discharge summaries and medication lists.

Information systems have to be easy to use and designed with the user in mind. If systems are difficult to use, time consuming, onerous or implemented without consultation they will not be used.[15]

Safe, effective patient care is reliant on good communication. This communication must link up services across acute, primary and community settings. When information flows properly between health settings then the chances of mistakes are reduced.[16]

[15] Bhansali, N., & Gupta, S. (2014). The Engine of Health Information Exchange. *Journal of Management*, *15*(3), 31.
[16] Banger, A., & Graber, M. L. (2015). Recent Evidence that Health IT Improves Patient Safety.

Theme 2: Improving hospital governance

Effective governance is vital to improvements in healthcare quality, including patient experiences and the safety and effectiveness of care. [17] [18]

As the Discussion Paper highlights, there are two key areas of influence which affect clinical governance within health services; the Department of Health and Human Services (the Department) and Hospital Boards.

Governance by the Department

The latest report by the Victorian Auditor General's Office (VAGO) *Patient Safety in Victorian Public Hospitals"*, tabled in March 2016 highlights several key failings by the Department.

Of particular concern to AMA Victoria are VAGO's findings that:

- DHHS has not complied with their 2011 Adverse Events Framework,
- DHHS has not implemented an effective state-wide incident reporting framework,
- DHHS does not aggregate or systematically analyse data to identify safety trends, and
- There is a lack of communication regarding data, trends and learnings.

Across health systems worldwide there are a number of externally imposed pressures and targets on healthcare providers. These targets are intended to improve the efficiency and safety of care however they can lead to reductions in both if appropriate clinical input is not sought before they are implemented.[19]

When the health system operates in silos, patient safety suffers. Proper data collection and appropriate communication with the health sector is vital to ensure continual improvement. Without appropriate and timely information health services cannot properly benchmark their performance or implement important learning from across the sector.

AMA Victoria supports the recommendations in the recent VAGO hospital safety audit and recommends that the Department allocate appropriate resources to implement them as a matter of priority.

Governance by hospital boards and chief executives

Hospital boards should provide strong and effective leadership to their hospitals. Several reviews and reports into hospital quality and safety have stressed the need for strong leadership in order to create a safe culture and improve patient outcomes.[20]

To be effective hospital Boards have to display strong leadership in all areas of hospital management. They must be prepared to lead the organisation, engage with medical

[17] Arnwine, D. L. (2002). Effective governance: the roles and responsibilities of Board members. *Proceedings (Baylor University. Medical Center)*, *15*(1), 19.
[18] Bismark, M. M., & Studdert, D. M. (2014). Governance of quality of care: a qualitative study of health service Boards in Victoria, Australia. *BMJ quality & safety*, *23*(6), 474-482.
[19] Clarke, J. R., Lerner, J. C., & Marella, W. (2007). The role for leaders of health care organizations in patient safety. American Journal of Medical Quality,
22 (5), 311-318.

[20] Wong, C. A., & Cummings, G. G. (2007). The relationship between nursing leadership and patient outcomes: a systematic review. *Journal of nursing management*, *15*(5), 508-521.

staff, reform systems and structures and institute appropriate quality management structures in order to improve patient safety.[21] Effective Board governance and leadership requires active engagement by the Board in the work that they are undertaking.[22] Strong Board leadership and governance also includes coordination and collaboration between other local and national systems of governance.[23]

Clinical governance is a major responsibility of hospital boards and CEO's but is often set aside to focus on corporate and financial governance.

The primary responsibility for the governing body of any hospital is ensuring the quality and safety of the services provided in order to protect patients.[24] Clinical input and decision making must be at the forefront of any service in a healthcare setting as it improves the ability of the organisation to maintain quality care, puts clinical governance at the heart of healthcare and is central to good practice.[25] To ensure that any targets or changes, internal or external, implemented within healthcare settings are done in a safe manner Boards must make quality of care and patient safety their main consideration. [26]

Medical board members can play a valuable role in strategic quality planning and may enhance board quality monitoring.[27] A higher number of medical practitioners on hospital boards is associated with higher quality ratings and lower morbidity rates.[28] To ensure appropriate leadership and clinical input AMA Victoria has recommended[29] that the Victorian Government amends the *Health Services Act 1988* (Vic) (s. 65T) to stipulate that hospital boards must include clinical representation, to be defined as a currently registered and practising medical practitioner.

Without medical representation on hospital boards, non-clinical board members are unable to fully understand and interpret clinical data, safety information, risk management and other issues that hospital boards are informed about and required to make decision on. It is important to note that the Victorian health service whose major clinical governance issues were exposed in 2015 did not have a medical representative on its board.

Some rural/regional hospitals will need support to appoint a medical practitioner to its board (one who is not also an employee). A medical practitioner from a different town (or potentially even metropolitan areas) will face various ancillary costs (such as travel, accommodation) associated with board duties. Rural/regional hospitals do not have the capacity to offer this remuneration from within their current resources.

Where health services can demonstrate that, despite all reasonable attempts, they have been unable to appoint a suitable medical practitioner to its board, the Department of Health and Human Services must fulfil its obligation to ensure safe governance arrangements and provide adequate financial support.

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[21] Gautam KS. A call for Board leadership on quality in hospitals. Qual Manag Health Care. 2005;14:18-30
[22] Prybil, L. D. (2006). Size, composition, and culture of high-performing hospital Boards. *American Journal of Medical Quality*, *21*(4), 224-229.
[23] Bismark, M. M., & Studdert, D. M. (2014). Governance of quality of care: a qualitative study of health service Boards in Victoria, Australia. *BMJ quality & safety*, *23*(6), 474-482.
[24] Clough, J., & Nash, D. B. (2007). Health care governance for quality and safety: The new agenda. *American Journal of Medical Quality*, *22*(3), 203-213.
[25] Cockram I, E., & Hicks, S. (2013). Clinical Decision Making. *Advanced Practice in Healthcare: Skills for Nurses and Allied Health Professionals*, 21.
[26] Clough, J., & Nash, D. B. (2007). Health care governance for quality and safety: The new agenda. *American Journal of Medical Quality*, *22*(3), 203-213.
[27] Weiner, B. J., Alexander, J. A., & Shortell, S. M. (1996). Leadership for quality improvement in health care: Empirical evidence on hospital boards, managers, and physicians. *Medical Care Research and Review*, *53*(4), 397-416.
[28] Veronesi, G., Kirkpatrick, I., & Vallascas, F. (2013). Clinicians on the board: what difference does it make? *Social Science & Medicine*, *77*, 147-155.
[29] AMA Victoria Submission to the 2016-17 Victorian State Budget

In addition to ensuring clinical representation on all hospital boards there must be appropriate consultation pathways in place to allow board members to seek further advice and information and to ensure they are able to properly understand the information they are receiving. There should be a direct link between Senior Medical Staff and hospital governance structures that includes strong lines of communication in both directions.

Appropriate board training is vital. Funding must be provided to ensure that all hospital board members and CEOs are able to undertake best practice governance training programs.

Theme 3: Strengthening oversight of safety and clinical governance

Clinical incident reporting pathways

A key gap in current reporting systems is evident where clinical issues are 'larger' than a single health service but smaller than 'industry wide'. This is particularly so in smaller rural hospitals. Often these issues can fall under the radar as local management will be presented with differing advice on appropriate clinical management of a service. This may be attributed to an unexpected growth in throughput, a debate between specialties i.e. GP Obstetricians v Obstetricians or when a breakdown in the relationship occurs between the local GPs and hospital.

All can lead to a substandard service whilst the debate occurs around quality care. These issues can be compounded where there is a lack of appropriate physician representation on the hospital board.

In these situations it is not clear that a pathway exists for elevating the matter beyond the hospital Board for consideration and review. At best it can be advanced in the media or worse, not advanced at all.

A number of processes are available to staff that have grievances regarding their employment with their hospital. However if concerns exist about the quality of care, there appears to be little effective avenues for people to be heard and the concerns assessed.

In the absence of such a process, the breakdown in relationships deepens, care suffers and concerns are raised in other forums.

The role of the VMIA

VMIA is in a position to play a larger role in strengthening the oversight of safety and clinical governance. VMIA has three roles, as identified in the VAGO audit report on Patient Safety in Victorian Public Hospitals (March 2016), being risk management adviser to health services, adviser to the government and state insurer. The VAGO audit found that VMIA has supported health services to improve patient safety outcomes, however poor sharing of DHHS data with VMIA has hindered VMIA's ability to systematically prioritise its support to health services and optimize its role in supporting health services and DHHS to mitigate patient safety risks. Providing VMIA with the necessary data to allow it to enhance its through better patient safety data should occur.

Complaints against clinicians

Clinicians must meet very specific credentialing requirements in relation to their appointment and ongoing employment in hospitals. There is a credentialing cycle timeline which, amongst other things, defines the scope of appointment of practitioners, covers performance development, clinical audits, peer review and other quality activities, with the requirement that clinicians must undertake re-credentialling at the end of a term. As such hospitals in meeting their obligations during the credentialing process ought to be able to identify practitioners and systems issues that are likely to impact on safety. Similarly health services boards are in a position to impact on safety issues, whether practitioner related or system related by complying with the strict governance requirements imposed on them, including clinical governance and risk management.

If the credentialing requirements and governance obligations of health services boards are applied correctly and read in conjunction with sub-section 130(3)(a)(iv) of the National Law, where practitioners are already required to notify the National Board of restrictions or the withdrawal of their right to practice at a hospital or another facility at which health services are provided, because of the practitioner's conduct, professional performance or health, it is clear that the law already provides for the protection and safety of the public. It is a matter of ensuring that hospitals are diligent in meeting their obligations.

A proposition was raised that the Medical Board of Australia should provide advice on doctors subject to a significant number of complaints. In addition doctors should declare their involvement in legal settlements.

Apart from the obvious problem of making confidential settlements of no value, such a process does tend to look at history of legal action as a determination of poor practice.

Some specialties are prone to more complaints than others due to the risk of procedures i.e. spinal surgery, or other agendas as can be the case with Independent Medical Examiners not providing favorable reports to plaintiffs.

However doctors in areas of higher risk care are required to provide information to their hospital either through the credentialing process or engagement contract.

The Department of Health issued a handbook on *Credentialling and defining the scope of clinical practice for medical practitioners in Victorian health services*. The handbook includes a model application for credentialing, and recredentialing, that contains requirements to declare complaints and claims or limits imposed on the clinician (see section 7 of Appendix 2 and section 6 Appendix 3 of the Handbook).[30]

The Department also has its *Partnering for Performance* guide for specialists working in hospitals[31]. Again this is a further method for ensuring the doctor is performing at an appropriate level in these areas of higher risk.

The benefits of further disclosures by the Board is very unclear when processes already exist that are better targeted.

Where there are instances of undisclosed complaints, one can assume it is because hospitals fail to engage available processes and resources and therefore do not ask the questions or do not check the answers.

Mental Health

The current mental health system in Victoria is difficult to navigate and severely under-resourced. The lack of coordination and the fragmentation in the system makes it difficult to appropriately track service provision and outcomes. The severe and ongoing lack of resourcing across the sector means the focus remains on acute setting and this narrow focus is reflected in current performance reporting.

Performance reporting needs to take a broader, system-wide, approach to ensure the needs of patients are being met and that the public can judge the availability and performance of services.

[30] Department of Health *Credentialling and defining the scope of clinical practice for medical practitioners in Victorian health services – a policy* handbook. Accessed April 11 2016 at; file://control/home$/geoffo/Downloads/credentialling-and-defining-scope-of-clinical-practice-2011-update%20-%20PDF%20(2).pdf

[31] Department of Health, *Partnering for Performance Guide*. Accessed April 11 at; https://www2.health.vic.gov.au/about/publications/policiesandguidelines/partnering-performance-guide

Performance reporting must centre on areas such as:

- Access to appropriate services in the community,
- Wait times to access inpatient beds,
- Length of time spent in inpatient services, and
- Readmission rates.

Greater transparency around the use of mental health funds is needed. Health services are funded to provide mental health services but current reporting requirements mean that it is not possible to see exactly how this money is being utilised. Unless there is clear information on how current funding is being used it is not possible to understand or improve the efficiency, effectiveness or safety of mental health services.

Theme 4: Advancing transparency

Transparency of health performance information is vital. It is not sufficient to simply publish information, the information must be easy to interpret and meaningful.

AMA Victoria is supportive of the *Transparency in Government Bill 2015* but believes that the measures required to be reported under this legislation need improvement.

Data Reporting

The current statements of priority indicators do not provide sufficient insight into hospital safety and quality for public reporting. The terminology and presentation of this information is meaningless to the general public. Language such as "no outliers" or "full compliance" do not provide any details as to what has actually happened inside the health service or allow the public to make a judgement on the safety or quality of care.

The choice of performance indicators used in the statements of priorities need to be improved to ensure they are useful to the public. Indicators such as "the number of central line-associated blood stream infections" is an important safety indicator within the health system but is unlikely to provide any useful insights into a hospitals performance to a member of the public.

AMA Victoria is particularly supportive of provisions in the *Transparency in Government Bill 2015* that require timely publication of data, including the statements of priorities. Timeliness of information is imperative to ensure its usefulness.

Transparency of hospital performance could also be improved by ensuring that statements of priorities report on a standardized set of indicators, in addition to specific indicators for a hospital. It would also be appropriate for these standardized data sets to be presented in a summarized format. These improvements would make it easier for the public to quickly compare health services across the state.

Performance indicators, across the entire health system, need to be meaningful and easy to interpret to ensure that the public is able to appropriately judge their local health service and make decisions about their care.

Performance indicators should reflect the information that people need to know, such as:

- How long do patients actually wait to receive care?
    - This means providing information on the actual wait times people experience in the system, not just the average or the 90th percentile.
- What does compliance with cleaning standards actually mean?
    - Information on things such as what hospitals are required to comply with and why might some of them be non-compliant.

Improving performance indicators will allow the public to gain a greater understanding of how hospitals are measured and assessed.

Doctors, and other health care providers, must be engaged in the process of setting reporting measures to ensure that they are meaningful and reflect true activity within the health system.

Data reporting must also take a greater focus on the measurement of quality and safety, not simply financial, numerical or time based targets and engage doctors

AMA Victoria is also concerned by comments in the latest VAGO report that suggests quarterly performance reports are inadequate as the patient safety indicators only partially measure patient safety and do not comprehensively reflect performance. The reporting of quarterly performance indicators could also be improved in line with the above comments.

The use of qualitative information

The provision of quantitative information and explanation would also assist the public in interpreting data and will increase public awareness and understanding of hospital performance.

To be useful qualitative information must be clear and concise. Long explanations or large slabs of text could be used to confuse or inappropriately frame data and will not improve transparency in the system.

Qualitative information could include explanations of particular indicators, explanations of acceptable limits within indicators or information on why targets were not met.

While increased access to performance information is a positive step for transparency, it is not appropriate for individual clinicians, hospitals or services to independently publish their own data that has not been verified of analysed. The publication of superfluous information can be confusing and make it more difficult for the public to judge performance.

Prisoner Health

Increased information regarding the safety and quality of health care in the prison system would be a positive step forward.

The quality and outcomes of services provided to prisoners impacts the health of the prison population and also the broader community. Improving the reporting requirements would assist in driving improvements through increased accountability.

To increase transparency reporting measures should include:

- The number of days (highest, lowest and average) spent waiting for access to a mental health bed
- The number of days (highest, lowest and average) spent waiting for mental health services (psychiatric reviews, sessions etc.)
- The number of new communicable infections – Hepatitis, HIV
- The number of prisoners entering the system with existing infections
- The number of prisoners being treated in prison
- Drug use information including the availability of replacement therapies such as methadone
- The number/percentage of prisoners being referred to follow-up health care for relevant conditions upon release – this should also include a sub-indicator for the number of prisoners making contact with the follow-up care provider
- The number of mental health and general health clinicians working in the system