

Offender Health Services Review Final Report

*Department of Health,
Clinical Excellence
Division*

*Offender Health
Services Review - Final
Report*

October 2018

CCC EXHIBIT

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Executive summary

This report details the findings and recommendations arising from an independent review of offender health services in Queensland. It is the culmination of a review of relevant white and grey literature from other Australian and selected international jurisdictions, extensive consultation with key stakeholders within Queensland and an analysis of the available data relevant to the provision of Queensland offender health services.

Scope of review

In April 2018, PricewaterhouseCoopers Australia (PwC) was engaged by the Queensland Department of Health (DoH) to conduct a state-wide review of offender health services (OHS). Specifically, PwC was requested to:

- 1 Conduct an information review (including literature, exemplars and current service models) to identify contemporary offender health service models relevant to the Queensland and Australian contexts.
- 2 Review the delivery of offender health services in Queensland. In conducting the review, consult with key stakeholders including: key executive and operational staff within Hospital Health Services (HHSs); the DoH; Queensland Corrective Services (QCS); Office of the Health Ombudsman; consumer and employee representative organisations and relevant experts. This review included:
 - a An analysis of the services currently provided in each offender health service
 - b An analysis of the operational costs of health service provision at correctional centres in Queensland
 - c An examination of health service complaints regarding offender health services funded by the DoH.
- 3 Provide recommendations to improve the system governance, service model(s) which would optimise efficiency and effectiveness, and sustainable resourcing.

Definition of in-scope services

The review's scope included an examination of health services provided to people who are accommodated within the adult, publicly operated correctional centres in Queensland. Health services in scope included publicly provided primary, secondary and tertiary health care whether provided in a correctional centre health centre (a health centre), or in the Secure Unit of the Princess Alexandra Hospital (PAH Secure Unit). It also included mental health and oral health services provided within correctional centres by Queensland Health.

Different HHSs use different terminology for the primary health care services delivered within prisons. Names used include 'offender health services', 'prison health services', and 'prisoner health services'. For the purpose of this report, the term 'offender health services' is used to describe primary health care services within correctional centres. It encompasses primary mental health care treatment analogous to that provided within general practice in the community. Specialist mental health services are delivered within correctional centres by the statewide Prison Mental Health team.

In this report, various terms are used to refer to Queensland prisoners, including 'prisoners', 'offenders', 'people', 'individuals', and when prisoners are accessing healthcare, 'patients'. The terms are used interchangeably according to what is most appropriate to the context in each instance.

Drivers of the review

In 2012 with the implementation of the national hospital and health reforms, public offender health services in Queensland were devolved to relevant HHSs. Since that time several issues have emerged that have affected offender health services including:

- The *Review of State-wide Services* in response to the Barrett Adolescent Centre Commission of Inquiry (BACCOI) identifying the need for improved clarity regarding the role and function of the DoH and that of HHSs with respect to the provision of state-wide services (including offender health services)
- The Queensland Audit Office's audit *Management of privately operated prisons Report 11: 2015-16*, identifying that Queensland Health did not have a central governance arrangement for coordinating prisoner health services and that there may be some inefficiency in the delivery of publicly provided offender health services
- Different levels of access to health services for prisoners between HHSs, difficulties in addressing systemic issues, and the impact of overcrowding within correctional facilities on prisoner health and their access to services, as identified by QCS
- An increasing number of complaints to the Office of the Health Ombudsman about offender health services
- Growing demand for offender health services in recent years due to growth in prisoner numbers.

Key findings

There are strengths observed in the Queensland Offender Health Service delivery system, being one of a small number of jurisdictions that meets the international guideline of providing an organisational separation between the entity responsible for custody, (in this case, QCS), and the entity responsible for health service delivery.¹

This separation is important as it helps ensure that health staff working in prisons have the sole mission to care for and advocate for the health and well-being of prisoners. Importantly, it also helps to ensure that health services for offenders are integrated with services provided to the general community, thereby contributing to the principle of equivalence in the quality and availability of health services to that for the general public.²

We spoke with many health staff who strive to provide a quality health service for prisoners. These staff provide health care and treatment to a group of people that generally have relatively complex health needs, including a high prevalence of mental health conditions, communicable diseases, illicit drug use, poor oral health, and certain chronic diseases when compared to the general population.

The efforts of these staff, however, have been hampered by a lack of system wide governance, which has meant that systemic challenges have not been addressed from a health perspective. These challenges include:

¹ World Health Organisation (2013). Good governance for prison health in the 21st century. A policy brief on the organization of prison health. Copenhagen, Denmark.

² Justice Section, Division for Operations (2015). The United Nations Standard Minimum Rules for the Treatment of Prisoners (the Nelson Mandela Rules). United Nations Office on Drugs and Crime. Vienna, Austria.

- An increase in total prisoner numbers of 19.4 per cent on an average annual head count basis between 2015 and 2018 (including prisoners in public and private prisons)^{3 4}
- Overcrowding of the prisoner population, with most correctional centres operating above built capacity
- The consequences of overcrowding, including the need for QCS to change their processes in order to maintain safety and security
- The continued use of a historic funding model that may no longer reflect the costs of service delivery at correctional health centres
- Complex health needs of prisoners
- The nature of different correctional centres (eg reception centres versus placement centres) drives variation in workload and cost.
- The lack of suitable infrastructure within which to deliver health care services
- Conflict between the corporate objectives of QCS and the delivery of health services.

These unaddressed systemic challenges have resulted in a range of issues:

- A workforce that at times feels unsupported and frustrated by their inability to deliver the level and standard of services that they strive to provide.
- A prison population whose health care needs have not been consistently met.
- Inefficiencies in care delivery due to the capacity to focus only on the day to day delivery of basic care and little capacity to address issues strategically.
- Fragmentation in the delivery of services.
- Significant variability in the nature and availability of services for prisoners.

These system-wide challenges cannot be addressed by an individual clinician, an individual offender health service, or even a single HHS; rather they require system leadership.

The role and function of the DoH and that of HHS, as statutory independent bodies, has been established under the *Hospital and Health Boards Act 2011* (the Act). Parts 2 and 3 of the Act specifies the respective roles, functions and authorities of the respective entities.

Generally, HHSs are responsible for the delivery of publicly funded health services, whilst the DoH is responsible for the overall management of the health system. The *Review of State-wide Services* reinforced the importance of the DoH exercising its system manager responsibilities including being accountable for policy, strategic planning, governance and risk management, funding arrangements and performance management.

This system leadership should not be seen as an autocratic, command and control system but rather a collaborative arrangement where the role and function of the DoH and that of HHSs is complimentary, with each having clear accountabilities and responsibilities.

The following recommendations emanating from this review of offender health services in and of themselves will not resolve all the challenges that have been identified but are

³ Source: Prisoner number information was provided by QCS through the Department of Health. It included a count of prisoners at correctional centres at the end of the last day of each month (for example, count of prisoners at 30 June 2018). Funding information was provided by the Department of Health.

⁴ Data for 2018 does not incorporate a full years' data set. The request for data was made in May 2018 with responses received between May and June 2018.

designed to enable the system to establish a mechanism that can address current and future issues. These recommendations have been structured under five key themes:

- Relationships and governance
- Workforce
- Access
- Service standards and models
- The correctional environment & interfaces.

Whilst structured under these five themes, the recommendations are inter-related; ie they are a suite of actions designed to achieve a common goal.

A key recommendation is the establishment of a small program coordination unit within the DoH to be responsible for the coordination of state-wide offender health, including functions such as:

- strategy
- policy, standards and quality assurance
- planning
- funding
- information management
- performance monitoring
- research.

To be successful, implementation will require collaborative effort from the DoH, HHSs and QCS. It will require each of these entities to work in partnership whilst respecting each entity's roles and responsibility, and at times require new ways of working for each entity.

If implemented effectively, these recommendations will enable Queensland Health to achieve a significant improvement in the delivery of services, better health outcomes for prisoners, higher levels of staff satisfaction and ultimately a healthier Queensland.

In conducting the review, it was identified that offender health services in each HHS face unique challenges. As such, the sequencing of improvements may need to be applied flexibly.

In keeping with the principles of equivalence (to the community standard) and continuity of care outlined in the Mandela Rules, the prison population should be seen as part of the broader community that the HHSs support. Whilst 'offender health' funding provides for the primary care needs for prisoners, this should not mean that prisoners are excluded from other health services that are delivered by the HHS to its catchment population under other existing funding arrangements. We have provided an indicative timetable of next steps to implement the recommendations. Actual implementation timeframes will be reliant on the level of available resources to implement the plan.

Acknowledgement

This review was conducted with the guidance and support of the Offender Health Services Steering Committee Alliance (OHSSCA). Their expertise, guidance and support were pivotal to enabling this report to be produced.

This report would also not have been made possible without the hard work, support and assistance of offender health staff, correctional centre staff and the willingness of prisoners to share their stories. We thank each and every one of you.

Key themes, findings and recommendations

The following pages discuss the key findings and recommendations identified through this review. These have been structured under five key themes (as discussed above), with further context given through the report.

1. Relationships and Governance (G)

Key themes and findings

Queensland currently aligns to international guidance in delivering offender health services under the jurisdiction of the health department. The DoH is designated as the 'system manager' under the *Hospital and Health Boards Act 2011* (the Act). However, the Department has not been exercising this role with respect to offender health, leaving service provision to become fragmented across the state in the absence of leadership from the Department. As a result, services provided vary between HHSs and correctional centres, and service effectiveness depends upon the strength of relationships between offender health staff and correctional centre management, as well as between offender health staff and staff within other areas of their respective HHSs. Cultural differences between QCS and Queensland Health lead to differing approaches, priorities and philosophies, and in the absence of clear escalation pathways, issues are not always resolved promptly and effectively, impacting health care provision in correctional centres.

Recommendations

Recommendation G1: The Queensland Department of Health should establish a state-wide program coordination unit within the DoH, to oversee state-wide offender health. The state-wide program coordination unit would have responsibility for the governance functions in the recommendations that follow, including policy (clinical and administrative), planning, funding, information, performance, quality and research. An early priority of this unit should be to establish and lead the collaborative arrangements necessary to achieve the goals of the Offender Health Strategic Plan (see G1.1), including liaison with key stakeholder groups in the DoH, HHSs and other government agencies.

Recommendation G1.1: Develop and implement a state-wide offender health services Strategic Plan articulating clear and measurable service priorities and goals. Ideally, QCS should be involved in the development of the Strategic Plan.

Recommendation G1.2: Develop and implement policies and procedures aimed at standardising critical elements of care delivery. Consideration may be given to the development of a 'Queensland charter of healthcare rights for prisoners', aligned to the Australian Charter of Healthcare Rights.

Recommendation G1.3: Negotiate a single state-wide Memorandum of Understanding (MoU) between Queensland Health and QCS that sets out the agreement between the two organisations, including:

- Role and responsibilities of Queensland Health (Department and HHSs), including the health services to be provided at each correctional centre and arrangements for provision of hospital-based care. This would include clarifying the role of each party with respect to the provision of health care in privately operated correctional centres.
- Role and responsibilities of QCS (Department and correctional centres)
- Guiding principles for the relationship and for decision-making
- Governance arrangements (see G1.4 and G1.5 below)
- Minimum service standards
- Key Performance Indicators (KPIs) and reporting requirements (see G1.7 below)
- Regular meetings and communication channels (see G1.4 and G1.5 below)
- Requirements for local, operational agreements between HHS and correctional centre.

Note: This MoU shall be consistent with the requirements set out under the *Hospital and Health Boards Act 2011* (the Act), and will exclude agreements pertaining to information sharing, which is subject to a regulation under the Act and therefore is dealt with in a specific MoU.

Recommendation G1.4: Develop and implement a formal mechanism for interagency liaison regarding offender health services, such as dedicated contacts within relevant agencies including QCS initially, and the Queensland Police Service (QPS) and the Department of Justice and Attorney-General (DJAG) to follow. Interagency liaison will include planned collaboration (eg joint Cabinet Budget Review Committee (CBRC) submissions) and unplanned issue resolution (eg escalation of issues that cannot be resolved at the local level between HHSs and QCS). The interagency arrangement should operate to a documented Terms of Reference.

Recommendation G1.5: Facilitate a clinical governance network to support the resolution of state-wide clinical issues and provide a forum for professional development, networking and dissemination of leading practices in offender health. The network should include appropriate representation of different professions and regions, and work to a documented Terms of Reference. Functions should include:

- Input into the strategic planning process
- Monitoring systemic clinical risks and issues escalated to the network, which may emerge through analysis of aggregated data (see below) and suggesting appropriate mitigation actions
- Assisting in the development and review of clinical practice guidelines as they relate to Offender Health Services.

Recommendation G1.6: Develop and implement an activity data collection, in accordance with eHealth Queensland requirements, for offender health (ie primary health care) services to enable performance to be monitored across the system. The collection should include standard data definitions and reporting requirements. This should be integrated into the state-wide offender health electronic medical record system (see G1.8) to facilitate reporting.

Recommendation G1.7: Develop and implement a service evaluation and development system for offender health services as part of the existing HHS performance management framework. As part of the implementation, there should be regular reporting to the state-wide program coordination unit, which will feed into the monthly relationship management meeting between Health Purchasing and System Performance Division (HPSP) and HHSs. As necessary, incentive payments linked to the achievement of objectives in the service evaluation and development system may be appropriate (ie output or outcome based funding). The service evaluation and development system should align to the Strategic Plan and incorporate at a minimum:

- Objectives
- Key performance indicators (KPIs) to measure progress in achieving objectives. KPIs may include:
 - KPIs relevant to all health facilities and staff; for example compliance with notifiable incident and notifiable disease reporting, accreditation, credentialing, incident reporting etc.
 - Initial assessment: percentage of comprehensive assessments, triaging and referrals completed within 24 hours of reception.

- Chronic disease management: percentage of patients with chronic disease for whom a chronic disease plan is implemented.
 - Communicable disease: percentage of patients offered communicable disease screening upon reception (eg HIV, viral Hepatitis, other sexually transmitted infections (STIs)).
 - Communicable disease: percentage of patients vaccinated for communicable diseases including all vaccinations covered in the childhood immunisation schedule, and seasonal influenza.
 - Communicable disease: rates of transmission within correctional centres of STIs and blood borne viruses (BBV).
 - Access: Waiting times for appointments with the medical practitioner, dentist or mental health practitioner (see Access section below).
 - Patient satisfaction with offender health services.
 - NB: KPIs may need to be targeted to cohorts of prisoners with certain lengths of sentence.
- Targets for the KPIs.

Recommendation G1.8: Department of Health to lead implementation of state-wide offender health electronic medical record, with state-wide program coordination unit to be system owner with ongoing support from HHS, due to the associated state-wide data collection.

Recommendation G2: HPSP should update HHS service agreements to reflect specified expectations for offender health (as per offender health service evaluation and development system).

2. Workforce (W)

Key themes and findings

The majority of offender health service delivery is provided by the offender health nursing workforce. Some HHS have reported difficulty in attracting and retaining offender health staff, and as a result have a high reliance on the use of agency staff and high staff turnover. High turnover impacts the ability to provide continuity of care, develop expertise in prison health, and drive an appropriate team culture, all of which may impact effective health care provision.

The offender health medical workforce is challenged in providing comprehensive primary care within the health centres, due to factors such as insufficient onsite diagnostic equipment.

Recommendations

Recommendation W1: Once established, the DoH's offender health program coordination unit should collaborate with HHSs to develop a multidisciplinary resourcing model to guide the level of staffing required for offender health services, aligned to the new service model (see Recommendation S1), including:

- structuring the nursing workforce appropriately to provide a career pathway within offender health and enable nurses to work to full scope of practice
- appropriate access to medical officer resourcing
- appropriate access to pharmacy support including time on site at the correctional centre health centre, to support improved approaches to medication management
- appropriate access to oral health resourcing (which may be funded separately)
- appropriate access to primary mental health services and specialist prison mental health services
- appropriate access to allied health resourcing (funded as part of the HHS' allied health service provision)
- appropriate access to workforce to support the provision of culturally appropriate care for Indigenous offenders
- appropriate use of administrative staff to undertake tasks that do not require clinical input (eg. sourcing collateral information from patients' regular general practitioners upon reception)
- NB implementation of the above workforce model to suit local needs at each correctional centre will be led by the relevant HHSs.

Recommendation W2: Hospital and Health Services should implement a system whereby clinical staff can rotate between offender health and other health care settings within the HHS, in line with international contemporary practice. This would:

- ensure that staff maintain broad skills across their full scope of practice
- enable staff to develop expertise specific to offender health

- enable staff to build and maintain networks with the broader HHS, which would be beneficial for individual staff but also for fostering understanding within HHSs about the context and constraints of the offender health environment
- give staff 'time out' from the at-times challenging offender health environment.

Recommendation W3: HHSs should work with higher education institutions to design pathways into correctional health care; for example, clinical placements for students.

Recommendation W4: The Department should support HHSs (if needed) to establish local pools of casual staff and/or HHS staff who can provide backfill services at offender health centres, to reduce the use of agency staff, which is high at some HHSs' offender health centres.

3. Access (A)

Key themes and findings

Consultation suggested that there are numerous barriers to accessing timely and appropriate health services for offenders. Some of the barriers are within Queensland Health's power to change, such as ensuring that services such as allied health, which are funded as part of the HHSs' service agreements, are made available to offenders as they are to the general population. Conversely, factors such as the impact of the correctional centres' structured day or the prison health centre infrastructure would require negotiation with QCS if changes are to be made; these are discussed in more detail within Theme 5, (The correctional environment and interfaces with QCS) below. It appears that some HHSs do not view the offender population as part of the general HHS population, despite generally short sentences meaning that offenders cycle between prison and the community, and require health care in both settings.

Recommendations

Recommendation A1: Through the state-wide governance arrangements and implementation of the service evaluation and development system, work to increase offenders' access to health services, by implementing:

- access to allied health care, oral health services and mental health services to a similar standard to what is available in the community-based public health services, with modifications as required to accommodate the correctional environment (eg some equipment may not be permitted in a correctional centre)
- agreed and consistent service hours among offender health centres for peer group categories
- agreed and consistent state-wide medications formulary to increase continuity of care for prisoners that move between correctional centres, and reduce prisoner complaints
- optimised use of alternative service delivery approaches to avoid the need for unnecessary escorts (eg telehealth).
- collaboration with QCS to ensure the health centre infrastructure enables the delivery of a contemporary health delivery.

4. Services Standards and Models (S)

Key themes and findings

The most prominent finding is that delivery arrangements and service availability and offering significantly varies between HHSs, largely due to a lack of coherent strategy, planning, standards and performance management across Queensland offender health.

There is also a lack of complete, reliable and comparable activity and cost data for offender health across the state. Taken together with the small size of the offender population, the above findings mean that the current approach of block funding offender health services is appropriate. Block funding for offender health is also consistent with other jurisdictions examined.

Despite the lack of quantitative activity data, consultation revealed areas where a redesign approach would be expected to improve efficiency and therefore release capacity within the current offender health workforce, due to the current manual processes in use (see Recommendation S3 below).

Recommendations

Recommendation S1: Continue block funding of offender health services in a resource-based model, ensuring that funding is efficiently allocated to HHSs for offender health services based upon consistent funding principles.

Recommendation S1.1: In the absence of data that enables health need to be established in the Queensland prison population, initially funding may be allocated based upon known data points, as follows:

Peer group	Principle	Funding implication	Notes	Relevant CCs
Group 1: Base funding	Number of prisoners at correctional centre	Base level of per head allocation (base level of funding allocated per head aligned to average annual occupancy of the correctional centre)	Provision of top-up funding likely to be required as average annual occupancy increases. Top-up funding could increase at a lower rate than the base funding level due to economies of scale.	All correctional centres
Group 2: High security	Restricted movement and access	Base funding plus high security loading	High security correctional centres present challenges to efficient delivery of health services and may also be less amenable to service delivery improvements that would improve health service efficiency	High security correctional centres
Group 3: Remand and reception	Turnover of prisoners at correctional centre	Base funding plus high security loading plus loading to account for administration associated with new receptions and discharge, as well as stabilisation of new receptions	% loading (intake) multiplied by number of new entrants % loading (discharge) multiplied by number of discharges	Remand and reception centres

Recommendation S1.2: Given the availability of state-wide activity data sets, oral health and Prison Mental Health are amenable to the development of resource based funding models. An oral health resource based funding model is under development; however it is recommended that the Prison Mental Health resource model is reviewed against current levels of demand.

Recommendation S2: Develop and implement a service delivery model that increases standardisation across the state. Key considerations include:

- Continued use of a nurse-led primary care model with increased emphasis on preventative care. This would be expected to benefit Queensland Health more broadly through the avoidance of costly hospital care during incarceration and following release. Health economic and integrated care principles may be used to design services.
- Agreed clinical capability levels to match the agreed model of care, supported by appropriate health centre space, physical layout, facility standards; and appropriate training for clinical staff as required.
- Provision of the following services:
 - Comprehensive reception assessment.
 - Communicable disease screening, vaccination and treatment, including access to universal testing and treatment for Hepatitis C in Queensland correctional centres in conjunction with broader population health approaches in the community, to ensure that correctional centres do not become a reservoir for Hepatitis C.
 - Access to allied health services including podiatry, dietetics and physiotherapy.
 - Diagnostic services appropriate to the primary care setting.
 - Medication management, including a consistent state-wide offender health formulary, that reduces the risk of errors and support patients to self-manage as part of a transition back to the community.
 - Oral health services including general dental care for patients with sentences above 12 months.
 - Multidisciplinary alcohol and other drugs (AOD) addiction services.
 - Multidisciplinary chronic pain management services.
 - Chronic disease screening and ongoing management.
 - Sexual health care and education.
 - Discharge planning, including sending discharge summaries to patients' My Health Record to enable continuity of care in the community
 - The above services should be regarded as forming part of the suite of services provided by HHSs to the general HHS population.
- Increased, consistent use of telehealth. This will reduce unnecessary hospital transfers, which will benefit QCS through reduced patient transport costs and Queensland Health through reduced admission costs.
- Agreed patient transfer pathways, adopting the principle whereby the HHS that has responsibility for delivering primary health services to prisoners should deliver all health services to those prisoners, including oral health, mental health, and specialist outpatient and inpatient care. The only exceptions to this principle would be if there is no facility within the HHS with a suitable CSCF level to provide the required care, if a prolonged inpatient stay is required (in which case, admission to a secure unit may be more appropriate), or as required under the *Mental Health Act 2016* and/or the *Chief Psychiatrist Policy for Classified Patients*.

- Conducting a review to determine the appropriate locations for secure inpatient care. Principles to determine appropriateness may include:
 - Proximity to the largest number of current and planned correctional centres
 - CSCF level of the hospital.
- To alleviate pressure on hospitals, consider the feasibility of:
 - ‘hospital in the prison’ (with similar services to Hospital in the Home), which would be expected to reduce costs to both Queensland Health, by reducing hospital utilisation, and to QCS, by reducing transports.
 - mobile x-ray machines that could be utilised within health centres where applicable. Cost effectiveness would depend upon size of correctional centre and demand for x-ray services.

Recommendation S3: Undertake a clinical service redesign program to increase efficiencies. For example for medications management:

- Investigate use of automated technology to dispense medications and thereby reduce medication errors (similar to the system used in Capricornia Correctional Centre by CQHHS) and reduce nursing workload.
- Work with QCS to develop appropriate policies and processes for prisoner self-medication, targeted at appropriate prisoners and applying only to medications deemed safe and not at risk of diversion within correctional centres.
- Ensure ready access to PRN medications (eg analgesics that, in the community, are available ‘over the counter’ without a prescription).

Recommendation S4: Ensure strong and consistent local complaints management policies to enable local resolution without the need for complaints to external agencies. This should include attendance by offender health staff at Prisoner Advisory Committee meetings.

Recommendation S5: Ensure that patient safety and quality of care issues and incidents are appropriately captured in the relevant enterprise system and that this information is shared with the Department of Health Patient Safety and Quality Improvement Unit to enable the state-wide identification of systemic issues and timely development of solutions and improvements.

5. The Correctional Environment & Interfaces with QCS (I)

Key themes and findings

The corrections environment, specifically the operating systems and processes, impacts the ability to provide efficient and effective health care services in prisons. Part of this barrier involves the finite physical footprint of the health centres, limiting the capacity for offender health services to cope with the increased overcrowding. Another includes the availability of transport and escorts, which often leads to rescheduling of planned hospital care to accommodate emergency transfers to hospital. A lack of coherent systems and processes between QCS and OHS staff is further evidenced through safety orders. Although generally initiated by QCS, they impact the workload of OHS staff, with the processes surrounding the requirements generally outside of the control of OHS staff. OHS staff are generally reactive rather than proactive in addressing prisoners' health needs due to the physical environment and demands beyond their control, with limited paths to escalate issues for resolution.

Recommendations

Recommendation I1: In line with recommendation G1.2, HHSs should develop and implement local offender health arrangements between the HHS and correctional centre. Such arrangements should:

- Align to the state-wide MoU to be developed under G1.2
- Clearly set out the roles, responsibilities, service provision and expectations of each side
- Engage both HHS and correctional centre leadership in offender health, to ensure that both organisations understand the benefits of providing effective offender health services
- Help to ensure that services remain consistent and well-understood even when there is a change in leadership of the HHS, the correctional centre, or the offender health service.

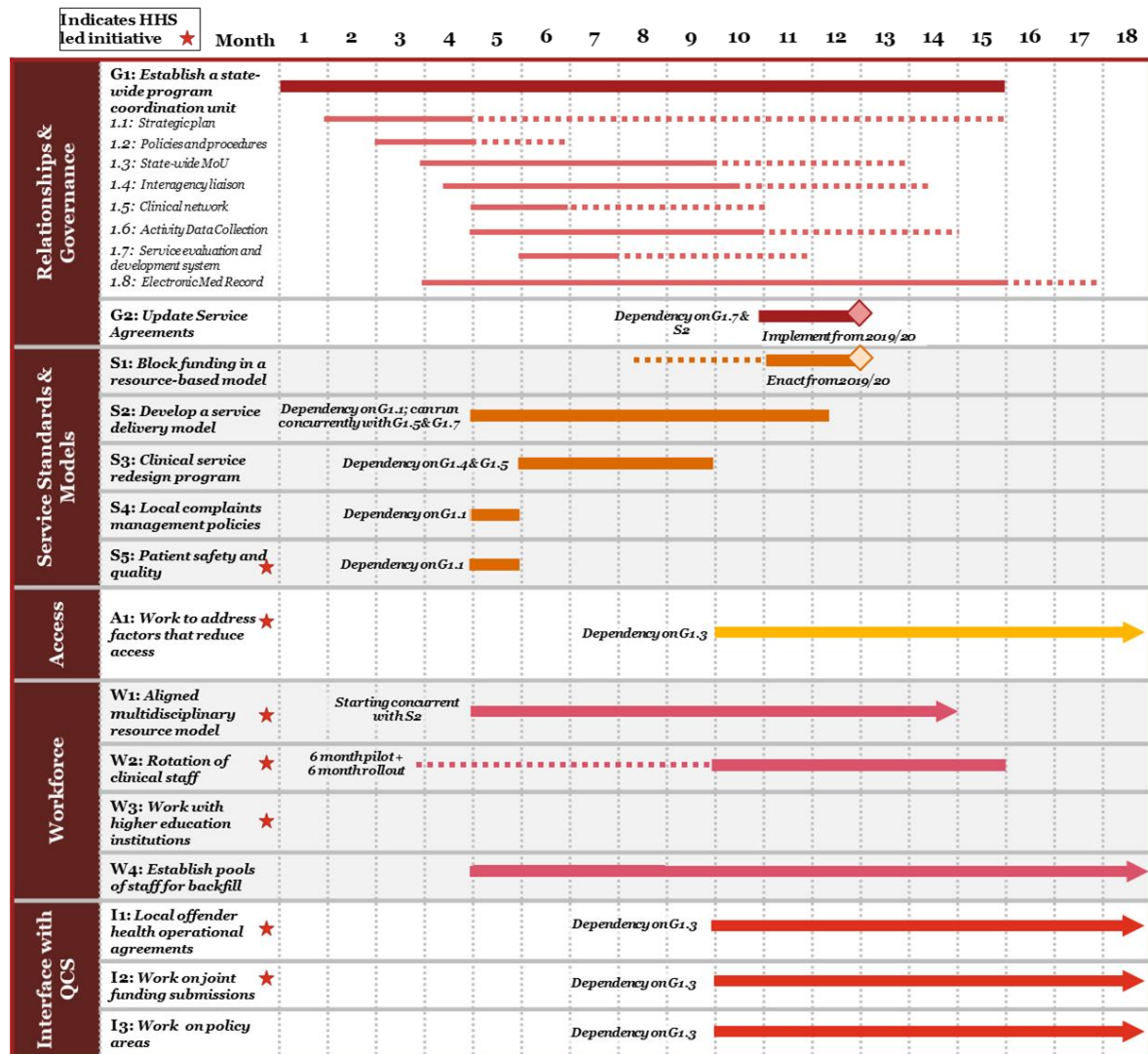
Recommendation I2: As a priority, the Department and HHSs should work with QCS on joint funding submissions to upgrade health centres in line with changing prisoner numbers, prisoner demographics, health needs and accreditation requirements.

Recommendation I3: The state-wide offender health governance group should work with QCS on policy areas such as:

- needle exchange (required to ensure spread of blood borne viruses is reduced). This would be enabled by an offender health research governance framework which could access the efficacy and safety of such an approach before broad roll out
- provision of condoms (required to ensure spread of blood borne viruses is reduced)
- changes to medication management
- changes to the use of the PA Hospital Secure Unit.

Next steps

The diagram below sets out a suggested timetable for implementing the above recommendations:



The recommendations and implementation timetable as outlined above are envisioned as a long-term strategic plan for the delivery and governance of offender health services. Although an important and necessary initiative for the Department, it is necessary to consider the resourcing available to implement such recommendations. Given the complexity of the issues and recommendations, implementation will need to be sequenced over a period of months.

Contents

Executive summary	i
1 Introduction	3
1.1 Background	3
1.2 Review objectives	3
1.3 Methodology and approach	4
2 Current state	7
2.1 Patient demographics and trends	7
2.2 Aboriginal and Torres Strait Islander prisoner population health needs	11
2.3 Consumer consultation – Conducted by Health Consumers Queensland	14
2.4 Patient journey mapping	17
3 Summary of the literature and information review	20
3.1 Context	20
3.2 Background	20
3.3 Governance of offender health	21
3.4 Performance management	26
3.5 Clinical governance	27
3.6 Complaints	27
3.7 Service delivery	28
3.8 Conclusion	31
4 Consultation summary	32
5 Overview of offender health services	42
5.1 State-wide profile	42
5.2 Relationships and governance	48
5.3 Workforce	53
5.4 Access	60
5.5 Service standards and models	63

CCC EXHIBIT

Contents

5.6	The correctional environment and interface with QCS	74
5.7	Complaints profile	78
6	Next steps	80
Appendix A	Glossary of terms	85
Appendix B	Stakeholders Consulted	87

1 Introduction

1.1 Background

In 2012, Queensland Health, as part of the National Health Reform Agreement, was divided into the Department of Health and statutory Hospital and Health Services (HHSs). At that time, the Department underwent various structural changes, one of which was the disbanding of the State-wide Offender Health Services Unit, and devolution of governance and delivery of offender health to the eight HHSs responsible for offender health service delivery within correctional centres. At the time, there were no arrangements for the department to retain any corporate governance, nor was any system-wide leadership responsibility for offender health services identified in the department or within individual HHSs. This is not dissimilar to recent consolidations of other state-wide services.⁵

Subsequently, two reviews have suggested that Queensland Health should assess the viability of re-establishing central governance for offender health services. The Auditor-General of Queensland released a performance audit report in 2016 examining the privately operated prisons. During this audit, significant variances in offender health costs and services between private and public prisons were found. This led the Auditor-General to recommend that central oversight be re-established. Additionally, a review of state-wide services in 2016 recommended that state-wide health services should have a single point of governance; however, classification of offender health services as a state-wide health services is complex and therefore subject to ongoing debate.

1.2 Review objectives

In April 2018, PricewaterhouseCoopers Australia (PwC) was engaged by the Queensland Department of Health (DoH) to conduct a state-wide review of offender health services (OHS). Specifically, PwC was requested to:

- 1 Conduct an information review (including literature, exemplars and current service models) to identify contemporary offender health service models relevant to the Queensland and Australian contexts.
- 2 Review the delivery of offender health services in Queensland. In conducting the review, consult with key stakeholders including: key executive and operational staff within Hospital Health Services (HHSs); the DoH; Queensland Corrective Services (QCS); Office of the Health Ombudsman; consumer and employee representative organisations and relevant experts. This review included:
 - a An analysis of the services currently provided in each offender health service
 - b An analysis of the operational costs of health service provision at correctional centres in Queensland
 - c An examination of health service complaints regarding offender health services funded by the DoH.
- 3 Provide recommendations to improve the system governance, service model(s) which would optimise efficiency and effectiveness, and sustainable resourcing.

This report provides the findings and recommendations arising from the State-wide Offender Health Services Review (the review).

⁵ Queensland Government. Barrett Adolescent Centre Commission of Inquiry Report. June, 2016.

1.3 Methodology and approach

Clinical Excellence Division (CED) requested that the review be conducted in several phases:

- Literature and information review
- Consultation
- Data analysis
- Reporting.

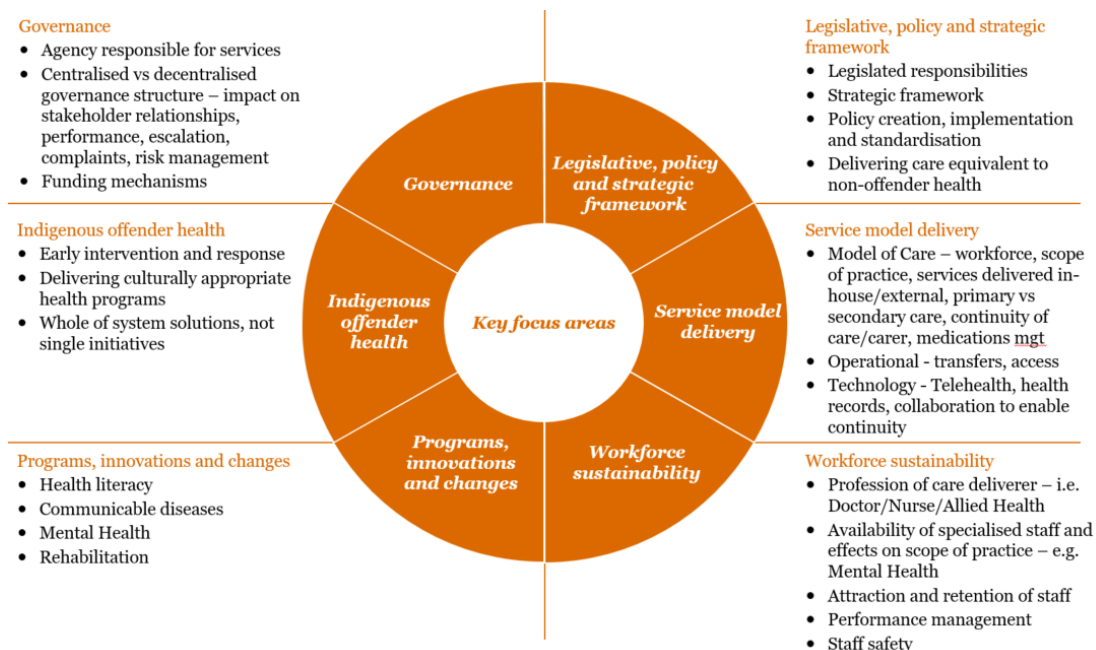
This section outlines the approach to each of these phases of work during the review.

1.3.1 Literature and information review

The purpose of the literature and information review was to perform a comparative review of equivalent offender health service models in other jurisdictions, to identify contemporary models relevant to the Queensland and Australian contexts. As per the Request for Quote, the objective was to identify alternative approaches to delivering offender health services, specifically in relation to system and clinical governance, performance management and funding mechanisms and structures.

This phase of work progressed through four key steps:

- The scope of research was defined, determining the guidelines of the research and establishing what information and data was important to capture in the report.
- An initial desktop review was conducted and involved a search of reports (policy documents, service plans and strategic plans) by government and government-funded bodies, white papers, project/program evaluation reports, peer-reviewed academic literature and internal reports provided by the Clinical Excellence Division within the Department of Health.
- Through a supplementary specific review, PwC utilised networks in New South Wales, Victoria, Norway and Canada to test our understanding of arrangements and obtain additional information to ensure we collected the depth of information required for this review.
- The final step in this review was to synthesise the information collected and present as per the document framework below.



1.3.2 Consultation

Consultation was planned in conjunction with the CED Project Director at a planning workshop, with the agreed aims being to:

- Identify key stakeholders from HHSs, the DoH, and other organisations with an interest in offender health services (please refer to 6Appendix B for a list of stakeholders consulted during this review).
- Determine the communication strategy to enable high levels of input and engagement.
- Determine an indicative consultation schedule.

The PwC team contacted the initial list of stakeholders to schedule consultation sessions. In many cases, these initial contacts identified additional stakeholders who were consulted either in conjunction with the initially identified stakeholders, or in some cases, separately.

The majority of consultation was conducted in person or via teleconference. Throughout the consultation phase, site visits to each of the 12 public, adult correctional centres and the Princess Alexandra Hospital Secure Unit were also conducted. These visits involved interviews with clinical, and in some cases, administrative staff and correctional centre management, as well as a tour of the health centre. In some cases, a tour of other parts of the correctional centre, such as residential and secure prisoner accommodation, industrial units and detention units was also provided to the review team.

Consultation was conducted across a broad range of stakeholders including:

- Key staff members from the Queensland DoH and QCS.
- Chief Executives and other executives from HHSs that deliver the health services for correctional centres across the state.
- Offender health services staff (ie nursing and other staff who work in the health centres within correctional centres).

- QCS staff working within the correctional centres.
- Other government agencies that have an involvement with offender health or prisoner advocacy that was determined to be relevant to the scope of the review.
- Non-government organisations that have an involvement with offender health or prisoner advocacy that was determined to be relevant to the scope of the review.

1.3.3 Data analysis

Throughout this project, data was requested from the DoH and all HHSs operating within a Correctional Centre. Information requested included details regarding staffing, expenditure, funding and activity undertaken. This request was developed in conjunction with the CED Project Director.

This engagement did not include an audit of the accuracy of the raw data provided. It is assumed that:

- all data provided related to offender health services only
- all data provided was complete and correct.

While most HHSs provided data in comparable formats, caution should be exercised in drawing conclusions solely from the data because:

- Some HHSs were unable to provide all data requested.
- Some HHSs were unable to provide all data in a usable format.
- Some HHSs were unable to provide sufficient/timely explanation of data.
- Some HHSs were unable to provide data within the timeframes of the review. This has impacted some of the analysis that could be completed. As a result, some 'state-wide' analysis does not include all HHSs, as indicated with each graph.
- Some data (such as activity) is collected inconsistently across HHSs. It has also been noted that activity information is not collected by all HHSs.
- While data regarding Prison Mental Health Services was provided by the Mental Health Alcohol and Other Drugs Branch, it was unable to be analysed. Caveats with the raw data provided indicated that expenditure, full-time equivalent (FTE), and grant information regarding Prison Mental Health Services provided within a Correctional Centre are unable to be isolated from the broader Forensic Mental Health data set provided.

2 Current state

2.1 Patient demographics and trends

2.1.1 The Australian prison population

As of 30 June 2017, Queensland had 8,476 prisoners, or 20.6 per cent of the 41,202 prisoners held in Australian prisons. The crude imprisonment rate in Queensland for 2017 was 221.8 prisoners per 100,000 adult persons, up from 206.3 per 100,000 in 2016. Males comprised 92 per cent of the total prisoner population in Queensland.⁶

In Queensland, Aboriginal and/or Torres Strait Islander people are 11 times more likely than non-Aboriginal and/or Torres Strait Islander people to be in prison.⁷

Government reports suggest that the health issues facing Australian prisoners are similar to those faced by prisoners internationally.⁸ Prisoners will generally access health services in the community less than the average Australian, so present with a number of issues.⁹ Upon entry to prison, one-third of entrants have previously been told that they had a chronic condition, with one-quarter reporting they still had a current chronic condition, the most coming being asthma.¹⁰ Drug usage is common, with two-thirds of prisoners reporting to have used illicit drugs in the 12 months prior to prison. Given this, Hepatitis C virus infection is very common among prisoners, with an overall prevalence of 29 per cent.¹¹ Prisons have a high self-reported prevalence of mental health issues, with prisoners twice as likely to be taking antidepressants or mood stabilisers, and nine times more likely to be taking antipsychotic medication, compared to the general population.

After release from custody, poor health treatment during prison stays places a significant burden on the individual, their families, the health system and the wider community. However, a recent 2017 study found that in Queensland, former prisoners visit GPs at twice the rate of the general population.¹² Attendance is higher among participants with a history of poor health or risky behaviour; that is, more likely to have complex health needs. The study suggests that increasing access to primary health care after prison, with the aim of improving the health of former prisoners, may be insufficient; rather, focus should be placed on improving the quality, continuity and cultural appropriateness of care during incarceration and after release.¹³

The study also provides an insight into the health status of prisoners following their release. Data relating to 1,190 prisoner participants were collected during the two years following release, most of whom were men (78 per cent), with 61 per cent aged 25-44 years, and 25 per cent identifying as Aboriginal and/or Torres Strait Islander. Sixty-seven per cent of participants reported they had been diagnosed with a chronic illness, 46 per cent reported

⁶ Queensland Government Statistician's Office (2017). Prisoners in Queensland, 2017; Queensland Government Statistician's Office (2014). Prisoners in Queensland: 2014.

⁷ Ibid.

⁸ Australian Institute of Health and Welfare (2015). The health of Australia's prisoners. Canberra, ACT. Available at: <https://www.aihw.gov.au/reports/prisoners/health-of-australias-prisoners-2015/contents/table-of-contents>.

⁹ Australian Institute of Health and Welfare (2015). The health of Australia's prisoners. Canberra, ACT.

¹⁰ Ibid.

¹¹ Ibid.

¹² Carroll, M., et al. (2017). *High rates of general practice attendance by former prisoners: a prospective cohort study*. The Medical Journal of Australia **207**(2): 75.

¹³ Ibid.

receiving some form of medication in prison, and 27 per cent tested positive for Hepatitis C.¹⁴

A 2018 study of the same Queensland prisoner cohort found that those with a dual diagnosis of mental illness and substance use disorder were 12 times more likely to be hospitalised and three times more likely to have an injury resulting in hospital contact after release from prison compared to those without dual diagnosis.¹⁵ The study suggests that incarceration provides an opportunity for offender health services to prevent injury morbidity post-incarceration in people with co-occurring disorders, by engaging with integrated psychiatric and additional treatments whilst incarcerated.¹⁶

2.1.2 Australian prisoner numbers

Prisoner numbers in Australia, and Queensland have been growing steadily for several years (see Figure 1 and Figure 2).

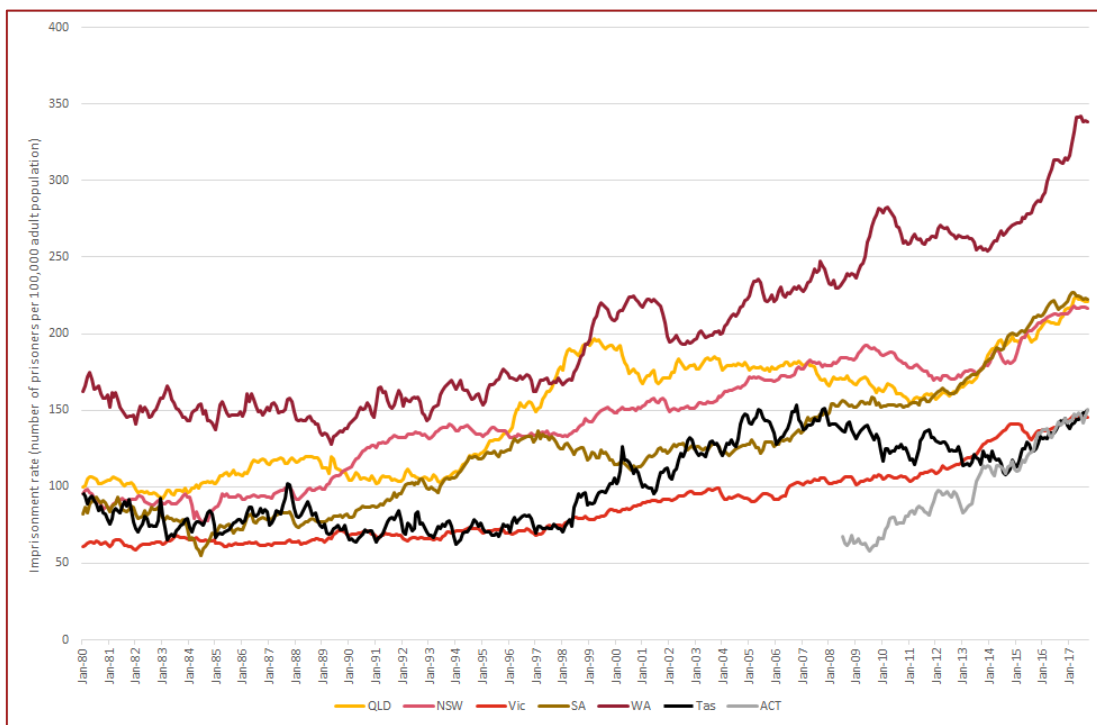


Figure 1 The Australian imprisonment rate (number of prisoners per 100,000 adult population) has grown from 1980 - 2017¹⁷

¹⁴ Ibid.

¹⁵ Young, J. T., et al. (2018). "Dual diagnosis of mental illness and substance use disorder and injury in adults recently released from prison: a prospective cohort study." *The Lancet Public Health* 3(5): e237-e248.

¹⁶ Ibid.

¹⁷ Source: Prisoner number information was provided by QCS through the Department of Health.

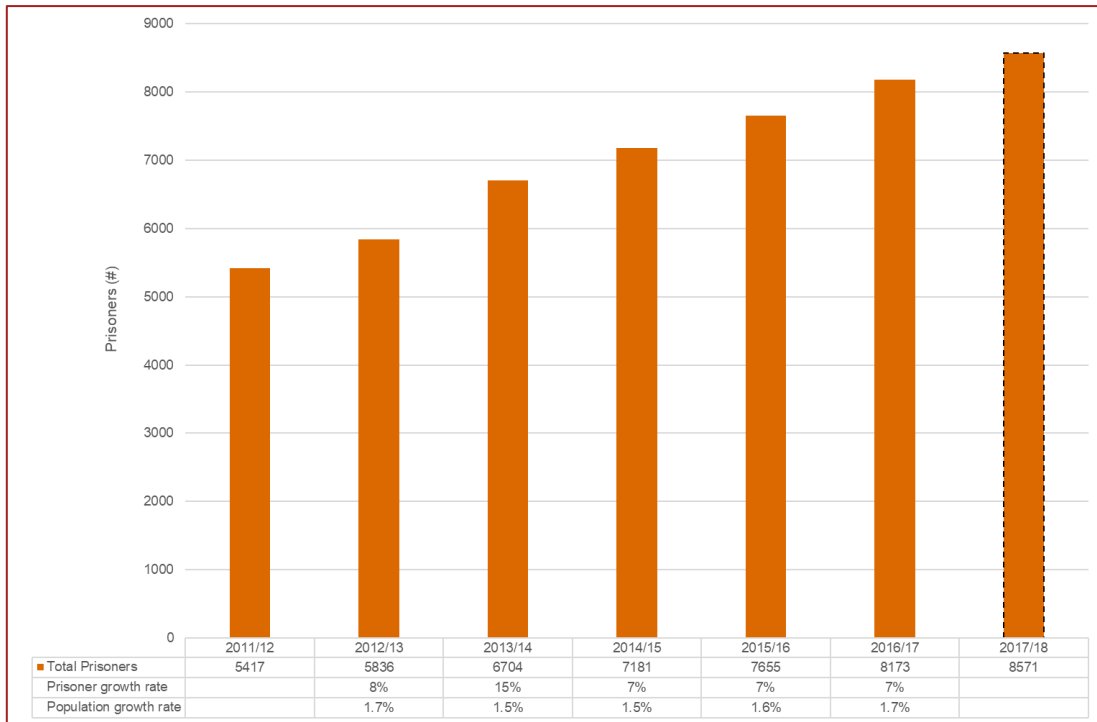


Figure 2 Queensland prisoner growth rate from 2011/12 to 2017/18^{18 19}

The prisoner population has for several years been growing faster than the National average population growth rate and the Queensland average population growth rate of 1.6 per cent per annum²⁰, as shown in Figure 2 and Figure 1. The majority of Queensland prisons are now exceeding their built cell capacity. In addition, due to relatively short sentences, the prisoner population turns over, on average, multiple times per year, as shown in Figure 3. Brisbane Correctional Centre, as the main reception centre in south east Queensland, has the highest annual turnover rate at close to 1,000 per cent.

Combined, prisoner population growth and turnover create challenges for the provision of health services within Queensland correctional centres, particularly since the majority of health centres within correctional centres have not been expanded to keep pace with the population growth.

¹⁸ Source: Prisoner number information was provided by QCS through the Department of Health. It included a count of prisoners at a correctional centre at the end of the last day of each month (for example, count of prisoners at 30 June 2017).

¹⁹ Source: Australian Bureau of Statistics (2018). *Australian Demographic Statistics, Dec 2017, 3101.0 Table 1*. Available at: <http://www.abs.gov.au/AUSSTATS/abs@.nsf/DetailsPage/3101.0Dec%202017?OpenDocument>.

²⁰ Source: Queensland Government Statistician’s Office (2018). *Population growth highlights and trends, Queensland, 2018 edition*. Available at: <http://www.qgso.qld.gov.au/products/reports/pop-growth-highlights-trends-qld/pop-growth-highlights-trends-qld-2018-edn.pdf>.

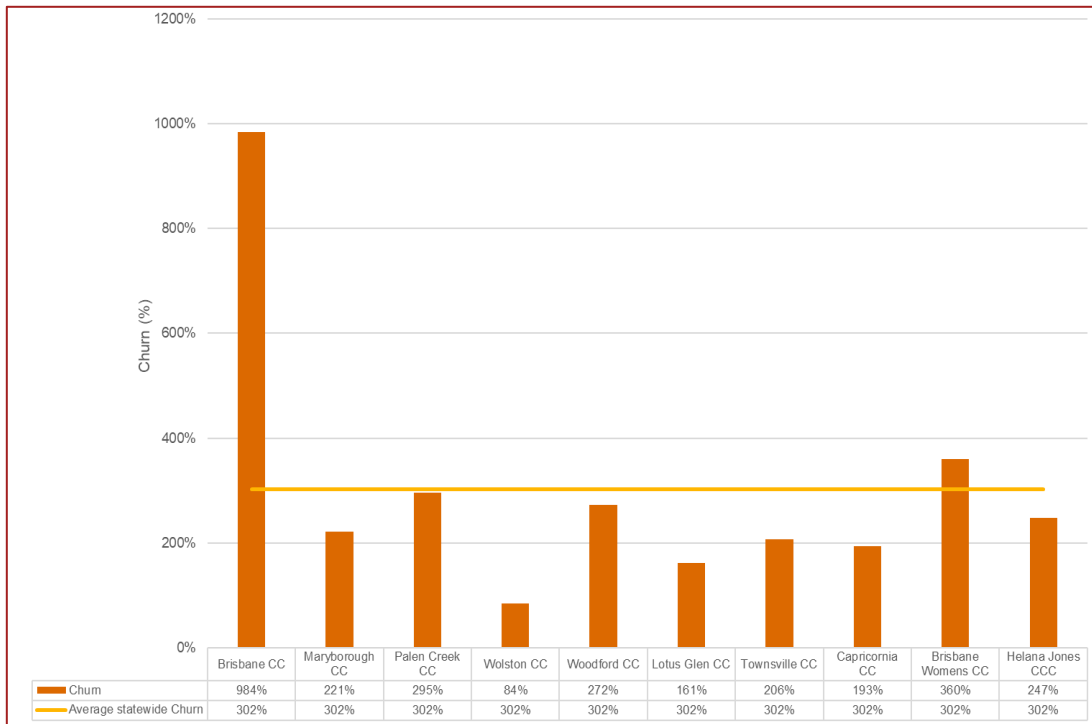


Figure 3 Queensland annual prison population turnover (financial year 2016/17) ²¹ ²² ²³

²¹ **Notes:** Total Queensland prison population turnover (churn) may be defined using (admissions)/(average population). ie,

$$Churn = \frac{(Admissions, aka first reception)}{(Average population)}$$

calculation excludes transfers in or change in status:

²² Source: Prisoner number information was provided by QCS through the Department of Health. It included a count of prisoners at a correctional centre at the end of the last day of each month (for example, count of prisoners at 30 June 2018).

²³ Turnover has not be calculated for Borallon Training and Correctional Centre. As the only correctional centre yet to meet built cell capacity and on track to grow, it is noted that the formula applied to other correctional centres does not apply accurately to BTCC.

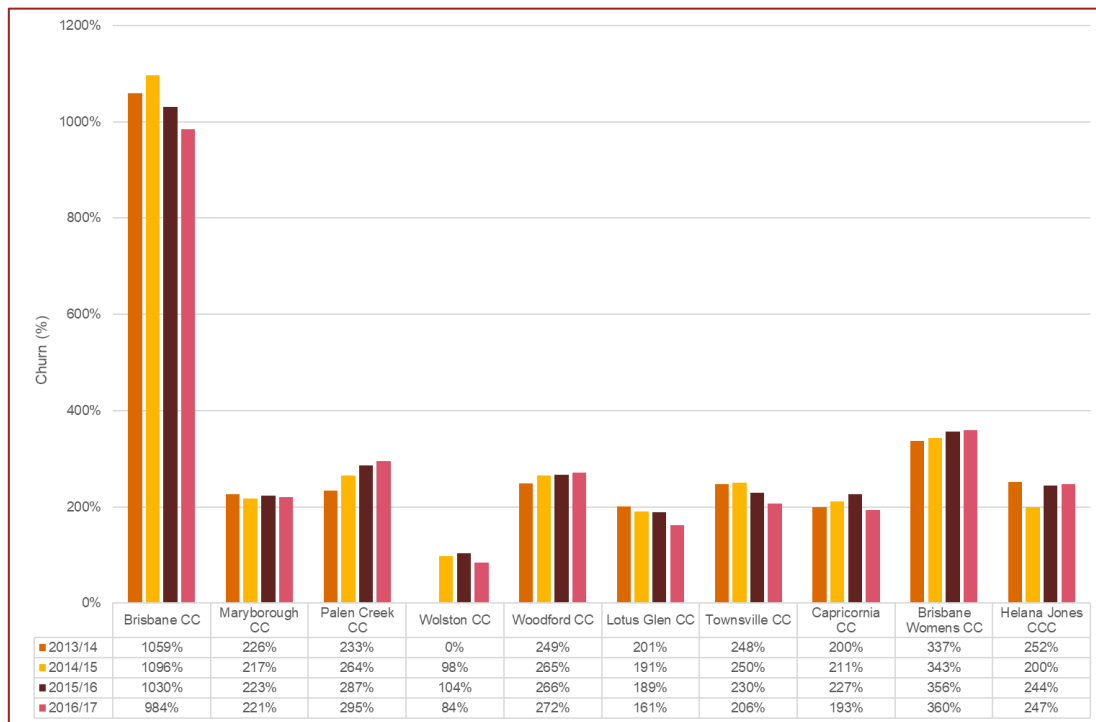


Figure 4 Queensland year-on-year annual prison population turnover, 2014-2017^{24 25}

2.2 Aboriginal and Torres Strait Islander prisoner population health needs

There are complex links between incarceration, social adversity and poor mental health for Indigenous people in Australia. According to published information, Aboriginal and Torres Strait Islander people represent 26 per cent of the custodial population in Victoria, despite comprising approximately three per cent of the Australian population.²⁶ In Queensland, Aboriginal and Torres Strait Islander people

“ Health [for Aboriginals and Torres Strait Islanders] does not just mean the physical well-being of the individual but refers to the social, emotional and cultural well-being of the whole community. This is a whole of life view and includes the cyclical concept of life-death-life. Health care services should strive to achieve the state where every individual can achieve their full potential as human beings and thus bring about the total well-being of their communities (National Aboriginal Community Controlled Health Organisation, 2018). ”

²⁴ Notes: Total Queensland prison population turnover (churn) may be defined using (admissions)/(average population). I.e, calculation excludes transfers in or change in status:

$$\text{Churn} = \frac{(\text{Admissions, aka first reception})}{(\text{Average population})}$$

²⁵ Source: Prisoner number information was provided by QCS through the Department of Health. It included a count of prisoners at a correctional centre at the end of the last day of each month (for example, count of prisoners at 30 June 2018).

²⁶ Victorian Aboriginal Community Controlled Health Organisation (2015). Keeping our mob healthy in and out of prison; Exploring Prison Health in Victoria to Improve Quality, Culturally Appropriate Health Care for Aboriginal People, Available at : <http://apo.org.au/node/54717>.

comprised 32 per cent of the prisoner population on average during 2017/18.²⁷

The prison health system presents an opportunity to mitigate the effects of harmful behaviours, improve Indigenous prisoners' health and wellbeing, and diagnose and treat health problems.²⁸ Improving prison health systems for Aboriginal people can also reduce high rates of post-release hospitalisation and mortality experienced by Aboriginal prisoners and improve quality of life.²⁹

Attending to the social and emotional wellbeing of Indigenous and non-Indigenous prisoners requires that staff within prison settings interact with prisoners as individuals who are simultaneously family and community members.^{30,31}

Compared to Aboriginal people in the community, rates of tobacco, alcohol, cannabis, methamphetamine, and pain killer use are higher among Aboriginal prisoners across all age groups³². Aboriginal prisoners self-report poorer health than non-Aboriginal prisoners and are less likely to have accessed healthcare outside prison, and are also more likely to have high blood sugar and diabetes, elevated liver-disease markers, asthma, and other illnesses.³³

Rates of blood borne viruses such as hepatitis B and C and sexually transmitted infections such as chlamydia, gonorrhoea, and syphilis are higher among Aboriginal and Torres Strait Islander people compared to non-Indigenous Australians.³⁴ A survey of needle-dispensing pharmacies in New South Wales found that Aboriginal people were much more likely to have been in prison in the last year than non-Aboriginal clients. They were also more likely to share injecting equipment and possessed less knowledge of the hepatitis C virus.³⁵ The prevalence of Hepatitis C is likely to increase among prisoners, with rates rising among Aboriginal people aged 20-29 years.³⁶

A recent report on the general health of Aboriginal inmates suggested that the prevalence of mental disorder among Indigenous inmates was high.³⁷ Similarly, the high rates of death by drug overdose and suicide, and of hospital admissions for severe mental illness in this group in the immediate post-release period, support this premise. Although previous studies have

²⁷ Information provided by Queensland Corrective Services.

²⁸ Ibid.

²⁹ Indig D, McEntyre E, Page J, Ross B (2009). NSW Inmate health survey: Aboriginal health report. Available at: http://www.justicehealth.nsw.gov.au/publications/Inmate_Health_Survey_Aboriginal_Health_Report.pdf; Commonwealth of Australia, Department of the Prime Minister and Cabinet (2018). Closing the Gap Prime Minister's Report.

³⁰ AIHW (2011). The health of Australia's prisoners 2010, Cat. no. PHE 149. Canberra: Australian Institute of Health and Welfare, Australian Government.

³¹ National Aboriginal Community Controlled Health Organisation (2017). 94 per cent of Indigenous inmates in the NT have significant hearing loss.

³² Victorian Aboriginal Community Controlled Health Organisation (2015). Keeping our mob healthy in and out of prison; Exploring Prison Health in Victoria to Improve Quality, Culturally Appropriate Health Care for Aboriginal People, Available at : <http://apo.org.au/node/54717>.

³³ Ibid.

³⁴ Treloar C, McCredie L, and Lloyd AR (2016) The Prison Economy of Needles and Syringes: What Opportunities Exist for Blood Borne Virus Risk Reduction When Prices Are so High? PLoS One, 119(e0162399). Available at: <https://doi.org/10.1371/journal.pone.0162399>.

³⁵ The Kirby Institute (2011). Bloodborne viral and sexually transmitted infections in Aboriginal and Torres Strait Islander people: Surveillance and Evaluation Report. Sydney: the University of New South Wales.

³⁶ Ibid 18, 19.

³⁷ Ibid 13.

pointed to a high prevalence of mental illness among Indigenous prisoners, many studies have been confounded by a lack of cultural sensitivity in the conceptualisation of mental illness and study design and implementation.³⁸

The findings from the Royal Commission into Aboriginal Deaths in Custody identified support for mental health and treatments for mental illness as priorities for Aboriginal and Torres Strait Islander people in custody and in the broader community.³⁹ In a study conducted by Heffernan, Anderson, Dev and Kinner, it was found that the 12 month mental illness prevalence among Aboriginal prisoners in Queensland was 73 per cent among males and 86 per cent among females.⁴⁰ This compares to 20 per cent among the general population and 41 per cent among non-Aboriginal prisoners.⁴¹ Substance use and affective disorders were the most prevalent form of mental illness, with rates of substance misuse 13 times greater among males and 14 times among females when compared to the general population.⁴²

For mental health services for Indigenous people to be effective, they must be culturally capable, and accessible both in custody and in the community, with a focus on enabling continuity of care between the two. Such services can only be achieved through appropriate resourcing and stewardship. Their development is not only supported based on public health considerations, it is also supported based on human rights considerations. While the marked over-representation of Indigenous people in Australian prisons remains a significant concern, prisons provide an opportunity to provide health care for a population who under-access health care in the community. Access to appropriate treatment may help prevent the “revolving door” of incarceration.⁴³

High rates of illness have post-release implications, with higher rates of recidivism and criminal activity associated with prisoners that have any type of health condition (physical, mental or substance abuse).⁴⁴ Prisoners are also more likely to be hospitalised after they are released from prison, with more than one in five Aboriginal prisoners in Western Australia hospitalised at least once within 12 months of their release.⁴⁵ Almost one-third of female Aboriginal prisoners were hospitalised in that period, with mental and behavioural disorders the second most common reason for hospitalisation.⁴⁶

³⁸ Heffernan et. al (2012). Prevalence of mental illness among Aboriginal and Torres Strait Islander people in Queensland prisons. *MJA* 197 (1). doi: 10.5694/mja11.11352.

³⁹ Royal Commission into Aboriginal Deaths in Custody (1991) Final report of the Royal Commission into Aboriginal Deaths in custody, Canberra.

⁴⁰ Ibid.

⁴¹ Ibid.

⁴² Ibid.

⁴³ Ibid.

⁴⁴ Ibid.

⁴⁵ Ibid.

⁴⁶ Ibid.

2.3 Consumer consultation – Conducted by Health Consumers Queensland

As a peak organisation representing the interests of health consumers and carers in the state, Health Consumers Queensland (HCQ) was contracted by the Queensland DoH to conduct consumer consultation in conjunction with the overall Offender Health Services Review. The below summary of HCQ's findings is presented here with permission from HCQ and DoH.

The purpose of the HCQ consumer consultation was to hear directly from patients and consumers of Offender Health services. QCS organised with their facility management for HCQ to visit various correctional centres to enable direct consultation with Prisoner Advisory Committees (PACs).

The purpose of each PAC is to:

- provide opportunities for prisoners to raise matters of concern with facility management in relation to policy or operational issues
- promote prisoner ideas to improve the quality of daily living within the facility for both prisoners and visitors
- act as a channel of communication between prisoners, management and staff and promote positive interaction
- provide a forum to facilitate prisoner recommendations for changes to operations or routines
- assist in reducing conflict
- assist in the development and or implementation of policy initiatives for the facility where appropriate.

HCQ's consultation focused on:

- hearing the 'consumer' voice as part of the Offender Health Services Review
- gaining a first-hand understanding of what and how health services are provided by HHSs and the consumers' understanding and expectations of those services
- what the consumers considered to be working well, working not so well, and what changes and improvements could be made to current health service provision.

HCQ consulted with PACs at a number of correctional centres across Queensland. Throughout these consultations, many patients commented that staff were mostly there to do the right thing, with the realisation that in some correctional centres, the staff are under-resourced and are at time 'beaten by the system'. There was also acknowledgement that there are good nurses who listen and are approachable, and are non-judgmental when a prisoner makes a request. Across all correctional centres, and BWCC in particular, there was recognition that good nurses are over-loaded and overworked.

Other issues identified were the lack of culturally appropriate healthcare, and the impact of low literacy levels on the ability of some prisoners to seek care.

From these consultation sessions, five core themes emerged regarding the current provision of health services within correctional centres:

1. Communication and culture:
 - a. Attitude of Medical Centre staff (ie rude, disrespectful and dismissive of patients' complaints).
 - b. No professional relationship creates issues with continuity of care.
 - c. Relationship between Medical Centre staff and QCS staff prevents access to care.
2. Medical requests – Access to health services, and responses to requests:
 - a. Lack of communication and feedback from health centre staff regarding their request for health care.
 - b. Resorting to self-harm to get attention from health centre staff.
 - c. Barriers to filling in medical request forms due to limited writing skills.
 - d. Confidentiality issues when requesting assistance.
3. Medication management – prescription practices and administration
 - a. Ceasing medications without any consultation, particularly when these were prescribed by a doctor outside the offender health service.
 - b. Difficulty in getting Panadol or Nurofen to deal with pain, as only made available through medication rounds.
 - c. Timing of receiving medications (ie having to choose between gym or medication), or not receiving if there is a lock-down or incident.
4. Oral health care – Access and treatment options:
 - a. Long wait times which cause aggression issues for inmates and corrections staff.
 - b. No medication provided as prisoners await appointments.
 - c. Dental hygiene equipment not readily provided (eg dental floss).
 - d. Care provided only if sentence longer than a certain period.
5. Mental health care – Access and treatment options:
 - a. Impact of overcrowding and impact on mental health (ie showering in front of an unknown person).
 - b. Access to services requires the completion of the medical request form, which places them at risk being sent to the observation unit.
 - c. Concerns not taken seriously by Corrections Officers.
 - d. Lack of continuity of mental health care or counselling.

During consultation, PAC members were asked for suggestions and solutions to improve health care provision. These included:

- Return the slip on the medical request form with details of appointment date and time or if not being seen
- Being seen when it's needed
- Access to healthy or diet foods to support better health outcomes.
- More healthy food options on buy-up
- Better triaging of appointments
- The opportunity to access external private health care for those with private health insurance
- An increase in telehealth may reduce some access issues
- More medical centre staff to deal with increased numbers in correctional centres
- Access to 24-hour health care
- Improved attitude of doctors and nurses
- Not all be considered as 'drug-seekers'
- More compassion from health centre staff
- Not dismiss everyone with 'drink more water' or with breathing exercises
- Need better treatment programs or education
- Provide access or better access to physiotherapists, chiropractors, podiatry and optometry
- Extension of the opioid substitution therapy program.
- Provide an explanation or education on why prescription medication has been denied or ceased
- Opportunity for second opinion by another doctor when medication is refused
- Being given correct medication
- Provide wellness programs to help reduce anxiety and stress – yoga, meditation and boxercise
- More access to pathways out and pre-release programs.

2.4 Patient journey mapping

The purpose of the following patient journeys is to provide a perspective of the provision of health services that patients could encounter, and the flow of health-related information as a patient moves from the community to the corrections system. These patients are indicative of certain demographics within the correctional services environment.

The patient journey persona 'Jessica' has been developed through a workshop with former female inmates of Queensland correctional centres as a component of the consultation phase of the review. The feelings and thoughts of the persona were assembled from the perspectives of the workshop participants.

Attempts were made during the course of the review to engage male prisoners for similar focus groups; however, attempts proved unsuccessful due to non-attendance.

Further exploration was undertaken to create an information flow journey that could be encountered by a male prisoner 'Billy', in conjunction with Queensland Health project members.

PwC would like to extend our thanks to both Health Consumers Queensland, the Queensland Probation and Parole Office and Sisters Inside for their support in organising the patient focus groups.

2.4.1 Patient journey: Jessica

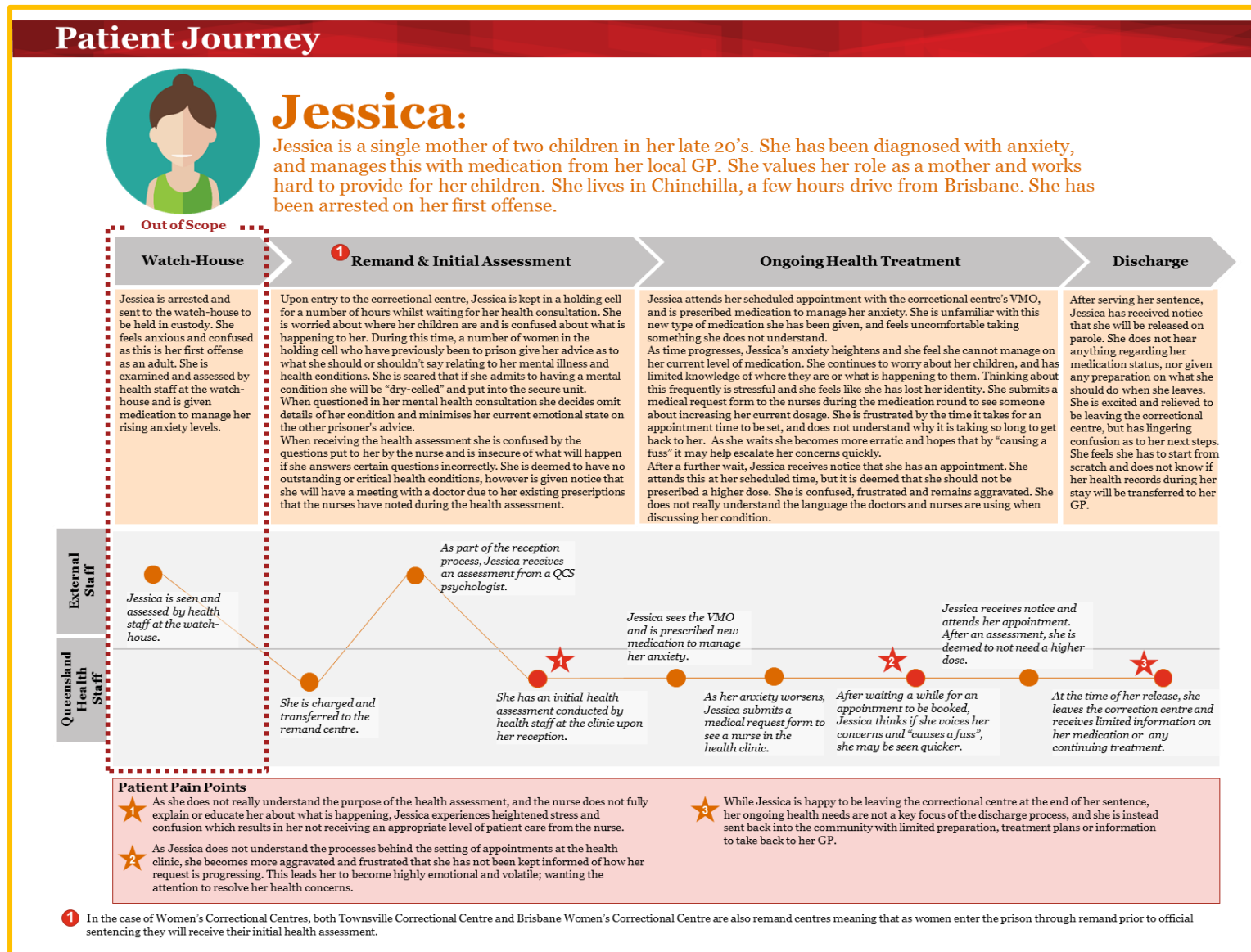


Figure 5 Patient journey

2.4.2 Information journey: Billy

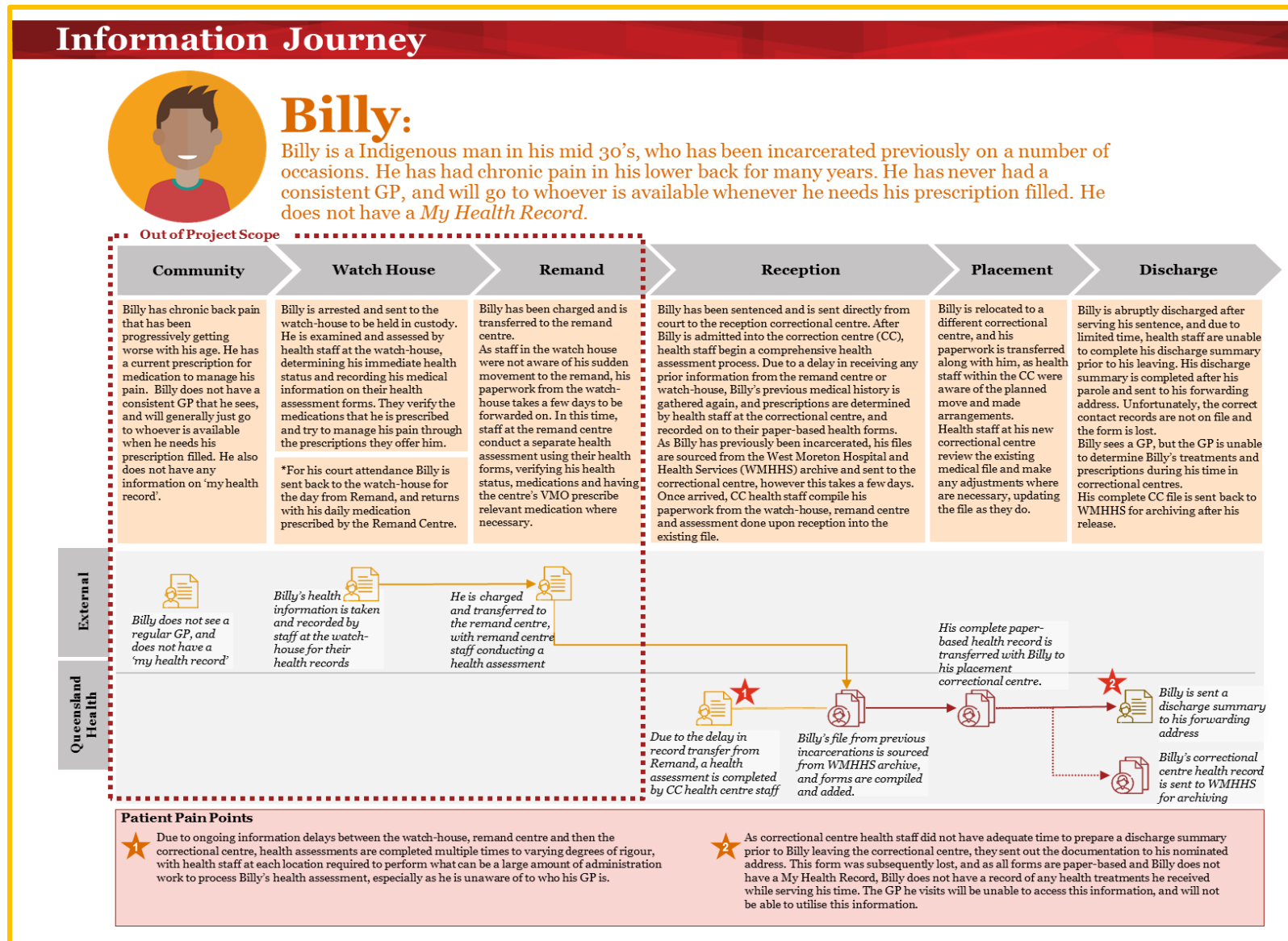


Figure 6 Information journey

Department of Health, Clinical Excellence Division

PwC

3 Summary of the literature and information review

3.1 Context

The literature and information review was the first deliverable of the offender health services review project. It focused on a review of the governance and service delivery arrangements of offender health in five jurisdictions agreed with CED: New South Wales, Victoria, England, Canada and Norway. The aim of literature and information review was to provide a baseline of information regarding alternative ways to structure, govern and deliver offender health services, which informed the information sought through consultation with Queensland offender health services, as well as possible recommendations for new approaches, where relevant and appropriate.⁴⁷

3.2 Background

In Australia and other jurisdictions, prisoner numbers are growing more rapidly than built capacity of prisons. In addition, prisoners have complex health needs, described briefly below. This combination of volume and a high level of health needs drive demand for health care services for prisoners, and contribute to the complexity of delivering such services. In such a situation, strong governance and efficient and effective service delivery approaches are vital to ensure sustainability, safety and quality of services.

“ In Australia and other jurisdictions, prisoner numbers are growing more rapidly than built capacity of prisons, with increasing complexity of health needs. This combination of volume and a high level of health needs drive demand for health care services for prisoners, and contribute to the complexity of delivering such services. ”

It is widely accepted that prisoners have greater health needs than others in the general population, and that health services made available during incarceration provide a unique opportunity for health intervention.⁴⁸ Amongst the population of prisoners worldwide, there is a significantly higher prevalence of mental health disorders, alcohol consumption, illicit drug use, and communicable and chronic diseases than the general population. A generally low utilisation rate of health care prior to incarceration means that many prisoners present with significant and complex health needs, such that they are often considered to be geriatric at the age of 50-55 rather than the usual age of 65.⁴⁹ Social determinants such as lower educational attainment, high unemployment, homelessness and a range of cognitive impairments also contribute to a prisoner’s complex health needs.

⁴⁷ The material in this chapter was presented to the Offender Health Services Steering Committee Alliance (OHSSCA) on 17 May 2018.

⁴⁸ Australian Institute of Health and Welfare (2015). The health of Australia’s prisoners. Canberra, ACT. Available at: <https://www.aihw.gov.au/reports/prisoners/health-of-australias-prisoners-2015/contents/table-of-contents>.

⁴⁹ Williams, B. A., et al. (2012). "Addressing the Aging Crisis in U.S. Criminal Justice Health Care." *Journal of the American Geriatrics Society* 60(6): 1150-1156.

Prisoner numbers continue to rise around in the world.⁵⁰ In Australia, there were 41,202 full time inmates (sentenced and un-sentenced) in prisons as of 30 June 2017.⁵¹ Between 2016 and 2017, the national imprisonment rate increased by 4 per cent from 208 to 216 prisoners per 100,000 adult population.⁵² Queensland’s imprisonment rate exceeds the national rate, climbing from 169.4 per 100,000 in June 2013, to 222.8 in June 2017; an increase of 32 per cent over four years (Figure 1).⁵³ In that same period, Victoria’s imprisonment rate grew by only 12 per cent.⁵⁴ As at 30 June 2017 there were 8,476 prisoners in Queensland prisons; just shy of a 40 per cent increase in absolute numbers compared to 2013.⁵⁵

There is a complex relationship between police, the justice system, social services policy settings at a state and national level, and the incarceration rate and prisoner numbers. The increase in rate and absolute number of prisoners since 2013 has caused prison overcrowding and required “doubling up” of accommodation, where more prisoners are housed per unit than the units were designed to accommodate. Anecdotally, Queensland Corrective Services is implementing a number of strategies to manage overcrowding, including increased use of lock-downs and staggered unlocks (where only a portion of prisoners are released from their cells at one time, commensurate with resourcing levels of correctional officers in the prison). Although necessary to maintain security and order in the prisons, the use of such strategies can impact on the ability for prisoners to access and receive health services, such as dosing of medications at required time points during the day or evening.

3.3 Governance of offender health

The United Nations Commission on Crime Prevention and Criminal Justice on 22 May 2015 adopted updated standard minimum rules on the treatment of prisoners, known as the ‘Mandela Rules’.⁵⁶ This update to the original 1955 rules details the provision of health care to prisoners, and includes principles of equivalence (to the community standard); independence; multidisciplinary care including psychological and psychiatric, and dental; and continuity of care back to the community upon release from prison.

A section of the Mandela Rules deals specifically with health care services for prisoners. A selection of relevant rules are quoted below:⁵⁷

Rule 24.1: prisoners should enjoy the same standards of health care that are available in the community

Rule 24.2: health care services should be organised in close relationship to the general public health administration and in a way that ensures continuity of treatment and care

Rule 25.2: the health care service shall ... encompass sufficient expertise in psychology and psychiatry, and the services of a qualified dentist shall be available to every prisoner.

⁵⁰ Roy Walmsley (2016). World Prison Population List, World Prison Brief. Available at: http://www.prisonstudies.org/sites/default/files/resources/downloads/world_prison_population_list_11th_edition_o.pdf.

⁵¹ Australian Bureau of Statistics (2017). Prisoners in Australia, 2017. Canberra, ACT.

⁵² Ibid.

⁵³ Queensland Government Statistician’s Office (2017). Prisoners in Queensland: 2017. Brisbane, QLD., Queensland Government Statistician’s Office (2014). Prisoners in Queensland: 2014. Brisbane, QLD.

⁵⁴ Australian Bureau of Statistics (2017). Prisoners in Australia, 2017. Canberra, ACT.

⁵⁵ Queensland Government Statistician’s Office (2017). Prisoners in Queensland, 2017; Queensland Government Statistician’s Office (2014). Prisoners in Queensland: 2014.

⁵⁶ Justice Section, Division for Operations (2015). The United Nations Standard Minimum Rules for the Treatment of Prisoners (the Nelson Mandela Rules). United Nations Office on Drugs and Crime. Vienna, Austria.

⁵⁷ Ibid.

Rule 26.2: medical files shall be transferred to the health care service of the receiving institution upon transfer of a prisoner and shall be subject to medical confidentiality.

Rule 27.2: clinical decisions may only be taken by the responsible health care professionals and may not be overruled or ignored by non-medical prison staff.

Rule 46: health care personnel shall not have any role in the imposition of disciplinary sanctions or other restrictive measures.

In Australia, health services in the general community are provided through both the federal government and the relevant state or territory government. However, health services for prisoners are the responsibility of state and territory governments only, and hence the agency responsible for these services varies from state to state. Throughout both Australia and overseas, the agency tasked with the delivery and/or governance of offender health services is generally either the Department of Health, or the Department of Justice or Corrections.

Despite international leading practice suggesting that delivery and governance of offender health services should reside within departments responsible for health,⁵⁸ only a minority of jurisdictions worldwide have enacted such an approach. Australia performs well in this regard, with all states and territories except Victoria currently having responsibility for the delivery and/or governance of offender health services overseen by the Department of Health, or in the process of enacting such arrangements (Western Australia).

Governance of offender health by the health department helps to ensure that the two interrelated principles of equivalence of care to the community standards and integration of services into general health policies and systems are implemented. Importantly, it also helps to ensure that clinicians are able to work with clinical independence and autonomy, avoiding conflicts of interest that may arise (or be perceived to arise) if clinicians are employed by Corrections departments. This separation is also likely to be beneficial for the establishment and maintenance of therapeutic relationships, enabling clinicians to advocate for the needs of their patients. Despite describing this approach as best practice, these guiding principles must be viewed in the context of each jurisdiction's health and correctional system. This issue is not as relevant to the Queensland context, given that offender health services already sit with the Department of Health.

Five jurisdictions were agreed with CED for review in this document; New South Wales, Victoria, England, Canada and Norway.

Of the five jurisdictions reviewed, governance for offender health services is the domain of the Department of Health, or an independent statutory body, which reports to the Department of Health in three of five cases, as shown in Figure 7 below.

⁵⁸ World Health Organisation (2013). Good governance for prison health in the 21st century. A policy brief on the organization of prison health. Copenhagen, Denmark.

DEPARTMENT OF JUSTICE/CORRECTIONS	DEPARTMENT OF HEALTH	
	Within Dept of Health	Oversight by Dept of Health
Victoria: Department of Justice and Regulation Canada (federal): Correctional Services Canada	Norway: Ministry of Health and Care Services	New South Wales: Justice Health & Forensic Mental Health Network England: NHS England Health and Justice

Figure 7 Jurisdictions analysed in the Literature & Information Review

Notably, regardless of the agency with ultimate accountability for offender health, every jurisdiction examined (with the possible exception of Norway⁵⁹) had a single, jurisdiction-wide position, team or entity (such as a Board) with accountability for offender health services for the entirety of the jurisdiction.

3.3.1 New South Wales

Justice Health & Forensic Mental Health Network (JH&FMHN) is a state-wide, board-governed Specialty Health Network responsible for the delivery of care to adults and young people in contact with the forensic mental health and criminal justice systems. It is led by a Chief Executive, who reports to the Board and to the Secretary of NSW Health. JH&FMHN sets the policy and standards for all health services, as well as delivering the services. As such, the JH&FMHN Board provides a centralised point of governance over services provided internally by the network.

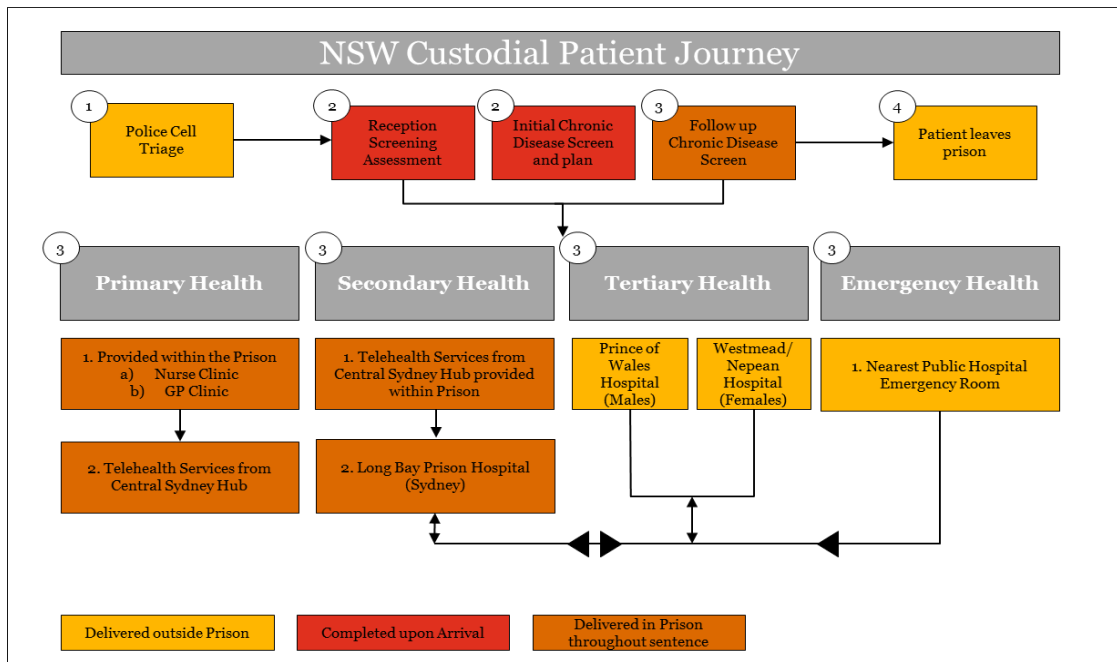


Figure 8 NSW custodial patient journey

⁵⁹ Norway’s arrangements were difficult to determine because little information was available in English, and translations using online tools were not always straightforward to interpret.

3.3.2 Victoria

The Victorian Department of Justice and Regulation is accountable for both corrective services and offender health services in Victoria. The Department is organised into four divisions. Both Corrections and Justice Health are separate business units within the Policy and Programs division. All health services are provided by contracted service providers; hence, Justice Health’s main duty is contract managing the health service providers in all public prisons. Corrections is responsible for contract-managing the prison operator for three private prisons, with health services sub-contracted by the prison operator. However, Justice Health sets the policy and standards for health care in all prisons, and audits all prisons against these policies and standards, which are described in the Justice Health Quality Framework. As such, Justice Health provides a centralised point of governance over services provided externally by private contractors.

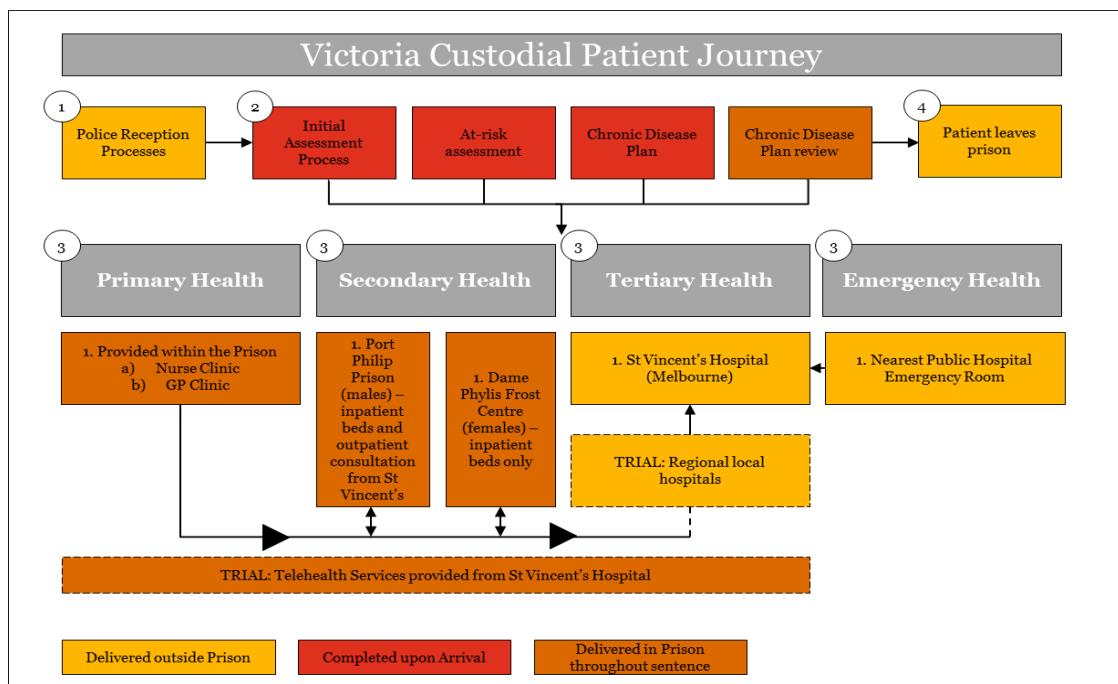


Figure 9 Victorian custodial patient journey

3.3.3 England

National Health Service (NHS) England (formerly the NHS Commissioning Board) is an independent statutory authority which commissions the majority of healthcare services in England. NHS England Health & Justice is responsible for the commissioning of healthcare for children, young people and adults across secure and detained settings, which includes prisons. Services are commissioned via 10 Health and Justice teams across four regions (North, Midlands, London and South). As such, NHS Health & Justice provides a centralised point of governance over services provided externally by private contractors.

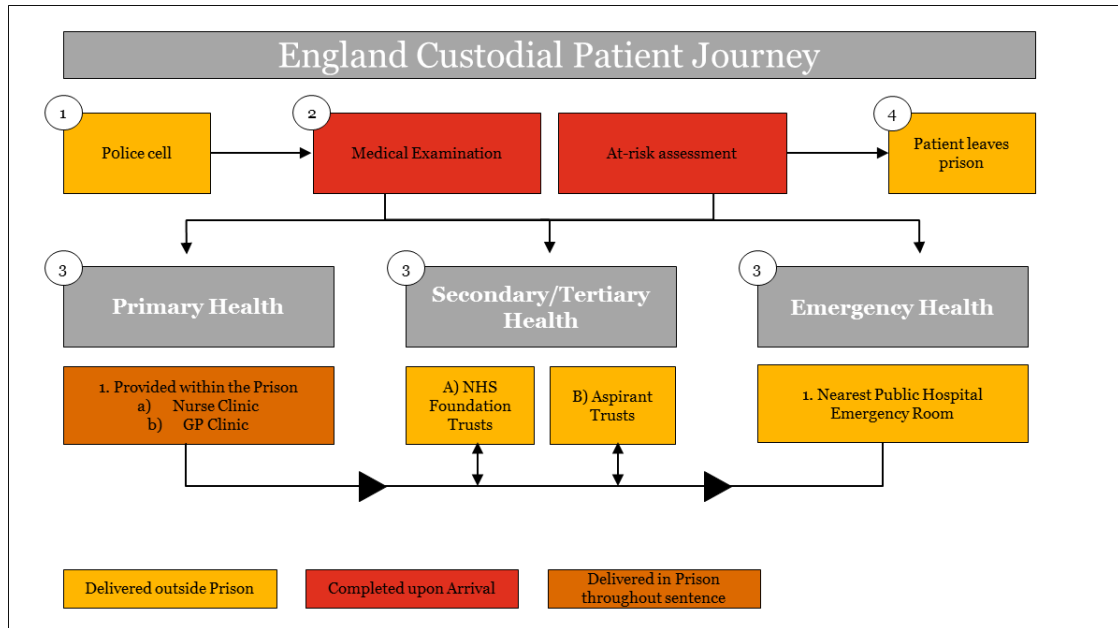


Figure 10 English custodial patient journey

3.3.4 Canada

In Canada, prisoners sentenced to two years or more are sent to a federal facility operated by the federal agency, Correctional Service Canada (CSC). Offender health services are led by an Assistant Commissioner of Health Services, who reports to the CSC Commissioner. The overall planning and policy development is conducted by the Clinical Services Branch, the Public Health Branch, and the Mental Health Branch, in line with CSC’s mandate to provide clinical, public health and mental health services to all prisoners. Each branch is located at CSC’s National Headquarters, with a Regional Director of Offender Health Services located in each of CSC’s five administrative regions. As such, CSC provides a centralised point of governance over services provided internally by the agency.

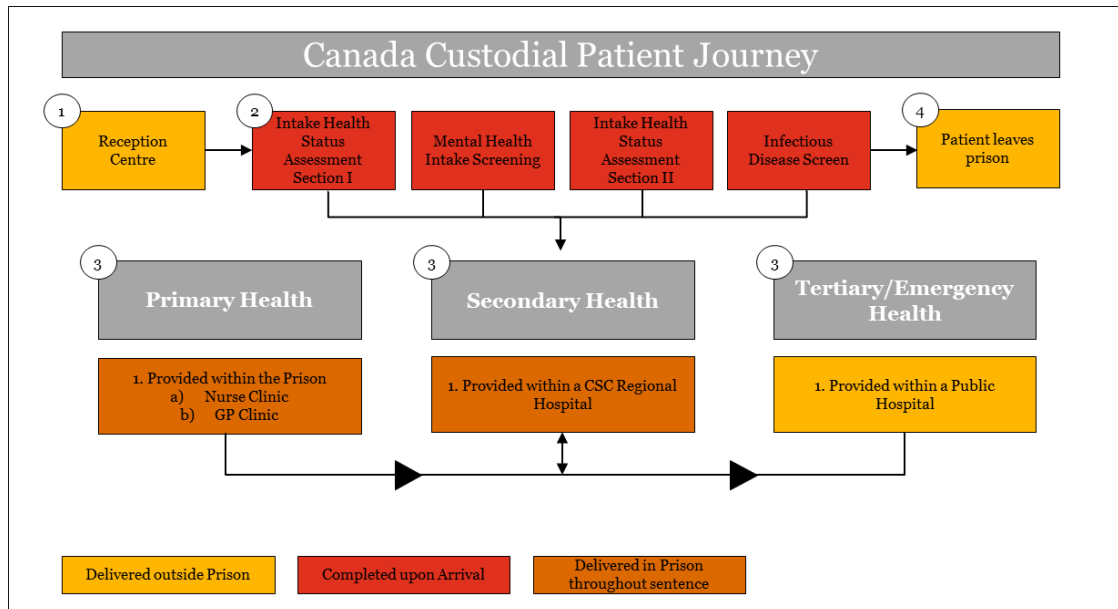


Figure 11 Canadian custodial patient journey

3.3.5 Norway

Norway was one of the first countries to transfer health services to the Ministry of Health and Care Services in 1987. Given Norway’s philosophy that imprisonment should comprise

“deprivation of liberty and nothing else”, Norway has adopted the ‘import model’, whereby services are imported from the Ministry of Health and Care Services and provided in prisons. As such, the Ministry of Health and Care Services provides a centralised point of governance over services provided internally by health agencies.

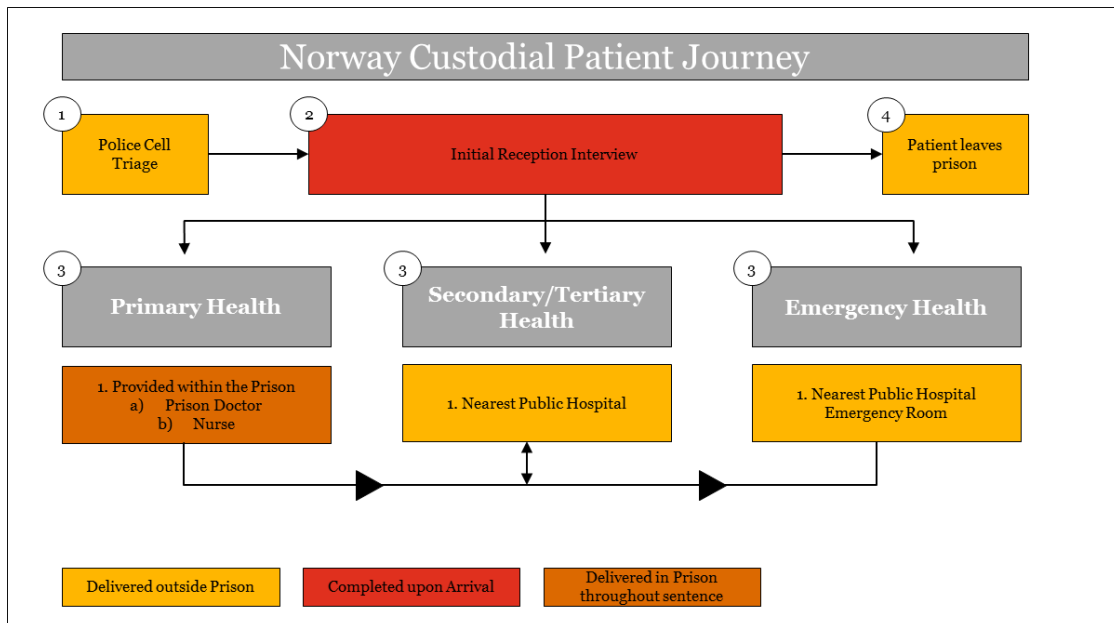


Figure 12 Norwegian custodial patient journey

3.4 Performance management

As described above, all jurisdictions analysed provide a centralised point of governance over services that are predominantly provided internally by the same agency, or externally by contracted private health service providers. Despite all providing centralised governance, jurisdictions analysed have various approaches to managing performance of the services delivered, with the Australian jurisdictions being an exemplar of this.

3.4.1 New South Wales

In NSW, the delivery of services are dictated by a Service Agreement between the Secretary NSW Health and the Chief Executive JH&FMHN. The Service Agreement lists a number of KPIs under seven strategies (eg keeping people healthy, providing world class clinical care, etc). These strategies are identical to Service Agreements entered into between the Secretary NSW and other Local Health Districts. However, the KPIs under the strategies are tailored to JH&FMHN (eg targets for treating Hepatitis C). As such, the KPIs are shaped by activities JH&FMHN can do to link in with the overall objectives of the Ministry of Health.

3.4.2 Victoria

Justice Health has developed a Quality Framework which applies to both publicly and privately operated prisons (all of which have health services delivered by contracted providers). The Quality Framework articulates the standards to which care must be provided, and the systems and some measures by which those standards are monitored and improved. Additional, there are three Commissioner’s Requirements that relate specifically to the delivery of health services in all prisons, including conducting an initial health assessment within 24 hours, identification of at-risk patient and follow-up appointment within 2 hours, and the creation of chronic healthcare plan within 29 days. The Quality Framework is not available in the public domain, nor are any reported performance outcomes against the Quality Framework or the Commissioner’s Requirements. However, the requirements in the Quality Framework and the Commissioner’s Requirements act as KPIs for the health service providers.

3.4.3 International jurisdictions

In comparison to NSW and Victoria, international jurisdictions do not provide as much information regarding prison health service performance in the public domain. Performance management in Canada is limited, with Correctional Services Canada only having a small number of performance measurements that relate to health services. These are articulated in the CSC Report on Plans and Priorities, a yearly report presented to parliament which outlines CSC's yearly goals. For 2016-17, there were only six specific KPIs relating to offender health for 2016-17, mainly around staff training and Hepatitis C and HIV treatment. No performance measurements were able to be found for Norway or England, which are specific to offender health services. Given that no jurisdiction was found to publicly disclose their performance against these performance indicators, it was not possible to form a view of the effectiveness of the various approaches.

3.5 Clinical governance

In most jurisdictions, there also exists a centralised point for the oversight of clinical governance in prisons.

3.5.1 New South Wales and Victoria

In JH&FMHN in NSW, clinical governance sits with the Executive Director of Corporate and Clinical Governance, and is supported by a Clinical Governance Committee, who reports to the Quality Council Board subcommittee. There also exists a single point of clinical governance oversight in Justice Health in Victoria, with the Justice Health Clinical Advisory Committee providing advice in relation to clinical best practice.

3.5.2 International jurisdictions

Canada does not have an internal centralised point for oversight of clinical governance; rather, all health services are accredited each year by Accreditation Canada, an independent non-government organisation. Despite the requirement to be accredited, CSC has recognised the need to strengthen its clinical governance framework. To this end, CSC has formed a National Medical Advisory Committee in 2018, to bring the voice of clinical practice to policy development and clinical oversight. Similarly in England, the Care Quality Commission is an independent regulator of health and care services in England, and inspects and regulates all health services in prisons. Norway's clinical governance model is based on all counties, municipalities and Regional Health Authorities that provide offender health services having mandatory internal control systems, with oversight provided by the Board of Health Supervision. Alert systems ensure that hospitals inform the board of serious adverse events, and the board may then decide to investigate particular incidents. Local audits of prison health providers are performed by County Governors, who report to the Board of Health Supervision.

3.6 Complaints

All jurisdictions reviewed have procedures in place to lodge complaints, with the differentiating factor being whether the complaint mechanism is to a health related agency, or to a general government agency. In Victoria, NSW and England, a local resolution is encouraged in the first instance. Consultation suggested that complaint agencies will generally push the complaint back down to the prison, if no attempts have been made to resolve at the prison level in the first instance. All three jurisdictions have a specific health complaint pathway where required, being the Health Care Complaints Commission in NSW, the Office of the Health Services Commission in Victoria, and the NHS Customer Contact Centre Complains Service in England.

In comparison, prisoners in Canada do not have a specific health avenue for health complaints, with all prisoner complaints being directed to the Office of the Correctional Investigator of Canada. The lack of a dedicated health complaint avenue and minimal triaging means health complaints may not be prioritised above non-serious, non-health related complaints. Similarly in Norway, complaints are made to the County Governor, who

is the government's representative in the country. The Governor is responsible for liaising with the Norwegian Public Health Authority, who has overall responsibility for health complaints.

3.6.1 Incident reporting

NSW was the only jurisdiction with an incident management policy available in the public domain. Reportable Incident Briefs (RIB) are required for all SAC 1 incidents (Severity Assessment Code), and some SAC level 2 and 3 incidents at the discretion of the Chief Executive, including incidents that may attract media attention. SAC 1 incidents include any unexpected deaths in custody (suicide or homicide), with SAC 2 incidents including events that present opportunities to improve clinical care and may be similar to SAC 1 events, but do not result in death. All RIBs must be approved by the Chief Executive prior to submission to the NSW Ministry of Health, which must be submitted within 24 hours of the notification of the incident in the Information Incident Management System.

3.7 Service delivery

Generally, offender health services delivered within prisons take the form of a nurse-led, primary health care model, with Norway being the exception of a medical practitioner-led model among jurisdictions examined in this review. Each jurisdiction has arrangements in place to transfer prisoners to hospitals for emergency and planned specialist care as required. Prisoners are generally subject to similar waiting times for access to public specialist services as non-prisoners.

3.7.1 Primary health model of care

Most jurisdictions have adopted a nurse-led model of care, with part time medical staff providing consultations in routine clinic sessions. These services are provided in a prison clinic. Access to primary care services are generally via self-referral, or through scheduled reviews. In the Victorian women's prison, nursing staff is available 24 hours a day, seven days a week, with a general practitioner employed to work 10am-6pm on weekdays, and 10am-3pm on Saturdays. High priority cases will be seen within one week, medium priority cases within one month, and low priority case will be allocated to next available appointment. In NSW, only five out of forty-two prisons have 24 hour nursing services, with all other prisons having on-call nursing staff outside of normal working hours.

3.7.2 Initial assessment

All jurisdictions were found to have a mandated initial health assessment process, with a number of jurisdictions having specific KPIs for conducting assessments. NSW has a standardised clinical screening and assessment process which cannot be alerted at a local level, ensuring that identification, management and review of patients is kept consistent across the state. This issue seems to be relevant in England's assessment process, which does not have a standardised screening and assessment process, but a set of guidelines which can be tailored by the individual service provider.

Canada's assessment process includes a 24-hour health assessment, a 14-day health assessment, a 14-day infectious disease screen, and a computerised mental health intake assessment. A 2017 review of these processes found that the assessment tools were effective in identifying offender health needs; however, duplication of offender health information collected through the intake assessment process resulted in inefficiencies and duplication of information and follow-up bookings.

3.7.3 Secondary/Tertiary health

Secondary services are generally provided either in an inpatient service provided at a prison, or a specific prison hospital, with all tertiary services provided in designated hospitals, some with secure units.

In Victoria, St Vincent's Correctional Health Services provides state-wide secondary inpatient prison bed-based services through the St John's ward within Port Philip Prison

(male prison). The St Thomas's ward, also within Port Philip Prison, provides access to specialist outpatient services, including clinics provided by attending specialists from St Vincent's Hospital in Melbourne. There are similar services available at Dame Phyllis Frost Centre (female prison). Tertiary health services are provided in the St Augustine's ward at St Vincent's Hospital in Melbourne for both male and female prisoners, where there is a 10-bed maximum security inpatient unit. However, patients will be admitted to a ward with general members of the community if they require specialist care. Justice Health is trialing sending patients to local regional hospitals for emergency care, instead of being transported to St Vincent's in Melbourne.

Similarly in NSW, the Long Bay Prison Hospital in Sydney provides the majority of secondary health services, and includes an Aged Care and Rehabilitation unit, a Medical Subacute Unit, and a Mental Health unit. It provides 24-hour nursing service, 7 days a week. Hospital Area 1 has one ward dedicated to medical cases, and three others for short and long term psychiatric cases. Hospital Area 2 houses both transient medical inmates who are being assessed or have been cleared from medical appointments. For any specialist or tertiary care, prisoners are taken to a secure unit within the Prince of Wales Hospital. For any emergencies, patients will be taken to the nearest emergency department, and transferred to the Prince of Wales Hospital Secure Unit or the Medical Subacute Unit at the Long Bay Hospital when stable.

In Canada, Secondary care is generally provided in a Correctional Service Canada Regional Hospital. Each of CSC's five administrative regions will have one hospital located within the compound of a multilevel or maximum security level prison, which provides specialised or comprehensive health care services on a 24-hour basis. This can include postoperative care, trauma care, observation, dialysis, palliative care, and any condition requiring 24-hour nursing services. Prisoners will be treated in the community (that is, regular hospitals) for emergency services, specialised health care services and for hospitalisation that cannot be accommodated in CSC's Regional Hospitals. In Norway, secondary services are provided at a Polyclinic located within the hospital, with any tertiary care provided within the hospital.

3.7.4 Service innovations – Medication management

Examples of service innovations have been identified through literature and consultation. Generally, the aim of such improvements appears to be to improve efficiency, particularly in reducing nursing resource requirements, and reducing the need for transfers to hospital, as described below.

Some form of self-medication management programs exist across all jurisdictions reviewed. In England, self-medication is the normal position unless there are clearly identifiable factors as to why this should not be the case. Consultation suggested that self-management of medication is also used in some prisons in Victoria, including use of pharmacy technicians and corrections staff to provide pre-packaged medication to suitable prisoners when nursing staff are not available. Methadone, schedule 8 drugs,⁶⁰ and any other drugs deemed divertible, are only administered by nurses. A report by the Victorian Ombudsman notes that pre-packaged medication was trialed in the women's prison in early 2017, but was discontinued by prison management after 'incidents', which were not described.⁶¹

In Canada, prisoners are able to receive several weeks' worth of medication in a blister pack. Otherwise, prisoners present to the window/gate during medication parade/clinic, but only if their name is on the 'Inmate medication attendance list daily'. However, due to a high incidence of prison lockdowns, a 2016 presentation by Public Health Ontario advised that

⁶⁰ Schedule 8 (S8): Controlled drugs which are addictive.

⁶¹ Victoria Ombudsman (2017). Implementing OPCAT in Victoria: report and inspection of the Dame Phyllis Frost Centre. Melbourne, VIC. Available at: <https://www.ombudsman.vic.gov.au/getattachment/432871e4-5653-4830-99be-8bb96c09b348>.

Nurses usually do all medication rounds, passing medications ‘across the grill’ to patients, presenting a number of security and privacy issues.

A particular service innovation in medication management was seen by JH&FMHN in NSW. An expansion in 2017 of the pharmacy building in one of NSW’s largest prisons has allowed for a new centralised self-medication program, which has resulted in a 25 per cent increase in enrolments prisoners who conduct self-medication.⁶² Suitable prisoners are either placed on a daily or monthly program, which has saved Nurses from conducting 3-4 deliveries of Medication per day direct to prisoner’s cells. The purchase of an automated medication dispensing machine provides suitable prisoners with 1 months’ worth of medication, which has reduced nursing effort required for administering medication. Scripts are sent to a centralised Pharmacy Department in Sydney, which sends the information directly to the medication dispensing machine.

3.7.5 Service innovations – Technology

Telehealth

Other service innovations by JH&FMHN include the increased use of telehealth services, which has allowed JH&FMHN to move away from hiring a specialist in each prison and towards a centralised ‘hub and spoke’ model from Sydney. Patients will either be transported to the central Sydney hub if an in-person consultation is required, or conduct the consultation via telehealth if the patient does not require an in-person consultation. Patients are screened, triaged and separated into appropriate appointment codes to reflect an in-person or telehealth appointment. Specialists are employed by JH&FMHN to work specifically at the central Sydney hub. Consultation suggested that a Specialist is able to see 20 patients per clinic via telehealth, in comparison to 8 patients per clinic had the specialist conducted the appointment in person. This has resulted in better efficiencies, reduced waiting lists, and the ability to manage patients in a timely manner.

Victoria has also increased the use of telehealth services, with the use of telehealth services in Victorian prisons first piloted in 2013. This was overseen by a Coordinator at St Vincent’s Hospital, who was crucial in driving consultant support and identifying appointments that could be conducted via Telehealth. Five years since its establishment, and now 85 per cent of all St Vincent’s specialist consultations occur by Telehealth, and 40 per cent of specialist consultations for prisoners now occur via Telehealth from St Vincent’s. A small annual investment (coordinator wage) has resulted in substantial uptake of telehealth for prisoner specialist consultations, creating substantial savings in escort and transport costs.

Electronic medical records

All jurisdictions analysed have some form of electronic medical records, but most do not interface with systems in the broader public health system. This is the case in Victoria, where if specialist conducts a telehealth consultation with a prisoner, the Nurse at the prison is required to export the patient’s information from JCare, and email it to the specialist. This is also the case in NSW, where the Justice Health electronic Health System (JHeHS) does not integrate with the other Ministry of Health EMR systems. If a patient wishes to access their information after being released, they must submit a request to JH&FMHN. In 2017, JH&FMHN introduced QlikView, which is an electronic system enabling the creation of data visualisations and dashboards across all aspects of the Network’s services. The network is also in the process of implementing an electronic pathology ordering solution within JHeHS to allow clinicians to order pathology electronically.

⁶² Justice Health & Forensic Mental Health Network (2017). 2016-2017 Year in Review. Sydney, NSW. Available at http://www.justicehealth.nsw.gov.au/publications/201617_YIR.pdf.

Similarly, England's current EMR system SystmOne does not link to NHS Spine (the nationwide health records network). However, England is currently in the process of replacing SystmOne with the Health and Justice Information Service (JHIS). This will facilitate patient continuity of care through data sharing functionality between prison and all community healthcare services. Correctional Service Canada only began rollout of a prison EMR system in 2016, which includes both an Electronic Medical Record component and an Electronic Pharmacy System.

3.8 Conclusion

The information available demonstrates some similarities between offender health services provision in Australia and other jurisdictions, including central governance, use of nurse-led primary care models with transfers to hospital for specialist and emergency care, and innovations such as controlled self-management of medication by prisoners, increasing use of telehealth, and use of electronic medical records. Consultation with NSW and Victoria has indicated that telehealth and self-management of medications have both contributed to increased efficiency of services. However, the general lack of available performance data or publicly available program or service evaluations has limited the ability to draw any conclusions regarding service effectiveness in the jurisdictions examined. What is evident from the literature is that there is no one best model for the delivery and governance of offender health services, with comparison of international jurisdictions difficult due to the intricacies of both Australian and international jurisdictions.

4 Consultation summary

Following the consultation phase a number of key themes emerged, and through consultation with the Clinical Excellence Division, five core areas were chosen to reflect consistent elements of service delivery, levels of existing governance, impacts of correctional environmental factors, and staffing workforces across the health centres within correctional centres (Figure 13).

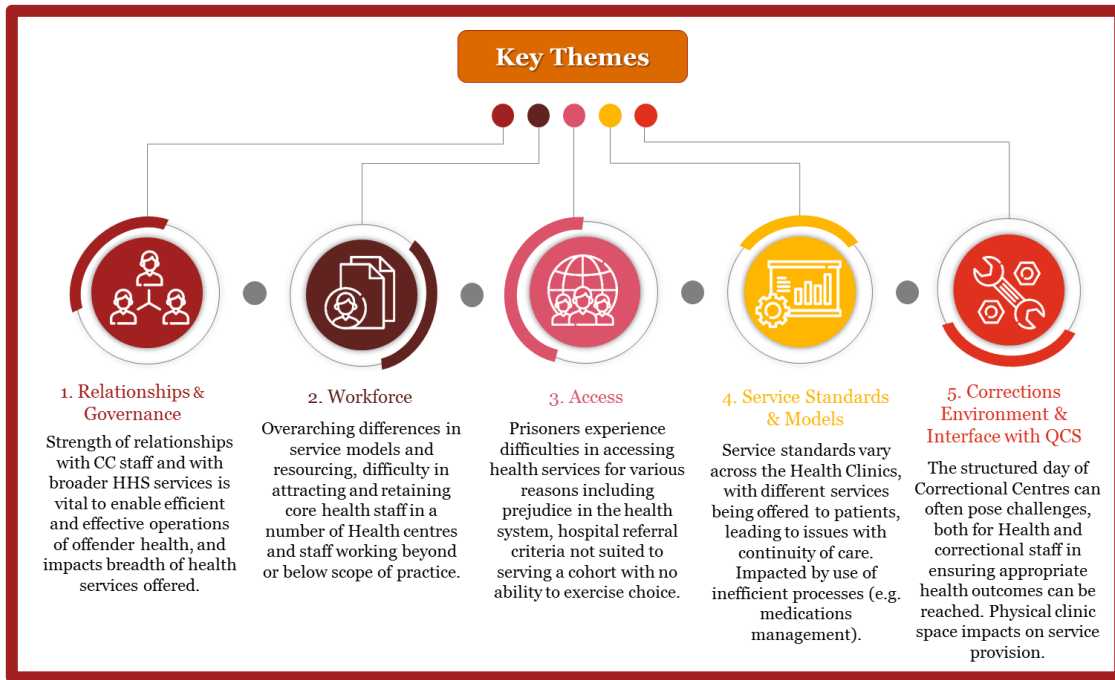


Figure 13 Key consultation themes.

A brief summary of consensus issues raised under each theme is provided below⁶³.

Topic of engagement	Key consultation remarks
Relationships & governance	<ul style="list-style-type: none"> All stakeholders agreed that a single point of contact and escalation across the state would enable: <ul style="list-style-type: none"> more proactive services. streamlined processes. easier and more consistent issue resolution. Current local governance structures mean that the inter-agency relationships are operational in nature. The lack of a central body to oversee OHS, combined with some longstanding interagency relationships, has led to some examples of unorthodox interagency engagement; for example the design of the new

⁶³ The material in this chapter was presented to the Offender Health Services Steering Committee Alliance (OHSSCA) on 7 June 2018.

Topic of engagement	Key consultation remarks
	<p>Capricornia health centre involved engagement between QCS and West Moreton HHS rather than Central Queensland HHS.</p> <ul style="list-style-type: none"> • The structured day of Correctional centres has a substantial impact on the workings of the health centre. As such, good working relationships between QCS and offender health services staff and leadership gives OHS staff a seat at the table, allowing them to effectively advocate on behalf of their patients. • Relationships are generally dependent on personal connections and networks, not broader structural arrangements. • Changes in correctional centre management has, in some instances, led to changes in support and focus for health initiatives. The level of support for the health needs of prisoners depends on the philosophy of the general manager of each correctional centre. • At some correctional centres there were examples provided which highlighted the strength of the QCS/OHS relationship, which benefited patients; for example, a greater ability for Health staff to access and treat patients during lockdown times. • Certain OHS health centres have a very constructive relationship with Queensland Corrective Services, while others see room to improve and strengthen relationships. • In most correctional centres, the relationship at the leadership levels (eg general manager and nurse unit manager) is strong. Relationships among operational staff are described as more variable in part due to cultural differences and differing organisational goals. • There are different cultures and views between Queensland Corrective Services and Offender health (eg a focus on community protection from QCS vs community health promotion from OHS). • Examples have been provided of certain instances where the health team felt more supported by Queensland Corrective Services staff and management due to the close nature of their relationship, than by their HHS. This was described as having a detrimental impact on morale for the OHS staff and feelings of powerlessness to advocate for their patients' need to access health services outside of the correctional centre health centre. • A number of correctional centre general managers were complimentary of improvements in provision of health care since OHS has transferred from QCS to Queensland Health.
<p>Workforce</p>	<p>Workforce – general</p> <ul style="list-style-type: none"> • Some OHS health centres are facing ongoing problems with attraction and retention of core health staff. • Agency staff are often utilised to supplement resourcing numbers and ensure a level of care continues, and in some centres there is an overreliance on agency staff. • Conversely, some OHS report having a waiting list of nurses who would like to work in the correctional environment. This is likely the result of recruitment strategy, networks and a focus on OHS within the HHS, including developing the expertise in correctional health among nursing staff. Two HHSs reported working with universities for student nurse placements and a graduate nurse model of development.

Topic of engagement	Key consultation remarks
	<p>Workforce – medical</p> <ul style="list-style-type: none"> • A number of OHS health centres highlighted their concerns over the low level of medical resourcing for offender health. The majority of OHS do not have full time medical coverage. Some, staffed by design, and others limited by the ability to recruit and retain medical staff⁶⁴. • Some health centres have extended medical support on-call, but this appears to extend to telephone support only. • Examples of well-resourced health centres in terms of medical coverage were Lotus Glen and Townsville⁶⁵. • Medical staff may be unable to work to their full scope of practice due to limited on-site diagnostic capability (eg a lack of equipment such as X-ray and fully functional iSTAT). • Anecdotally, medical staff spend a large proportion of their time dealing with medication requests. • Examples were given by medical staff of instances where people with complex health needs entered correctional centres, despite the inability of the OHS health centres to provide the level of acute care required. In such instances, medical staff may spend significant time attempting to arrange appropriate care for such patients in the inpatient setting. <p>Workforce – nursing</p> <ul style="list-style-type: none"> • OHS is generally a nurse-led model, although the grade mix of nurses varies. • There are examples of staff maybe working beyond scope of practice due to resourcing levels and arrangements made with relevant stakeholder groups such as QCS and Prison Mental Health (PMH). Examples include: <ul style="list-style-type: none"> – the provision of mental health care by OHS staff in some instances due to inability of patients to access PMH services. – medications management processes whereby nurses are dispensing medication. • Conversely, in some circumstances, some nursing staff are working below their full scope of practice due to factors such as resourcing models (eg clinical nurse-only models) and inefficient processes (eg manual medications management processes⁶⁶). • There is an opportunity for clinical nurse to act as the clinical experts in offender health. • It was observed that in some occasions these roles were dedicated to medication administration as a large focus of their shift. • Some OHS retain a primarily Clinical Nurse model of care which does not enable succession planning and may give rise to leadership tensions. • Conversely, some Services have been able to implement student nurse rotations and employ graduate nurses, and have an ethos of ‘growing our

⁶⁴ As a result of the low level of medical resourcing, the review team were able to speak with medical officers from six of the 12 in-scope correctional centres.

⁶⁵ NB. Resourcing will be described quantitatively in the final report once data have been received and analysed.

⁶⁶ Please note: different OHS have different processes for medications management, formulary etc.

Topic of engagement	Key consultation remarks
Access	<p>own’.</p> <ul style="list-style-type: none"> • Consultation suggests that offenders experience difficulty in accessing health services for various reasons, including: <ul style="list-style-type: none"> – Cultural issues within health services (eg services provided by HHSs outside of the correctional health centres) such as prejudice against offenders and a disinclination to serve them. – Hospital referral criteria that reject referrals from patients with low-acuity needs, which excludes prisoners who have very limited ability to exercise choice of health service provider. – Constraints relating to Queensland Corrective Services resourcing for escorts to hospital. – Refusal of some medical specialties at hospitals to use telehealth, even though facilities are available at both the correctional centre and the hospital. – Reportedly, a breakdown in processes such as: <ul style="list-style-type: none"> ◦ escort to health centre by QCS staff, in prisons where escorted movement is required within the prison. ◦ failure to pass on health request forms. ◦ inability to locate patients within the prison due to movement between workstations during the structured day. – Queensland Corrective Services operational policies and perceptions can impact on health of offenders; for example relating to: <ul style="list-style-type: none"> ◦ inability of offenders to hold medications in their cells and therefore self-administer as they would in the community. ◦ needle exchange programs. ◦ provision of condoms. – Patient refusal to access care, even when health need is acute, due to factors such as: <ul style="list-style-type: none"> ◦ experiencing prejudice and discrimination at hospital ◦ not wanting to go via Brisbane Correctional Centre and Brisbane Women’s Correctional Centre to access PAH Secure Unit ◦ not wanting to travel long distances to PAH in uncomfortable QCS transport vehicles eg Maryborough Correctional Centre ◦ not wanting to miss other appointments such as family visits, legal visits or court appearances that clash with medical appointments. • Continuity of care is reportedly low due to factors such as: <ul style="list-style-type: none"> – Inconsistent local approaches and service offerings between offender health services. – In some instances, a failure to transfer a patient’s paper medical record between correctional centres; for example, if the person is sent to the PA Hospital Secure Unit. – Variable levels of discharge planning and assistance to access ongoing healthcare services in the community.
Service standards and models	<p>Service strategy, planning and performance</p> <ul style="list-style-type: none"> • The current decentralised and “fragmented” governance for Offender Health has enabled varying standards, approaches and policies to be implemented by the OHS teams serving the different correctional centres. • HHSs often find themselves assembling clinical services based on relationships between OHS and other HHS service areas, which leads to

Topic of engagement	Key consultation remarks
	<p>discrepancies of services between OHS health centres.</p> <ul style="list-style-type: none"> • There is a lack of understanding of OHS performance, due to the lack of defined service planning, standards, strategic direction or performance expectations for OHS. • There is a lack of visibility of OHS activity because: <ul style="list-style-type: none"> – there is no offender health data collection. – where OHS do collect activity data, they are doing so according to local definitions rather than a standardised definition and classification of activity. – paper medical records are used. <p>Service availability</p> <ul style="list-style-type: none"> • Different health services are offered at different health centres, leading to differing effectiveness in meeting health needs. In many health centres, there is a lack of provision of: <ul style="list-style-type: none"> – Allied Health services, particularly podiatry and physiotherapy. – Preventative oral health care. In most health centres, only emergency oral health care (ie extractions and fillings in response to pain) is provided. There is little to no preventative oral health care and denture provision, despite prisoners having generally high oral health care needs. – ongoing chronic disease care and education. – health promotion services. – sexual health services. – care plans and referrals upon release to the community. • Some examples were provided of where consideration has been given to integrating OHS into the broader health services provided by the HHS and the community. For example: <ul style="list-style-type: none"> – Townsville HHS: <ul style="list-style-type: none"> ◦ quarterly meetings comprising the medical officer, nursing leadership, oral health, and the correctional centre leadership to discuss issues with provision of health care. ◦ meetings between the correctional centre general manager and the health service chief executive (HSCE) several times per year to discuss OHS and also the ongoing provision of laundry services to the Townsville Hospital by the prison. ◦ OHS does monthly performance reporting to executive, similar to rest of HHS (measures for financial, HR, quality and activity aspects). ◦ midwifery and women’s health services provided in the women’s correctional centre by HHS clinicians who also work in the community, enabling continuity of care should the patients wish. ◦ mentoring arrangements for OHS staff with mentors from the broader THHS. ◦ utilise Townsville Hospital (rather than PA Hospital Secure Unit) unless there is a long length of stay. For longer hospitals stays, the use of the secure unit is preferred because restraints are not required. – Central Queensland HHS (Capricornia correctional centre): <ul style="list-style-type: none"> ◦ OHS reports to the Executive Directors, Rural and District-wide Services, whose portfolio also includes mental health and oral health.

Topic of engagement	Key consultation remarks
	<ul style="list-style-type: none"> ◦ Public health services from CQHHS in-reach to correctional centre. ◦ Quarterly interagency meeting including OHS, prison mental health, public health, probation and parole etc to review activity data. ◦ Service for female Indigenous prisoners nearing release (New Endings) to help them to access community services including transport to enable access to health services in the community. ◦ Liaison with CQHHS Executive Director Quality and Safety regarding complaints management. ◦ Utilise Rockhampton Hospital (rather than PAH Secure Unit) unless the required treatment is not available at Rockhampton. ◦ OHS uses CQHHS clinical handover protocols. ◦ Health and Wellbeing Nurse does discharge planning, with a focus on chronic disease patients, and helps link to community services such as housing, alcohol and other drugs services. This Nurse also provides health promotion and education eg sleep advice. ◦ OHS Clinical Nurse Consultant (CNC) provides educational sessions at Rockhampton Hospital regarding the importance of clinical handover, discharge summaries and only discharging prisoners when their health needs can be met within the limited capabilities of the OHS health centre. ◦ Allied Health services include optometry and podiatry (provided through contracts with private providers), diabetes education and on-site pharmacy support. <ul style="list-style-type: none"> • The only example of designated acute/non-acute beds was at Lotus Glen Correctional Centre, which has a renal chair for haemodialysis, and a Nurse Practitioner to provide the service. • There are examples of in-reach services (particularly Allied Health and Oral Health) being reduced in frequency, sometimes without warning or explanation by the HHS to the OHS team. • In general, there appears to be a lack of culturally appropriate health care provision for Indigenous prisoners. A small number of examples were provided of programs aiming to improve continuity of care for Indigenous people returning to the community; however, these were not funded on an ongoing basis. <p>Mental health</p> <ul style="list-style-type: none"> • Prison Mental Health was an area of concern at some health centres; for example: <ul style="list-style-type: none"> – Lack of space to accommodate visiting PMH staff, and a lack of visibility of when PMH would visit leading to an inability to effectively manage space. – Referral criteria in some HHSs are viewed as too restrictive, leaving OHS staff to manage a large population of patients with mental health conditions such as depression and anxiety who are not seen by PMH. – The central PMH team determines required resourcing based on a clinician to patient ratio based on a formula used in the UK; however some health centres believe that the ratio is not reached. The reason for this is not clear but may be due to HHSs diverting funds from PMH to other mental health services outside of the correctional environment. • Conversely, some OHS centres noted PMH as a service that worked well. • In general, it appears that comprehensive, multidisciplinary alcohol and other drugs (AOD) services are not available. • In particular, mental health appears to have strong clinical governance,

Topic of engagement	Key consultation remarks
	<p>with many OHS staff mentioning regular interagency meetings attended by PMH, OHS and the QCS psychology staff to share information regarding prisoners at-risk of suicide.</p> <ul style="list-style-type: none"> – Despite the above three clinical groups each providing mental health services, the role and responsibility of each group appears to be well understood by stakeholders and was generally not a cause of concern. – Mental health staff feel the split of responsibilities between themselves and the QCS psychology resources is appropriate, because they see the role of the QCS psychologists (being to assess for suicide risk and put high risk patients in the observation unit, effectively in isolation) as incompatible with contemporary therapeutic practice which would be used in a non-correctional setting. <p>Medications management</p> <ul style="list-style-type: none"> • Some processes reduce efficiency of health service provision. A key example is medication management: <ul style="list-style-type: none"> – In most correctional centres, nurses prepare doses of medications 2-3 times per day, for up to 50% of the prison population, and distribute them in the units. – Some offender health services have pre-packaged medications, which are prepared off-site and require substantial manual work to deal with changes. – Only one correctional centre, Capricornia, has fully established a medications packaging model which reduces onsite demand on nurses, freeing up their time to oversee health concerns, and which incorporates the automated provision of a high level of patient-identification and medication-identification information, through use of photos on medication packages. – Medication management processes differ between health centres and approaches appear to partly historically based ('this is how we have always done it') and partly due to operational requirements and physical layout of the correctional centre. However, in many of the health centres there is a high level of manual processing which is labour intensive, error prone, and can at times contribute to nursing scope of practice issues: <ul style="list-style-type: none"> ◦ In some instances, clinical nurses are not working to their full scope of practice due to manual medication management processes ◦ In some instances, it would appear that nursing staff may be dispensing medication, which is generally outside of nursing scope of practice. • Differing availability of medications in particular appears to be driving a large volume of complaints, given the high volume of patient transfers between correctional centres (over which OHS staff have no control). • Several offender health services expressed the need for standardised processes, policies, medical formularies etc. across the state to increase efficiency and reduce complaints. • The lack of a mobile electronic medical record also increases the risk of medication errors and/or reduces efficiency. Nurses are unable to take the paper charts on the medication distribution rounds (due to the large numbers of patients involved), meaning they are not able to refer to the chart in real-time when patients query the medications.

Topic of engagement	Key consultation remarks
	<p>Clinical capability</p> <ul style="list-style-type: none"> • There are differing clinical capability levels at the different offender health services. This is driven partly by available resourcing (eg night shift, NP model etc), and by the limited clinical space made available and the impact that has on attracting and retaining certain clinical capabilities. <ul style="list-style-type: none"> – For example some health centres offer only basic life support, while others can offer intermediate or advanced life support. • Few OHS health centres have full time medical coverage. Time demands and resource constraints impact the ability of medical officers to work to their full scope of practice. <ul style="list-style-type: none"> – Anecdotally, doctors working within the health centres observed that their time was primarily spent prescribing and reviewing medications, advocating for patients with complex needs and paperwork, due to the level of demand that exists within correctional centres vs supply of medical officers. – One correctional centre conversely had a VMO note that substantial time was spent triaging very severe and complex injuries that could not be dealt with by other health staff and nurses. • The level of onsite diagnostic capability is variable across the health centres, and is partially dependent on the HHS sponsoring of equipment and staff scope of practice. • The lack of diagnostic equipment means patients must be sent to an emergency department for basic services and diagnoses (e.g. medical imaging). <ul style="list-style-type: none"> – QCS has limited resourcing for patient transports to hospital (both human resources and transport vehicles), meaning that transport for scheduled care or testing is often cancelled to accommodate emergency cases – Conversely, transporting patients for low-level diagnostic services places a cost burden on QCS – There may be opportunities to better utilise technology (eg use of telehealth to access radiologists if OHS centres had onsite capability such as X-Ray) – However, in many health centres the limited physical space would prevent acquisition of additional equipment in the short term. • In other health centres the clinical capability is similar to a GP clinic; including basic pathology collections and tests, suturing, and diagnostics such as ECGs and spirometry. • Most health centres report the use of telehealth, although in some instances a lack of willingness on the part of some medical officers hampers full uptake of telehealth, leading to increased costs (to QCS) in patient transport. <ul style="list-style-type: none"> – Greater use of telehealth for specialist care would enable more timely access to services for patients, given the anecdotally high incidence of rescheduling of care to accommodate more urgent cases that emerge (due to constrained resources for transport as described above). – In some centres, increased use of telehealth would be hampered by physical space constraints. <p>PA Hospital Secure Unit (the Secure Unit)</p> <ul style="list-style-type: none"> • QCS is strongly supportive of the Secure Unit model because restraint and escorts are not required. Conversely, admission to regular hospital units requires prisoners to be restrained and continuously escorted under QCS policies. This contributes to QCS costs.

Topic of engagement	Key consultation remarks
	<ul style="list-style-type: none"> • The use of restraint (during admitted care outside of the Secure Unit) was cited as a reason for refusal of treatment, and can also hamper some clinical treatment processes. • In south east Queensland, HHSs are also supportive of the use of this facility. However, they note a reduction in access since the PA Hospital implemented the Referral Hub, because prisoners are triaged to the same criteria as non-prisoners, despite the level of clinical capability at some OHS centres meaning that prisoners may have no option other than hospital care. • HHSs and OHS outside of south east Queensland are less likely to utilise the Secure Unit unless a patient will have a long stay or needs tertiary level care not available locally, due to the transport conditions for patients over long distances, and high incidence of patient refusal, documented above under Access. • Although some areas of the Secure Unit are in need of refurbishment, any refurbishments should be considered against a longer-term strategic consideration as to how hospital services are provided for prisoners across the state, and the future role and need of the Secure Unit. <p>Technology and data</p> <ul style="list-style-type: none"> • There is no state-wide OHS data dictionary and data standards, and no consistent collection of activity data. Some HHSs collect activity data according to their own internal requirements, but it cannot be compared to data from another HHS. • Whilst an electronic medical record is under development, the current practice of paper medical records hinders the sharing of information between OHS when prisoners are transferred and/or re-enter the correctional system. This impacts continuity of care and likely results in re-work, for example in repeating assessment when patients transfer between correctional centres. • A portable electronic medical record (eg using a tablet device) would assist with efficiency and error reduction for example during medication rounds. • It is important that such a system: <ul style="list-style-type: none"> – Integrates with other key Queensland Health systems as well as the My Health Record. – Provides suitable medications management functionality.
<p>The Correctional Environment & Interface with QCS</p>	<p>Structured day and correctional centre operations</p> <ul style="list-style-type: none"> • The structured day of Correctional centres has an impact on the workings of the health centre. • General scheduling within the structured day means there is a need for workarounds and a limited number of patients can be seen. • Various other aspects of correctional centre operations impact health services provision; for example: <ul style="list-style-type: none"> – In correctional centres where prisoners must be escorted throughout the facility, access to the health centre depends on availability of QCS staff to escort – Lockdowns affect access to the health centre, although in some correctional centres with particularly strong relationships between QCS leadership and OHS, some access during lockdowns is accommodated. – Moving around a correctional centre is a slow process due to: <ul style="list-style-type: none"> ◦ central control of doorways.

Topic of engagement	Key consultation remarks
	<ul style="list-style-type: none"> ◦ long distances to cover when clinical staff must travel to patients; for example up to 1.5 km for a medication round. – In correctional centres with protection and mainstream units, health centre logistics are further impacted by the need to keep these groups separated at all times. – Medications must be administered at set times; depending on the medication (eg insulin or antibiotics) this may result in medications being administered at non-optimal intervals. – OHS staff are under pressure to complete medication administration rounds within the same time periods to fit with the structured day, despite increasing prisoner numbers. Staff fear that this may be increasing error rates. <p>Health centre space</p> <ul style="list-style-type: none"> • Physical space for health centres is a primary cause for concern, and impacts the ability to provide health care with due regard for patient confidentiality. • The issue is particularly acute given the number of visiting health services (mental health, oral health, allied health, women’s health etc) that all need to use the same space. • Increasing prisoner populations and complex medical issues means infrastructure will become further constrained. In general, health centres were designed with lower prisoner numbers and less complex health needs in mind than the prisons are currently accommodating. • Several Offender Health teams talked about pressure from the correctional centre management to maintain ‘medical beds’ which were in place from when Offender Health was run by QCS. Some Offender Health teams have shut down these beds as they are not suitable for ongoing observations due to factors such as location within the health centre, availability of suitably trained staff, lack of required support services. Some centres, however, maintain these beds, but use them only in limited circumstances for low-risk patients. In these circumstances, it is felt that the beds have a role in reducing transport to hospital for low-acuity patients. <p>Prisoner transport</p> <ul style="list-style-type: none"> • There are constraints placed on QCS to transport patients externally to appointments or for emergency care due to limited QCS escort capability. • A high prevalence of emergency ‘code blues’ results in a number of scheduled appointments being rescheduled. • Anecdotally, there is a high incidence of transport to emergency department in correctional centres without a night shift in the health centre. <p>Technology interoperability</p> <ul style="list-style-type: none"> • ICT firewalls and the current QCS and Queensland Health ICT systems do not allow for the optimal use of on-site diagnostic equipment, e.g. iSTAT, within a number of health centres

5 Overview of offender health services

5.1 State-wide profile

5.1.1 Data and benchmarking

Various data sets were requested from the Department of Health and the relevant HHSs to enable a state-wide profile of offender health services to be generated.

While most HHSs provided data in comparable formats, there were some instances of inconsistent approaches to data collection. This may be attributable to inadequately documented or defined common terms or definitions to assist each HHS in collecting accurate and comparable data. This lack of common definitions can result in misinterpretation and state-wide variations in data for comparative purposes. This was further compounded by a difference in offender health services provided by each HHS. Each piece of analysis included below lists footnotes which indicate the data sources, the analysis and any assumptions made during the analysis.

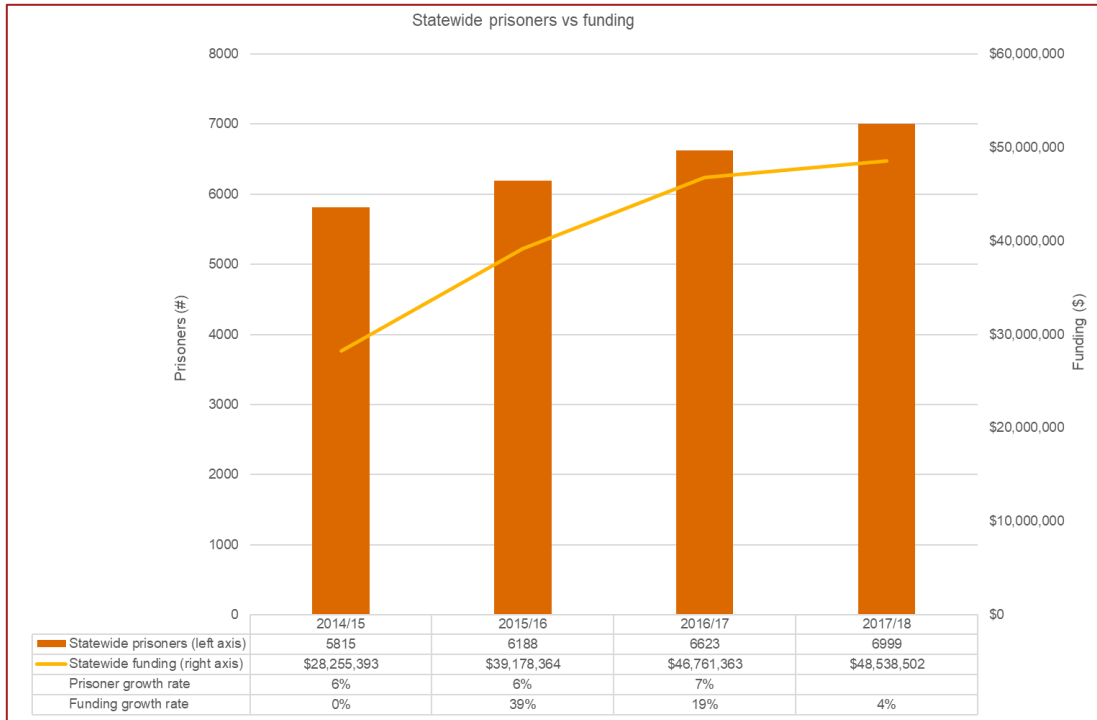


Figure 14 State-wide prisoner numbers vs offender health funding^{67 68}

Analysis of growth in prisoner numbers and offender health over time has demonstrated steady growth in prisoner numbers (see Figure 14). Conversely, since 2015, Queensland Health has made a significant investment in offender health services state-wide. Total funding has grown over 70 per cent during this time, from \$28.3 million to \$48.5 million; whereas prisoner numbers have increased by 20 per cent on an average annual head count basis.

⁶⁷ Source: Prisoner number information was provided by QCS through the Department of Health. It included a count of prisoners at a correctional centre at the end of the last day of each month (for example, count of prisoners at 30 June 2018). Funding information was provided by the Department of Health. Prisoner numbers and offender health funding cover all publicly operated adult correctional centres in Queensland.

⁶⁸ Data for 2018 does not incorporate a full years' data set. The request for data was made in May 2018 with responses received between May and June 2018.

There is variation between HHSs in the average offender health expenditure per prisoner

There is substantial variation in average expenditure per prisoner among the offender health services⁶⁹; the highest-spending HHS (WMHHS) spends more than double, on average, per prisoner than the lowest spending (MNHHS). However, some WMHHS expenditure covers specified activities; namely, state-wide offender health medical record archiving, and the procurement of a state-wide offender health electronic medical record. It should also be noted that WMHHS operates health services within Brisbane Correctional Centre (BCC) and Brisbane Women’s Correctional Centre (BWCC), both of which are the primary reception centres for the state and therefore experience above-average rates of prisoner turnover (Figure 16). This analysis assumes that complete and correctly coded cost centre data have been provided by each HHS. The average expenditure on health services per prisoner among the HHSs included was \$6,739 per annum in 2016/17, the most recent year for which full-year data was available.

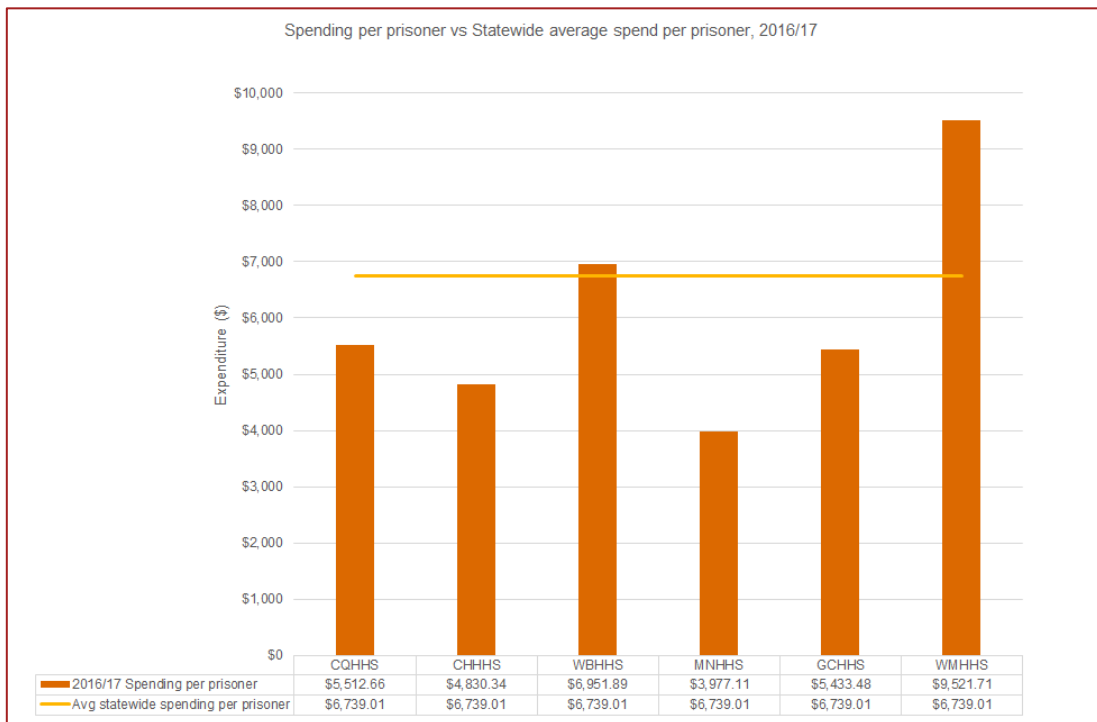


Figure 15 Average offender health spending per prisoner by HHS, 2016/17^{70 71}

⁶⁹ Data were provided by the relevant HHSs, according to cost centres coded to offender health. The analysis presented, presumes that complete expenditure data was provided.

⁷⁰ Data sources: Expense data was provided by the relevant HHSs. For MSHHS and THHS, data were not provided in a comparable format. Expense data was requested at the cost centre level for only those cost centres coded for Offender Health Services. Prisoner number information was provided by QCS via the Department of Health. It included a count of prisoners at a correctional centre at the end of the last day of each month.

⁷¹ The calculation for a state-wide average spend per prisoner does not include prisoner and expense data for MSHHS and THHS.

There is variation between HHSs in funding received per prisoner

WMHHS receives the highest per capita funding allocation of the eight HHSs providing offender health services. However, WMHHS is currently providing a state-wide records management/archiving service for offender health medical records, and procuring a state-wide offender health electronic medical record system. In addition, WMHHS provides offender health services to Borallon Training and Correctional Centre (BTCC), which is funded under a different arrangement to other correctional centres. Differences between HHSs in funding per prisoner may be related to the growth rate of prisoners, and/or turnover rate in some correctional centres (see Figure 16). The average state-wide funding level per prisoner per annum was \$7,060 in 2016/17, the most recent year for which full-year data was available at the time of conducting this review (see Figure 17).

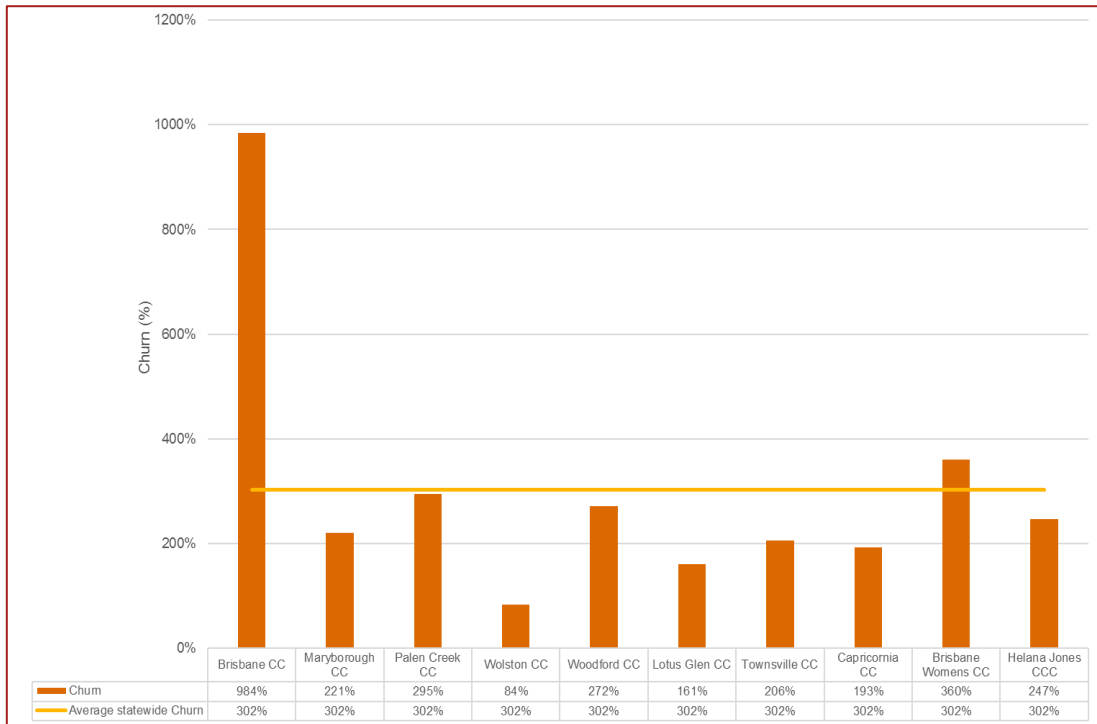


Figure 16 Queensland annual prison population turnover, 2016/17^{72 73 74}

⁷² **Notes:** Total Queensland prison population turnover (churn) may be defined using (admissions)/(average population). ie,

$$Churn = \frac{(Admissions, aka first reception)}{(Average population)}$$

calculation excludes transfers in or change in status:

⁷³ Source: Prisoner number information was provided by QCS through the Department of Health. It included a count of prisoners at a correctional centre at the end of the last day of each month (for example, count of prisoners at 30 June 2018).

⁷⁴ Turnover has not be calculated for Borallon Training and Correctional Centre. As the only correctional centre yet to meet built cell capacity and on track to grow, it is noted that the formula applied to other correctional centres does not apply accurately to BTCC.

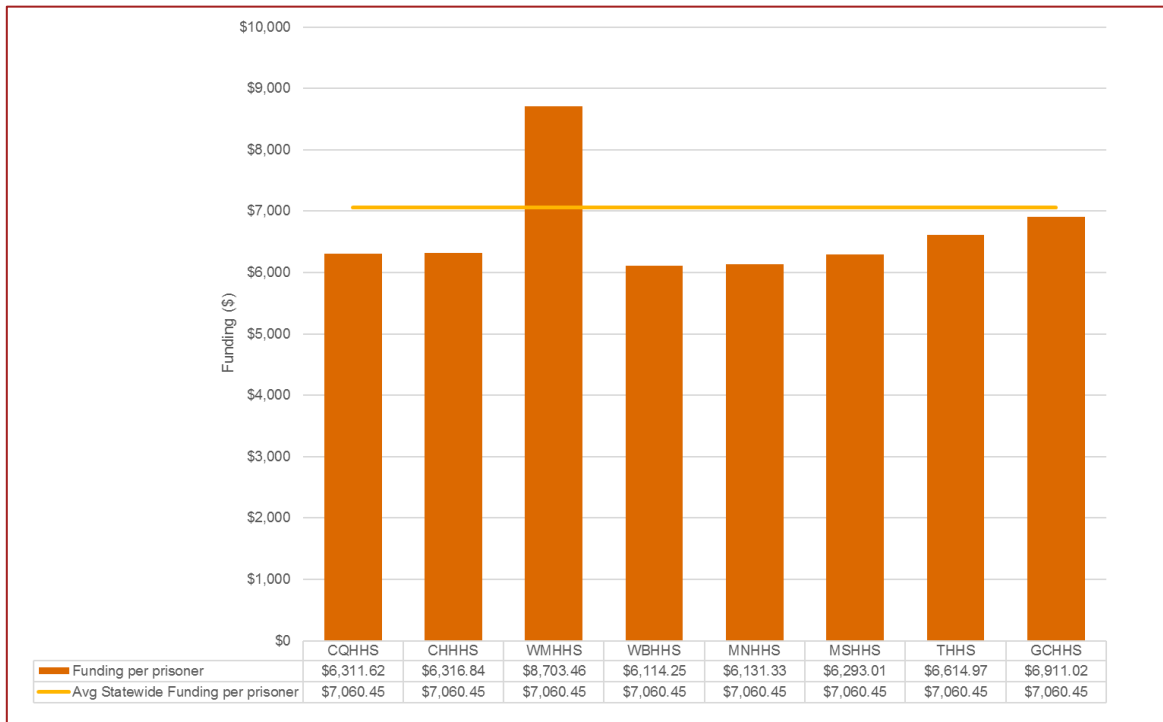


Figure 17 Average HHS offender health funding per prisoner, 2016/17⁷⁵ ⁷⁶

⁷⁵ Data sources: Funding information was provided by the Department of Health at the HHS level. Prisoner number information was provided by QCS via the Department of Health. It included a count of prisoners at a correctional centre at the end of the last day of each month. . Prisoner numbers and offender health funding cover all publicly operated adult correctional centres in Queensland.

⁷⁶ The calculation for a state-wide average funding per prisoner includes prisoners and funding for all HHSs. As such, the state-wide average funding per prisoner listed here cannot be compared to the previous graph indicating a state-wide average spending per prisoner. A comparable average funding per prisoner (excluding THHS and MSHHS) is \$7161.78 for 2016/17.

The majority of HHSs for which data was available, do not expend their full offender health budget allocation

Six of eight HHSs provided data regarding offender health expenditure for 2016/17. Of these, four underspent against their budget, while two overspent⁷⁷ (see Figure 18). This implies that some HHSs may be able to provide additional services to improve offenders’ health outcomes; however, the analysis assumes that each HHS provided complete and correct expenditure data.

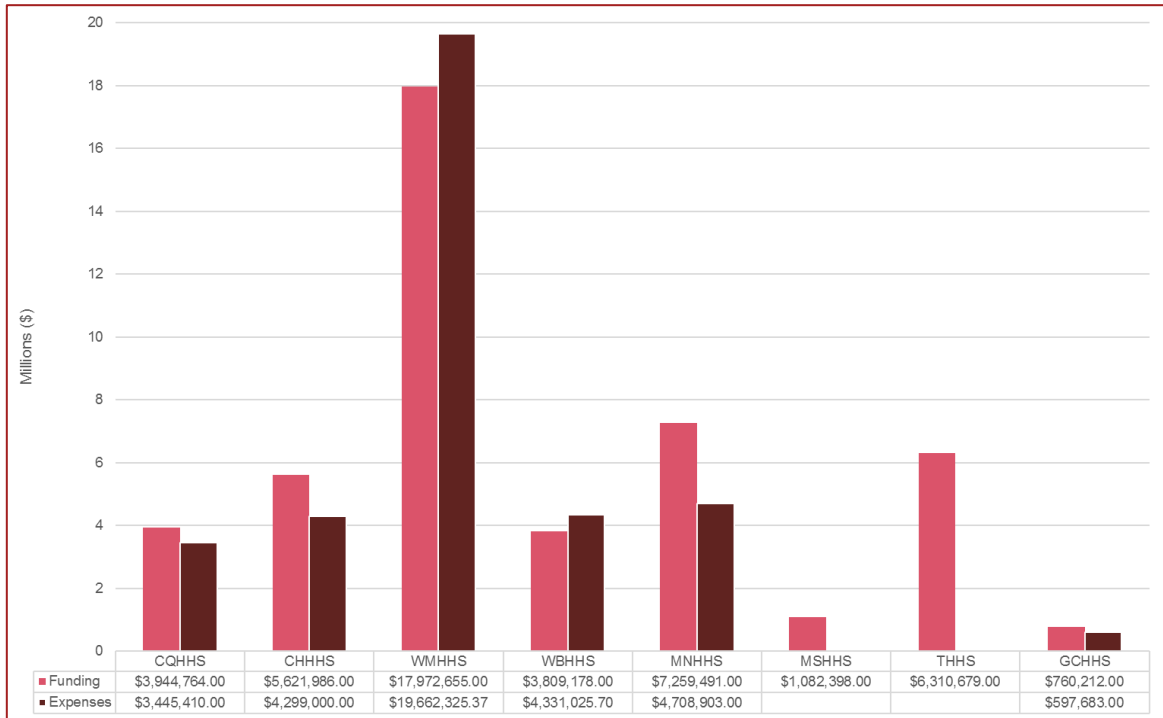


Figure 18 HHS spending vs funding for 2016/17^{78 79}

⁷⁷ This assumes that complete expenditure was captured in the data set provided by each HHS.

⁷⁸ Data sources: Funding information was provided by the Department of Health. Expense data was provided by the relevant HHSs. For MSHHS and THHS, data was not provided in a comparable format.

⁷⁹ Expense data was requested at the cost centre level with a caveat that only those cost centres coded for offender health services were to be included. Some expenses included were labour, clinical supplies, drugs, repairs and maintenance and travel expenses.

5.2 Relationships and governance

5.2.1 Current state

Queensland aligns to international guidance in delivering offender health services under the jurisdiction of the health department...

The fact that Queensland offender health services is the responsibility of the Department of Health, is considered best practice according to the international literature. Only a minority of jurisdictions globally had adopted this governance arrangement at the time of writing this report.

International standards and literature suggests that provision of offender health services by the health system rather than the justice or correctional system leads to better health outcomes for patients within correctional centres.

...however, governance of offender health across the Queensland system is fragmented

Queensland has no system-wide governance mechanism in place to provide oversight of health provision within correctional centres.

This contrasts to the governance structures that have been established in the other jurisdictions examined as part of the literature review component of this project (NSW, Victoria, England, Norway and Canada), all of which have a centralised governance mechanism, such as a Board, or a single responsible service provider for the entire jurisdiction.

Stakeholders consistently provided feedback that creating a centralised governance mechanism would be beneficial to drive increased consistency in service delivery and outcomes, and clarify how health and corrective agencies will work together.

The Department of Health as the system manager does not have a clear understanding of performance or the outcomes being achieved within offender health. There has been a substantial funding uplift for Queensland offender health services in recent years (see Figure 14) to address the demand for services. This has been done in the absence of any consideration of system-wide redesign opportunities that may yielded efficiencies. Other jurisdictions reviewed have performance frameworks that enable performance to be assessed. For example, Victoria has a Quality Framework that sets out clinical governance requirements and (generally qualitative) service standards, while NSW has KPIs aligned to the overall NSW Health strategic plan.

There are further opportunities to work with QCS to effect service improvements that are being missed due to a lack of escalation pathways. For example, joint submissions for infrastructure funding could enable upgrades to the health centres within correctional centres, which were generally designed when prisoner populations were much smaller than the present day. At present, there is a separate memorandum of understanding (MoU) between QCS and each of the eight HHSs delivering offender health services, as well as a separate state-wide MoU between QCS and Queensland Health (ie the Department of Health plus the HHSs) setting out roles and responsibilities of each agency. There are differences in the MoUs, particularly relating to the services to be provided within the health centres, reflecting the current lack of standardised models and policies/procedures.

There are cultural differences between QCS and Queensland Health, which impact provision of health care

QCS' priority is security of the correctional centre and safety of the public, whereas Queensland Health's priority is to provide health care to patients who need it.

The philosophy and mentality of the correctional centre general manager towards the provision of health service affects the way the corrections and health staff work together.

In the absence of formalised agreements and performance expectations, the ability to provide health services within correctional centres is relationship-dependent.

Health care services provided, and flexibility to work around the correctional centres' structure day, are influenced by the strength of interpersonal relationships; in particular between:

- OHS management (eg the nurse unit manager) and correctional centre management (eg general manager, deputy general manager)
- OHS management and the HHS (eg the leadership of the HHS organisational unit to which OHS belongs)
- HHS leadership (health service chief executive and business unit executives) and correctional centre management.

This relationship dependency compounds the variability in services provided between correctional centres and HHSs. Strong relationships as well as the correctional centre management philosophy enables some exceptions to the structured day in some correctional centres.

Relationships and resultant impacts on health service provision are not static, but based on personal connections. This means that things can change for the better, or the worse, if a key officer from either the correctional centre or the offender health service leaves.

5.2.2 Future state

Stakeholders consulted during this review were generally in favour of strengthened governance and pathways to work with QCS. In the future, Queensland Health should implement a state-wide approach to governance of offender health, to ensure that there is strong accountability and a means to resolve issues. Below are recommendations to improve governance and performance.

“ Queensland Health should implement a state-wide approach to governance of offender health, to ensure that there is strong accountability and a means to resolve issues. ”

1. Relationships and Governance (G)

Key themes and findings

Queensland currently aligns to international guidance in delivering offender health services under the jurisdiction of the health department. The DoH is designated as the 'system manager' under the *Hospital and Health Boards Act 2011* (the Act). However, the Department has not been exercising this role with respect to offender health, leaving service provision to become fragmented across the state in the absence of leadership from the Department. As a result, services provided vary between HHSs and correctional centres, and service effectiveness depends upon the strength of relationships between offender health staff and correctional centre management, as well as between offender health staff and staff within other areas of their respective HHSs. Cultural differences between QCS and Queensland Health lead to differing approaches, priorities and philosophies, and in the absence of clear escalation pathways, issues are not always resolved promptly and effectively, impacting health care provision in correctional centres.

Recommendations

Recommendation G1: The Queensland Department of Health should establish a state-wide program coordination unit within the DoH, to oversee state-wide offender health. The state-wide program coordination unit would have responsibility for the governance functions in the recommendations that follow, including policy (clinical and administrative), planning, funding, information, performance, quality and research. An early priority of this unit should be to establish and lead the collaborative arrangements necessary to achieve the goals of the Offender Health Strategic Plan (see G1.1), including liaison with key stakeholder groups in the DoH, HHSs and other government agencies.

Recommendation G1.1: Develop and implement a state-wide offender health services Strategic Plan articulating clear and measurable service priorities and goals. Ideally, QCS should be involved in the development of the Strategic Plan.

Recommendation G1.2: Develop and implement policies and procedures aimed at standardising critical elements of care delivery. Consideration may be given to the development of a 'Queensland charter of healthcare rights for prisoners', aligned to the Australian Charter of Healthcare Rights.

Recommendation G1.3: Negotiate a single state-wide Memorandum of Understanding (MoU) between Queensland Health and QCS that sets out the agreement between the two organisations, including:

- Role and responsibilities of Queensland Health (Department and HHSs), including the health services to be provided at each correctional centre and arrangements for provision of hospital-based care. This would include clarifying the role of each party with respect to the provision of health care in privately operated correctional centres.
- Role and responsibilities of QCS (Department and correctional centres)
- Guiding principles for the relationship and for decision-making
- Governance arrangements (see G1.4 and G1.5 below)
- Minimum service standards
- Key Performance Indicators (KPIs) and reporting requirements (see G1.7 below)
- Regular meetings and communication channels (see G1.4 and G1.5 below)
- Requirements for local, operational agreements between HHS and correctional centre.

Note: This MoU shall be consistent with the requirements set out under the *Hospital and Health Boards Act 2011* (the Act), and will exclude agreements pertaining to information sharing, which is subject to a regulation under the Act and therefore is dealt with in a specific MoU.

Recommendation G1.4: Develop and implement a formal mechanism for interagency liaison regarding offender health services, such as dedicated contacts within relevant agencies including QCS initially, and the Queensland Police Service (QPS) and the Department of Justice and Attorney-General (DJAG) to follow. Interagency liaison will include planned collaboration (eg joint Cabinet Budget Review Committee (CBRC) submissions) and unplanned issue resolution (eg escalation of issues that cannot be resolved at the local level between HHSs and QCS). The interagency arrangement should operate to a documented Terms of Reference.

Recommendation G1.5: Facilitate a clinical governance network to support the resolution of state-wide clinical issues and provide a forum for professional development, networking and dissemination of leading practices in offender health. The network should include appropriate representation of different professions and regions, and work to a documented Terms of Reference. Functions should include:

- Input into the strategic planning process
- Monitoring systemic clinical risks and issues escalated to the network, which may emerge through analysis of aggregated data (see below) and suggesting appropriate mitigation actions
- Assisting in the development and review of clinical practice guidelines as they relate to Offender Health Services.

Recommendation G1.6: Develop and implement an activity data collection, in accordance with eHealth Queensland requirements, for offender health (ie primary health care) services to enable performance to be monitored across the system. The collection should include standard data definitions and reporting requirements. This should be integrated into the state-wide offender health electronic medical record system (see G1.8) to facilitate reporting.

Recommendation G1.7: Develop and implement a service evaluation and development system for offender health services, as part of the existing HHS performance management framework. As part of the implementation, there should be regular reporting to the state-wide program coordination unit, which will feed into the monthly relationship management meeting between Health Purchasing and System Performance Division (HPSP) and HHSs. As necessary, incentive payments linked to the achievement of objectives in the service evaluation and development system may be appropriate (ie output or outcome based funding). The service evaluation and development system should align to the Strategic Plan and incorporate at a minimum:

- Objectives
- Key performance indicators (KPIs) to measure progress in achieving objectives. KPIs may include:
 - KPIs relevant to all health facilities and staff; for example compliance with notifiable incident and notifiable disease reporting, accreditation, credentialing, incident reporting etc.
 - Initial assessment: percentage of comprehensive assessments, triaging and referrals completed within 24 hours of reception.

- Chronic disease management: percentage of patients with chronic disease for whom a chronic disease plan is implemented.
 - Communicable disease: percentage of patients offered communicable disease screening upon reception (eg HIV, viral Hepatitis, other sexually transmitted infections (STIs)).
 - Communicable disease: percentage of patients vaccinated for communicable diseases including all vaccinations covered in the childhood immunisation schedule, and seasonal influenza.
 - Communicable disease: rates of transmission within correctional centres of STIs and blood borne viruses (BBV).
 - Access: Waiting times for appointments with the medical practitioner, dentist or mental health practitioner (see Access section below).
 - Patient satisfaction with offender health services.
 - NB: KPIs may need to be targeted to cohorts of prisoners with certain lengths of sentence.
- Targets for the KPIs.

Recommendation G1.8: Department of Health to lead implementation of state-wide offender health electronic medical record, with state-wide program coordination unit to be system owner with ongoing support from HHS, due to the associated state-wide data collection.

Recommendation G2: HPSP should update HHS service agreements to reflect specified expectations for offender health (as per offender health service evaluation and development system).

5.3 Workforce

5.3.1 Current state

The majority of offender health service delivery is provided by the offender health nursing workforce

Across all HHSs, the majority of offender health FTE are nursing staff (see Figure 19), ranging from enrolled nurses to nurse practitioners (see Figure 20).

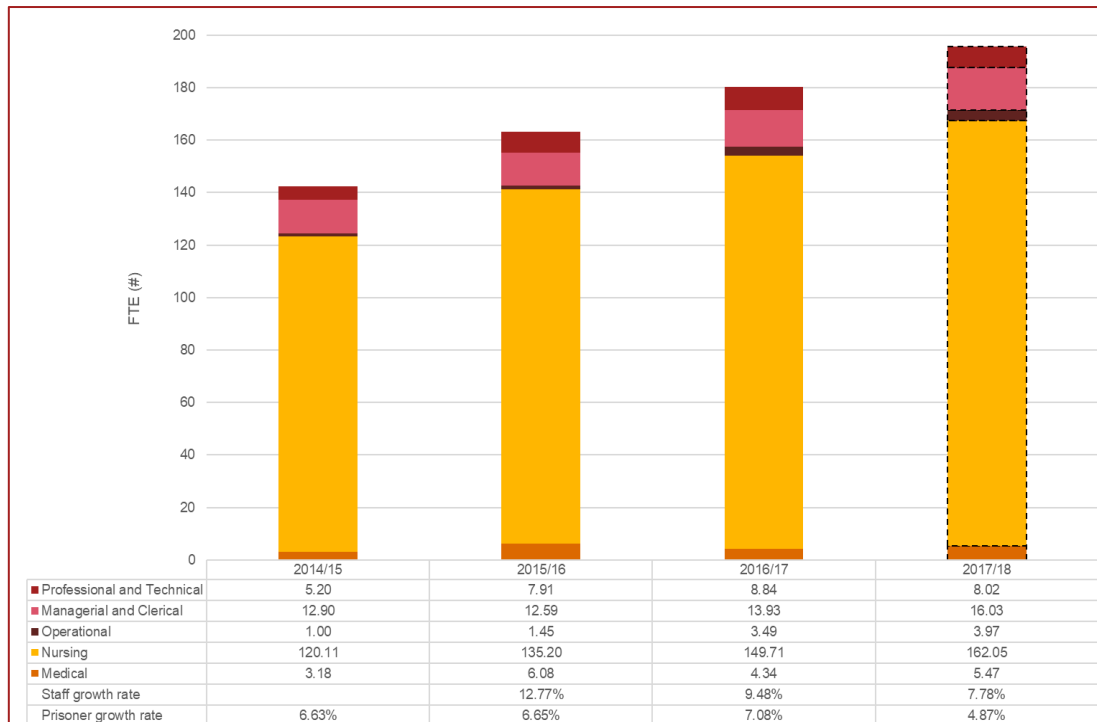


Figure 19 State-wide offender health staffing by type. The table shows full-time equivalent (FTE) staffing levels for various professional streams ⁸⁰ ⁸¹ ⁸² ⁸³

Until 2008, offender health was the responsibility of Queensland Corrective Services. Residual elements still exist from the QCS staffing model. For example, there are different shift lengths for nursing staff between offender health services, ranging from 8 to 12 hours.

During the period 2015/16 to 2017/18, the offender health workforce has grown more rapidly than the growth rate of the average prison population (see Figure 19). In the absence of

⁸⁰ Source: MOHRI occupied staffing data and Agency staffing data was provided by each HHS. The graph includes the total of these indicating the total occupied staffing information for the state (excluding THHS, MSHHS, and MNHHS data which was not provided in a comparable format). The 'professional and technical' stream includes allied health resources.

⁸¹ Data for 2018 does not incorporate a full years' data set. The request for data was made in May 2018 with responses received between May and June 2018. For some HHSs there is no indication of the period of data extracted, for others, this lies between April and May 2018.

⁸² Source: Prisoner number information was provided by QCS through the Department of Health. It included a count of prisoners at a correctional centre at the end of the last day of each month (for example, count of prisoners at 30 June 2018). MOHRI occupied and Agency staffing details were provided by each HHS. Both prisoner numbers and staffing numbers exclude THHS, MSHHS, MNHHS due to lack of comparable data.

⁸³ Prisoner number calculation methodology: $Prisoners\ for\ FY = \frac{Total\ prisoners\ for\ FY}{Total\ months\ in\ FY}$

performance or outcomes data, or specified staffing ratios, it is not clear to what extent the rapid growth in the size of the offender health workforce has been appropriate and has enabled improved health or other outcomes.

Several HHSs appear to have a flat nursing workforce model, composed largely of clinical nurses. Contemporary practice would normally have a 'beginner to expert' model allowing for the development of registered nurses to advanced practice of a clinical nurse. A flat line clinical nurse structure does not provide for a career structure that supports development of registered nurses. This reduces the potential for attraction and retention of nursing staff. Together, clinical nurses (CN) and clinical nurse consultants (CNC) make up the largest group within the offender health workforce in Queensland. Conversely, WMHHS has implemented a nursing model with the full spectrum of nursing roles from enrolled nurse through to nurse practitioner, enabling career progression. Townsville HHS has registered nurses, clinical nurses and clinical nurse consultants.

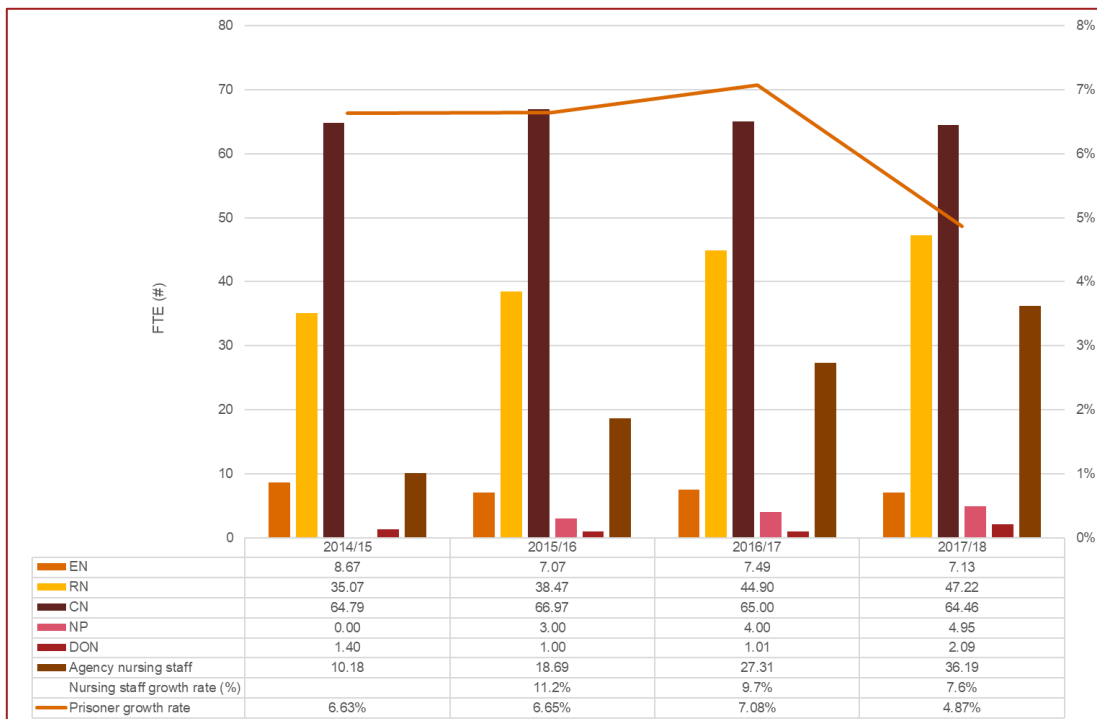


Figure 20 State-wide offender health nursing breakdown ^{84 85}

In some instances, the workforce structure is forcing some nurses to work below their full scope of practice, or to be unable to assume the leadership focus expected of, for example, a CN or CNC.

⁸⁴ Source: MOHRI occupied staffing data and Agency staffing data was provided by each HHS. Based on the role description for each nursing role (for example, Enrolled Nurse – Grade 3, Clinical Nurse / Midwife – Grade 6 etc.), all MOHRI Nursing FTE are allocated to the categories in the graph. As Agency staffing information was generally provided at a higher level (for example, Nursing – external), this is represented in its own category. The graph excludes THHS, MSHHS, and MNHHS data which was not provided in a comparable format.

⁸⁵ Data for 2018 does not incorporate a full years' data set. The request for data was made in May 2018 with responses received between May and June 2018. For some HHSs there is no indication of the period of data extracted, for others, this lies between April and May 2018.

Some HHSs have reported difficulty in attraction and retention of offender health staff. Some HHSs report substantial use of agency staff to cover workforce shortages (mainly nurses); in particular WMHHS and WBHHS. However, other HHSs have operational policies that limit the use of agency staff. These HHSs must use overtime to backfill absences, and/or carry vacancies. According to data received, as at April 2018, the equivalent of 36.19 MOHRI FTE had been filled by agency nursing staff (see Figure 20).

Prison Mental Health Service (PMHS) is a multidisciplinary in-reach service for prisoners with mental health problems, and may include medicine (psychiatry), nursing, psychology, occupational therapy, social work and Aboriginal and Torres Strait Islander mental health workers. The composition and structure of these multidisciplinary teams will vary across locations. It is a priority for the service to ensure that it has a sufficient workforce to meet the current needs of the population, provide a high quality and culturally capable health service, and continue to expand in order to service the growing size of the Queensland prison population. Based on consultation with Prison Mental Health Services, state-wide PMHS resourcing is at approximately 50 per cent of the recommended FTE across the state.

The offender health medical workforce is challenged in providing comprehensive primary care in correctional centres

Some HHSs report difficulties with attraction and retention of medical officers to work in offender health.

Medical officers may not be working to their full scope of practice because:

- Medical officers report that a majority of their time is spent on medication and administration-related activities.
- Limited availability of diagnostic equipment affects medical officers' ability to provide comprehensive primary care on site.

Oral health service provision is provided by HHSs, but resourcing is low

In 2017/18, there were 3.6 FTE of dental officers providing services to prisoners across the eight HHSs, from among the HHS' usual oral health staffing complement (see Figure 21). In addition, in 2017/18 there were 5.21 FTE of dental assistants working across correctional centres (see Figure 22). However, in consultation, offender health staff noted that offenders tend to have high oral health needs and that prison represents an opportunity to provide services that may not have been accessed while in the community.

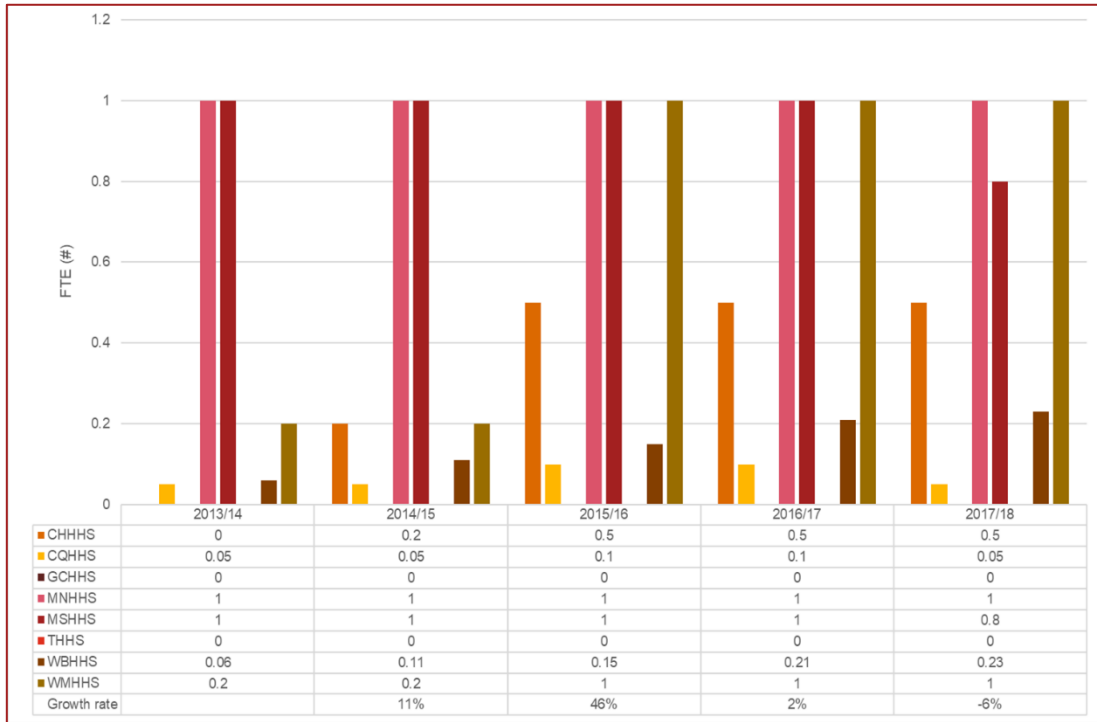


Figure 21 State-wide dental officer FTE^{86 87}

⁸⁶ Data for Oral Health was provided by the Department of Health and has not be audited or verified. It is assumed that raw data provide only includes information regarding oral health services provided with a Correctional Centre setting.

⁸⁷ Oral Health data also includes data for Arthur Gorrie and Southern Queensland Correctional Centres as these form a part of the scope.

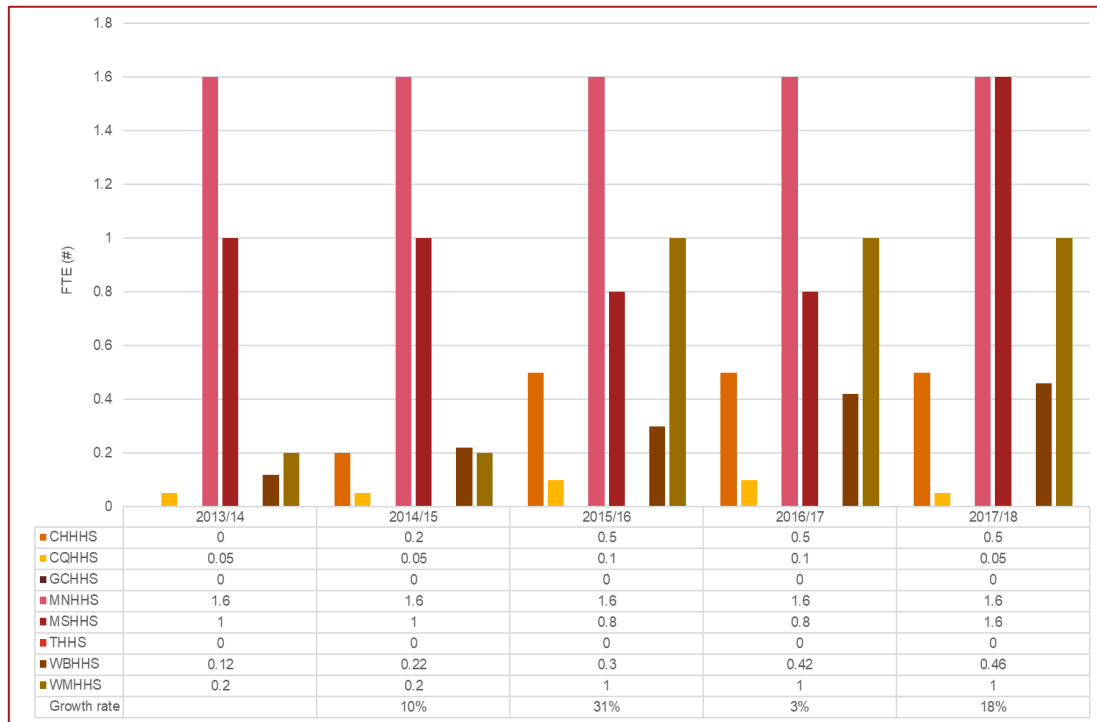


Figure 22 State-wide dental assistant FTE ⁸⁸ ⁸⁹

5.3.2 Future state

In the future, workforce attraction and retention are likely to be aided if offender health services are structured in a way that provides a career pathway, particularly for the nursing workforce, which comprises the bulk of resourcing. Such a structure would also enable clinicians to practice at the top of scope. It will also be important to ensure availability of other professions (eg allied health); however, this can be provided through in-reach services as part of the HHS' broader service provision. Following are recommendations regarding future approaches to structuring and maintaining the offender health workforce.

“ Workforce attraction and retention are likely to be aided if offender health services are structured in a way that provides a career pathway, particularly for the nursing workforce, which comprises the bulk of resourcing. ”

⁸⁸ Data for Oral Health was provided by the Department of Health and has not be audited or verified. It is assumed that raw data provide only includes information regarding oral health services provided with a Correctional Centre setting

⁸⁹ Oral Health data also includes data for Arthur Gorrie and Southern Queensland Correctional Centres as these form a part of the scope.

2. Workforce (W)

Key themes and findings

The majority of offender health service delivery is provided by the offender health nursing workforce. Some HHS have reported difficulty in attracting and retaining offender health staff, and as a result have a high reliance on the use of agency staff and high staff turnover. High turnover impacts the ability to provide continuity of care, develop expertise in prison health, and drive an appropriate team culture, all of which may impact effective health care provision.

The offender health medical workforce is challenged in providing comprehensive primary care within the health centres, due to factors such as insufficient onsite diagnostic equipment.

Recommendations

Recommendation W1 Once established, the DoH's offender health program coordination unit should collaborate with HHSs to develop a multidisciplinary resourcing model to guide the level of staffing required for offender health services, aligned to the new service model (see Recommendation S1), including:

- structuring the nursing workforce appropriately to provide a career pathway within offender health and enable nurses to work to full scope of practice
- appropriate access to medical officer resourcing
- appropriate access to pharmacy support including time on site at the correctional centre health centre, to support improved approaches to medication management
- appropriate access to oral health resourcing (which may be funded separately)
- appropriate access to primary mental health services and specialist prison mental health services
- appropriate access to allied health resourcing (funded as part of the HHS' allied health service provision)
- appropriate access to workforce to support the provision of culturally appropriate care for Indigenous offenders
- appropriate use of administrative staff to undertake tasks that do not require clinical input (eg. sourcing collateral information from patients' regular general practitioners upon reception)
- NB implementation of the above workforce model to suit local needs at each correctional centre will be led by the relevant HHSs.

Recommendation W2: Hospital and Health Services should implement a system whereby clinical staff can rotate between offender health and other health care settings within the HHS, in line with international contemporary practice. This would:

- ensure that staff maintain broad skills across their full scope of practice
- enable staff to develop expertise specific to offender health

- Enable staff to build and maintain networks with the broader HHS, which would be beneficial for individual staff but also for fostering understanding within HHSs about the context and constraints of the offender health environment
- Give staff ‘time out’ from the at-times challenging offender health environment.

Recommendation W3: HHSs should work with higher education institutions to design pathways into correctional health care; for example, clinical placements for students.

Recommendation W4: The Department should support HHSs (if needed) to establish local pools of casual staff and/or HHS staff who can provide backfill services at offender health centres, to reduce the use of agency staff, which is high at some HHSs’ offender health centres.

5.4 Access

5.4.1 Current state

Consultation suggested that there are numerous barriers to accessing timely and appropriate health services for patients

These include:

- Disinclination on the part of mainstream facilities to provide health services to prisoners.
- Gaps between services that can be provided within the OHS centre and hospital.
- Limited availability of QCS resources to escort patients to hospital (see also section 5.6 below).
- QCS operational procedures that impact the health of offenders. For example, the inability of offenders to hold medications in their cells and self-administer as they would in the community, results in health staff spending a portion of their day conducting medication rounds, reducing time available to assess and treat patients. It also means that patients do not always have access to medication at the optimal time of day.
- Patient refusal of care due to:
 - Long transit times to the Princess Alexandra Hospital Secure Unit, or other hospital
 - Previous experiences at BCC (men) or BWCC (women)⁹⁰
 - Clashes with other appointments that are important to prisoners, such as family visits, legal visits or court appearances.

Supporting data and analysis

Generally, access can be measured through analysis of parameters such as waiting times and percentage treated in turn. However, such data was not available for analysis of OHS.

Conversely, other jurisdictions track against some access-related KPIs and quality standards; for example:

- Incidence of Patients/Clients receiving timely diagnostic test results.
- Number of external/off-site outpatient appointments booked, by type.
- Number of external/off-site outpatient appointments attended, by type.
- Patients/Clients are able to access dental services within five (5) weeks of a request for an appointment for a general or denture dental assessment.
- Patients discharged from an acute mental health unit who are seen by a mental health team within 7 days of that discharge (%).

⁹⁰ NB: due to QCS escort schedules between Correctional centres and the PA Hospital, patients from other correctional centres must often spend several days at either BCC or BWCC in order to access the PA Hospital Secure Unit

- One jurisdiction tracks patients who receive appointments within the following target timeframes according to the type of service required:
 - Primary health nurse clinic: within 3 days
 - GP consultation: within 10 days
 - Allied health appointment: within 40 days
 - Oral health: within 5 weeks of request for general dental or denture assessment (for patients with sentences greater than 12 months only).
- Conversely in a different Australian jurisdiction access targets are determined by offender health-specific triage categories:
 - Category 1: appointment within 1 – 3 days
 - Category 2: appointment within 4 – 14 days
 - Category 3: appointment within 15 days – 3 months
 - Category 4: appointment within 3 – 12 months.

5.4.2 Future state

Some factors affecting access to health care for offenders are outside of the control of Queensland Health; for example, QCS policies relating to the level of escort resourcing required within various correctional centres or for transports. In these instances, Queensland Health should seek to work with QCS to achieve mutually beneficial outcomes. Conversely, some factors are within the control of the health system; particularly relating to consistency of health services between correctional centres and HHSs. A state-wide governance mechanism (refer to recommendation G1) will provide a means to design and implement improvements that aim to increase patient access to health care.

“ A state-wide governance mechanism will provide a means to design and implement improvements that aim to increase patient access to health care. ”

3. Access (A)

Key themes and findings

Consultation suggested that there are numerous barriers to accessing timely and appropriate health services for offenders. Some of the barriers are within Queensland Health's power to change, such as ensuring that services such as allied health, which are funded as part of the HHSs' service agreements, are made available to offenders as they are to the general population. Conversely, factors such as the impact of the correctional centres' structured day or the prison health centre infrastructure would require negotiation with QCS if changes are to be made; these are discussed in more detail within Theme 5, (The correctional environment and interfaces with QCS) below. It appears that some HHSs do not view the offender population as part of the general HHS population, despite generally short sentences meaning that offenders cycle between prison and the community, and require health care in both settings.

Recommendations

Recommendation A1: Through the state-wide governance arrangements and implementation of the service evaluation and development system, work to increase offenders' access to health services, by implementing:

- access to allied health care, oral health services and mental health services to a similar standard to what is available in the community-based public health services, with modifications as required to accommodate the correctional environment (eg some equipment may not be permitted in a correctional centre)
- agreed and consistent service hours among offender health centres for peer group categories
- agreed and consistent state-wide medications formulary to increase continuity of care for prisoners that move between correctional centres, and reduce prisoner complaints
- optimised use of alternative service delivery approaches to avoid the need for unnecessary escorts (eg telehealth).
- collaboration with QCS to ensure the health centre infrastructure enables the delivery of a contemporary health delivery.

5.5 Service standards and models

5.5.1 Current state

Delivery arrangements vary across HHSs

All offender health services within correctional centres use a nurse-led primary care model, which is consistent with most jurisdictions examined in the literature review.

However, as shown in Figure 23, offender health services are delivered in eight HHSs through a variety of arrangements, which in many cases appear to be historically based. Core primary care is delivered in health centres within correctional centres; however, the HHS delivering offender health is not always the HHS within which the correctional centre is located. Although Figure 23 represents the most common location for delivery of services, additional services may be delivered by the PA Secure Unit for prisoners from regional Correctional Centres on an ad-hoc basis.

Mental health services are a composite between:

- Prison Mental Health – in-reach mental health services for people with severe and complex mental illness; may not be delivered by the same HHS as is responsible for primary care at the correctional centre.
- General mental health for example depression, anxiety, insomnia is delivered by OHS clinicians.
- At-risk assessments are completed by QCS psychologists.

Oral health is delivered as an in-reach service with each correctional centre's health centre having a dental chair on site. However, the HHS delivering oral health services and primary care in a correctional centre are not always the same, as shown below.

CORRECTIONAL CENTRE	GEOGRAPHIC LOCATION	PRIMARY CARE	HOSPITAL CARE	ORAL HEALTH	PMHS (SPECIALIST MENTAL HEALTH)
Helana Jones CC	MNHHS	WMHHS	Royal Brisbane and Women's Hospital	External Dentist	WMHHS (PMH employees)
Brisbane Womens CC	MSHHS	WMHHS	PA Hospital (Ipswich Hosp & Mater Mothers for complex)	MSHHS	WMHHS (PMH employees)
Brisbane CC	MSHHS	WMHHS	PA Hospital	MSHHS	WMHHS (PMH employees)
Wolston CC	MSHHS	WMHHS	PA Hospital	MSHHS	WMHHS (PMH employees)
Borallon Training & CC	WMHHS	WMHHS	PA Hospital	WMHHS	WMHHS (PMH employees)
Palen Creek CC	MSHHS	MSHHS	Beaudesert Hospital	MSHHS	WMHHS (PMH employees)
Maryborough CC	WBHHS	WBHHS	Maryborough/Hervey Bay Hospital	WBHHS	WBHHS (PMH employees)
Numinbah CC	GCHHS	GCHHS	Gold Coast University Hospital	GCHHS	WMHHS (PMH employees)
Woodford CC	MNHHS	MNHHS	Caboolture Hospital	MNHHS	WMHHS (PMH employees)
Capricornia CC	CQHHS	CQHHS	Rockhampton Hospital	CQHHS	CQHHS (PMH employees)
Townsville CC	THHS	THHS	Townsville Hospital	THHS	THHS (PMH employees)
Lotus Glen CC	CHHHS	CHHHS	Mareeba Hospital	CHHHS	CHHHS (PMH employees)
Arthur Gorrie CC	WMHHS	Out of Scope (Under contract with QCS)	PA Hospital	WMHHS	WMHHS (PMH employees)
Southern Queensland CC	MSHHS	Out of Scope (Under contract with QCS)	PA Hospital	WMHHS	WMHHS (PMH employees)

Figure 23 Provision of services across HHSs⁹¹

Hospital-based care (inpatient and specialist outpatient care) is delivered at a variety of locations. Many south-east Queensland correctional centres send people to the Princess Alexandra Hospital Secure Unit (PA Hospital Secure Unit), for both inpatient and outpatient services.

PA Hospital Secure Unit

The PA Hospital Secure Unit is a 12 bed unit on the PA Hospital campus that is staffed by MSHHS nursing staff and QCS officers to ensure security. Medical officers from the PA Hospital attend the secure unit to provide inpatient and outpatient care.

In consultation, some HHSs stated that “they cannot send patients elsewhere” than the PA Hospital Secure Unit. Such HHSs appear to prefer to use this facility to keep offenders away from other patients. QCS prefers to use PA Hospital Secure Unit as it lowers the cost of escorts (due to permanent QCS staffing and secure rooms).

Conversely, HHSs further away from south east Queensland stated that they send patients to the PA Hospital Secure Unit only when an extended length of stay is anticipated, or if a level of specialist care that cannot be provided locally is required, due to the difficulty in transporting prisoners for long distances. Figure 24 confirms that correctional centres located in north Queensland, such as Capricornia and Lotus Glen, have low episodes of care at the PA Hospital Secure Unit combined with relatively high length of stay. Likewise there is little use of the PA Hospital Secure Unit to treat prisoners from Townsville, likely reflecting the high level of clinical capability of the Townsville Hospital. The highest utilisation of the PA Hospital Secure Unit was by prisoners from Wolston Correctional Centre, likely reflecting

⁹¹ Remit of care and responsibility for service provision provided anecdotally by Queensland Health staff.

its proximity to the PA Hospital, as well as the demographic profile of this correctional centre, which tends to accept ‘aged and infirm’ male prisoners. Given that the PA Hospital Secure Unit is primarily servicing non-MSHHS correctional centres, the future location of a Secure Unit in SEQ may be better located in WMHHS, which provides health services to large numbers of prisoners. This could be as part of the Ipswich Hospital redevelopment unit, or as a ward within a new or existing correctional centre.

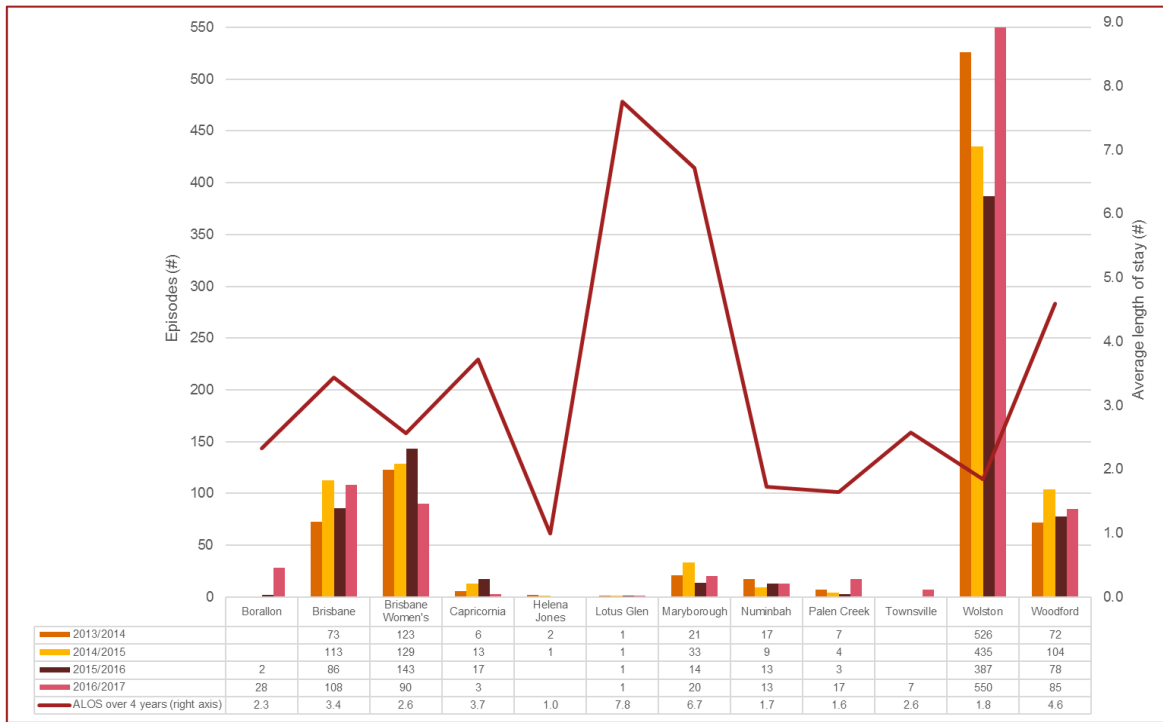


Figure 24 PA Hospital Secure Unit episodes and Average Length of Stay (ALOS) by correctional centre ⁹² ⁹³

Figure 25 graphs the top 10 outpatient occasions of service delivered at the PA Hospital to people with a usual address of a correctional centre. Nine of the top 10 tier 2 clinics were for specialist outpatient appointments. However, the sixth most common clinic type for prisoners was physiotherapy, likely reflecting comments made during consultation at a number of sites, that physiotherapy is not available as an in-reach service. Together, the top 10 clinics comprise approximately 58 per cent of outpatient activity being delivered to prisoners at the PA Hospital.

⁹² Source: Admitted data for PAH treating persons whose usual address was recorded as a correctional centre was provided through the Department of Health. It is assumed that the data provided relates to activity occurring only within the Secure Unit at the PA Hospital.

⁹³ Average length of stay is calculated by dividing Total Secure Unit Ward days by Total Secure Unit Episodes per Correctional Centre.

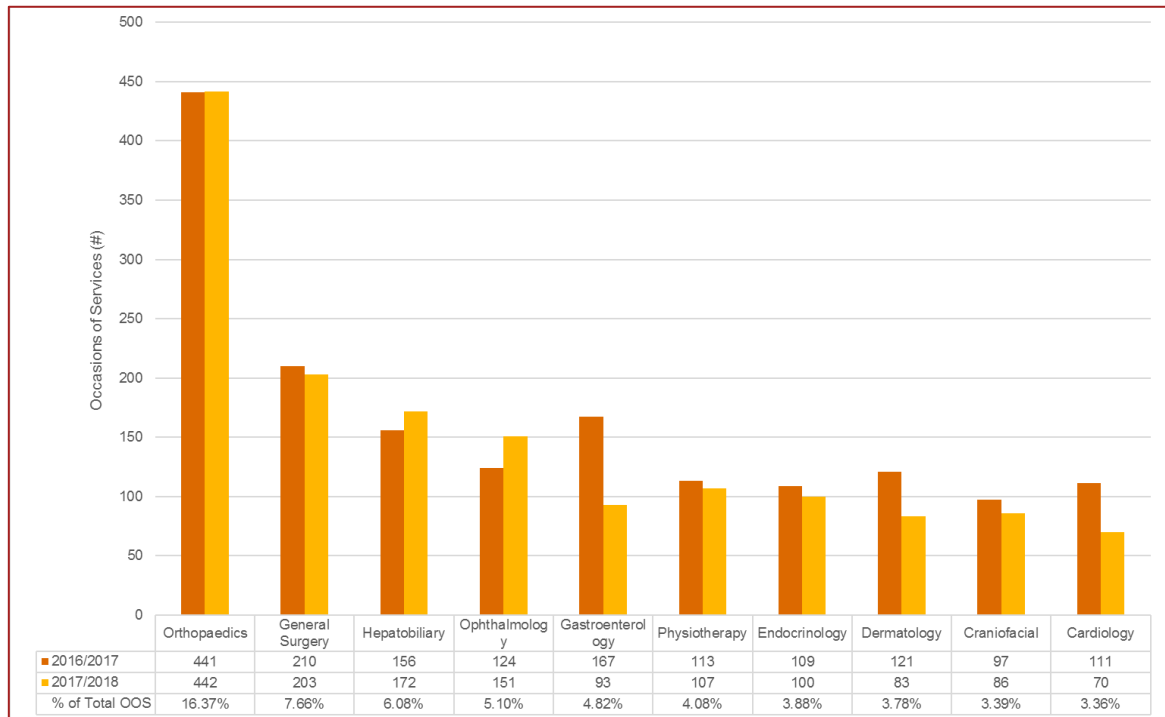


Figure 25 Top ten outpatients occasions of service at PAH, 2016/17 and 2017/18⁹⁴

As noted under section 5.4, it appears that prisoners may in some cases refuse treatment at the PA Hospital Secure Unit for a variety of reasons. It is likely that prisoners are being sent to the PA Hospital (ie a large training hospital) for care that could be safely provided:

- at closer facilities with lower CSCF level
- within offender health centres
- using telehealth.

In general, other jurisdictions reviewed have a secure unit or prison hospital, but are also exploring ways to provide hospital care closer to correctional centres or through the use of telehealth.

In general, the further from south-east Queensland, the less likely it is that a prisoner will be transferred to the PA Hospital Secure Unit and the more likely that they will be treated at the nearest hospital with an appropriate CSCF level.

Strategy, planning and standards are lacking in Queensland offender health

At present, there is no offender health strategy, standards or KPIs, at either the state-wide level or at individual HHSs, although some HHSs did mention tracking similar metrics to their broader HHS, using a balanced scorecard approach.

⁹⁴ Source: Non-admitted OoS data for PAH treating persons whose usual address was recorded as a correctional centre was provided through the Department of Health. It is assumed that the data provided relates to outpatients occasions of service occurring within the Secure Unit at the PAH, although this was not apparent from the data.

Conversely, jurisdictions analysed in the literature review have various frameworks, plans and other guiding documents. For example:

- Victoria Justice Health has a *Quality Framework*, which contains qualitative statements for the required features of offender health services, and some KPIs; this enables Justice Health to manage contractual arrangements with private providers.
- NSW JH&FMHN has a *Strategic Plan 2018-22* which aligns to the NSW government priorities.
- NHS England has implemented the *Strategic Direction for Health Services in the Justice System: 2016-2020*.
- Correctional Health Canada has the *Public Health Strategy for Offenders*.

At present, there are no Queensland offender health KPIs and consistent data collection to enable an understanding of performance (eg efficiency, effectiveness, safety and quality).

Offender health is block funded, consistent with other jurisdictions examined

Offender health services in Queensland are block funded. In the literature, no examples of funding formulae were found. All OHS in jurisdictions reviewed appear to be blocked funded.

- Total offender health funding has grown 70 per cent since 2014/15, compared to 20 per cent growth in the prisoner population (see Figure 14).
- Of the six HHSs where data were available, four HHSs appear to be spending below average per prisoner on offender health, while two HHSs appear to be spending above average (see Figure 15).
- Average expenditure per prisoner was \$6,739 in 2016/17 for these six HHSs (see Figure 15).

Given the poor health status and social determinants of the prisoner population⁹⁵, coupled with an inherently inefficient environment, high per capita spend is not surprising (see Figure 17).

Consistent with the broader population, it would be expected that demand for offender health services would be driven by factors such as population growth (of the prison population) and the demographic factors and health needs of the population; for example:

- Age
- Social determinants
- Substance abuse
- Chronic disease
- Communicable disease.

⁹⁵ Australian Institute of Health and Welfare (2015). The health of Australia's prisoners. Canberra, ACT.

However, as Queensland has no offender health data definitions or data collection, it is not possible to quantify demand factors other than prison population, prisoner turnover rates and factors relating to the prison itself (eg security level).

Conversely, oral health and Prison Mental Health have activity data as part of the relevant state-wide data collections. At the time of writing this document, the Office of the Chief Dental Officer was developing an oral health resource model (dental staff to patient ratio) based on the DMFT (decayed-missing-filled-teeth) Index.

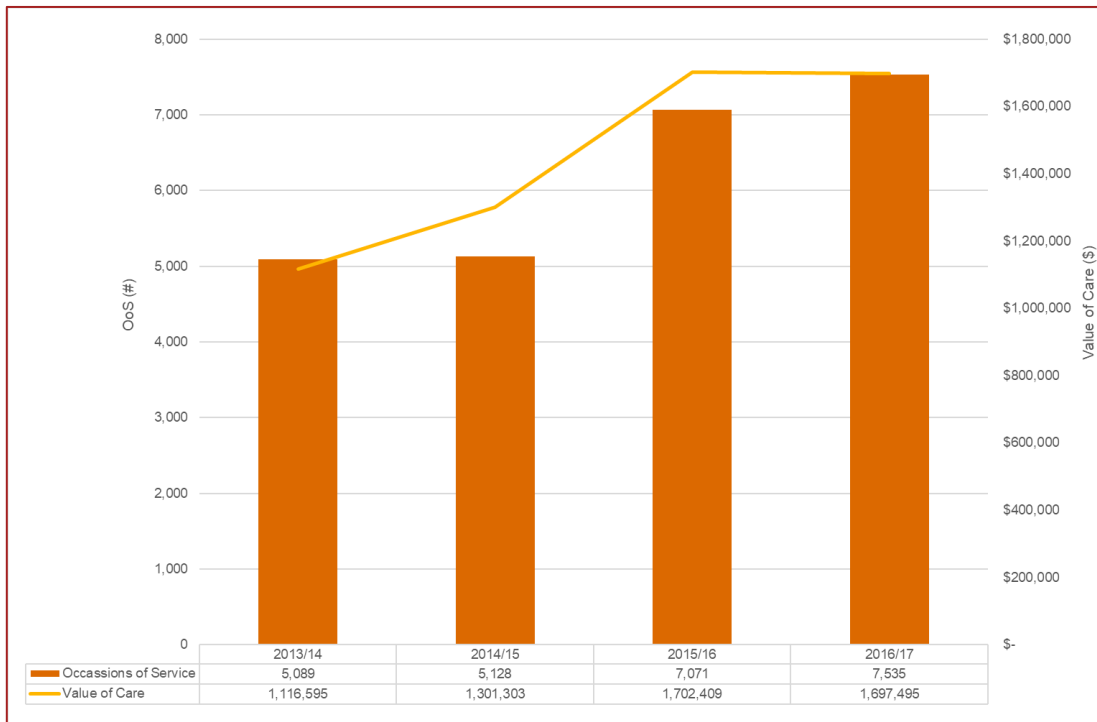


Figure 26 Oral health state-wide occasions of service vs value of care ^{96 97 98}

Oral health services to correctional centres are often provided by differing HHSs to primary care services (see Figure 23). Oral Health Value of Care is the expenditure associated with oral health at each correctional centre. The increase in occasions of service and value of care in 2016 (Figure 26) may be a result of a 0.8 FTE dentist being occupied at Borallon Training and Correctional Centre (see Figure 22).

Prison Mental Health noted in consultation that they use a staff to patient ratio based upon a model developed in the United Kingdom. However, stakeholders expressed concerns as to whether the ratio is consistently achieved and whether referral criteria are enabling the required level of access to specialist mental health services for the prison population.

PwC has developed funding models for other government agencies, and has identified a number of design requirements for effective funding models. These represent key “prerequisites” that a funding model should meet in order to drive successful outcomes for

⁹⁶ Data for Oral Health was provided by the Department of Health and has not be audited or verified. It is assumed that raw data provide only includes information regarding oral health services provided with a Correctional Centre setting.

⁹⁷ Data was only provided for those correctional centres listed within the graph. As such, the state-wide averages do not take into account Palen Creek Correctional Centre, Helena Jones Centre and Numinbah Correctional Centre.

⁹⁸ Oral Health data also includes data for Arthur Gorrie and Southern Queensland Correctional Centres as these form a part of the scope.

for the service being funded. In broad terms, the key elements of a successful funding model are:

- effective governance arrangements, including a rigorous and agreed performance framework, to facilitate the operation of the funding model
- clearly defined and agreed upon services, service standards and terms of service provision
- transparent and agreed methodologies which provide certainty and predictability of cost apportionment, fees and revenue
- commitment to the ongoing success of the funding model from both the funder and service provider.

At present, these prerequisites are not in place for offender health. As a result of this review, it is likely that governance, performance management and service specifications will all change. Thus, it is premature to consider developing a new offender health funding model. Below, a recommended interim approach is provided, based upon prison security level.

Service availability and offering varies between HHSs

Different health services are offered at different health centres, leading to differing effectiveness in meeting patients' health needs. Through consultation, it appears that in many offender health centres, there is a lack of provision of:

- allied health services, particularly podiatry and physiotherapy
- preventative oral health care. In most health centres, only emergency oral health care (ie extractions and fillings in response to pain) is provided. There is little to no preventative oral health care and denture provision, despite prisoners having generally high oral health care needs
- ongoing chronic disease care and education
- health promotion services
- sexual health services
- care plans and referrals upon release to the community.

However, due to the lack of a consistent state-wide data collection, the above could not be verified.

Medications management represents an opportunity to improve efficiency and free up resource to provide new or additional health services, or to improve timeliness of service delivery

Through consultation, in general HHSs stated that approximately 50 per cent of prisoners are taking regular medications. However, due to the lack of a consistent state-wide data collection or electronic medical record for offender health, this could not be verified.

Some HHS use pre-packaged medications, which are prepared off-site, reducing manual processing and risk of errors. Such an approach is consistent with NSW JH&FMHN and Victoria. While the use of pre-packaged medications prepared off-site still requires manual work to make medication changes, in consultation HHSs stated that pre-packaged medications nevertheless improved efficiency and reduced medication errors. A single HHS had an on-site medication dispensing machine situated within the prison health centre; and stated that this had substantially reduced the time required for medication rounds.

Conversely, some HHS offender health services use manual processes to prepare medication 2-3 times per day for the patient population. Given the high proportion of prisoners taking regular medication, medication rounds generally involve preparing and distributing medication to hundreds of people at several sites around the correctional centre.

The only examples in Queensland of patient self-management of medications is at the low security facilities (including some of the work camps). In these instances, only certain medications can be self-administered. For example, s8 drugs⁹⁹ can never be self-administered in Queensland prisons.

Conversely, other jurisdictions reviewed in the literature review have more extensive self-medication provisions in prisons which factor in the nature of the medications and a risk assessment of prisoners which is not linked to security level. For example, NHS England's 'In-possession risk assessment' is aligned to the NHS England policy position that "*Medicines in use, together with associated monitoring and administration devices, should normally, as a matter of principle, be held in the possession of prisoners*".¹⁰⁰

5.5.2 Future state

In the future, a key objective for offender health should be to increase consistency across the state. This includes a consistent basis for funding, and a consistent level of service provision

“ A key objective for offender health should be to increase consistency across the state. This includes a consistent basis for funding, and a consistent level of service provision proportional to demand. ”

proportional to demand. A key consideration will be to drive a contemporary harm minimisation approach in design of health services for offenders. This approach will mean various changes to policy and service delivery will be required, in collaboration with QCS. In addition, a culture of continuous improvement should be fostered across the state. To achieve this, a commitment to clinical redesign and appropriate management of complaints and clinical incidents will be vital.

The below funding model is based on allocating blocked-funds based on a categorisation of low security, high security and remand and reception prisoners. This enables funding to be allocated equitably across HHSs, with how the final decision of how those funds are distributed left to the individual HHS. However, this categorisation does not indicate the total amount of funding and resources that will be provided to each prisoner (eg additional funding based on Indigenous status maternal health, etc). Given the Department and HHSs do not currently collect sufficient funding data, and the level of expenditure on offender health services equate to less than 1 per cent of total Queensland Health spending, the model provides a level of sophistication that enables understanding of cost drivers, and how to equitably allocate funds based on those drivers.

⁹⁹ S8 ('schedule 8') drugs are drugs of dependence under the regulatory requirements under the Health (Drugs and Poisons) Regulation 1996. These prescription medicines that have a recognised therapeutic need but also a higher potential for misuse, abuse and dependence.

¹⁰⁰ NHS England, Northamptonshire Healthcare NHS Foundation Trust (2016). Policy for 'Medication in-possession' in HMP Onley. Available at: <https://www.nhft.nhs.uk/download.cfm?doc=docm93jjm4n1566.pdf&ver=6848>.

4. Services Standards and Models (S)

Key themes and findings

The most prominent finding is that delivery arrangements and service availability and offering significantly varies between HHSs, largely due to a lack of coherent strategy, planning, standards and performance management across Queensland offender health.

There is also a lack of complete, reliable and comparable activity and cost data for offender health across the state. Taken together with the small size of the offender population, the above findings mean that the current approach of block funding offender health services is appropriate. Block funding for offender health is also consistent with other jurisdictions examined.

Despite the lack of quantitative activity data, consultation revealed areas where a redesign approach would be expected to improve efficiency and therefore release capacity within the current offender health workforce, due to the current manual processes in use (see Recommendation S3 below).

Recommendations

Recommendation S1: Continue block funding of offender health services in a resource-based model, ensuring that funding is efficiently allocated to HHSs for offender health services based upon consistent funding principles.

Recommendation S1.1: In the absence of data that enables health need to be established in the Queensland prison population, initially funding may be allocated based upon known data points, as follows:

Peer group	Principle	Funding implication	Notes	Relevant CCs
Group 1: Base funding	Number of prisoners at correctional centre	Base level of per head allocation (base level of funding to be allocated per head aligned to average annual occupancy of the correctional centre)	Provision of top-up funding likely to be required as average annual occupancy increases. Top-up funding could increase at a lower rate than the base funding level due to economies of scale.	All correctional centres
Group 2: High security	Restricted movement and access	Base funding plus high security loading	High security correctional centres present challenges to efficient delivery of health services and may also be less amenable to service delivery improvements that would improve health service efficiency	High security correctional centres
Group 3: Remand and reception	Turnover of prisoners at correctional centre	Base funding plus high security loading plus loading to account for administration associated with new receptions and discharge, as well as stabilisation of new receptions	% loading (intake) multiplied by number of new entrants % loading (discharge) multiplied by number of discharges	Remand and reception centres

Recommendation S1.2: Given the availability of state-wide activity data sets, oral health and Prison Mental Health are amenable to the development of resource based funding models. An oral health resource based funding model is under development; however it is recommended that the Prison Mental Health resource model is reviewed against current levels of demand.

Recommendation S2: Develop and implement a service delivery model that increases standardisation across the state. Key considerations include:

- Continued use of a nurse-led primary care model with increased emphasis on preventative care. This would be expected to benefit Queensland Health more broadly through the avoidance of costly hospital care during incarceration and following release. Health economic and integrated care principles may be used to design services.
- Agreed clinical capability levels to match the agreed model of care, supported by appropriate health centre space, physical layout, facility standards; and appropriate training for clinical staff as required.
- Provision of the following services:
 - Comprehensive reception assessment.
 - Communicable disease screening, vaccination and treatment, including access to universal testing and treatment for Hepatitis C in Queensland correctional centres in conjunction with broader population health approaches in the community, to ensure that correctional centres do not become a reservoir for Hepatitis C.
 - Access to allied health services including podiatry, dietetics and physiotherapy.
 - Diagnostic services appropriate to the primary care setting.
 - Medication management, including a consistent state-wide offender health formulary, that reduces the risk of errors and support patients to self-manage as part of a transition back to the community.
 - Oral health services including general dental care for patients with sentences above 12 months.
 - Multidisciplinary alcohol and other drugs (AOD) addiction services.
 - Multidisciplinary chronic pain management services.
 - Chronic disease screening and ongoing management.
 - Sexual health care and education.
 - Discharge planning, including sending discharge summaries to patients' My Health Record to enable continuity of care in the community.
 - The above services should be regarded as forming part of the suite of services provided by HHSs to the general HHS population.
- Increased, consistent use of telehealth. This will reduce unnecessary hospital transfers, which will benefit QCS through reduced patient transport costs and Queensland Health through reduced admission costs.
- Agreed patient transfer pathways, adopting the principle whereby the HHS that has responsibility for delivering primary health services to prisoners should deliver all health services to those prisoners, including oral health, mental health, and specialist outpatient and inpatient care. The only exceptions to this principle would be if there is no facility within the HHS with a suitable CSCF level to provide the required care, if a prolonged inpatient stay is required (in which case, admission to a secure unit may be more appropriate), or as required under the *Mental Health Act 2016* and/or the *Chief Psychiatrist Policy for Classified Patients*.

- Conducting a review to determine the appropriate locations for secure inpatient care. Principles to determine appropriateness may include:
 - Proximity to the largest number of current and planned correctional centres
 - CSCF level of the hospital.
- To alleviate pressure on hospitals, consider the feasibility of:
 - ‘hospital in the prison’ (with similar services to Hospital in the Home), which would be expected to reduce costs to both Queensland Health, by reducing hospital utilisation, and to QCS, by reducing transports.
 - mobile x-ray machines that could be utilised within health centres where applicable. Cost effectiveness would depend upon size of correctional centre and demand for x-ray services.

Recommendation S3: Undertake a clinical service redesign program to increase efficiencies. For example for medications management:

- Investigate use of automated technology to dispense medications and thereby reduce medication errors (similar to the system used in Capricornia Correctional Centre by CQHHS) and reduce nursing workload.
- Work with QCS to develop appropriate policies and processes for prisoner self-medication, targeted at appropriate prisoners and applying only to medications deemed safe and not at risk of diversion within correctional centres.
- Ensure ready access to PRN medications (eg analgesics that, in the community, are available ‘over the counter’ without a prescription).

Recommendation S4: Ensure strong and consistent local complaints management policies to enable local resolution without the need for complaints to external agencies. This should include attendance by offender health staff at Prisoner Advisory Committee meetings.

Recommendation S5: Ensure that patient safety and quality of care issues and incidents are appropriately captured in the relevant enterprise system and that this information is shared with the Department of Health Patient Safety and Quality Improvement Unit to enable the state-wide identification of systemic issues and timely development of solutions and improvements.

5.6 The correctional environment and interface with QCS

5.6.1 Current state

The corrections environment impacts the ability to provide efficient and effective health care services in prisons

The inherent environment of correctional centres impacts patient flow through the health centre, and to and from the hospital.

In addition, the structured day of a corrections centre impacts effective patient delivery; for example, the requirement to deliver medications to cell blocks.

The physical environment of the correctional centre also impacts the efficiency of health care provision. This includes:

- the size and layout of the correctional centre and the distance for movement across the property due to the variable proximity of the health centre to prisoner quarters.
- gates and access points management to allow patients to move across the correctional centre for appointments, often resulting in patients being late for appointments.

Capacity and overcrowding

Prisoner numbers in Queensland have increased rapidly over recent years, such that the majority of correctional centres are now occupied at levels substantially above their built capacity. In general, health centres within prisons were designed to provide services to a lower number of prisoners than are currently accommodated.

There is limited capacity for offender health services to cope with overcrowding due to the finite physical footprint of the health centres.

Availability of transport and escorts leads to rescheduling of planned hospital care to accommodate emergency transfers to hospital

Health centres have limited access to transport vehicles, with a finite number of escorts (vehicles and escort staff) available each day.

Rule 27.2 of the Nelson Mandela rules states that “*Clinical decisions may only be taken by the responsible health-care professionals and may not be overruled or ignored by non-medical prison staff*”.¹⁰¹ However, the limited capacity of QCS to provide transfers to hospital means that emergency cases force offender health staff to decide who should keep their appointments for scheduled hospital-based care, and who should have their appointments rescheduled. Likewise, a lack of vehicles can be overcome by calling for an ambulance during emergencies, but QCS policy still requires that correctional staff accompany the prisoner to hospital. This leads to delays in accessing hospital based care, eg for medical imaging.

Safety orders are generally issued by QCS, but impact the workload of offender health staff

Safety orders are made when a prisoner is deemed to be at risk of self-harm, of harming others or being harmed by others. Safety orders are generally made by QCS psychologists as a result of an at-risk assessment. There are requirements under section 57 of the *Corrective*

¹⁰¹ Justice Section, Division for Operations (2015). The United Nations Standard Minimum Rules for the Treatment of Prisoners (the Nelson Mandela Rules). United Nations Office on Drugs and Crime. Vienna, Austria.

Services Act 2006 for a doctor or nurse to conduct a health examination of prisoners subject to a safety order at least every seven days.

This requirement impacts the workload of offender health staff, and despite the importance that these staff play in the health and wellbeing of prisoners, processes surrounding these requirements are generally outside of their control. Although under legislation offender health staff are able to initiate safety orders, in reality the majority are initiated by QCS. It has also been reported that prisoners are less likely to be open and honest about thoughts of self-harming, due to the consequence of being placed in an environment where they may be considered to be “safe”, but are sensorially deprived. To better manage safety orders, effective liaison is required between QCS and offender health staff, as both have a role to play in advocating for the wellbeing of prisoners.

Figure 27 demonstrates that safety orders are generally remaining stable or growing slowly at correctional centres other than Brisbane Correctional Centre and Woodford Correctional Centre, where there were substantial increases during the past several years, and Lotus Glen Correctional Centre, where safety orders are climbing steadily.

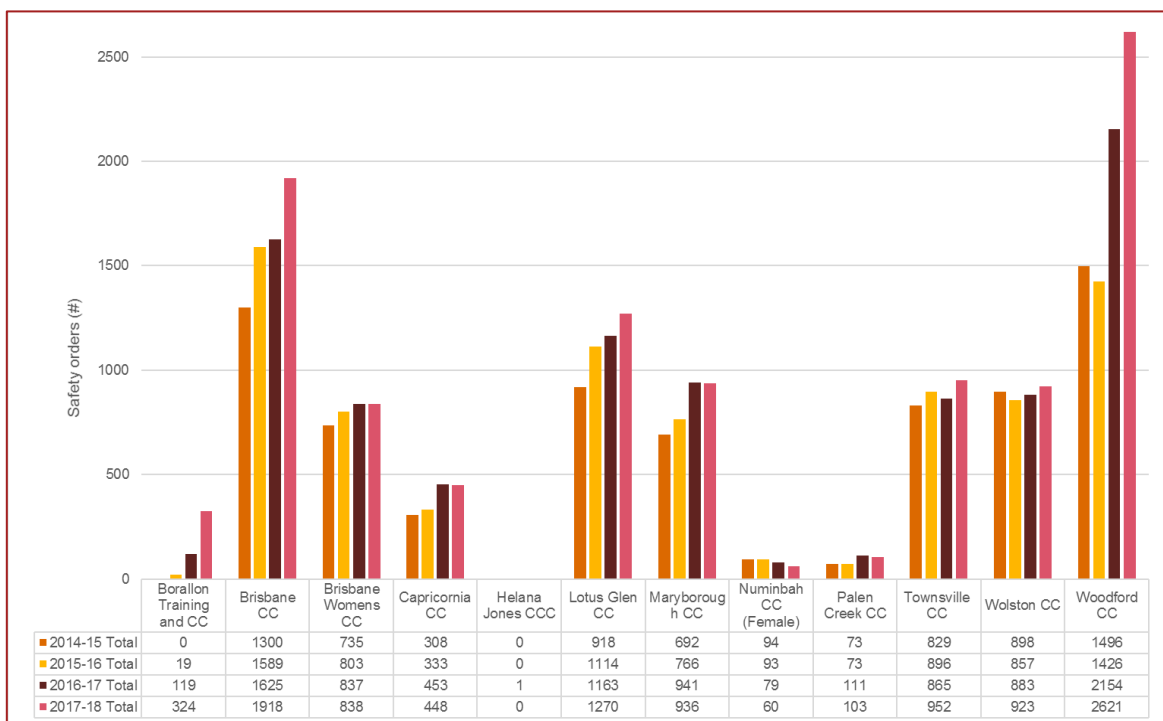


Figure 27 Safety order occurrences by correctional centre¹⁰²

¹⁰² Source: Safety orders data was provided by QCS through the Department of Health, dated to 30 April 2018. Safety orders data for 2018 was prorated from 10 months to 12 months.

5.6.2 Future state

In the future, there should be a state-wide memorandum of understanding between Queensland Health and QCS (see Governance recommendations above). To enact the agreements within local contexts, it will be important that HHSs and the correctional centres they serve jointly prepare the local operational agreement. The state-wide MoU and local agreements would then form a solid basis upon which to:

- collaborate on areas of common interest such as funding.
- negotiate changes to health service provision that would require a change to QCS state-wide policies or local procedures.

“To enact the agreements within local contexts, it will be important that HHSs and the correctional centres they serve jointly prepare the local operational agreement.”

5. The Correctional Environment & Interfaces with QCS (I)

Key themes and findings

The corrections environment, specifically the operating systems and processes, impacts the ability to provide efficient and effective health care services in prisons. Part of this barrier involves the finite physical footprint of the health centres, limiting the capacity for offender health services to cope with the increased overcrowding. Another includes the availability of transport and escorts, which often leads to rescheduling of planned hospital care to accommodate emergency transfers to hospital. A lack of coherent systems and processes between QCS and OHS staff is further evidenced through safety orders. Although generally initiated by QCS, they impact the workload of OHS staff, with the processes surrounding the requirements generally outside of the control of OHS staff. OHS staff are generally reactive rather than proactive in addressing prisoners' health needs due to the physical environment and demands beyond their control, with limited paths to escalate issues for resolution.

Recommendations

Recommendation I1: In line with recommendation G1.2, HHSs should develop and implement local offender health arrangements between the HHS and correctional centre. Such arrangements should:

- Align to the state-wide MoU to be developed under G1.2
- Clearly set out the roles, responsibilities, service provision and expectations of each side
- Engage both HHS and correctional centre leadership in offender health, to ensure that both organisations understand the benefits of providing effective offender health services
- Help to ensure that services remain consistent and well-understood even when there is a change in leadership of the HHS, the correctional centre, or the offender health service.

Recommendation I2: As a priority, the Department and HHSs should work with QCS on joint funding submissions to upgrade health centres in line with changing prisoner numbers, prisoner demographics, health needs and accreditation requirements.

Recommendation I3: The state-wide offender health governance group should work with QCS on policy areas such as:

- needle exchange (required to ensure spread of blood borne viruses is reduced). This would be enabled by an offender health research governance framework which could access the efficacy and safety of such an approach before broad roll out
- provision of condoms (required to ensure spread of blood borne viruses is reduced)
- changes to medication management
- changes to the use of the PA Hospital Secure Unit.

5.7 Complaints profile

Complaints received by the Office of Health Ombudsman (OHO) from prisoners currently residing within various correctional centres across the state form a critical picture of patient and health concerns that are escalated and reported to this external body. There is substantial variation between HHSs regarding complaints to OHO, which may be driven in part by local approaches to complaints management (see Figure 28). For some HHSs, the majority of HHS-related complaints relate to offender health.¹⁰³ During consultation, various stakeholders commented that a driver of complaints appears to be inconsistencies in service delivery between offender health services. In particular, staff understood that differing availability of medications among correctional centres was a key issue for offenders. This is supported by data which demonstrates medications was the second most common issue raised in complaints to OHO from offenders (see Figure 29). External offender health experts engaged during the review were of the view that a state-wide formulary would be of assistance in managing patient expectations and reducing complaints.

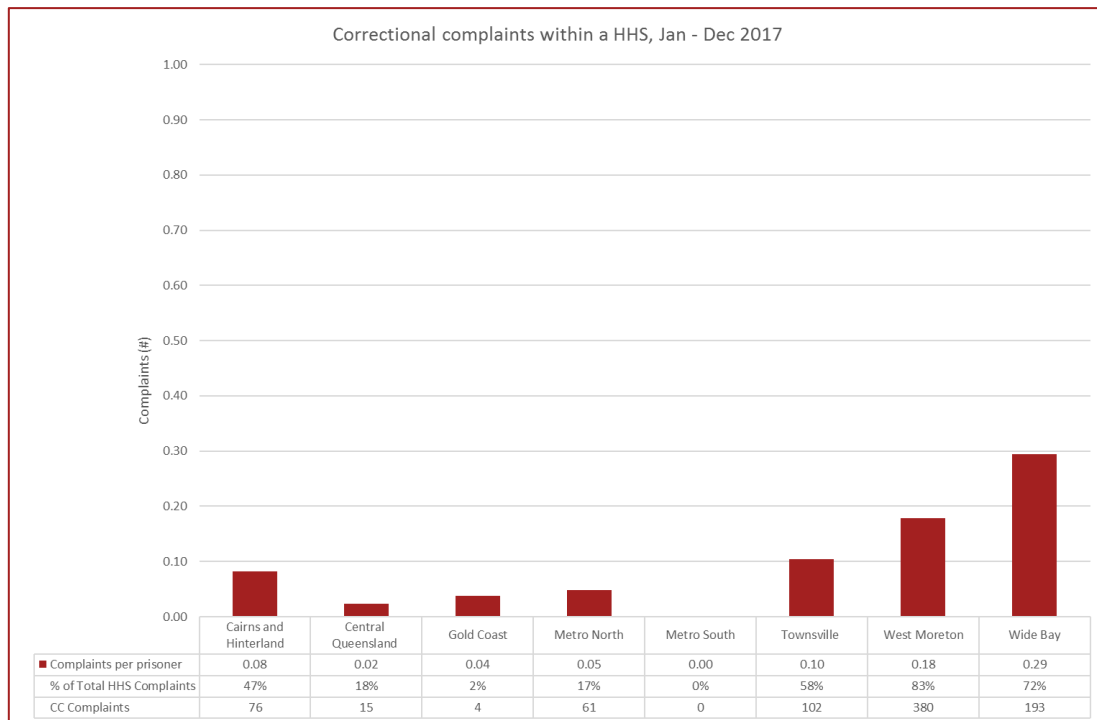


Figure 28 Number of correctional centre complaints to the Office of the Health Ombudsman by HHS and complaints per prisoner, calendar year 2017^{104 105 106}

It is noted that the HHS identified as the complaint recipient may not be the HHS where the service which relates to the complaint was delivered.

Figure 29 shows the top five issues raised within complaints to OHO. Over 90 per cent of complaints related to professional performance, medication or access to health services. This

¹⁰³ It should be noted however that OHO manages various other categories of health service complaints, many of which are not classified as HHS complaints.

¹⁰⁴ Source: State-wide complaints data was provided by OHO. The raw data provided has not been audited or verified.

¹⁰⁵ Source: Prisoner number information was provided by QCS through the Department of Health. It included a count of prisoners at a correctional centre at the end of the last day of each month (for example, count of prisoners at 30 June 2018).

¹⁰⁶ Complaints per prisoner was calculated by dividing offender health related complaints for a HHS by the average number of prisoners for that year.

was reflected in the consumer consultation conducted by Health Consumers Queensland as part of the broader body of work being overseen by Clinical Excellence Division.

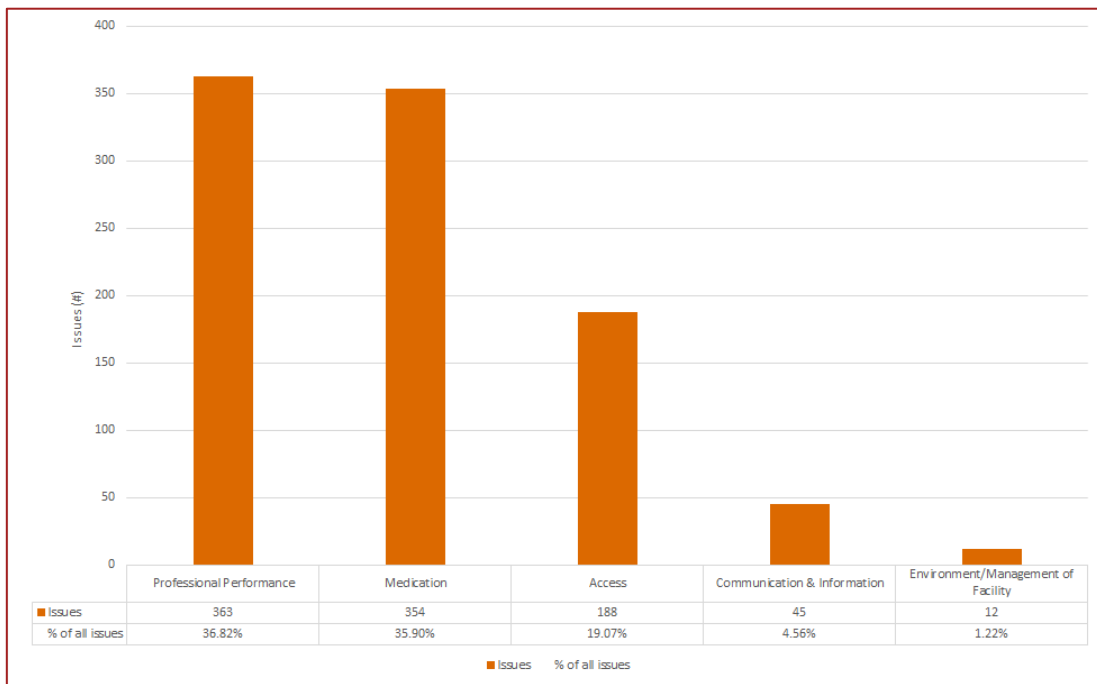


Figure 29 Top five complaint types to the Office of the Health Ombudsman, relating to offender health services for calendar year 2017. State-wide aggregated data ¹⁰⁷

As identified by Health Consumers Queensland in their conversations with Prisoner Advisory Committees, lack of communication and feedback from health centre staff regarding a prisoners request for health care was raised as one of the most significant issues. In most cases, this related to not being provided with a response to their medical request forms, with prisoners unaware of their appointment until they are called to attend the medical centre. Taken together with the complaints data presented in Figure 29, this suggests that simply providing a response to medical requests may improve patient satisfaction and reduce complaints.

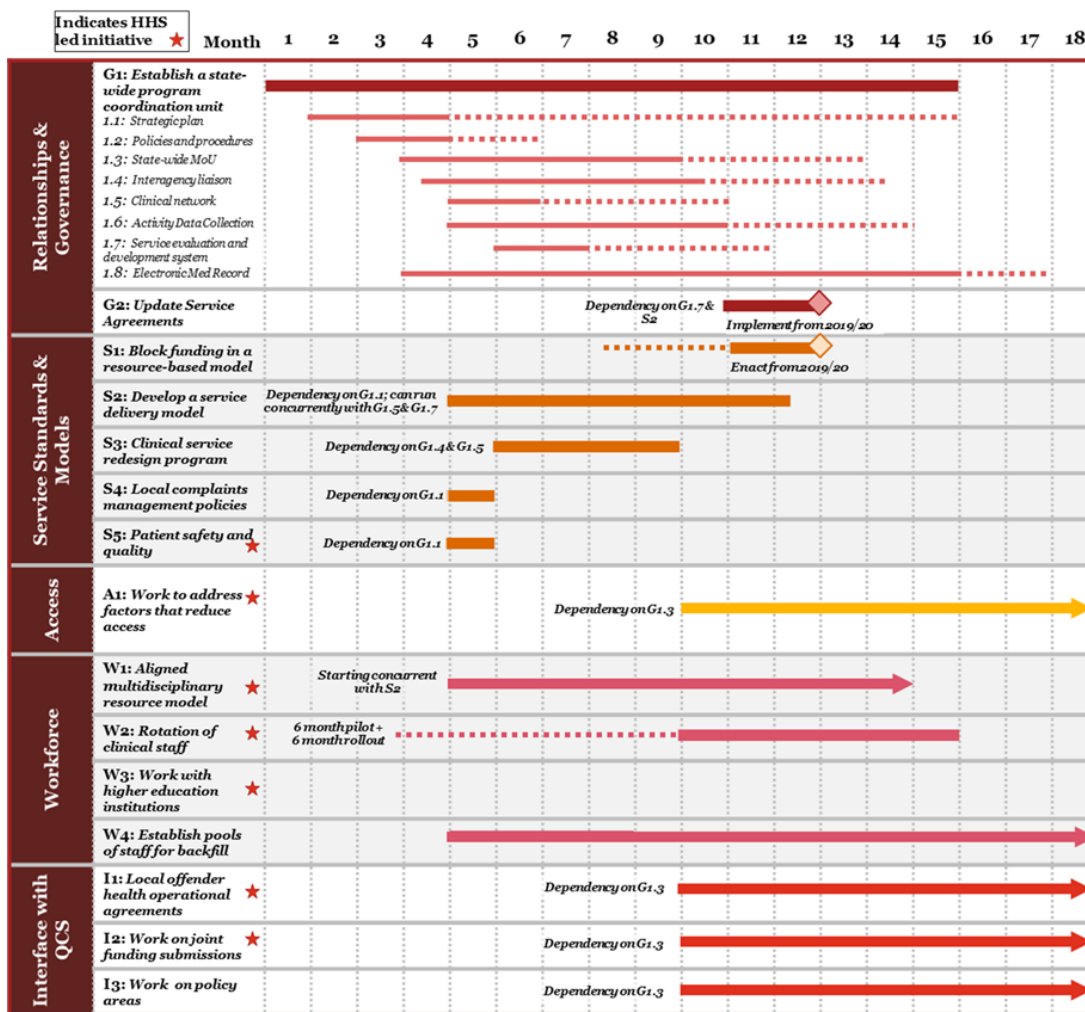
¹⁰⁷ Source: State-wide complaints data was provided by OHO. The raw data provided has not been audited or verified.

6 Next steps

Enacting the recommendations in this report is expected to drive benefits such as:

- Improved health outcomes for offenders
- An improved ability to understand, and where required, improve, the performance of offender health services
- Increased standardisation of services offered between correctional centres, leading to improved continuity of care
- Reduction in complaints from prisoners.

The diagram below sets out a suggested timetable for implementing the recommendations; commencing with establishing the state-wide program coordination unit, which will enact and drive most of the change. It is expected that the change journey will require up to 18 months to complete. The size of the offender health governance entity will determine the capacity to implement the initiatives outline below, and as such should be viewed as an indicative timeline.



Key success factors will include:

- Effective communication and engagement with stakeholders across relevant agencies and teams, with a focus on identifying 'win-wins' where possible
- Use of collaborative, co-design processes, that draw upon the combined expertise of offender health staff
- Consideration of patient needs and wellbeing as the key outcome of changes to offender health services
- A learning approach that leverages approaches that are used successfully to deliver offender health in other jurisdictions.

The opportunity to make a significant difference to vulnerable members of the community is substantial as a result of the recommended change program. It is likely that benefits would flow to the broader health system, through a reduction in hospital utilisation during and after incarceration.

Acknowledgement of Taskforce Flaxton

In April 2018, the Queensland Crime and Corruption Commission commenced Taskforce Flaxton, an examination of corruption and corruption risks in Queensland adult corrective services facilities. During the 13 days of public hearings, the issue of overcrowding and the impact that has on the delivery of services, including health services, received significant attention. Given the scrutiny corrective facilities will likely receive throughout and after the examination, consideration should be given to the recommendations of the final Taskforce Flaxton report upon its public release, and the constraints that may have on the recommendations contained in this report.

Acknowledgement to stakeholders

PwC would like to acknowledge the multiple stakeholders that were involved in this review, and thank them for their willingness to contribute their knowledge and insights in consultation sessions, help organise and facilitate on-site prison visits, and collate and provide numerous data requests. Without their efforts and input, this report would not have been possible.

CCC EXHIBIT

Appendices

Appendix A Glossary of terms	85
Appendix B Stakeholders Consulted	87

CCC EXHIBIT

Appendix A Glossary of terms

Acronym / term	Definition
Allied health	Allied Health is a term used to describe the broad range of health professionals who are not doctors, dentists or nurses, such as physiotherapists, podiatrists and speech pathologists.
BCC	Brisbane Correctional Centre
BWCC	Brisbane Women's Correctional Centre
CC	Correctional Centre
Department of Health	The Queensland department which has the role of system manager of the Queensland state based public health system as provided for by the <i>Hospital and Health Boards Act 2011</i>
HCQ	Health Consumers Queensland
Hospital and Health Services (HHS)	The 16 statutory bodies that are the principal providers of public sector health services in Queensland as provided for by the <i>Hospital and Health Boards Act 2011</i>
HJC	Helana Jones Centre
HHS	Hospital and Health Service
LGCC	Lotus Glen Correctional Centre
MCC	Maryborough Correctional Centre
MOHRI	Minimum Obligatory Human Resource Information
MOHRI occupied FTE	Includes only those FTE that are classified as Active/Paid
Offender health services	Primary health care services within correctional centres. The term 'prison health services' and 'prisoner health services' are used synonymously between different HHSs
Queensland Health	The entire Queensland state based public health system, comprising the Queensland Department of Health and the Hospital and Health Services

Acronym / term	Definition
	(HHSs)
Prisoners	A person incarcerated in a Queensland adult correctional centre. In this report, terms such as 'prisoner', 'prisoners', 'offenders', 'people', 'individuals', are used synonymously as appropriate for the context in each case. When prisoners are accessing healthcare, the word 'patients' is used.
TCP	Townsville Correctional Precinct
WCC	Woodford Correctional Centre
WLCC	Wolston Correctional Centre

Appendix B Stakeholders Consulted

Stakeholder Name ¹⁰⁸	Organisation	Stakeholder Title / Position
	Office of the Health Ombudsman	Director, Local Resolution & Conciliation
	Department of Health	Executive Director, Mental Health, Alcohol and Other Drugs Branch
	WMHHS	Nurse Practitioner, Borallon Training and Correctional Centre
	Office of the Public Guardian	Director Guardianship
	MSHHS	Deputy Director Medical Services
	GCHHS	Service Director, Specialist Programs and Alcohol and Other Drugs
	Prisoner Legal Service	Principal Casework Solicitor
	WMHHS	Primary Mental Health Clinical Nurse Consultant, Borallon Training and Correctional Centre
	MNHHS	Nurse Practitioner, Woodford Correctional Centre
	WBHHS	Executive Director, Mental Health and Specialised Services
	WBHHS	Assistant Director of Nursing, Prison Health Service
	Department of Health	Chief Dental Officer
	WMHHS	Clinical Nurse Consultant, Brisbane Women's Correctional Centre
	QCS	Deputy General Manager, Palen Creek Correctional Centre

¹⁰⁸ NB. Stakeholder names have been redacted from this report prior to publication.

Stakeholder Name¹⁰⁸	Organisation	Stakeholder Title / Position
	WMHHS	Registered Nurse, Brisbane Correctional Centre
	WMHHS	Dentist, WMHHS (in-reach to BTCC)
	MNHHS	Deputy Director Medical Services
	MNHHS	Nursing and Midwifery Director
	CHHHS	Director of Nursing and Facility Manager, Mareeba Hospital and Lotus Glen Health Service
	GCHHS	Clinical Nurse, Numinbah Correctional Centre
	QCS	Correctional Supervisor, Maryborough Correctional Centre
	Health Consumers Queensland	Engagement Consultant
	Office of the Chief Inspector	
	Sisters Inside	Policy Officer
	Queensland Law Society	Principal Policy Solicitor
	Other	Office of the Chief Nursing and Midwifery Officer
	WMHHS	Dental Assistant, WMHHS (in-reach to BTCC)
	QCS	Manager, Helana Jones Centre
	WMHHS	Director of Operations/Nursing Director
	THHS	Nurse Unit Manager, Townsville Correctional Precinct
	QCS	General Manager, Brisbane Women's Correctional Centre
	Office of the Health Ombudsman	Executive Director
	WMHHS	A/Service Development and Performance Manager, Mental Health and Specialised Services
	Justice Health & Forensic Mental Health Network	Chief Executive
	WMHHS	Health Service Chief Executive

CCC EXHIBIT

Stakeholder Name ¹⁰⁸	Organisation	Stakeholder Title / Position
	WMHHS	Executive Director, Mental Health and Specialised Services
	Department of Health	Director, Clinical Forensic Medicine Unit, Health Support Queensland
	Department of Health	Director, Forensic Mental Health Services
	QCS	Deputy General Manager, Woodford Correctional Centre
	WMHHS	Nurse Practitioner, Wolston Correctional Centre
	QNMU	QNMU Officer
	Office of the Health Ombudsman	Director, Assessment and Intake
	CQHHS	Director of Nursing
	CHHHS	Executive Director, Rural and Remote Services
	WMHHS	Administration Officer, Brisbane Correctional Centre
	QCS	General Manager, Strategy and Governance
	WMHHS	Nurse Unit Manager, Borallon Training and Correctional Centre
	Arthur Gorrie Correctional Centre	General Manager
	CHHHS	Nurse Unit Manager, Lotus Glen Correctional Centre
	WMHHS	Primary Mental Health Clinical Nurse Consultant, BTCC
	Arthur Gorrie Correctional Centre	Health Services Manager, Arthur Gorrie Correctional Centre
	WMHHS	Registered Nurse, Borallon Training and Correctional Centre
	MNHHS	Clinical Nurse Consultant, Woodford Correctional Centre
	THHS	Health Service Chief Executive
	Sisters Inside	Chief Executive Officer

Stakeholder Name¹⁰⁸	Organisation	Stakeholder Title / Position
	CQHHS	Executive Director, Rural & District Wide Services
	CQHHS	Clinical Nurse, Capricornia Correctional Centre
	Queensland Law Society	Senior Policy Solicitor
	WMHHS	Clinical Nurse, Borallon Training and Correctional Centre
	QCS	Deputy General Manager, Capricornia Correctional Centre
	QCS	General Manager, Lotus Glen Correctional Centre
	QCS	General Manager, Capricornia Correctional Centre
	QCS	Centre Supervisor, Numinbah Correctional Centre
	Healthcare Australia	Registered Nurse, Helana Jones Centre
	Office of the Public Guardian	Director, Legal Services/Investigations, Office of the Public Guardian
	WMHHS	Registered Nurse, Brisbane Correctional Centre
	MSHHS	Nurse Unit Manager, PAH Secure Unit
	Department of Health	Chief Nursing and Midwifery Officer
	GCHHS	Registered Nurse, Numinbah Correctional Centre
	THHS	Midwifery/Nursing Director, Health and Wellbeing Service Group
	QCS	Deputy General Manager, Maryborough Correctional Centre
	CHHHS	CNC, Lotus Glen Correctional Centre
	MNHHS	Program Coordinator, Prison Mental Health
	MNHHS	Nurse Unit Manager, Woodford Correctional Centre
	MNHHS	Visiting Medical Officer, Woodford Correctional Centre
	Queensland Audit Office	Senior Performance Auditor
	Justice Health Victoria	Director Health Services and Clinical Governance
	WMHHS	Nurse Unit Manager, Wolston Correctional Centre

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Stakeholder Name ¹⁰⁸	Organisation	Stakeholder Title / Position
	Other	Chief Psychiatrist, PMH
	Southern Queensland Correctional Centre	
	Southern Queensland Correctional Centre	
	WMHHS and QNMU	Registered Nurse, Brisbane Correctional Centre and QNMU Member
	WBHHS	Director of Nursing, WBHHS
	QCS	A/g Deputy Commissioner State-wide Operations
	QNMU	Professional Officer - Team Leader
	QCS	Acting General Manager, Wolston Correctional Centre
	MSHHS	Director of Nursing, MSHHS
	WMHHS	Registered Nurse, Borallon Training and Correctional Centre
	MNHHS	Acting Director of Nursing, Metro North HHS
	Department of Health, Health Purchasing, Funding and Performance Division	Deputy Director-General
	THHS	Nurse Unit Manager, Townsville Correctional Precinct
	Office of the Health Ombudsman	Senior Investigations Officer
	Queensland Audit Office	Director, Performance Audit
	QNMU	Director, Organising & Professional Services
	Department of Health, Clinical Excellence Division	Deputy Director-General
	Southern Queensland Correctional Centre	Director, Southern Queensland Correctional Centre
	ATSILS	Senior Prisoner Through Care Officer
	MSHHS	Nurse Unit Manager, Palen Creek Correctional

Stakeholder Name ¹⁰⁸	Organisation	Stakeholder Title / Position
		Centre
	CQHHS	Nurse Unit Manager, Capricornia Correctional Centre
	WMHHS	Nurse Practitioner, Brisbane Women's Correctional Centre
	WMHHS	Clinical Director, Prison Health Service
	CQHHS	Health Service Chief Executive
	Department of Health	Chief Health Officer

CCC EXHIBIT

